



Notice of Request for Proposal

SOLICITATION # YH18-0001

Arizona Long Term Care System (ALTCS) Elderly & Physical Disability (E/PD) Program Contract for Contractors

SECTION A: SOLICITATION PAGE

Chief Procurement Officer

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Issue Date: November 1, 2016

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION (AHCCCS)**
Procurement Office (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **ARIZONA LONG TERM CARE SYSTEM (ALTCS) ELDERLY & PHYSICAL DISABILITY (E/PD) PROGRAM CONTRACT FOR CONTRACTORS**

PROPOSAL DUE DATE: **January 23, 2017** **AT 3:00 P.M. ARIZONA TIME**

Pre-Proposal Conference: A Pre-Proposal Prospective Offerors' Conference has been scheduled for Tuesday, November 8, 2016 starting at 9:00A.M. Arizona Time. The Conference will be held in the following location:

**AHCCCS
Gold Room, Third Floor
701 E. Jefferson Street
Phoenix, AZ 85034**

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE PROCUREMENT OFFICER NAMED ABOVE, IN WRITING, VIA E-MAIL, AS SPECIFIED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE RFP YH18-0001 QUESTIONS AND RESPONSE TEMPLATE LOCATED IN THE BIDDERS' LIBRARY. ANSWERS TO QUESTIONS WILL BE POSTED IN THE AHCCCS WEBSITE IN THE FORM OF A SOLICITATION AMENDMENT FOR THE BENEFIT OF ALL POTENTIAL OFFERORS.

In accordance with A.R.S. §36-2906, which is incorporated herein by reference, competitive sealed Proposals will be received at the above specified location, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read.

Proposals must be in the actual possession of AHCCCS on or prior to the time and date and at the location indicated above.

Late Proposals shall not be considered.

Proposals must be submitted in a sealed envelope or package with the Solicitation Number and the Offeror's name and address clearly indicated on the envelope or package. All Proposals must be typewritten. Additional instructions for preparing a Proposal are included in this solicitation document.

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the person named above. Requests should be made as early as possible to allow time to arrange the accommodation.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and final Proposal revisions (if any). Signature also certifies Small Business Status.

Arizona Transaction (Sales) Privilege Tax License No.:

For clarification of this offer, contact:

Federal Employer Identification No.:

Name: _____

Title: _____

E-Mail Address: _____

Phone: _____

Company Name

Signature of Person Authorized to Sign Offer

Address

Printed Name

City State Zip

Title

CERTIFICATION

By signature in the Offer section above, the Offeror certifies:

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-09 or A.R.S. §§ 41-1461 through 1465.
3. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. The Offeror certifies that the above referenced organization _____ is / _____ is **not** a small business with less than 100 employees or has gross revenues of \$4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits, amendments and final Proposal revisions (if any), contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached Contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS. The Contractor is cautioned not to commence any billable work or to provide any material or service under this Contract until Contractor receives written notice to proceed.

This Contract shall henceforth be referred to as Contract No. YH18-0001.

Award Date: _____

MEGGAN HARLEY, AHCCCS Chief Procurement Officer

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SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS

The Contractor shall provide services as described in this Contract. This section will be amended to include capitation rates awarded to the Successful Offeror and Contractor-specific requirements.

SECTION C: DEFINITIONS**PART 1. DEFINITIONS PERTAINING TO ALL AHCCCS CONTRACTS**

The definitions specified in Part 1 below refer to terms found in all AHCCCS Contracts. The definitions specified in Part 2 below refer to terms that exist in one or more Contracts but do not appear in all Contracts.

638 TRIBAL FACILITY	A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facility, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.
ACUTE CARE CONTRACTOR	A contracted managed care organization (also known as a health plan) that provides acute care physical health services to AHCCCS members in the acute care program who are Title XIX or Title XXI eligible. The Acute Care Contractor is also responsible for providing behavioral health services for its enrolled members who are treated by a Primary Care Provider (PCP) for anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). Acute Care Contractors are also responsible for providing behavioral health services for dual eligible adult members with General Mental Health and/or Substance Abuse (GMH/SA) needs.
ACUTE CARE SERVICES	Medically necessary services that are covered for AHCCCS members and which are provided through contractual agreements with managed Care Contractors or on a Fee-For-Service (FFS) basis through AHCCCS.
ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.
ADMINISTRATIVE SERVICES SUBCONTRACTS	<p>An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:</p> <ol style="list-style-type: none">1. Claims processing, including pharmacy claims,2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization),3. Management Service Agreements,4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,5. DDD acute care subcontractors. <p>Providers are not Administrative Services Subcontractors.</p>
ADULT	A person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.

AGENT	Any person who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.
AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS MEMBER	See "MEMBER."
AHCCCS RULES	See "ARIZONA ADMINISTRATIVE CODE."
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.
AMERICAN INDIAN HEALTH PROGRAM (AIHP)	An acute care Fee-For-Service program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider. AIHP was formerly known as AHCCCS IHS.
AMERICANS with DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as "Rules." AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The State agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona’s Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
BALANCED BUDGET ACT (BBA)	See “MEDICAID MANAGED CARE REGULATIONS.”
BEHAVIORAL HEALTH (BH)	Mental health and substance use collectively.
BEHAVIORAL HEALTH DISORDER	Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders (DSM) excluding those diagnoses such as mental retardation, learning disorders and dementia, which are not typically responsive to mental health or substance abuse treatment.
BEHAVIORAL HEALTH PROFESSIONAL	As specified in A.A.C. R9-10-101, an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to: <ol style="list-style-type: none"> 1. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; or 2. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101.; 3. A psychiatrist as defined in A.R.S. §36-501; 4. A psychologist as defined in A.R.S. §32-2061; 5. A physician; 6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or 7. A behavior analyst as defined in A.R.S. §32-2091; or 8. A registered nurse.
BEHAVIORAL HEALTH SERVICES	Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue. See also “COVERED SERVICES.”
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.

BORDER COMMUNITIES	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children’s Health Insurance Program.
CHILD	A person under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.
CHILD AND FAMILY TEAM (CFT)	A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)	Children under age 19 who are blind, children with disabilities, and related populations (eligible for SSI under Title XVI). Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett); in foster care or other out-of-home placement; receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS).
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.
CLIENT INFORMATION SYSTEM (CIS)	The centralized processing system for files from each TRBHA/RBHA to AHCCCS as well as an informational repository for a variety of BH related reporting. The CIS system includes Member Enrollment and Eligibility, Encounter processing data, Demographics and SMI determination processes.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
CONTRACT SERVICES	See "COVERED SERVICES."
CONTRACTOR	An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, A.R.S. §36-2940, or A.R.S. §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
CONVICTED	A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.
CORRECTIVE ACTION PLAN (CAP)	A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/ tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.

COVERED SERVICES	The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements or the Scope of Work Section.
CREDENTIALING	The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.
DAY	A day means a calendar day unless otherwise specified.
DAY – BUSINESS/WORKING	A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.
DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)	The State agency that formerly had the duties set forth by the legislature to provide BH services within Arizona.
DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with a developmental/intellectual disability.
DISENROLLMENT	The discontinuance of a member’s eligibility to receive covered services through a Contractor.
DIVISION OF HEALTH CARE MANAGEMENT (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home.
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)	A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively

utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

**EMERGENCY MEDICAL
CONDITION**

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

**EMERGENCY MEDICAL
SERVICE**

Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

ENCOUNTER

A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

ENROLLEE

A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.2].

ENROLLMENT

The process by which an eligible person becomes a member of a Contractor's plan.

EQUITY PARTNERS

The sponsoring organizations or parent companies of the managed care organization that share in the returns generated by the organization, both profits and liabilities.

EVIDENCE-BASED PRACTICE

An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of care health professionals; and the unique needs, concerns and preferences of the person receiving services.

EXHIBITS	All items attached as part of the solicitation.
FEDERAL FINANCIAL PARTICIPATION (FFP)	FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FEE-FOR-SERVICE (FFS)	A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.
FEE-FOR-SERVICE MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
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.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.
GRIEVANCE AND APPEAL SYSTEM	A system that includes a process for member grievances and appeals including SMI grievances and appeals, provider claim disputes. The Grievance and Appeal system provides access to the State fair hearing process.
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.
HEALTH PLAN	See "CONTRACTOR."
INCURRED BUT NOT REPORTED (IBNR)	Liability for services rendered for which claims have not been received.

INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)	See "SERVICE PLAN"
INDIAN HEALTH SERVICES (IHS)	The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as outlined in 25 U.S.C. 1661.
INFORMATION SYSTEMS	The component of the Offeror's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
INTERGOVERNMENTAL AGREEMENT (IGA)	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).
LIABLE PARTY	An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in A.A.C. R9-22-1001.
LIEN	A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MAJOR UPGRADE	Any systems upgrade or change to a major business component that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.

MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
MATERIAL CHANGE TO BUSINESS OPERATIONS	Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency [42 CFR 455.101].
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.
MEDICAID MANAGED CARE REGULATIONS	The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICAL RECORDS	A chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the provider's physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.

MEDICALLY NECESSARY	As defined in 9 A.A.C. 22 Article 101. Medically necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.
MEMBER INFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.
OFFEROR	An organization or other entity that submits a Proposal to AHCCCS in response to a Request For Proposal as defined in 9 A.A.C. 22 Article 1 and 9 A.A.C. 28 Article 1.
PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.
PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
PERFORMANCE STANDARDS	A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors.

POSTSTABILIZATION CARE SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438.114(a)].
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 and §36-2944.01 for all payments made to Contractors for the Contract Year.
PRIMARY CARE PROVIDER (PCP)	An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.
PRIMARY PREVENTION	The focus on methods to reduce, control, eliminate and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.
PRIOR AUTHORIZATION	Prior authorization is a process used to determine, in advance of provision of services, whether or not a prescribed procedure, service, or medication will be covered.
PRIOR PERIOD	See "PRIOR PERIOD COVERAGE."

PRIOR PERIOD COVERAGE (PPC)	<p>The period of time prior to the member’s enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis. HPE does not apply to ALTCS members. The time period for prior period coverage does not include the time period for prior quarter coverage.</p>
PRIOR QUARTER COVERAGE	<p>The period of time prior to an individual’s month of application for AHCCCS coverage, during which a member may be eligible for covered services. Prior Quarter Coverage is limited to the three month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant:</p> <ol style="list-style-type: none">1. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and2. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made. Refer to A.A.C. R9-22-303 <p>AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.</p>
PROGRAM CONTRACTOR	See “CONTRACTOR”
PROVIDER	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.
PROVIDER GROUP	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

PRUDENT LAYPERSON (for purposes of determining whether an emergency medical condition exists)	A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)	A person determined eligible under A.A.C. R9-29-101 et seq. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.
REFERRAL	A verbal, written, telephonic, electronic or in-person request for health services.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	A Managed Care Organization that has a Contract with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the managed care organization. Additionally the Managed Care Organization shall coordinate the delivery of comprehensive physical health services to all eligible persons with a serious mental illness enrolled by the administration to the managed care organization.
REINSURANCE	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Offeror 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.
REQUEST FOR PROPOSAL (RFP)	A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a Proposal under 9 A.A.C. 22 Article 6 and 9 A.A.C. 28 Article 6.

ROOM AND BOARD (or ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.
SCOPE OF SERVICES	See "COVERED SERVICES."
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract.
SERVICE PLAN	A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
SPECIAL HEALTH CARE NEEDS	Serious or chronic physical, developmental and/or behavioral health conditions. Members with special health care needs require medically necessary services of a type or amount beyond that generally required by members.
SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
STATE	The State of Arizona.
STATEWIDE	Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE PLAN	The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.

SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract, as defined in 9 A.A.C. 22 Article 1.
SUBCONTRACTOR	<ol style="list-style-type: none">1. A provider of health care who agrees to furnish covered services to members.2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUBSIDIARY	An entity owned or controlled by the Contractor.
SUBSTANCE USE DISORDERS	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY (TPL)	See "LIABLE PARTY."
TITLE XIX	Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which includes those populations described in 42 U.S.C. 1396 a(a)(10)(A).

TITLE XIX MEMBER

Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults \leq 106%), Adult Group above 106% Federal Poverty Level (Adults $>$ 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.

TREATMENT

A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue. Refer to A.A.C. R9-10-101.

**TRIBAL REGIONAL
BEHAVIORAL HEALTH
AUTHORITY (TRBHA)**

A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407.

[END OF PART 1 DEFINITIONS]

PART 2. DEFINITIONS PERTAINING TO ONE OR MORE AHCCCS CONTRACTS

1931 (ALSO REFERRED TO AS TANF RELATED)	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL). See also "TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)."
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 and A.R.S. §13-3623.
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.
ACUTE CARE ONLY (ACO)	The enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who 1) refuses HCBS offered by the case manager; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Care Services cannot be provided; or 4) has equity value in a home that exceeds \$552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive LTC institutional, alternative residential or HCBS.
ADMINISTRATIVE OFFICE OF THE COURTS (AOC)	The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.
ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)	Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).
ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS <=/ 106%)	Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.

AID FOR FAMILIES WITH DEPENDENT CHILDREN (AFDC)	See "TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)."
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member is enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a person to change Contractors every 12 months.
ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)	<p>The department established pursuant to A.R.S. §8-451 to protect children and to perform the following:</p> <ol style="list-style-type: none"> 1. Investigate reports of abuse and neglect. 2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect. 3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations. 4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.
ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.
BED HOLD	A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and therapeutic leave. Refer to the Arizona Medicaid State Plan, 42 CFR 447.40 and 42 CFR 483.12, 9 A.A.C. 28 and AMPM Chapter 100.
BEHAVIORAL HEALTH PARAPROFESSIONAL	<p>As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:</p> <ol style="list-style-type: none"> 1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and 2. Are provided under supervision by a behavioral health professional.

BEHAVIORAL HEALTH RESIDENTIAL FACILITY	As specified in A.A.C. R9-10-101, health care institution that provides treatment to an individual experiencing a behavioral health issue that: <ol style="list-style-type: none"> 1. Limits the individual's ability to be independent, or 2. Causes the individual to require treatment to maintain or enhance independence.
BEHAVIORAL HEALTH TECHNICIAN	As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that: <ol style="list-style-type: none"> 1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and 2. Are provided with clinical oversight by a behavioral health professional.
BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.
CARE MANAGEMENT PROGRAM (CMP)	Activities to identify the top tier of high need/high cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care management is an administrative function performed by the health plan. Distinct from case management, Care Managers should not perform the day-to-day duties of service delivery.
CARE MANAGEMENT	A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.
CASE MANAGEMENT	A collaborative process which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
CASH MANAGEMENT IMPROVEMENT ACT (CMIA)	Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.

CHILDREN’S REHABILITATIVE SERVICES (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 22.
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS’ data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors.
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.
COMPETITIVE BID PROCESS	A State procurement system used to select Contractors to provide covered services on a geographic basis.
COUNTY OF FISCAL RESPONSIBILITY	The county of fiscal responsibility is the Arizona county that is responsible for paying the State's funding match for the member’s ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
CRS-ELIGIBLE	An individual AHCCCS member who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS-related services as specified in 9 A.A.C. 22.
CRS RECIPIENT	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS related covered Services.
DEVELOPMENTAL DISABILITY (DD)	<p>As defined in A.R.S. §36-551, a strongly demonstrated potential that a child under six years of age has a developmental disability or will become a child with a developmental disability, as determined by a test performed pursuant to section 36-694 or by other appropriate tests, or a severe, chronic disability that:</p> <ol style="list-style-type: none">1. Is attributable to cognitive disability, cerebral palsy, epilepsy or autism.2. Is manifested before age eighteen.3. Is likely to continue indefinitely.4. Results in substantial functional limitations in three or more of the following areas of major life activity:<ol style="list-style-type: none">a. Self-care.b. Receptive and expressive language.c. Learning.d. Mobility.e. Self-direction.f. Capacity for independent living.

	<p>g. Economic self-sufficiency.</p> <p>5. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.</p>
EPISODE OF CARE	The period between the beginning of treatment and the ending of covered services for an individual. The beginning and end of an episode of care is marked with a demographic file submission. Over time, an individual may have multiple episodes of care.
FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member.
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may also include siblings, grandparents, aunts and uncles.
FEDERAL EMERGENCY SERVICES (FES)	A program delineated in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of "health center" under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.
FIELD CLINIC	A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.
FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.

GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMH/SA)	Behavioral health services provided to adult members age 18 and older who have not been determined to have a serious mental illness.
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 defined in A.A.C. R9-28-101.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.
INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF)	A placement setting for persons with intellectual disabilities.
JUVENILE PROBATION OFFICE (JPO)	An officer within the Arizona Department of Juvenile Corrections assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile's who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program. (A.R.S. §8-353)
KIDSCARE	Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).
MEDICAL PRACTITIONER	A physician, physician assistant or registered nurse practitioner.

MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
PERSON WITH A DEVELOPMENTAL/ INTELLECTUAL DISABILITY	An individual who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). Services for AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.
RATE CODE	Eligibility classification for capitation payment purposes.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.
RURAL HEALTH CLINIC (RHC)	A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.
SERIOUS MENTAL ILLNESS (SMI)	A condition as defined in A.R.S. §36-550 and determined in a person 18 years of age or older.
SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA)	Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.
SMI ELIGIBILITY DETERMINATION	The process, after assessment and submission of required documentation to determine, whether a member meets the criteria for Serious Mental Illness.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.
SUBSTANCE ABUSE	As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that: <ol style="list-style-type: none"> 1. Alters the individual's behavior or mental functioning; 2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and 3. Impairs, reduces, or destroys the individual's social or economic functioning.
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).
TITLE XXI	Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "Children's Health Insurance Program" (CHIP). The Arizona version of CHIP is referred to as "KidsCare."
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.
VIRTUAL CLINICS	Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

[END OF PART 2 DEFINITIONS]

[END OF SECTION C: DEFINITIONS]

SECTION D: PROGRAM REQUIREMENTS**1. PURPOSE, APPLICABILITY, AND INTRODUCTION*****PURPOSE AND APPLICABILITY***

The purpose of the Contract between AHCCCS and the Contractor is to implement and operate the Arizona Long Term Care System (ALTCS) Program for individuals who are Elderly and/or have a Physical Disability (EPD) pursuant to A.R.S. §36-2931 et seq.

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

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

INTRODUCTION**AHCCCS' Mission and Vision**

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

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

The ALTCS Program

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

The ALTCS population is 58,654 as of October 1, 2016. Approximately 50% of members in the ALTCS Program are individuals who are elderly and/or who have physical disabilities.

ALTCS Guiding Principles**◆ *Member-Centered Case Management***

The member is the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of long term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goals(s) for achieving or maintaining his/her highest level of self-sufficiency. Education and up-to-date information about the ALTCS program, choices of options and mix of services must be readily available to members.

- ◆ *Member-Directed Options*
To the maximum extent possible, members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making decisions about how best to have needs met including who will provide the service and when and how the services will be provided.
- ◆ *Person-Centered Planning*
The Person-Centered Planning process maximizes member-direction and supports the member to make informed decisions, so that he/she can lead/participate in the Person-Centered Planning process to the fullest extent possible. The Person-Centered Plan safeguards against unjustified restrictions of member rights, and ensures that members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible. The Plan ensures responsiveness to the member's needs and choices regarding service delivery and personal goals and preferences. The member and family/representative shall have immediate access to the member's Person-Centered Plan.
- ◆ *Consistency of Services*
Development of network accessibility and availability serve to ensure delivery, quality and continuity of services in accordance with the Person-Centered Plan as agreed to by the member and the Contractor.
- ◆ *Accessibility of Network*
Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for aging members and members with disabilities, cultural preferences, and individual health care needs. Services are available to the same degree as services for individuals not eligible for AHCCCS.
- ◆ *Most Integrated Setting*
Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.
- ◆ *Collaboration with Stakeholders*
Ongoing collaboration with members/families, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

2. ELIGIBILITY

Financial Eligibility: Anyone may apply for ALTCS E/PD at any of the ALTCS eligibility offices located throughout the State. The applicant must be an Arizona resident as well as a U.S. citizen or qualified legal immigrant as defined in A.R.S. §36-2903.03. To qualify financially for the ALTCS E/PD Program applicants must have countable income and resources below certain thresholds. Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance provides a detailed discussion of all eligibility criteria. The Manual is available on the AHCCCS website.

Medical Eligibility: In addition to financial eligibility an individual must meet the medical and functional eligibility criteria as established by the Preadmission Screening tool (PAS). The PAS is conducted by an AHCCCS registered nurse or social worker with consultation by a physician, if necessary, to evaluate the person's medical status. The PAS is used to determine whether the person is at immediate risk of placement in a nursing facility. In most cases, AHCCCS does not re-evaluate the medical status of each ALTCS E/PD member annually; however, the Contractor is responsible for notifying AHCCCS of significant changes in a member's condition, which may result in a change in eligibility. See Section D, Paragraph 15, ALTCS Transitional Program and Section D, Paragraph 18, Reporting Changes in Members' Circumstances.

3. ENROLLMENT AND DISENROLLMENT

AHCCCS has the exclusive authority to enroll and disenroll members. AHCCCS does not use passive enrollment procedures [42 CFR 438.54(d)]. AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions.¹

The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS [42 CFR 438.56(b)(3)].

The Contractor may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs [42 CFR 438.56(b)(2)]. For disenrollment requests for medical continuity, the Contractor shall follow the procedures outlined in ACOM Policy 403 [42 CFR 438.56(d)(2)(ii, iii, iv)].

An AHCCCS member may request disenrollment from the Contractor for cause at any time. Cause includes: poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in addressing the member's care needs [42 CFR 438.56(d)(2)(v)]. When a member requests disenrollment for cause, the member must use the Contractor's Grievance and Appeal System process for the request and the Contractor shall issue a decision no later than 30 days from the date of the request. If as a result of the grievance process, the Contractor approves the disenrollment, AHCCCS is not required to make a determination [42 CFR 438.56(d)(5)(iii)]. If the Contractor approves a request for disenrollment, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member or Contractor files the request [42 CFR 438.56(e)(1)]. If, as a result of the grievance process, the Contractor denies the request for disenrollment, the Contractor shall notify members of their right to request a State Fair Hearing no later than 30 days from the date of the adverse determination.

The Contractor shall notify AHCCCS Division of Member Services of disenrollment approvals.

AHCCCS will disenroll the member from the Contractor when:

1. The member becomes ineligible for the AHCCCS program,
2. In certain situations when the member moves out of the Contractor's service area,
3. The member changes Contractors during the member's open enrollment and annual enrollment choice period,

4. The Contractor does not, because of moral or religious objections, cover the service the member seeks, or
5. The member is approved for a Contractor change through ACOM Policy 403.

ALTCS Eligibility Determinations During Hospitalization: During an individual's acute hospitalization, AHCCCS will process an application for ALTCS eligibility. Enrollment of an applicant who is determined eligible will be effective during the hospital stay.

Prior Quarter Coverage: Pursuant to Federal Regulation 42 CFR 435.915, AHCCCS offers Prior Quarter Coverage eligibility which expands the time period during which AHCCCS pays for covered services for eligible individuals to include services provided during any of the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during that month. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter. Upon verification or notification of Prior Quarter Coverage eligibility, providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period.

Prior Period Coverage: AHCCCS provides prior period coverage for the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services. Prior Period Coverage refers to the timeframe from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. The Contractor receives notification from AHCCCS of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services provided to members during prior period coverage. This may include services provided prior to the Contract year and in a Geographic Service Area where the Contractor was not contracted at the time of service delivery.

The Contractor is liable for costs for covered services provided during the prior period as described in Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance.

Provider Refund Payments: Nursing facilities must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

Unless the Contractor's provider contracts state otherwise, all other providers, including in-home care and Alternative HCBS Setting providers, are not required to refund any payment received from a member (applicant) or family member (in excess of share of cost and/or room and board) for the period of time from the effective date of Medicaid eligibility until the Medicaid enrollment date.

Disenrollment to Acute Care Program: When a member becomes ineligible for ALTCS E/PD but remains eligible for the Acute Care Program, the member must choose an Acute Care Contractor. In such cases, the Contractor shall obtain the member's choice of Acute Care Contractor and submit that choice to AHCCCS. When the reason for termination is due to a voluntary withdrawal from the member (obtained by the case manager) or the member fails the Pre-Admission Screening (PAS), obtaining the member's choice of Acute Care Contractor is part of transition planning. See ACOM Policy 403 and AMPM Policy 520.

4. ANNUAL AND OPEN ENROLLMENT CHOICE

Annual Enrollment Choice: AHCCCS conducts an Annual Enrollment Choice (AEC) in Geographic Service Areas (GSAs) with multiple Contractors for members on their annual anniversary date [42 CFR 438.56(c)(2)(ii)]. During AEC, members may change Contractors subject to the availability of other Contractors within their GSA. Members are notified as required by the Medicaid Managed Care Regulations, 60 days prior to their AEC date. Members may choose a new Contractor by contacting AHCCCS to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made (except for approved changes under ACOM Policy 403). The Contractor shall comply with ACOM Policy 402, ACOM Policy 403, and AMPM Policy 1620.

Open Enrollment: AHCCCS may hold an open enrollment in any GSA as deemed necessary. In the event AHCCCS adds a Contractor to a GSA where choice of Contractor is currently unavailable, members currently enrolled in that GSA may be provided an open enrollment period to choose a Contractor. Members who do not elect to change Contractors will remain with the Contractor of enrollment.

5. ENROLLMENT HIERARCHY

When multiple Contractors are available in an ALTCS member's GSA, that member will have the opportunity to choose which Contractor they will be enrolled with to receive ALTCS services.

New Members: ALTCS E/PD applicants residing in a GSA with multiple Contractors are permitted to select a Contractor of their choice at the time of their initial enrollment into the program. When an ALTCS application is received in an ALTCS eligibility office, required materials in 42 CFR 438.10(e) for enrollment choice will be sent to the applicant's home with an appointment notice for an interview. During the application process, the applicant and/or the applicant's authorized representative will be provided with informational material required by 42 CFR 438.10(e) from each available Contractor to assist them in making a choice. AHCCCS will assist the member to select the most appropriate Contractor using criteria such as the member's current place of residence, current primary care provider, and other factors identified by the member. If a Contractor is not selected, AHCCCS determines the Contractor using the auto-assignment algorithm described below.

Auto-Assignment Algorithm: If the member does not exercise enrollment choice and AHCCCS is not able to make an enrollment determination using the process referenced above, an auto-assignment algorithm will be utilized to systematically select a Contractor for the member. The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals.

Central Geographic Service Area: Members will be auto-assigned equally (33%) among the three Contractors. The extra percentage point will be assigned to the Contractor with the highest overall score on the RFP.

Pima County: Members will be auto-assigned equally between the two Contractors.

AHCCCS may change the algorithm at any time during the term of this Contract. AHCCCS is not obligated to adjust the algorithm for any financial impact this may have on a Contractor.

6. PLAN CHANGES

In Geographic Service Areas where the member has a choice of Contractors, the member may change Contractors in accordance with ACOM Policy 403.

Members may submit Contractor change requests to the Contractor or AHCCCS. A denial of any Contractor change request shall include the Contractor's reason for not approving the change and options for resolution. The notice shall advise the member of the AHCCCS and Contractor's grievance policies and timeframes for filing a grievance. The notice shall also advise the member of his/her right to request a hearing, including how to request a hearing and the timeframe for making the request.

7. COUNTY OF FISCAL RESPONSIBILITY

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

If a member is placed out of the current Contractor's service area, the current Contractor may request a Contractor change in accordance with ACOM Policy 403. The Contractor shall cooperate in all transition activities as required in ACOM Policy 402 and ACOM Policy 403.

A Contractor Change Request Form (DE-621) is not required when a member moves from the Contractor's service area to receive home and community based services in their home outside the current Contractor's service area; however, the Contractor shall report the change in address to the ALTCS local office within five days of becoming aware of the change in address. For more detailed information, refer to A.A.C. R9-28 Article 7 and ACOM Policy 403 and AMPM Policy 1620, Exhibit 1620-8.

8. ACCOMODATING AHCCCS MEMBERS

The Contractor shall ensure that members are provided covered services without regard to race, color, national origin, sex, sexual orientation, gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, age or disability [42 CFR 438.3(d)] [45 CFR Part 92].

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

1. Denying or not providing a member any covered service or access to an available facility,
2. 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,

3. 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, and
4. Assigning times or places for the provision of services on the basis of the race, color, age, national origin, sexual orientation, gender identity, genetic information, income status, AHCCCS membership, or disability of the participants to be served.

The Contractor shall assure members the rights as delineated in 42 CFR 438.100.

The Contractor must ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the Contractor must provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills. The Contractor must provide accommodations to members and individuals with disabilities at no cost to afford such persons an equal opportunity to benefit from the covered services. [45 CFR 92.202 – 92.205]

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

If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, it shall promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures may place the Contractor in default of its Contract.

9. TRANSITION ACTIVITIES

Member Transition: The Contractor shall comply with the AMPM and the ACOM standards for member transitions to or from an AHCCCS Contractor. The Contractor shall develop and implement policies and procedures, which comply with AHCCCS policy to address transitions of ALTCS members.

The relinquishing Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special needs of transitioning members. The Contractor, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with Contractor and service information, emergency numbers and instructions on how to obtain services. See ACOM Policy 402, ACOM Policy 403 and AMPM Chapter 500. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

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

1. Members living in their own home who have significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, and ventilators,

2. Members who are receiving ongoing services such as daily in-home care, behavioral health, dialysis, home health, pharmacy prescriptions, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition,
3. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services,
4. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth,
5. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media, and
6. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement.

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. The individual appointed to this position must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee transition issues, responsibilities, and activities. The Transition Coordinator of the relinquishing Contractor shall interact closely with the Transition Coordinator and staff of the receiving Contractor to ensure a safe, timely, and orderly transition. See ACOM Policy 402 for more information regarding the role and responsibilities of the Transition Coordinator.

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

Transitioning Members Residing in Non-Contracted Facilities: When a member resides in an AHCCCS registered setting which does not hold a contract with the receiving Contractor at the time of member enrollment, and the Contractor is not willing or able to secure a contract, the receiving Contractor must give at least seven days advance written notice advising the member that he or she must move to a facility contracting with the receiving Contractor. The reasons for the transfer must be included in the notice to the member and/or the member's representative. Medical assistance to members who do not move to a contracting facility is limited to acute care services only. If a member's condition does not permit transfer to another facility, the Contractor shall compensate the registered non-contracting provider at the AHCCCS Fee-For-Service rate or at a rate negotiated with the provider, until the member can be transferred.

Contract Termination: In accordance with ACOM Policy 440, in the event the Contract or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members to other Contractors, and shall abide by standards and protocols as delineated by AHCCCS. In addition, AHCCCS reserves the right to extend the term of the Contract on a month-to-month basis to assist in any transition of members. AHCCCS may discontinue enrollment of new members with the Contractor three months prior to the contract termination date or as otherwise determined by AHCCCS. The Contractor shall make provisions for continuing all management and administrative services until the transition of all members is completed and all other requirements of this Contract are satisfied. The Contractor shall submit a detailed plan to AHCCCS for approval regarding the transition of members in the event of Contract expiration or

termination. The name and title of the Contractor's Transition Coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this Contract and necessary for the transition process and shall be responsible for the following:

1. Notifying of subcontractors and members.
2. Paying of all outstanding obligations for medical care rendered to members, until AHCCCS is satisfied that the Contractor has paid all such obligations. The Contractor shall provide a monthly claims-aging report including Incurred But Not Reported (IBNR) amounts due the 15th day of the month, for the prior month.
3. Providing Quarterly and Audited Financial Statements up to the date of contract termination. The financial statement requirement will not be absolved without an official release from AHCCCS.
4. Continuing encounter reporting until all services rendered prior to contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from AHCCCS.
5. Cooperating with reinsurance audit activities on prior Contract Years until release has been granted by AHCCCS.
6. Cooperating with AHCCCS to complete and finalize any open reconciliation until release has been granted by AHCCCS. AHCCCS will work to complete any pending reconciliations as timely as possible, allowing for appropriate lag time for claims run-out and/or changes to be entered into the system.
7. Submitting quarterly Quality Management and Medical Management reports as required by Section D, Paragraph 20, Quality Management and Performance Improvement, and Section D, Paragraph 21, Medical Management, as appropriate to provide AHCCCS with information on services rendered up to the date of contract termination. This will include quality of care (QOC) concern investigation and reporting based on the date of service.
8. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by AHCCCS.
9. Maintaining a Performance Bond as long as the Contractor has liabilities of \$50,000 or more outstanding or 15 months following the termination date of this Contract, whichever is later. At that time, a formal request to release the performance bond, as well as a balance sheet, must be submitted.
10. Indemnifying AHCCCS for any claim by any third party against the State or AHCCCS arising from the Contractor's performance of this Contract and for which the Contractor would otherwise be liable under this Contract.
11. Returning to AHCCCS any funds advanced to the Contractor for coverage of members for periods after the date of termination. Funds must be returned to AHCCCS within 30 days of termination of the Contract.
12. Providing a monthly accounting of Member Grievances and Claim Disputes and their disposition.
13. Preserving and making available records within the timeframes required by State and federal law, including but not limited to, 45 CFR 164.530(j)(2) and 42 CFR 438.3(u)].

The above list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met. Any dispute by the Contractor, with respect to termination or suspension of this Contract by AHCCCS, shall be exclusively governed by the provisions of Section E, Paragraph 19, Disputes.

10. SCOPE OF SERVICES

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

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

1. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)],
2. Any information the member needs in order to decide among all relevant treatment options,
3. The risks, benefits, and consequences of treatment or non-treatment, and
4. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(b)(2)(iv)].

Moral or Religious Objections

The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. If AHCCCS does not approve the Contractor's Proposal, AHCCCS will disenroll members who are seeking these services from the Contractor and assign members to another Contractor [42 CFR 438.56]. The Proposal must:

1. Be submitted to AHCCCS in writing prior to entering into a contract with AHCCCS or at least 60 days prior to the intended effective date of the change in the scope of services based on moral or religious grounds,
2. Place no financial or administrative burden on AHCCCS,
3. Place no significant burden on members' access to the services,
4. Be accepted by AHCCCS in writing, and
5. Acknowledge an adjustment to capitation, depending on the nature of the proposed solution.

If AHCCCS approves the Contractor's Proposal for its members to access the services, the Contractor must immediately develop a policy implementing the Proposal along with a notification to members of how to access these services. The notification and policy must be consistent with the provisions of 42 CFR 438.10 and shall be approved by AHCCCS prior to dissemination. The notification must be provided to newly assigned members within 12 days of enrollment, and must be provided to all current members at least 30 days prior to the effective date of the Proposal [42 CFR 438.102(a)(2)a].

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

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. (1903(i) final sentence and 1903(i)(16) of the Social Security Act.ⁱⁱ

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

Notice of Adverse Benefit Determination: The Contractor shall notify the requesting provider, and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.[42 CFR 438.400(b)] The notice must meet the requirements of 42 CFR.438.404, AHCCCS Rules and ACOM Policy 414. The notice to the provider must also be in writing as specified in Section F, Attachment F1, Member Grievance and Appeal System Standards [42 CFR 438.210(c)]. The Contractor must comply with all decision timelines outlined in ACOM Policy 414.

ACUTE CARE SERVICES

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

American Indians: American Indian members, title XIX and XXI, on- or off-reservation, eligible to receive services, may choose to receive services at any time from an American Indian Health Facility (I/T/U) - Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, Urban Indian Health Program) [ARRA Section 5006(d), and SMD letter 10-001].ⁱⁱⁱ The Contractor shall not impose enrollment fees, premiums, or similar charges on American Indians served by an American Indian Health Facility (I/T/U) - Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, Urban Indian Health Program) (ARRA Section 5006(d), SMD letter 10-001).^{iv}

American Indian Health Program (AIHP): AHCCCS Division of Fee-For-Service Management (DFSM) will reimburse claims for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided by an IHS or 638 tribal facility to Title XIX members enrolled with the Contractor and when the member is eligible to receive services at the IHS or 638 tribal facility.

Encounters for Title XIX services billed by an IHS or 638 tribal facility will not be accepted by AHCCCS or considered in capitation rate development.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and von Willebrand's disease. See Section D, Paragraph 53, Reinsurance.

Audiology: The Contractor shall provide medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids are covered only for members under the age of 21 receiving EPSDT services.

Children's Rehabilitative Services (CRS): Members shall receive treatment for one or more of the CRS qualifying medical conditions in A.A.C R9-28-203 through the Contractor.

Chiropractic Services: The Contractor shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. For Qualified Medicare Beneficiaries, regardless of age, Medicare approved chiropractic services shall be covered subject to limitations specified in 42 CFR 410.21.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illnesses discovered by the screenings for members under age 21. The Contractor shall ensure that these members receive required health screenings, including developmental and behavioral health screenings, in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule (AMPM Exhibit 430-1 and 430-1A), including appropriate oral health screening intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant or nurse practitioner.

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention: The Contractor shall provide health care services through screening, diagnosis and medically necessary treatment for members 21 years of age and older. These services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis and HIV/AIDS; breast cancer, cervical cancer and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in A.A.C. R9-28-202.

Emergency services: The Contractor shall provide emergency services per the following:

1. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by A.A.C. R9-28 Article 1. Emergency medical services are covered without prior authorization. The Contractor shall be responsible for educating members and providers

regarding appropriate utilization of emergency room services, including behavioral health emergencies. The Contractor shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this Contract, a prudent layperson is a person who possesses an average knowledge of health and medicine,

2. All medical services necessary to rule out an emergency condition, and
3. Emergency transportation.

Per the Medicaid Managed Care regulations, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency services:

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

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

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

Additionally, the Contractor may not:

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

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

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

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

Family Planning: The Contractor shall provide family planning services in accordance with the AMPM, and consistent with the terms of the Section 1115 Waiver Demonstration, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, are also included. If the Contractor does not provide family planning services due to moral and religious objections, it must contract for these services through another health care delivery system or have an approved alternative in place or AHCCCS will disenroll from the Contractor members who are seeking these services and assign the members to another Contractor.

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

Immunizations: The Contractor shall provide medically necessary immunizations for adults (21 years of age and older). Refer to the AMPM for current immunization requirements. The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 20, Quality Management and Performance Improvement.

Incontinence Briefs: In general, incontinence briefs (diapers) are not covered for members unless medically necessary to treat a medical condition. However, for AHCCCS members over three years of age and under 21 years of age incontinence briefs, including pull-ups and incontinence pads, are covered to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances. For members in the ALTCS Program who are 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads are also covered in order to prevent skin breakdown as outlined in AMPM Policy 310-P. See A.A.C. R9-28-202 and AMPM Chapters 300 and 400.

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 free standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory with Clinical Laboratory Improvement Act (CLIA) licensure or a Certificate of Waiver.

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

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

Maternity: The Contractor shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant. Members anticipated to have a low-risk delivery may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by certified nurse midwives or licensed midwives, if they are in the Contractor's provider network. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

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

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary HIV/AIDS testing and the availability of medical counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter to encourage pregnant women to be tested and instructions on where to be tested. The Contractor shall report to AHCCCS, Division of Health Care Management (DHCM), the number of pregnant women who have been identified as HIV/AIDS positive for each quarter during the Contract Year. This report is due as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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 as specified in the AMPM. The medical foods, including metabolic formula and modified low protein foods, must be prescribed or ordered under the supervision of a physician.

Medical Supplies, Durable Medical Equipment (DME), and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the AMPM. Prosthetic devices must be medically necessary and meet criteria as described in the AMPM. For persons age 21 and older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs. Medical equipment

may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

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

Oral Health: Members under the age of 21: The Contractor shall provide all members under the age of 21 with all medically necessary dental services including emergency dental services, dental screening, preventive services in accordance with the AHCCCS Dental Periodicity Schedule, as well as therapeutic dental services, therapeutic services and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor must develop processes to assign members to a dental home by one year of age and communicate that assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care as outlined in AMPM Policy 431. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 20, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified in writing when dental screenings are due, if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

Members 21 years of age and older: Pursuant to A.R.S. §36-2939, dental services, including dentures, are covered for persons 21 years of age or older in an amount of \$1,000.00 per member for each 12 month period beginning October 1 through September 30. The Contractor shall provide dental services to members according to the AMPM and shall develop systems to monitor utilization to assure appropriate Medicaid payments.

Orthotics: Orthotics are covered for AHCCCS members under the age of 21 as outlined in AMPM Policy 430. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply, see AMPM Policy 310-P:

1. The use of the orthotic is medically necessary as the preferred treatment option and consistent with Medicare guidelines,
2. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
3. The orthotic is ordered by a physician or primary care practitioner.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

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

Podiatry Services: Pursuant to A.R.S. §36-2907, podiatry services performed by a podiatrist licensed pursuant to A.R.S. Title 32, Chapter 7 are covered for members when ordered by a primary care physician or primary care practitioner.

Poststabilization Care Services: Pursuant to A.A.C. R9-28-202 and 42 CFR 438.114; 42 CFR 422.113(c); and 42 CFR 422.133, the following conditions apply with respect to coverage and payment of emergency and poststabilization care services, except where otherwise noted in Contract.

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

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

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

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

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

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This form must be submitted to the Contractor's Medical Director and meet the requirements specified in the AMPM. The Certificate must certify that, in the physician's professional judgment, the criteria have been met.

Prescription Medications: Medications ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, Contractor formularies and prior authorization requirements. An appropriate over the counter medication may be prescribed as defined in the AMPM when it is determined to be a lower-cost alternative to a prescription medication. The Contractor shall comply with AMPM Policy 310-V.

Pharmaceutical Rebates: The Contractor, including the Contractor's Pharmacy Benefit Manager (PBM), is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section.

If the Contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements. For pharmacy related encounter data information see Section D, Paragraph 68, Encounter Data Reporting.

Medicare Part D: The Medicare Modernization Act of 2003 (MMA) created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. AHCCCS does not cover prescription drugs that are covered under Part D for dual eligible members. AHCCCS will not cover prescription drugs for this population whether or not they are enrolled in Medicare Part D. AHCCCS covers federally reimbursable drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed by or under the direction of a licensed pharmacist, in accordance with Arizona State Board of Pharmacy Rules and Regulations, subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered Medicare excluded drugs and are not covered by AHCCCS. This applies to members who are enrolled in Medicare Part D or are eligible for Medicare Part D. See AMPM Policy 310-V.

340B Drug Pricing Program: All federally reimbursable drugs identified in the 340B Drug Pricing Program are required to be billed at the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price. The Contractor shall ensure that these drugs be reimbursed at the lesser of the two amounts above plus a professional (dispensing) fee. See Laws 2016, Second Regular Session, Chapter 122, A.R.S. §36-2930.03, and A.A.C. R9-22-710 (C) for further details. The 340B drug pricing program includes:

Eligible Organizations and Covered Entities	Effective Date
Drugs dispensed by FQHC/RHC and FQHC Look-Alike 340B pharmacies	Already implemented
Drugs dispensed by other 340B covered entities	Effective the later of January 1, 2017 or upon CMS approval
Drugs administered by 340B entity providers (including drugs administered by physicians)	To Be Determined during CYE 17
Drugs dispensed by licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital	Excluded from 340B reimbursement mandate at this time
Drugs administered by providers in licensed hospital and outpatient facilities that are owned or operated by a licensed hospital.	Excluded from 340B reimbursement mandate at this time

The Contractor is required to comply with any changes to reimbursement methodology for 340B entities.

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

Radiology and Medical Imaging: These services are covered when ordered by the member's PCP, attending physician or dentist and are provided for diagnosis, prevention, treatment or assessment of a medical condition.

Rehabilitation Therapy: The Contractor shall provide medically necessary 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. Outpatient Physical Therapy for members 21 years of age or older are subject to visit limits per Contract year as described in the AMPM.

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

Substance Abuse Transitional Facility: An agency that provides behavioral health services to an individual who is intoxicated or may have a substance abuse problem (A.A.C. R9-10-101).

Therapeutic Leave and Bed Hold Days: Therapeutic leave and bed hold days are covered. Refer to AMPM Chapter 100.

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM, for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation, donor search, organ/tissue harvesting or procurement, preparation and transplantation services, and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided within limitations after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 53, Reinsurance.

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 or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Treat and Refer: Interaction with an individual who has accessed 911 or a similar public emergency dispatch number, but whose illness or injury does not require ambulance transport to an emergency department based on the clinical information available at that time. The interaction must include:

1. Documentation of an appropriate clinical and/or social evaluation,
2. A treatment/referral plan for accessing social, behavioral, and/or healthcare services that address the patient's immediate needs, and
3. Evidence of efforts to follow-up with the patient to ascertain adherence with the treatment plan, and
4. Documentation of efforts to assess customer satisfaction with the treat and refer visit. Treat and Refer standing orders shall be consistent with medical necessity and consider patient preference when the clinical condition allows.

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

Vision Services/Ophthalmology/Optomety: The Contractor shall provide emergency eye care, and all medically necessary vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition. In addition cataract removal, and medically necessary vision examinations, prescriptive lenses and frames are covered if required following cataract removal. Refer to AMPM Policy 310-G.

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

Well Exams: Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program.

LONG TERM SERVICES AND SUPPORTS

A more detailed description of services can be found in A.A.C. R9-28 Article 2, and AMPM Chapter 1200.

Adult Day Health Services: A program that provides planned care, supervision and activities, personal care, personal living skills training, meals and health monitoring in a group setting during a portion of a continuous twenty-four hour period. Adult day health services may also include preventive, therapeutic and restorative health-related services that do not include behavioral health services (A.R.S. §36-401).

Attendant Care: A direct care service provided by a Direct Care Worker (See ACOM Policy 429 and AMPM Policy 1240-A for Direct Care Worker training requirements) for members who reside in their own homes and is a combination of services which may include homemaker services, personal care, coordination of services, general supervision and assistance, socialization and skills development. Attendant care services are not considered duplicative of hospice services.

Self-Directed Attendant Care (SDAC): A member-directed service delivery model option. The Direct Care Worker who provides these services is an employee, not of an agency, but of the member who hires, trains and supervises the caregiver. Members selecting SDAC may direct their Direct Care Worker to provide certain skilled services. See AMPM Chapters 1200, 1300 and 1600 for requirements pertaining to SDAC.

Spouses as Paid Caregivers: A service delivery model option where a member may choose to have attendant care services provided by his/her spouse. See AMPM Chapters 1200 and 1600 for requirements pertaining to Spouses as Paid Caregivers.

Agency with Choice: A member-directed service delivery model option. Members selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service delivery model option, the member or individual representative may recruit, select and dismiss paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Independent Contractor Model: A service delivery model option. The Direct Care Worker contracts with a provider agency and enters into an agreement with a member to provide services in accordance with the member's service plan. The provider agency is required to oversee compliance to the contract and monitor fidelity to the service plan.

Community Transitional Services: A service to assist members residing in an institutional setting to reintegrate the member into the community by providing financial assistance to move from an institutional setting to their own home or apartment. Members moving from an institutional setting to an Alternative HCBS Setting such as assisted living facilities or group homes are not eligible for this service. This service is limited to a one-time benefit per five years per member.

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.

End of Life Care: A service which encompasses all health care and support services provided at any age or stage of an illness. The goals of End of Life care focus on comfort and quality of life. Services include Advance Care Planning, palliative care, supportive care and hospice. Members who receive End of Life care can opt to receive curative care until they choose to receive hospice care.

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

Agency with Choice: A member-directed service delivery model option. Members selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service delivery model option, the member or individual representative may recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Independent Contractor Model: A service delivery model option. The Direct Care Worker contracts with a provider agency and enters into an agreement with a member to provide services in accordance with the member's service plan. The provider agency is required to oversee compliance to the contract and monitor fidelity to the service plan.

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

Home Health Services: This service includes nursing, therapies, supplies and home health aide services and shall be provided under the direction of a physician to prevent hospitalization or institutionalization. Home health services shall be provided on a part-time or intermittent basis. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless AHCCCS Provider Registration verifies compliance with the surety bond requirements specified in Sections 1861(o)(7) and 1903(i)(18) of the Social Security Act.^v

Homemaker: A direct care service in which assistance is provided for the performance of routine household activities such as shopping, cooking, and cleaning. (See ACOM Policy 429 and AMPM Chapter 1200 for Direct Care Worker training requirements)

Agency with Choice: A member-directed service delivery model option. Members selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service delivery option, the member or individual representative may recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Independent Contractor Model: A service delivery model option. The Direct Care Worker contracts with a provider agency and enters into an agreement with a member to provide services in accordance with the member's service plan. The provider agency is required to oversee compliance to the contract and monitor fidelity to the service plan.

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

Hospice: A service that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with the Contractor. Contractors are required to pay nursing facilities 100% of the class specific contracted rate when a member elects the hospice benefit. The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. ALTCS services which are duplicative of the services included in the hospice benefit shall not be provided. If, however, the hospice agency is unable to provide or cover medically necessary services the Contractor must provide the services. Attendant care services are not considered duplicative.

Personal Care: A direct care service that provides intermittent assistance with personal physical needs such as washing hair, bathing, and dressing. (See ACOM Policy 429 and AMPM Chapter 1200 for Direct Care Worker training requirements).

Agency with Choice: A member-directed service delivery model option for the delivery of Personal Care. Members selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service delivery model option, the member or individual representative may recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Independent Contractor Model: A service delivery model option. The Direct Care Worker contracts with a provider agency and enters into an agreement with a member to provide services in accordance with the member's service plan. The provider agency is required to oversee compliance to the contract and monitor fidelity to the service plan.

Private Duty Nursing: Nursing services for 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 member's primary care provider or physician of record. Contractors who contract with independent nurses to provide private duty nursing must develop oversight activities to monitor service delivery and quality of care.

Respite Care: A service that provides an interval of rest and/or relief to a family member or other person(s) caring for the member. It is available for up to 24-hours per day and is limited to 600 hours per benefit year. Refer to AMPM Policy 1240-B and AMPM Policy 1250-D.

Independent Contractor Model: A service delivery model option. The Direct Care Worker contracts with a provider agency and enters into an agreement with a member to provide services in accordance with the member's service plan. The provider agency is required to oversee compliance to the contract and monitor fidelity to the service plan.

Supported Employment: Short-term or ongoing supports to assist members in obtaining and/or maintaining employment. See *Individual Supported Employment* and *Group Supported Employment below*.

1. **Individual Supported Employment:** A service that provides job development, assistance in matching the member with an integrated, competitive job. The service may be provided on a time-limited or on an ongoing basis.
2. **Group Supported Employment:** A service that provides supports and training activities such as job-related discovery of assessment, training and systematic instruction, job coaching in an on-site, supervised work environment in a community employment setting. The service may be provided on a time-limited or on an ongoing basis.

INSTITUTIONAL SETTINGS

Institution for Mental Disease (IMD): A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Bureau of Medical Facilities Licensing licenses behavioral health inpatient facilities with more than 16 beds; which are considered IMDs.

Behavioral Health Inpatient Facility: A health care institution, as defined in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

1. Have a limited or reduced ability to meet the individual's basic physical needs,
2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality,
3. Be a danger to self,
4. Be a danger to others,
5. Be a person with a persistent or acute disability as defined in A.R.S. §36-501, or
6. Be a person with a grave disability as defined in A.R.S. §36-501.

Nursing Facility, including Religious Nonmedical Health Care Institutions: The Contractor shall provide nursing facility services for members. The nursing facility must be licensed and Medicare/Medicaid certified by ADHS in accordance with 42 CFR 483.75 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Religious Nonmedical Health Care Institutions are exempt from State licensing requirements.

ALTERNATIVE HCBS SETTINGS

Members may receive services in Alternative HCBS Settings as defined in 9 A.A.C. 28 Article 1. Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting. For the Alternative HCBS Settings described below, when room and board are included in the setting, members residing in these settings are responsible for the room and board payment.

Alternative HCBS Settings include the following:

Adult Developmental Home: An Alternative HCBS Setting for adults (18 or older) with developmental disabilities which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents. Refer to A.R.S. §36-551.

Home Care Training to Home Care Client: These services are provided by behavioral health therapeutic home providers and are designed to maximize a member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the member's service plan.

Adult: Home Care Training to Home Care Client services can only be provided for no more than three adults in an Adult Behavioral Health Therapeutic Home (A.A.C. R9-10-101) licensed by ADHS or a home licensed by federally recognized tribes that attest to CMS via AHCCCS that they meet equivalent requirements.

Child: Home Care Training to Home Care Client services can only be provided for no more than three children in a Professional Foster Care Home (A.A.C. R6-5-5850) licensed by DES or a home licensed by federally recognized tribes that attest to CMS via AHCCCS that they meet equivalent requirements. A Professional Foster Care Home may be larger to accommodate sibling groups.

Assisted Living Facility: An Assisted Living Facility (ALF) is a residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All approved residential settings in this category are required to meet ADHS licensing criteria as defined in A.A.C. R9-10 Article 8. Covered settings include:

Adult Foster Care Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.

Assisted Living Home: An Alternative HCBS Setting that provides room and board, supervision and coordination of necessary services to 10 or fewer residents.

Assisted Living Center: An Alternative HCBS Setting as defined in, A.R.S. §36-401, that provides room and board, supervision and coordination of necessary services to more than 11 residents.

Child Developmental Foster Home: An Alternative HCBS Setting for children (under age 18) with developmental disabilities which is licensed by DES and provide room and board, supervision and coordination of habilitation and treatment for up to three residents.

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

BEHAVIORAL HEALTH SERVICES

The Contractor shall provide medically necessary behavioral health services to all members in accordance with AHCCCS policies and A.A.C. R9-28, Article 11. Behavioral Health services are described in detail in the AHCCCS Covered Behavioral Health Services Guide and the AMPM Chapter 300. Behavioral health services include but are not limited to the following:

Behavioral Health Day Program Services: Include services such as therapeutic nursery, in-home stabilization, after school programs, and specialized outpatient substance abuse programs.

Behavioral Health Residential Facility Services: Services provided by a licensed behavioral health service agency that provides treatment to an individual experiencing a behavioral health symptom that:

1. Limits the individual's ability to be independent, or
2. Causes the individual to require treatment to maintain or enhance independence (A.A.C. R9-10-101).

Case Management: All case management services are provided by the Contractor See Section D, Paragraph 16, Case Management.

Crisis Services: Crisis services shall be community based, recovery-oriented, and member focused and shall work to stabilize individuals as quickly as possible to assist them in returning to their baseline of functioning. The Regional Behavioral Health Authorities (RBHAs) within the Contractor's geographic service area(s) are responsible for the delivery of timely crisis services, including telephone, community-based mobile and facility-based stabilization (including observation not to exceed 24 hours). See the AHCCCS Covered Behavioral Health Services Guide, Section II. E. The RBHAs are responsible for notifying the Contractor within 24 hours of a member engaging in crisis services so subsequent services can be initiated by the Contractor.

The Contractor is responsible for all other medically necessary services related to a crisis episode. The Contractor shall develop policies and procedures to ensure timely communication with RBHAs for members that have engaged crisis services. The Contractor shall ensure timely follow up and

care coordination for members after receiving crisis services, whether the member received services within, or outside the Contractor's GSA at the time services were provided, to ensure stabilization of the member and appropriate delivery of ongoing necessary treatment and services.

The Contractor shall:

1. Assess the member's needs, identify the supports and services that are necessary to meet those needs, and connect the member to appropriate services,
2. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more restricted setting, and
3. Engage peer and family support services when responding to crisis situations, as preferred and identified by the member.

Court Ordered Services: The Contractor shall develop a collaborative process with the counties to ensure coordination of care and information sharing for timely access to pre-petition screening, court ordered evaluation, and court ordered treatment provided for in A.R.S. Title 36 (Ch. 5, Article 4). Reimbursement for pre-petition screening and court ordered evaluation services are the responsibility of the County pursuant to A.R.S. §36-545. For additional information regarding behavioral health services refer to A.A.C. R9-22 Article 2 and Article 12.

The Contractor and its providers must comply with State recognized tribal court orders for members determined to have an SMI. When tribal providers are also involved in the care and treatment of court ordered tribal members, the Contractor and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment (COT) and when members are transitioned to services on the reservation, as applicable. The Contractor is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members. See also, AMPM Policy 320-U and ACOM Policy 423.

The Contractor shall develop policies that outline the Contractor's role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must be submitted for review as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The policy must address the processes provided for in A.R.S. Title 36 (Ch. 5, Article 4):

1. Involuntary pre-petition screening, evaluation, and treatment processes,
2. Processes for tracking the status of court orders,
3. Execution of court orders, and
4. Judicial review processes.

Refer to ACOM Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation. Refer to ACOM Policy 423 regarding financial responsibility for the provision of DUI and Domestic Violence Offender Treatment. For more information, refer to the AHCCCS Covered Behavioral Health Services.

Inpatient Services: Inpatient services provided by a licensed facility including the following:

1. Hospitals (including room and board)

2. Subacute Facilities
3. Residential Treatment Centers (RTC)

These facilities provide a structured treatment setting with 24 hour supervision and an intensive treatment program, including medical support services.

Rehabilitation Services: Include the provision of educating, coaching, training and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Rehabilitation services include:

1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training,
2. Cognitive Rehabilitation,
3. Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion), and
4. Supported Employment [Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)].

Support Services: Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services include but are not limited to:

1. Home Care Training Family Services (Family Support)
2. Self-Help/Peer Services (Peer Support)
3. Home Care Training to Home Care Client (HCTC)
4. Unskilled Respite Care (See also subheading: *Acute Care Services* in this Paragraph)

Treatment Services: Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services include:

1. Behavioral Health Counseling and Therapy
2. Assessment, Evaluation and Screening Services
3. Other Professional

11. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its *Quality Assessment and Performance Improvement Strategy* certain populations with special health care needs and the mechanisms used to identify persons with special health care needs as defined by the State [42 CFR 438.208(c)(1)].^{vi}

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs if the medical condition simultaneously meets the following criteria:^{vii}

1. Lasts or is expected to last one year or longer, and
2. Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:^{viii}

1. Members who are recipients of services provided through the Children’s Rehabilitative Services (CRS) program,
2. Members who are recipients of services provided through the contracted Regional Behavioral Health Authorities (RBHAs),
3. Members diagnosed with HIV/AIDS, and
4. Arizona Long Term Care System:
 - a. Members enrolled in the ALTCS program who are elderly and/or have a physical disability, and
 - b. Members enrolled in the ALTCS program who have a developmental disability.

AHCCCS monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational and Financial Reviews of Contractors and the review of required Contractor deliverables set forth in Contract, program specific performance measures, and performance improvement projects.^{ix}

The Contractor shall have in place mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring, or transition to another AHCCCS program [42 CFR 438.330240(b)(4)]. The assessment mechanisms must use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c)(2)] [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member’s needs so that those activities need not be duplicated [42 CFR 438.208(b)(43) and (c)(3)]. Members enrolled in the ALTCS Program who are elderly or have a physical disability or have a developmental disability are automatically identified as having special health care needs.

The Contractor shall ensure that members with special health care needs have an individualized clinical and behavioral treatment plan and conduct multi-disciplinary staffings for members with challenging behaviors or health care needs.[42 CFR 438.208(c)(3)

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

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

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

1. Accessible
2. Continuous
3. Coordinated
4. Family-centered
5. Comprehensive
6. Compassionate
7. Culturally effective

The Contractor shall ensure that populations with ongoing medical needs for services, including but not limited to dialysis, radiation and chemotherapy services, obtain coordinated, reliable, and medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of their scheduled treatment.

12. BEHAVIORAL HEALTH

The Contractor shall adhere to the following requirements with respect to delivery of behavioral health services as outlined below.

Adult and Children Service Delivery: The Contractor shall adhere to the Guiding Principles and clinical documents as outlined below when providing services for adults and children.

Adult Service Delivery System-Nine Guiding Principles: These Principles were developed to provide a shared understanding of the key elements needed for an adult behavioral health system to promote recovery. System development efforts, programs, service provision, and stakeholder collaboration must be guided by these principles.

1. Respect

Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. Persons In Recovery Choose Services And Are Included In Program Decisions And Program Development Efforts

A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. Focus On Individual As A Whole Person, While Including And/Or Developing Natural Supports

A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual’s social community.

4. Empower Individuals Taking Steps Towards Independence And Allowing Risk Taking Without Fear Of Failure

A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. Integration, Collaboration, And Participation With The Community Of One’s Choice

A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one’s role

as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. Partnership Between Individuals, Staff, And Family Members/Natural Supports For Shared Decision Making With A Foundation Of Trust

A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. Persons In Recovery Define Their Own Success

A person in recovery -- by their own declaration -- discovers success, in part, by quality of life community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. Strengths-Based, Flexible, Responsive Services Reflective Of An Individual's Cultural Preferences

A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. Hope Is The Foundation For The Journey Towards Recovery

A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Children's Service Delivery: The Contractor shall ensure delivery of services to children in conformance with the following:

1. AHCCCS Clinical Guidance Documents,
 - a. Support and Rehabilitation Services for Children, Adolescents and Young Adults
 - b. Family and Youth Involvement in the Children's Behavioral Health System
 - c. The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with the Department of Child Safety(DCS) (formerly known as CPS)
 - d. Children's Out-of-Home Services
2. The Child Family Team, and
3. Arizona-Vision Twelve Principles for Children Service Delivery as outlined in AMPM Policy 430.

Coordination of Care: There shall be procedures in place for ensuring that members' behavioral health services are appropriately provided, are documented in the member's record and are tracked by the case manager. The Contractor shall also have procedures in place for ensuring communication occurs between the case manager, the PCP and behavioral health providers and that care is coordinated with other agencies and involved parties. The Contractor shall ensure members transitioning to the ALTCS E/PD program receive uninterrupted behavioral health services and

supports and shall coordinate with the relinquishing Contractor to ensure the member is appropriately transitioned.

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

In the event that a covered behavioral health service is temporarily unavailable for persons in an inpatient or residential facility, policies and procedures shall be in place which stipulate the process for allowing that the member remain in that setting until the service is available or ensure intensive outpatient services/case management/peer support services are available to the member while waiting for the desired service.

In order to promote early intervention and prevent an unnecessary change of placement, the Contractor shall have a policy and process in place to timely involve a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member presents new or existing challenging behaviors in a non-behavioral health setting. When attempting to place a member in a Nursing Facility or Alternative HCBS Setting, the Contractor shall disclose all information that pertains to the behaviors demonstrated by members. See AMPM Chapter 1600 and AMPM Appendix H, *Policy for Management of Acute Behavioral Health Situations*.

Arizona State Hospital Discharges: For enrolled members who are inpatient at the Arizona State Hospital (AzSH), the Contractor is required to follow ACOM Policy 432 and AMPM Policy 1020 regarding care coordination/case management for these members.

The Contractor shall, in accordance with AMPM Policy 1020 requirements, provide high touch care management for members on Conditional Release from the Arizona State Hospital (AzSH) that includes but is not limited to coordination with AzSH for discharge planning; participating in the development of conditional release plans; member outreach and engagement to ensure compliance with the approved conditional release plan; attendance in outpatient staffings at least once per month; care coordination with the member's treatment team and providers of both physical and behavioral health services, and routine delivery of comprehensive status reporting to the Psychiatric Review Board (PSRB) and AzSH. The Contractor shall submit deliverables as required to support an individual's conditional release into the community. The Contractor shall also identify a key clinical single point of contact at the Contractor leadership level for collaboration with AzSH and the PSRB and remediation of identified concerns.

Special Assistance (for members who have an SMI designation): The Contractor shall comply with requirements to assure member rights and responsibilities in conformance AMPM Policy 320-R.

The Contractor shall require its staff, subcontractors, and service providers to identify all persons in need of special assistance to the AHCCCS Division of Health Care Advocacy and Advancement (DHCAA), Office of Human Rights, and ensure consistency with the requirements as outlined in AMPM Policy 320-R. The Contractor shall cooperate with the Human Rights Committee in meeting its obligations as outlined in AMPM Policy 320-R. The Contractor shall submit the deliverables related to Special Assistance Services reporting in accordance with Section F, Attachment F3, Contractor Chart of Deliverables.

Referrals: The Contractor shall develop, monitor and continually evaluate its processes for timely referral, evaluation and treatment planning for behavioral health services, including services provided out-of-state. Requests for behavioral health services may be initiated by the member, family, or guardian. When the Contractor receives a request or identifies the need for behavioral health services, the Contractor shall ensure a referral is sent to a behavioral health provider for an initial assessment on the same day that the request was received or a need is identified. See Section D, Paragraph 37, Appointment Standards and AMPM Policy 1620. A direct referral for a behavioral health assessment/evaluation may be made by the member. A direct referral for a behavioral health assessment/evaluation may be made by any health care professional in coordination with the case manager and PCP assigned to the member.

EPSDT: As specified in Section D, Paragraph 10, Scope of Services, the Contractor must provide developmental/behavioral health screenings for members up to 21 years of age in compliance with the AHCCCS periodicity schedule. See AMPM Policy 430, Exhibit 430-1. The Contractor shall ensure the initiation and coordination of behavioral health referrals when determined necessary through the screening process

SMI Eligibility Determination: Payment for assessments conducted for the purpose of an SMI eligibility determination is the responsibility of the Contractor. The Contractor shall ensure assessments are sent to the AHCCCS designee which conducts SMI eligibility determinations. The Contractor shall comply with the requirements of AMPM Policy 320-P in the same manner as required of the Regional Behavioral Health Authorities.

SMI Decertification: The process that results in the removal of the SMI behavioral health category designation from the member's record. An SMI Decertification may occur in one of the following ways:

Administrative: A member who has an SMI designation may request an SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years. The Contractor shall direct the member to notify AHCCCS DHCM Customer Service; AHCCCS will evaluate the member's request and make a determination.

Clinical: An SMI Clinical Decertification is a determination that a member who has an SMI designation no longer meets SMI criteria. The Contractor shall coordinate with the AHCCCS designee which conducts SMI eligibility determinations. The AHCCCS designee will evaluate the submitted documents to determine if there is sufficient clinical documentation for SMI decertification.

In addition to the grievance and appeals procedures described herein, the Contractor shall also make available the grievance and appeals processes described in Arizona Administrative Code Title 9, Chapter 21, Article 4 for persons determined under Arizona law to be seriously mentally ill.

Quality Management: Quality management processes for behavioral health services must be included in the Contractor's Quality Management Plan and shall meet the quality management requirements of AHCCCS as specified in the AMPM Policy 910. The Contractor shall ensure that its quality management program incorporates monitoring of the PCP's referral to, coordination of care with, and transfer of care to behavioral health providers as well as usage of Arizona's Controlled Substances Prescription Monitoring Program (CSPMP) as required under this Contract. The Contractor shall have procedures in place for ensuring communication occurs between prescribers when controlled substances are used and include provider-mandated usage of the CSPMP.

Comprehensive Workforce Training and Development Program: The Contractor is required to create, implement and manage a comprehensive system of workforce training and development programs. These programs shall be designed to develop a qualified, knowledgeable, skilled, and culturally competent subcontractor workforce that consistently provides high quality services to members.

The workforce training and development programs created by the Contractor shall comply with the requirements A.A.C. R9-10-1006 and AMPM Policy 1060 in the same manner as required of the Regional Behavioral Health Authorities. The Contractor shall submit deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals, including but not limited to, ACOM, AMPM, Reporting Guides, and Manuals are hereby incorporated by reference into this Contract. All Guidelines, policies and manuals are available on the AHCCCS website. The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to the AHCCCS guidelines, policies, and manuals. The Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS Rules, Statutes and other resources are available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available to Contractors on the AHCCCS website.

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

ALTCS members who are temporarily out of the Contractor's service area may be provided long term care services, including HCBS, while out of the service area. The Contractor is not expected to set up special contractual arrangements to provide long term care services out of the service area but, should consider authorization when member-specific providers, such as family Attendant Care, are available during the temporary absence. ALTCS members temporarily absent from Arizona without authorization from the Contractor are eligible for services in accordance with 42 CFR 431.52. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Contractor shall report absences of more than 30 days from the State to the ALTCS eligibility office for a determination of continued eligibility as specified in AMPM Policy 1620.

The Contractor shall submit a written request to AHCCCS Division of Health Care Management as specified in the AMPM Chapter 1600, before placing a member in a residential facility outside the State to facilitate a coordinated review with the Division of Member Services for any potential eligibility impact.

15. ALTCS TRANSITIONAL PROGRAM

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

ALTCS Transitional members are entitled to all ALTCS covered services except for institutional custodial care (services provided at an institutional level in a nursing facility or intermediate care facility). When institutional custodial care is determined to be medically necessary, the period of institutionalization may not exceed 90 consecutive days. If institutional care is expected to exceed 90 consecutive days, the Contractor shall request a medical eligibility reassessment Pre-Admission Screening (PAS) within 45 days of institutional admission. 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 disposition date of the PAS reassessment.

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

16. CASE MANAGEMENT

Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes. The process involves a review of the member's strengths and needs by the member, his/her family or representative and the case manager. The review is expected to result in a mutually agreed upon appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.

A basic tenet of case management is to ensure involvement of the member and the member's family in making informed decisions and identifying strengths and needs of the member. The foundation of case management is respect for the member and member's family's preferences, interests, needs, culture, language and belief system. The member and family/representative are partners with the case managers in the development of the service plan.

A case manager must have a degree in social work, be a licensed registered nurse, or have experience serving persons who are elderly and/or persons with physical or developmental disabilities and/or members determined to have a Serious Mental Illness (SMI). Refer to AMPM Policy 1630. Case managers shall not provide direct services to members, but shall authorize appropriate services and/or refer members to appropriate services.

Case managers shall promote the values of the ALTCS Program of dignity, independence, individuality, privacy and choice and shall foster a member-centered and holistic approach in supporting member and family self-determination.

In accordance with AMPM Policy 1620-B the case managers shall:

1. Respect the member's rights,
2. Support the member to have a meaningful role in planning and directing their own care to maximum extent possible,
3. Provide adequate information and training to assist the member and family/representative in making informed decisions and choices. This information must be reviewed until such time as the member and family/representative indicates s/he understands it,
4. Be available to answer questions and address service issues raised by the member or family/representative, including between regularly scheduled review visits,
5. Provide a continuum of service options that support the expectations and agreements established through the service plan process,
6. Educate the member and family/representative on how to timely report unavailability or other problems with service delivery to the Contractor or AHCCCS in order that unmet needs can be addressed as quickly as possible,
7. Facilitate access to non-ALTCS services available throughout the community,
8. Advocate for the member and/or family/representative as the need occurs,
9. Allow the member and family/representative to identify their role in interacting with the service system including the extent to which the family/informal support system will provide uncompensated care,
10. Provide members with flexible and creative service delivery options,
11. Educate members about member directed options for delivery of designated services. Review these options, at least annually, with members living in their own homes,
12. Educate members on their option to choose their spouse as their paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs,
13. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services,
14. 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,
15. Educate members/family on End of Life care, person centered planning, services and supports including covered services and assist members in accessing those services
16. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment, and
17. Refer member cases, via an Electronic Member Change Report (EMCR), to the AHCCCS Division of Member Services for a medical eligibility reassessment if a member is assessed to no longer require an institutional level of care. See the ALTCS Member Change Request User Guide for MCR instructions.

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

The case manager shall make initial contact and periodic placement/service reviews with the member and family/representative within the appropriate timeframes and locations outlined in AMPM Policy

1620-A and AMPM Policy 1620-E. The purpose of these visits shall be to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as to evaluate the member's living environment, identify potential barriers to quality of the care delivered by the member's service providers and to assess for any unmet needs. The case manager shall be responsible for assessing and documenting the member's overall functional, physical and behavioral health status at each review. Additionally, at these reviews the member and family/representative shall be asked to sign a service plan that indicates whether the member and family/representative agrees or disagrees with the services to be authorized. If the member disagrees, the case manager shall follow appropriate procedures for providing the member written notice of Adverse Benefit Determination and the member's right to appeal the decision.

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

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

The Contractor 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 an event (e.g. assessment, service approval, placement change, discontinuance of a service). Unless the Contractor is currently transmitting data to CATS electronically, all data entry shall be directly entered into CATS. If the Contractor is not currently entering data directly into CATS, it must have a systems interface in place so it can update the case management information no less than twice per month with an error rate of 5% or less. The Contractor is not required to enter service authorizations into the CATS. The Contractor is, however, expected to maintain a uniform tracking system in each member chart documenting the begin and end date of services inclusive of renewal of services and the number of units authorized for services as required by the AMPM Chapter 1600. See ACOM Policy 411 for a tutorial on access to and data entry into CATS.

The Contractor shall submit to AHCCCS for approval, case manager ratio plans based on national standards that will take into account member acuity, legal, and environmental needs.

The Contractor shall comply with established caseload ratios for case managers assigned to serve children identified as having high/complex needs.

The Contractor shall ensure adequate staffing to meet case management requirements. Each case manager's caseload may not exceed a weighted value of 96. The Contractor may assign a weighted value lower than those outlined below however, the Contractor must obtain authorization from the

Division of Health Care Management prior to implementing caseloads whose values exceed these AHCCCS standards.

The following formula represents the standard maximum allowable per case manager:

1. For members in an institutional setting, a weighted value of **1.0** is assigned. Case managers may have up to 96 members ($96 \times 1.0 = 96$).
2. For members in an HCBS (own home) setting, a weighted value of **2.2** is assigned. Case managers may have up to 43 members ($43 \times 2.2 = 96$ or less).
3. For members in an Alternative HCBS setting, a weighted value of **1.8** is assigned. Case managers may have up to 53 members ($53 \times 1.8 = 96$ or less).
4. For members in Acute Care Only (ACO) status, a weighted value of **1.0** is assigned. Case managers may have up to 96 members ($96 \times 1.0 = 96$).
5. If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

$$\begin{array}{r}
 (\# \text{ of members in an institutional setting} \times 1.0) \\
 + \\
 (\# \text{ of members in an HCBS (own home) setting} \times 2.2) \\
 + \\
 (\# \text{ of members in an Alternative HCBS setting} \times 1.8) \\
 + \\
 (\# \text{ of members in Acute Care Only (ACO) status} \times 1.0) \\
 \hline
 = 96 \text{ or less}
 \end{array}$$

In addition, effective October 1, 2019, the following formula represents the maximum number of members allowable per E/PD case manager serving members determined to have an SMI. Each case manager's caseload must not exceed a weighted value of 96:

1. For members in an institutional setting determined to have an SMI, a weighted value of **1.4** is assigned. Case managers may have up to **68** members with an SMI determination ($68 \times 1.4 = 96$ or less).
2. For members in an HCBS (own home) setting determined to have an SMI, a weighted value of **3.0** is assigned. Case managers may have up to **32** members with an SMI determination ($32 \times 3.0 = 96$).
3. For members in an Alternative HCBS setting determined to have an SMI, a weighted value of **1.9** is assigned. Case managers may have up to **50** members with an SMI determination ($50 \times 1.9 = 96$ or less).
4. For members in Acute Care Only (ACO) status determined to have an SMI, a weighted value of **1.0** is assigned. Case managers may have up to 96 ACO members with an SMI determination ($96 \times 1.0 = 96$).

5. If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

$$\begin{aligned}
 & (\# \text{ of members in an institutional setting} \times 1.0) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members determined to have an SMI who are in an institutional setting} \times \\
 & 1.4) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members in an HCBS (own home) setting} \times 2.2) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members determined to have an SMI who are in an HCBS (own home) } \\
 & \text{setting} \times 3.0) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members in an Alternative HCBS setting} \times 1.8) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members determined to have an SMI who are in an Alternative HCBS } \\
 & \text{setting} \times 1.9) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members in Acute Care Only (ACO) status} \times 1.0) \\
 & \qquad \qquad \qquad + \\
 & (\# \text{ of members determined to have an SMI who are in Acute Care Only (ACO) } \\
 & \text{status} \times 1.0) \\
 \hline
 & \qquad \qquad \qquad = 96 \text{ or less}
 \end{aligned}$$

The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources within the Contractor's service area. In general, this individual must be available to assist case managers with up to date information designed to aid members in making informed decisions about their independent living options as well as oversight, tracking and reporting on the Housing request and referral system used by the Contractor. This includes the submission of Housing deliverables specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall submit a Referral Report for all members who have requested Housing Assistance as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The report shall include:

1. Member Name
2. AHCCCS ID
3. SMI Indicator
4. Date of Person's Request
5. Date of Housing Referral to Housing Provider
6. Date Housing Provider made direct contact with Referred Person or designated representative (voice message/email/regular mail do not qualify)
7. Outcome of Housing Referral
8. Date Housed
9. New Address

The staff designated as the housing expert is responsible for identifying housing resources and building relationships with contracted Housing Providers and public housing authorities for the purposes of developing innovative practices to expand housing options, assisting Case Managers in making appropriate referrals for members in need of housing and tracking requests, referrals and outcomes. The Contractor shall identify members with housing needs and develop a monitoring process to support transition or post-transition activities including, but not limited to, requests and referrals, transition wait times, transition barriers and special needs, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition. As outlined in the Network Development Plan, the Contractor shall report annually on the status of any affordable housing networking strategies and innovative practices/initiatives it elects to implement.

The Contractor shall ensure housing experts, are trained in the following standards and practices, including but not limited to:

1. Fair housing laws,
2. The Arizona Residential Landlord Tenant Act,
3. Use of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment tools,
4. Fundamentals of the SAMHSA Permanent Supportive Housing program,
5. Housing Quality Standards (HQS), and
6. Current and emerging tools and best practices.

The staff designated as the employment expert must receive training from the Work Incentive Information Network (WIIN) (www.wiinaz.org). Furthermore, the staff is responsible for educating Case Managers on how to incorporate the Arizona Disability Benefits 101 (www.az.db101.org) resource tool into personal goal development planning discussions with members, developing and implementing strategies to educate members on the resource tool and report member employment outcomes to the WIIN.

Monitoring, Training and Education: The Contractor must conduct case management orientation for new staff and on-going training programs for all case management staff that includes case management standards (as outlined in AMPM Policy 1630), the ALTCS guiding principles and subjects relevant to the population served (e.g., geriatric and/or disability issues, behavioral health, member rights, case manager's quality management role).

The Contractor is responsible for training case managers and providers, in sufficient detail and frequency, to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services and referrals, how to access services, including the pre-petition screening and court-ordered evaluation processes provided for in A.R.S. Title 36 (Ch. 5, Article 4), how to involve the member and their family in decision-making and service planning, and information regarding initial and quarterly behavioral health consultation requirements. The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Training for case managers and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. The Contractor shall maintain documentation of the behavioral health trainings in accordance with AMPM Policy 1630.

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

The Contractor shall provide AHCCCS, within the timeline specified in Section F, Attachment F3, Contractor Chart of Deliverables, with an annual Case Management Plan. The Case Management Plan shall outline how all case management and administrative standards in AMPM Chapter 1600 will be implemented and monitored by the Contractor. The administrative standards shall include but not be limited to a description of the Contractor's systematic method of monitoring its case management program and methodology for assigning and monitoring case management caseloads. The Case Management Plan shall also include an evaluation of the Contractor's Case Management Plan from the prior year, to include lessons learned and strategies for improvement.

17. MEMBER INFORMATION

In addition to compliance with other pertinent federal laws and regulations, the Contractor shall ensure its member communications comply with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act, 45 CFR Part 92, 42 CFR Part 438 and related state requirements. The Contractor shall ensure that it takes reasonable steps to provide meaningful access to each individual with Limited English Proficiency eligible to be served or likely to be encountered in its health programs and activities. As part of this obligation, the Contractor shall identify the prevalent non-English languages spoken by members in its service area and develop and implement an effective written language access plan as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with Limited English Proficiency. [45 CFR 92.201(c)] For significant communications and publications, the Contractor shall comply with the nondiscrimination notice provisions in 45 CFR 92.8. In addition to the general requirements set forth in Section D, Paragraph 17, Member Information, the Contractor shall implement all other activities necessary to comport with federal and state requirements.

The Contractor shall provide members the Contractor's toll free and TTY/TDY telephone numbers for customer service which shall be available during normal business hours. All informational materials prepared by the Contractor shall be approved by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 404 for further information and requirements for member communications.

The Contractor shall make interpretation services available to its members free of charge including: written translation of vital materials in prevalent non English languages in its service area, availability of oral interpretation services in all languages, use of auxiliary aids such as TTY/TDY and American Sign Language. [42 CFR 438.10(d)(4)]

The Contractor shall notify its members of the following upon request and at no cost:

1. That oral interpretation is available for any language,
2. That written translation is available in each of the prevalent non-English languages in the Contractor's service area,

3. That auxiliary aids and services are available for enrollees with disabilities, and
4. How members may access the services above [42 CFR 438.10(d)(5)].

All written materials to members must be written in easily understood language, use font size of at least 12 points, and be available in alternative formats and through provision of auxiliary aids and services that take into account the special needs of members with disabilities or Limited English Proficiency. All written materials must also include large print taglines and information (in font size of at least 18 point) explaining how to request auxiliary aids and services, including the provision of materials in alternative formats. [42 CFR 438.10(d)(6)]

The Contractor shall make its written materials that are critical to obtaining services (also known as vital materials) available in the prevalent non-English language spoken for each LEP population in the Contractor's service area. [42 CFR 438.3(d)(3)] These written materials must also be made available in alternate formats upon request at no cost. Auxiliary aids and services must also be made available upon request and at no cost. Additionally, the materials shall include taglines in the prevalent non-English languages in Arizona and include large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services to understand the information with the Contractor's toll free and TTY/TDY telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials.

Vital materials include, at a minimum, the following:

1. Member Handbooks
2. Provider Directories
3. Consent forms
4. Appeal and Grievance Notices
5. Denial and Termination Notices

When there are program changes, notification shall be provided to members at least 30 days before implementation [42 CFR 438.10(f)(4)].

Social Networking Activities: The Contractor shall adhere to the requirements for Social Networking Activities as described in ACOM Policy 425.

Member Handbook and Provider Directory: The Contractor shall provide the following printed information to each member/representative or household within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]:

1. A Member Handbook which, at a minimum, shall include the items listed in ACOM Policy 404.

The Contractor shall review and update the Member Handbook at least once a year. The Handbook must be submitted to AHCCCS, Division of Health Care Management for approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

2. A Provider Directory, which at a minimum, includes those items listed in ACOM Policy 404.

The Contractor has the option of providing the Provider Directory in hard copy format or providing written notification of how the Provider Directory information is available on the Contractor's website, via electronic mail, or via postal mailing as described in ACOM Policy 404. The written notification shall be sent to members within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)].

The Contractor must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)].

The Contractor shall have information available for potential enrollees as described in ACOM Policy 404 [42 CFR 438.10(f)(4)].

Member Newsletter: The Contractor must develop and distribute, at a minimum, two member newsletters during the Contract year. Member Newsletters must be developed in accordance with ACOM Policy 404.

Member Rights: The Contractor will, on an annual basis, inform all members of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)]. This information may be sent in a separate written communication or included with other written information such as in a member newsletter.

1. An updated Member Handbook at no cost to the member
2. The Provider Directory as described in ACOM Policy 404

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

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

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

Website Requirements: The Contractor shall develop and maintain a website that is focused, informational, user-friendly, functional, and provides the information as required in ACOM Policy 416 and ACOM Policy 404.

18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS Electronic Member Change Report (EMCR) provides the Contractor with a method for complying with notification to the ALTCS eligibility offices and AHCCCS of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, living arrangements,

share of cost, income or resources; a change in medical condition which could affect eligibility; no long term care services provided; demographic changes or the member's death. See the ALTCS Member Change Report User Guide for MCR instructions.

19. PRE-ADMISSION SCREENING AND RESIDENT REVIEW

The Contractor shall ensure members are screened using the Pre-Admission Screening and Resident Review (PASRR) prior to admission to a nursing facility as specified in the AMPM Policy 1220-C. The PASRR screening consists of a two-stage identification and evaluation process (Level I and Level II screening) and is conducted to assure appropriate placement and treatment for those identified with Mental Illness (MI) and Intellectual Disability (ID). Level I screening is required for members entering a nursing facility to determine the presence of a diagnosis or other presenting evidence that suggests the possibility of a mental illness or intellectual disability. Level II screening, if indicated, is conducted by DES for members with an intellectual disability or by AHCCCS for members with a mental illness to further evaluate and make a determination as to whether the member is indeed mentally ill or has an intellectual disability. It also determines whether the member needs the level of care provided in a nursing facility and/or needs specialized services. Failure to have the proper PASRR screening prior to placement of members in a nursing facility may result in Federal Financial Participation (FFP) being withheld from AHCCCS. Should withholding of FFP occur, AHCCCS will recoup the withheld amount from a Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the nursing facility which admitted the member without the proper PASRR.

20. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

The Contractor shall provide quality medical care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established Quality Management and Performance Improvement (QM/PI) processes. The Contractor shall execute processes to assess, plan, implement, evaluate, and as mandated report, quality management and performance improvement activities, as specified in the AMPM Chapters 400 and 900 [42 CFR 438.330(a)(1) and (e)]. See also Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall ensure that the Quality Management/Performance Improvement Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Case Management. The Contractor is expected to integrate quality management processes, such as tracking and trending of issues through all areas of the organization, with ultimate responsibility for quality management/performance improvement residing within the Quality Management.

QM/PI positions performing work functions related to the Contract shall have a direct reporting relationship to the local Chief Medical Officer (CMO) and the local Chief Executive Officer (CEO). The local CMO and CEO shall have the ability to direct, implement and prioritize interventions resulting from quality management and performance improvement activities and investigations. Contractor staff, including administrative services subcontractors' staff that performs functions under this Contract related to QM and PI shall have the work directed and prioritized by the Contractor's local CEO and CMO.

Federal regulation prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) and that meet the following criteria:^x

1. Is identified in the State plan
2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines
3. Has a negative consequence for the beneficiary
4. Is auditable
5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient [42 CFR 438.6(f)(2)(i), 42 CFR 434.6(a)(12)(i), 42 CFR 447.26(b)]

If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation as outlined in AMPM Chapter 900 and Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.6(f)(2)(ii) and 42 CFR 434.6(a)(12)(ii)].^{xi}

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

Quality Management Program

The Contractor shall have an ongoing quality management program for the services it furnishes to members. The quality management program shall include but is not limited to:

1. A written Quality Management and Performance Improvement (QM/PI) plan and an evaluation of the previous year's QM/PI program in accordance with 42 CFR 438.330 and AMPM Chapter 900.
2. Quality management quarterly reports that address strategies for QM/PI activities.
3. QM/PI program monitoring and evaluation activities which include Peer Review and Quality Management Committees which are chaired by the Contractor's local Chief Medical Officer.
4. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
5. Member rights and responsibilities [42 CFR 438.100(b)(1)].
6. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credentialing for all provider types [42 CFR 438.206(b)(6); 42 CFR 438.214(b)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's local Medical Director. The Contractor must comply with requirements as specified in AMPM Policy 950 and refer to Section F, Attachment F3, Contractor Chart of Deliverables, for reporting requirements [42 CFR 438.214]
7. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation, and unexpected deaths. The Contractor must comply with requirements as specified in AMPM Policy 960.
8. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs and comply with requirements as specified in AMPM Policy 920 [CFR 438.330(b)(4)].

9. Requirement for any ADHS licensed or certified provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. The Contractor shall monitor contracted providers for compliance with quality management measures including supervisory visits conducted by a Registered Nurse when a home health aide is providing services.
10. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
11. Performance improvement programs including performance measures and performance improvement projects.

Credential Verification Organization Contract: The Arizona Association of Health Plans (AzAHP) has established a contract with a Credential Verification Organization (CVO) that is responsible for receiving completed applications, attestations and primary source verification documents. The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements. The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and re-credentialing process regardless of membership in the AzAHP. This requirement eases the administrative burden for providers that contract with AHCCCS Contractors which often results in duplicative submission of information used for credentialing purposes. The Contractor shall follow the AHCCCS re-credentialing timelines for providers that submit their credentialing data and forms to the AzAHP CVO. The Contractor is responsible for completing the credentialing process. The Contractor shall continue to include utilization, performance, complaint, and quality of care information, as specified in the AMPM, to complete the credentialing or re-credentialing files that are brought to the Credentialing Committee for a decision. In addition, the Contractor must also meet the AMPM Policy 950 requirements for provisional/temporary credentialing.

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall calculate and report to AHCCCS as outlined in AMPM Policy 950. The Contractor shall report the credentialing information with regard to all credentialing applications as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Long Term Services and Supports (LTSS): The Contractor must have mechanisms to assess the quality and appropriateness of care provided to members receiving LTSS services, including a comparison of the settings of care with the member's service plan [42 CFR 438.330(b)(5)(i)].

HCBS Monitoring: The Contractor must have a process in place to conduct monitoring and oversight of care and services provided in the home and community based setting (HCBS). Monitoring of HCBS sites may include a collaborative process involving quality management and case management staff, including the utilization of the case manager onsite visits with members. The Contractor must develop a process that, at a minimum, meets the requirements specified in the AMPM Policy 920 and AMPM Chapter 1600.

Performance Improvement: The Contractor's quality management program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and non-clinical care which are expected to have a favorable effect on health outcomes and member satisfaction [42 CFR 438.330(b)(2) and (c)]:

The Contractor must:

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

Performance Improvement Program: The Contractor shall have an ongoing program designed to achieve and sustain, through ongoing measurements and interventions, significant improvement in the areas of clinical and non-clinical care, as specified in the AMPM, and that involve the following [42 CFR 438.330(b)(1) and (d)(1) and (2)]:

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

Performance Improvement Projects (PIPs) are mandated by AHCCCS, the Contractor shall also self-select additional projects based on opportunities for improvement identified by internal data and information. The Contractor shall report the status and results of each project to AHCCCS as requested using the AHCCCS Performance Improvement Project Reporting Template included in AMPM Chapter 900. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year [42 CFR 438.330(d)].

Performance Measures: The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS performance measures. Technical specification of these performance measures are based on the National Committee for Quality Assurance (NCQA) HEDIS methodology, the CMS Core Measure Set, other methodology sources, or may be AHCCCS developed. The EPSDT Participation and the EPSDT dental preventive care performance measure descriptions utilize the methodology established in CMS "Form 416," which can be found on the AHCCCS website.

The methodology for select performance measures was developed by AHCCCS including methodologies for Advanced Directives and Influenza Vaccination based on comparable methodologies available from other sources. Complete descriptions of these measures, links to the CMS and the measure host sites can be found on the AHCCCS website.

The Contractor must comply with Federal performance measures and levels that may be identified and developed by CMS or those that are developed in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid and CHIP programs. As the Core Measure sets are implemented, performance measures required by AHCCCS may be updated to include these measures. Additionally, AHCCCS may add measures specific to End of Life Care.

AHCCCS may utilize a hybrid or other methodologies for collecting and reporting performance measure rates, as allowed by the NCQA, for selected Healthcare Effectiveness Data and Information Set (HEDIS) measures or as allowed by other entities for nationally recognized measure sets. The Contractor shall collect data from medical records, electronic records or through approved processes such as those utilizing a health information exchange and provide these data with supporting documentation, as instructed by AHCCCS, for each hybrid measure. The number of records that each Contractor collects will be based on HEDIS, External Quality Review Organization (EQRO), or other sampling guidelines and may be affected by the Contractor's previous performance rate for the measure being collected.

The Contractor shall have a process in place for monitoring performance measures rates. The Contractor shall utilize a standard methodology established or adopted by AHCCCS for measurement of each required performance measure. The Contractor's QM/PI Program will report its measured performance on an ongoing basis to its Administration. The Contractor performance measure monitoring results shall also be reported to AHCCCS in conjunction with its EPSDT Improvement and Adult Quarterly Monitoring Report.

The Contractor must meet AHCCCS stated Minimum Performance Standards (MPS) for each population for which AHCCCS reports results. AHCCCS-reported rates are the official rates utilized for determination of Contractor compliance with performance requirements. It is equally important that in addition to meeting the contractual MPS, the Contractor continually improve performance measure outcomes from year to year. Contractor calculated and/or reported rates will be used strictly for monitoring Contractor actions and not be used for official reporting or for consideration in corrective action purposes.

Minimum Performance Standard: A MPS is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to sanctions for each deficient measure.

A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically significant improvement in a measure rate as calculated by AHCCCS. Sanctions may also be imposed for statistically significant declines of rates even if they meet or exceed the MPS, for any rate that does not meet the AHCCCS MPS, or a rate that has a significant impact to the aggregate rate for the State. AHCCCS may require that the Contractor demonstrate that it is allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan for measures that are below the MPS or that show a statistically significant decrease in its rate, even if it meets or exceeds the MPS.

An evidence-based corrective action plan that outlines the problem, planned actions for improvement, responsible staff and associated timelines as well as a place holder for evaluation of activities must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up desktop or on-site review to verify compliance with a corrective action plan.

Performance Measures described below may apply across all lines of business and populations or may apply only to specific lines of business and/or populations. [42 CFR 438.330(a)(2);(b)(2)and(c)]. AHCCCS may analyze and report results by placement (HCBS vs. nursing facility), GSA or County and/or

other applicable demographic factors.

AHCCCS has established standards for the measures listed below.

The following tables identify the MPS for each measure:

ALTCS/EPD Contractor Quality Management Performance Measures

Quality Management Performance Measure	Minimum Performance Standard (MPS)
Inpatient Utilization	95 Per 1000 Member Months
ED Utilization	80 Per 1000 Member Months
Hospital Readmission	17%
Quality Management Performance Measure	Minimum Performance Standard (MPS)
Follow-up After Hospitalization for Mental Health, 7 Days	85%
Follow-up After Hospitalization for Mental Health, 30 Days	95%
Mental Health Utilization*	Baseline Measurement Year
Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer*	Baseline Measurement Year
Screening for Clinical Depression and Follow-Up Plan*	Baseline Measurement Year
Adults' Access to Preventive/Ambulatory Health Services	75%
CDC – HbA1c Testing	77%
CDC – HbA1c Poor Control (>9.0%)	43%
CDC – Eye Exam	49%
Diabetes Admissions, Short-Term Complications (PQI-01)	300 Per 100,000 Member Months
<i>Flu Shots for Adults, Ages 18 and Older (FVA)**</i>	75%
Annual Monitoring for Patients on Persistent Medications: Combo Rate	75%

Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	950 Per 100,000 Member Months
Heart Failure Admission Rate (PQI-09)	350 Per 100,000 Member Months
Advanced Directives	55%
EPSDT Participation, members aged 18-21 ¹	68%
Percentage of Eligibles Who Received Preventive Dental Services ²	46%
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk*	Baseline Measurement Year; CMS will be establishing MPS
Weight Assessment and Counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	50%
Developmental Screening in the First Three Years of Life	55%

Notes:

(*) AHCCCS will develop Minimum Performance Standards once baseline data has been analyzed for these measures.

The only deviation will be that the measure dates will be reflective of Federal Fiscal Year (October 1 - September 30) vs. Calendar Year (January 1 - December 31).

** The Influenza measure (Flu Shot for Adults) will be analyzed via hybrid data collection. If an alternative solution (such as a Long Term Care CAHPS survey) is identified, the measure methodology will be revised at that time.

⁽¹⁾ The EPSDT Participation rate is the percent of all children and adolescents younger than 21 years who were due for at least one EPSDT visit, depending on their age and the State's EPSDT Periodicity Schedule, and had a visit during the Contract Year.

⁽²⁾ EPSDT Dental Participation Standards are based on the CMS-established goal that States improve their rate of children ages one through 20 enrolled in Medicaid and who received any preventive dental service, by 10 percentage points over a five-year period.

Contractor Performance is evaluated annually using the AHCCCS-reported rate for each measure. AHCCCS rates are considered the official measurement for each Performance Measure. AHCCCS calculated rates by Contractor for each measure will be compared with the MPS specified in the Contract in effect during the measurement period. For instance, Performance Standards in the current Contract Year apply to results calculated by AHCCCS for that measurement period. AHCCCS will utilize methodologies that are reflective of the requirements for the measurement period. For instance, performance measure data will be based on the published CMS Core Sets and HEDIS technical specifications. Contractors are

responsible for monitoring and reporting to AHCCCS CQM the status of, and any discrepancies identified in encounters received by AHCCCS including paid, denied and pended for purposes of Performance Measure monitoring prior to the AHCCCS Performance Measure rate calculations being conducted.

AHCCCS will measure and report the Contractor's EPSDT Participation rate and Dental Participation (Preventive Dental) rate, utilizing the CMS-416 methodology. The EPSDT Participation rate is the number of children younger than 21 years that receive medical screens in compliance with the State's Periodicity Schedule, compared to the number of children expected to receive medical screens per the State's Periodicity Schedule. The Preventive Dental Participation rate is the number of children aged one through 20 who have a preventive dental visit, compared to the number of children who has at least 90-days continuous enrollment during the Contract Year (measurement period).

The Contractor is responsible for applying the correct CMS-416 methodology as developed and maintained by CMS for its internal monitoring of performance measure results.

AHCCCS uses the national CMS-416 methodology to generate the EPSDT Participation and Dental Participation rates through a CMS-validated process. The rates are generated one time a year and reported to CMS within specified timeframes. Aggregate rates as well as Contractor-specific rates are included in this process.

The Contractor must participate in the delivery and/or results review of member surveys as requested by AHCCCS. Surveys may include Home and Community Based (HCBS) Member Experience surveys, HEDIS Experience of Care (Consumer Assessment of Healthcare Providers and Systems – CAHPS) surveys, and/or any other tool that AHCCCS determines will benefit quality improvement efforts. While not included as an official performance measure, survey findings or performance rates for survey questions may result in the Contractor being required to develop a Corrective Action Plan (CAP) and/or participate in technical assistance or AHCCCS-led workgroups to improve any areas of concern noted by AHCCCS. Failure to effectively develop or implement AHCCCS-approved CAPs and drive improvement may result in additional regulatory action.

Data Collection Procedures: When requested, by AHCCCS, the Contractor must submit data for standardized Performance Measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data and using qualified staff and personnel to collect the data. The Contractor must ensure that data collected by multiple parties/people for Performance Measures and/or PIP reporting is comparable and that an inter-rater reliability process was used to ensure consistent data collection. Data collected for Performance Measures and/or PIPs must be returned by the Contractor in a format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

Engaging Members through Technology: The Contractor shall engage its membership through web based applications. The Contractor shall identify populations who can benefit from web based applications used to assist members with self-management of health care needs such as, chronic

conditions, pregnancy, or other health related topics the Contractor considers to be most beneficial to members. The Contractor shall submit an executive summary to AHCCCS, DHCM, Quality Management Unit as specified in the AMPM and Section F, Attachment F3, Contractor Chart of Deliverables to include at a minimum:

1. Criteria for identifying at least 10% of the Contractor's members who can benefit from web based applications,
2. Listing of identified population(s),
3. Description of web applications in development or being utilized to engage members,
4. Strategies used to engage the identified members in the use of the web applications, and
5. Description of desired outcomes.

AHCCCS may amend the reporting requirements effective October 1, 2017,

21. MEDICAL MANAGEMENT

The Contractor shall ensure an integrated Medical Management process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

The Contractor shall implement processes to assess, plan, implement, evaluate, and as mandated, report Medical Management (MM) monitoring activities as specified in the AMPM Chapter 1000. This shall include the Quarterly Inpatient Hospital Showings report, HIV Specialty Provider List, Transplant Log and Prior Authorization Requirements report as specified in the AMPM and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall evaluate MM activities, as specified in the AMPM Chapter 1000, including:

1. Utilization Data Analysis and Data Management [42 CFR 438.330(b)(3)]
2. Concurrent Review
3. Discharge Planning [42 CFR 438.208]
4. Prior authorization and Service Authorization [42 CFR 438.210(b)(2)]
5. Inter-rater Reliability
6. Retrospective Review
7. Clinical Practice Guidelines [42 CFR 438.236]
8. New Medical Technologies and New Uses of Existing Technologies
9. Care Coordination/Case Management [42 CFR 438.208]
10. Disease/Chronic Care Management
11. Drug Utilization Review

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM committee shall analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. The Contractor shall implement procedures to deliver primary care to and coordinate health care service for members. These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and

a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member [42 CFR 438.208].

The Contractor will assess, monitor and report quarterly through the MM Committee, medical decisions to assure compliance with timeliness, language and Notice of Adverse Benefit Determination intent, and that the decisions comply with all Contractor coverage criteria. This includes quarterly evaluation of all Notice of Adverse Benefit Determination decisions that are made by a subcontracted entity.

The Contractor shall maintain a written MM Plan and Work Plan that addresses monitoring of MM activities (AMPM Policy 1010). The MM Plan and Work Plan shall be submitted for review within timelines specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Criminal Justice System Reach-in Care Coordination: To facilitate the transition of members transitioning out of jails and prisons into communities, AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in criminal justice system "reach-in" care coordination efforts.

The Contractor shall conduct reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release. When behavioral health needs are identified, the Contractor shall also collaborate with the member's behavioral health Contractor (if the member's care is not integrated).

The Contractor shall report the Reach-In Plan to AHCCCS, as described below, in the annual Medical Management Plan and report outcome summaries in the Medical Management Evaluation, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

Reach-in Plan Administrative Requirements

1. Designation of a Justice System Liaison who will be responsible for the reach-in initiative and who:
 - a. Resides in Arizona,
 - b. Is the single point of contact to communicate with justice systems and
 - c. Is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC) and Probation Departments
2. Identification of the name(s) and contact information for all criminal justice system partner(s)

3. Description of the process for coordination with Maricopa County jail, if appropriate, for identification of those members in probation status
4. Designation of parameters for identification of members requiring reach-in care coordination (e.g. definition of chronic and/or complex care needs) through agreement with reach-in partners
5. Description of the process and timeframes for communicating with reach-in partners
6. Description of the process and timeframes for initiating communication with reach-in members
7. Description of methodology for assessment of anticipated cost savings to include analysis of medical expense for these identified members prior to incarceration and subsequent to reach in activities and release.

Reach-in Plan Care Coordination Requirements

1. Develop process for identification of members meeting the established parameters for reach-in care coordination (chronic and/or complex care needs). The Contractor must utilize the 834 file data provided to the Contractor by AHCCCS to assist with identification of members. The Contractor may also use additional data if available for this purpose.
2. Strategies for providing member education regarding care, services, resources, appointment information and health plan case management contact information
3. Requirements for scheduling of initial appointments with appropriate provider(s) based on member needs; appointment to occur within 7 days of member release
4. Strategies regarding ongoing follow up with the member after release from incarceration to assist with accessing and scheduling necessary services as identified in the member's care plan
5. Should re-incarceration occur, strategies to reengage member and maintain care coordination
6. Strategies to improve appropriate utilization of services
7. Strategies to reduce recidivism within the member population
8. Strategies to address social determinants of health

The Contractor must notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Section D, Paragraph 54, Capitation Adjustment.

Outreach to Service Members, Veterans and Families: The Contractor shall partner with community organizations which provide care and support for service members, veterans and families. Utilizing a collaborative approach, the Contractor shall identify members who may benefit from outreach regarding available programs and services and shall develop and implement outreach activities which inform members and families of the benefits available and how to access those services. The Contractor shall train staff on the available community resources and appropriate actions to take to ensure members are afforded the ability to be connected to these resources. The Contractor shall report its activities regarding these services in the annual MM Plan and Work Plan, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Monitoring Controlled and Non-Controlled Medication Utilization: The Contractor shall engage in activities to monitor controlled and non-controlled medication use as outlined in AMPM Policy 310-FF to ensure members receive clinically appropriate prescriptions. The Contractor is required to report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, a

Pharmacy and/or Prescriber - Member Assignment report which includes the number of members which on the date of the report are restricted to using a specific Pharmacy or Prescriber/Providers due to excessive use of prescriptive medications (narcotics and non-narcotics).

Inappropriate Emergency Department Utilization: The Contractor shall identify and track members who utilize Emergency Department (ED) services inappropriately four or more times within a six month period. Interventions shall be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service. The Contractor shall submit a semi-annual report as specified in AMPM Policy 1020 and Section F, Attachment F3, Contractor Chart of Deliverables.

Transplant Services and Immunosuppressant Medications: AHCCCS covers medically necessary transplantation services and related immunosuppressant medications in accordance with Federal and State law and regulations. The Contractor shall not make payments for organ transplants not provided for in the State Plan except as otherwise required pursuant to 42 USC 1396d(r)(5) for persons receiving services under EPSDT. The Contractor must follow the written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees per Sections (1903(i) and 1903(i)(1)) of the Social Security Act. Refer to the AMPM, Chapter 300, Exhibit 310-DD and the AHCCCS Reinsurance Policy Manual.^{xii}

22. GRIEVANCE AND APPEAL SYSTEM

The Contractor shall have in place a written Grievance and Appeal System process for members, subcontractors, and providers, which defines their rights regarding disputed matters with the Contractor. The Contractor's Grievance and Appeal System for members includes a grievance process (the procedures for addressing member grievances), an appeals process and access to the State's fair hearing process as outlined in Section F, Attachment F1, Member Grievance and Appeal System Standards. The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Section F, Attachment F2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Section F, Attachment F1, Member Grievance and Appeal System Standards, and Attachment F2, Provider Claim Dispute Standards, and 42 CFR Part 438 Subpart F.

Information to members must meet cultural competency and Limited English proficiency requirements as specified in Section D, Paragraph 17, Member Information and Section D, Paragraph 63, Cultural Competency.

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

The Contractor shall also ensure that it timely provides written information to both members and providers, which clearly explains the Grievance and Appeal System requirements. This information must include a description of:

1. The right to a State fair hearing, the method for obtaining a State fair hearing,
2. The Rules that govern representation at the hearing,
3. The right to file grievances, appeals and claim disputes,
4. The requirements and timeframes for filing grievances, appeals and claim disputes,
5. The availability of assistance in the filing process,
6. The toll-free numbers that the member can use to file a grievance or appeal by phone,
7. That benefits will continue when requested by the member in an appeal or State fair hearing request concerning certain actions which are timely filed,
8. That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and
9. That a provider may file an appeal on behalf of a member with the member's written consent.

The Contractor must provide reports on the Grievance and Appeal System as required in the AHCCCS Grievance and Appeal System Reporting Guide available on the AHCCCS website. See also Section F, Attachment F3, Contractor Chart of Deliverables.

In addition to the grievance and appeals procedures described herein, the Contractor shall also make available the grievance and appeals processes described in Arizona Administrative Code Title 9, Chapter 21, Article 4 for persons determined under Arizona law to be seriously mentally ill.

23. MATERNITY CARE PROVIDER REQUIREMENTS

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

1. Arizona licensed allopathic and/or osteopathic physicians who are Obstetricians or general practice/family practice providers who provide maternity care services,
2. Physician Assistants,
3. Nurse Practitioners,
4. Certified Nurse Midwives, and
5. Licensed Midwives.

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that s/he is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the

member's home. Labor and delivery services may also be provided in the member's home by physicians, certified nurse practitioners and certified nurse midwives who include such services within their practice.

24. MEMBER COUNCILS

To promote a collaborative effort to enhance the service delivery system in local communities while maintaining a member focus, the Contractor shall establish an ALTCS Member Council that participates in providing input on policy and programs. The Contractor shall establish at least one ALTCS Member Council in each GSA. However, the Contractor should consider expanding its ALTCS Member Council structure to establish a Council by County or Counties rather than GSA in order to ensure Council participation in consideration of County population, travel requirements, and/or unique community needs.

Every effort shall be made to include a cross representation of ALTCS members and families/representatives, member advocacy groups and providers that reflect the population and community served. The ALTCS Member Council should consist of at least 10 Council members. ALTCS members and families/representatives and member advocacy groups shall make up at least 50% of the membership. The Contractor shall assist in recruiting an ALTCS E/PD member of the Council who will serve on the AHCCCS ALTCS Member Council.

The Contractor shall provide council members with orientation and ongoing training that includes sufficient information and ensures understanding of Council member responsibilities. The Council shall be chaired by the Contractor's Administrator/CEO or designee and will meet at least quarterly with a quorum of members in attendance when Council recommendations or approvals are required.

The Contractor shall submit an ALTCS Member Council Plan to AHCCCS, Division of Health Care Management (DHCM) as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The ALTCS Member Council Plan shall include:

1. Justification for Council by GSA/County(ies),
2. Meeting schedule,
3. Membership,
4. Trainings,
5. Goals and objectives, and
6. An evaluation of the prior year's plan.

All ALTCS Member Council agendas, meeting minutes and list of attendees shall be submitted to DHCM as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

25. STAFF REQUIREMENTS

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

1001.1901(b), 42 CFR 1003.102(a)(2)]. The Contractor is obligated to screen employees and subcontractors to determine whether they have been excluded from participation in Federal health care programs, as outlined in Section D, Paragraph 64, Corporate Compliance.

The Contractor shall employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS as outlined in Section D, Paragraph 74, Administrative Actions, of the Contract.

The Contractor shall have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies such as Arizona Department of Health Services (ADHS)/ Bureau of Medical Facilities on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardy (IJ), fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, ability to initiate new placements/services, and have the availability to perform status checks at affected facilities and perform ongoing monitoring, if necessary. The Contractor shall supply AHCCCS Clinical Quality Management (CQM) with the contact information for these staff, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. AHCCCS CQM must be notified and provided backup contact information when the primary contact person will be unavailable.

For functions not required to be in State, the Contractor must notify AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables, prior to moving functions outside the State of Arizona. The notification must include an implementation plan for the transition. The Contractor shall be responsible for any additional costs associated with on-site audits or other oversight activities which result when required systems are located outside of the State of Arizona.

Except as otherwise specified below, a staff member is prohibited from occupying more than two positions within one line of business or from occupying two positions across multiple lines of business (including non-AHCCCS lines of business) unless prior approval is obtained by AHCCCS, Division of Health Care Management (DHCM). AHCCCS will not permit any Contractor staff to hold positions which may present a conflict of interest. The following additional restrictions apply:

1. The Administrator/CEO is limited to holding one position which is either
 - o The Administrator/CEO of the ALTCS E/PD line of business, or
 - o The Administrator/CEO of the ALTCS E/PD and Medicare D-SNP lines of business. Otherwise, the Administrator/CEO is prohibited from holding any other position in any other line of business
2. The Quality Management Manager is limited to holding one position for the ALTCS E/PD line of business. The QM Manager is prohibited from holding any other position in any other line of business, and
3. AHCCCS prohibits the Corporate Compliance Officer from holding any other position other than the Contract Compliance Officer position.

The Contractor must submit an annual attestation that it is adhering to staffing requirements/limitations for all staff as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall inform AHCCCS DHCM, in writing as specified in Section F, Attachment F3, Contractor Chart of Deliverables, when an employee leaves one of the key Staff positions listed below. The name of the interim contact person should be included with the notification. Unless otherwise approved by AHCCCS, an individual staff member is limited to occupying an interim position for no longer than six months from the date of notification submitted to AHCCCS. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff.

The Contractor shall inform AHCCCS DHCM, in writing as specified in Section F, Attachment F3, Contractor Chart of Deliverables when any of the following contact information for an individual holding a Key Staff position changes: the individual's name, the individual's telephone number, the individual's email address, or the individual's location.

AHCCCS has the discretion to review all submitted key staff positions and reserves the right to direct Contractor actions regarding staffing decisions it deems are in the best interest of the State.

At a minimum, the following staff is required:

Key Staff Positions

1. **Administrator/Chief Executive Officer (CEO)** who is located in Arizona and must directly oversee the entire operation of the Contractor on a day-to-day basis, including actively directing and prioritizing work and operations of the organization, regardless of where that work is performed or the site of operations. The Contractor's Administrator/CEO is accountable to AHCCCS for compliance with the requirements and obligations under this Contract.
2. **Medical Director/Chief Medical Officer (CMO)** who is located in Arizona and who is an Arizona-licensed physician in good standing. The Medical Director shall actively provide oversight and management of the clinical, Quality Management and Medical Management components of the Contractor.
3. **Chief Financial Officer (CFO)** who is responsible for oversight of the budget, accounting systems and financial reporting requirements.
4. **Pharmacy Coordinator/Pharmacy Director** who is an Arizona licensed pharmacist or physician in good standing, who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or subcontractor of the Contractor.
5. **Dental Director** who is located in Arizona, is an Arizona licensed general or pediatric dentist in good standing, and is responsible for leading and coordinating the dental activities of the Contractor including review and denial of dental services, provider consultation, utilization review, and participation in tracking and trending of quality of care issues as related to dental services. The Dental Director may be an employee or subcontractor of the Contractor but may not be from the Contractor's delegated dental subcontractor.
6. **Corporate Compliance Officer** who is located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and

- make independent referrals to AHCCCS, Office of the Inspector General. See Section D, Paragraph 64, Corporate Compliance for more information.
7. **Contract Compliance Officer** who is located in Arizona and who serves as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer include, but are not limited to, coordination of the tracking and submission of all Contract deliverables, fielding and coordinating responses to AHCCCS inquiries, coordinating the preparation and execution of Contract requirements such as Operational Reviews (ORs), random and periodic audits and ad hoc visits.
 8. **Quality Management Manager** who is an Arizona-licensed registered nurse, physician or physician's assistant in good standing or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The QM Manager must be located in Arizona and have experience in quality management and quality improvement. Sufficient local staffing to meet the AHCCCS quality management contractual and policy requirements must also be in place. Staff must report directly to the Quality Management Manager. The primary functions of the Quality Management Manager position are:
 - a. Ensure individual and systemic quality of care
 - b. Conduct comprehensive quality-of-care investigations
 - c. Conduct onsite quality management visits/reviews
 - d. Conduct Care Needed Today/Immediate Jeopardy investigations
 - e. Integrate quality throughout the organization
 - f. Implement process improvement
 - g. Resolve, track and trend quality of care grievances
 9. **Performance/Quality Improvement Coordinator** who is located in Arizona and who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in health plan data and outcomes measurement. Staff reporting to this position must be appropriate to meet the AHCCCS quality improvement contractual and policy requirements and must be located in Arizona. The primary functions of the Performance/Quality Improvement Coordinator are:
 - a. Focus organizational efforts on improving clinical quality performance measures
 - b. Develop and implement performance improvement projects
 - c. Utilize data to develop intervention strategies to improve outcomes
 - d. Report quality improvement/performance outcomes
 10. **Credentialing Coordinator** who is located in Arizona and who has appropriate education and/or experience to effectively complete all requirements of the position. The primary functions of the Credentialing Coordinator are:
 - a. Serve as the single point of contact to AHCCCS for credentialing-related questions and concerns
 - b. Responsible for timely and accurate completion of all credentialing-related deliverables
 - c. Ensure all credentialing requirements, including timeframes, are adhered to by the Contractor
 - d. Provide a detailed, transparent description of the credentialing process to providers and serve as the single point of contact for the Contractor to address provider questions about the credentialing process.
 11. **Maternal Child Health/EPSTD Coordinator** who is located in Arizona and is an Arizona licensed nurse, physician, or physician's assistant in good standing, or who has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM certification. Staff reporting to this position must be appropriate to meet the AHCCCS MCH/EPSTD contractual and policy requirements, and quality and performance measure goals, and must be located in Arizona. Maternal Child Health (MCH)/EPSTD staff must either report

directly to the MCH/EPSTD Coordinator or the MCH/EPSTD Coordinator must have the ability to ensure that AHCCCS MCH/EPSTD requirements are met. The primary functions of the MCH/EPSTD Coordinator are:

- a. Ensure receipt of EPSTD services
 - b. Ensure receipt of maternal and postpartum care
 - c. Promote family planning services
 - d. Promote preventive health strategies
 - e. Identify and coordinate assistance for identified member needs
 - f. Interface with community partners
12. **Medical Management Manager** who is located in Arizona and is a registered nurse, physician or physician's assistant in good standing. This position manages all medical management requirements under AHCCCS policies, State regulations and Contract, including but not limited to: application of appropriate medical necessity criteria, concurrent review, discharge planning, care coordination, disease management, and prior authorization functions. Sufficient local staff reporting to this position must be in place to meet medical management requirements.
 13. **Case Management Administrator/Manager** who is an Arizona licensed registered nurse in good standing or a social worker with a minimum of three years of management experience. The Case Management Administrator/Manager must be located in Arizona to oversee all functions of case management.
 14. **Behavioral Health Coordinator** who is a behavioral health professional as described in Health Services Rule, A.A.C. R9-10-101, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are met, including but not limited to: coordination of behavioral health care and physical health care between all providers, review network to reduce out of state placements, active involvement in out of state placements.
 15. **Transition Coordinator** who is a health care professional or who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all member transition issues, responsibilities and activities. The Transition Coordinator shall ensure safe, timely, and orderly member transitions. Refer to ACOM Policy 402.
 16. **Transplant Coordinator** who is an Arizona licensed registered nurse in good standing and who is responsible for the timely review and authorization of transplant services in accordance with AHCCCS policy and State regulations. Refer to AMPM Policy 310-DD.
 17. **Justice System Liaison** who resides in Arizona, is the single point of contact for communication with the justice system, is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Juvenile Corrections (ADJC), Arizona Office of the Courts (AOC) and Probation Departments and is responsible for Justice System reach-in initiatives.
 18. **Network Administrator** who manages and oversees network development, network sufficiency and network reporting functions. This position is located in Arizona and ensures network adequacy and appointment access, develops network resources in response to identified unmet needs, and ensures a member's choice of providers.
 19. **Provider Services Manager** who is located in Arizona and coordinates communications between the Contractor and providers. This position ensures that providers receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program. Sufficient local staffing under this position must be in place to ensure providers receive assistance and appropriate and prompt responses. See Section D, Paragraph 28, Network Management.
 20. **Claims Administrator** who shall ensure prompt and accurate provider claims processing. Sufficient staffing under this position must be in place to ensure the timely and accurate processing of original

- claims, resubmissions and overall adjudication of claims. The primary functions of the Claims Administrator are:
- a. Develop and implement claims processing systems capable of paying claims in accordance with State and Federal requirements
 - b. Develop processes for cost avoidance
 - c. Ensure minimization of claims recoupments
 - d. Ensure claims processing timelines are met
21. **Encounter Manager** who shall ensure AHCCCS encounter reporting requirements are met. Sufficient staffing under this position must be in place to ensure timely and accurate processing and submission of encounter data and reports to AHCCCS.
22. **Provider Claims Educator** who is located in Arizona and facilitates the exchange of information between the grievances, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator are:
- a. Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer
 - b. Educate contracted and non-contracted providers on available Contractor resources such as provider manuals, website, fee schedules, etc.
 - c. Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
 - d. Identify trends and guide the development and implementation of strategies to improve provider satisfaction
 - e. Frequently communicate with providers, including on-site visits, to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
23. **Dispute and Appeal Manager** who is responsible for managing and adjudicating member grievances and appeals, and provider claim disputes, arising under the Grievance and Appeal System and for forwarding all requests for hearing to AHCCCS Office of Administrative Legal Services (OALS) with the required information. The Dispute and Appeal Manager and any staff reporting to this position who manage and adjudicate disputes and appeals must be located in Arizona. See Section D, Paragraph 22, Grievance and Appeal System.
24. **Information Systems (IS) Administrator** who is responsible for information system management including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all data and data exchange elements. Sufficient staffing reporting to this position must be in place to ensure timely and accurate information systems management to meet system and data exchange requirements.
25. **Continuity of Operations and Recovery Coordinator** who is located in Arizona, and is responsible for the coordination and implementation of the Contractor's Continuity of Operations and Recovery Plan, and training and testing of the Plan, as outlined in ACOM Policy 104.
26. **Cultural Competency Coordinator** who is responsible for implementation and oversight of the Contractor's Cultural Competency Program and the Cultural Competency Plan.
27. **Social Networking Administrator** who is responsible for policy development, implementation and oversight of all social networking activities.
28. **MSA Administrator** who is responsible for oversight of the Management Services Agreement (MSA) subcontractor and is the Contractor's Key Contact for AHCCCS coordination and who is not employed by the MSA. This position is only required when the Contractor operates under a subcontract with a MSA.

Additional Required Staff:

29. **Prior Authorization staff** to authorize health care services. This staff shall include but is not limited to Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. The staff will work under the direction of an Arizona-licensed physician.
30. **Concurrent Review staff** who are located in Arizona and who conducts inpatient medical necessity reviews. This staff shall include but is not limited to Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. The staff will work under the direction of an Arizona-licensed physician.
31. **Case Management Supervisor(s)** who is an Arizona licensed registered nurse in good standing or a social worker with a minimum of three years of case management experience. The Case Management Supervisor must be located in Arizona to oversee case management staff.
Case Managers who are Arizona licensed registered nurses in good standing, social workers, or individuals 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 and have been determined to have an SMI, the requirement as of October 1, 2019 is as follows: (Refer to AMPM Policy 1630)
1. One year of case management experience serving elderly and/or persons with physical or developmental disabilities, and
 2. Two years of case management experience serving members determined to have an SMI.
- Case managers must be sufficient in numbers and located in Arizona to perform assessment and care planning services for all enrolled members.
32. **Housing, Education and Employment staff** designated as the subject matter expert(s) on housing, education and employment issues and resources within the Contractor's service area as outlined in Section D, Paragraph 16, Case Management.

The Contractor must submit to the following items as specified in Section F, Attachment F3, Contractor Chart of Deliverables:

1. An organization chart complete with the key staff positions. The chart must include the person's name, title, location and portion of time allocated to each Medicaid Contract and other lines of business.
2. A functional organization chart of the key program areas, responsibilities and reporting lines.
3. A listing of all Key Staff to include the following:
 - a. Individual's name,
 - b. Individual's title,
 - c. Individual's telephone number,
 - d. Individual's email address,
 - e. Individual's location(s),
 - f. Documentation confirming applicable Key Staff functions are filled by individuals who are in good standing (for example, a printout from the Arizona Medical Board webpage showing the CMO's active license), and
 - g. A list of all Key Staff functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past Contract year.
4. An attestation adhering to staffing requirements/limitations for all staff.

Staff Training and Meeting Attendance

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

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

All transportation, prior authorization and member services representatives must be trained in the geography of any/all GSA(s) in which the Contractor holds a Contract and have access to mapping search engines and/or applications for the purposes of authorizing services in, recommending providers in, and transporting members to the most geographically appropriate location.

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

26. WRITTEN POLICIES AND PROCEDURES

The Contractor shall develop and maintain written policies and procedures for each functional area, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies and procedures. All policies and procedures shall be reviewed at least annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's Administrator or appropriate executive officer. Minutes reflecting the review and approval of the policies by an appropriate committee, chaired by the Contractor's Chief Executive Officer/Administrator, Medical Director/Chief Medical Officer or Chief Financial Officer are also acceptable documentation. All medical and quality management policies shall be approved and signed by the Contractor's Medical Director/Chief Medical Officer.

If AHCCCS deems a Contractor's policy or process to be inefficient and/or place an unnecessary burden on the members or providers, the Contractor must work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS.

27. NETWORK DEVELOPMENT

The provider network must be a foundation that supports an individual member's needs as well as the membership as a whole. The Contractor shall develop, maintain and monitor a comprehensive provider network that is diverse and supports the unique needs of the ALTCS E/PD population. The provider network shall include in home care services and Alternative HCBS Settings that are supported by written agreements and which is sufficient to provide all covered services ensuring access at or above community norms. Priority shall be placed on allowing members to live in the most integrated and least restrictive setting and ensuring members have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home, or choosing an Alternative HCBS Settings rather than residing in an institution.

The Contractor shall incorporate the following critical requirements in the development of a sufficient and effective network in order to meet the needs of members:

1. Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles as outlined in Section D, Paragraph 1, Purpose, Applicability, and Introduction:
 - a. Member-Centered Case Management
 - b. Member-Directed Options
 - c. Person-Centered Planning
 - d. Consistency of Services
 - e. Accessibility of Network
 - f. Most Integrated Setting
 - g. Collaboration with Stakeholders
2. Ensuring support of the member's informal support system (e.g., family caregivers).
3. Developing HCBS settings to meet the needs of members who are elderly or have a physical disability and those who have cognitive impairments, behavioral health needs, and other special health care needs.
4. Promoting the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity [42 CFR 438.206]. See ACOM Policy 405 and Section D, Paragraph 63, Cultural Competency.

The Contractor is prohibited from utilizing as a placement setting for members, Group Homes for the Developmentally Disabled, as administered under Arizona Administrative Code, Title 6, Chapter 6, Articles 10 and 11.

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers to maximize member choice. Services shall be accessible to members in terms of timeliness, amount, duration and scope as those are available to beneficiaries under Fee-For-Service Medicaid [42 CFR 438.210(a)(2)]. The Contractor shall ensure its provider network provides physical access, accessible equipment, reasonable accommodations, culturally competent communications, for all members including those with physical or cognitive disabilities.

The Contractor shall meet Network Standards as specified in ACOM Policy 436.

The Contractor shall design its provider network to maximize the availability of community based primary care and specialty care access. The network shall also be designed to reduce utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems.

The Contractor is required to have available non-emergent after-hours physician or primary care services within its network. If the network is unable to provide medically necessary services required under Contract, the Contractor shall ensure timely and adequate coverage of these

services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

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

Arizona Early Intervention Program (AzEIP): The Contractor must pay all AHCCCS registered AzEIP providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services. Refer to AMPM Policy 430, Exhibit 430-3. AHCCCS has developed an AzEIP Speech Therapy Fee Schedule and rates incorporating one procedure code, along with related modifiers, settings, and group sizes. The Contractor shall utilize this methodology and these rates for payment for the speech therapy procedure when provided to an AHCCCS member who is a child identified in the AHCCCS system as an AzEIP recipient.

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

Network Development and Management Plan: The Contractor shall develop and maintain a Network Development and Management Plan which ensures the provision of covered services [42 CFR 438.207(b)]. The submission of the Network Management and Development Plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Network Development and Management Plan must include the requirements outlined in ACOM Policy 415 and those listed below:

Alternative HCBS Settings: To ensure members are residing in the most appropriate, least-restrictive setting the Contractor shall develop and implement proactive strategies directed at reducing the percentage, not to exceed 20%, of members residing in their own homes and in Alternative HCBS Settings. The strategies that are developed and/or implemented shall not lead

to or incentivize an increase in the percentage of members residing in nursing facilities and shall not infringe upon member's choices and preference.

Upon identification that 20% or more of the Contractor's membership are residing in Alternative HCBS Settings, in any GSA, the Contractor will be required to reevaluate and provide evidence of interventions utilized to reduce the percentage. The strategies that are developed and/or implemented shall not lead to or incentivize an increase in the percentage of members residing in nursing facilities and shall not infringe upon member's choices and preference.

Gap in Critical Services: The Contractor is responsible for establishing a network of contracted providers adequate to ensure that Critical Services are provided without gaps in care. The Contractor shall resolve gaps in Critical Services within two hours of a gap being reported. The Contractor shall have back-up caregivers available on-call to substitute for those times when an unforeseeable gap in Critical Service occurs.

The term "Critical services" includes attendant care, personal care, homemaking, and respite care, and is inclusive of, but not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

"Gap in Critical Services" is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of the scheduled type of critical services that are actually delivered to the member. See AMPM Policy 1620 for an explanation of critical services.

The Contractor shall implement policies and procedures to identify, correct, track, and report gaps in critical services. Reference ACOM Policy 413 and AMPM Chapter 1600, and submit deliverables as specified Section F, Attachment F3, Contractor Chart of Deliverables.

Workforce Development: The economy, population growth and career advancement opportunities all play a role in the viability of a paraprofessional workforce sufficient to meet the needs of and provide quality care to ALTCS members. The Contractor shall have as part of its Network Management and Development Plan a component regarding workforce development for nursing facilities, alternative HCBS Settings and direct care service agencies (attendant care, personal care and homemaker). Work Force Development is defined as all activities that sustain a number of competent individuals participating in the long-term health care workforce including workforce preparation, recruitment and retention. The Contractor shall implement strategies to:

1. Proactively identify potential challenges and threats to the viability of the workforce,
2. Conduct analysis of the potential impact of the challenges and threats to access to care for members,
3. Develop and implement interventions to prevent or mitigate threats to workforce viability, and
4. Develop indicators to measure and monitor workforce sustainability.

DME Service Delivery: Durable Medical Equipment (DME) (e.g. wheelchairs, walkers, hospital beds, and oxygen equipment) is critical in optimizing the member's independence and functional level, both physically and mentally, and to support service delivery in the most integrated setting and

foster engagement in the community. The Contractor is required to provide medically necessary DME to members in a timely manner consistent with AHCCCS Policy. The Contractor shall track and report timeliness of DME service delivery as outlined in ACOM Policy 415 and submit deliverables as specified Section F, Attachment F3, Contractor Chart of Deliverables.

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

MSICs are established facilities providing interdisciplinary services for members with qualifying CRS conditions as described in A.A.C. R9-28-203. The Contractor is encouraged to contract with MSICs for any member benefiting from interdisciplinary services.

28. NETWORK MANAGEMENT

The Contractor shall have policies on how the Contractor will [42 CFR 438.214(a)]:

1. Communicate and negotiate with the network regarding contractual and/or program changes and requirements;
2. Monitor network compliance with policies and Rules of AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
3. Evaluate the quality of services delivered by the network;
4. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
5. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
6. Process provisional credentials;
7. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;
8. Provide training for its providers and maintain records of such training;
9. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate; and
10. Ensure that provider calls are acknowledged within three business days of receipt; resolved and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from AHCCCS).

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

Material Change to Provider Network: The Contractor is responsible for evaluating all provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's provider network [42 CFR 438.207 (c)]. All material changes to the provider network must be approved in advance by AHCCCS, Division of Health Care Management. The Contractor must submit the request for approval of a material change to the provider network as outlined in ACOM Policy 439 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. A material change to the provider network is defined as one that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and/or provider network standards as described in this Contract including, but not limited to, any change that would cause or is likely to cause more than 5% of members in a GSA to change the location where services are received or rendered.

See Section D, Paragraph 41, regarding material changes by the Contractor that may impact business operations.

See Section D, Paragraph 54 regarding material changes by the Contractor that may impact capitation rates.

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

Provider/Network Changes Report: The Contractor must submit a Quarterly Provider/Network Changes Due to Rates Report as described in ACOM Policy 415 and Section F, Attachment F3, Contractor Chart of Deliverables.

29. PROVIDER MANUAL

The Contractor shall develop, distribute and maintain a provider manual as described in ACOM Policy 416.

30. PROVIDER REGISTRATION

The Contractor shall ensure that all its subcontractors register with AHCCCS as an approved service provider. For specific requirements on Provider Registration refer to the AHCCCS website.

The National Provider Identifier (NPI) is required on all claim submissions from providers and subsequent encounters that are eligible for an NPI. The Contractor shall work with providers to obtain their NPI.

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

31. PROVIDER AFFILIATION TRANSMISSION

The Contractor must submit information regarding its provider network in the format described in the AHCCCS Provider Affiliation Transmission (PAT) User Manual which can be found on the AHCCCS website. The Contractor shall also validate its compliance with minimum network requirements against the network information provided in the PAT through the submission of a completed Minimum Network Requirements Verification Template (see ACOM Policy 436 for Template). The PAT and the Minimum Network Requirements Verification Template must be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

32. SUBCONTRACTS

The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as outlined in this Paragraph, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified person or organization [42 CFR 438.6].

The Contractor shall oversee, and is accountable for, any functions and responsibilities that it delegates to any subcontractor [42 CFR 438.230(a)]. All such subcontracts must be in writing [42 CFR 438.6(l)].

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

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

The Contractor shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this Contract [42 CFR 434.6(c)].

Minimum Subcontract Provisions: All subcontracts must reference and require compliance with the Minimum Subcontract Provisions. See the AHCCCS Minimum Subcontract Provisions on the AHCCCS website. In addition, each subcontract must contain the following:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor,
2. Identification of the name and address of the subcontractor,
3. Identification of the population, to include patient capacity, to be covered by the subcontractor,
4. The amount, duration and scope of services to be provided, and for which compensation will be paid,

5. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation,
6. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability,
7. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to the Contractor,
8. A description of the subcontractor's patient, medical, dental and cost record keeping system,
9. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM,
10. A provision stating that a Change in Organizational Structure of an Administrative Services Subcontractor shall require a Contract amendment and prior approval of AHCCCS,
11. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population,
12. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage,
13. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members,
14. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract,
15. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this Contract and applicable law and regulation,
16. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor, and
17. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

In the event of a modification to the AHCCCS Minimum Subcontract Provisions the Contractor shall issue a notification of the change to its subcontractors within 30 days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first. See ACOM Policy 416.

Provider Agreements: The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Furthermore, the Contractor shall not prohibit a provider from providing services for any other AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

The Contractor must make reasonable efforts to enter into a written agreement with any provider providing services at the request of the Contractor more than 25 times during the previous Contract year and/or are anticipated to continue providing services for the Contractor. The Contractor must

follow ACOM Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the adequacy of its network.

For all subcontracts in which the Contractor and subcontractor have a capitated arrangement/risk sharing arrangement, the following provision must be included verbatim in every contract:

If <the Subcontractor> does not bill <the Contractor>, < the subcontractor's> encounter data that is required to be submitted to <the Contractor> pursuant to contract is defined for these purposes as a "claim for payment". <The Subcontractor's> provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) §36-2918, §36-2932, and 36-2957.

If the Contractor has a contract for specialty services with a nursing facility or Alternative HCBS Setting, the contract must include a Work Statement that outlines the special services being purchased, including admission criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description and other non-clinical services such as increased activities. In the event that a contract is terminated with a nursing facility or Alternative HCBS Setting, in a GSA with more than one ALTCS E/PD Contractor, the Contractor must adhere to the requirements outlined in ACOM Policy 421.

Nursing Facility subcontracts shall include a provision to ensure temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e) 3 and (g) 2. The provision must also require the subcontractor to ensure these registry personnel are fingerprinted as required by A.R.S. §36-411.

If the Contractor delegates the collection of member Share of Cost (SOC) to a provider, the provider contract must spell out complete details of both parties' obligations in SOC collection.

Administrative Services Subcontracts: All Administrative Services Subcontracts entered into by the Contractor require prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this Contract. Proposed Administrative Services Subcontracts shall be submitted as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA. The Contractor's Administrator/CEO must retain the authority to direct and prioritize any delegated contract requirements.

Delegated agreements for operational functions which are determined by AHCCCS to inhibit integrated service delivery for the Medicaid or Medicare D-SNP lines of business are prohibited. Examples of delegated functions which are prohibited include Case Management, management of behavioral health service delivery, and the Grievance and Appeal System. Examples of delegated functions which may be permissible include credentialing, PBM Claims processing, disease management, and transportation. The Contractor's Administrator/CEO must retain the authority to direct and prioritize any delegated contract requirements.

Before entering into an Administrative Services Subcontract which delegates duties or responsibilities to a subcontractor, the Contractor must evaluate the prospective subcontractor's ability to perform

the activities to be delegated. If the Contractor delegates duties or responsibilities then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the Administrative Services Subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the Administrative Services Subcontractor's performance is inadequate.

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion. Additionally, if at any time during the period of the Administrative Services Subcontract the subcontractor is found to be in non-compliance, the Contractor shall notify AHCCCS and comply with ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor must submit an annual Administrative Services Subcontractor Evaluation Report as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall require Administrative Services Subcontractors to adhere to screening and disclosure requirements as described in Section D, Paragraph 64, Corporate Compliance.

A change to a subcontract due to a Change in Organizational Structure of an Administrative Services Subcontractor requires prior approval of AHCCCS, as outlined in ACOM Policy 438.

33. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing advance directives for adults as specified in 42 CFR 438.3(j) and 42 CFR 422.128; and AMPM Policy 640 and AMPM Policy 930:

1. Each contract or agreement with a hospital, nursing facility, hospice, and providers of home health care or personal care services must comply with Federal and State law regarding advance directives for adult members [42 CFR 438.3(j)(1)]. Requirements include:
 - a. Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. §36-3205.C.1,
 - b. Providing written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives including any conscientious objections [42 CFR 438.3(j)(3)],
 - c. Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed,
 - d. Preventing discrimination against a member because of his or her decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive, and

- e. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care services, if any advanced directives are executed by members to whom they are assigned to provide services.
2. The Contractor shall require PCPs which have agreements with the entities described in paragraph a. above, to comply with the requirements of subparagraph 1.(a.) through 1.(e.) above.
 3. The Contractor shall require health care providers specified in subparagraph 1 above 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 and, provide education to staff on issues concerning advance directives.
 4. The Contractor shall provide written information to adult members and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231, regarding the following [42 CFR 422.128]:
 - a. A member's rights regarding advance directives under Arizona State law,
 - b. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience,
 - c. A description of the applicable State law and information regarding the implementation of these rights,
 - d. The member's right to file complaints directly with AHCCCS,
 - e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience

This statement, at a minimum must do the following:

- Clarify institution-wide conscientious objections and those of individual physicians,
 - Identify State legal authority permitting such objections, and
 - Describe the range of medical conditions or procedures affected by the conscience objection, and
- f. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.3(j)(4)]
5. Written information regarding advance directives shall be provided to members at the time of enrollment with the Member Handbook. Refer to ACOM Policy 404 for member information and Member Handbook requirements.
 6. The Contractor is not relieved of its obligation to provide the above information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

34. SPECIALTY CONTRACTS

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

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty contractors to enhance the cost effectiveness of service delivery. Medical management and adjudication of claims related to payments provided under specialty contracts shall remain the responsibility of the Contractor.

AHCCCS has specialty contracts, including but not limited to, transplant services, anti-hemophiliac agents, and pharmaceutical related services. AHCCCS shall provide at least 60 days advance written notice to the Contractor prior to the implementation of any specialty contract. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

35. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

In the absence of a contract between the Contractor and a hospital providing otherwise, the Contractor shall reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. §§36-2904 and 2905.01, and 9 A.A.C. 22, Article 7, which includes without limitation: reimbursement of the majority of inpatient hospital services with discharge dates on and after October 1, 2014, using the APR-DRG payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81; reimbursement of limited inpatient hospital services with discharge dates on and after October 1, 2014, using per diem rates described in A.A.C. R9-22-712.61; and, in Pima and Maricopa Counties, payment to non-contracted hospitals at 95% of the amounts otherwise payable for inpatient services.

The Contractor is encouraged to obtain subcontracts with hospitals in all GSAs. A Contractor serving out-of-state border communities (excluding Mexico) shall establish contractual agreements with those out-of-state hospitals in counties that are identified by GSA in ACOM Policy 436. In the event contractual agreements cannot be obtained, the Contractor shall obtain contracts with physicians who have admitting and treating privileges at these hospitals to meet requirements outlined in ACOM Policy 436. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

The Contractor may conduct prepayment, concurrent and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims may be subject to recoupment. If the Contractor fails to identify lack of medical necessity through prepayment and/or concurrent medical review, lack of medical necessity shall not constitute a basis for recoupment of paid hospital claims, including outlier claims, unless the Contractor identifies the lack of medical necessity through a post-payment medical review of information that the Contractor could not have discovered during a prepayment and/or concurrent medical review through the exercise of due

diligence. The Contractor shall comply with Section D, Paragraph 42, Claims Payment/Health Information System.

For information on Value Based Purchasing Differential Adjusted Payments see Section D, Paragraph 80, Value-Based Purchasing.

36. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this Contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)]. Except for annual well woman exams, behavioral health and children's dental services, and consistent with the terms of the demonstration, covered services must be provided by or coordinated with a primary care provider.

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. The Contractor shall adjust the size of the PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. AHCCCS shall inform the Contractor when a PCP has a panel of more than 1,800 AHCCCS members, to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis.

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to develop a methodology to assign members to those providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes. The Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCP's with assigned members diagnosed with AIDS or as HIV-positive shall meet criteria and standards set forth in the AMPM.

The Contractor shall ensure that providers serving EPSDT-aged members utilize the AHCCCS-approved EPSDT Tracking forms and standardized developmental screening tools and are trained in the use of the tools. EPSDT-aged members shall be assigned to providers who are trained on and who use AHCCCS approved developmental screening tools.

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m) and 438.52(d) and this Contract. Any American Indian who is enrolled with the Contractor and who is eligible to receive services from a participating I/T/U provider may elect that I/T/U as his or her primary care provider, if that I/T/U participates in the network as a primary care provider and has capacity to provide the services per ARRA Section 5006(d) and SMD letter 10-001.^{xiii} The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs,

the process for changing the PCP assignment, should the member desire to do so, as well as the information required in ACOM Policy 404 for member information requirements. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

1. Supervising, coordinating and providing care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral),
2. Initiating of referrals for medically necessary specialty care,
3. Maintaining continuity of care for each assigned member,
4. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health,
5. Utilizing the AHCCCS approved EPSDT Tracking form,
6. Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider, and
7. If serving children, for enrolling as a Vaccines for Children (VFC) provider, and
8. Utilizing the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing controlled medications.

The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty and referral services provided to assigned members by specialty physicians, and other health care professionals.

37. APPOINTMENT STANDARDS

The Contractor shall actively monitor and track provider compliance with appointment availability standards as required in ACOM Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that providers offer a range of appointment availability, per appointment timeliness standards, for intakes, initial services, and ongoing services based upon the clinical need of the member. The exclusive use of same-day only appointment scheduling and/or open access is prohibited within the Contractor's network. The Contractor is required on a quarterly basis to conduct review of the availability of and report this information as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

If the Contractor's network is unable to provide medically necessary services required under contract, the Contractor must adequately and timely cover these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

For medically necessary non-emergent transportation, the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the

appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. Also see Section D, Paragraph 11, Special Health Care Needs. The Contractor must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

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

The Contractor shall establish processes to monitor and reduce the appointment “no-show” rate by provider and service type. As best practices are identified, AHCCCS may require implementation by the Contractor.

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

38. INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives

The Contractor must ensure compliance with all applicable physician incentive requirements, including but not limited to 42 CFR 438.3(i), 42 CFR 422.208 and 42 CFR 422.210. These regulations, in part, prohibit Contractors from operating any physician incentive plan that directly or indirectly makes payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a member.

The Contractor shall not enter into contractual arrangements that place providers at substantial financial risk as defined in 42 CFR 422.208 unless prior written approval of the contractual arrangement is received by AHCCCS, Division of Health Care Management. For those proposed contractual arrangements which meet the definition of substantial financial risk, the following must be submitted to the AHCCCS, Division of Health Care Management, for review and approval at least 45 days prior to the implementation of the contract as specified in Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.6(g)]:

1. The type of incentive arrangement,
2. A plan for a member satisfaction survey,
3. Details of the stop-loss protection provided,
4. A summary of the compensation arrangement that meets the substantial financial risk definition, and
5. Any other items as requested by AHCCCS

Upon request from CMS or AHCCCS, the Contractor shall promptly disclose all requested information regarding its physician incentive plans. In addition, the Contractor shall provide the information specified in 42 CFR 422.210 to any member who requests it.

Any Contractor-selected and/or developed pay for performance initiative that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management prior to implementation as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

AHCCCS shall review the Value-Based Purchasing deliverables required under Section D, Paragraph 80, Value-Based Purchasing.

39. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

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

1. Use of referral forms clearly identifying the Contractor.
2. Process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services.
3. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services.
4. Referral to Medicare.
5. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners [42 CFR 438.206(b)(2)].
6. For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
7. Allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

The Contractor shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act and their implementing regulations which include but are not limited to 42 CFR Part 411, Part 424, Part 435 and Part 455. Sections 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services are:

1. Clinical laboratory services
2. Physical therapy services
3. Occupational therapy services
4. Outpatient speech-language pathology services
5. Radiology and certain other imaging services
6. Radiation therapy and supplies
7. Durable medical equipment and supplies
8. Parenteral and enteral nutrients, equipment and supplies

9. Prosthetics, orthotics and prosthetic devices and supplies
10. Home health services
11. Outpatient prescription drugs
12. Inpatient and outpatient hospital services

40. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

The Contractor is encouraged to use Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) and FQHC Look-Alikes in Arizona to provide covered services. FQHCs/RHCs and FQHC Look-Alikes are paid unique, cost-based Prospective Payment System (PPS) rates for non-pharmacy ambulatory Medicaid-covered services. The PPS rate is an all-inclusive per visit rate.^{xiv}

To ensure compliance with the requirement of 42 USC 1396b(m)(2)(A)(ix) that the Contractor's payments, in aggregate, will not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC or FQHC Look-Alike:^{xv}

1. For dates of service from October 1, 2014 through March 31, 2015, the Contractor shall negotiate rates of payment with FQHCs/RHCs and FQHC Look-Alikes for non-pharmacy ambulatory services that are comparable to the rates paid to providers that provide similar services.
2. For dates of service on and after April 1, 2015, the Contractor shall pay the unique PPS rates, or negotiate sub-capitated agreements comparable to the unique PPS rates, to FQHCs/RHCs and FQHC Look-Alikes for PPS-eligible visits.

AHCCCS reserves the right to review a Contractor's rates with an FQHC/RHC and FQHC Look-Alikes for reasonableness and to require adjustments when rates are found to be substantially less than those being paid to other, non-FQHC/RHC/FQHC Look-Alikes providers for comparable services, or not equal to or substantially less than the PPS rates.

The Contractor shall be required to submit member month information for members for each FQHC/RHC/FQHC Look-Alikes as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS may perform periodic audits of the member information submitted. Refer to the AHCCCS Financial Reporting Guide for ALTCS Contractors, for further guidance. The FQHCs/RHCs and FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website.

See Section D, Scope of Services Paragraph 10, *Prescription Medications* for more information related to 340B Drug Pricing.

41. MATERIAL CHANGE TO BUSINESS OPERATIONS

The Contractor is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's business operations [42 CFR 438.207 (c)]. All material changes to the business operations must be approved in advance by AHCCCS, Division of Health Care Management. The Contractor must submit the request for approval of a material change to business operations as outlined in ACOM Policy 439 and as specified in Section F, Attachment F3, Contractor Chart of

Deliverables. A material change to business operations is defined as any change in overall business operations (e.g., policy, process, protocol such as prior authorization or retrospective review) that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.

The Contractor may be required to conduct meetings with providers to address issues (or to provide general information, technical assistance, etc.) related to Federal and State requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by AHCCCS.

See Section D, Paragraph 28, regarding material changes by the Contractor that may impact the provider network.

See Section D, Paragraph 67, for additional submission requirements regarding system changes and upgrades.

42. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes and systems that ensure the accurate collections and processing of claims, analysis, integration, and reporting of data. These processes and systems shall result in information on areas including, but not limited to, service utilization and claim disputes and member appeals [42 CFR 438.242(a)].

General Claims Processing Requirements

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

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
2. Multiple Procedure/Surgical Reductions, and
3. Global Day E & M Bundling standards.

The Contractor's claims payment system must be able to assess and/or apply data related edits including but not limited to:

1. Benefit Package Variations
2. Timeliness Standards
3. Data Accuracy
4. Adherence to AHCCCS Policy
5. Provider Qualifications
6. Member Eligibility and Enrollment
7. Over-Utilization Standards

The Contractor must produce a remittance advice related to the Contractor's payments and/or denials to providers and each must include at a minimum:

1. The reason(s) for denials and adjustments
2. A detailed explanation/description of all denials, payments and adjustments

3. The amount billed
4. The amount paid
5. Application of COB and copays
6. Provider rights for claim disputes

Additionally, the Contractor must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. See Section D, Paragraph 67, Systems and Data Exchange Requirement, for specific standards related to remittance advice and EFT payment.

AHCCCS requires the Contractor to attend and participate in AHCCCS workgroups including Technical Consortium meetings to review upcoming initiatives and other technical issues.

Per A.R.S. §36-2904, unless a shorter time period is specified in Contract, the Contractor shall not pay a claim initially submitted more than six months after the date of service or date of eligibility posting whichever is later, or pay a clean claim submitted more than 12 months after date of service or date of eligibility posting, whichever is later; except as directed by AHCCCS or otherwise noted in this Contract.

Regardless of any subcontract with an AHCCCS Contractor, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor), the provider may file a claim for payment with the responsible Contractor. The responsible Contractor shall not deny a claim on the basis of lack of timely filing if the provider submits a clean claim to the responsible Contractor no later than 60 days from the date of the recoupment, 12 months from the date of service, or 12 months from date that eligibility is posted, whichever date is later.

Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. §36-2904. Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

In accordance with the Deficit Reduction Act of 2005, Section 6085, SMD letter 06-010, and Section 1932(b)(2)(D) of the Social Security Act, the Contractor is required to reimburse non-contracted emergency services providers at the AHCCCS Fee-For-Service rate.^{xvi} This applies to in State as well as out of State providers.

In accordance with A.R.S. §36-2904 the Contractor is required to reimburse providers of hospital and non hospital services at the AHCCCS fee schedule in the absence of a contract or negotiated rate. This requirement applies to services which are directed out of network by the Contractor or to emergency services. For inpatient stays at urban hospitals pursuant to A.R.S. §36-2905.01 for non-emergency services, the Contractor is required to reimburse non-contracted providers at 95% of the AHCCCS fee schedule specified in A.R.S. §36-2903.01. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

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

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim to the Contractor which includes the documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization; an EOB, policy or procedure, Provider Manual excerpt.

For hospital clean claims, in the absence of a contract specifying otherwise, a Contractor shall apply a quick pay discount of 1% on claims paid within 30 days of receipt of the clean claim. For hospital clean claims, in the absence of a contract specifying other late payment terms, a Contractor is required to pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. §36-2903.01).

For all non-hospital clean claims, in the absence of a contract specifying other late payment terms, a Contractor is required to pay interest on payments made after 45 days of receipt of the clean claim (as defined in this contract). Interest shall be at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

In the absence of a contract specifying other late payment terms, a claim for an authorized service submitted by a licensed skilled nursing facility, assisted living ALTCS provider or a home and community based ALTCS provider shall be adjudicated within 30 calendar days after receipt by the Contractor. A Contractor is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (A.R.S. §36-2943(D)).

The Contractor shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

Standardized claims for services must be submitted per A.A.C. R9-28-701.10(5), therefore roster billing is not permitted for nursing facilities.

See ACOM Policy 203 for additional information regarding requirements for the adjudication and payment of claims.

Recoupments: The Contractor's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims.

Any individual recoupment in excess of \$50,000 per provider, or Tax Identification Number within a Contract year or greater than 12 months after the date of the original payment must be approved as specified in Section F, Attachment F3, Contractor Chart of Deliverables and as further described in ACOM Policy 412.

When recoupment amounts for a Provider TIN cumulatively exceed \$50,000 during a Contract year (based on recoupment date), the Contractor must report the cumulative recoupment monthly to the designated AHCCCS Operations and Compliance Officer as outlined in the AHCCCS Claims Dashboard Reporting Guide and Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. AHCCCS may validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. Refer to ACOM Policy 412 and AHCCCS Encounter Manual for further guidance.

Appeals: If the Contractor or a Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process as a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

Claims Processing Related Reporting: The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide and Section F, Attachment F3, Contractor Chart of Deliverables.

AHCCCS may require the Contractor to review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for specified requirements. AHCCCS shall determine and provide a format for the reporting of this data at the time of the request.

Claims System Audits: The Contractor shall develop and implement an internal ongoing claims audit function that will include, at a minimum, the following:

1. Verification that provider contracts are loaded correctly
2. Accuracy of payments against provider contract terms

Audits of provider contract terms must be performed on a regular and periodic basis and consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology must be documented in policy and the Contractor shall review the contract loading of both large groups and individual practitioners at least once every five year period in addition to any time a contract change is initiated during that timeframe. The findings of the audits described above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

In addition, in the event of a system change or upgrade, the Contractor may also be required to initiate an independent audit of the Claim Payment/Health Information System, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Division of Health Care Management will approve the scope of this audit, and may include areas such as a verification of eligibility and enrollment information loading, contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

43. PERFORMANCE BOND OR BOND SUBSTITUTE

In addition to the initial minimum capitalization requirements, the Contractor shall be required to establish and maintain a performance bond, in accordance with ACOM Policy 305 for as long as the Contractor has AHCCCS-related liabilities of \$50,000 or more outstanding, or 15 months following the termination date of this Contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to providers, and (2) performance by the Contractor of its obligations under this Contract [42 CFR 438.116]. The performance bond shall be in a form acceptable to AHCCCS as described in ACOM Policy 305.

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

1. Paying any damages sustained by providers, contracted or otherwise, because of a breach of the Contractor's obligations under this Contract;
2. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and
3. Reimbursing AHCCCS for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this Contract, including, but not limited to, expenses incurred after termination of this Contract for reasons other than the convenience of the State by AHCCCS.

In the event AHCCCS agrees to accept substitute security in lieu of the security types outlined in ACOM Policy 305, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce AHCCCS' security interest in such substitute security including, but not limited to, security agreements and necessary Uniform Commercial Code filings pursuant to the Arizona Uniform Commercial Code. The Contractor must request acceptance from AHCCCS when a substitute security in lieu of the security types outlined in ACOM Policy 305 is established. In the event such substitute security is agreed to and accepted by AHCCCS, the Contractor acknowledges that it has granted AHCCCS a security interest in such substitute security to secure performance of its obligations

under this Contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. AHCCCS may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide AHCCCS with a form of security described in ACOM Policy 305. The Contractor may not change the amount, duration or scope of the performance bond without prior approval from AHCCCS, Division of Health Care Management.

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

44. AMOUNT OF PERFORMANCE BOND

The initial amount of the performance bond shall be equal to 100% of the total capitation payment, including acute care only members, expected to be paid to the Contractor in the first month of the Contract year, or as determined by AHCCCS. The total capitation amount excludes premium tax. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall review the capitation amounts of the Contractor on a monthly basis to determine if the performance bond must be increased. The Contractor shall increase the amount of the performance bond no later than 30 days following notification by AHCCCS. The Performance Bond amount that must be maintained after the Contract term shall be sufficient to cover all outstanding liabilities and will be determined by AHCCCS. The Contractor may not change the amount, duration or type of the Performance Bond without prior written approval from AHCCCS, Division of Health Care Management. Refer to ACOM Policy 305 for more details.

45. ACCUMULATED FUND DEFICIT

The Contractor and its owners must review financial statements for accumulated fund deficits on a quarterly and annual basis. In the event the Contractor has a fund deficit, the Contractor and its owners shall fund the deficit through capital contributions in a form acceptable to AHCCCS. The capital contributions must be for the period in which the deficit is reported and shall occur within 30 days of the financial statement due date to AHCCCS. AHCCCS at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. AHCCCS may, at its option, impose sanctions and/or enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

46. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

If the Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management in accordance with ACOM Policy 438. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made.

If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. Refer to ACOM Policy 317. AHCCCS may impose enrollment caps in any or all GSA's as a result of a change in ownership. AHCCCS may also offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two

Contractors within the same line of business to utilize the same management service company in the same GSA.

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 32, Subcontracts and Section F, Attachment F3, Contractor Chart of Deliverables and as outlined in ACOM Policy 438.

47. ADVANCES, EQUITY DISTRIBUTIONS, LOANS AND INVESTMENTS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, equity distributions, loans, loan guarantees, or investments, including, but not limited to those to related parties or affiliates including another fund or line business within its organization. The Contractor shall not, without prior approval of AHCCCS, make loans or advances to providers in excess of \$50,000. All requests for prior approval are to be submitted to DHCM as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 418 for further information.

48. FINANCIAL VIABILITY STANDARDS

The Contractor must comply with the AHCCCS established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Member; Medical Expense Ratio; and the Administrative Cost Percentage. These same standards will be reviewed for the financial statements applicable to the Contractor's Medicare line of business if the Contractor is certified by AHCCCS.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. AHCCCS will take into account the Contractor's unique programs for managing care and improving the health status of members when analyzing medical expense and administrative ratio results. However, if a critical combination of the Financial Viability Standards is not met, additional monitoring, such as monthly reporting, may be required.

Financial Viability Standards:

Current Ratio

(Current assets divided by current liabilities). Current assets may include any long-term investments that can be converted to cash within 24 hours without significant penalty, i.e., greater than 20%.

Standard: At least 1.00

If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.

Equity per Member

(Unrestricted equity, less on-balance sheet performance bond divided by the number of members at the end of the period) Additional information regarding the Equity per Member requirement may be found in Policy 305.

Standard: At least \$2,000

Medical Expense Ratio

Total medical expense, including case management less TPL, divided by total payments received from AHCCCS less premium tax.

Standard: At least 85%

Total Administrative Cost Percentage

Total administrative expenses (excluding case management, premium tax and income taxes), divided by total payments received from AHCCCS less premium tax.

Standard: No greater than 8%

Financial Viability Standard – Medicare Advantage Plan Certified by AHCCCS:**Equity per Member**

Unrestricted equity, less on-balance sheet performance bond, divided by the number of Medicare Advantage Plan dual eligible members enrolled at the end of the period.

Standard: At least \$350

Additional information regarding the Equity per Member requirement may be found in ACOM Policy 305.

The Contractor shall comply with all financial reporting requirements contained in Section F, Attachment F3, Contractor Chart of Deliverables and the AHCCCS Financial Reporting Guide for ALTCS Contractors; a copy of which may be found on the AHCCCS website. This reporting is required for both the ALTCS E/PD and Medicare lines of business, regardless of the licensing or certifying entity for the Medicare Advantage Plan. If the Contractor is a Medicare Advantage Plan licensed through the Department of Insurance, quarterly reporting to AHCCCS is required for informational purposes only. The required reports are subject to change during the Contract term and are summarized in Section F, Attachment F3, Contractor Chart of Deliverables. See ACOM Policy 313 for more detail.

49. AFFILIATED CORPORATION

Within 120 days of contract award, a non-governmental Contractor shall have established an affiliated corporation for the purposes of this Contract, whose sole activity is the performance of the requirements of this Contract or other contracts with AHCCCS (A.R.S. §36-2906.01).

50. CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

A change in Contractor organizational structure shall require prior approval of AHCCCS, as specified in ACOM Policy 317 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor must submit notification and a detailed transition plan to AHCCCS 180 days prior to the effective date as outlined in ACOM Policy 317. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to perform the Contract requirements, ensure that services

to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by any change in organizational structure. AHCCCS reserves the right to obtain stakeholder input on proposed changes in a Contractor's organizational structure through a public notice and feedback process. In addition, AHCCCS reserves the right to temporarily suspend a Contractor's new member enrollment including, but not limited to, auto-assignment pending AHCCCS review and final determination regarding a Contractor's Change in Organizational Structure.

A change in organizational structure may require a Contract amendment. If the Contractor does not obtain prior approval, or AHCCCS determines that a change in organizational structure is not in the best interest of the State, AHCCCS may terminate this Contract pursuant to Section E, Contract Terms and Conditions. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in organizational structure occur. AHCCCS will not permit one organization to own or manage more than one Contract within the same line of business in the same GSA.

51. COMPENSATION

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

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

Where payments are made by electronic funds transfer, AHCCCS shall not be liable for any error or delay in transfer, nor indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor.

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

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

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

Capitation Payments: Capitation is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

Actuaries establish the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purpose of setting and rebasing and/or updating the capitation rates:

1. Utilization and unit cost data derived from fully adjudicated and approved encounters
2. Both unaudited and audited financial statements reported by the Contractors
3. HCBS and Institutional inflation trends
4. AHCCCS Fee-For-Service schedule pricing adjustments
5. Market Basket Inflation Trends
6. Population Risk/Risk Profile of membership
7. Programmatic or Medicaid covered service changes that affect reimbursement
8. Additional administrative requirements for the Contractor
9. Other changes to medical practices that effect reimbursement

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The following are examples of risk factors that may be included:

1. Reinsurance (as described in Section D, Paragraph 53, Reinsurance)
2. GSA
3. Medicare enrollment
4. HCBS member mix
5. Member share of cost amounts

For services or pharmaceuticals, in instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan or the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions approved by CMS; however, those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)] (Section 1903(i) and 1903(i)(17) of the Social Security Act).^{xvii} Graduate Medical Education payments (GME) are not included in the capitation rates but paid out separately consistent with the terms of Arizona's State Plan.^{xviii} Likewise, because AHCCCS does not delegate any of its responsibilities for administering Electronic Health Record (EHR) incentive payments to the Contractor, EHR payments are also excluded from the capitation rates and are paid out separately by AHCCCS pursuant to Section 4201 of the HITECH Act, 42 USC 1396b(t), and 42 CFR 495.300 et seq.^{xix}

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

The Contractor may receive two types of prospective capitation: full long term care capitation and acute care only capitation. Full long term care capitation is paid for those members who are receiving long term care services and reside in a nursing facility, a certified home and community based setting

or in their own home. At a minimum, the member must receive long term care services at least once every 30 days.

Acute care only capitation is paid for members who:

1. Reside in a living arrangement in which Long Term Care (LTC) Service benefits cannot be provided,
2. Refuse long term care LTC services,
3. Have equity value in a home that exceeds the allowable amount,
4. Have made an uncompensated transfer that makes him or her ineligible to receive LTC Services, or
5. Have not received LTC services in a full calendar month due to the following:
 - a. Refusal of LTC services,
 - b. Departure from the State for more than 30 days, or
 - c. LTC provider not available.

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

Reconciliation of PPC Costs to Reimbursement: AHCCCS will reconcile the Contractor’s PPC medical expense to PPC capitation paid to the Contractor during the year. This reconciliation will limit the Contractor’s profits and losses to 5%. Any losses in excess of 5% will be reimbursed to the Contractor, and likewise, profits in excess of 5% will be recouped. Refer to ACOM Policy 302A.

Reconciliation of Value-Based Purchasing Initiative: AHCCCS will settle the Contractor’s quality contributions and quality distributions through a reconciliation. Quality distributions in excess of quality contributions will be paid to the Contractor. Quality contributions in excess of quality distributions will be recouped from the Contractor. Value-Based Purchasing (VBP) payments made by the Contractor to providers will be incorporated in the reconciliation. Refer to Section D, Paragraph 80, Value-Based Purchasing for further details.

Home and Community Based Services Reconciliation: The Contractor’s capitation rate is based in part on the assumed ratio (“mix”) of HCBS member months to the total number of member months (i.e. HCBS + institutional). After the end of the Contract year, AHCCCS will compare the *actual* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. Member months for those members who received acute care services only are not included in this reconciliation. If the Contractor’s actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup or reimburse the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded, or was less than, the assumed percentage. This reconciliation will be made in accordance with the following schedule and ACOM Policy 303:

Percent <i>over/under</i> assumed percentage:	Amount to be recouped/reimbursed:
0 – 1%	0% of capitation

	over/underpayment
>1%	50% of capitation over/underpayment

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

NF Enhanced Payment Reconciliation: After the end of the Contract year, AHCCCS will compare actual NF Enhanced Payment funds to the NF Enhanced Payment allotment assumed in the calculation of the capitation rate. Assumed NF Enhanced Payment will be fully reconciled to actual NF Enhanced Payment funds, and AHCCCS will reimburse the total difference.

Health Insurer Fee: Section 9010 of the Patient Protection and Affordable Care Act (ACA) requires that the Contractor, if applicable, pay a Health Insurer Assessment Fee (HIF) annually beginning in 2014 based on its respective market share of premium revenues from the preceding year. Subject to the receipt of documentation from the Contractor regarding the amount of the Contractor's liability for the HIF, AHCCCS shall make a capitation rate adjustment consistent with a methodology approved by CMS to approximate the cost associated with the HIF. The cost of the Assessment Fee will include both the Assessment Fee itself and the corporate income tax liability the Contractor incurs related to the Assessment Fee. The Contractor must submit the items specified in Section F, Attachment F3, Contractor Chart of Deliverables to the DHCM Finance Manager. See ACOM Policy 320 with further details.

For Fee Year 2017, the Federal Government has placed a suspension for HIF taxes that would be paid in 2017 based on revenue received in 2016. Therefore, AHCCCS will suspend Contractor submission of the Form 8963, Report of Health Insurance Provider Information, and ACOM Policy 320, Attachment B, Health Insurer Fee Liability Reporting Template, related to Fee Year 2017 due September 30, 2017. AHCCCS will not make HIF payments to the Contractor for fee year 2017. Additionally, AHCCCS will suspend Contractor submission of the copies of its Federal and State filings for fee year 2017 due April 30, 2018.

Provider Rate Requirements: The Contractor shall ensure that individual Nursing Facility rates are at least equal to the Fee-For-Service rates. For HCBS contracted rates effective 10/01/17, the Contractor may be required to pass through an increase equal to the FFS rate increase, if any, for all HCBS rates in place as of 07/01/17 for all HCBS providers.

AHCCCS may verify that these pass through requirements for HCBS providers have been met.

The Contractors shall provide AHCCCS with documentation to support rate adjustments that need to be considered when building the capitation rates. AHCCCS expects provider contracts to be finalized by the start of the Contract year. All negotiations on rates are to be done in good faith.

It is the intent of AHCCCS to reevaluate the Level I, Level II and Level III nursing facility FFS rates to be effective October 1, 2017. This review may encompass a rate rebase, and/or may include an

expansion of the FFS rates to include specialty and/or add on rates. It is the expectation that the Contractor would adopt FFS rate methodology changes made by AHCCCS, if any. See Section D, Paragraph 76, Pending Issues for further information regarding a potential alternative reimbursement methodology for the AHCCCS FFS rates in the future.

For information on Value Based Purchasing Differential Adjusted Payments see Section D, Paragraph 80, Value-Based Purchasing.

52. MEMBER BILLING AND LIABILITY FOR PAYMENT

AHCCCS registered providers may charge AHCCCS members for services which are excluded from AHCCCS coverage, which are provided in excess of AHCCCS limits, or as otherwise described in A.A.C. R9-28-701.10(2).

Except for permitted copayments and calculated share of cost, the Contractor or its subcontractors must ensure that members are not held liable for:

1. The Contractor's or any subcontractor's debts in the event of the Contractor's or the subcontractor's insolvency
2. Covered services provided to the member except as permitted under A.A.C. R9-28-701.10(2) [42 CFR 438.106(b)(1)]
3. Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly [42 CFR 438.106(b)(2); 42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230]

53. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services as described in this paragraph and incurred for a member beyond an annual deductible. AHCCCS is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage (see table below). The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this Contract. Any change would have a corresponding impact on capitation rates. The reinsurance contract year is the year beginning on October 1 and ending on September 30. Refer to the AHCCCS Reinsurance Policy Manual for further details on the Reinsurance Program.

The deductible level is based on the Contractor's statewide ALTCS enrollment as of October 1st of each Contract Year. The following table represents current deductible and coinsurance levels:

Reinsurance Case Type	Statewide Plan Enrollment	Deductible With Medicare Part A	Deductible Without Medicare Part A	Coinsurance
Regular Reinsurance	0-1,999	\$10,000	\$20,000	75%
Regular Reinsurance	2,000 +	\$20,000	\$30,000	75%
Catastrophic Reinsurance	N/A	N/A	N/A	85%
Transplant and Other Case Types	N/A	N/A	N/A	85%

Annual deductible levels apply to all members.

Reinsurance Case Types

For all reinsurance case types, for services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the computation of reinsurance will be the lesser of the contracted/mandated amount or the Contractor paid amount.

Regular Reinsurance: Regular reinsurance coverage applies to prospective enrollment periods and is only available for members who have had an inpatient stay during the reinsurance contract year. Reinsurance covered services include dental, pharmacy and inpatient-and-outpatient hospital services. Once an inpatient stay has occurred, reinsurance covered services for the entire reinsurance contract year may be applied to meet the deductible. Professional services and other services reported on Form Type A will not be covered under reinsurance. See the AHCCCS Reinsurance Policy Manual for further details.

Effective October 1, 2018, AHCCCS intends that regular reinsurance coverage will include inpatient hospital services only (limited to reinsurance covered services as described in the AHCCCS Reinsurance Policy Manual). Services other than inpatient hospital services will be eliminated from regular reinsurance coverage.

Prior Period Coverage Reinsurance: PPC expenses are not covered for any members under the reinsurance program unless they qualify under transplant reinsurance.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biological drugs, and those members diagnosed with hemophilia, von Willebrand's Disease, or Gaucher's Disease, as follows:

Biological Drugs: Catastrophic reinsurance is available to cover the cost of certain biological drugs when medically necessary. The biological drugs covered under reinsurance may be reviewed by AHCCCS at the start of each reinsurance contract year. Refer to the Reinsurance Policy Manual for a complete list of the approved biological drugs. When a generic equivalent of a biological drug is available, AHCCCS will reimburse at the lesser of

the biological drug or its generic equivalent for reinsurance purposes, unless the generic equivalent is contra-indicated for a specific member.

Hemophilia: Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia.

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

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

For additional detail and restrictions refer to the AHCCCS Reinsurance Policy Manual. There are no deductibles for catastrophic reinsurance cases. For member's receiving biological drugs, AHCCCS will reimburse at 85% of the cost of the drug only. For those members diagnosed with hemophilia, von Willebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the reinsurance contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, whichever is lower, depending on the subcap/CN1 code indicated on the encounter.

AHCCCS holds a specialty contract for anti-hemophilic agents and related services for hemophilia. The Contractor may access anti-hemophilic agents and related pharmaceutical services for hemophilia or von Willebrand's under the terms and conditions of the specialty contract for members enrolled in their plans. In that instance, the Contractor is the authorizing payor. As such, the Contractor will provide prior authorization, care coordination, and reimbursement for all components covered under the contract for their members. A Contractor utilizing the contract will comply with the terms and conditions of the contract. A Contractor may use the AHCCCS contract or contract with a provider of their choice. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower.

The Contractor must notify AHCCCS, DHCM, Medical Management of cases identified for catastrophic reinsurance coverage, as specified in Attachment F3, Contractor Chart of Deliverables. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. All catastrophic claims are subject to medical review by AHCCCS.

High Cost Behavioral Health: Effective October 1, 2007 high cost behavioral health was discontinued under catastrophic reinsurance unless the case was approved prior to October 1, 2007 and was active on September 30, 2007.

Members considered by AHCCCS Division of Health Care Management to be high-cost behavioral health will be covered under catastrophic reinsurance using separate guidelines. In order to qualify for reinsurance reimbursement these members must have been approved by AHCCCS prior to October 1, 2007 and active on September 30, 2007. Behavioral health reinsurance will cover the institutional or HCBS setting only. Acute care services and all other ALTCS services are not covered by catastrophic behavioral health reinsurance but are covered under regular reinsurance as

described above, subject to applicable deductible levels and coinsurance percentages. The Contractor will be reimbursed at 75% of allowable payments with no deductible.

Transplant Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplants. Refer to AMPM Policy 310-DD and the AHCCCS Reinsurance Policy Manual for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplant services rendered, or 85% of the Contractor's paid amount. Transplant contracts include per diem rates for inpatient follow-up care post-transplant (day 11+ for kidneys and day 61+ for all other transplants). Reinsurance for these days follows the regular reinsurance reimbursement, including a deductible requirement. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplant rates may be found on the AHCCCS website. The Contractor must notify AHCCCS DHCM, Medical Management when a member is referred to a transplant facility for evaluation for an AHCCCS covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS DHCM Medical Management within 30 days of referral to the transplant facility for evaluation.

If a Contractor intends to use an out-of-state transplant facility for a covered transplant and AHCCCS already holds an in-state contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. Depending on the unique circumstances of each approved out-of-state transplant, AHCCCS Finance/Reinsurance may consider, on a case-by-case basis, reinsurance coverage at 85% of the Contractor's paid amount for comparable case/component rates. If no prior approval is obtained, and the Contractor incurs costs at the out-of-state facility, those costs are not eligible for either transplant or regular reinsurance.

Other Reinsurance: For all reinsurance case types other than transplants, the Contractor is reimbursed 100% for all medically necessary covered expenses provided in a reinsurance contract year, after the reinsurance case reaches \$650,000. It is the responsibility of the Contractor to notify AHCCCS, DHCM, Reinsurance Supervisor, once a reinsurance case reaches \$650,000. Failure to notify AHCCCS or failure to adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters for 100% reimbursement consideration.

Encounter Submission and Payments for Reinsurance

Encounter Submission: Contractors are reimbursed for reinsurance claims by submitting encounters that associate to a reinsurance case. All reinsurance associated encounters, except as provided below for "Disputed Matters", must reach an adjudicated/approved status within 15 months from the end date of service, or date of eligibility posting, whichever is later.

Encounters for claims which cross over reinsurance contract years will not be eligible for reinsurance.

AHCCCS will not pay reinsurance on encounters for interim claims. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the hospital stay do not cross reinsurance contract years.

AHCCCS will not pay reinsurance on encounters containing any Prior Period Coverage (PPC) for regular, catastrophic and other reinsurance case types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

Disputed Matters: For encounters which are the subject of a member appeal, provider claim dispute, or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the longer of: 1) 90 days from the date of the final decision in that proceeding/action or 2) 15 months from the end date of service/date of eligibility posting to file the reinsurance encounter AND for the reinsurance encounter to reach adjudicated/approved status. Therefore, reinsurance encounters for disputed matters will be considered timely if the encounters reach adjudicated/approved status no later than 90 days from the date of the final decision in that proceeding/action even though the 15 month deadline has expired.

Failure to submit encounters within the applicable timeframes specified above will result in the denial of reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.

The Contractor must void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. For replacement encounters resulting in an increased claim value, the replacement encounter must reach adjudicated status within 15 months of end date of service to receive additional reinsurance benefits. The Contractor should refer to Section D, Paragraph 68, Encounter Data Reporting, for encounter reporting requirements.

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

When a member changes Contractors within a reinsurance contract year, for reinsurance purposes, no costs incurred for that member follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current reinsurance contract year) will not be applied toward the receiving Contractor's deductible level.

Payment of Transplant Reinsurance Cases: Reinsurance reimbursement is based upon the lesser of the AHCCCS transplant contract amount or the Contractor's paid amount, subject to coinsurance percentages. Reinsurance payments are linked to transplant encounter submissions. The Contractor is required to submit all supporting encounters for transplant services and additional documentation as identified in the AHCCCS Reinsurance Policy Manual. In order to receive reinsurance payment for transplant stages, billed amounts and Contractor paid amounts for adjudicated encounters must equal the amounts on the required documentation submitted to AHCCCS. Timeliness for each component payment will be calculated based on the latest

adjudication date for the complete set of encounters related to the component. Refer to the AHCCCS Reinsurance Policy Manual for the appropriate billing of transplant services.

Reinsurance Audits: AHCCCS may perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits and Contractors will be given appropriate advance notice.

54. CAPITATION ADJUSTMENTS

Rate Adjustments: The rates set forth in Section B shall not be subject to renegotiation during the term of the Contract.

Capitation rates may be modified during the term of the Contract when changes to provisions in the Contract require adjustment to maintain actuarially sound rates. In addition, AHCCCS, at its sole discretion, may adjust capitation rates to address fundamental changes in circumstances such as:

1. Program changes
2. Legislative requirements
3. Changes in trend assumptions
4. Updated encounter experience
5. Actuarial assumptions
6. CMS mandates

If a capitation rate adjustment is determined necessary, the adjustment and assumptions may be discussed with the Contractor prior to modifying capitation rates. The Contractor may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review.

The Contractor is responsible for notifying AHCCCS of program and/or expenditure changes initiated by the Contractor during the Contract term that may result in material changes to the current or future capitation rates.

Contractor Default: If the Contractor is in any manner in default in the performance of any obligation under this Contract, AHCCCS may, at its option and in addition to other available remedies, adjust the amount of payment until there is satisfactory resolution of the default.

Change in Member Status: The Contractor shall reimburse AHCCCS and/or AHCCCS may deduct from future monthly capitation for any portion of a month during which the Contractor was not at risk due to, for example:

1. Death of a member
2. Inmate of a public institution
3. Duplicate capitation to the same Contractor
4. Adjustment based on change in member's contract type
5. Voluntary withdrawal

AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this Contract.

Inmate of a Public Institution Reporting: Several Counties are submitting a daily file of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a “no-pay” status for the duration of their incarceration or their eligibility period if shorter. AHCCCS will provide the Contractor with incarceration information for the member on the Contractor’s 834 file. The file will indicate an “IE” code for ineligible associated with the disenrollment. The file will also include a data element indicating the County of jurisdiction and “CTYPRI” as the new health plan of enrollment due to incarceration. Upon release from jail, the member will be enrolled using the current enrollment rules and hierarchy as follows: SMI designation, Native American on reservation, re-enroll with their previous Contractor if less than 90 days from disenrollment, or enrollment choice or auto-assign if more than 90 days from disenrollment. A member is eligible for covered services until the effective date of the member’s “no-pay” status.

If the Contractor becomes aware of a member who becomes an inmate of a public institution and who is not identified in the AHCCCS reporting above, the Contractor must notify AHCCCS for an eligibility determination. Notifications must be sent via email to the following email address: MCDUJustice@azahcccs.gov

Notifications must include:

1. AHCCCS ID
2. Name
3. Date of Birth (DOB)
4. When incarcerated
5. Where incarcerated

The Contractor does **not** need to report members incarcerated with the Arizona Department of Corrections.

55. MEMBER SHARE OF COST

ALTCS E/PD 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 (SOC), have a SOC in the amount of \$0.00. Generally, only institutionalized ALTCS members have a SOC. Certain HCBS ALTCS members may be liable for a SOC, particularly those who become eligible through a special treatment income trust [42 CFR 438.108]. See Arizona’s Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance on the AHCCCS website for a complete list of SOC adjustments.

The Contractor receives monthly capitation payments which incorporate an assumed deduction for the SOC members contribute to the cost of care. Refer to Section D, Paragraph 51, Compensation, for details on the share of cost reconciliation. The Contractor or its subcontractors has sole responsibility for collecting members’ SOC. The Contractor has the option of collecting the SOC or delegating this responsibility to the provider. The Contractor may transfer this responsibility to nursing facilities, Institutions for Mental Disease for those 65 years of age and older, Inpatient Psychiatric Facilities for those under 21 years of age, and HCBS Providers and compensate these facilities net of the SOC amount. If the Contractor delegates this responsibility to the provider, the

provider contract must spell out complete details of both parties' obligations in SOC collection. The Contractor or its subcontractors shall not assess late fees for the collection of the SOC from members.

56. COPAYMENTS

The Contractor is required to comply with ACOM Policy 431 and other directives by AHCCCS. The members covered under this Contract are currently exempt from mandatory and non-mandatory (also known as nominal or optional) copayments. Those populations exempt from copayments or subject to non-mandatory copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108].

57. PEDIATRIC IMMUNIZATIONS AND THE VACCINE FOR CHILDREN PROGRAM

Through the Vaccine for Children Program (VFC) Federal and State governments purchase, and make available to providers at no cost, vaccines for AHCCCS children under age 19. Therefore, the Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Contractor shall contact AHCCCS, DHCM, Clinical Quality Management for guidance. Any provider licensed by the State to administer immunizations may register with ADHS as a "VFC provider" to receive these free vaccines. The Contractor shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS. The Contractor shall comply with all VFC requirements and monitor contracted providers to ensure that providers are registered as VFC providers when acting as Primary Care Providers (PCPs) for members under the age of 19 years.

Due to low numbers of children in their panel, providers in certain Geographic Service Areas may choose not to provide vaccinations. Whenever possible, members shall be assigned to VFC providers within the same or a nearby community. When it is not possible, the Contractor shall develop processes to ensure vaccinations are available through a VFC enrolled provider or through the appropriate County Health Department. In all instances, the antigens are to be provided through the VFC program. The Contractor shall develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

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

58. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

AHCCCS is the payor of last resort unless specifically prohibited by applicable State or Federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall take reasonable measures to identify potentially legally liable third party sources. Refer to ACOM Policy 434.

If the Contractor discovers the probable existence of a liable third party that is not known to AHCCCS, or identifies any change in coverage, the Contractor must report the information within 10 days of discovery via the TPL Leads File or the TPL Referral Web Portal, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 74, Administrative Actions.

AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the AHCCCS Technical Interface Guidelines.

The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. Title 9, Chapter 28, Article 9., so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this Contract. The two methods used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as described in A.A.C. Title 9, Chapter 28, Article 9., Federal and State law, and ACOM Policy 434. For Contractor cost sharing responsibilities for members covered by both Medicare and Medicaid see ACOM Policy 201.

The Contractor shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There are limited circumstances when cost avoidance is prohibited and the Contractor must apply post-payment recovery processes as described further below.

Cost Avoidance: For purposes of cost avoidance, establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established, the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor shall be subject to sanctions.

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the Contractor is responsible for making these payments in accordance with ACOM Policy 434.

Claims for inpatient stay for labor, delivery and postpartum care, including professional fees when there is no global OB package, must be cost avoided. [42 CFR 433.139]

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

Members Covered by both Medicare and Medicaid (Duals): See Section D, Paragraph 59, Medicare Services and Cost Sharing.

Post-Payment Recoveries: Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, the Contractor must adjudicate the claim and then utilize post-payment recovery processes which

include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payor Sources, and other third party liability recoveries. Refer to ACOM Policy 434 for further guidance.

Pay and Chase: The Contractor shall pay the full amount of the claim according to the AHCCCS Capped-Fee-For-Service Schedule or the contracted rate and then seek reimbursement from any third party if the claim is for the following:

1. Prenatal care for pregnant women, including services which are part of a global OB Package,
2. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
3. Services covered by third party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement

Retroactive Recoveries Involving Commercial Insurance Payor Source: For a period of two years from the date of service, the Contractor shall engage in retroactive third party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the Contractor must seek recovery from the commercial insurance. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way, unless the provider was paid in full from both the Contractor and the commercial insurance.

See ACOM Policy 434 for details regarding retroactive recoveries, encounter adjustments as a result of retroactive recoveries, and the processes for identifying claims that have a reasonable expectation of recovery.

Other Third Party Liability Recoveries: The Contractor shall identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

1. Motor Vehicle Cases
2. Other Casualty Cases
3. Tortfeasors
4. Restitution Recoveries
5. Worker's Compensation Cases

Upon identification of a potentially liable third party for any of the above situations, the Contractor shall, within 10 business days, report the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 74, Administrative Actions. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or Fee-For-Service payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or Fee-For-Service payments are involved. By contrast, a "joint" case is

one where Fee-For-Service payments and/or reinsurance payments are involved. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Cases: In "total plan" cases, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916. The Contractor shall use the AHCCCS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The Contractor may retain up to 100% of its recovery collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the Contractor's financial liability for the member,
2. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (i.e., lien filing , etc.), and,
3. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS or AHCCCS' authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 74, Administrative Actions.

The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Settlement Notification Form (see ACOM Policy 434), within 10 business days from the settlement date or in an AHCCCS-approved monthly file, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 74, Administrative Actions.

Joint and Mass Tort Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Contractor. In joint and mass tort cases, AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Contractor is responsible for responding to requests from AHCCCS or AHCCCS' TPL contractor to provide a list of claims related to the joint or mass tort case within 10 business days of the request. The Contractor will be responsible for their prorated share of the contingency fee. The Contractor's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Contractor.

Other Reporting Requirements

All TPL reporting requirements are subject to validation through periodic audits and/or operational reviews which may include Contractor submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Unit shall provide the format and reporting schedule for this information to the Contractor.

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

Cost Avoidance/Savings/Recoveries Report: The Contractor shall submit quarterly reports regarding cost avoidance/saving/recovery activities, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

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

59. MEDICARE SERVICES AND COST-SHARING

The Contractor must pay Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost-sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor must limit their cost sharing responsibility according to A.A.C. R9-29-301 and A.A.C. R9-29-302 and as further outlined in ACOM Policy 201. Refer to Section D, Paragraph 10, Scope of Services, for information regarding prescription medication for Medicare Part D.

Dual eligible members shall have choice of all providers in the network and shall not be restricted to those that accept Medicare.

As provided under section 1860D-14 of the Social Security Act, full-benefit dual eligible institutionalized individuals have no cost-sharing for covered Part D drugs under their PDP or MA-PD plan. Effective January 1, 2012, Section 1860D-14 of the Act also eliminates Part D cost-sharing for full-benefit dual eligible individuals who are receiving home and community-based services (HCBS) either through a home and community-based waiver authorized for a State under §1115 or subsection (c) or (d) of §1915 of the Act.

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year.

60. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including ACOM Policy 101 [42 CFR 438.104]. The Contractor shall submit all proposed marketing materials including, giveaways, sponsorships, press releases, and requests for participation in events that will involve the general public to the AHCCCS Marketing Committee as specified in Section F, Attachment F3, Contractor Chart of Deliverables and as outlined in ACOM Policy 101. All marketing materials that have been approved by the Marketing Committee may be distributed by the Contractor for a period of two years from the date of approval and must be re-approved after that time.

61. SURVEYS

The Contractor may be required to perform annual surveys. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. The final survey tool shall be approved in advance by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The results and the analysis of the results shall be submitted to the DHCM as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall utilize member survey findings to improve care for ALTCS E/PD members.

For non-AHCCCS required surveys, the Contractor shall provide notification as specified in Section F, Attachment F3, Contractor Chart of Deliverables, prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and analysis of the results of any Contractor initiated surveys shall be submitted to the DHCM as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Surveys performed by the Contractor to evaluate plan satisfaction for previous members (exit surveys), are subject to the above notification requirement for non-AHCCCS required surveys and are not subject to AHCCCS Marketing Committee approval.

AHCCCS may conduct surveys of a representative sample of the Contractor's membership and/or providers. The results of AHCCCS conducted surveys will become public information and available to all interested parties on the AHCCCS website. The Contractor may be responsible for reimbursing AHCCCS for the cost of such surveys based on its share of AHCCCS enrollment.

As specified in Section F, Attachment F3, Contractor Chart of Deliverables, the Contractor is required to perform periodic surveys of its membership, as outlined in ACOM Policy 424, in order to verify that members have received services that have been paid for by the Contractor and to identify potential service/claim fraud [42 CFR 455.20 and 433.116].

62. PATIENT TRUST ACCOUNT MONITORING

The Contractor shall have a policy regarding on-site monitoring of trust fund accounts for institutionalized members to ensure that expenditures from a member's trust fund comply with Federal and State regulations. Suspected incidents of fraud involving the management of these accounts must be reported in accordance with Section D, Paragraph 64, Corporate Compliance.

If the Contractor identifies that a patient trust account combined with other resources will exceed the allowable resource limit outlined in A.A.C R9-28-407, or a balance nearing that limit, they shall submit a Member Change Request (MCR) to the ALTCS eligibility office.

63. CULTURAL COMPETENCY

The Contractor shall implement a program to serve members in a culturally competent manner which takes into account the cultural and ethnic diversity of the Contractor's population.

The Contractor shall develop and implement a Cultural Competency Plan which meets the requirements of ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, as

specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall ensure the Plan addresses cultural considerations for those with Limited English Proficiency and diverse cultural and ethnic backgrounds, for all services and settings, (e.g., attendant care, assisted living facilities) [42 CFR 438.206(c)(2)]

64. CORPORATE COMPLIANCE

Corporate Compliance Program

The Contractor shall be in compliance with 42 CFR 438.608. The Contractor must have a mandatory Corporate Compliance Program that is designed to guard against fraud and abuse and is supported by other administrative procedures including a Corporate Compliance Plan. The Contractor shall appoint a Corporate Compliance Officer in accordance with Section D, Paragraph 25, Staff Requirements. The Contractor's written Corporate Compliance Plan must adhere to Contract, including ACOM Policy 103, and must be submitted annually to AHCCCS-OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The compliance program shall be designed to prevent, detect, and report fraud, waste, and abuse.

The compliance program must include:

1. Written policies, procedures, and standards of conduct that articulates the organization's commitment to and processes for complying with all applicable Federal and State rules, regulations, guidelines, and standards.
2. The Corporate Compliance Officer must be an onsite management official who reports directly to the Contractor's senior management. The Corporate Compliance Officer must be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract.
3. Effective lines of communication between the Corporate Compliance Officer and the Contractor's employees.
4. Enforcement of standards through well-publicized disciplinary guidelines.
5. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly to reduce the potential for recurrence, ongoing compliance with requirements under the Contract, and external monitoring and auditing of subcontractors. The Contractor shall provide the external auditing schedule and executive summary of all audits to AHCCCS-OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables.
6. The establishment of a Regulatory Compliance Committee involving the Board of Directors and the Contractor's senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements of the Contract.
7. Pursuant to the Deficit Reduction Act of 2005 (DRA), Contractors, as a condition for receiving payments shall establish written policies for employees detailing:
 - a. The Federal False Claims Act provisions,
 - b. The administrative remedies for false claims and statements,
 - c. Any State laws relating to civil or criminal penalties for false claims and statements, and
 - d. The whistleblower protections under such laws.

8. The Contractor must require, through documented policies and subsequent Contract amendments, that subcontractors and providers train their staff on the following aspects of the Federal False Claims Act provisions:
 - a. The administrative remedies for false claims and statements,
 - b. Any State laws relating to civil or criminal penalties for false claims and statements, and
 - c. The whistleblower protections under such laws.
9. The Contractor must establish a system for training and education for the Corporate Compliance Officer, the Contractor's senior management, all staff and new hires on the Federal and State standards and requirements under the Contract, including the items in number 7 above. All training must be conducted in such a manner that can be verified by AHCCCS.
10. The Contractor must notify AHCCCS, DHCM Data Analysis and Research, as specified in Section F, Attachment F3, Contractor Chart of Deliverables of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

Fraud Waste, and Abuse: In accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and ACOM Policy 103, the Contractor, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding all allegations of fraud, waste, or abuse involving the AHCCCS Program. The Contractor shall not conduct any investigation or review of the allegations of fraud, waste, or abuse involving the AHCCCS Program. Notification to AHCCCS-OIG shall be in accordance with ACOM Policy 103 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor must also report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, any credentialing denials including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. [42 CFR 455.17][42 CFR 455.1(a)(1)].

The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS-OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic, or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the AHCCCS-OIG upon request and at no cost. The AHCCCS-OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the AHCCCS-OIG request.

Once the Contractor has referred a case of alleged fraud, waste, or abuse to AHCCCS, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments. In the event that AHCCCS-OIG, either through a civil monetary penalty or assessment, a global civil settlement or judgment, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. The Contractor hereby assigns to AHCCCS any and all of its rights to recover overpayments due to fraud, waste or abuse.

AHCCCS-OIG will notify the Contractor when the investigation concludes. If it is determined by AHCCCS-OIG to not be a fraud, waste, or abuse case, the Contractor shall adhere to the applicable AHCCCS policy manuals for disposition.

In addition, the Contractor must furnish to AHCCCS or CMS within 35 days of receiving a request, full and complete information, pertaining to business transactions [42 CFR 455.105]:

1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of request; and
2. Any significant business transactions between the Contractor, any subcontractor, and wholly owned supplier, or between the Contractor and any subcontractor during the five year period ending on the date of the request.

Disclosure of Ownership and Control [42 CFR 455.100 through 106](SMDL09-001)(Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act):^{xx}

The Contractor must obtain the following information regarding ownership and control [42 CFR 455.104]:^{xxi}

1. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 CFR 455.100-104)
2. The Name, Address, Tax Identification Number of any corporation with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 CFR 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
3. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling
4. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity, as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest
5. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section D, paragraph 25) of the Contractor as defined in 42 CFR 455.101

Disclosure of Information on Persons Convicted of Crimes [42 CFR 455.101 through 106; 455.436](SMDL09-001)

The Contractor must do the following:

1. Confirm the identity and determine the exclusion status of any person with an ownership or control interest in the Contractor, and any person who is an agent or managing employee of the Contractor (including Key Staff personnel as noted in Section D, Paragraph 25), through routine checks of Federal databases; and
2. Disclose the identity of any of these excluded persons, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

The Contractor shall, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

1. The List of Excluded Individuals (LEIE)
2. The System for Award Management (SAM) formerly known as the Excluded Parties List (EPLS)
3. Any other databases directed by AHCCCS or CMS

The Contractor shall provide the above-listed disclosure information to AHCCCS at any of the following times (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act, and 42 CFR 455.104(c)(3)):^{xxii}

1. Upon the Contractor submitting the Proposal in accordance with the State's procurement process;
2. Upon the Contractor executing the contract with the State;
3. Within 35 days after any change in ownership of the Contractor; and
4. Upon request by AHCCCS.

The results of the ***Disclosure of Ownership and Control*** and the ***Disclosure of Information on Persons Convicted of Crimes*** shall be held by the Contractor. Upon renewal or extension of the contract, the Contractor shall submit an annual attestation as specified in Section F, Attachment F3, Contractor Chart of Deliverables, that the information has been obtained and verified by the Contractor, or upon request, provide this information to AHCCCS. Refer to ACOM Policy 103 for further information.^{xxiii}

The Contractor must immediately notify AHCCCS-OIG of any person who has been excluded through these checks as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Federal Financial Participation (FFP) is not available for any amounts paid to a Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:^{xxiv}

1. The Contractor is controlled by a sanctioned individual
2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or

indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act.

3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:
 - a. Any individual or entity excluded from participation in Federal health care programs
 - b. Any entity that would provide those services through an excluded individual or entity (Section 1903(i)(2) of the Social Security Act, 42 CFR 431.55(h), 42 CFR 438.808, 42 CFR 1002.3(b)(3), SMD letter 6/12/08, and SMD letter 1/16/09).

The Contractor shall require Administrative Services Subcontractors adhere to the requirements outlined above regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes as outlined in 42 CFR 455.101 through 106, 42 CFR 455.436 and SMDL09-001. Administrative Services Subcontractors shall disclose to AHCCCS-OIG the identity of any excluded person.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) and (1903(i) and 1903(i)(2)(A)) of the Social Security Act.^{xxv}

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) (Sections 1903(i) and 1903(i)(2)(B)) of the Social Security Act).^{xxvi}

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the State has failed to suspend payments during any period in which the State has notified the Contractor of a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments (Section 1903(i) and 1903(i)(2)(C)) of the Social Security Act).^{xxvii}

65. RECORDS RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor agrees to make available at all reasonable times during the term of this Contract any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or

Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

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

The Contractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

The Contractor shall comply with the record keeping requirements delineated in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the Contractor shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

If this Contract is completely or partially terminated records shall be retained as described above.

66. MEDICARE REQUIREMENTS

Medicaid members who are also enrolled in Medicare are referred to as dual eligible members. To improve care coordination for dual eligible members, AHCCCS requires the Contractor, or its corporate affiliate, to be a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP). The D-SNP service area shall match the ALTCS E/PD Medicaid Contract Geographic Service Area. To match the population served, the D-SNP Type must be a D-SNP subset that matches this Contract.

Medicare Structure: As required by A.R.S. §36-2906.01, the Contractor shall establish an affiliated corporation whose only authorized business is to provide services under this Contract to AHCCCS eligible persons enrolled with the Contractor. The Contractor must have, and assure AHCCCS it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this Contract and the Medicare product to the extent necessary to ensure integration of AHCCCS and Medicare services for persons enrolled with the Contractor for both programs. The Contractor must ensure the integration of Medicare and Medicaid services.

Medicare Branding: The Contractor must establish branding for the Medicare product that ensures it is easily identifiable to members and providers as an integrated plan for both Medicare and Medicaid.

Medicare State Certification: Medicare Advantage plans are required to be licensed under State law. As outlined in A.R.S 36-2903(B)(2) AHCCCS has the authority to certify its Contractors for

Medicare purposes. The Contractor may apply for certification through AHCCCS or apply and receive licensure through the Arizona Department of Insurance. The AHCCCS certification process is detailed in ACOM Policy 313.

State Contracting with D-SNPs: Per ACOM Policy 107, AHCCCS will not contract with any D-SNP to serve the ALTCS population outside of awarded ALTCS E/PD Contracts. Detailed D-SNP responsibilities are outlined in Medicare Advantage D SNP Health Plan Agreement.

Alignment Efforts: AHCCCS will continue to establish practices which improve alignment for dual eligible members.

The Contractor shall provide seamless conversion enrollment of newly Medicare eligible individuals who are currently enrolled with the Contractor for Medicaid only, into the Contractor's companion D-SNP, subject to CMS approval. This directive is based on CMS guidance provided in the Medicare Managed Care Manual, Chapter 2, Section 40.1.5 and will include individuals who have aged-in to Medicare as well as those qualified for Medicare upon the completion of the 24 month waiting period due to a disability.

67. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

The Contractor is required to exchange data with AHCCCS relating to the information requirements of this Contract and as required to support the data elements to be provided to AHCCCS. All data exchanged must be in the formats prescribed by AHCCCS which includes those required/covered by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the HIPAA Transaction Companion Guides & Trading Partner Agreements, the AHCCCS Encounter Manual and in the AHCCCS Technical Interface Guidelines available on the AHCCCS website.

The information exchanged with AHCCCS shall be in accordance with all procedures, policies, Rules, or statutes in effect during the term of this Contract. If any of these procedures, policies, Rules, regulations or statutes are hereinafter changed both parties agree to conform to these changes following notification by AHCCCS.

Electronic Transactions: The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or prior authorization requests; or the receipt of electronic remittance. The Contractor must be able to make claims payments via electronic funds transfer and have the capability to accept electronic claims attachments.

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations and control documents are required, including the completion and submission of the EDI Trading Partner Agreement in order to exchange data with AHCCCS.

With the completion of required documents as outlined in the AHCCCS Encounter Manual, each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

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

The Contractor is required to provide attestation that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606] as outlined by AHCCCS in the HIPAA Transaction Companion Guides & Trading Partner Agreements.

Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's subcontractors resulting from error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

Member Data: The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in the AHCCCS prescribed electronic data exchange formats. Upon request, the Contractor shall provide to AHCCCS PCP assignments in an AHCCCS prescribed electronic data exchange format.

Claims Data: This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2903 and §36-2904 and A.A.C. R9-28-701.10. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

On a recurring basis (no less than quarterly based on adjudication date), AHCCCS shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services, during the member's enrollment period, from Medicare (Part D Plan, D-SNP, and/or FFS when appropriate) or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

In addition, the Contractor shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

1. Receive 85% of total claims (e.g. professional, institutional and dental), with a minimum 60% requirement by form type, based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically.
2. Produce and distribute 75% of remittances electronically.
3. Provide 85% of claims payments via EFT.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems

contact will be assigned after Contract award. AHCCCS will work with the Contractor as they evaluate Electronic Data Interchange options.

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to AHCCCS for review and comment as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Health Insurance Portability and Accountability Act (HIPAA): The Contractor shall comply with the Administrative Simplification requirements of 45 CFR Parts 160 and 162 that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

Data Security: The Contractor is required to have a security audit performed by an independent third party on an annual basis. The annual audit report must be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The audit must include, at a minimum, a review of Contractor compliance with all security requirements as outlined in the AHCCCS Security Rule Compliance Summary Checklist, as specified in ACOM Policy 108. In addition, the audit must include a review of Contractor policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Contractor's business practices, and the production processing systems.

The audit must result in a findings report and as necessary a corrective action plan, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The corrective action plan must also include timelines for corrective actions related to all issues or discrepancies identified. The annual report must include the findings and corrective action plan and must be submitted to AHCCCS for review and approval. AHCCCS will verify that the required audit has been completed and the appropriate approved remediation plans are in place and being followed.

Health Information Exchange: The Contractor is required to contract with Arizona Health-e Connection, a non-profit organization which provides a secure network ("The Network") for health information exchange. Each Contractor shall sign a participation agreement for The Network. As a participant of The Network, each Contractor shall be identified by The Network as a "data user" and will be required to become a data supplier, as defined by The Network-

To further the integration of technology based solutions and the meaningful use of electronic health records within the system of care, AHCCCS will increase opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption and use of health information technology may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing

electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates accelerating statewide Health Information Exchange (HIE) participation for all Medicaid providers and Contractors by:

1. Requiring that behavioral health and physical health providers use The Network for secure sharing of clinical information between physical and behavioral health providers
2. Administering an HIE onboarding program for high volume Medicaid hospitals, Federally Qualified Health Centers, Rural Health Clinics, Look-a-Like clinics and other eligible groups of Medicaid providers
3. Supporting the acceleration of electronic prescribing by Arizona Medicaid providers
4. Joining the State level HIE for governance, policy making, and information technology service offerings
5. Identifying value-based purchasing opportunities that link with a provider's adoption and use of Health Information Technology (HIT)

The Contractor shall encourage providers that are participating in the Medicaid EHR Incentive Program (i.e. eligible hospitals and eligible professionals) to continue to move through the Meaningful Use continuum, accelerate the participation of other provider types in their network, and participate in planning activities that will result in improved care coordination and health care delivery for members. The Contractor is expected to collaborate with AHCCCS, Arizona Health-e Connection and The Network to target efforts to specific areas where HIT and HIE can bring significant change and progress including efforts focused on:

1. Coordinating the secure sharing of clinical health information between behavioral health and physical health providers
2. Identifying additional partnerships for integrated care among other health care delivery participants
3. Identifying and implementing strategies for High need/high cost members
4. Coordinating care for members who are enrolled in the American Indian Health Program (AIHP)
5. Coordinating care for members who are transitioning between AHCCCS and Qualified Health Plans
6. Coordinating care for AHCCCS eligible and enrolled members involved in transitioning in or out of the Justice system
7. Pharmacy management
8. Quality improvement activities and reporting as identified by the Contractor or AHCCCS
9. Other activities as identified by AHCCCS

68. ENCOUNTER DATA REPORTING

Complete, accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set Fee-For-Service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. Furthermore, increased emphasis on encounter data is highlighted in the Medicaid Managed Care Regulations published on May 6, 2016. The Contractor shall submit encounter data to AHCCCS for all services for which a Contractor incurred

financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred including services provided during prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)][42 CFR 455.1(a)(2)].

New Contractors must successfully exchange encounter data for all applicable form types with AHCCCS no later than 120 days after the start of the contract or be subject to possible corrective actions up to and including sanctions.

Encounter Submissions: Encounters must be submitted in the format prescribed by AHCCCS. Encounter data must be provided to AHCCCS as outlined in the HIPAA Transaction Companion Guides & Trading Partner Agreements and the AHCCCS Encounter Manual, including, but not limited to, inclusion of data to identify the physician who delivers services to patients per Section 1903(m)(2)(A)(xi) of the Social Security Act.^{xxviii}

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Failure to submit encounters within 240 days may result in sanctions as specified in the AHCCCS Encounter Manual.

Covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act; the State shall collect such rebates from manufacturers. (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMD letter 10-006)^{xxix}To ensure AHCCCS' compliance with this requirement, pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. The Contractor must report information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed (other than covered outpatient drugs that under subsection (j)(1) of Section 1927 of the Social Security Act [42 USCS § 1396r-8] are not subject to the requirements of that section) and such other data as required by AHCCCS (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMD letter 10-006).^{xxx}

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor must provide attestation that the services listed were actually rendered.

The Contractor shall be subject to sanctions for noncompliance with encounter submission completeness, accuracy, and timeliness requirements.

Encounter Reporting: The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions and revisions of encounters. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual or as directed by AHCCCS and as further specified in Section F, Attachment F3, Contractor Chart of Deliverables.

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 18 months of approved, voided, plan-denied, pending and AHCCCS-denied encounters received and processed by

AHCCCS. These files must be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

Encounter Supporting Data Files: AHCCCS provides the Contractor with periodic (no less than twice monthly) full replacement files containing provider and medical coding information as stored in PMMIS. These files shall be used by the Contractor in conjunction with the Contractor's data to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information regarding the content and layouts of these files.

Encounter Corrections: The Contractor is required to monitor and resolve pended encounters, and encounters denied by AHCCCS.

The Contractor if further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters, including, approved, pended, denied and voided encounters, impact completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days for example), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

Encounter Validation Studies: Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. These studies may result in sanctions of the Contractor and/or require a correction action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS Encounter Data Validation Technical Document for further information.

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

69. PERIODIC REPORTING REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 74, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows:

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

The Contractor shall comply with all reporting requirements contained in this Contract. AHCCCS requirements regarding reports, including but not limited to, report content, report frequency, and report submission, are subject to change at any time during the term of the Contract. The Contractor shall comply with all changes specified by AHCCCS, including those pertaining to subcontractor reporting requirements. The Contractor shall be responsible for continued reporting beyond the term of the Contract.

70. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this Contract, request financial, clinical or other information from the Contractor. Responses shall fully disclose all financial, clinical or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information to AHCCCS as requested no later than 10 business days after the receipt of the request unless otherwise specified in the request itself.

If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed statement to AHCCCS, within the timeframe designated by AHCCCS, setting forth the reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

71. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS, or the Federal government, to its members and subcontractors. All costs shall be the responsibility of the Contractor.

72. READINESS REVIEWS

The purpose of a Readiness Review is to assess a Contractor's readiness and ability to provide covered services to members in accordance with this Contract. A Readiness Review is conducted at the discretion of AHCCCS to review programmatic operations of the Contractor. Programmatic operations subject to readiness reviews include but are not limited to: service delivery changes, IT system modifications, and change of Contractor. The Contractor must satisfy AHCCCS' requirements on all Readiness Review elements in order to continue operating under this Contract.

73. MONITORING AND OPERATIONAL REVIEWS

The Contractor shall comply with all reporting requirements contained in this Contract and AHCCCS policy. In accordance with CMS requirements, AHCCCS has in effect procedures for monitoring the Contractors' operations to ensure program compliance and identify best practices, including, but not limited to, evaluation of submitted deliverables, ad hoc reporting, and periodic focused and operational reviews.^{xxxix}

These monitoring procedures will include, but are not limited to, operations related to the following:^{xxxix}

1. Member enrollment and disenrollment;
2. Processing grievances and appeals;
3. Violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438,
4. Violations of the conditions for receiving federal financial participation, as set forth in Subpart J of 42 CFR 438, and
5. All other provisions of the Contract, as appropriate. [42 CFR 438.66(a)]

Operational Reviews: In accordance with CMS requirements [42 CFR 434.6 (a)(5)] and Arizona Administrative Code, [Title 9, A.A.C. Chapter 28Article 5], AHCCCS, or an independent agent, will conduct periodic Reviews of the Contractor to ensure program compliance and identify best practices [42 CFR 438.204].

The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements and provide the Contractor with technical assistance when necessary. The type and duration of the review will be solely at the discretion of AHCCCS.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled Operational Review. AHCCCS reserves the right to conduct reviews without notice to monitor contractual requirements and performance as needed.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out of State locations and will coordinate travel arrangements and accommodations with the Contractor.

In preparation for the reviews, the Contractor shall cooperate with AHCCCS by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request.

Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. Should the review be conducted on-site, the Contractor shall provide the Review Team with appropriate workspace, access to a telephone, electrical outlets, internet access and privacy for conferences.

The Contractor will be furnished a copy of the draft Operational Review report and given the opportunity to comment on any review findings prior to AHCCCS issuing the final report. AHCCCS reserves the right to publish information related to the results of any Operational Review. The Contractor must develop corrective action plans based on recommendations provided in the final report. The corrective action plans and modifications to the corrective action plans must be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational Review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the Operational Review Tool, draft Operational Review Report or final report to other AHCCCS Contractors.

74. ADMINISTRATIVE ACTIONS

Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, ACOM Policy 408 and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension, refusal to renew, or termination of the Contract, or any related subcontracts [42 CFR 422.208; 42 CFR 438.700, 702, and 704, 706, 722, 45 CFR 92.36(i)(1); 45 CFR 74.48].

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. R9-34-401 et seq.

Notice to Cure: AHCCCS may provide a written Notice to Cure to the Contractor outlining the details of the non-compliance and timeframe to remedy the Contractor's performance. If, at the end of the specified time period, the Contractor has complied with the Notice to Cure requirements, AHCCCS may choose not to impose a sanction.

Technical Assistance: For Technical Assistance the Contractor shall note the following Technical Assistance Provisions:

1. Recognize AHCCCS' technical assistance to help the Contractor achieve compliance with any relevant Contract terms or Contract subject matter issues does not relieve the Contractor of its obligation to fully comply with all terms in this Contract.
2. Recognize that the Contractor's acceptance of AHCCCS' offer or provision of technical assistance shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue.

3. Recognize that AHCCCS not providing technical assistance to the Contractor as it relates to compliance with a Contract requirement or any and all other terms, shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue.

Recognize that a Contractor's subcontractor participation in a technical assistance matter, in full or in part, does not relieve the Contractor of its contractual duties nor modify the Contractor's contractual obligations.

75. MEDICAID SCHOOL BASED CLAIMING PROGRAM

Pursuant to an Intergovernmental Agreement with the Department of Education, and a contract with a Third Party Administrator, AHCCCS pays participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the member's Individualized Education Program (IEP) as medically necessary for the child to obtain a public school education. See AMPM Chapter 700.

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

The Contractor's evaluations and determinations of medical necessity shall be made independent of the fact that the child is receiving MSB services. If a request is made for services that also are covered under the MSB program for a child enrolled with the Contractor, the request shall be evaluated on the same basis as any request for a covered service.

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

76. PENDING ISSUES

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

AHCCCS and its Contractors are subject to legislative mandates, directives, regulatory changes, executive and court orders related to any term in this Contract that may result in changes to the

program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the Contract by reference.

Managed Care Regulations: On May 6, 2016 the Centers for Medicare & Medicaid Services (CMS) published final rules focused on: advancing delivery system reform, strengthening quality and consumer protections, promoting accountability, and aligning Medicaid managed care rules with other health insurance coverage programs. The provisions of the rule will be implemented in phases throughout years 2016, 2017, and 2018.

The final rule provisions include significant operational changes to numerous areas of the Medicaid Program, including but not limited to the following:

1. Requirements for Long Term Services and Supports
2. Network development standards
3. Grievance and Appeal System
4. Enrollee rights
5. Member information
6. Quality improvement
7. Capitation rate development
8. Limitations on capitation payments for services provided to persons age 21-64 receiving services in an Institution for Mental Disease (IMD)

Mental Health Parity and Addiction Equity Act: On March 30, 2016, final rules were published providing that financial and treatment limitations on mental health and substance use disorder benefits may be no more restrictive and applied no more stringently than to medical/surgical benefits. On or before October 1, 2017, the Contractor shall demonstrate that services are delivered in compliance with mental health parity consistent with 42 CFR 438.900 et seq. Future information will be provided regarding deliverables and timelines to ensure compliance.

Section 1115 Waiver Demonstration: As the Section 1115 Waiver Demonstration for the period October 1, 2016 through September 30, 2021, has recently been approved by CMS, the Waiver approval may necessitate changes to the terms of this Contract which will be executed through a Contract amendment if necessary.

Home and Community Based Services Settings Rules: On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final rules regarding requirements for home and community based services (HCBS) operated under section 1915 of the Social Security Act. The rules mandate certain requirements for alternative residential or community settings where Medicaid beneficiaries receive long term care services and supports. CMS states “The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.”

While AHCCCS’ ALTCS program is operated under Section 1115 of the Act, CMS is requiring compliance with those regulations for all long term care home and community based settings. To that end, AHCCCS has established a plan for meeting those standards on a timeline consistent with its Section 1115 Waiver submission (effective October 2016). All HCBS residential and non-residential settings must come into compliance by the end of a five-year transition period

(September 2021) with the HCBS Rules. These requirements impact ALTCS members receiving services in the following residential and non-residential settings:

Residential

1. Assisted Living Facilities
2. Group Homes
3. Adult and Child Developmental Homes
4. Behavioral Health Residential Facilities

Non-Residential

1. Adult Day Health Programs
2. Day Treatment and Training Programs
3. Center-Based Employment Programs
4. Group-Supported Employment Programs

AHCCCS submitted the Arizona Systemic Assessment and Transition Plan to CMS for approval on September 30, 2015. AHCCCS will have five years to come into compliance with the rules under the Transition Plan. During the five-year transition period, AHCCCS will work with a variety of multi-stakeholder workgroups to implement the Plan. Additionally, AHCCCS will host focus groups at the onset of each transition plan year to receive input about progress made the previous year and provide input regarding planned actions for the upcoming year.

The Contractor is required to participate in the multi-stakeholder workgroups for each of the residential and non-residential setting types noted above and provide input on each phase of the five-year transition plan including orientation of members, providers and case managers; policy and contract revisions and compliance monitoring tools and processes. Furthermore, Contractors will be primarily responsible for the following:

1. Disseminating member and family member educational materials
2. Executing provider and case manager training
3. Monitoring site-specific settings for compliance
4. Reporting site-specific setting compliance to AHCCCS

Visit the AHCCCS website for more detailed information on Arizona's Systemic Assessment and Transition Plan to comply with the HCBS Rules.

The five-year transition plan timeline and milestones are subject to change upon CMS approval.

Person-Centered Planning: In collaboration with members, families, providers and Contractors, AHCCCS will be creating uniform person centered planning policies, forms and practices for all ALTCS members. The new standards will support the successful implementation and monitoring of the State's compliance with the HCBS Rules on an individual member level. The development of the standards is currently underway and estimated to be completed by February 2019.

The Contractor will be required to participate in a multi-stakeholder workgroup to provide input on revisions to policies, forms and practices and competency-based training for case managers. Upon

completion of the Person-Centered Planning project, the Contractor will be required to replicate the competency-based training for new case managers.

Electronic Visit Verification (EVV): AHCCCS issued a Request for Information on March 30, 2016, soliciting responses from EVV vendors to explore opportunities that may exist in the marketplace to verify in-home service delivery, including date of service, site of service, provider of service, and duration of service. AHCCCS is considering implementing EVV for services provided to members living in their own homes including attendant care, personal care, homemaker, habilitation, respite and skilled nursing services. The goals of instituting EVV in the ALTCS program include:

1. Ensuring timely service delivery for members including real time service gap reporting and monitoring
2. Reducing administrative burden associated with hard copy timesheet processing by AHCCCS providers
3. Generating cost savings from the prevention of fraud, waste and abuse

Section 1557 of the Affordable Care Act: Pursuant to 45 CFR Part 92, the Contractor is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability in health programs and activities, any part of which receives federal funding. Under the final rule, sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, sex stereotyping, and gender identity. AHCCCS is reviewing existing policies and system edits to implement necessary changes to conform to the law. The Contractor shall be required to adopt any such changes.

Nursing Facility Workgroup: AHCCCS intends to establish a workgroup with representatives from the ALTCS E/PD Contractors and providers to consider alignment between the Minimum Data Set (MDS) and the AHCCCS Uniform Assessment Tool (UAT). The workgroup will explore options to develop a standardized tool for the assessment of members' levels of care and related payment methodologies. It is AHCCCS' intention that the MCO retain the responsibility for level of care determinations.

Encounter Submissions: It is AHCCCS' intent that effective October 1, 2018, Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS no later than 210 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. This is a change from the current 240 day requirement as outlined in Section D, Paragraph 68, Encounter Data Reporting. Failure to submit encounters within 210 days may result in sanctions.

77. CONTINUITY OF OPERATIONS AND RECOVERY PLAN

The Contractor shall develop a Continuity of Operations and Recovery Plan, as detailed in ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. All staff shall be trained on, and be familiar with, the Plan. This Plan shall, at a minimum, include planning and training for:

1. Electronic/telephonic failure
2. Complete loss of use of the main site and any satellite offices in and out of State
3. Loss of primary computer system/records

4. Extreme weather conditions
5. Communication between the Contractor and AHCCCS in the event of a business disruption
6. Periodic testing (at least annually)

The Continuity of Operations and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

78. MEDICAL RECORDS

The member's medical record shall be maintained by the provider who generates the record. Medical records include those maintained by Primary Care Providers (PCPs) or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers. Each member is entitled to one copy of his or her medical record at no cost annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

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

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

The Contractor shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with AMPM Policy 940. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment.

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

The Contractor shall comply with medical record review requirements as outlined in AMPM Policy 940.

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

79. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A daily capitation transaction, as outlined in the HIPAA Transaction Companion Guides, and Trading Partner Agreements, will be produced to provide Contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

80. VALUE-BASED PURCHASING

Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value based health care systems where members' experience and population health are improved, per-capita health care cost is limited to the rate of general inflation through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality

improvement and learning. The Contractor shall participate in VBP efforts. Because VBP strategies are dynamic and ever changing to keep current with the marketplace and national trends, VBP policy decisions regarding the areas of focus below will be communicated after contract award and prior to October 1, 2017.

Value-Based Purchasing Initiative: The purpose of the VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies, as delineated by ACOM Policy 318 CYE 16 and CYE 17 and as specified in Attachment F3, Contractor Chart of Deliverables. Quality distributions to Contractors will be funded by assessing 1 percent of Prospective Gross Capitation (Quality Contribution) exclusive of Acute Care Only payments. One hundred percent (100%) of the Quality Contribution will be distributed to one or more Contractors according to the Contractors' performance on selected Quality Management Performance Measures relative to minimum performance standards established by CQM and the Contractors' ranking on QMPMs. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a Contract Year basis. It is the intent of AHCCCS to require that the Contractor move to the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3 and 4 effective October 1, 2017. Additionally, AHCCCS intends to update ACOM Policy 318 CYE 16 and CYE 17 requirements regarding the percentage of payments that must be governed by VBP strategies. That language shall require that both the ALTCS E/PD Contract, and the MA-DSNP Contract for ALTCS E/PD Duals, each reach 35% and 50% of total payments governed by VBP strategies for CYE 18 and CYE 19 respectively.

Value-Based Providers: The Contractor shall develop strategies that ensure that members are directed to providers who participate in VBP initiatives and who offer value as determined by measureable outcomes. The Contractor shall submit annually to AHCCCS, DHCM a Value Based Providers/Centers of Excellence Report as specified in Attachment F3, Contractor Chart of Deliverables, describing its strategies to direct members to valued providers. See below for report details. Effective October 1, 2017, AHCCCS may amend the reporting requirements for Value-Based Providers.

Centers of Excellence: Centers of Excellence are facilities that are recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Identification of a Center of Excellence should be based on criteria such as procedure volumes, clinical outcomes, and treatment planning and coordination. Identification of appropriate conditions and/or procedures most suitable to a relationship with a Center of Excellence should be based on analysis of the Contractor's data which demonstrates a high degree of variance in cost and/or outcomes. To encourage Contractor activity which incentivizes utilization of the best value providers for select, evidenced based, high volume procedures or conditions, the Contractor shall submit a Value Based Providers/Centers of Excellence Report annually to AHCCCS, DHCM, as specified in Attachment F3, Contractor Chart of Deliverables. Effective October 1, 2017, AHCCCS may amend the reporting requirements for Centers of Excellence.

The report criteria effective October 1, 2016 incorporates implementation of one to two contracts with Centers of Excellence based on the criteria above. The Contractor shall identify the Centers of Excellence under contract and shall include a description as to how these Centers were selected.

Value Based Providers/Centers of Excellence Report

The Value Based Providers/Centers of Excellence Report shall outline the Contractor's process to develop, maintain and monitor activities for both high value providers and Centers of Excellence and include at a minimum:

1. Thorough description of the Contractor's initiatives to encourage member utilization
2. Goals and outcome measures for the Contract Year
3. Description of monitoring activities to occur throughout the year
4. Evaluation of the effectiveness of the previous year's initiatives (*excluded from first report*)
5. Summary of lessons learned and any implemented changes (*excluded from first report*)
6. Description of the most significant barriers
7. Plans to encourage providers determined to offer high value but not participating in VBP arrangements, if any, to participate in VBP contracts
8. Plan for next Contract Year

E-Prescribing: E-prescribing is an effective tool to improve members' health outcomes and reduce costs as delineated in ACOM Policy 321. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to: reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, and increased prescription accuracy. The Contractor shall increase its E-Prescribing rate of original prescriptions in accordance with ACOM Policy 321. Effective October 1, 2017, AHCCCS may amend the requirements for E-Prescribing.

The NCPDP Prescription Origin Code and Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

VBP Differential Adjusted Payments: AHCCCS has introduced multiple VBP Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. AHCCCS may amend the VBP differential adjusted payment components effective October 1, 2017, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The VBP differential adjusted payments effective October 1, 2016 require that the Contractor adjust payments for specific providers and provider types as described below:

Nursing Facility: For CYE17, for qualified AHCCCS-registered Arizona Nursing Facility providers meeting criteria as set forth below, the Contractor is required to pass through an additional 1.0% increase in payments above the rates that the Contractor would otherwise pay, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the pneumococcal vaccine measure qualify for the VBP Differential Adjusted Payment increase.

- The pneumococcal vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine

- The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of June 1, 2016

Hospital: For CYE17, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Hospital providers (provider type 02) meeting criteria as set forth below, the Contractor is required to pass through an additional 0.5% increase in payments above the rates that the Contractor would otherwise pay, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

- The hospital must participate in the Network, the State's health information exchange, by June 1, 2016 as described in A.A.C. R9-22-712.71, and
- The hospital must have achieved Meaningful Use Stage 2 for Program Year 2015 as described in A.A.C. R9-22-712.71

Integrated Clinic: For CYE17, for qualified AHCCCS-registered Integrated Clinics (ICs) meeting criteria as set forth below, the Contractor is required to pass through an additional 10% increase in payments above the rates that the Contractor would otherwise pay for select physical health services, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

- Providers registered with AHCCCS as Integrated Clinics and licensed by the Arizona Department of Health Services as Outpatient Treatment Center which provide both behavioral health services and physical health services
 - The provider qualifies at any time during CYE17 for those dates of service in CYE17 that coincide with the provider's registration as an IC
- Physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code

[END OF SECTION D: PROGRAM REQUIREMENTS]

SECTION E. CONTRACT TERMS AND CONDITIONS**1. ADVERTISING AND PROMOTION OF CONTRACT**

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

2. 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.

3. ARBITRATION

The parties to this Contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. §12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this Contract. Delegation of less than all of the duties of this Contract must conform to the requirements of Section D, Subcontracts.

5. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

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

6. AUDIT AND INSPECTION

The Contractor shall comply with all provisions specified in applicable A.R.S. §35-214 and §35-215 and AHCCCS rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.3(h)].

The Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.3(h)].

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

The right to audit under this section exists during the term of this Contract and for 10 years from the termination of this Contract or the date of completion of any audit, whichever is later [42 CFR 438.3(h)].

7. AUTHORITY

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

8. CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this Contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this Contract, the Contractor may request an adjustment in compensation paid under this Contract. The Contractor must request an adjustment within 30 days from the date of receipt of the change notice.

Contract amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS), and approval is withheld until all amendments are signed by the Contractor. When AHCCCS issues an amendment to modify the contract, the Contractor shall ensure Contract amendments are signed and submitted to AHCCCS by the date specified by AHCCCS. The provisions of such amendment will be deemed to have been accepted even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

9. CHOICE OF FORUM

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

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

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

Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

In accordance with 42 CFR 438.3(d), A.R.S. §41-1461 et seq., and Executive Order 2009-09, the Contractor will not discriminate against individuals eligible to enroll on the basis of health status or need for healthcare services, race, color, national origin, sex, sexual orientation, gender identity or disability and the Contractor will not use any policy or practice that has the effect of discriminating on any of these bases.

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall safeguard information in accordance with Federal and State statutes and regulations, including but not limited to: the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); 45 CFR Parts 160 and 164; 42 CFR Part 431, Subpart F; 42 CFR Part 2; A.R.S. §36-664; A.R.S. §36-2903; A.R.S. §36-2932; A.R.S. §41-1959; A.R.S. §46-135; and any rules implanting those state statutes (e.g. A.A.C. R9-22-503, A.A.C. R9-22-512 and A.A.C. R9-28-514).

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

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

12. CONFLICT OF INTEREST

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

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

14. CONTRACT

The Contract between AHCCCS and the Contractor shall include: 1) the Request for Proposal (RFP) including AHCCCS policies and procedures incorporated by reference as part of the RFP, 2) the Proposal submitted by the Contractor in response to the RFP including any Best and Final Offers, and 3) any Contract amendments. In the event of a conflict in language between the Proposal (including any Best and Final Offers) and the RFP (including AHCCCS policies and procedures incorporated by reference), the provisions and requirements set forth and/or referenced in the RFP (including AHCCCS policies and procedures incorporated by reference) shall govern.

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

15. 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 Contracting Officer on behalf of the State and signed by a duly authorized representative of the Contractor.

16. COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by AHCCCS employees.

17. COVENANT AGAINST CONTINGENT FEES

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

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who reports directly to the CEO or CFO [42 CFR 438.606 et seq.].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by A.A.C. Title 9, Chapter 28, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and A.R.S. §36-2932. All disputes except as provided under A.A.C. Title 9, Chapter 28, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this Contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S §41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

21. EFFECTIVE DATE

The effective date of this Contract shall be the date referenced on page 1 of this Contract or any subsequent amendments.

22. EMPLOYEES OF THE CONTRACTOR

All employees of the Contractor employed in the performance of work under the Contract shall be considered employees of the Contractor at all times, and not employees of AHCCCS or the State. The Contractor shall comply with the Social Security Act, Workman's Compensation laws and Unemployment laws of the State of Arizona and all State, local and Federal legislation relevant to the Contractor's business.

23. FEDERAL IMMIGRATION AND NATIONALITY ACT

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

24. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a

representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

25. INCORPORATION BY REFERENCE

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

26. INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency):

The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

Contractor/Vendor Indemnification (Public Agency):

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

27. INDEMNIFICATION - PATENT AND COPYRIGHT

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

28. INSURANCE

The Contractor is required to maintain insurance, at a minimum, as specified in *Standard Professional Service Contract - Working with Children or Vulnerable Adults*.

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INDEMNIFICATION CLAUSE:

To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor shall procure and maintain, until all of their obligations have been discharged, including any warranty periods under this Contract, insurance against claims for injury to persons or damage to property arising from, or in connection with, the performance of the work hereunder by the Contractor, its agents, representatives, employees or subcontractors.

The *Insurance Requirements* herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or subcontractors, and the Contractor is free to purchase additional insurance.

A. MINIMUM SCOPE AND LIMITS OF INSURANCE: Contractor shall provide coverage with limits of liability not less than those stated below.

1. Commercial General Liability (CGL) – Occurrence Form

Policy shall include bodily injury, property damage, and broad form contractual liability coverage.

- General Aggregate \$2,000,000

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- Products – Completed Operations Aggregate \$1,000,000
- Personal and Advertising Injury \$1,000,000
- Damage to Rented Premises \$50,000
- Each Occurrence \$1,000,000

- a. The policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor.
- b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.
- c. The policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than \$500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.
- d. Contractor must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.”

2. Business Automobile Liability

Bodily Injury and Property Damage for any owned, hired, and/or non-owned automobiles used in the performance of this Contract.

- Combined Single Limit (CSL) \$1,000,000

- a. Policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by, or on behalf of, the Contractor involving automobiles owned, hired and/or non-owned by the Contractor.
- b. Policy shall contain a waiver of subrogation endorsement as required by this written agreement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

3. Workers’ Compensation and Employers' Liability

- Workers' Compensation Statutory
- Employers' Liability
 - Each Accident \$1,000,000
 - Disease – Each Employee \$1,000,000
 - Disease – Policy Limit \$1,000,000

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- a. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.
- b. This requirement shall not apply to each Contractor or subcontractor that is exempt under A.R.S. § 23-901, and when such Contractor or subcontractor executes the appropriate waiver form (Sole Proprietor or Independent Contractor).

4. Professional Liability (Errors and Omissions Liability)

Each Claim	\$ 2,000,000
Annual Aggregate	\$ 2,000,000

- a. If SAM coverage is being provided under this policy then Contractor must provide the following statement on their Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded." This coverage may be sub-limited to no less than \$500,000.
- b. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.
- c. Policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of this Contract.

B. ADDITIONAL INSURANCE REQUIREMENTS: The policies shall include, or be endorsed to include, as required by this written agreement, the following provisions:

- 1. The Contractor's policies, as applicable, shall stipulate that the insurance afforded the Contractor shall be primary and that any insurance carried by the Department, its agents, officials, employees or the State of Arizona shall be excess and not contributory insurance, as provided by A.R.S. §41-621 (E).
- 2. Insurance provided by the Contractor shall not limit the Contractor's liability assumed under the indemnification provisions of this Contract.

C. NOTICE OF CANCELLATION: Applicable to all insurance policies required within the Insurance Requirements of this Contract, Contractor's insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without thirty (30) days prior written notice to the State of Arizona. Within two (2) business days of receipt, Contractor must provide notice to the State of Arizona if they receive notice of a policy that has been or will be suspended, canceled, materially changed for any reason, has expired, or will be expiring. Such notice shall be sent to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of this Contract.

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- D. **ACCEPTABILITY OF INSURERS:** Contractor's insurance shall be placed with companies licensed in the State of Arizona or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers. Insurers shall have an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.
- E. **VERIFICATION OF COVERAGE:** Contractor shall furnish AHCCCS with certificates of insurance (valid ACORD form or equivalent approved by the State of Arizona) evidencing that Contractor has the insurance as required by this Contract. An authorized representative of the insurer shall sign the certificates.

All such certificates of insurance and policy endorsements must be received by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of this Contract before work commences. The State's receipt of any certificates of insurance or policy endorsements that do not comply with this written agreement shall not waive or otherwise affect the requirements of this agreement.

Each insurance policy required by this Contract must be in effect at, or prior to, commencement of work under this Contract. Failure to maintain the insurance policies as required by this Contract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this Contract shall be sent directly to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of this Contract. The AHCCCS contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete copies of all insurance policies required by this Contract at any time.

- F. **SUBCONTRACTORS:** Contractor's certificate(s) shall include all subcontractors as insureds under its policies or Contractor shall be responsible for ensuring and/or verifying that all subcontractors have valid and collectable insurance as evidenced by the certificates of insurance and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the relevant insurance section of the AHCCCS Minimum Subcontract Provisions located on the AHCCCS website. AHCCCS reserves the right to require, at any time throughout the life of the Contract, proof from the Contractor that its subcontractors have the required coverage. All subcontractors are required to maintain insurance and to provide verification upon request.
- G. **APPROVAL AND MODIFICATIONS:** AHCCCS, in consultation with State Risk, reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the life of this Contract, as deemed necessary. Such action will not require a formal Contract amendment but may be made by administrative action.

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- H. **EXCEPTIONS:** In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a certificate of self-insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

[END INSURANCE REQUIREMENTS]

29. IRS W9 FORM

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

30. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in Federal and State Law and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the system.

31. LOBBYING

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

32. NO GUARANTEED QUANTITIES

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

33. NON-EXCLUSIVE REMEDIES

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

34. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

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

35. ORDER OF PRECEDENCE

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

of the CMS Section 1115 waiver for the State of Arizona; the Arizona State Plan; the Constitution and laws of Arizona, and applicable State Rules; the terms of this Contract which consists of the RFP, the Proposal of the Successful Offeror, and any Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

36. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this Contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this Contract, as otherwise allowed under this Contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this Contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable State and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this Section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this Contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for State or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 75.

37. RELATIONSHIP OF PARTIES

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

38. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any sums due the Contractor any expenses or costs incurred by AHCCCS or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the Contract, including but not limited to expenses, costs and damages.

39. RIGHT TO ASSURANCE

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

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

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

41. SEVERABILITY

The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the contract.

42. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

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

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

43. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR Part 438, Subpart I, and A.R.S. §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or

charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Pursuant to 42 CFR 438.706, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

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

44. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this Contract, starting October 1, 2017, shall be for an initial period of three years with three renewal periods: one renewal of two years, and two renewals of one year each. The Contract Year is October 1 through September 30 with an annual October 1 renewal. The terms and conditions of any such contract extension shall remain the same as the original contract except, as otherwise amended. Any contract extension or renewal shall be through Contract amendment, and shall be at the sole option of AHCCCS.

If the Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCS may renew the Contractor's contract in one GSA, but not in another. In the event AHCCCS determines there are issues of noncompliance by the Contractor in one GSA, AHCCCS may request an enrollment cap for the Contractor's contracts in all other GSAs. Further, AHCCCS may require the Contractor to renew all currently awarded GSAs, or may terminate the contract if the Contractor does not agree to renew all currently awarded GSAs.

Contract amendments, including renewals, are subject to approval by the Centers for Medicare and Medicaid Services (CMS). When the Contracting Officer issues an amendment to extend or renew the contract, the provisions of such extension or renewal will be deemed to have been accepted 30

days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension or renewal amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension or renewal amendment. Failure of an existing Contractor to accept an amendment to extend or renew may result in immediate suspension/termination of member assignment. If the Contractor provides such notification, the Contracting Officer may initiate contract termination proceedings.

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

45. TERMINATION

AHCCCS reserves the right to terminate this contract in whole or in part by reason of force majeure, due to the failure of the Contractor to comply with any term or condition of the contract, including, but not limited to, circumstances which present risk to member health or safety, and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. The term force majeure means an occurrence that is beyond the control of AHCCCS and occurs without its fault or negligence. Force majeure includes acts of God and other similar occurrences beyond the control of AHCCCS which it is unable to prevent by exercising reasonable diligence.

If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.710 AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the Contract.

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

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

46. TERMINATION - AVAILABILITY OF FUNDS

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

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

47. TERMINATION FOR CONFLICT OF INTEREST

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

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

48. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS immediately upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

49. THIRD PARTY ANTITRUST VIOLATIONS

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

50. TYPE OF CONTRACT

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

51. WARRANTY OF SERVICES

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

[END OF SECTION E: CONTRACT TERMS AND CONDITIONS]

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

SECTION F: ATTACHMENTS**ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS**

The Contractor shall have a written policy delineating its Grievance and Appeal System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall also furnish this information to members within 12 days after the Contractor receives notice of the enrollment and annually thereafter. The Contractor shall provide this information to subcontractors at the time of contract and make this information available in its provider manual and on its website. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to members describing the Grievance and Appeal System as well as Contractor appeal and grievance notices, including denial and termination notices, shall be available in the prevalent non English language spoken for each LEP population in the Contractor's service area. [42 CFR 438.3(d)(3)] These written materials must also be made available in alternate formats upon request at no cost. Auxiliary aids and services must also be made available upon request and at no cost. These written materials shall include taglines in the prevalent non-English languages in Arizona and in large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services to understand the information and include the Contractor's toll free and TTY/TDY telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials. Refer to ACOM Policy 404 for additional information and requirements.

The Contractor shall inform members that oral interpretation services are available in any language and alternative communication formats are available for enrollees who have hearing or vision impairment.

For additional information regarding the member Notice of Adverse Benefit Determination process, the Contractor should refer to ACOM Policy 414 and 42 CFR Part 438. For additional information regarding member information requirements, the Contractor should refer to ACOM Policy 404. Failure to comply with any of these provisions may result in an imposition of sanctions.

At a minimum, the Contractor must comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

1. The Contractor shall maintain records of all grievances and appeals which must contain at a minimum the following [42 CFR 438.416]:
 - a. A general description of the reason for an appeal or grievance
 - b. The date received
 - c. The date of each review or, if applicable, review meeting
 - d. The resolution at each level of appeal or grievance
 - e. The date of resolution at each level
 - f. The name of the member for whom the appeal or grievance was filed
 - g. The name of the individual filing the appeal or grievance on behalf of the member, if applicable
 - h. The date the request for hearing was received, if applicable

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

2. The Contractor has a mechanism for tracking receipt, acknowledgement, investigation and resolution of grievances and appeals, and for tracking requests for hearing within the required timeframes.
3. The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement.
4. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance, appeal or request for hearing.
5. The Contractor must provide members any reasonable assistance in completing forms and taking other procedural steps related to the grievance and appeal process. This included but is not limited to auxiliary aids and services upon request, such as interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability [42 CFR 438.406(a)].
6. The availability of toll-free numbers that a member can use to file a grievance or appeal by phone if requested by the member. Oral inquiries appealing an adverse benefit determination are treated as appeals.
7. The Contractor shall permit both oral and written appeals and grievances.
8. The Contractor shall acknowledge receipt of each grievance and appeal. For grievances, the Contractor is not required to acknowledge receipt of the grievance in writing, however, if the member requests written acknowledgement, the acknowledgement must be made within five business days of receipt of the request. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one day of receipt of expedited appeals.
9. The Contractor shall ensure individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making, or a subordinate of such individuals. The Contractor shall also ensure individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) grievances regarding denials of expedited resolutions of appeals or 3) grievances or appeals involving clinical issues have the appropriate clinical expertise in treating the member's condition or disease. [42 CFR 438.406(b)]
10. The Contractor shall not delegate the Grievance and Appeal System requirements to its providers.
11. Define a grievance as a member's expression of dissatisfaction with any matter, other than an adverse benefit determination [42 CFR 438.400(b)]. There are no time limits for filing a member grievance.
12. A member must file a grievance with the Contractor and the member is not permitted to file a grievance directly with the AHCCCS.
13. The Contractor shall address identified issues as expeditiously as the member's condition requires and must resolve each grievance within 10 business days of receipt, absent extraordinary circumstances.

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed. [42 CFR 438.408(b)]

14. The Contractor responds to a grievance in writing, if a member requests a written explanation of the resolution, and the response must be mailed within 10 business days of resolution of the grievance.
15. If resolution to a grievance is not completed when the timeframe expires, the member is deemed to have exhausted the Contractor's grievance process and the can file a request for hearing.
16. Define a service authorization request as a member's request for the provision of a service. [42 CFR 438.210]
17. Define a standard authorization request. For standard authorization decisions, the Contractor must provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 additional calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's best interest [42 CFR 438.210(d)(1)]. The Notice of Adverse Benefit Determination must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service or when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.
18. Define an expedited authorization request. For expedited authorization decisions, the Contractor must provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 72 hours following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's interest [42 CFR 438.210(d)(2)].
19. Define an Adverse Benefit Determination as set forth below [42 CFR 438.400(b)] and permit a member, or their designated representative, to file an appeal of an adverse benefit determination taken by the Contractor. Adverse benefit determinations are any of the following:
 - a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
 - b. Reduction, suspension, or termination of a previously authorized service;
 - c. Denial, in whole or in part, of payment for a service;
 - d. Failure to provide services in a timely manner, as defined by the State;
 - e. Failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) required for standard resolution of appeals and standard disposition of grievances; or
 - f. Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area
 - g. Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

20. The Notice of Adverse Benefit Determination for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the Contractor must give the member written notice of the reason to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the member's health condition requires and no later than the date the extension expires.
21. The Contractor shall notify the requesting provider, in writing, of the decision to deny or reduce a service authorization request.
22. The Contractor shall mail a Notice of Adverse Benefit Determination: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least five days before the date of adverse benefit determination in the case of suspected fraud; 3) at the time of any adverse benefit determination affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 calendar days from receipt of a standard service authorization request and within 72 hours from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Adverse Benefit Determination provides the member with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Adverse Benefit Determination no later than the date of adverse benefit determination when:
- a. The Contractor receives notification of the death of a member;
 - b. The member signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
 - c. The member is admitted to an institution where he/she is ineligible for further services;
 - d. The member's address is unknown and mail directed to the member has no forwarding address;
 - e. The member has been accepted for Medicaid in another local jurisdiction.
23. The Notice of Adverse Benefit Determination must explain: 1) the adverse benefit determination the Contractor has taken or intends to take, 2) the reasons for the adverse benefit determination including the right of the member to be provided upon request, and at no charge, reasonable access to copies of all documents, records and other information related to the adverse benefit determination; this information includes medical necessity criteria, any processes, strategies or evidentiary standards used in setting coverage limits, 3) the member's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the member's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay for the cost of these services. The Notice of Adverse Benefit Determination shall comply with ACOM Policy 414.
24. Define an appeal as the request for review of an adverse benefit determination, as defined above. [42 CFR 438.400(b)]

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

25. Define a standard appeal. The Contractor shall resolve standard appeals no later than 30 calendar days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
26. Define an expedited appeal as an appeal in which the Contractor determines (for a request from a member) or the Provider indicates (when making the request for the member or in support of the member's request) that taking the time for standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor shall resolve all expedited appeals not later than 72 hours from the date the Contractor receives the appeal (unless an extension is in effect). The Contractor shall make reasonable efforts to provide oral notice to a member regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
27. A member shall be given 60 days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal.
28. Explain that a provider acting on behalf of a member and with the member's written consent, may file an appeal.
29. The Contractor includes, as parties to the appeal, the member, the member's legal representative, or the legal representative of a deceased member's estate.
30. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal. [42 CFR 438.410(b)]
31. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 calendar days if the member requests the extension or if the Contractor establishes a need for additional information and that the delay is in the member's interest. [42 CFR 438.408(c)]
32. If the Contractor extends the timeframe for resolution of an appeal when not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice and follow-up within two calendar days with a written notice of the reason for the decision to extend the timeframe and the member's grievance rights.
33. The Contractor shall establish and maintain an expedited review process for appeals when 1)the Contractor determines (for a request from a member) the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function or 2)the provider indicates (in making the request on behalf of the member or in support of the member's request) the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
34. If the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30 calendar day timeframe for a standard appeal. The Contractor must make reasonable efforts to give

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

the member prompt oral notice and follow-up within two calendar days with a written notice of the denial of expedited resolution and the member's grievance rights.

35. For appeals, the Contractor provides the member a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing. The Contractor must inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe. [42 CFR 438.406]
36. For appeals, the Contractor provides the member and his/her representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal. This information must be provided at no charge to the member and sufficiently in advance of the resolution timeframe. [42 CFR 438.406]
37. The Contractor shall provide written Notice of Appeal Resolution to the member and the member's representative or the representative of the deceased member's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of members: a) the member's right to request a State fair hearing (including the requirement that the member must file the request for a hearing in writing) no later than 120 days after the date the member receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing when the member has requested a hearing within 10 calendar days from the date the notice of resolution was sent and how to request continuation of benefits and c) information explaining that the member may be held liable for the cost of benefits if the hearing decision upholds the Contractor.
38. Benefits shall continue until a hearing decision is rendered if: 1) the member files an appeal before the later of a) 10 calendar days from the mailing of the Notice of Adverse Benefit Determination or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment that has not yet expired or b) the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service, 3) the services were ordered by an authorized provider and 4) the member requests a continuation of benefits.

For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction, or suspension which has been appealed.
39. The Contractor shall continue extended benefits originally provided to the member until any of the following occurs: 1) the member withdraws the appeal or request for State fair hearing, 2) the member has not specifically requested continued benefits pending a hearing decision within 10 calendar days of the Contractor mailing of the appeal resolution notice, or 3) AHCCCS issues a State fair hearing decision adverse to the member.
40. If the member files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS) as specified by OALS.

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

The file provided by the Contractor must contain a cover letter that includes:

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

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

- a. The Member's written request for hearing
 - b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records
 - c. The Contractor's Notice of Appeal Resolution
 - d. Other information relevant to the resolution of the appeal
41. If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal or the pendency of the hearing process, the Contractor shall authorize or provide the services as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 438.424]. Services must be authorized within the above timeframe irrespective of whether the Contractor contests the decision.
42. If the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation.
43. If the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, Rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.
44. If the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending the appeal or State fair hearing decision, the Contractor may recover the cost of those services from the member.

[END OF ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS]

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

The Contractor shall have in place a written claims dispute policy for its subcontractors and non-contracted providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies.

Failure to comply with any of these provisions may result in the imposition of sanctions.

The Contractor shall comply with the following provisions:

1. The Provider Claim Dispute Policy shall stipulate that all claim disputes must be adjudicated in Arizona, including those claim disputes arising from claims processed by an Administrative Services Subcontractor.
2. The Provider Claims Dispute Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the Contractor shall send a copy of its Provider Claims Dispute Policy within 45 days of receipt of a claim. The policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
3. The Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.
4. The Provider Claim Dispute Policy must specify a physical local address in Arizona for the submission of all provider claim disputes and hearing requests.
5. That specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.
6. The Contractor shall develop and maintain a tracking log for all claims disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claims dispute, resolution of the claim dispute, and the date of resolution.
7. That claim disputes are acknowledged in writing and within five business days of receipt.
8. Claims disputes are thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
9. All documentation received by the Contractor during the claim dispute process is dated upon receipt.
10. All claim disputes are filed in a secure designated area and are retained for five years following the Contractor's decision, AHCCCS decision, judicial appeal or close of the claims dispute, whichever is later, unless otherwise provided by law.
11. The Provider Claim Dispute Policy must specify a copy of the Contractor's Notice of Decision (Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail the following:

- a. The nature of the claim dispute.
 - b. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member name, pertinent dates of service, dates and specific reasons for the Contractor denial / payment of the claim, and whether or not the provider is a contracted provider.
 - c. An explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.
 - d. The provider's right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Contractor's decision
 - e. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision
12. If the Provider files a written request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS), no later than five business days from the date the Contractor receives the provider's written hearing request. The file sent by the Contractor must contain a cover letter that includes the following information:
- a. The provider's name
 - b. The provider's Address
 - c. The member's name and AHCCCS Identification Number
 - d. The provider's phone number (if applicable)
 - e. The date that the claim dispute was received by the Contractor
 - f. A summary of the actions undertaken by the Contractor to resolve the claim dispute and basis of the determination

The following materials shall be included in the file sent by the Contractor:

- a. The written request for hearing filed by the Provider
 - b. Copies of the entire file including pertinent records and the Contractor's Decision
 - c. Other information relevant to the Decision
13. If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor must review the matter to determine why the request for hearing was filed and resolve the matter when appropriate.
14. If the Contractor's Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision, along with any applicable interest, within 15 business days of the date of the Decision.

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

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

[END OF ATTACHMENT F2: PROVIDER CLAIMS DISPUTE STANDARDS]

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES**ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES**

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM Arizona Time on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM Arizona Time on the next business day.

If a Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
AHCCCS PROCUREMENT OFFICE	Ad Hoc	Certifications of Insurance	Within 10 days of notification of contract award and prior to commence ment of any services under this contract.	Section E	Paragraph 28	N/A	AHCCCS Procurement Office	Email notification to AHCCCS Procurement
AHCCCS PROCUREMENT OFFICE	Ad Hoc	Insurance Material Change	Within 30 days of event	Section E	Paragraph 28	N/A	AHCCCS Procurement Office	Email notification to AHCCCS Procurement

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DBF TPL UNIT	Ad Hoc	Third Party Liability Reporting - Involving Commercial Insurance Payor Sources: TPL Leads File or Via the TPL Referral Web Portal	Within 10 days of discovery	Section D	Paragraph 58	AHCCCS Technical Interface Guidelines	AHCCCS ISD or the AHCCCS TPL Contractor (HMS)	AHCCCS SFTP or the TPL Referral Web Portal: https://ecenter.hmsy.com/
DBF TPL UNIT	Ad Hoc	Third Party Liability Reporting - Other Third Party Liability Recoveries: For Determination of a Mass Tort, Total Plan Case, or Joint Case	Within 10 days of discovery	Section D	Paragraph 58	AHCCCS Technical Interface Guidelines	AHCCCS TPL Contractor	Email, Fax, or mail submission

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ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DBF TPL UNIT	Ad Hoc	Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)	20 th day of the month	Section D	Paragraph 58	ACOM Policy 434	AHCCCS TPL Management Analyst	Email, Fax, or mail submission
DBF TPL UNIT	Ad Hoc	Total Plan Case Settlement Reporting via the Settlement Notification Form (When reporting, Contractors must use the monthly file or the ad hoc form)	Within 10 business days from the settlement date	Section D	Paragraph 58	ACOM Policy 434 Attachment A	AHCCCS TPL Management Analyst	Email, Fax, or mail submission
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Actions Reported to the NPDB or a Regulatory Board	Within one business day	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Adverse Action Reporting (Including Limitations and Terminations)	Within one business day	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager

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Contract/RFP No. YH18-0001

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Advise of Significant Incidents/Accidents Including Abuse, Neglect and Unexpected Death	Within 1 day of awareness	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Requests	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Communication of Adverse Action to Provider	Within one business day	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Credentialing and Re-credentialing Denials	Within 1 business day	Section D	Paragraph 64	AMPM 950	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager

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ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Engaging Members Through Technology Executive Summary	December 1, 2017	Section D	Paragraph 20	N/A	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	HCAC and OPPC	Upon identification by Contractor	Section D	Paragraph 20; Paragraph 21	AMPM Chapter 900; AMPM Chapter 1000	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Immunization Audit	As requested by AHCCCS	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Performance Improvement Project Reports – Baseline, Interim, Final, and Updates as Requested	Refer to AMPM	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Physician Incentives: Contractor-Selected and/or Developed Pay for Performance Initiatives	Prior Approval Required	Section D	Paragraph 38	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

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ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Physician Incentives: Contractual Arrangements with Substantial Financial Risk	45 days prior to implementation of the contract	Section D	Paragraph 38	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Stillbirth Supplement Request	Immediately following procedure	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Court Ordered Treatment Policy	15 days after the start of the contract year	Section D	Paragraph 12	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Dental Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	EPSDT Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Maternity Care Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Administrator

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Baseline	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Re-Measurement	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Quality Assessment/Performance Improvement Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Monthly Pregnancy Termination	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Sterilization Reporting	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Credentialing Quarterly Report	30 days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	EPSDT Improvement and Adult Quarterly Monitoring Report	15 days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Key Staff: Staff Primary and Back-Up Contact Information for Urgent Issue Resolution	30 days after the end of each quarter	Section D	Paragraph 25	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	QM Quarterly Report	45 Days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Semi-Annually	Semi-Annual Report of Number of Pregnant Women who are HIV/AIDS Positive	30 days after the reporting periods of: [10/1 through 3/31] & [4/1 through 9/30]	Section D	Paragraph 10	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Corporate Compliance: CMS Compliance Issues Related to HIPAA Transaction and Code Set Complaints or Sanction	Immediately upon discovery	Section D	Paragraph 64	N/A	DHCM Encounter Administrator	Email notification
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Medical Records or Supporting Documentation	As specified in the requesting letter	Section D	Paragraph 68	AHCCCS Data Validation Technical Document	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Annually	AHCCCS Security Rule Compliance Report	June 1 st	Section D	Paragraph 67	ACOM Policy 108	DHCM Data Analysis and Research Manager	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Monthly	Corrected Pended Encounter Data	Monthly, according to established schedule	Section D	Paragraph 68	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Monthly	New Day Encounter	Monthly, according to established schedule	Section D	Paragraph 68	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Encounter Submission and Tracking	15 days after the end of each quarter	Section D	Paragraph 68	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Overrides	15 days after the end of each quarter	Section D	Paragraph 68	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Voids	15 days after the end of each quarter	Section D	Paragraph 68	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM FINANCE	Ad Hoc	Equity Distributions	Submit for approval prior to effective date	Section D	Paragraph 47	N/A	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Corporate Cost Allocation Plans and Adjustment in Management Fees	Prior approval required	Section D	Paragraph 50	N/A	DHCM Finance Manager	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Ad Hoc	Performance Bond or Bond Substitute	30 days after notification from AHCCCS of the amount required	Section D	Paragraph 43	ACOM Policy 305	DHCM Program Compliance Auditor	Hardcopy
DHCM FINANCE	Ad Hoc	Health Insurer Fee: No fee due (if Annual Reporting Does Not Apply) Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 51	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Automatic Clearing House (ACH) Vendor Authorization Form	45 days prior to the effective date and commencement of operations	Section D	Paragraph 50	ACOM Policy 317	DHCM Financial Consultant	FTP server with email notification

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Annual Reconciliation to Draft Audit	90 days after year end	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Final Audit	120 days after year end	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Related Party Transaction Statement	120 days after year end	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Draft Annual Financial Reporting Package	90 days after the end of each fiscal year	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Final Annual Financial Reporting Package	120 days after the end of each fiscal year	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Management Letter	120 days after year end	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Health Insurer Fee: Federal and State Income Tax Filings Suspended for 04/30/2018	April 30 th of the year following the fee year	Section D	Paragraph 51	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Health Insurer Fee: Liability Reporting Template Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 51	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Health Insurer Fee: Report of Health Insurance Provider Information (IRS Form 8963) Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 51	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Nursing Facility Acuity Report	September 15 th	Section D	Paragraph 69	N/A	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Value-Based Purchasing (VBP) Strategies Certification (Initial)	Within 60 days of the start of the measurement year	Section D	Paragraph 80	ACOM Policy 318	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Value-Based Purchasing (VBP) Strategies Certification (Final)	Within 180 days of the end of the measurement year	Section D	Paragraph 80	ACOM Policy 318	DHCM Finance Manager	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Summary of Contract Rates for Long Term Care, Behavioral Health and Home and Community Based Services	October 15th	Section D	Paragraph 80	AHCCCS Financial Reporting Guide For ALTCS Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Cost Avoidance/Recovery Report	Due 45 days after the reporting quarter: (Oct - Dec: Due Feb 14) (Jan – March: Due May 15) (Apr – June: Due August 14) (July – Sept: Due Nov 14)	Section D	Paragraph 58	AHCCCS Program Integrity Reporting Guide	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	FQHC Member Information	60 days after the end of each quarter	Section D	Paragraph 40	AHCCCS Financial Reporting Guide For ALTCS Contractors	DHCM Program Compliance Auditor	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Premium Tax Reporting	March 15th, June 15th, September 15th , December 15th	Section D	Paragraph 69	ACOM Policy 304	DHCM Finance Program Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Quarterly Financial Reporting Package	60 days after the end of each quarter	Section D	Paragraph 48	AHCCCS Financial Reporting Guide For ALTCS Contractors	DHCM Program Compliance Auditor	FTP server with email notification

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Verification of Receipt of Paid Services	15th day after the end of the quarter that follows the reporting quarter (Oct – Dec: Due April 15) (Jan – March: Due July 15) (April – June: Due Oct 15) (July – Sept: Due Jan 15)	Section D	Paragraph 61	ACOM Policy 424	DHCM Program Compliance Auditor	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	Case Management Plan	December 15th	Section D	Paragraph 16	AMPM Chapter 1600	DHCM Case Management	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	HIV Specialty Provider List	December 15th	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	MM Plan, Evaluation and Work Plan	December 15th	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM MEDICAL MANAGEMENT	Annually	Non-Transplant and Catastrophic Reinsurance	By October 30 of each contract year and when newly enrolled in the plan or newly diagnosed.	Section D	Paragraph 53	AMPM Chapter 1000; AHCCCS Reinsurance Policy Manual	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Quarterly Inpatient Hospital Showings	15 days after the end of each quarter	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Transplant Log	15 days after the end of each quarter	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Semi-Annually	Emergency Department Diversion Summary	October 15 and April 15	Section D	Paragraph 21	AMPM Chapter 1020	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Semi-Annually	Pharmacy and/or Prescriber - Member Assignment Report	April 15 and October 15	Section D	Paragraph 21	AMPM 310-FF	DHCM Medical Management Unit	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontractor Non-Compliance Reporting	Within 30 days of discovery	Section D	Paragraph 32	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontracts	60 days prior to the beginning date of the subcontract	Section D	Paragraph 32	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	AHCCCS Required Survey Results	45 days after the completion	Section D	Paragraph 61	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Appointment Availability Review Methods	30 days prior to implementation of the proposed method	Section D	Paragraph 37	ACOM Policy 417	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Claim Recoupments >1 2 Months from Original Payment	Upon identification by Contractor	Section D	Paragraph 42	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Completed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Documents required after AHCCCS Approval	Within 120 days of the completed merger, acquisition, reorganization, joint venture, or change in ownership	Section D	Paragraph 50	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Data Processes for Recoupments	120 days from receipt of approval	Section D	Paragraph 42	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Final Survey Tool	90 days prior to the intended start	Section D	Paragraph 61	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Hospital Subcontracts and Amendments	Upon Request by AHCCCS	Section D	Paragraph 35	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	ID Cards requiring AHCCCS Approval	30 days prior to dissemination	Section D	Paragraph 17	ACOM Policy 433	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Independent Audits of Claims Payment/Health Information Systems	Upon request by AHCCCS	Section D	Paragraph 42	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Staff: Contact Information Change	Within one business day of the change	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Staff: Key Position Change	Within 7 days of learning of resignation	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Staff: Notification of Moving Functions Out of State	60 days prior to proposed change	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Marketing Materials	21 days prior to dissemination	Section D	Paragraph 60	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov
DHCM OPERATIONS	Ad Hoc	Material Change to Business Operations	60 days prior to expected implementation of the change	Section D	Paragraph 41	ACOM Policy 439	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Material Change to Provider Network	60 days prior to expected implementation of the change	Section D	Paragraph 28	ACOM Policy 439	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Member Handbook (Final Approved Version)	On or before the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Member Information Materials	15 days prior to release	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Non-AHCCCS Required Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	Section D	Paragraph 61	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Notification	180 days prior to the effective date	Section D	Paragraph 50	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Transition Plan Initial Documents	180 days prior to the effective date	Section D	Paragraph 50	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Transition Plan Final Documents	90 days prior to the effective date	Section D	Paragraph 50	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Provider Advances and Loans	10 Days prior to disbursement of Funds	Section D	Paragraph 47	ACOM Policy 418	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Single Claim Recoupments >\$50,000	30 days prior to initiating the recoupment, or earlier if the information is available	Section D	Paragraph 42	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	System Change Plan	Six months prior to expected implementation	Section D	Paragraph 42	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Unexpected Change to Provider Network	Within one business day	Section D	Paragraph 28	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Value Based Providers/Centers of Excellence Report	December 31	Section D	Paragraph 80	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Administrative Services Subcontractor Evaluation Report	Within 90 days of the start of the contract year	Section D	Paragraph 32	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	ALTCS Member Council Plan	December 15th	Section D	Paragraph 24	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual Website Certification	45 days after the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Continuity of Operations and Recovery Plan Summary	15 days after the start of the contract year	Section D	Paragraph 77	ACOM Policy 104	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Cultural Competency Plan Assessment	45 days after the start of the contract year	Section D	Paragraph 63	ACOM Policy 405	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Attestation of Staffing Compliance	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Key Staff: Functional Organization Chart	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Listing of All Key Staff Information	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Organization Chart	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Language Plan	45 days after the start of the contract year	Section D	Paragraph 17	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DBF CONTRACTS & PURCHASING	Annually	Marketing Attestation Statement	45 days after the start of the contract year	Section D	Paragraph 60	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OFFICE OF BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT	Annually	Training Curriculum	15 days after the start of the contract year	Section D	Paragraph 12	AMPM Policy 1060	Office of Behavioral Health Workforce Development Administrator	FTP server with email notification or if Contractor is using a learning management system, provide access to the system for review of materials and content
DHCM OFFICE OF BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT	Annually	Workforce (Training) Development Plan	15 days after the start of the contract year	Section D	Paragraph 12	AMPM Policy 1060	Office of Behavioral Health Workforce Development Administrator	FTP server with email notification or if Contractor is using a learning management system, provide access to the system for review of materials and content
DHCM OFFICE OF BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT	Quarterly	Workforce (Training) Development Report	15 days after the end of each quarter	Section D	Paragraph 12	AMPM Policy 1060	Office of Behavioral Health Workforce Development Administrator	FTP server with email notification or if Contractor is using a learning management system, provide access to the system for review of materials and content
DHCM OPERATIONS	Annually	Member Handbook	August 1 and 30 days prior to any changes	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Member Information Attestation Statement	45 days after the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Provider Network Development and Management Plan	45 days after the start of the contract year	Section D	Paragraph 27	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Social Networking Administrator (Name and Contact Information)	Within 90 days of the start of the contract year and within 30 days of any changes	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Social Networking Applications Listing with URLs	Within 90 days of the start of the contract year and within 30 days of any changes	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Social Networking Attestation	Within 90 days of the start of the contract year	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Monthly	*Claims Dashboard	15th day of the month following the reporting period	Section D	Paragraph 42	AHCCCS Claims Dashboard Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Grievance and Appeal System Report	First day of the 2nd Month following the month Being Reported	Section D	Paragraph 22	AHCCCS Grievance and Appeal System Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Marketing Activities Report	10th of the month for the previous months activities	Section D	Paragraph 60	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov
DHCM OPERATIONS	Quarterly	Appointment Availability Review Methods	15 days after the end of each quarter	Section D	Paragraph 37	ACOM Policy 417	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Gap in Critical Services Log	October 15, January 15, April 15, July 15	Section D	Paragraph 27	ACOM Policy 413	DHCM Operations and Compliance Officer	FTP server with email notification

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Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
DHCM OPERATIONS	Quarterly	Housing Referral Report	15 days after the end of each quarter	Section D	Paragraph xx	N/A	DHCM Housing Administrator	FTP server with email notification
DHCM OPERATIONS	Quarterly	Housing Referral and Placement Report	15 th day of the month following the end of the FY quarters. January 15, April 15, July 15, October 15	Section D	Paragraph 16	N/A	AHCCCS Housing Administrator	FTP server with email notification
DHCM OPERATIONS	Quarterly	Minimum Network Requirements Verification Template	October 15, January 15, April 15, July 15	Section D	Paragraph 31	ACOM Policy 436	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider Affiliation Transmission	October 15, January 15, April 15, July 15	Section D	Paragraph 31	AHCCCS Provider Affiliation Transmission Manual	DHCM Operations Executive Staff Assistant	FTP server with email notification

SECTION F: ATTACHMENTS

Contract/RFP No. YH18-0001

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Quarterly	Provider/Network Changes Due to Rates Report	15 days after the end of each quarter	Section D	Paragraph 28	ACOM Policy 415 Attachment D and Attachment E	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	DME Service Delivery Reporting	October 15, January 15, April 15, July 15	Section D	Paragraph 27	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Semi-Annually	ALTCS Member Council Correspondence Including Agendas and Minutes	April 15 th November 15 th	Section D	Paragraph 24	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Semi-Annually	Gap In Critical Services Report	November 15 th ; May 15 th	Section D	Paragraph 27	ACOM Policy 413	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Semi-Annually	Member Newsletter	30 days prior to intended publication date	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
OFFICE OF INSPECTOR GENERAL	Annually	Attestation of Disclosure Information: Ownership and Control and Persons Convicted of a Crime	15 days after the start of the contract year	Section D	Paragraph 64	ACOM Policy 103	Office of Inspector – Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Annually	Corporate Compliance Plan	15 days after the start of the contract year	Section D	Paragraph 64	ACOM Policy 103	Office of Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Exclusions Identified Regarding Persons Convicted of a Crime	Immediately upon identification	Section D	Paragraph 64	N/A	Office of Inspector - Inspector General	FTP server with email notification

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/ Policy	Send To	Submitted Via
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information	45 days prior to the effective date and commencement of operations	Section D	Paragraph 50	ACOM Policy 317	Office of Inspector – Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Report Alleged Fraud/Waste/Abuse of the AHCCCS Program	Immediately upon identification	Section D	Paragraph 64	ACOM Policy 103	Office of Inspector	As noted on reporting form
OFFICE OF INSPECTOR GENERAL	Semi-Annually	Corporate Compliance: Audits Summary	July 15 and January 15	Section D	Paragraph 64	N/A	Office of Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Semi-Annually	Corporate Compliance: External Auditing Schedule	April 15 and October 15	Section D	Paragraph 64	N/A	Office of Inspector General	FTP server with email notification

[END OF ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES]

SECTION G: CERTIFICATIONS OF OFFEROR AND DISCLOSURE INFORMATION TEMPLATE

Provided Separately on the AHCCCS Website
See the AHCCCS Website YH18-0001 - ALTCS E/PD Bidders' Library for Documents

SECTION H: INSTRUCTIONS TO OFFERORS

This Request for Proposal (RFP) solicits participation by Offerors to provide covered health care services to members who are elderly and/or have a physical disability (E/PD) and who are enrolled in the ALTCS E/PD Program. Covered services are to be provided in a managed care environment with reimbursement to Offerors awarded contracts on a capitated rate basis. Offerors are advised that transition services are anticipated to begin on March 7, 2017 and program and medical services implementation shall commence on October 1, 2017.

All Successful Offerors are required to be organizations that contract with the Centers for Medicare and Medicaid Services to provide and manage Medicare benefits for dual eligible members in all Geographic Service Areas (GSAs) in which they are awarded a Contract. See RFP Section I: Exhibit E, Medicare Requirements and RFP Section D, Paragraph 66, Medicare Requirements for additional details regarding this requirement.

The Solicitation Process shall be in accordance with the *RFP and Contract Process* rules set forth in A.A.C. Title 9, Chapter 28 Article 6.

Note that *days* as referenced in Instructions to Offerors means *calendar days*, unless otherwise specified. If a due date falls on a Saturday, Sunday or legal holiday, then the due date is considered the next *business day*. A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

Computation of time begins the day after the event that triggers the period and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next business day.

RFP decisions have been incorporated in the Contract. To the extent possible, draft AHCCCS policies and guides have been developed in support of new or changed requirements and will be posted to the Bidders' Library.

Definitions

Incumbent Contractor means an entity that is a party to State Contract Number YH12-0001 as of the date the Proposals are due under this RFP.

Successful Incumbent Contractor means an Incumbent Contractor that is awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2017 in one or more of the same counties comprising the specific GSA(s) established for October 1, 2017.

The definition of Successful Incumbent Contractor also includes an Incumbent Contractor that is awarded a Contract for Pima County-only under this RFP where the Incumbent Contractor holds a Contract through September 30, 2017 in Pima County.

Successful Offeror means a responsible and responsive Offeror that is awarded a Contract under this RFP. The definition of Successful Offeror also includes an Unsuccessful Incumbent Contractor in Maricopa County that is granted a capped Contract.

Unsuccessful Incumbent Contractor means an Incumbent Contractor that is not awarded a Contract for a specific GSA under this RFP where the Incumbent Contractor holds a Contract through September 30, 2017 in one or more of the same counties comprising the specific GSA(s) established for October 1, 2017.

The definition of Unsuccessful Incumbent Contractor also includes an Incumbent Contractor that is not awarded a Contract for Pima County-only under this RFP where the Incumbent Contractor holds a Contract through September 30, 2017 in Pima County.

RFP Sections, Attachments, & Exhibits

The RFP document consists of Title XIX requirements found in Section D as well as requirements for the provision of non-Title XIX services found in Section J.

Offerors will submit a single Proposal for both the Title XIX and non-Title XIX service requirements. Offerors are not to submit a capitation bid for non-Title XIX services. Payment for non-Title XIX services is managed outside of the capitation rates.

Effective October 1, 2017, the Title XIX requirements and non-Title XIX requirements will be set forth into two separate Contracts. The Title XIX Contract will be submitted to CMS for approval; the non-Title XIX companion Contract does not require CMS approval.

Sections A, B, & C

Section A: Solicitation Page

Section B: Capitation Rates

Section C: Definitions

Section D: Program Requirements

Section E: Contract Terms and Conditions

Section F: Attachments

Attachment F1: Member Grievance and Appeal System Standards

Attachment F2: Provider claim Dispute Standards

Attachment F3: Chart of Deliverables

Section G: Certifications of Offeror and Disclosure Information Template

Section H: Instructions to Offerors

Section I: Exhibits

Exhibit A: Offeror's Checklist

Exhibit B: Offeror's Bid Choice Form

Exhibit C: Narrative Submission Requirements

Exhibit D: AHCCCS Minimum Subcontract Provisions

Exhibit E: Medicare Requirements

Exhibit F: A.R.S. §35-393.01 Attestation

Section J: Non-Title XIX Contract Provisions

1. PROSPECTIVE OFFERORS' INQUIRIES

Any questions related to this Request for Proposal Solicitation must be directed to the Procurement Officer listed in RFP Section A, Solicitation Page and as delineated in Paragraph 6, Amendments to RFP in this Section. Offerors shall not contact or ask questions of AHCCCS staff related to the RFP unless authorized by the AHCCCS Chief Procurement Officer. Exceptions to this instruction include:

- Technical questions related to the Capitation Bid Tool (instructions for which can be found in the Data Supplement, Capitation Bid Tool Overview document in the Bidders' Library), and
- Questions related to the Information Technology Systems Demonstration (instructions for which can be found in the IT Demonstration Q&A Process Provisions document in the Bidders' Library)

2. PROSPECTIVE OFFERORS' CONFERENCE AND TECHNICAL INTERFACE MEETING

A Prospective Offerors' Conference and Technical Interface Meeting will be held on November 8, 2016, beginning at 9:00 A.M. Arizona Time, at AHCCCS, 701 E. Jefferson, in the Gold Room on the 3rd Floor.

The purpose of this conference will be to:

1. Orient new Offerors to AHCCCS,
2. Clarify the contents of this solicitation, and
3. Clarify AHCCCS PMMIS System and interface requirements.

Questions posed during the Prospective Offerors' Conference and Technical Interface Meeting must be submitted by the Offerors as specified in Paragraph 1, Prospective Offerors' Inquiries and Paragraph 6, Amendments to RFP, in this Section. Verbal responses provided during the Prospective Offerors' Conference and Technical Interface Meeting are not binding.

3. PROPOSAL OPENING

After the deadline for submitting Proposals, AHCCCS may open Proposals publicly and announce and record the names of the Offerors.

4. LATE PROPOSALS

Late Proposals received after 3:00 p.m. Arizona Time on January 23, 2017 will not be considered.

5. WITHDRAWAL OF PROPOSAL

At any time prior to the Proposal due date and time, the Offeror may withdraw any previously submitted Proposal. Withdrawals must be provided in writing and submitted to the Chief Procurement Officer listed in RFP Section A, Solicitation Page.

6. AMENDMENTS TO RFP

AHCCCS may issue amendments subsequent to the issue date of this solicitation on its own initiative. Additionally, amendments may be issued as a result of questions submitted by prospective Offerors.

Questions pertaining to the RFP shall be submitted in accordance with the schedule included in Paragraph 12, RFP Milestone Dates in this Section or as otherwise specified in the Bidders' Library. Questions shall be e-mailed to the Chief Procurement Officer listed in RFP Section A, Solicitation Page utilizing the '*ALTCS E/PD RFP YH18-0001 Questions and Responses Template*' available in the Bidders' Library. Offerors shall not modify the format of the '*ALTCS E/PD RFP YH18-0001 Questions and Responses Template*'. AHCCCS will respond in writing to all questions submitted through this process via a formal amendment to the RFP in accordance with the schedule of RFP Milestone Dates. Refer to Paragraph 12, RFP Milestone Dates in this Section.

The Offeror shall acknowledge all amendments to the RFP by signing the signature page of each amendment and by submitting to AHCCCS all signed signature pages with the Offerors' RFP Proposal.

7. EVALUATION FACTORS AND SELECTION PROCESS

The items which are designated for scoring in this RFP shall be evaluated and scored using only the information submitted to AHCCCS by the Offeror, including verbal responses provided as part of the Oral Presentation. It is the responsibility of the Offeror to clearly and comprehensively respond to each requested item and to ensure that there are no omissions or ambiguities. Failure of the Offeror to provide a clear, thorough, and detailed response may affect the award of points for a scored item.

It is critical that the Offeror recognize the importance of all contractual provisions and their value to the AHCCCS Program. The Submission Requirements address limited subject matter areas; however, the importance of topics not addressed in the Submission Requirements, are not to be minimized. Regardless of whether or not a particular topic is presented in the Submission Requirements, a Successful Offeror is required to comply with all contractual provisions as acknowledged by the Offeror's submittal of a signed Proposal.

AHCCCS shall award a Contract to the responsible and responsive Offeror whose Proposal is determined most advantageous to the State under A.R.S. §36-2944. (R9-28 Article 6)

The final decision regarding both the number of Contracts awarded in a particular GSA, as well as the particular Offerors awarded Contracts, will be made by AHCCCS. The decision will be guided, but not bound, by the scores awarded by the evaluators. AHCCCS will ultimately make its decision based on a determination of which Proposals are deemed to be most advantageous to the State.

If AHCCCS deems that there is a negligible difference in scores between two or more competing Proposals for a particular GSA, in the best interest of the State AHCCCS may consider additional factors in awarding the Contract including, but not limited to:

- Potential disruption to members, and/or
- An Offeror who is an incumbent Contractor and has performed in an adequate manner (in the interest of continuity of care), and/or
- An Offeror who participates satisfactorily in other lines of AHCCCS business, and/or
- An Offeror's past performance with AHCCCS, and/or
- An Offeror's past Medicare performance, and/or
- Amount of choice and competition, and/or
- The nature, frequency and significance of any compliance actions, and/or
- Any convictions or civil judgments entered against the Offeror's organization, and/or
- Administrative burden to the Agency.

The Offeror should note that, if awarded a Contract, the Offeror must meet all AHCCCS requirements, irrespective of what is requested and evaluated through this solicitation. The Proposal submitted by the Offeror will become part of the Contract with AHCCCS.

Contracts will be awarded to Offerors whose Proposals are deemed to be most advantageous to the State in accordance with Paragraph 9, Award of Contract, in this Section.

Scoring

AHCCCS has established a scoring methodology to evaluate an Offeror's ability to provide cost-effective, high-quality contract services in a managed care setting in accordance with the AHCCCS mission and goals. The following four components will be evaluated and weighted in the order listed:

- Program (Program includes Oral presentations)
- Capitation
- Access to Care/Network
- Administrative

The Capitation section will be scored by GSA. The remaining submission areas will be scored on a statewide basis, not specific to any GSA. The scores received for each of the four required components will be weighted separately and then combined to derive a final score for the Offeror, by GSA.

8. READINESS REVIEW

AHCCCS will conduct readiness reviews evaluating Successful Offerors' ability to implement the terms of the Contract. Readiness reviews, which will be conducted when transition services begin, assess Successful Offerors' ability to provide covered services to members at the start of the program and medical service implementation date. (Refer to Paragraph 12, RFP Milestone Dates in this Section)

Successful Offerors may be subject to on-site review(s) as part of readiness reviews to determine the adequacy of successful Offerors' infrastructure to support the provision of services to the ALTCS population for the awarded GSA.

The Offeror shall ensure it has a comprehensive network that complies with all network sufficiency standards as outlined in RFP YH18-0001 and ACOM Policy 436, no later than August 1, 2017.

Successful Offerors will be permitted to commence operations only if readiness review factors are met to AHCCCS' satisfaction. AHCCCS reserves the right to not assign membership to Successful Offerors that are determined to not meet readiness requirements.

9. AWARD OF CONTRACT

AHCCCS shall award a Contract to the responsible and responsive Offeror whose Proposal is determined most advantageous to the State under A.R.S. §36-2944 (R9-28 Article 6).

Notwithstanding any other provision of this solicitation, AHCCCS expressly reserves the right to:

1. Waive any immaterial mistake or informality;
2. Reject any or all Proposals, or portions thereof; and/or
3. Reissue a Request for Proposal

A response to this Request for Proposal is an offer to contract with AHCCCS based upon the terms, conditions, scope of work and specifications of the RFP. All of the terms and conditions of the Contract are contained in this solicitation, solicitation amendments and subsequent Contract amendments, if any, signed by the AHCCCS Chief Procurement Officer. Proposals do not become Contracts unless and until they are accepted by the AHCCCS Chief Procurement Officer. The Proposal provided by the Offeror will become part of the Contract with AHCCCS. A Contract is formed when the AHCCCS Chief Procurement Officer signs the award page and provides written notice of the award(s) to the Successful Offeror(s), and the Offeror accepts any special provisions to the Contract and the final rates awarded. All Offerors will be promptly notified of Contract award.

The Successful Offeror must accept all Contract awards or decline all Contract awards as specified in the award letter. If a Successful Offeror declines an awarded Contract, the Successful Offeror must ensure that AHCCCS is notified in writing within seven calendar days of the date of the award letter.

If an Offeror had a Contract that was terminated by AHCCCS, and that Offeror submits a Proposal, AHCCCS may reject the Proposal.

AHCCCS may reject a Proposal from the Offeror before the date of *Contracts Awarded/Transition Services Begin* if the Offeror is materially out of compliance with a Managed Care Contract with any governmental entity.

Notwithstanding the number of awards identified in the table below for each GSA/Pima County-only, AHCCCS will award Contracts in each GSA/Pima County-only to Successful Offerors in the best interest of the State.

AHCCCS anticipates awarding Contracts as follows:

GSA Name/Countries	Number of Awards
<u>North</u> Mohave/Coconino/Apache/Navajo/Yavapai	Maximum of 1
<u>South</u> Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma	Maximum of 1 (with an exception for Pima County which will have a maximum of 2)*
<u>Central</u> Maricopa/Gila/Pinal	Maximum of 3

*AHCCCS anticipates awarding the entire South GSA to the Successful Offeror with the highest score for the South GSA. In addition, AHCCCS anticipates awarding Pima County-only to the Successful Offeror with the second highest score for the South GSA when not in conflict with the provisions in Paragraph 7, Evaluation Factors and Selection Process and Paragraph 9, Award of Contract in this Section.

Individual Offeror Opportunities

An individual Offeror may be awarded a Contract as follows except as otherwise determined by AHCCCS due to the best interest of the State:

1. Both the Central GSA and the North GSA
2. Both the Central GSA and the South GSA
3. Both the Central GSA and Pima County-only
4. The North GSA only
5. The South GSA only
6. Both the North GSA and the South GSA
7. Both the North GSA and Pima County-only
8. Pima County-only

AHCCCS does not intend to award contracts for all GSAs to a single Offeror.

In order to be considered for award in the Central GSA, the Offeror must also submit a competitive bid in the North GSA. A submission for the Central GSA that does not include a Proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a Contract for both the Central and North GSAs to a single Offeror.

At any time during the term of this Contract (including extensions thereof), AHCCCS may make additional awards to Offerors based on the evaluations of the Proposals received in response to this RFP.

Management Service Agreement

AHCCCS will not make an award in a GSA to an Offeror that also has a management service agreement with another Successful Offeror in the same GSA. AHCCCS will not make an award to two or more Offerors that utilize the same management service company in that GSA. In either of those events, AHCCCS will make an award to the higher scoring Offeror. A Capped Contractor shall not serve as an MSA for a Successful Offeror.

Capped Contract Awards

An Unsuccessful Incumbent Contractor for the Central GSA that holds a Contract expiring September 30, 2017 in Maricopa County, may request, in writing, to have its enrollment capped in Maricopa County and to continue providing services under the terms and condition of this RFP. The deadline for such a request is two calendar days from the date of the non-award letter. AHCCCS may, at its sole discretion, grant or deny a capped contract request. If AHCCCS approves a capped Contract in Maricopa County, only one capped contract will be granted. Capped contracts will not be allowed in any other Counties/GSAs. If more than one Unsuccessful Incumbent Contractor in Maricopa County requests a capped Contract, AHCCCS shall consider the request of the Unsuccessful Incumbent Contractor with the highest overall score except, when AHCCCS determines differences in scores between requesting Unsuccessful Incumbent Contractors to be negligible. When AHCCCS determines the difference in scores to be negligible, AHCCCS shall consider for a capped contract the request it determines to be in the best interest of the State based upon the factors outlined in Paragraph 7, Evaluation Factors and Selection Process in this Section. If a capped contract is granted in Maricopa County, AHCCCS shall notify the requesting Unsuccessful Incumbent Contractor(s) and all Successful Offerors in Maricopa County within nine calendar days of the non-award letter.

If AHCCCS grants an Unsuccessful Incumbent Contractor's request for a capped contract, the Unsuccessful Incumbent Contractor, by accepting the capped Contract, shall agree to waive and forego any and all rights to file a protest of the RFP and any Contract awards pursuant to the RFP.

If a capped contract is granted, the Contractor shall be required to serve its existing members and shall also be subject to an enrollment cap which shall not be lifted at any time during the term of the contract, and any extensions thereof, except as specified below. Through the enrollment cap, the capped Contractor shall not receive any new members, including through member choice and auto-assignment. AHCCCS may elect to lift the enrollment cap only under one or more of the following conditions:

1. Another Contractor is terminated and increased member capacity is needed, or
2. Legislative action creates an unforeseen increase in the overall AHCCCS population, or
3. Extraordinary and unforeseen circumstances make such an action necessary and in the best interest of the State.

AHCCCS may elect to hold an open enrollment during the first year of the contract for all members enrolled with the capped Contractor to allow members a choice of all available Contractors.

The Capped Contractor shall be awarded capitation rates factoring in the following:

1. The bottom of the published actuarially-determined rate range for the medical component for Maricopa County only (as adjusted by RFP Section D, Paragraph 51, Compensation and RFP Section D, Paragraph 54, Capitation Adjustments), and
2. The lesser of the lowest awarded administrative component rate for the Central GSA or the Offeror's bid administrative component rate for the Central GSA, and
3. The lesser of the lowest awarded case management component rate for the Central GSA (as adjusted by RFP Section D, Paragraph 51, Compensation and RFP Section D, Paragraph 54, Capitation Adjustments specific to Maricopa County only) or the Offeror's bid case management component rate for the Central GSA (as adjusted by RFP Section D, Paragraph 51,

Compensation and RFP Section D, Paragraph 54, Capitation Adjustments specific to Maricopa County only).

At no time during the term of a capped Contract shall any Contractor in the Central GSA be entitled to any reconciliations other than those reconciliations explicitly specified in this RFP.

Transition Services Implementation: Post-Award Deliverables

Successful Offerors are required to submit to AHCCCS the following via the FTP server by March 27, 2017:

1. An explanation of how the Contractor intends to fulfill the affiliated corporation requirement
2. The Successful Offeror's organization charts:
 - a. Corporate structure, and
 - b. Functional organization chart of the key program areas, responsibilities and reporting lines, and position titles
3. A network development plan, outlining the Successful Offeror's strategy for building its provider network during the readiness review period

Delay in Program and Medical Service implementation

In the event a protest or unforeseen circumstance delays the October 1, 2017 implementation of Program and Medical Service in one or more GSAs, Incumbent Contractor(s) shall be required to continue provision of services according to the terms of their existing Contract, until such time as determined by AHCCCS and in the best interest of the State.

10. ENROLLMENT AFTER CONTRACT AWARD

GSA: North

AHCCCS will enroll all members with the Successful Offeror.

GSA: South

Pima County

In Pima County where multiple Contracts will be awarded, if there is one or more Unsuccessful Incumbent Contractor(s), AHCCCS will "selectively assign" the members of the Unsuccessful Incumbent Contractor(s) to a New and/or Successful Incumbent Contractor applying the selective assignment method outlined below. For more information, refer to *Selective Assignment* below.

After selective assignments have been made, only those members selectively assigned will be offered choice of Contractor, effective October 1, 2017. Any members who do not exercise choice will remain with the Contractor to which they were selectively assigned. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after contract awards.

All other Counties

AHCCCS will enroll all members with the Successful Offeror.

GSA: Central

In the Central GSA where multiple Contracts will be awarded for the entire GSA, if there is one or more Unsuccessful Incumbent Contractors (in any or all of the three Counties), AHCCCS will “selectively assign” the Unsuccessful Incumbent Contractor(s) members to New and/or Successful Incumbent Contractor(s) applying the selective assignment method outlined below. In the event an Unsuccessful Incumbent Contractor is granted a capped Contract, the members enrolled with the Unsuccessful Incumbent Contractor will not be included in selective assignment. As noted in Paragraph 9, Award of Contract in this Section, AHCCCS may elect to hold an open enrollment for all members assigned to the capped Contractor during the first year of the Contract to allow members a choice of all available Contractors.

After selective assignments have been made, only those members selectively assigned will be offered choice of Contractor, effective October 1, 2017. Any members who do not exercise choice will remain with the Contractor to which they were selectively assigned. AHCCCS will notify Contractors of the transition process and timelines as soon as possible after Contract awards.

Because choice of Contractor has not previously been an option for members in Gila and Pinal Counties, in the event there is a Successful Incumbent Contractor for Gila and Pinal Counties via a Central GSA award, AHCCCS may offer members in Gila and Pinal Counties choice of Contractor, effective October 1, 2017. Any members who do not exercise choice will remain with the Successful Incumbent Contractor.

An Unsuccessful Incumbent Contractor granted a capped contract in Maricopa County will not be assigned any members from another Unsuccessful Incumbent Contractor. At no time will the capped Contractor be an available option for member choice for the Central GSA. Refer to Paragraph 9, Award of Contract in this Section for more information regarding capped Contracts.

Selective Assignment

The purpose of selective assignment is to maximize the assignment of members to Contractors with the lowest capitation rates to the extent compatible with the primary goal of minimizing the need for members to change in-home service providers, alternative HCBS providers or nursing facility providers. AHCCCS may consider other factors consistent with the best interest of the member when determining which Contractor best aligns with the member’s needs.

If there is a need for selective assignment in Pima County and/or the Central GSA, after all Contracts have been awarded and accepted, AHCCCS shall allow Successful Offerors, with the exception of a capped Contractor and Contractors exceeding enrollment thresholds as specified below, an opportunity to accept a lower capitation rates which may improve their outcome through the selective assignment process as follows:

- The Successful Offeror in Pima County-only will be permitted to accept the lowest awarded capitation rate in the South GSA (adjusted for Pima County-only as described in Paragraph 16, Submission Requirements in this Section).

- The Successful Offerors in the Central GSA will be permitted to accept the lowest awarded capitation rate in the Central GSA.

Although Successful Offerors may lower their capitation rate, lowering the capitation rate does not assure an improved outcome in the selective assignment process.

Successful Incumbent Contractors with enrollment thresholds as described below in Pima County and/or the Central GSA are excluded from the opportunity to lower capitation rates with the potential to improve their outcome in the selective assignment process via a capitation rate adjustment:

1. Pima County – 50% or more enrollment in Pima County based on enrollment as of the date AHCCCS commences selective assignment
2. Central GSA – 33% or more enrollment in the GSA based on enrollment as of the date AHCCCS commences selective assignment

Selective Assignment Considerations

Selective assignment will be based upon consideration of the following factors:

- The provider network which best aligns with the member's service provider(s)
 - In-home service providers,
 - Alternative HCBS providers
 - Nursing facility providers
- The awarded capitation rate
- Successful Offeror(s) with the least number of members in Pima County and the least number of members within the Central GSA

No Contractor will be assured a minimum membership at any time, including when members are selectively assigned.

Member Transitions

A Successful Offeror which is assigned members from an Unsuccessful Incumbent Contractor as a result of a Contract award shall ensure a smooth transition for members by continuing a member's services including those identified on the member's service plan for 90 days after the member transition unless mutually agreed to by the member or responsible party.

Members who transition to a Successful Offeror (with the exception of a capped Contractor) and members who become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

During the selective assignment process in Pima County/Central GSA, AHCCCS may identify that there is no Successful Offeror which is contracted with providers of in-home, alternative HCBS, or Nursing Facility services for specific members. In this case, AHCCCS will work with the Successful Offeror(s) in an effort to preserve member services and placement.

11. FEDERAL DEADLINE FOR SIGNING CONTRACT

The Centers for Medicare and Medicaid Services (CMS) has imposed strict deadlines for finalization of Contracts in order to qualify for Federal Financial Participation (FFP). This Contract, and all subsequent amendments, must be timely, completed and signed by both AHCCCS and the Successful Offeror. The Successful Offeror shall ensure this Contract and all subsequent amendments are submitted to AHCCCS sufficiently in advance for submission to CMS prior to the effective date of the initial Contract and/or Contract amendments. AHCCCS shall specify the date that signed Contracts and amendments are due. All public entity Offerors must ensure that the approval of this contract is placed on appropriate agendas sufficiently in advance of the deadline to ensure compliance with this requirement. In the event CMS denies or withholds Federal Financial Participation (FFP) due to the Successful Offeror's failure to execute this contract or a subsequent contract amendment within the timeframe prescribed by AHCCCS, in addition to any other remedies and/or sanctions, AHCCCS may deny or withhold payments to the Contractor until such time CMS authorizes expenditure of FFP.

12. RFP MILESTONE DATES

The following is the schedule of events regarding the solicitation process:

Activity	Date
Issue Request for Proposal	November 1, 2016
Pre-Proposal Prospective Offerors' Conference and Technical Interface Meeting	November 8, 2016
First Set of RFP Questions Due	November 10, 2016
First RFP Amendment Including Responses to RFP Questions Issued On or Before	November 30, 2016
Second Set of RFP Questions Due	December 07, 2016
Release Date for Capitation Rate Ranges/Rates	December 19, 2016
Second RFP Amendment Including Responses to RFP Questions Issued On or Before	December 21, 2016
Third Set of RFP Questions Due - <i>Limited to Published Capitation Rate Ranges/Rates</i>	December 27, 2016
Third RFP Amendment Including Responses to RFP Questions Issued On or Before	January 5, 2017
Proposals Due by 3:00 p.m. Arizona Time	January 23, 2017
Contracts Awarded/Transition Services Begin On or Before	March 7, 2017
Transition Services Implementation: Post-Award Deliverables	March 27, 2017
Program and Medical Service Implementation On or After	October 1, 2017

Note: Dates and activities are subject to change.

13. BIDDERS' LIBRARY

The Bidders' Library contains critical reference material, including but not limited to, AHCCCS policies, Offeror's Checklist, Offeror's Bid Choice Form, utilization and cost data, member data, and performance requirements to assist the Offeror to prepare a response to this Solicitation. References are made throughout this Solicitation to materials in the Bidders' Library, and Offerors are responsible for reviewing the contents of the Bidders' Library materials as if the materials were printed in full herein. AHCCCS may continue to update the Bidders' Library after this Solicitation is released; the Offeror is responsible for monitoring updates to the Bidders' Library. The Bidders' Library is located on the AHCCCS website at:

<https://azahcccs.gov/PlansProviders/HealthPlans/YH18-0001.html>.

14. MINIMUM CAPITALIZATION

The Successful Offeror is required to meet a minimum capitalization requirement for each GSA awarded within 30 days after notification of Contract award. Once the new Contract period commences, the minimum capitalization may be applied to the Successful Offeror's equity per member standard, which continues throughout the term of the Contract. See RFP Section D, Paragraph 48, Financial Viability Standards.

Minimum Capitalization Requirements

Minimum capitalization requirements by GSA are as follows:

GSA	Capitalization Requirement
<u>North</u> Mohave/Coconino/Apache/Navajo/ Yavapai	\$2,600,000
<u>South</u> Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma	\$4,200,000
<u>Central</u> Maricopa/Gila/Pinal	\$6,000,000

To be considered for a Contract award in a given GSA or multiple GSAs, an Offeror must meet the minimum capitalization requirements listed above. The capitalization requirement is subject to a \$7,500,000 ceiling regardless of the number of GSAs awarded. This requirement is in addition to the Performance Bond requirements defined in RFP Section D, Paragraphs 43, Performance Bond or Bond Substitute, and RFP Section D, Paragraph 44, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment.

15. CONTENTS OF OFFEROR'S PROPOSAL

If AHCCCS determines a Proposal to be non-responsive, AHCCCS may elect not to score the Proposal. Responsive Offeror is defined in R9-28 Article 6.

The Offeror shall submit the following to AHCCCS by 3:00 p.m. Arizona Time on January 23, 2017:

Hard Copy Submission

One original Proposal and nine hard copies shall be submitted to the AHCCCS Chief Procurement Officer as noted in RFP Section A, Solicitation Page. RFP Section G, Representations and Certifications of Offeror shall be excluded from the original and hard copies.

Electronic Submission

Via the SFTP Server:

One PDF version of the Offeror's Proposal (excluding Section G: Representations and Certifications of Offeror); and

One PDF version of RFP Section G: Representations and Certifications of Offeror including Section G-2: Disclosure Information Template

The Offeror's Proposal and all copies shall be organized with strict adherence to RFP Section I, Exhibit A, Offeror's Checklist and submitted using the forms and specifications provided in this RFP.

Instructions for access to the SFTP server are included in the Bidders' Library. The Offeror will upload the Proposal to a secured location on the SFTP server as follows:

- Folder: ALTCS-EPD-RFP18
 - Sub-Folder: CapitationandProposalSubmission
 - Sub-Folder: <Offeror's Name>

In the event that hard copy submissions differ from electronic submissions, the hard copy submissions will prevail.

AHCCCS will post all Proposals including capitation rate bids to the AHCCCS website once the Contract awards have been made. The Offeror shall not designate any information to be proprietary in nature with the exception of Section G: Representations and Certifications of Offeror. All pages will be disclosed regardless of their designation, with the exception of Section G: Representations and Certifications of Offeror.

All pages of the Offeror's Proposal must be numbered sequentially with documents placed in sturdy 3-ring binders. All responses shall be in Calibri 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations, or other manual modifications in the Proposal are prohibited.

AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's Proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the Proposal when reviewing a specific response to an individual submission requirement.

Except in the case of a negligible difference in scores between two or more competing Proposals for a particular GSA, as referenced in Paragraph 7, Evaluation Factors and Selection Process in this Section, only information expressly provided by the Offeror will be considered. No inferences or assumptions will be made by the evaluation team when scoring in order to evaluate information submitted by the Offeror which is not clear, explicit, or thoroughly presented. Use of contingent language such as 'exploring' or 'taking under consideration' will not be given any weight during the scoring evaluation process. A policy, brochure, or reference to a policy or manual does not constitute an adequate response and will not be given any weight during the scoring evaluation process.

It is the responsibility of the Offeror to examine the entire RFP, timely seek clarification of any requirement that may not be clear, and review all responses for accuracy before submitting its Proposal. The Proposal becomes a part of the Contract. Therefore, whatever information is stated in the Proposal may be evaluated either during the Proposal evaluation process or subsequently during other reviews. Proposals may not be withdrawn after the published due date and time.

All Proposals will become the property of AHCCCS. AHCCCS will not reimburse the Offeror for the cost of Proposal preparation.

Each section of the Proposal shall be separated by a divider and contain all information requested in this Solicitation. Numbering of pages shall continue in sequence through each separate section. For example, "Executive Summary and Disclosure" would begin with the page number following the last page number in "Capitation Submission."

Proposals that are not submitted in conformance with the requirements described herein may not be considered. References to certain sections of the RFP document in Section H are intended only to provide general assistance to Offerors and are not necessarily intended to represent all requirements. Other possible resources may be found in the Bidders' Library. It is the obligation of the Offeror to identify all relevant information.

16. SUBMISSION REQUIREMENTS

The Offeror shall ensure its Proposal is in compliance with, at a minimum, relevant statutes, rules, policies, the requirements specified in this RFP, and other referenced sources.

The Offeror shall complete and submit RFP Section I, Exhibit A, Offeror's Bid Checklist. The Offeror shall submit all items delineated in RFP Section I, Exhibit A, Offeror's Checklist using the forms and specifications provided in this RFP. This paragraph does not address each submission requirement identified on the Offeror's Checklist but describes selected items from the checklist.

Offeror's Bid Choice Form

The Offeror shall complete and submit RFP Section I, Exhibit B, Offeror's Bid Choice Form in accordance with the permissible bids by GSA outlined below and the Offeror's Bid Choice Form.

Permissible Bids by GSA

The table below identifies those GSAs and combinations of GSAs for which the Offeror may submit a Proposal. Proposals submitted outside of the combinations below will not be considered.

PERMISSABLE BIDS BY GSA	
Central Only	No
Central and South Only	No
North Only	Yes
South Only	Yes
North and South Only	Yes
Central and North Only ¹	Yes
Central and North and South ²	Yes

¹In order to be considered for award in the Central GSA, the Offeror must submit a competitive bid in the North GSA as well. A submission for the Central GSA that does not include a Proposal for the North GSA will not be considered. However, AHCCCS may choose not to award a contract for both GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract in this Section.

²AHCCCS does not intend to award contracts for all GSAs to a single Offeror. For award of GSAs see Paragraph 9, Award of Contract in this Section.

Capitation Bid Submission

Capitation is a fixed (per member) monthly payment to the Contractor for the provision of covered services to members. It is an actuarially sound amount computed to cover expected utilization and costs.

AHCCCS will only evaluate the Offeror's dual and non-dual long term care capitation rates. The PPC and Acute Care Only rates will be set by the AHCCCS actuaries and not bid by the Offeror. The PPC and Acute Care Only rates will be published by AHCCCS prior to October 1, 2017.

The Offeror is encouraged to submit its most competitive bid as there will be no best and final offers. The Offeror should note that AHCCCS will not increase a Contractor's capitation rates throughout the term of this Contract if a Contractor later determines that the rates bid (with or without subsequent adjustment and update by AHCCCS) are insufficient.

To facilitate the preparation of its capitation Proposal, AHCCCS will provide Offerors with a Data Supplement located in the Bidders' Library. This data source should not be used as the sole source of information in making decisions concerning the capitation Proposal. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its capitation Proposal.

All GSAs in which an Offeror bids will require both a dual and non-dual capitation rate bid submission. Each dual and non-dual capitation rate bid will encompass three components: a medical component, a case management component, and an administrative component.

A Capitation Bid Template/Tool is included in the Data Supplement. A separate Template/Tool must be completed for each GSA in which the Offeror submits a bid. The Template/Tool includes all three components of the capitation bid. The Template(s)/Tool(s) must be submitted in Microsoft Excel to AHCCCS via the SFTP server by 3 p.m. Arizona Time on the Proposal Due Date in Paragraph 12, RFP Milestone Dates in this Section. Instructions for access to the SFTP are included in the General section of the Bidders' Library.

In addition to the electronic submission of the Capitation Bid Template(s)/Tool(s), hard copies of the completed Template(s)/Tool(s) for each GSA in which the Offeror submits a bid must be included in the RFP submission. In the case of differences between the hard copies and the electronic template submissions, the hard copies will prevail and will be the official bids that are scored.

The Offeror must ensure that an actuary who is a member of the American Academy of Actuaries certifies that the bid submission is actuarially sound by including a signed hard copy of an actuarial certification of all rates submitted with the RFP submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid.

AHCCCS is also providing Offerors with a Case Management Model Template. This Model Template is designed to assist Offerors in establishing the case management component of the capitation rates. The Case Management Model Template will not be scored and is not a required submission. The Offeror's case management component bid shall be included on the Capitation Bid Template/Tool. For historical case management information, the Offeror may review financial statements in the Data Supplement in the Bidders' Library, and case management component amounts included in the current and historical capitation rates. The case management component amounts included in capitation rates can be found in the ALTCS E/PD actuarial certifications which are located on the AHCCCS website.

Bid component limits:

- AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates on or around December 19, 2016. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from the minimum to the midpoint. AHCCCS' actuaries set rate ranges based on average expenditures.
 - Capitation bids submitted with any medical component outside of the published range will earn a medical component score of zero points.
- AHCCCS will limit the administrative component to a maximum of 8%. The administrative component is calculated as: Administration / (Net NF prior to Share of Cost offset + Net HCBS + Acute Care prior to Reinsurance offset + Case Management).

- Capitation bids submitted with an administrative component above the administrative maximum will earn an administrative component score of zero points.
- AHCCCS will not provide a range or a maximum for the case management component.
- The lowest dollar bid within each GSA for dual and non-dual risk groups will receive the maximum allowable points. Conversely, the highest dollar bid will receive the least number of points.

AHCCCS reserves the right to request supporting documentation for any component of the capitation rate bids submitted.

AHCCCS' actuaries utilized average per member per month costs contained in the Databook provided in the Data Supplement of the Bidders' Library to develop the actuarially sound medical component rate ranges. It is recommended that the Offeror bid rates utilizing the average per member per month costs provided in the Databook.

If any moral or religious objections are submitted as specified in Paragraph 16, Submission Requirements in this Section, the Offeror must not exclude from the capitation bid(s) the direct and related costs of the services to which the Offeror has objections. If awarded a Contract, capitation will be reduced for these costs via a subsequent Contract amendment.

The Pima County-only Contractor will be awarded capitation rates factoring in the following:

1. The Offeror's bid medical component rate for the South GSA (as adjusted by RFP Section D, Paragraph 51, Compensation and RFP Section D, Paragraph 54, Capitation Adjustments specific to Pima County-only), and
2. The Offeror's bid administrative component rate for the South GSA, and
3. The Offeror's bid case management component rate for the South GSA (as adjusted by RFP Section D, Paragraph 51, Compensation and RFP Section D, Paragraph 54, Capitation Adjustments specific to Pima County-only).

After award, AHCCCS will adjust the medical and case management components of the awarded capitation rates for Contractor-specific capitation factors (e.g. Nursing Facility/HCBS mix adjustments) and reserves the right to adjust awarded capitation rates for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Population Risk
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates

- CMS mandates

Prior to October 1, 2017, AHCCCS will provide the Successful Offeror fully loaded capitation rates including the following components by risk group by GSA:

- The awarded medical component, adjusted as noted above
- The awarded administrative component
- The awarded case management component, adjusted as noted above
- The reinsurance offset determined by AHCCCS' actuaries
- The share of cost amounts determined by AHCCCS' actuaries
- Risk contingency and premium tax

Executive Summary and Disclosure

Executive Summary

The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting Contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in RFP Section I, Exhibit E, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following Contract awards. (3 page limit)

Moral or Religious Objections

The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may submit a Proposal addressing members' access to the services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. The Proposal shall be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

Narrative Submission Requirements

The Offeror is required to respond to the Narrative Submission Requirements found in RFP Section I, Exhibit C, Narrative Submission Requirements utilizing the instructions specified in Paragraph 15, Contents of Offeror's Proposal in this Section.

Oral Presentations

Offerors shall participate in a scheduled oral presentation pertaining to key areas of the ALTCS E/PD Program. The duration of the oral presentation session will be limited to three hours, which shall include allotted time for discussion and preparation. All presentations will be scheduled to occur during the weeks of January 30 and February 6, 2017. Presentations will be audio-taped by AHCCCS for the Agency's use in the evaluation process. Audio-taped oral presentations will be published to the AHCCCS website once the Contract awards have been made. AHCCCS shall notify each Offeror of its scheduled presentation no later than 5:00 pm Arizona Time on January 26, 2017.

The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate. Among these six individuals, the Offeror shall include persons with expertise in:

- Medical/Clinical Management,
- Case Management, and
- Behavioral Health

The Offeror shall submit with its Proposal a list of names and titles along with resumes of the participating individuals.

The Offeror will not be permitted to bring electronic devices into the room, including but not limited to, laptops, cellular or smart phones, and tablets. Outside communication will be prohibited, including but not limited to, use of cell phones, telephones or text messaging. The Offeror will not be permitted to distribute previously-prepared presentations or materials to AHCCCS. The Offeror will be permitted to utilize any hard copy reference material brought with them, including copies of policies and procedures to assist with preparing for the presentation. AHCCCS will provide a white board or flip charts and markers for Offeror use in preparing for the Oral Presentation.

AHCCCS will have staff in the room for the duration of the oral presentations to ensure compliance with these requirements.

A.R.S. §35-393.01 Attestation

Pursuant to legislation which was enacted to prohibit the State from contracting with companies currently engaged in a boycott of Israel, to ensure compliance with A.R.S. §35-393.01, RFP Section I, Exhibit F must be completed and returned with the response to the Solicitation and any supporting information to assist the State in making its determination of compliance.

[END OF SECTION H: INSTRUCTIONS TO OFFERORS]

SECTION I: EXHIBITS
EXHIBIT A: OFFEROR'S CHECKLIST

Contract/RFP No. YH18-0001

SECTION I: EXHIBITS

EXHIBIT A: OFFEROR'S CHECKLIST

Provided Separately on the AHCCCS Website
See the AHCCCS Website YH18-0001 - ALTCS E/PD Bidders' Library for Documents

SECTION I: EXHIBITS

EXHIBIT B: OFFEROR'S BID CHOICE FORM

Provided Separately on the AHCCCS Website
See the AHCCCS Website YH18-0001 - ALTCS E/PD Bidders' Library for Documents

EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS

PROGRAM	
1.	An 85 year old American Indian member currently enrolled with the Offeror, with Medicare Part A and Part B, and unknown tribal affiliation resides alone in Parker. The member has had several transitions in the last three years between Tribal ALTCS and the Offeror’s ALTCS E/PD Health Plan. The member has received services from multiple IHS and 638 facilities as well as providers in the Offeror’s network and through Medicare’s network. Her diagnoses include Unspecified Depressive Disorder, Panic Disorder with agoraphobia, Transient Ischemic Attacks and history of CVA. Her vision has also been impaired by cataracts. This member also has demonstrated difficulty remembering conversations and confusion over her prescribed medications, resulting in inconsistencies in taking medications. Describe how the Offeror will manage care to achieve the best outcome for the member.
2.	A 71 year old Hispanic member, residing in Kingman, diagnosed with schizophrenia, Opiate Use Disorder, diabetes and dementia was enrolled with the Regional Behavioral Health Authority with a Serious Mental Illness determination. He was residing in a Behavioral Health Residential Facility to stabilize his behaviors and to improve his independence with activities of daily living. The member was on court ordered treatment, was noncompliant with taking his medication, and began to exhibit suicidal ideation with a plan to commit suicide. He was subsequently transferred to a Psychiatric Level I Facility in Kingman. Since being admitted, the member’s condition has stabilized and he is ready for discharge; however, his dementia has progressed such that he is ALTCS eligible and is now enrolled in the Offeror’s health plan. His family would like him to be transferred to Flagstaff to be closer to them. Describe how the Offeror will initiate and manage care, including services, supports and treatment options to achieve the best outcome for the member.
3.	Provide a description of the Offeror’s past experience as a Medicare D-SNP Plan. The Offeror must include examples demonstrating its most effective initiatives (excluding CMS mandates and the provision of supplemental benefits) yielding improved health outcomes and experiences for dual members. Provide implementation dates of each initiative, the metrics and/or the measurement process utilized to support these outcomes, size of the Medicare D-SNP membership and the number of members participating in each initiative. Describe how the Offeror will replicate these initiatives in any and all awarded GSAs.
4.	Approximately 20% of the ALTCS E/PD population dies annually representing a significant percentage of the membership. This requires an increased emphasis on supporting members through life transitions such as declining health, aging and/or terminal illness. Describe the Offeror’s experience in serving members during these life transitions. Describe new innovative strategies the Offeror will use to support members with decision-making and care needs throughout the term of the Contract.

PROGRAM	
5.	The Offeror has a newly-enrolled 32 year old male with a Traumatic Brain Injury who temporarily resides in a Skilled Nursing Facility. He has limited mobility and functioning due to morbid obesity with a weight of 390 pounds and has a newly developed Stage 3 pressure ulcer on his buttocks. The member reports being depressed due to his divorce, loss of his job and social life. He attributes the “run-of-bad luck” to his obesity. He is sure he could get his life back if he could lose weight and become active again. Describe how the Offeror will assist the member to ensure he receives the highest quality care, services and supports.
6.	A young male Veteran with a service connected spinal cord injury and Post Traumatic Stress Disorder (PTSD) is currently residing in an Assisted Living Facility. He would like to someday own his own home, but will require in-home care/supports indefinitely. He would like to pursue other career opportunities and, although he is very motivated to return to work, he is concerned about losing his health care and other benefits. His interests include outdoor recreational activities that he pursued prior to his deployment and injury. Explain how the Offeror would support this member.
ACCESS TO CARE/NETWORK	
7.	It is estimated one in four Arizonans will be over the age of 60 by 2020. It is reported that this increase in the aging population will result in exponential job growth in the long term care paraprofessional workforce over the next eight years. Present the Offeror’s perspective on Arizona’s current paraprofessional labor market and describe the Offeror’s anticipated labor needs to adequately serve its membership through the term of the Contract. Describe innovative strategies the Offeror will implement to ensure recruitment, hiring and retention of a paraprofessional workforce by providers sufficient to meet the needs of, and provide quality care, to members in any and all awarded GSAs throughout the term of the Contract.
8.	A 16 year old male who is paraplegic secondary to a gunshot wound to the spine is currently enrolled with the Offeror. The member is currently receiving treatment in a Behavioral Health Residential Facility for inappropriate sexual behaviors perpetrated against a sibling and previous exposure to drug and alcohol abuse in the family home. In recent months, he has met all of his treatment goals and is ready for discharge. Due to his history of inappropriate sexual behaviors, the Child and Family Team recommends he not return to the family home. The family has heard about and visited an out of state group home where they would like to see the member placed. Describe how the Offeror will address the appropriate placement and service needs for this member.
9.	The Offeror holds an ALTCS E/PD Contract for both the Central and North GSAs and receives \$280 million per year in capitation revenue. Twenty-eight percent of the Offeror’s members reside in nursing facilities; 72% of members reside in an HCBS setting. Of those members residing in HCBS, 18% live in Alternative HCBS Settings. The Offeror’s revenue under the D-SNP Contract for the same Counties which match the Central and North GSAs is approximately \$75 million. Annual expenses by category of service are as follows:

Inpatient Hospitalization	37%
Physician	22%
Pharmacy	22%
SNF and Home Health	7%
Emergency Room	3%
Outpatient Facility	4%
Other Medical	5%

The Offeror shall have at least the following percentage of contracts executed with health care providers under VBP arrangements in its second year of the Contract (CYE 19):

1. 50% of total ALTCS E/PD prospective payments, and
2. 50% of total DSNP payments

Describe how the Offeror will meet these requirements. The Offeror’s response shall be limited to methods that meet the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework for categories 2, 3 and 4, and address the following at a minimum:

- Similarities and differences regarding VBP contracting approaches in the Medicaid and Medicare lines of business, and
- The urban/rural dichotomy

The Offeror’s response regarding ALTCS E/PD must include, but need not be limited to, contracting arrangements addressing integrated behavioral health and physical health service delivery, contracting arrangements for both HCBS and Nursing Facility settings, and relevant outcome measures of all VBP contracts.

The Offeror’s response regarding the D-SNP must include, but need not be limited to, contracting arrangements addressing integrated behavioral health and physical health service delivery, inpatient readmissions and ED visits, and relevant outcome measures of all VBP contracts.

ADMINISTRATIVE

10. The Offeror recently received an authorization request for an increase in attendant care hours for a member. The Offeror has already approved 20 hours a week of attendant care for this member, but the member’s representative, who is also the member’s spouse and caregiver, believes 45 hours are necessary due to the member’s declining condition. The member’s representative is very upset at the current allocation of hours and has contacted five different agencies, including the legislature. How would the Offeror address this situation, including an explanation of processes associated with approval and processes associated with denial of the request?

ADMINISTRATIVE	
11.	<p>A provider who is a specialty surgeon, filed a claim dispute contesting the Offeror's recent recoupment of the entire payment amount for a claim it paid 26 months earlier. The Offeror's notification of recoupment to the provider stated the following language:</p> <p style="padding-left: 40px;">Claim reference number <u>xxx</u> for Member <u>yyy</u> will be recouped in the next payment cycle. Not all services are covered. No prior authorization obtained.</p> <p>In its claim dispute, the surgeon insists that the recoupment was improper, stating that all services were critically necessary, and referring the Offeror to the extensive medical records previously submitted with the claim. The provider's medical records submitted with the claim indicate that the member was admitted to the hospital directly from another physician's office as a result of severe flank pain, inability to stand, vomiting, and fever. The surgeon is not employed by the hospital where the surgery was performed but has admitting privileges at the hospital.</p> <p>Identify all steps and describe all activities the Offeror will take in response to the claim dispute as part of the grievance and appeal process. Include the type and full content of any communications the Offeror will send to the provider. Also, explain/describe how the Offeror will handle this dispute if the provider files a request for hearing and discuss the legal and factual arguments that will be made by the Offeror to support its position.</p>
12.	<p>Information Technology (IT) Systems Demonstration</p> <p>By participating in mock Information Systems scenarios over a 10-day period, the Offeror shall demonstrate its comprehensive understanding and its capability to accurately and timely:</p> <ul style="list-style-type: none">• Process data exchanged with AHCCCS• Administer actions based on the data processed <p>Supplemental materials to assist in preparation for this demonstration are available in the Bidders' Library under the heading "Information Technology (IT) Systems Demonstration," and include:</p> <p style="padding-left: 80px;">Guidelines 10-day Calendar User Guides and Manuals</p> <p>These mock scenarios will begin on Tuesday, January 24, 2017.</p> <p>For this Submission Requirement, the Offeror shall provide written acknowledgement as follows: <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 24, 2017, constitutes fulfillment of Submission Requirement No. 11. <Offeror> acknowledges that it will comply with the stated guidelines and calendar for this process. <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal.</p>

[END OF EXHIBIT C: NARRATIVE SUBMISSION REQUIREMENTS]

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

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

“Subcontract” means any Contract between the AHCCCS Contractor and a third party for the performance of any or all services or requirements specified under the Contractor’s Contract with AHCCCS, and includes any Provider Participation Agreement or Group Biller Agreement with AHCCCS.

“Subcontractor” means any third party with a Contract with the Contractor for the provision of any or all services or requirements specified under the Contractor’s Contract with AHCCCS, or any entity which has a Provider Participation Agreement or Group Biller Agreement with AHCCCS.

Subcontractors who provide services under the AHCCCS Long Term Care Programs, including ALTCS/EPD and DES/DDD must comply with the following applicable rules and statutes:

- ALTCS - Arizona Administrative Code (A.A.C.) Title 9, Chapter 28. AHCCCS statutes for long term care are generally found in Arizona Revised Statute (A.R.S.) Title 36, Chapter 29, Article 2.
- Medicare Cost Sharing - A.A.C. Title 9, Chapter 29 (for Acute) and A.A.C. Title 9, Chapter 29 (for ALTCS).
- DES/DDD - A.A.C. Title 9, Chapter 22, 28, and 33. Statutes for DDD are generally found in A.R.S. Title 36, Chapter 5.1 and § 36-2932.

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

The following provisions must be referenced and compliance required in every Subcontract.

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

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

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, Subcontractors or State employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor, Subcontractor or State employee.

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

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

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

The Subcontractor certifies that all representations set forth herein and in the Subcontract are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

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

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

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

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

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

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

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

8. CONFIDENTIALITY REQUIREMENT

The Subcontractor shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to, 42 CFR Part 431, Subpart F, A.R.S. §§36-107, 36-2903 (for Acute), 36-2932 (for ALTCS), 41-1959 and 46-135, the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936), 45 CFR Parts 160 and 164, and AHCCCS Rules.

9. CONFLICT IN INTERPRETATION OF PROVISIONS

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

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S. Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules, A.R.S. §36-2901 et seq. (for Acute) and A.R.S. §36-2931 et seq. (for ALTCS).

11. ENCOUNTER DATA REQUIREMENT

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

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

AHCCCS 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 the Subcontract.

13. E-VERIFY REQUIREMENTS

In accordance with A.R.S. §41-4401, the Subcontractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

14. FEDERAL IMMIGRATION AND NATIONALITY ACT

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

15. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor must report the incident to AHCCCS, Office of the Inspector General (AHCCCS-OIG) immediately within one business day and to the Contractor.

16. INSURANCE AND INDEMNIFICATION

For any Subcontract valued at less than \$50,000.00 for the entire term of the Subcontract, the Subcontractor is required to maintain insurance, at a minimum, as specified in the Standard Professional Service Contract – Working with Children and/or Vulnerable Adults - Under \$50,000 subsection. For all other Subcontracts, the Subcontractor is required to maintain insurance, at a minimum, as specified in the Standard Professional Service Contract - Working with Children and/or Vulnerable Adults subsection. Subcontractor adherence to insurance requirements shall be verified by the Contractor for all existing Subcontracts and as new Subcontracts are initiated.

STANDARD PROFESSIONAL SERVICE CONTRACT - WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS

Indemnification Clause

To the fullest extent permitted by law, Subcontractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Subcontractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers' Compensation Law or arising out of the failure of such Subcontractor to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Subcontractor from and against any and all claims. It is agreed that Subcontractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of the Subcontract, the Subcontractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Subcontractor for the State of Arizona.

This indemnity shall not apply if the Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

Insurance Requirements

Subcontractors shall procure and maintain, until all of their obligations have been discharged, including any warranty periods under this Contract or Subcontract, insurance against claims for injury to persons or damage to property arising from, or in connection with, the performance of the work hereunder by the Subcontractor, its agents, representatives, employees or Subcontractors.

The Insurance Requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or Subcontractors, and the Contractor is free to purchase additional insurance. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Subcontractor from liabilities that arise out of the performance of the work under this Contract or Subcontract by the Subcontractor, its agents, representatives, employees or subcontractors, and the Subcontractor is free to purchase additional insurance.

A. Minimum Scope and Limits of Insurance

Subcontractor shall provide coverage with limits of liability not less than those stated below.

1. Commercial General Liability (CGL) – Occurrence Form

Policy shall include bodily injury, property damage, and broad form contractual liability coverage.

General Aggregate \$2,000,000

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

Products – Completed Operations Aggregate	\$1,000,000
Personal and Advertising Injury	\$1,000,000
Damage to Rented Premises	\$50,000
Each Occurrence	\$1,000,000

- a. The policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.
- b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.
- c. For Subcontractors providing direct services to children and/or vulnerable adults (as defined by A.R.S. §46-451(A)(9)), the policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than \$500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.
- d. Subcontractors must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.”

2. Business Automobile Liability

Bodily Injury and Property Damage for any owned, hired, and/or non-owned automobiles used in the performance of this Contract.

Combined Single Limit (CSL) \$1,000,000

- e. Policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor, involving automobiles owned, hired and/or non-owned by the Subcontractor.
- f. Policy shall contain a waiver of subrogation endorsement as required by this written agreement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.

3. Workers' Compensation and Employers' Liability

Workers' Compensation

Statutory

Employers' Liability	
Each Accident	\$1,000,000
Disease – Each Employee	\$1,000,000
Disease – Policy Limit	\$1,000,000

- g. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.
- h. This requirement shall not apply to each Contractor or Subcontractor that is exempt under A.R.S. §23-901, and when such Contractor or Subcontractor executes the appropriate waiver form (Sole Proprietor or Independent Contractor).

4. Professional Liability (Errors and Omissions Liability)

Each Claim	\$ 2,000,000
Annual Aggregate	\$ 2,000,000

- i. For Subcontractors providing direct services to children and/or vulnerable adults (as defined by A.R.S. §46-451(A)(9)), if SAM coverage is being provided under this policy, then Subcontractors must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.” This coverage may be sub-limited to no less than \$500,000.
- j. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Subcontractor warrants that any retroactive date under the policy shall precede the effective date of this Contract and the Subcontract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract or the Subcontract is completed, whichever is later.
- k. Policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of the Contract or Subcontract.

B. Additional Insurance Requirements

The policies shall include, or be endorsed to include, as required by this written agreement, the following provisions:

The Subcontractor’s policies, as applicable, shall stipulate that the insurance afforded the Subcontractor shall be primary and that any insurance carried by the Department of Administration, its agents, officials, employees or the State of Arizona shall be excess and not contributory insurance, as provided by A.R.S. §41-621 (E).

Insurance provided by the Subcontractor shall not limit the Subcontractor’s liability assumed under the indemnification provisions of this Contract.

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

C. Notice of Cancellation

Applicable to all insurance policies required within the Insurance Requirements of this Contract or the Subcontract, Subcontractor's insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without thirty (30) days prior written notice to the State of Arizona. Within two (2) business days of receipt, Contractor must provide notice to the State of Arizona if they receive notice of a policy that has been or will be suspended, canceled, materially changed for any reason, has expired, or will be expiring. Such notice shall be sent to AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract.

D. Acceptability of Insurers

Subcontractor's insurance shall be placed with companies licensed in the State of Arizona or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers. Insurers shall have an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor or Subcontractor from potential insurer insolvency.

E. Verification of Coverage

Contractor shall furnish AHCCCS with certificates of insurance (valid ACORD form or equivalent approved by the State of Arizona) evidencing that Subcontractor has the insurance as required by this Contract and/or the Subcontract. An authorized representative of the insurer shall sign the certificates.

All such certificates of insurance and policy endorsements must be received by AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract before work commences. The State's receipt of any certificates of insurance or policy endorsements that do not comply with this written agreement shall not waive or otherwise affect the requirements of this agreement.

Each insurance policy required by this Contract or the Subcontract must be in effect at, or prior to, commencement of work under this Contract or Subcontract. Failure to maintain the insurance policies as required by this Contract or Subcontract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this Contract shall be sent directly to AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract. All Subcontractors are required to maintain insurance and to provide verification upon request. The AHCCCS contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete copies of all insurance policies required by this Contract at any time.

F. Subcontractors

Subcontractors' certificate(s) shall include all of its subcontractors as insureds under its policies or Subcontractor shall be responsible for ensuring and/or verifying that all of its subcontractors have valid and collectable insurance as evidenced by the certificates of insurance and endorsements for each of its subcontractor. All coverages for subcontractors shall be subject to the Minimum Subcontract Provisions located on the AHCCCS website. AHCCCS reserves the right to require, at any time throughout the life of the Contract, proof from the Subcontractor that its subcontractors have the required coverage.

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

G. Approval and Modifications

AHCCCS, in consultation with State Risk, reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the life of this Contract or Subcontract, as deemed necessary. Such action will not require a formal contract or subcontract amendment but may be made by administrative action.

H. Exceptions

In the event the Contractor or Subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a certificate of self-insurance. If the Contractor or Subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

[END OF STANDARD PROFESSIONAL SERVICE CONTRACT – WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS]

STANDARD PROFESSIONAL SERVICE CONTRACT - WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS – UNDER \$50,000

Indemnification Clause

To the fullest extent permitted by law, Subcontractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as “Indemnitee”) from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys’ fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as “Claims”) for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Subcontractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers’ Compensation Law or arising out of the failure of such Subcontractor to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Subcontractor from and against any and all claims. It is agreed that Subcontractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of the Subcontract, the Subcontractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Subcontractor for the State of Arizona.

This indemnity shall not apply if the Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

Insurance Requirements

Subcontractor shall procure and maintain, until all of their obligations have been discharged, including any warranty periods under this Contract or Subcontract, insurance against claims for injury to persons or damage to property arising from, or in connection with, the performance of the work hereunder by the Subcontractor, its agents, representatives, employees or Subcontractors.

The Insurance Requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or Subcontractors, and the Contractor is free to purchase additional insurance. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Subcontractor from liabilities that arise out of the performance of the work under this Contract or Subcontract by the Subcontractor, its agents, representatives, employees or subcontractors, and the Subcontractor is free to purchase additional insurance.

A. Minimum Scope and Limits of Insurance

Subcontractor shall provide coverage with limits of liability not less than those stated below.

1. Commercial General Liability (CGL) – Occurrence Form

Policy shall include bodily injury, property damage, and broad form contractual liability coverage.

General Aggregate \$1,000,000

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

Products – Completed Operations Aggregate	\$500,000
Personal and Advertising Injury	\$500,000
Damage to Rented Premises	\$25,000
Each Occurrence	\$500,000

- a. The policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.
- b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.
- c. For Subcontractors providing direct services to children and/or vulnerable adults (as defined by A.R.S. §46-451(A)(9)), the policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than \$250,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.
- d. Subcontractors must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.”

2. Business Automobile Liability

Bodily Injury and Property Damage for any owned, hired, and/or non-owned automobiles used in the performance of this Contract.

Combined Single Limit (CSL) \$1,000,000

- a. Policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor, involving automobiles owned, hired and/or non-owned by the Subcontractor.
- b. Policy shall contain a waiver of subrogation endorsement as required by this written agreement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor, or on behalf of the Subcontractor or Contractor.

3. Workers' Compensation and Employers' Liability

Workers' Compensation

Statutory

Employers' Liability	
Each Accident	\$500,000
Disease – Each Employee	\$500,000
Disease – Policy Limit	\$500,000

- a. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.
- b. This requirement shall not apply to each Contractor or Subcontractor that is exempt under A.R.S. §23-901, and when such Contractor or Subcontractor executes the appropriate waiver form (Sole Proprietor or Independent Contractor).

4. Professional Liability (Errors and Omissions Liability)

Each Claim	\$ 1,000,000
Annual Aggregate	\$ 1,000,000

- a. For Subcontractors providing direct services to children and/or vulnerable adults (as defined by A.R.S. §46-451(A)(9)), if SAM coverage is being provided under this policy then Subcontractors must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.” This coverage may be sub-limited to no less than \$250,000.
- b. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Subcontractor warrants that any retroactive date under the policy shall precede the effective date of this Contract and Subcontract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract or Subcontract is completed, whichever is later.
- c. Policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of this Contract or Subcontract.

B. Additional Insurance Requirements

The policies shall include, or be endorsed to include, as required by this written agreement, the following provisions:

The Subcontractor’s policies, as applicable, shall stipulate that the insurance afforded the Subcontractor shall be primary and that any insurance carried by the Department of Administration, its agents, officials, employees or the State of Arizona shall be excess and not contributory insurance, as provided by A.R.S. §41-621 (E).

Insurance provided by the Subcontractor shall not limit the Subcontractor’s liability assumed under the indemnification provisions of this Contract.

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

C. Notice of Cancellation

Applicable to all insurance policies required within the Insurance Requirements of this Contract or Subcontract, Subcontractor's insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without thirty (30) days prior written notice to the State of Arizona. Within two (2) business days of receipt, Contractor must provide notice to the State of Arizona if they receive notice of a policy that has been or will be suspended, canceled, materially changed for any reason, has expired, or will be expiring. Such notice shall be sent to AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract.

D. Acceptability of Insurers

Subcontractor's insurance shall be placed with companies licensed in the State of Arizona or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers. Insurers shall have an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor or Subcontractor from potential insurer insolvency.

E. Verification of Coverage

Subcontractor shall furnish AHCCCS with certificates of insurance (valid ACORD form or equivalent approved by the State of Arizona) evidencing that Subcontractor has the insurance as required by this Contract and/or the Subcontract. An authorized representative of the insurer shall sign the certificates.

All such certificates of insurance and policy endorsements must be received by AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract before work commences. The State's receipt of any certificates of insurance or policy endorsements that do not comply with this written agreement shall not waive or otherwise affect the requirements of this agreement.

Each insurance policy required by this Contract or the Subcontract must be in effect at, or prior to, commencement of work under this Contract or Subcontract. Failure to maintain the insurance policies as required by this Contract or Subcontract, or to provide evidence of renewal, is a material breach of contract.

All certificates required by this Contract shall be sent directly to AHCCCS as specified in Attachment____, "Contractor Chart of Deliverables", of this Contract. All Subcontractors are required to maintain insurance and to provide verification upon request. The AHCCCS contract number and project description shall be noted on the certificate of insurance. The State of Arizona reserves the right to require complete copies of all insurance policies required by this Contract at any time.

F. Subcontractors

Subcontractors' certificate(s) shall include all of its subcontractors as insureds under its policies or Subcontractor shall be responsible for ensuring and/or verifying that all of its subcontractors have valid and collectable insurance as evidenced by the certificates of insurance and endorsements for each of its subcontractors. All coverages for subcontractors shall be subject to the Minimum Subcontract Provisions located on the AHCCCS website. AHCCCS reserves the right to require, at any time throughout the life of the Contract, proof from the Subcontractor

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

that its subcontractors have the required coverage. All subcontractors are required to maintain insurance and to provide verification upon request.

G. Approval and Modifications

AHCCCS, in consultation with State Risk, reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the life of this Contract or Subcontract, as deemed necessary. Such action will not require a formal contract or subcontract amendment but may be made by administrative action.

H. Exceptions

In the event the Contractor or Subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a certificate of self-insurance. If the Contractor or Subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

[END OF STANDARD PROFESSIONAL SERVICE CONTRACT - WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS – UNDER \$50,000]

17. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

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

18. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

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

19. NON-DISCRIMINATION REQUIREMENTS

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

20. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

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

21. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

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

22. RECORDS RETENTION

The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

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

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

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

patient medical records, the Subcontractor shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the Subcontractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If the Subcontract 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 unless a longer period of time is required by law. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Subcontract, or costs and expenses of the Subcontract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (42 CFR 431.17; A.R.S. §41-2548)

23. SEVERABILITY

If any provision of the Subcontract, including these Minimum Subcontract Provisions, is held invalid or unenforceable, the remaining provisions shall continue to be valid and enforceable to the full extent permitted by law.

24. SUBJECTION OF SUBCONTRACT

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

25. TERMINATION OF SUBCONTRACT

AHCCCS may, by written notice to the Subcontractor, terminate the Subcontract if it is found that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or subcontract, or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the State makes such findings may be challenged through an administrative appeals process. If the Subcontract is terminated under this section, unless the Subcontractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. [A.A.C. R2-5-501; A.R.S. §41-2616 C.; 42 CFR 434.6(a)(6)]

26. VOIDABILITY OF SUBCONTRACT

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

EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS

27. WARRANTY OF SERVICES

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

28. COMPLIANCE WITH THE FEDERAL IMMIGRATION AND NATIONALITY ACT (FINA) AND ALL OTHER FEDERAL IMMIGRATION LAWS AND REGULATIONS RELATED TO IMMIGRATION STATUS OF ITS EMPLOYEES

By entering into the Contract, the Subcontractor warrants compliance with the Federal Immigration and Nationality Act (FINA) and all other Federal immigration laws and regulations related to the immigration status of its employees. The Subcontractor shall obtain statements from any of its Subcontractors certifying compliance and shall furnish the statements to the AHCCCS Chief Procurement Officer, upon request. These warranties shall remain in effect through the term of the Contract. The Subcontractor and its Subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the U.S. Department of Labor's Immigration and Control Act, for all employees performing work under the Contract. I-9 forms are available for download at USACIS.GOV.

The State may request verification of compliance for any Subcontractor or its Subcontractor performing work under the Contract. Should the Contractor suspect or find that the Subcontractor or any of its Subcontractors are not in compliance, the Contractor may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Subcontractor. All costs necessary to verify compliance are the responsibility of the Subcontractor.

29. COMPLIANCE REQUIREMENTS FOR A.R.S. §41-4401, GOVERNMENT PROCUREMENT: E-VERIFY REQUIREMENT

The Subcontractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A. (That subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the E-Verify program.")

A breach of a warranty regarding compliance with immigration laws and regulations shall be deemed a material breach of the Contract and the Subcontractor may be subject to penalties up to and including termination of the Contract.

Failure to comply with a State or Contractor audit process to randomly verify the employment records of Subcontractors and any of its Subcontractors shall be deemed a material breach of the Contract and the Subcontractor may be subject to penalties up to and including termination of the Contract.

The State Agency and Contractor retains the legal right to inspect the papers of any employee who works on the Contract to ensure that the Contractor or Subcontractor is complying with the warranty.

[END OF EXHIBIT D: AHCCCS MINIMUM SUBCONTRACT PROVISIONS]

EXHIBIT E: MEDICARE REQUIREMENTS

Arizona Long Term Care System (ALTCS) Program: A Title XIX program administered by the AHCCCS Administration as authorized by A.R.S. Title 36, Chapter 29, Article 2. The ALTCS program provides long term, acute, behavioral health care and case management services to two distinct populations: persons who are elderly and/or who have physical disabilities and persons who have developmental disabilities. In order to qualify for ALTCS, individuals are determined to need an institutional level of care as well as meet other financial and eligibility criteria.

Medicaid members who are also enrolled in Medicare are referred to as dual eligible members. To improve care coordination for AHCCCS dual eligible members, the State requires all ALTCS E/PD Contractors to provide Medicare benefits to dual eligible members as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in all awarded counties..

Medicare Structure

As required by A.R.S. §36-2906.01, the awarded Contractor shall establish an affiliated corporation whose only authorized business is to provide services under this contract to AHCCCS eligible persons enrolled with the Contractor. This affiliated corporation must be established within 120 days of the contract award. In addition, the Contractor must by January 1, 2018 operate a D-SNP serving beneficiaries eligible for both Medicare and Medicaid. The Contractor must have, and assure AHCCCS it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this contract and the Medicare product to the extent necessary to ensure integration of AHCCCS and Medicare services for persons enrolled with the Contractor for both programs. The Contractor must ensure the integration of Medicare and Medicaid services.

In addition, the Contractor must establish or assure AHCCCS that it intends to establish branding for the Medicare product that ensures it is easily identifiable to members and providers as an integrated plan for both Medicare and Medicaid.

Medicare State Certification

Medicare Advantage plans are required to be licensed under State law. As outlined in A.R.S 36-2903(B)(2) AHCCCS has the authority to certify its Contractors for Medicare purposes. The Contractor may apply for certification through AHCCCS or apply and receive licensure through the Arizona Department of Insurance. The AHCCCS certification process is detailed in ACOM Policy 313.

Participation as a Medicare Advantage Special Needs Plan

All ALTCS E/PD Contractors will be required to provide Medicare benefits to dual eligible members as a D-SNP in all awarded counties. Contractors will be required to implement Medicare business on **January 1, 2018** and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as a D-SNP to CMS no later than **November 10, 2016**. Additional information and exact submission dates for 2017 can be found here:

<https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/>.

To comply with the statute A.R.S. §36-2906.01, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll ALTCS E/PD full benefit dual eligible members and must have a D-SNP subset that matches this Contract. All Offerors must also submit D-SNP

applications to CMS by **February 2017**. Additional information on D-SNPs can be found at: <http://www.cms.gov/SpecialNeedsPlans>.

State Contracting with D-SNPs

AHCCCS will not contract with any D-SNP to serve the ALTCS E/PD Medicaid population outside of awarded ALTCS E/PD contracts. Contractors who fail to maintain a D-SNP in all awarded counties will be subject to sanctions. The D-SNP is subject to AHCCCS Value-Based Purchasing (VBP) Policy, see ACOM Policy 318 for current contract year requirements.

Incumbent ALTCS E/PD Contractors not awarded this contract will be required to maintain their D-SNP contract through December 31, 2017.

D-SNP Responsibilities

This section outlines requirements which are designed to improve care coordination and timely information sharing for dual eligible members enrolled in D-SNPs consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Affordable Care Act.

Care Coordination: If the dual eligible member is eligible for AHCCCS ALTCS benefits, then the D-SNP is responsible for coordination of both Medicare and Medicaid services regardless of whether the individual is enrolled with the D-SNP for Medicaid.

- If the dual eligible member is enrolled with the same Health Plan for both Medicare and Medicaid (aligned members) services the D-SNP is responsible for coordinating all benefits covered by both the D-SNP and AHCCCS.
- If the dual eligible member is not enrolled with the same Health Plan for both Medicare and Medicaid (unaligned members) services, the D-SNP is responsible for coordinating Medicaid-only benefits with the member's AHCCCS Contractor. Coordination of Medicaid benefits is not the beneficiary's responsibility.
- AHCCCS will ensure that the D-SNP has access to the dual eligible member's AHCCCS ALTCS E/PD Medicaid Health Plan enrollment data through daily files and AHCCCS Online.
- The D-SNP will establish a contact at each ALTCS E/PD Medicaid Health Plan that will be responsible to share, at minimum, timely inpatient hospital, emergency room, and chronic illness information to assist the ALTCS E/PD Medicaid Health Plan to coordinate care when benefit coverage transitions from Medicare to Medicaid.
- The D-SNP will provide AHCCCS with the name of the contact person at the D-SNP who will be responsible for the coordination of care for dual eligible members.

The D-SNP will participate in AHCCCS meetings, virtual or otherwise, relating to care for dual eligible members, and timely provide any necessary information and data.

Medicaid Eligibility: D-SNPs are responsible for coordinating care for full benefit dual eligible ALTCS E/PD members. These members are eligible for receiving full Medicaid benefits and are defined as:

1. Qualified Medicaid Beneficiary with AHCCCS Benefits (QMB+)
2. Specified Low Income Beneficiary with AHCCCS Benefits (SLMB+)
3. Other Full Benefit Dual Eligible Beneficiary (FBDE)

Benefits Covered by D-SNP: The D-SNP is not responsible for the provision or reimbursement of any Medicaid benefits. The D-SNP is responsible to maintain current knowledge and familiarity with Medicaid covered services through ongoing review of AHCCCS laws, rules, policies, contracts, and guidance, as well as through information posted on AHCCCS' website.

Medicaid Cost-Sharing Protections Covered Under the D-SNP: The D-SNP providers shall not impose Medicare cost sharing on dual eligible members for services covered by both Medicare and Medicaid. The D-SNP providers agree to accept the D-SNP payment as payment in full for services covered by both Medicare and Medicaid, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid. Dual eligible members shall be responsible for any applicable AHCCCS copayment. The State cost sharing policy is located in ACOM Policy 201.

Section 1902(n)(3)(B) of the Social Security Act prohibits Medicare providers from balance billing QMB members for Medicare cost-sharing, including deductibles, coinsurance, and copayments. QMB members have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. The D-SNP shall include a provision in all provider agreements specifying that the provider agrees to accept the D-SNP payment as payment in full, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid.

Identification and Sharing of Information on Medicaid Providers: The D-SNP shall develop a network of providers which includes an overlap of providers in the D-SNP network who are also contracted with ALTCS E/PD Contractors. ALTCS E/PD Contractor networks can be accessed online through individual websites from <https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx>.

Verification of Eligibility for both Medicare and Medicaid: The D-SNP is responsible for accurately verifying both Medicare and Medicaid eligibility of potential and enrolled members. The D-SNP will have access to AHCCCS Online to verify member real-time Medicaid eligibility and to data transmitted through daily files from AHCCCS.

D-SNP Service Area: The D-SNP service area shall match the ALTCS E/PD Medicaid contract geographic service area.

Medicare Data

The D-SNP is required to submit Medicare encounter data as requested by AHCCCS. AHCCCS has completed a data use agreement with CMS to receive Medicare data for care coordination. This data will provide AHCCCS with information on services paid for by Medicare.

Member Transition

The D-SNP is required to participate in all activities as directed by AHCCCS which pertain to member transitions as a result of termination of a D-SNP contract. This applies to terminations directed from AHCCCS, CMS or D-SNP. The D-SNP is required to notify AHCCCS in the case of significant changes to the terms of the contract with CMS to protect beneficiary and State interests including, but not limited to;

SECTION I: EXHIBITS
EXHIBIT E: MEDICARE REQUIREMENTS

Contract/RFP No. YH18-0001

D-SNP non-renewals, service area changes, terminations, deficiencies, notices of intent to deny, and novation agreements. The D-SNP must submit any CMS warning letters or corrective action plans within 10 business days of receipt to AHCCCS DHCM, Operations.

Improving Alignment

AHCCCS will continue to establish requirements to improve alignment for dual eligible members.

[END OF EXHIBIT E: MEDICARE REQUIREMENTS]

EXHIBIT F: A.R.S. §35-393.01 ATTESTATION

Provided Separately on the AHCCCS Website
See the AHCCCS Website YH18-0001 - ALTCS E/PD Bidders' Library for Documents

SECTION J: NON-TITLE XIX CONTRACT PROVISIONS

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SECTION J: DEFINITIONS**HOUSING REFERRAL**

A written authorization from the Contractor for the provision of covered services to an eligible member. The Housing Referral will constitute the agreement of the provider to provide services identified in the tenant's Service Plan. Housing Referrals will be in such form and format determined by the Contractor.

SUPPORTED HOUSING SERVICES

Services, as defined in the AHCCCS Covered Behavioral Health Services Guide that are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include: Utility subsidies, Relocation services to a person or family for the purpose of securing and maintaining housing, employment services, budget and finance counseling, and eviction prevention.

SUPPORTIVE HOUSING

Housing, as defined in 24 CFR Part 583, in conjunction with which supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless persons with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless persons and families.

SECTION J: PROGRAM REQUIREMENTS**1. PURPOSE, APPLICABILITY, AND INTRODUCTION**

This Contract describes the responsibilities for provision of Non-Title XIX services for Title XIX ALTCS E/PD members with an SMI designation who are accessing behavioral health services. In addition, this Contract (Section J: Non-Title XIX Contract Provisions) provides for State only funded pregnancy termination services for all ALTCS E/PD members regardless of SMI designation.

The Contractor shall ensure the delivery of medically necessary and clinically appropriate covered behavioral health services to eligible members based on availability of funding and in conformance with the AHCCCS Covered Behavioral Health Services Guide.

Based on funding availability, the U.S. Government may make additional grant funding available to AHCCCS for the populations served under this Non-Title XIX Contract ("Future Grant"). At its sole discretion, AHCCCS may notify the Contractor in writing of an offer to become a sub-recipient of the Future Grant and the requirements of the Future Grant. Should the Contractor agree to be a sub-recipient of the Future Grant, it shall notify AHCCCS in writing of the acceptance of AHCCCS' offer. The Contractor's acceptance of this grant funding shall amend this Contract to obligate the Contractor to fulfill all requirements of the Future Grant ("Future Grant Amendment"). All other provisions of this Contract shall remain unchanged and shall apply to any Future Grant Amendment. If a provision of the Future Grant Amendment conflicts with this Contract, the Future Grant Amendment shall control.

This Contract hereby incorporates by reference the Title XIX Contract YH18-0001, which includes any and all of its Contract amendments, the Contractor's Proposal, best and final offer accepted by AHCCCS, and any approved subcontracts, thereto.

2. SCOPE OF SERVICES

To the extent not covered by the Title XIX YH18-0001 Contract, the Contractor agrees to provide the following services for all ALTCS E/PD members regardless of SMI designation:

Pregnancy Terminations: Pregnancy terminations which are medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

1. Creating a serious physical or mental health problem for the pregnant member,
2. Seriously impairing a bodily function of the pregnant member,
3. Causing dysfunction of a bodily organ or part of the pregnant member,
4. Exacerbating a health problem of the pregnant member, or
5. Preventing the pregnant member from obtaining treatment for a health problem.

Conditions, Limitations and Exclusions:

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the *Certificate of Necessity for Pregnancy Termination* and clinical information that supports the medical necessity for the procedure, as referenced in AMPM Policy 410. This form must be submitted to the appropriate assigned Contractor Medical Director or designee for enrolled pregnant members, or the AHCCCS Chief Medical Officer or designee for Fee-For-Service (FFS) members. The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria have been met.

Pregnancy terminations must be provided in compliance with AMPM Policy 410.

All outpatient medically necessary covered services related to the pregnancy termination, for dates of service only on the day the pregnancy was terminated, will be considered for reimbursement at 100% of the lesser of the contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reimbursement.

Moral or Religious Objections: The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may submit a Proposal addressing members' access to services. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. If AHCCCS does not approve the Contractor's Proposal, AHCCCS will disenroll members who are seeking these services from the Contractor and assign members to another Contractor [42 CFR 438.56]. The Proposal must:

1. Be submitted to AHCCCS in writing prior to entering into a contract with AHCCCS or at least 60 days prior to the intended effective date of the change in the scope of services based on moral or religious grounds;
2. Place no financial or administrative burden on AHCCCS;
3. Place no significant burden on members' access to the services;
4. Be accepted by AHCCCS in writing; and
5. Acknowledge an adjustment to capitation, depending on the nature of the proposed solution.

If AHCCCS approves the Contractor's Proposal for its members to access the services, the Contractor must immediately develop a policy implementing the Proposal along with a notification to members of how to access these services. The notification and policy must be consistent with the provisions of 42 CFR 438.10 and shall be approved by AHCCCS prior to dissemination. The notification must be provided to newly assigned members within 12 days of enrollment, and must be provided to all current members at least 30 days prior to the effective date of the Proposal [42 CFR 438.102(a)(2)a].

The Contractor agrees to provide the following Non-Title XIX services for Title XIX ALTCS E/PD members with an SMI designation:

The Contractor shall ensure the delivery of medically necessary and clinically appropriate covered behavioral health services to eligible members based on availability of funding and in conformance with the AHCCCS Covered Behavioral Health Services Guide. See also AMPM Exhibit 300-2.

Auricular Acupuncture: The application by a certified acupuncturist practitioner pursuant to: A.R.S. §32-3922 of auricular acupuncture needles to the pinna, lobe or auditory meatus to treat alcoholism, substance use or chemical dependency.

Supported Housing: Supported housing services are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services include rent and/or utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing.

The Contractor shall subcontract with non-profit organizations to administer housing vouchers for rent, subsidies for utilities, relocation services, move-in assistance, and eviction prevention within the Contractor's Geographic Service Area(s) (GSA). The subcontractors shall be eligible to serve as Housing Providers and grantees for HUD funded grant programs to ensure compliance with HUD standards. The Contractor shall ensure that contracted Housing Providers identify, screen and refer members with an SMI designation and refer the prospective tenant to the available housing using the process determined by the Contractor. Housing Provider staff is required to have knowledge of Federal and State funding regulations.

The Contractor shall require Housing Providers to employ a sufficient number of staff qualified to perform the following, including but not limited to:

1. Assisting members with understanding lease agreements,
2. Assisting members with financial responsibilities, and
3. Identifying coordination opportunities with case managers

For appeals related to supported housing services for members with an SMI designation refer to RFP Section J, Paragraph 3, Grievance and Appeal System.

Housing related grievances and requests for investigation for persons with an SMI designation must be addressed in accordance with ACOM Policy 446 in the same manner as required of the Regional Behavioral Health Authorities.

The Contractor shall follow the Substance Abuse and Mental Health Services Administration (SAMHSA) model for permanent supportive housing programs as outlined below:

1. State Funded Supported Housing Programs

AHCCCS supports permanent supportive housing and has adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) model for permanent supportive housing programs.

2. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program are:
 - a. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.
 - b. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
 - c. Participation in services is voluntary and tenants cannot be evicted for rejecting services.
 - d. House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or otherwise interfere with a life in the community.
 - e. Housing is not time-limited, and the lease is renewable at tenants' and owners' option.
 - f. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
 - g. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
 - h. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.
 - i. Tenants have choices in the support services that they receive. Tenants are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.
 - j. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.
 - k. Support services promote recovery and are designed to help tenants choose, get, and keep housing.
 - l. The provision of housing and the provision of support services are distinct.

The Contractor shall comply with the following requirements to effectively manage limited housing funds in providing supported housing services to eligible members. See the AHCCCS Covered Behavioral Health Services Guide for additional information on Supported Housing. The Contractor:

1. Shall accept all persons with an SMI designation into a State Funded Housing Program subject to funding availability.
2. Shall ensure Housing is safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
3. Shall not actively refer or place individuals in a Homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities.
4. May charge up to, but not greater than, 30% of a tenant's income towards rent. If a rent payment is increased in State funded housing programs, the Contractor must provide the tenant with a 30 day notice at the time of the tenant's annual recertification.
5. Shall not use housing allocations for room and board charges in residential treatment settings. However, the Contractor may allow residential treatment settings to establish policies which require that persons earning income contribute to the cost of room and

board.

6. May provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, the Contractor must prioritize assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or items such as pots and pans, dishes, and sheets. The Contractor must not use housing allocations or other funding received from AHCCCS to purchase furniture.
7. Shall ensure that contracted providers deliver a range of housing services and present available options for housing to persons with an SMI designation consistent with the individual's goals and needs in the Individual Service Plan.

The Contractor is required to contract with Housing Providers trained in applying the following standards and practices:

1. Housing Quality Standards (HQS) for inspections,
2. Fair housing laws,
3. The Arizona Residential Landlord Tenant Act,
4. Use of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment tools,
5. Fundamentals of the SAMHSA Permanent Supportive Housing program, and
6. Current and emerging tools and best practices.

Traditional Healing Services: Treatment services for mental health or substance use problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the person's functional ability.

3. GRIEVANCE AND APPEAL SYSTEM

The Contractor shall implement and administer an SMI Grievance and Appeal System for members, subcontractors and providers which include processes for the following:

1. SMI Grievance,
2. SMI Appeal, and
3. Provider Claim Disputes for non-Title XIX services for Title XIX members with an SMI designation (Claim Disputes)

The Contractor shall ensure an SMI Grievance and Appeal System that complies with all applicable requirements in the federal and State laws and regulations, AHCCCS' Contractor Operations Manual, AHCCCS Medical Policy Manual, and the requirements under this Contract.

The Contractor shall not delegate or subcontract the administration or performance of the SMI Grievance and SMI Appeal processes.

The Contractor shall:

1. Provide written notification of the Contractor's Grievance and Appeal System processes to all subcontractors and providers at the time of entering into a subcontract.

2. Provide written notification with information about Contractor's SMI Grievance and Appeal System to members in the Member Handbook in conformance with ACOM Policy 404.
3. Provide written notification to members at least 30 days prior to the effective date of a change in a SMI Grievance and Appeal System policy.
4. Administer all SMI Grievance and Appeal System processes competently, expeditiously, and equitably for all members, subcontractors, and providers to ensure that SMI Grievances and Appeals, and Claim Disputes are effectively and efficiently adjudicated and/or resolved.
5. Continuously review SMI Grievance and Appeal System data to identify trends and opportunities for system improvement; take action to correct identified deficiencies; and otherwise implement modifications which improve SMI Grievance and Appeal System operations and efficiency.
6. Shall have professional, paraprofessional, and clerical/administrative resources necessary to represent the Contractor's, subcontractor's and/or provider's interests for Grievance and Appeal System cases that rise to the level of an administrative or judicial hearing or proceeding, except for a claim dispute. In the event of a claim dispute, the Contractor and the claimant are responsible to provide the necessary professional, paraprofessional and administrative resources to represent each of its respective interest. Absent written agreement to the contrary, the Contractor shall be responsible for payment of attorney fees and costs awarded to a claimant in any administrative or judicial proceeding.
7. Provide AHCCCS with any SMI Grievance and Appeal System information, report or document within the time specified within AHCCCS' request.
8. Fully cooperate with AHCCCS in the event AHCCCS decides to intervene in, participate in or review any Notice, SMI Grievance, SMI Appeal, or Claim Dispute or any other Grievance and Appeal System process or proceeding. The Contractor shall comply with or implement any AHCCCS directive within the time specified pending formal resolution of the issue.
9. Regularly review SMI Grievance and Appeal System data to identify members that utilize Grievance and Appeal System processes at a significantly higher rate than others.
10. Conduct a review and take any clinical interventions, revisions to service planning or referrals to the member's Case Manager as indicated when the data shows that a particular member is an outlier by filing repetitive grievances and/or appeals. See also, AMPM Policy 320-O.
11. Submit quarterly reports to AHCCCS, in a prior-approved format, of SMI grievances, SMI Appeals, and Claim Disputes as specified in Contractor Chart of Deliverables.

SMI Grievances: The Contractor shall develop and maintain an SMI Grievance process as delineated in A.A.C. Title 9, Chapter 21, Article 4 that supports the protection of the rights of members determined with an SMI designation and has mechanisms to correct identified deficiencies on both an individual and systemic level. The Contractor shall require SMI Grievance investigators to be certified by Council on Licensure, Enforcement and Regulation (CLEAR) or by an equivalent certification program approved by AHCCCS.

SMI Appeals: The Contractor shall implement all SMI appeal processes as delineated in A.A.C. Title 9, Chapter 21, Article 4 in a manner that offers appellants an opportunity to present an appeal in person at a convenient time and location for the member, and provide the privacy required by law. The Contractor shall require all staff facilitating in-person SMI appeal conferences to have training in mediation, conflict resolution or problem solving techniques.

Claim Disputes: The Contractor shall implement provider claim dispute standards and processes in the same manner as delineated in the Title XIX Contract YH18-0001 Attachment F2, Provider Claim Dispute Standards and A.A.C. R9-34 Article 4.

4. COMPENSATION

AHCCCS does not intend to prospectively provide funding nor pay on a Per Member Per Month (PMPM) capitation payment basis for services provided related to this Non-Title XIX Contract. AHCCCS intends to reserve a portion of Non-Title XIX SMI General Fund dollars for the Contractor for the provision of services under this Non-Title XIX Contract. The Contractor will access funding through AHCCCS on a cost reimbursement basis including an administrative add on component equivalent to the bid Title XIX administrative percentage. The specific methodology through which reimbursement will be conducted is to be determined by AHCCCS and will be communicated to the Contractor prior to the effective date of the Contract.

AHCCCS shall make payments to the Contractor that are conditioned upon the availability of funds authorized, appropriated and allocated to AHCCCS for expenditure in the manner and for the purposes set forth in this Non-Title XIX Contract.

The Contractor is not responsible for the provision of services in excess of the reserved portion of funds set aside for Non-Title XIX SMI services. Likewise, AHCCCS shall not be responsible for payment to the Contractor for any purchases, expenditures or subcontracts made by the Contractor in excess of reserved funding as communicated by AHCCCS.

The Contractor shall reimburse AHCCCS immediately upon demand all funds not expended in accordance with the terms of this Non-Title XIX Contract as determined by AHCCCS or the Arizona Auditor General.

AHCCCS does not reimburse the Contractor for any Health Insurer Fee payments on Non-Title XIX revenue. Funding is not available for room and board, housing acquisition, or renovation of housing stock.

Non-Title XIX payments are not subject to premium tax.

Profit Limit for Non-Title XIX Funds: There is no allowance for profit on the reserved funds related to this Non-Title XIX Contract.

Other Funding: At its sole discretion, AHCCCS may notify the Contractor in writing of an offer to become a sub-recipient of a Future Grant and the requirements of a Future Grant as outlined in RFP Section J, Paragraph 1, Purpose, Applicability, and Introduction.

5. MEDICARE SERVICES AND COST-SHARING

The Contractor shall utilize State only funds for payment of Medicare Part D copayments for medications on the AHCCCS Behavioral Health Drug List for dual eligible members. Such copayments are limited to coverage of medications prescribed by and obtained from in-network providers.

The Contractor shall utilize State only funds for coverage of behavioral health medications during the Medicare Part D coverage gap.

If a request for a medication has been denied by the Medicare Part D plan and the denial has been upheld through the appeals process, the Contractor may elect to utilize State only funds to cover the cost of the non-covered behavioral health Part D medication.

6. ENCOUNTER DATA REPORTING

Submitted encounters for Non-Title XIX services must be submitted in the same manner and timeframes as described in the AHCCCS Encounter Manual.

[END OF SECTION J: NON-TITLE XIX CONTRACT PROVISION]

SECTION J: CONTRACTOR CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor’s responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM Arizona Time on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM Arizona Time on the next business day.

If a Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference /Policy	Send To	Submitted Via
BEHAVIORAL HEALTH GRIEVANCE AND APPEALS	Quarterly	Serious Mental Illness (SMI) Grievance, Appeal Member Grievances/Complaints and Provider Claims Dispute Report	30 days after quarter end	Grievance and Appeal System Requirements	Paragraph 3	N/A	Office Chief, BH Grievance and Appeals	FTP server with email notification

ENDNOTES

The Contract language associated with the endnotes below is incorporated into the Contract pursuant to CMS contract Managed Care compliance requirements.

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