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

SECTION A. CONTRACT AMENDMENT

AMENDMENT NUMBER:	**CONTRACT NUMBER**:	**EFFECTIVE DATE OF AMENDMENT**:	**PROGRAM**:
43	AHCCCS # **YH6-0014** DES # **E 2005004**	April 1, 2013	ALTCS/DDD

CONTRACTOR'S NAME AND ADDRESS:

Sherri Wince, ALTCS Liaison
DES/DDD, Site Code 791-A
Arizona Department of Economic Security
1789 W. Jefferson Street
Phoenix, AZ 85007

PURPOSE OF AMENDMENT: To amend the Contract for the term April 1, 2013 through June 30, 2013 and to amend Section B, Capitation Rates and Contractor Specific Information, Section C, Definitions, Section D, Program Requirements.

The contract referenced above is amended as follows:

A. **Section B, Capitation Rates and Contractor Specific Information**

Capitation rates have been revised for the period of April 1, 2013 through June 30, 2013.

B. **Section C, Definitions**

C. **Section D, Program Requirements**:

Paragraph 10, *Covered Services* and Paragraph 58, *Reinsurance*

Please refer to the individual Contract sections for specific changes.

Note: Please sign, date and return executed file by E-Mail to: Meggan Harley at meggan.harley@azahcccs.gov Contracts Manager, AHCCCS Contracts & Purchasing and P.J. Schoenstene at pj.schoenstene@azahcccs.gov, Contracts, Division of Health Care Management

EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT. IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.

CONTRACTOR: DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES SIGNATURE OF AUTHORIZED REPRESENTATIVE:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM SIGNATURE OF AHCCCS CONTRACTING OFFICER:
TYPED NAME: **ELIZABETH G. CSAKI, CPPB**	TYPED NAME: **MICHAEL VEIT**
TITLE: **PROCUREMENT MANAGER**	TITLE: **CONTRACTS & PURCHASING ADMINISTRATOR**
DATE:	DATE:

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SECTION B - CAPITATION RATES and CONTRACTOR SPECIFIC INFORMATION

DES/DDD shall provide services as described in this contract. In consideration for the provision of services, DES/DDD will be paid as shown below for the term April 1, 2013 through June 30, 2013.

CAPITATION RATES
(Per Member Per Month)

DDD Rate

A. Long Term Care	$ 3,125.69
B. Behavioral Health	$ 120.67
C. Targeted Case Management Rate	$ 106.60

Stated rates are payable to DES/DDD until such time new rates are established as described in Section D, Paragraph 56, Compensation and Paragraph 57, Annual Submission of Budget.

SECTION C - DEFINITIONS

A.A.C.	Arizona Administrative Code. State regulations established pursuant to relevant statutes. Referred to in Contract as "AHCCCS Rules".
ABUSE (OF MEMBER)	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.
ABUSE (BY PROVIDER)	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
ACOM	AHCCCS Contractor Operations Manual available on the AHCCCS website at www.azahcccs.gov
ADHS	Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
ADJUDICATED CLAIM	Claims which have been received and processed by the Program Contractor which resulted in payment or denial of payment.
ADMINISTRATION	The Arizona Health Care Cost Containment System Administration, its agents, employees, and designated representatives, as defined in 9 A.A.C. 22, Article 1.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS	Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person, as defined in A.R.S. § 36-2902, et seq.
AIHP	The American Indian Health Program that delivers health care to the eligible American Indian population living on reservations through the Indian Health Service (IHS). Formerly known as AHCCCS IHS FFS Program
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by A.R.S. § 36-2932.
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.
AMPM	AHCCCS Medical Policy Manual available on the AHCCCS website at www.azahcccs.gov.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.

AT RISK	Refers to the period of time that a member is enrolled with a contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.
A.R.S.	Arizona Revised Statutes.
BBA	The Balanced Budget Act of 1997
BIDDERS' LIBRARY	A repository of manuals, statutes, rules and other reference material referred to in this document, located on the AHCCCS website at www.azahcccs.gov.
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
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 counties, due to service availability or distance. (R9-22-201.F, R9-22-201.G, R9-22-101.B)
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. § 36-2931 and 36-2942.
CATS	Client Assessment and Tracking System, 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 DES/DDD.
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.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services which administers the Medicare, Medicaid and State Children's Health Insurance Program.
CYE	Contract Year Ending; Corresponds to federal fiscal year (Oct. 1 through Sept. 30). For example, Contract Year 01 is 10/1/00 - 9/30/01.
CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with stated contract requirements, AHCCCS statute and rules and federal laws and regulations as defined in ARS 36-2901.
CONVICTED	A judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.
CO-PAYMENT	A monetary amount specified by the Director that the member pays directly to a contractor or provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 1.

COST AVOIDANCE	The process of identifying and utilizing all sources of first or third party benefits before services are rendered by DES/DDD or before payment is made by DES/DDD. (This assumes DES/DDD can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party contracted provider renders the service so that DES/DDD is only liable for coinsurance and/or deductibles.)
COVERED SERVICES	The health and medical services to be delivered by the DES/DDD as defined in 9 A.A.C. 28, Article 2; A.A.C. 31, Article 2, Section D of this contract and the AMPM. [42 CFR 438.210(a)(4)]
CRS	A program administered by the AHCCCS CRS Contractor. The CRS Contractor provides services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS covered services as specified in 9 A.A.C.7.
CRS RECIPIENT	An individual who has completed the CRS application process and has met all applicable criteria to be eligible to receive CRS covered Services.
DAYS	Calendar days unless otherwise specified.
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 Program Contractor pursuant to this contract.
DES/DDD	Department of Economic Security/Division of Developmental Disabilities.
DD	A person with a developmental disability.
DIRECTOR	The Director of AHCCCS.
DISENROLLMENT	The discontinuance of a member's ability to receive covered services through a contractor.
DME	Durable medical equipment, is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury as defined in 9 A.A.C. 22, Article 1.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's (or, with respect to a pregnant woman, the health of the woman or her unborn child) health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. (42 USC 13960-2) [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 438.10(a)]
ENROLLMENT	The process by which an eligible person becomes a member of a contractor's plan as defined by 9 A.A.C. 28, Article 4.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment services for eligible persons or members less than 21 years of age as defined in 9 A.A.C. 22, Article 2.
FFS	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
FFP	Federal financial participation (FFP) refers to the contribution that the federal government makes to the Title XIX and Title XXI programs portion of AHCCCS as defined in 42 CFR 400.203.
FQHC	Federally Qualified Health Center, an entity which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
FQHC LOOK-ALIKE	This is an organization that meets all of the eligibility requirements of an organization that receives a Public Health Service Section 330 Grant (FQHC), but does not receive grant funding. AHCCCS requires Contractors to credential providers employed by an FQHC Look-Alike through the temporary or provisional credentialing process.
FIRST PARTY LIABILITY	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by AHCCCS, a contractor, or member.
FFY	Federal Fiscal Year, October 1 through September 30.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law, as defined in 42 CFR 455.2.
FREEDOM TO WORK	Eligible individuals under the Title XIX expansion program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria; whose earned income, after allowable deduction, is at or below 250% of the FPL and who are not eligible for any other Medicaid program.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the state fair hearing system.
GSA	Geographic Service Area, 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. 28, Article 1. For the purposes of this agreement, GSA may be defined as District, when appropriate.
HCBS	Home and community-based services, as defined in A.R.S. § 36-2931 and 36-2939.

HIPAA	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996.
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a: health care institution defined in ARS § 36-401; residential care institution defined in ARS § 36-401; community residential facility defined in ARS § 36-551; or behavioral health service facility defined in A.A.C. 20, Article 1.
IBNR	Incurred But Not Reported liabilities, for services rendered for which claims have not been received.
IHS	Indian Health Service, authorized as a federal agency pursuant to 25 U.S.C. 1661.
LIABLE PARTY	A person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
LIEN	A legal claim filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality and medical management and the coordination of care.
MANAGEMENT SERVICE AGREEMENTS	A type of subcontract agreement with an entity in which the owner of the Program Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Program Contractor.
MANAGEMENT SERVICES SUBCONTRACTOR	A person or organization who agrees to perform any administrative service for DES/DDD related to securing or fulfilling DES/DDD's obligations to AHCCCS under the terms of the contract.
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.
MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MAJOR UPGRADE	Any upgrade or changes that may result in a disruption to the following: Loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MEDICAID	A federal/state program authorized by Title XIX of the Social Security Act, as

	amended.
MEDICAL MANAGEMENT (MM)	Is an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICARE	A federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
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.
NPI	National Provider Identifier assigned by the CMS contracted national enumerator.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. § 36-2939 and A.R.S. §36-2981 who does not have a subcontract with an AHCCCS contractor.
PAS	Pre-admission screening; is 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.
PAY AND CHASE	Recovery method used by DES/DDD to collect from legally liable first or third parties after DES/DDD pays the member's medical bills. The service may be provided by a contracted or non-contracted provider. Regardless of who provides the service, pay and chase assumes that DES/DDD will pay the provider, then seek reimbursement from the first or third party.
PCP	Primary Care Provider/ Practitioner, an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's or eligible person's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
PIP	Performance Improvement Project, formerly referred to as Quality Improvement Project (QIPs)
PMMIS	AHCCCS' Pre-paid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location. [42 CFR 438-114(a)]
POTENTIAL ENROLLEE	A Medicaid eligible recipient who is not enrolled with a contractor [42 CFR 438.10(a)].
QMB	Qualified Medicare Beneficiary**,** a person, eligible under A.R.S. §36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB, who is also eligible for Medicaid, is commonly referred to as a QMB dual

	eligible.
REINSURANCE	A risk-sharing program provided by the AHCCCS to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a monetary threshold, as defined in 9 A.A.C. 22, Article 1.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence DES/DDD, or a party that is, or may be, controlled or significantly influenced by DES/DDD. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RFP	The Request For Proposals, a document prepared by AHCCCS that describes the services required and that instructs prospective Offerors how to prepare a response (proposal), as defined in 9 A.A.C. 22, Article 1.
RBHA	Regional Behavioral Health Authority, an organization under contract with ADHS to administer covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a tribal regional behavioral health authority (TRBHA) for the provision of behavioral health services to American Indian members living on-reservation.
RBUC	Reported But Unpaid Claims; Liability for services rendered for which claims have been received but not paid.
RHC	Rural Health Clinic, a clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of DHHS as medically underserved or having insufficient number of physicians, which meets the requirements under 42 CFR 491.
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 residential setting (e.g. Assisted Living Home, Behavioral Health Level 2) or an apartment like setting that may provide meals.
SERVICE LEVEL AGREEMENT	A type of agreement with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Program Contractor specifically related to fulfilling the Program Contractor's obligations to AHCCCS under the terms of this contract.
SFY	State Fiscal Year, July 1 through June 30.
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that generally required by members.
STATE	The State of Arizona.
STATE PLAN	The written agreement between the State of Arizona and CMS which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.

SUBCONTRACT	An agreement entered into by a contractor with any of the following: a provider of health care services who agrees to furnish covered services to a member or with any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to fulfilling the contractor's obligations to the AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22, Article 1.
SUBCONTRACTOR	(1) A provider of health care who agrees to furnish covered services to members. (2) A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.
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 disabled and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY	See Liable Party.
TITLE XIX	Means Medicaid as defined in 42 U.S.C. 7.19.
TITLE XIX MEMBER	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
VENTILATOR DEPENDENT	For the purposes of ALTCS eligibility, an individual who is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, ICF MR residing in their own home or a HCBS approved alternative residential setting for 30 consecutive days, as defined in 9 A.A.C. 28, Article 1.
638 TRIBAL FACILITY	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.

[END OF DEFINITIONS]

SECTION D - PROGRAM REQUIREMENTS

1. PURPOSE AND APPLICABILITY:

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

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) DES/DDD shall comply with the requirements of the contract as amended, unless the AHCCCS Administration and DES/DDD otherwise stipulate in writing.

2. INTRODUCTION

AHCCCS' Mission and Vision

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

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

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

ALTCS Guiding Principles

- *Member-centered case management*
  The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.
- *Consistency of services*
  Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and DES/DDD.
- *Accessibility of network*
  Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed by DES/DDD to meet member's needs which are not limited to normal business hours.

- *Most integrated setting*
  Members are to be maintained in the most integrated setting that is medically necessary and appropriate. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- *Collaboration with stakeholders*
  The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

3. ENROLLMENT AND DISENROLLMENT

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

DES/DDD may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. If an applicant or member is or would meet the DES/DDD criteria but does not cooperate with DES/DDD, the applicant or member cannot be assessed for ALTCS eligibility as an EPD applicant.

DDD/DES will provide AHCCCS with access to FOCUS in order for the AHCCCS to determine the developmental disability status of an ALTCS member/recipient.

The effective date of enrollment with DES/DDD shall be retroactive to the effective date of ALTCS DD eligibility except when a member is enrolled with an acute health plan at the time of the ALTCS decision of approval. When this occurs, enrollment with DES/DDD will become effective the date the ALTCS enrollment action is processed by PMMIS (referred to as the "PMMIS update"). The disenrollment from the acute health plan will be effective the day before the DES/DDD effective enrollment date. Disenrollment from DES/DDD takes effect per the Division of Member Services Eligibility Policy Manual.

DES/DDD must continue to provide services until disenrollment from DES/DDD becomes effective. This includes reinstatement of ALTCS eligibility and DES/DDD enrollment pending a decision on the member's eligibility appeal with AHCCCS. Services must be continued whether or not DES/DDD has determined that the member no longer meets DES/DDD eligibility requirements.

4. RESERVED

5. RESERVED

6. RESERVED

7. RESERVED

8. TRANSITION ACTIVITIES

Member Transition:
DES/DDD shall comply with the AMPM and the ACOM Policy 402 for member transitions between Contractors, to or from an AHCCCS Contractor, upon eligibility termination and upon termination or expiration of a contract. Also, see Paragraph 3, Enrollment and Disenrollment. DES/DDD shall develop and implement policies and procedures, which comply with AHCCCS policy to address transition of all ALTCS members. The Enrollment Transition Information form must be completed for all ALTCS members and transmitted to the receiving Contractor. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

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

1. Home-based members with 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, medical supplies, transportation, 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 NICU after birth;
5. Members who frequently contact AHCCCS, state and local officials, the Governor's Office and/or the media;
6. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

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

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

Members who transition from a Contractor to DES/DDD are considered newly enrolled. Initial contact and on-site visit timeframes as specified in AMPM Chapter 1600 shall apply.

Other Transition Activities: When an ALTCS member resides in an AHCCCS registered setting with no contract at the time of enrollment, DES/DDD must give at least 7 days advance written notice advising the member that he or she must move to a facility contracting with DES/DDD. 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, DES/DDD should compensate the registered non-contracting provider's service rates or another reasonable alternative payment method until the member can be transferred.

9. AHCCCS GUIDELINES, POLICIES and MANUALS

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS website located at www.azahcccs.gov. DES/DDD is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS rules, Statutes and other resources are also available to all interested parties through the AHCCCS website. Upon adoption by AHCCCS, updates will be made available to DES/DDD. DES/DDD shall be responsible for implementing and maintaining current copies of updates.

10. COVERED SERVICES

DES/DDD shall, at a minimum, be responsible for providing the following acute, long term, behavioral health and case management services in accordance with the AHCCCS Medical Policy Manual *(*AMPM*)*, AHCCCS Behavioral Health Services Guide, ACOM, and as approved by the AHCCCS Director [42 CFR 438.210(a)(1)][42 CFR 438.210(a)(4) and 438.224]. DES/DDD must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the service is furnished. [42 CFR 438.210(a)(3)(i)(iii)] DES/DDD may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the enrollee. [42 CFR 438.210(a)(3)(ii)] DES/DDD 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.

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

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

DES/DDD must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. Notification must be submitted prior to entering into a contract with AHCCCS or prior to adopting the policy during the term of the contract [42 CFR 438.102(a)(2) and (b)(1)]. Members must be notified on how to access the services. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to members during their initial appointment, and must be provided to members at least 30 days prior to the effective date of the policy.

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

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

Notice of Action: DES/DDD must notify the requesting provider, and give the member written notice of any decision by DES/DDD 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, or for any action as defined in Attachment B(1). [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 Attachment B (1). [42 CFR 438.210(c)] DES/DDD must comply with all decision timelines outlined in ACOM Policy 414.

ACUTE CARE SERVICES

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

Anti-hemophilic Agents and Related Services: DES/DDD shall provide services for the treatment of hemophilia, and Von Willebrand's disease (See also ¶58, Reinsurance, *Catastrophic Reinsurance*).

***Audiology*:**
DES/DDD 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.

***American Indian Health Program (AIHP)*:** AHCCCS will reimburse claims on a FFS basis for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided to Title XIX members enrolled with the Contractor in an IHS or a 638 tribal facility. Encounters for Title XIX services in IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

***Behavioral Health*:** DES/DDD shall provide behavioral health services to all members, including Acute Care Only members, as described in Section D, Paragraph 12, Behavioral Health Services. Services are described in detail in the AMPM and the AHCCCS Behavioral Health Services Guide available on the AHCCCS website, at: http://www.azahcccs.gov/commercial/shared/BehavioralHealthServicesGuide.aspx

Children's Rehabilitative Services (CRS): See Section D, Paragraph 13, Children's Rehabilitative Services.

Chiropractic Services: DES/DDD shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by DES/DDD in order to ameliorate the member's medical condition. Medicare approved chiropractic services for any member shall also be covered, subject to limitations specified in 42 CFR 410.22, for Qualified Medicare Beneficiaries, regardless of age, if prescribed by the member's PCP and approved by DES/DDD.

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

***Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*:** DES/DDD shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings for members under age 21. DES/DDD shall ensure that these members receive required health screenings, including developmental and behavioral health screenings, in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule (Exhibit 430-1 in the AMPM).

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention: DES/DDD 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, HIV/AIDS, breast cancer, cervical cancer, and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the over- and under- 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 Arizona Administrative Code Section R9-22-205. AHCCCS does not cover well exams (i.e. physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examinations) for adult members.

Emergency services: DES/DDD shall have and/or provide emergency services per the AHCCCS AMPM Policy and the following as a minimum:

a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, 7-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule 9 A.A.C. 22, Article 1. Emergency medical services are covered without prior authorization. DES/DDD is encouraged to contract with emergency service facilities for the provision of emergency services. DES/DDD shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies. DES/DDD shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
b. All medical services necessary to rule out an emergency condition; and
c. 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:

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

DES/DDD 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 DES/DDD (an employee or subcontracting provider) instructs the member to seek emergency medical services.

Additionally, DES/DDD 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 DES/DDD of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claim submissions by the hospital within 10 calendar days of the member's presentation for emergency services constitutes notice to DES/DDD. 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 DES/DDD 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. DES/DDD shall comply with Medicaid Managed Care guidelines regarding the coordination of post-stabilization care.

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

Family Planning: DES/DDD shall provide family planning services in accordance with the AMPM, and consistent with the terms of the 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 DES/DDD does not provide family planning services, it must contract for these services through another health care delivery system.

Foot and Ankle Services-Children: DES/DDD shall provide foot care services for members under the age of 21 to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a nonprofessional person.

Foot and Ankle Services-Adults: DES/DDD shall provide foot and ankle services to include wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional person as described in the AMPM. Services are not covered for members 21 years of age and older, when provided by a podiatrist or podiatric surgeon.

Hospital: Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health emergency/crisis services. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. Outpatient services include any of the above services, which may be appropriately provided on an outpatient or ambulatory basis (i.e. laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis if determined reasonable and necessary 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 AHCCCS Medical Policy Manual for limitations on hospital stays.

Immunizations: DES/DDD shall provide medically necessary immunizations for adults (21 years of age and older Human Pappiloma virus (HPV) is covered only for EPSDT aged male and female members (through age 20) (Please refer to the AMPM for current immunization requirements.) (See also Section D Paragraph 62 Pediatric Immunizations and the Vaccine for Children Program).

Incontinence Supplies: DES/DDD shall cover incontinence supplies as specified in AHCCCS Rule A.A.C.R9-22-212 and the AMPM.

Laboratory: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a CLIA (Clinical Laboratory Improvement Act) approved free standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory.

Upon written request, DES/DDD may obtain laboratory test data on members from a laboratory or hospital based laboratory subject to the requirements specified in ARS § 36-2903 (Q) and (R). The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by the Administration.

Maternity: DES/DDD shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners or certified 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 DES/DDD, and DES/DDD has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by a certified nurse midwife or a licensed midwife, if they are in DES/DDD'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 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 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.

DES/DDD shall allow women and their newborns to receive 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. However, for payment purposes, inpatient limits will apply to the extent consistent with EPSDT.

DES/DDD shall inform all ALTCS DES/DDD enrolled pregnant women of voluntary HIV testing and the availability of counseling if the test is positive. DES/DDD shall provide information in the Member Handbook to encourage pregnant women to be tested and instructions on where to be tested. DES/DDD shall report to AHCCCS, Division of Health Care Management, the number of pregnant women who have been identified as HIV/AIDS positive for each quarter during the contract year. This report is due no later than 30 days after the end of the quarter.

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

Medical Supplies, Durable Medical Equipment (DME), Orthotic and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist 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 may be conducted as a part of the EPSDT screenings for members under age 21, and to assist ALTCS members 21 years of age and older whose health status may improve with over- and under- nutritional intervention. Assessment of nutritional status on a periodic basis may be provided as

determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. ALTCS covers nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary, 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: DES/DDD shall provide all members under the age of 21 with all medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services, and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule DES/DDD shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. DES/DDD is required to meet specific utilization rates for members as described in Section D, Paragraph 20, Performance Standards. DES/DDD shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from DES/DDD's provider network.

Pursuant to A.A.C. R9-22-207, for members who are 21 years of age and older, the Contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist. These services would be considered physician services if furnished by a physician. Limited dental services are covered for pre-transplant candidates and for members with cancer of the jaw, neck or head. Refer to the AMPM for specific details.

Orthotics: These services are covered for members under the age of 21 when prescribed by the member's PCP, attending physician, practitioner, or by a dentist as described in the AMPM. 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: DES/DDD shall provide physician services to include medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians.

Post-stabilization Care Services Coverage and Payment: Pursuant to AHCCCS Rule A.A.C.R9-22-210 and 42 CFR 438.114, 422.113(c) and 422.133, the following conditions apply with respect to coverage and payment of emergency and post-stabilization care services, except where otherwise noted in contract:

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

1. Post-stabilization care services that were pre-approved by DES/DDD; or,
2. Post-stabilization care services were not pre-approved by DES/DDD because DES/DDD 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. DES/DDD representative and the treating physician cannot reach agreement concerning the enrollee's care and a contractor physician is not available for consultation. In this situation, DES/DDD 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), DES/DDD financial responsibility for post-stabilization care services that have not been pre-approved ends when:

1. A DES/DDD physician with privileges at the treating hospital assumes responsibility for the member's care;
2. A DES/DDD physician assumes responsibility for the member's care through transfer;
3. A DES/DDD 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 DES/DDD's Medical Director, and meet the requirements specified in the AMPM. The Certificate must certify that, in the physician's professional judgment, one or more of the previously mentioned criteria have been met.

Prescription Medications: Medications ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, DES/DDD formularies and prior authorization requirements. An appropriate over the counter (OTC) medication may be prescribed as defined in the AMPM when it is determined to be a lower cost alternative to a prescription medication.

> Medicare Part D: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the DES/DDD'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 excluded drugs and will not be covered by AHCCCS. This applies to members that are enrolled in Medicare Part D or are eligible for Medicare Part D. (See AMPM Chapter 300, Section 310-V)

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

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

Rehabilitation Therapy: DES/DDD shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation. Outpatient Physical Therapy for members 21 years of age or older are subject to a 15 visit limit per contract year as described in the AMPM.

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

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

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

Triage/ Screening and Evaluation: These are covered services when provided by acute care hospitals, IHS facilities, a PL 93-638 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 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/Optometry**:** DES/DDD shall provide all medically necessary emergency eye care, 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, cataract removal, and/or medically necessary vision examinations and prescriptive lenses if required following cataract removal and other eye conditions as specified in the AMPM.

Members shall have full freedom to choose, within DES/DDD'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.

LONG TERM CARE SERVICES

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

Attendant Care: A service provided by a trained attendant (see ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care 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, companionship, socialization and skills development. Attendant care services are not considered duplicative of hospice services. See AMPM Chapters 1200 and 1600 for requirements pertaining to Spouses as Paid Caregivers, a service option under Attendant Care.

Community Transitional Services: A service to assist ALTCS institutionalized members to reintegrate into the community by providing financial assistance to move from an ALTCS institutional setting to their own home or apartment. Members moving from an ALTCS institutional setting to an alternative residential 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.

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

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

Homemaker: Assistance in the performance of routine household activities such as shopping, cooking, running errands, etc. (see ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care training requirements)

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

Hospice: A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with DES/DDD. DES/DDD is 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 should not be provided. If, however, the hospice agency is unable to provide or cover medically necessary services DES/DDD must provide the services. Attendant care services are not considered duplicative.

Personal Care: A 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 Attendant Care, Homemaker and Personal Care training requirements)

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

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

LONG TERM CARE - INSTITUTIONAL SETTINGS

Level 1 Psychiatric Acute Hospital: A behavioral health service facility licensed by ADHS, as defined in 9 A.A.C. 20, to provide continuous treatment to an individual who is experiencing a behavioral health issue that causes the individual to be a danger to self, a danger to others, or gravely disabled; or to suffer severe and abnormal judgment, reason, behavior, or the capacity to recognize reality. Some Level I facilities are IMDs.

Institution for Mental Disease (IMD)*:* A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Office of Behavioral Health Licensure licensed Level I facilities with more than 16 beds are considered IMDs. Reimbursement for services provided in an IMD to Title XIX persons age 21 through 64 years is not available. For Title XIX members under age 21 and 65 years of age or over, there is no benefit limitation. A Title XIX member who is receiving services in an

IMD who turns 21 may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. AHCCCS provider types B6 and 71 are IMDs.

Level 1 Residential Treatment Center (Available to Title XIX members under 21 years of age): Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A Title XIX member who is receiving services in an inpatient psychiatric facility considered to be an IMD who turns 21, may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. Some Level 1 Treatment Centers are IMDs.

Level 1 Sub-Acute Facility: A behavioral health facility licensed by ADHS as defined by 9 A.A.C. 20, to provide continuous treatment to a person who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Some Level 1 Sub-Acute Facilities are IMDs.

Intermediate Care Facility for Persons with Intellectual Disability (ICF): A facility whose primary purpose is to provide health, habilitative and rehabilitative services to individuals with intellectual disabilities.

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

LONG TERM CARE - HCBS ALTERNATIVE RESIDENTIAL SETTINGS

Under the Home and Community-Based Services program, members may receive certain services while they are living in their own home. (See Section C for a definition of "home".) In addition, there are other alternative HCBS settings as defined in 9 A.A.C. 28 Article 1 available to members. Members residing in these settings are responsible for the room and board payment. Every effort to advance a person-centered approach by promoting non-institutional, home-like settings that allows members to age in-place should be encouraged. Medicaid funds cannot be expended for room and board.

Alternative residential settings include the following:

Adult Developmental Home: An alternative residential setting for developmentally disabled adults (18 or older) which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents. Refer to A.R.S. 36.551.

Assisted Living Facilities: Residential care institutions that provide supervisory care services, personal care services or directed care services on a continuing basis. All ALTCS approved residential settings in this category are required to meet ADHS licensing criteria as defined in 9 A.A.C. 10, Article 7. Of these facilities, ALTCS has approved three as covered settings.

a. *Adult Foster Care:* An ALTCS HCBS approved alternative residential setting that provides supervision and coordination of necessary services within a family type environment for up to four adult residents.

b. *Assisted Living Home:* An ALTCS approved alternative residential setting that provides supervision and coordination of necessary services to ten or fewer residents.

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

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

Level III Behavioral Health Residential Agency: A behavioral health service agency licensed by ADHS, as defined in A.A.C. 20, to provide a residential setting with 24-hour supervision and intermittent treatment in a group setting to persons who are determined to be capable of independent functioning but still need some protective oversight.

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

Group Home for Developmentally Disabled: A community residential facility for up to six residents that provides room, board, personal care, supervision and habilitation. The DD Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs for ALTCS members who cannot physically or functionally live independently in the community. Refer to A.A.C. Title 9, Chapter 33, Article 1 and 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 Therapeutic Foster Care Home (R9-20-1501) licensed by ADHS/OBHL 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 Home (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 Foster Care Home may be larger to accommodate sibling groups.

Rural Substance Abuse Transitional Agency: An agency that provides behavioral health services to an individual who is intoxicated or has a substance abuse problem and is located in a county with a population of fewer than 500,000 individuals as defined in 9 A.A.C. 20, Article 14.

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

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

11. THERAPEUTIC LEAVE AND BED HOLD

Therapeutic leave and bed hold days are covered. Refer to the AMPM Chapter 100.

12. BEHAVIORAL HEALTH SERVICES

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

a. Behavior Management (family support/home care training, self-help/peer support)
b. Behavioral Health Case Management Services (with limitations)
c. Behavioral Health Nursing Services
d. Emergency Behavioral Health Care
e. Emergency and Non-Emergency Transportation
f. Evaluation and Assessment
g. Individual, Group and Family Therapy and Counseling
h. Inpatient Hospital Services - (DES/DDD may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.) (with limitations)
i. Level I Residential Treatment Centers and Sub-Acute Facilities
j. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
k. Opioid Agonist Treatment
l. Partial Care (Supervised day program, therapeutic day program and medical day program)
m. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
n. Psychotropic Medication
o. Psychotropic Medication Adjustment and Monitoring
p. Respite Care (with limitations)
q. Rural Substance Abuse Transitional Agency Services
r. Screening
s. Home Care Training to Home Care Client

Behavioral health needs shall be assessed and services provided in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and their family shall determine the types and intensity of services. Services should be provided in a manner that respects the member and family's cultural heritage and appropriately utilizes natural supports in the member's community.

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

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

Referrals: DES/DDD shall develop, monitor and continually evaluate its processes for timely referral, evaluation and treatment planning for behavioral health services. Requests for behavioral health services made by the family, guardian, or the member shall be assessed by DES/DDD for appropriateness within three business days of the request. If it is determined that services are needed, a referral for evaluation shall be made within one business day. A direct referral for a behavioral health evaluation may be made by the member. A direct referral for a behavioral health evaluation may be made by any health care professional in coordination with the case manager and PCP assigned to the member. Psychiatrists, psychologists, physician assistants, certified psychiatric nurse practitioners, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and licensed independent substance abuse counselors may bill independently. Other behavioral health professionals must be employed by or contracted with and bill through an AHCCCS registered behavioral health provider. DES/DDD shall ensure that all behavioral health services provided are medically necessary as determined by a qualified behavioral health professional.

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

EPSDT: DES/DDD shall ensure that PCPs screen for behavioral health needs at each EPSDT visit, and when appropriate, initiate a behavioral health referral. DES/DDD must develop a process to ensure that a referral is made when a behavioral health need is identified, and that the member is referred for appropriate medically necessary behavioral health services

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. DES/DDD 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.

DES/DDD 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. DES/DDD shall require the PCP to respond to provider information requests pertaining to behavioral health recipient 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. DES/DDD 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. DES/DDD 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 in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). For further guidance in addressing the needs of members with multi system involvement and complex behavior health and co-occurring conditions, refer to the AHCCCS AMPM Policy, Community Collaborative Care Teams, effective March 2012. When attempting to place a member in a NF or HCBS setting, the Contractor shall also disclose all information that pertains to the member's behaviors. To address members residing in a

non-behavioral health unit who present with behaviors that may be a danger to self or danger to others, in order to promote early intervention and avoid placement at an alternative setting. See AHCCCS AMPM Policy, *Management of Acute Behavioral Health Situations*. effective 10/1/11.

Quality management processes for behavioral health services must be included in DES/DDD's Quality Management Plan and shall meet the quality management requirements of AHCCCS as specified in the AMPM Chapter 900. DES/DDD must monitor to ensure that primary care physicians receive behavioral health information as established in AMPM Chapter 500, Policy 510, and AMPM Chapter 900, Policy 940. DES/DDD 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 required under this contract.

Co-morbidities: DES/DDD must ensure that members with diabetes who are being discharged from the Arizona State Hospital (AzSH) are issued the same brand and model of both glucometer and supplies they were trained to use while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

Additional Requirements: DES/DDD shall conduct an annual case review of the behavioral health care provided to its members and submit an analysis of the findings to AHCCCS no later than August 30. To meet this requirement, DES/DDD may independently perform the review, subcontract with ADHS or Regional Behavioral Health Authorities, or subcontract with a Professional Review Organization approved by AHCCCS. If applicable, DES/DDD shall have oversight responsibility to assure that the subcontractor performs the review as required and the results are accurate. DES/DDD shall ensure reviews are conducted on a sample of member records for both children and adults served for each geographic service area based on a sampling methodology approved by AHCCCS.

DES/DDD shall submit a proposed sampling methodology and case file review tool with instructions to AHCCCS for review and approval no later than 60 days prior to implementation. At a minimum, the case review should assess the following indicators or aspects of care:

a. Treatment goals are jointly established with the member, member's family, and other involved parties;
b. Individuals requiring specialty providers are referred for and receive specialty services;
c. There is evidence that behavioral health care has been coordinated with the member's PCP;
d. For persons with multi-agency involvement, treatment recommendations are collaboratively developed and implemented;
e. Individuals receive timely access to services;
f. Measures of quality outcomes.

DES/DDD shall monitor and provide feedback on all corrective action plans written as a result of the findings in the case file review to ensure improved performance.

For more information, refer to the AHCCCS Behavioral Health Services Guide that is available on the AHCCCS website at: http://www.azahcccs.gov/commercial/shared/BehavioralHealthServicesGuide.aspx

13. CHILDREN'S REHABILITATIVE SERVICES

Children's Rehabilitative Services (CRS) is a program for children with special health care needs. The CRS program is administered by AHCCCS utilizing a CRS Contractor for children who meet CRS eligibility criteria. DES/DDD shall refer children to CRS who are potentially eligible for services related to CRS covered conditions, as specified in R9-22, Article 2 and A.R.S. Title 36, Chapter 2, Article 3. In addition, the DES/DDD shall notify the member when a referral to CRS has been made. DES/DDD is responsible for care of members until those members are determined eligible by the CRS Contractor. In addition, DES/DDD is responsible for covered services for CRS eligible members unless and until DES/DDD has received written confirmation from the CRS Contractor that the CRS Contractor will provide the medically necessary, CRS

covered service. . DES/DDD shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Contractor. For detailed information regarding eligibility criteria, referral practices and Contractor CRS coordination issues, refer to the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractors' Operations Manual (ACOM) located on the AHCCCS website at www.azahcccs.gov.

DES/DDD shall respond to requests for services potentially covered by the CRS Contractor in accordance with the related ACOM and AMPM Policies. DES/DDD is responsible for addressing prior authorization requests if the CRS Contractor fails to comply with the timeframes specified in the related ACOM Policy. DES/DDD is responsible for payment of emergency department facility and professional claims (in or out of network), regardless of whether or not the service is related to the CRS condition. In addition, the Contractor remains ultimately responsible for the provision of all AHCCCS covered services denied by the CRS Contractor for the reason that it is not a service related to the CRS condition.

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

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

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

ALTCS members who are temporarily out of DES/DDD's service area may be provided long term care services while out of the service area, including HCB services. DES/DDD 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 DES/DDD are eligible for acute emergency services only. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. DES/DDD shall report all absences of more than 30 days from the state to the ALTCS eligibility office for a determination of continued eligibility as specified in The AHCCCS Eligibility Policy Manual.

DES/DDD shall submit a written request to AHCCCS Division of Health Care Management ALTCS Unit 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, DES/DDD shall arrange for home and community based placement as soon as possible, but not later than 90 days after the effective date of eligibility for the ALTCS Transitional Program.

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

DES/DDD compliance will be monitored through the AHCCCS Division of Health Care Management.

16. CASE MANAGEMENT

Case management is the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.

A case manager is a person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case managers shall not provide direct care services to members enrolled with DES/DDD, but shall authorize appropriate services and/or refer members to appropriate services.

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

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

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

a. Respect the member's rights;
b. Provide adequate information and training to assist the member/family in making informed decisions and choices;

c. Provide a continuum of service options that support the expectations and agreements established through the care plan process;
d. Facilitate access to non-ALTCS services available throughout the community;
e. Educate the member/family on how to timely report unavailability or other problems with service delivery to the DES/DDD or AHCCCS in order that unmet needs can be addressed as quickly as possible.
f. Advocate for the member and/or family/significant others as the need occurs;
g. Allow the member/family to identify their role in interacting with the service system;
h. Provide members with flexible and creative service delivery options;
i. Educate members on their option to choose their spouse as their paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs
j. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services;
k. Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member.
l. 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.

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

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

The case manager shall make initial contact and periodic placement/service reviews on-site with the member/family/significant others within appropriate timeframes established by AHCCCS policy. The purpose of these visits shall be to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers. Additionally, at these reviews the member/family/significant other shall be asked to sign a service plan that indicates whether the member/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 the action and the member's right to appeal the decision.

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

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

DES/DDD must notify AHCCCS when members are determined no longer eligible under DD criteria. AHCCCS staff will then perform an EPD PAS to see if the member meets EPD medical eligibility criteria. If so, the member will be disenrolled from DES/DDD and enrolled with an ALTCS EPD Contractor. In such situations,

DES/DDD must continue to provide services until the date of disenrollment from DES/DDD and ensure a smooth transition of the member's care to the EPD Contractor.

When screened as potentially Developmentally Disabled, an ALTCS applicant will be referred to DES/DDD for an eligibility determination. If a determination is not made within 30 days of the referral, a PreAdmission Screening (PAS) tool will be completed for medical eligibility. If the applicant meets the ALTCS eligibility criteria, the individual will be enrolled with DES/DDD. DES/DDD will then be responsible for assessing and providing for the member's needs in a timely manner until such time as the member is determined to not meet DES/DDD eligibility and is disenrolled. DES/DDD must provide notification of this determination to the local ALTCS office.

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

DES/DDD shall provide AHCCCS, within the timeline specified in Section F, Attachment D with an annual Case Management Plan. This plan shall outline how all case management and administrative standards in AMPM Chapter 1600 will be implemented and monitored by DES/DDD. The administrative standards shall include but not be limited to a description of DES/DDD's systematic method of monitoring its case management program as discussed in the following subparagraphs. The plan shall also include an evaluation of DES/DDD's Case Management Plan from the prior year, to include lessons learned and strategies for improvement.

DES/DDD 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). DES/DDD shall compile reports of these monitoring activities to include analysis of the data and a description of the continuous improvement strategies DES/DDD has taken to resolve identified issues. This information shall be made available upon request by AHCCCS.

DES/DDD shall ensure adequate staffing to meet case management requirements. DES/DDD's case management plan shall also describe their methodology for assigning and monitoring case management caseloads.

Caseload Ratios:
A 1:35 caseload ratio will be in effect for any membership above the number of enrolled members as of June 30, 2006 (17,910). AHCCCS will annually determine an average weighted caseload based on 1:40 and 1:35 case manager ratios, the membership as of June 30, 2006 and the number of members above the June 30, 2006 baseline.

If caseloads exceed the annually determined average of 1:39, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must also be sufficient to cover case manager absenteeism, turnover and out-of-state members.

17. MEMBER HANDBOOK and MEMBER COMMUNICATIONS

DES/DDD shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by DES/DDD, shall be approved by AHCCCS prior to distribution to members. The reading level and name of

the evaluation methodology used should be included. The Contractor should refer to the ACOM Policy 404 for further information and requirements

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

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

All written notices informing members of their right to interpretation and translation services in a language shall be translated when DES/DDD is aware that 1,000 or 5% (whichever is less) of DES/DDD's members speak that language and have LEP. [4 CFR 438.10(c)(3)]

Oral interpretation services must be available and free of charge to all members regardless of the prevalence of the language. DES/DDD must notify all members of their right to access oral interpretation services and how to access them. Refer to the ACOM Policy 404. [42 CFR 438.10(c)(4) and (5)]

DES/DDD shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM Policy 404. Regardless of the format chosen by DES/DDD, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. [42 CFR 438.10(b)(1) and (b)(3)] DES/DDD must notify its members that alternative formats are available and how to access them. [42 CFR 438.10(d)]

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

DES/DDD shall produce and 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)]:

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

   DES/DDD 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 within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution.

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

II. A description of DES/DDD's provider network, which at a minimum, includes those items listed in the ACOM Policy 404.

DES/DDD must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider. Affected members must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4) and (5)]. DES/DDD shall have information available for potential enrollees as described in the ACOM Policy 404.

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

- Educational information on chronic illnesses and ways to self-manage care

- Reminders of flu shots and other prevention measures at appropriate times
- Medicare Part D issues
- Cultural Competency, other than translation services
- DES/DDD specific issues (in each newsletter)
- Tobacco cessation information
- HIV/AIDS testing for pregnant women
- Other information as required by AHCCCS

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

a. An updated Member Handbook at no cost to the member
b. The network description as described in the ACOM Policy 404

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

DES/DDD 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.

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

DES/DDD 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 DES/DDD or its subcontractors treat the member. [42 CFR 438.100(c)]

18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS electronic Member Change Report provides DES/DDD 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.

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

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

20. QUALITY MANAGEMENT

DES/DDD shall provide quality medical care to members, regardless of payer source or eligibility category. DES/DDD shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement processes DES/DDD shall execute processes to monitor, assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities, as specified in the AMPM. [42 CFR 438.240(a)(1) and (e)(2) and CFR 42 447.26].

DES/DDD must ensure that the Quality Management/Quality Improvement Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Case Management. DES/DDD 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/quality improvement residing within the Quality Management Unit.

DES/DDD quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AMPM and this Paragraph. In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider –Preventable Condition (OPPC) (refer to AMPM Chapter 900 requirements). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.

A. Quality Management Program:
DES/DDD shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPM Chapter 900 and the following:

1. A written Quality Assessment and Performance improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and Quality Management Quarterly reports that address its strategies for performance improvement and conducting the quality management activities.
2. QM/PI Program monitoring and evaluation activities that include Peer Review and Quality Management Committees chaired by DES/DDD's Chief Medical Officer.
3. 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.
4. Member rights and responsibilities.

5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. DES/DDD shall demonstrate that its providers are credentialed and reviewed through DES/DDD's Credentialing Committee that is chaired by DES/DDD's Medical Director [42 CFR 438.214]. DES/DDD should refer to the AMPM and Attachment D, Chart of Deliverables, for reporting requirements. The process:
    a. Shall follow a documented process for provisional credentialing, initial credentialing, recredentialing and organizational credential verification of providers who have signed contracts or participation agreements with DES/DDD;
    b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
    c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
    a. Acknowledgement letter to the originator of the concern;
    b. Documentation of all steps utilized during the investigation and resolution process;
    c. Follow-up with the member to assist in ensuring immediate health care needs are met;
    d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns;
    e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
    f. Analysis of the effectiveness of the interventions taken.
7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).

9. Performance Improvement Programs including performance measures and performance improvement projects.

DES/DDD must have a process in place to conduct monitoring and oversight of care and services provided in the home and community based setting. Monitoring of HCBS sites may include a collaborative process involving quality management and case management staff (support coordinators), including the utilization of the case manager onsite visits with members. DES/DDD must develop a process that, at a minimum, meets the requirements specified in the AMPM Chapter 900.

B. Performance Improvement:
DES/DDD's quality management program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical care and non-clinical care that are expected to have a favorable effect on health outcomes and member satisfaction. DES/DDD must:
[42 CFR 438.240(b)(2) and (c)]:

1. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS;
2. Submit to the State data specified by the State, that enables the State to measure DES/DDD's performance; or
3. Perform a combination of these activities.

I. Performance Measures:
DES/DDD shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Complete descriptions of the AHCCCS clinical quality Performance Measures can be found in the most recently published reports of acute-care performance measures located on the AHCCCS website except for the measure titled "EPSDT Participation". AHCCCS bases the measurement of EPSDT Participation on the methodology established in CMS "Form 416," which can be found on the AHCCCS website:
(http://www.azahcccs.gov/reporting/quality/performancemeasures.aspx).

DES/DDD must comply with national performance measures and levels that may be identified and developed by the Centers for Medicare and Medicaid Services in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid programs. The current AHCCCS-established performance measures may be subject to change when these core measures are finalized and implemented.

DES/DDD must have in place a process for internal monitoring of performance measure rates, using a standard methodology established or adopted by AHCCCS, for each required performance measure. DES/DDD's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration. It also will report this performance measure data to AHCCCS in conjunction with its Quarterly EPSDT and Adult Monitoring Report.

DES/DDD must meet AHCCCS stated Minimum Performance Standards for each population for which AHCCCS reports results. However, it is equally important that DES/DDD continually improve performance measure outcomes from year to year. DES/DDD shall strive to meet the goal established by AHCCCS.

> ***Minimum Performance Standard*** – A Minimum Performance Standard (MPS) is the minimal expected level of performance by DES/DDD. If DES/DDD does not achieve this standard, DES/DDD will be required to submit a corrective action plan and may be subject to a sanction for each deficient measure.
>
> ***Goal*** – If DES/DDD has already met or exceeded the AHCCCS Minimum Performance Standard for any measure, DES/DDD must strive to meet the established Goal for the measure. However, it is

equally important that the Contractor continually improve performance measure outcomes from year to year.

DES/DDD must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on DES/DDD if it does not show statistically significant improvement in a measure rate and require that DES/DDD 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 and may sanction DES/DDD if it shows a statistically significant decrease in its rate, even if it meets or exceeds the Minimum Performance Standard.

An evidence-based corrective action plan 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 on-site reviews to verify compliance with a corrective action plan.

All Performance Measures apply to all member populations [42 CFR 438.240(a)(2), (b)(2) and (c)]. AHCCCS may analyze and report results by placement, by GSA or county, and/or applicable demographic factors.

Performance Measures

All Performance Measures described below may apply to all member populations [42 CFR 438.240(a)(2);(b)(2) and (c)]. AHCCCS may analyze and report results by placement (HCBS vs. nursing facility), GSA or county and/or applicable demographic factors.

AHCCCS has established standards for the measures listed below.

Performance Measures

EPSDT Participation	**60%**	**80%**
EPSDT Dental Participation - 3	**46%**	**54%**
Immunization of two-year-olds		
4:3:1:3:3:1:4 Series	**68%**	**80%**
4:3:1:3:3:1 Series	**74%**	**80%**
Tdap - 4 doses	**85%**	**90%**
Polio - 3 doses (*)	**90%**	**90%**
MMR - 1 dose (*)	**90%**	**90%**
Hib - 3 doses (*)	**86%**	**90%**
HBV - 3 doses (*)	**90%**	**90%**
Varicella - 1 dose (*)	**86%**	**90%**
PCV – 4 doses (*)	**82%**	**90%**
Adolescent Immunizations (2)	**54%**	**90%**
Dental Visits	**49%**	**57%**
Well-child Visits 3 - 6 Years	**52%**	**80%**
Adolescent Well-care Visits	**40%**	**50%**
Children's Access to PCPs		
12 – 24 months (5)	**85%**	**97%**
25 months – 6 years	**80%**	**97%**
7 – 11 years	**80%**	**97%**
12 – 19 years	**80%**	**97%**

Notes:

(1) Rates by Contractor for each measure will be compared with the MPS specified in the contract in effect during the measurement period. Thus, Performance Standards in the CYE 2012 contract apply to results calculated by AHCCCS based on the measurement period of CYE 2012.
(2) Goals are based on Healthy People 2010 objectives or other appropriate goals or benchmarks. Goals may be revised when Healthy People 2020 objectives become available.
(3) EPSDT Dental Participation Standards are based on the CMS-established goal that states improve their rates of children ages 1 through 20 enrolled in Medicaid or CHIP who received any preventive dental service by 10 percentage points over a five-year period.
(4) NCQA introduced a new measure of adolescent immunizations in HEDIS 2010, and national HEDIS and AHCCCS results for this measure have not been reported. The MPS is based on the National Immunization Survey (NIS) overall rate of 53.8 percent for one dose of meningococcal vaccine among 13-year-olds in 2009 (the rate for at least one dose of Td or Tdap was 70.5 percent).
(5) AHCCCS may not report rates for Children's Access to PCPs at 12 – 24 Months
(*) AHCCCS will continue to measure and report results of these individual antigens; however, the Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.

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

In addition to improving adult measures, DES/DDD must take affirmative steps to increase member participation in the EPSDT program. The EPSDT participation rate is the number of children younger than 21 years receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility.

The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. These activities will be monitored by AHCCCS during the Operational and Financial Review.

II. Performance Improvement Program:
DES/DDD shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas, as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

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

PIPs are mandated by AHCCCS, but DES/DDD may self-select additional projects based on opportunities for improvement identified by internal data and information. DES/DDD shall report the status and results of each project to AHCCCS as requested using the AHCCCS PIP Reporting Template included in the AMPM. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. [42 CFR 438.240(d)(2)]

III. Data Collection Procedures:
When requested, DES/DDD must submit data for standardized Performance Measures and/or Performance Improvement Projects as required by AHCCCS within specified timelines and according to AHCCCS procedures for collecting and reporting data. DES/DDD is responsible for collecting valid and reliable data,

including data collected by subcontracted acute-care health plans, and for using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or Performance Improvement Projects must be returned by DES/DDD in the format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on DES/DDD.

21. MEDICAL MANAGEMENT

DES/DDD 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 Report and Prior Authorization Requirements report as specified in the AMPM and Attachment D of this contract. The Contractor shall evaluate Medical Management (MM) activities, as specified in the AMPM Chapter 1000, including:

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer.
2. Prior authorization and Referral Management; for the processing of requests for initial and continuing authorizations of services DES/DDD shall:
    a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
    b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
    c. Monitor and ensure that all enrollees with special health care needs have direct access to care;
    d. Review all prior authorization requirements for services, items or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements; and
    e. Comply with all decision timelines as outlined in the ACOM and the AMPM.
3. Development and/or Adoption of Practice Guidelines [42 CFR 438.235(b)], that:
    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
    b. Consider the needs of DES/DDD's members;
    c. Are adopted in consultation with contracting health care professionals;
    d. Are reviewed and updated periodically as appropriate, but at least annually;
    e. Are disseminated by DES/DDD to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].
4. Concurrent review:
    a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services and other areas to which the guidelines apply [42 CFR 438.236(d)];
    b. Contractors must have policies and procedures for proactive discharge planning. The intent of discharge planning is to increase utilization management of inpatient admissions and decrease readmissions.
5. Continuity and coordination of care:
    a. Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
    b. Establish a process for timely and confidential communication of clinical information among providers;
    c. Must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.

6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438.240(b)(3)].
7. Evaluation of new medical technologies and new uses of existing technologies.
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee.

DES/DDD shall have a process to report MM data and management activities through a MM Committee. DES/DDD's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. DES/DDD shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438240(b)(4)].

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

DES/DDD shall maintain a written MM plan and a workplan that addresses monitoring MM activities (AMPM Chapter 1000). The plan and workplan must be submitted for review by AHCCCS, Division of Health Care Management (DHCM) within timelines specified in Attachment D.

22. GRIEVANCE SYSTEM

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

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

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

DES/DDD will provide reports on the Grievance System as required in the Grievance System Reporting Guide available on the AHCCCS website at http://www.azahcccs.gov.

23. RESERVED

24. RESERVED

25. STAFF REQUIREMENTS AND SUPPORT SERVICES

DES/DDD shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, DES/DDD 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)]. DES/DD is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of any individuals. The database can be accessed at http://www.oig.hhs.gov/fraud/excusions.asp.

DES/DDD must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. DES/DDD'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, including the requirement for providing culturally competent services. If the DES/DDD does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS, including but not limited to requiring DES/DDD to hire additional staff and actions specified in Section D, Paragraph 80, Sanctions, of the Contract.

DES/DDD shall have staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies (for example ADHS Licensure) on urgent issue resolutions, such as in the case of an Immediate Jeopardy (IJ) fires, or other public emergency situations. These staff person(s) shall have access to information necessary to identify members who may be at risk, their current health/service status, ability to initiate new placements/services, and to be available to perform status checks at affected facilities and potentially ongoing monitoring, if necessary. DES/DDD shall supply AHCCCS CQM with the contact information for these staff persons, such as a telephone number, to contact in these urgent situations.

DES/DDD must obtain approval from AHCCCS prior to moving functions outside the State of Arizona. Such a request for approval must be submitted to the Division of Health Care Management at least 60 days prior to the proposed changes in operations and must include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance.

DES/DDD 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.

An individual staff member is limited to occupying a maximum of two Key Staff positions listed below unless prior approval is obtained by AHCCCS, Division of Health Care Management. DES/DDD shall inform the Division of Health Care Management, in writing within seven days, when an employee leaves one of the **Key Staff** positions listed below (this requirement does not apply to Additional Required Staff, also listed below). The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff time allocation. Each year on July 15th, the Contractor must provide the name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as a, b and c below to the Office of the Inspector General (OIG). AHCCCS will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42 CFR 455.104].
At a minimum, the following staff is required:

Key Staff Positions

a. **Administrator/CEO/COO** or their designee must be available during working hours to fulfill the responsibilities of the position and to oversee the entire operation of DES/DDD. The Administrator shall devote sufficient time to DES/DDD's operations to ensure adherence to program requirements and timely responses to the AHCCCS.
b. **Medical Director/CMO** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all major clinical and QM and MM components of DES/DDD. The Medical Director shall devote sufficient time to DES/DDD's operations to ensure timely medical decisions, including after-hours consultation as needed (see Paragraph 27).
c. **Chief Financial Officer/CFO** to oversee the budget, accounting systems and financial reporting implemented by DES/DDD.
d. **Pharmacy Coordinator/Director** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or contractor of DES/DDD.
e. **Dental Director/Coordinator** that is responsible for coordinating dental activities of DES/DDD and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or contractor of the plan and must be licensed in Arizona if they are required to review or deny dental services.
f. **Compliance Officer** who will implement and oversee DES/DDD's compliance program. The compliance officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS, Office of the Inspector General. See paragraph 70 for more information.
g. **Dispute and Appeal Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for hearing and provider claim disputes.
h. **A Business Continuity Planning and Recovery Coordinator** as noted in the ACOM Policy 104.
i. **Contract Compliance Officer** who will serve as the primary point-of-contact for all DES/DDDC operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all contract deliverables; field and coordinate responses to AHCCCS inquiries, coordinate the preparation and execution of contract requirements such as OFRs, random and periodic audits and ad hoc visits.
j. **Quality Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant 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 Coordinator must have experience in quality management and quality improvements. The primary functions of the Quality Management Coordinator position are:
    - Ensure individual and systemic quality of care
    - Integrate quality throughout the organization
    - Implement process improvement
    - Resolve, track and trend quality of care grievances
    - Ensure a credentialed provider network
k. **Performance/Quality Improvement Coordinator** who will have a minimum qualification as a CPHQ or CHCQM or comparable education and experience in data and outcomes measurement. The primary functions of the Performance/Quality Improvement Coordinator are:
    - Focus organizational efforts on improving clinical quality performance measures
    - Develop and implement performance improvement projects
    - Utilize data to develop intervention strategies to improve outcomes
    - Report quality improvement/performance outcomes
l. **Maternal Health/EPSDT (child health) Coordinator** who is an Arizona licensed nurse, physician, or physician's assistant; or have a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. . Staffing under this position should be

sufficient to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator are:

- Ensuring receipt of EPSDT services
- Ensuring receipt of maternal and postpartum care
- Promoting family planning services
- Promoting preventive health strategies
- Identification and coordination assistance for identified member needs
- Interface with community partners

m. **Medical Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determination, who manages all required Medical management requirements under AHCCCS polices, rules and contract. The primary functions of the Medical Management Coordinator are:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity Criteria
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted
- Develop, implement and monitor the provision of care coordination, disease management and case management functions
- Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
- Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards

n. **Behavioral Health Coordinator** who shall be a behavioral health professional as described in Health Services Rule, 9 A.A.C. 20. The Behavioral Health Coordinator shall devote sufficient time to assure DES/DDD's Behavioral Health Program is implemented per AHCCCS requirements. The primary functions of the Behavioral Health Coordinator are:

- Coordinate member behavioral care needs with behavioral health providers
- Develop processes to coordinate behavioral health care between PCPs and behavioral health providers
- Participate in the identification of best practices for behavioral health in a primary care setting
- Coordinate behavioral care with medically necessary services

o. **Provider Services Manager** and staff to coordinate communications between DES/DDD and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program and maintain a sufficient provider network.

p. **Claims Administrator** to develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements. The primary functions of the Claims Administrator are:

- Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements
- Develop processes for cost avoidance
- Ensure minimization of claims recoupments
- Meet claims processing timelines
- Meet AHCCCS encounter reporting requirements

q. **Provider Claims Educator** (full-time equivalent employee for a Contractor with over 100,000 members). The position is fully integrated with the Contractor's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers, with a minimum of five years management/supervisory experience in the health care field. The primary functions of the Provider Claims Educator are:

- 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, and available Contractor resources such as provider manuals, website, fee

schedules, etc.
- Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
- Identify trends and guide the development and implementation of strategies to improve provider satisfaction
- Frequently communicates (i.e., telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices

r. **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of 5 years of management/supervisory experience in the health care field.

Additional Required Staff

s. **Prior Authorization staff** to authorize health care 24 hours per day, 7 days per week. This staff shall include an Arizona-licensed nurse, physician or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician or physician's assistant.
t. **Concurrent Review staff** to conduct inpatient concurrent review. This staff shall consist of an Arizona-licensed nurse, physician, physician's assistant. The staff will work under the direction of an Arizona licensed registered nurse, physician or physician's assistant.
u. **Clerical and support staff** to ensure proper functioning of DES/DDD's operation.
v. **Provider Services staff** to enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management, for more information).
w. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
x. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.
y. **Case Management Supervisor(s)** to oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16.
z. **Case Managers** in sufficient numbers and who meet the qualifications defined in Section D, Paragraph 16 to perform assessment and care planning services for all enrolled members. .

DES/DDD The must submit to the Division of Health Care Management the following items annually by August 15:

1. An organization chart complete with the "**key staff"** positions. The chart must include the person's name, title and telephone number 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 the areas which report to that position.
3. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

DES/DDD is responsible for maintaining a significant local (within the State of Arizona) presence. This presence includes staff listed below.

In State Positions

- Administrator/CEO/COO
- Medical Director/CMO
- Compliance Officer
- Dispute and Appeal Manager
- Contract Compliance Officer
- Quality Management Coordinator
- Maternal Health/EPSDT (child health) Coordinator

- Medical Management Coordinator
- Behavioral Health Coordinator
- Provider Services Manager
- Provider Claims Educator
- Concurrent Review Staff
- Clerical and Support Staff
- Provider Services Staff
- Case Management Administrator/Manager
- Case Management Supervisors
- Case Managers

Staff Training and Meeting Attendance:

DES/DDD shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of the position. AHCCCS may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of this contract and/or AHCCCS policies.

DES/DDD 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. DES/DDD 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.

New and existing 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 (e.g. MapQuest, Yahoo Maps, Google Maps, etc.) for the purposes of authorizing services in; recommending providers in; and transporting members to, the most geographically appropriate location.

DES/DDD shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. All meetings shall be considered mandatory unless otherwise indicated.

26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

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

All Administrative Directives developed by DES/DDD shall be incorporated into DES/DDD's Policy Manual as outlined on the AHCCCS approved workplan. DES/DDD shall submit a quarterly report to AHCCCS by the 10th day following the end of each quarter which will include the status of Administrative Directives applicable to ALTCS not yet incorporated into DES/DDD's Policy Manual.

Based on provider or member feedback, if AHCCCS deems a DES/DDD policy or process to be inefficient and/or place unnecessary burden on the members or providers, the DES/DDD will be required to work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS.

27. MEDICAL DIRECTOR

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

a. The development, implementation and medical interpretation of medical policies and procedures to guide and support the provision of medical care to members. This includes, among others, policies pertaining to prior authorization, concurrent review, claims review, discharge planning, credentialing and referral management, as well as for medical review in the grievance, appeal and fair hearing processes.
b. Oversight and involvement in provider recruitment activities.
c. As appropriate, reviewing all providers' applications and submitting recommendations to those with contracting authority regarding credentialing and reappointment of all professional providers who fall under DES/DDD's scope of authority for credentialing (i.e., physicians, dentists, nurse practitioners, midwives, podiatrists and other licensed independent practitioners) prior to the physician's contracting (or renewal of contract) with DES/DDD.
d. Oversight and involvement in provider profiling, provisional, initial, and organizational credentialing, and re-credentialing.
e. Administration of all medical management activities of DES/DDD.
f. Continuous assessment and improvement of the quality of care provided to members (e.g. oversight of quality of care issues, AHCCCS performance measures, Performance Improvement Projects, periodic medical study/audit).
g. The development and implementation of the quality management/utilization management plan and serving as Chairperson of Quality Management, Credentialing, Medical Management, and Peer Review Committees.
h. Oversight and involvement in provider education, in-service training and orientation.
i. Assuring that adequate staff and resources are available for the provision of proper medical care to members.
j. Attending AHCCCS Medical Director's meetings.
k. Oversight of the Medical/Utilization Management Committee and/or data reporting.

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

28. NETWORK DEVELOPMENT

It is critical for DES/DDD to develop a provider network that is diverse and flexible to meet a variety of member issues both in the immediate as well as long range basis. A priority should be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting. Some critical issues to consider in the development of an effective network are the following:

- Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles of (as defined in Section D, paragraph 2):
    - *Member-Centered Case Management*

- *Consistency of Services*
- *Available and Accessible Services*
- *Most Integrated Setting*
- *Collaboration with Stakeholders*

- Ensuring support of the member's informal support system (e.g., family caregivers).
- Development of HCB services and settings to meet the needs of members who have cognitive impairments, behavioral health needs and other special medical needs.
- Providing not only linguistic services but also developing services that are able to address, as needed, the culture, race, ethnic and religious facets in the process of meeting the needs of members as described in the ACOM Policy 405 and Paragraph 69, Cultural Competency.

Provider networks must be a foundation that supports an individual's need as well as the membership in general. To that end, DES/DDD shall develop, maintain and monitor a provider network, including home and community based service providers and alternative residential settings, that is supported by written agreements which is sufficient to provide all covered services to ALTCS members. DES/DDD shall ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation. DES/DDD must provide a comprehensive network to ensure its membership has access at least equal to, or better than community norms. Services shall be accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are available to non-ALTCS persons within the same service area [42 CFR 438.210.(a)(2)]. DES/DDD is encouraged 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, DES/DDD shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. DES/DDD shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

DES/DDD is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. DES/DDD shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces 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.

There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis. The development of home and community based services shall include provisions for the availability of services on a 7-day-a-week basis and for extended hours, as directed by member needs [42 CFR 438.206(b)(1); 42 CFR 438.206 (c)(1)(i), (ii) and (iii)].

DES/DDD shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The requirements for the Network Development and Management Plan are found in the ACOM Policy 415. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS by November 15th of the contract year. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of DES/DDD's provider network. DES/DDD shall also submit as needed an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

ALTCS Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. DES/DDD must have as part of their network development plan a component regarding

paraprofessional work force development in alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. DES/DDD supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

In accordance with the ALTCS Network Standards specified in ACOM Policy and the members' needs, DES/DDD's network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix or Tucson do not have to travel more than 5 miles to visit a PCP or pharmacy. A member residing outside the metropolitan boundary area, but within Maricopa or Pima County, must not have to travel more than 10 miles to see such providers if a provider resides within 10 miles and is willing to contract with DES/DDD. Any exceptions to the Network Standards must be prior approved by AHCCCS, Division of Health Care Management.

DES/DDD shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, DES/DDD shall 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 DES/DDD from limiting provider participation to the extent necessary to meet the needs of DES/DDD's members. This provision also does not interfere with measures established by DES/DDD to control costs consistent with its responsibilities under this contract nor does it preclude DES/DDD from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If DES/DDD 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)]. DES/DDD 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)].

Other: AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the state of Arizona. AHCCCS expects DES/DDD to support these efforts. AHCCCS encourages DES/DDD 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 DES/DDD's medical management and committee activities. In the event of a contract termination between DES/DDD and a Graduate Medical Education Residency Training Program or training site, DES/DDD 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. If a Residency Training Program is in need of patients in order to maintain accreditation, AHCCCS may require DES/DDD within the program's GSA to make members available to the program. Further, DES/DDD 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.

Ball v Betlach: In compliance with Orders by the District Court in Ball v Betlach, DES/DDD is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. DES/DDD shall resolve gaps in critical services within two hours of a gap being reported. DES/DDD 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" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. A "gap in critical services" is defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the

member. Also see AMPM Chapter 1600, Policy 1620, Standards IV (I) for an explanation of "critical services".

DES/DDD shall implement policies and procedures to identify, correct, and track gaps in service; see the ACOM Policy 413 and AMPM Chapter 1600. These policies shall, at a minimum, cover the following areas:

- Information (verbally and in writing) to members on their right to receive services as authorized, including the right to have any gaps in critical services filled within two hours and the right to have a back-up caregiver to substitute when an unforeseeable gap in critical service occurs.
- Information to members on how to contact DES/DDD, its Subcontractor or the AHCCCS Administration when one of the above stated services is not provided as scheduled.
- At the time of the initial and quarterly reassessment case managers are required to assess a member's needs, including a member's service preference level if a gap in services were to occur and develop a contingency plan in the event of a gap in a member's services.
- DES/DDD's process for providing services in the event of a gap in service. This shall include a description of the process used to ensure that DES/DDD or its Subcontractor timely provide a back-up caregiver in the event of an unforeseeable gap in service.
- Tracking and trending gaps in service and grievances as a result of gaps.

On a semi-annual basis, (November 15, May 15), DES/DDD shall submit a report to AHCCCS outlining trends and corrective actions regarding gaps in services, grievances related to service gaps, and other reports as deemed necessary to fulfill the settlement agreement in the Ball v. Betlach case. See also Section D, ¶16, Case Management.

29. NETWORK MANAGEMENT

DES/DDD shall have policies on how DES/DDD will [AMPM; 42 CFR 438.214(a)]:

a. Communicate and negotiate with the network regarding contractual and/or program changes and requirements;
b. Monitor network compliance with policies and rules of AHCCCS and DES/DDD, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
c. Evaluate the quality of services delivered by the network;
d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
f. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;
g. Provide training for its providers and maintain records of such training;
h. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate; and
i. Ensure that provider calls are acknowledged within 3 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). If not resolved in 30 days the Contractor must document why the issue goes unresolved; however, the issue must be resolved within 90 days.

DES/DDD policies shall be subject to approval by AHCCCS, Division of Health Care Management, and shall be monitored through operational audits.

Material Change to Operations and/or Provider Network:

Operations: A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol such as prior authorization or retrospective review) which affects, or can reasonably

be foreseen to affect, DES/DDD's ability to meet the performance standards as described in this contract. It also includes any change that would impact more than 5% of total membership and/or provider network in a specific GSA or District, as applicable.

DES/DDD must submit the request for approval of a material change to operations, including draft notification to affected members and providers, 60 days prior to the expected implementation of the change. The request should contain, at a minimum, information regarding the nature of the operational change; the reason for the change; methods of communication to be used; and the anticipated effective date. If AHCCCS does not respond to DES/DDD within 30 days; the request and the notices are deemed approved. A material change in Contractor operations requires 30 days advance written notice to affected providers and members. The requirements regarding material changes to operations do not extend to contract negotiations between DES/DDD and a provider.

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

Provider Network: All material changes in DES/DDD's provider network must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, DES/DDD's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA or District to change the location where services are received or rendered. DES/DDD must submit the request for approval of a material change in their provider network, including draft notification to affected members, 60 days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If AHCCCS does not respond within 30 days the request and the notice are deemed approved. A material change in DES/DDD's network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

DES/DDD shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network [42 CFR 438.207(c)]. This notification shall include (1) information about how the change will affect the delivery of covered services, and (2) DES/DDD's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

See Section D, Paragraph 59 regarding material changes by DES/DDD that may impact capitation rates.

DES/DDD shall give hospitals and provider groups 90 days notice prior to a contract termination without cause. Contracts between DES/DDD and single practitioners are exempt from this requirement.

30. PROVIDER MANUAL

DES/DDD shall develop, distribute and maintain a provider manual as described in the Policy 416.

31. PROVIDER REGISTRATION

DES/DDD shall ensure that each of its subcontractors register with AHCCCS as an approved service provider. For specific requirements on Provider Registration refer to the AHCCCS website at http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx

Effective July 31, 2012, DES/DDD shall begin submitting registration packets, including certification, for each group home serving ALTCS members to AHCCCS Provider Registration. DES/DDD shall have until December 31, 2012 to submit registration packets, including certification, for each existing group home serving ALTCS

members. AHCCCS Provider Registration will assign an independent provider registration number to each group home. DES/DDD shall also identify, by location, each group home registered under every DES/DDD Qualified Vendor Agreement.

The National Provider Identifier (NPI) will be required on all claim submissions and subsequent encounters (from providers that are eligible for a NPI). DES/DDD shall work with providers to obtain their NPI.

Except as otherwise required by law or as otherwise specified in a contract between DES/DDD 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 DES/DDD.

32. NETWORK SUMMARY

DES/DDD shall submit electronically, information regarding its provider network. This information shall be submitted as specified in ACOM Policy 419. This network summary should include a waiting list for therapy and HCBS services. Network Updates will be submitted on October 15 and May 15. The AHCCCS Division of Health Care Management will notify DES/DDD if there is a change in the frequency of submissions or file specifications.

33. SUBCONTRACTS

DES/DDD shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c). No subcontract shall operate to terminate the legal responsibility of DES/DDD to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by DES/DDD pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(1)]. See the ACOM Policy 203.

All subcontracts entered into by DES/DDD are subject to prior review and written approval by AHCCCS, Division of Contract Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS Division of Health Care Management for prior approval at least 60 days prior to the beginning date of the subcontract:

Administrative Services Subcontracts:

a. Delegated Agreements that subcontract:
    1. Any function related to the management of the contract with AHCCCS. Examples include member services, provider relations, quality management, medical management (e.g., prior authorization, concurrent review, issuance of denials or limited authorizations, member appeals, medical claims review, member record review)
    2. Claims processing, including pharmacy claims
    3. Credentialing including those for only primary source verification (CVO)
b. All Management Service Agreements
c. All service level agreements with any Division or Subsidiary of a corporate parent owner

DES/DDD shall submit to AHCCCS copies of Administrative Services subcontracts request for proposals (RFPs) at the time they are formally issued to the Public.

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.

DES/DDD shall maintain a fully executed original or electronic copy of all subcontracts which shall be accessible to AHCCCS within two business days of 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 written consent of DES/DDD except as required by law. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor, DES/DDD must evaluate the prospective subcontractor's ability to perform the activities to be delegated If DES/DDD delegates duties or responsibilities to a subcontractor, then DES/DDD shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance in inadequate. In order to determine adequate performance, DES/DDD shall monitor the 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 subcontractor in order to establish a corrective action plan. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion. [42 CFR 438.230(b)]

A merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS.

DES/DDD must submit the Administrative Services Annual Subcontractor Assignment and Evaluation Report (within 90 days from the start of the contract year) detailing any Contractor duties and responsibilities that have been subcontracted as described under Administrative Services Subcontracts previously listed in this section. The Administrative Services Annual Subcontractor Assignment and Evaluation Report will include the following:

- Subcontractor's name
- Delegated duties and responsibilities
- Most recent review date of the duties, responsibilities and financial position of the subcontractor
- Next scheduled review date
- Identified areas of deficiency
- A comprehensive summary of the evaluation of performance (operational and financial) of the subcontractor. The full report shall be made available upon request from AHCCCS.
- DES/DDD's corrective action plan as necessary

DES/DDD shall inform AHCCCS, Division of Health Care Management, within thirty (30) days if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract. DES/DDD will submit this in writing and provide the Corrective Action Plan and any measures taken by DES/DDD to bring the subcontractor into compliance.

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

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

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

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

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

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 (e.g., Subcontractor is capitated), 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.

All subcontracts must reference the provisions of the Minimum Subcontract Provisions, as posted on the AHCCCS website at http://www.azahcccs.gov/commercial/default.aspx. In addition, each provider subcontract must contain the following:

a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
b. Identification of the name and address of the subcontractor.
c. Identification of the population, to include patient capacity, to be covered by the subcontractor.
d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation.
f. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability.
g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to DES/DDD.
h. A description of the subcontractor's patient, medical, dental and cost record keeping system.
i. Specification that the subcontractor shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.
j. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of DES/DDD shall require a contract amendment and prior approval of AHCCCS.
k. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population.
l. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for

itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.

m. A provision that the subcontractor must obtain any necessary authorization from DES/DDD or AHCCCS for services provided to eligible and/or enrolled members.

n. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.

o. Provision(s) that allow DES/DDD to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.

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

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

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

34. ADVANCE DIRECTIVES

DES/DDD shall maintain policies and procedures addressing directives for adult members that specify [42 CFR 422.128]:

a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care must comply with federal and state law on advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:
   1. Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to ARS § 36-3205.C.1)
   2. Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].
   3. Documenting in the member's medical record as to whether the adult member has been provided the information and whether an advance directive has been executed.
   4. Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
   5. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health and personal care, of any advanced directives executed by members to whom they are assigned to provide services.

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

c. DES/DDD shall provide written information to adult enrollees that describe the following:
   1. A member's rights under State law, including a description of the applicable State law

2. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience
3. The member's right to file complaints directly with AHCCCS
4. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)].

35. SPECIALTY CONTRACTS

AHCCCS may at any time negotiate or contract on behalf of DES/DDD and AHCCCS for specialized hospital and medical services. AHCCCS will consider existing DES/DDD resources in the development and execution of specialty contracts. AHCCCS may require DES/DDD to modify its delivery network to accommodate the provisions of specialty contracts. AHCCCS may consider waiving this requirement in particular situations if such action is determined to be in the best interest of the State; however, in no case shall reimbursement 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 DES/DDD and specialty contractors to enhance the cost effectiveness of service delivery, medical management and adjudication of claims related to such payments provided under specialty contracts shall remain the responsibility of DES/DDD. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

For situations where 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 DES/DDD prior to the implementation of any specialty contract.

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

Maricopa and Pima counties only*:* The Inpatient Hospital Reimbursement Program is defined in the Arizona Revised Statutes (A.R.S.) 36-2905.01, and requires hospital subcontracts to be negotiated between DES/DDD in Maricopa and Pima counties and hospitals to establish reimbursement levels, terms and conditions. Subcontracts shall be negotiated by DES/DDD and hospitals to cover operational concerns, such as timeliness of claims submission and payment, payment of discounts or penalties, and legal resolution, which may, as an option, include establishing arbitration procedures. These negotiated subcontracts shall remain under close scrutiny by AHCCCS to insure availability of quality services within specific service districts, equity of related party interests and reasonableness of rates. The general provisions of this program encompass acute care hospital services and outpatient hospital services that result in an admission. DES/DDD, upon request, shall make available to AHCCCS all hospital subcontracts and any amendments. For non-emergency patient-days, DES/DDD shall ensure that at least 65% of its members use contracted hospitals. AHCCCS reserves the right to subsequently adjust the 65% standard. Further, if in AHCCCS' judgment the number of inpatient days at a particular non-contracted hospital becomes significant, AHCCCS may require a subcontract at that hospital., In accordance with R9-22-718, unless otherwise negotiated by both parties, the reimbursement for inpatient service, including outliers, provided at a non-contracted hospital shall be based on the rates as defined in A.R.S. § 36-2903.01, multiplied by 95%.

All counties EXCEPT Maricopa and Pima: DES/DDD shall reimburse hospitals for member care in accordance with AHCCCS Rule 9 A.A.C. 22, Article 7. DES/DDD is encouraged to obtain subcontracts with hospitals in all GSA's. DES/DDD, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

For Out-of-State Hospitals*:* DES/DDD shall reimburse out-of-state hospitals in accordance with 9 A.A.C. 28, Article 7. When serving border communities (excluding Mexico), DES/DDD is strongly encouraged to establish contractual agreements with bordering out-of-state hospitals.

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

***Outpatient Hospital Services*:** In the absence of a contract, the default payment rate for outpatient hospital services billed on a UB-04 will be based on the AHCCCS outpatient hospital fee schedule, rather than a hospital-specific cost-to-charge ratio (pursuant to ARS 36-2904).

37. PRIMARY CARE PROVIDER STANDARDS

DES/DDD shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by DES/DDD 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)].

DES/DDD 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. DES/DDD should also consider the PCP's total panel size (e.g., AHCCCS and non-AHCCCS patients) when making this determination. DES/DDD will adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards.

DES/DDD shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that DES/DDD's data regarding PCP assignments is current. DES/DDD 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.

DES/DDD 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.

DES/DDD shall offer members freedom of choice within its network in selecting a PCP, consistent with 42 CFR 438.6(m) and 438.52(d). DES/DDD 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 DES/DDD, DES/DDD shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of DES/DDD's receipt of notification of assignment by AHCCCS. DES/DDD shall include with the enrollment notification a list of all DES/DDD's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the ACOM Policy 404. DES/DDD 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, DES/DDD shall hold the PCP responsible for the following activities [42 CFR 438.208(b)(1)]:

a. Supervision, coordination and provision of care to each assigned member (except for children's dental services when provided without a PCP referral);
b. Initiation of referrals for medically necessary specialty care;

c. Maintaining continuity of care for each assigned member; and
d. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health;
e. Utilizing the AHCCCS approved EPSDT Tracking form; and
f. 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
g. If serving children, for enrolling as a Vaccines for Children (VFC) provider,

DES/DDD will work with AHCCCS to develop a methodology to reimburse school based clinics. AHCCCS and DES/DDD will identify coordination of care processes and reimbursement mechanisms. DES/DDD will be responsible for payment of these services directly to the clinics.

DES/DDD 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.

38. APPOINTMENT STANDARDS

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

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

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

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

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

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

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

DES/DDD shall actively monitor provider compliance with Appointment Standards through methods such as "mystery shopping" and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits [42 CFR 438.206(c)(1)(i)].

For **wait time in the office**, DES/DDD 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.

For **medically-necessary non-emergent transportation,** DES/DDD shall require its transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor to be picked up prior to the completion of treatment. Also see Section D, Paragraph 86, Special Health Care Needs.

DES/DDD must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization. DES/DDD 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.

DES/DDD shall establish processes to monitor and reduce the appointment "no-show" rate for PCPs, dentists and transportation providers. As best practices are identified, AHCCCS may require implementation by DES/DDD.

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

39. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives:
The reporting requirements under 42 CFR 417.479 have been suspended. No reporting to CMS is required until the suspension is lifted**.**

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

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

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

DES/DDD shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(i) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS.

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

Transparency

AHCCCS programs will be in compliance with Federal and State transparency initiatives. AHCCCS may publicly report or make available any data, reports, analysis or outcomes related to Contractor activities, operations and/or performance. Public reporting may include, but is not limited to, the following components:

a. Use of evidence based guidelines
b. Identification and publication of top performing Contractors
c. Identification and publication of top performing providers
d. Program pay for performance payouts
e. Mandated publication of guidelines
f. Mandated publication of outcomes
g. Identification of Centers of Excellence for specific conditions, procedures or member populations
h. Establishment of Return on Investment goals

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.

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

DES/DDD shall have adequate written procedures regarding referrals to specialists, to include, at a minimum, the following:

a. Use of referral forms clearly identifying the Contractor;
b. 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;
c. 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;
d. Referral to Medicare Managed Care Plan;
e. PCP referral shall be required for specialty physician services, except that women shall have direct access to in-network GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services [42 CFR 438.206(b)(2)]. In addition, for members with special health care needs determined to need a specialized course of treatment or regular care monitoring, DES/DDD must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. Any waiver of this requirement by DES/DDD must be approved in advance by AHCCCS.
f. 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)].
g. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.

DES/DDD 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 include:

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

41. MAINSTREAMING OF ALTCS MEMBERS

To ensure mainstreaming of ALTCS members, DES/DDD shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information or physical or mental disability. DES/DDD must take into account a member's literacy and culture, when addressing members and their concerns, and must take reasonable steps to encourage subcontractors to do the same. DES/DDD must also make interpreters, including assistance for the visual and hearing impaired, available to members to ensure appropriate delivery of covered services.

Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f)

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

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

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

42. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHCS)

DES/DDD is encouraged to use FQHCs/RHCs and FQHC Look-Alikes in Arizona to provide covered services. AHCCCS requires DES/DDD to negotiate rates of payment with FQHCs/RHCs/FQHC Look-Alikes for non-pharmacy services that are comparable to the rates paid to providers that provide similar services. AHCCCS reserves the right to review DES/DDD's negotiated rates with an FQHC/RHC/FQHC Look-Alikes for reasonableness and to require adjustments when negotiated rates are found to be substantially less than those being paid to other, non-FQHC/RHC/FQHC Look-Alikes providers for comparable services.

For FQHC and FQHC Look-Alike pharmacies, all 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. These drugs shall be reimbursed at the lesser of the two amounts above plus a dispensing fee. See AHCCCS Rule R9-22-710 (C) for further details.

DES/DDD is required to submit member month information for Title XIX members for each FQHC/RHC/FQHC Look-Alikes on a quarterly basis to AHCCCS Division of Health Care Management. AHCCCS will perform periodic audits of the member information submitted. DES/DDD should refer to the AHCCCS reporting Guide for ALTCS Program Contractors for further guidance. THE FQHCs/RHCs/FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website: www.azahcccs.gov.

43. RESERVED

44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

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

System Requirements:

DES/DDD must have a health information system that integrates member demographic data, case management information, provider information, service provision, claims submission and reimbursement. This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management. DES/DDD shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules R9-28 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements as needed.

DES/DDD must include nationally recognized methodologies to correctly pay claims including but not limited to:

- Medicaid Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services;
- Multiple Surgical Reductions;
- Global Day E & M Bundling.

DES/DDD claims payment system must be able to assess and/or apply data related edits including but not limited to:

- Benefit Package Variations;
- Timeliness Standards;
- Data Accuracy;
- Adherence to AHCCCS Policy;
- Provider Qualifications;
- Member Eligibility and Enrollment;
- Over-Utilization Standards.

This system must produce a remittance advice related to DES/DDD's payments and/or denials to providers and must include, at a minimum:

- An adequate description of all denials and adjustments;
- The reasons for such denials and adjustments;
- The amount billed;
- The amount paid;

- Application of COB and SOC; and
- Provider rights for claim disputes.

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

General Claims Processing Requirements:
AHCCCS will require DES/DDD to participate in an AHCCCS workgroup to develop uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, including billing rules and documentation requirements. The workgroup may be facilitated by an AHCCCS selected consultant. The Contractor will be held responsible for the cost of this project based on its share of AHCCCS enrollment.

Standardized claims for services must be submitted per R9-22-710, therefore:
- Roster billing is not permitted for nursing facilities for dates of service on or after October 1, 2011;
- DES/DDD shall work with all other providers to eliminate roster billing and submit standardized claims with dates of service on or after October 1, 2012.

A claim for an authorized service submitted by a licensed skilled nursing facility, alternative residential setting or other home and community based provider (see Section D, ¶10. Subsection Long Term Care Services) shall be adjudicated within thirty calendar days after receipt by DES/DDD. Any clean claim for an authorized service provided to a member that is not paid within thirty calendar days after the claim is received accrues interest at the rate of one per cent per month from the date the claim is submitted. The interest is prorated on a daily basis and must be paid by the Program Contractor at the time the clean claim is paid. (A.R.S. 36-2943.D)

Unless a shorter time period is specified in contract, DES/DDD shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service except as directed by AHCCCS or otherwise noted in this contract. 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 DES/DDD's specified claims mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date or the effective date of eligibility posting, whichever is later as stated in A.R.S. 36-2904H.

In accordance with the Deficit Reduction Act of 2005, Section 6085, Contractor is required to reimburse non-contracted emergency services providers at no more then the AHCCCS FFS rate. This applies to in state as well as out of state providers.

In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, Contractor is required to reimburse non-contracted non-emergent in-state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at ninety-five percent of the AHCCCS fee-for-service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 2903.01. Effective for all non-hospital clean claims (excluding licensed skilled nursing facilities, alternative residential settings and home and community based claims) in the absence of a contract specifying other late payment terms, Contractors are required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance or claim dispute situations, interest shall accrue from the day following 45 days after receipt of the clean claim through the date of payment resulting from the grievance/claim dispute decision. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue

starting on the first day after the contracted clean claim payment date. When slow payment penalties or interest is paid, the Contractor must report penalty or interest as directed in the AHCCCS Encounter Manual.

Unless a subcontract specifies otherwise, DES/DDD shall ensure that 90% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

DES/DDD must have procedures for either pre-payment or post payment claims review that includes review of supporting documentation such as medical records, home health visit notes, in addition to authorizations.

Electronic Transactions:
DES/DDD is required to accept and generate required HIPAA compliant electronic transactions from/to any provider interested in and capable of electronic submission or electronic remittance receipt; and, must be able to make claims payments via electronic funds transfer. In addition, DES/DDD shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

a) Receive claims electronically based on volume of actual claims processed excluding claims processed by Pharmacy Benefit Managers (PBMs). Benchmarks as follows:

2011-2012 30%
2012-2013 40%
2013-2014 50%
2014-2015 60%
2015-2016 60%

b) Pay 60% of all claims electronically based on volume of paid claims excluding claims processed by Pharmacy Benefit Managers (PBMs).

DES/DDD shall submit a report to the DHCM Operations staff on December 15th of each contract year if either electronic claims submission or payment volume is below 60%. The annual report shall at a minimum, include measureable goals, the success of previous interventions, barriers to goals, the action/tasks DES/DDD will take to facilitate meeting goals and the anticipated timeframe to accomplish goals.

Recoupments:
DES/DDD's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by AHCCCS, Division of Health Care Management. AHCCCS will respond within 30 days of the recoupment request. AHCCCS must be notified of any cumulative recoupment greater than $50,000 per provider Tax Identification Number per contract year. DES/DDD shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim without prior approval of AHCCCS as further described in the ACOM Policy 412.

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

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim with 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, etc.

DES/DDD must void encounters 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 will 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. DES/DDD should refer to the ACOM Policy 412 and the AHCCCS Encounter Manual for further guidance.

Appeals:
If DES/DDD or the Director's Decision reverses a decision to deny, terminate, reduce or suspend authorization of services, and the member received the disputed services while the appeal was pending, DES/DDD shall process a claim for payment from the provider in a manner consistent with DES/DDD'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 DES/DDD for payment. For all claims submitted as a result of a reversed decision, DES/DDD is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. DES/DDD 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: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

System Related Reporting:
DES/DDD shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide.

AHCCCS may in the future require DES/DDD to review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

System Changes and Upgrades:
DES/DDD will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least 6 months before the anticipated implementation date, the contractor shall provide the system change plan to AHCCCS for review and comment.

System Audits:
DES/DDD shall develop and implement an internal claims audit function that will include the following:

- Verification that provider contracts are loaded correctly
- Accuracy of payments against provider contract terms

Audits of provider contract terms should 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 should be documented in policy, and DES/DDD should review the contract loading of providers at least once in every 5 year period in addition to any time a provider 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.

Additionally, AHCCCS may require the Contractor to have an independent audit of the Claims Payment/Health Information System completed within a specified time period. Upon notification by AHCCCS DES/DDD must submit a signed agreement, entered into with an independent auditing firm of their selection to be approved by the AHCCCS Division of Health Care Management. The signed agreement must include a schedule for audit completion. The Division of Health Care Management will monitor the scope of this audit, to include no less than a verification of contract information management (contract loading and auditing), claims processing and encounter submission processes. In addition to this requirement, DES/DDD may be required in future contract years to initiate additional independent Claim System/Health Information System audit at the direction of the AHCCCS Administration. In the event of a system change or upgrade, DES/DDD will be required to initiate an independent Claim System/Health Information System audit.

45. RESERVED

46. RESERVED

47. RESERVED

48. ACCUMULATED FUND DEFICIT

DES/DDD must review for accumulated fund deficits on a quarterly and annual basis. In the event the Contractor has a fund deficit, the Contractor 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 enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLANS

If DES/DDD has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS upon request. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or cost allocations made. If there is a change in ownership of the entity with which DES/DDD has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to DES/DDD should a change in ownership occur. AHCCCS will not permit two Contractors 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 33, Subcontracts and Attachment D: Chart of Deliverables.

50. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

DES/DDD shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line of business within its organization. DES/DDD shall not, without prior approval of AHCCCS, make loans or advances to its providers in excess of $50,000. All requests for prior approval and notifications are to be submitted to the AHCCCS Division of Health Care Management. Refer to the ACOM Policy 418 for further information.

51. RESERVED

52. FINANCIAL VIABILITY STANDARDS

DES/DDD 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 DES/DDD: Medical Expense Ratio and Total Administrative Cost Percentage.

Sanctions may be imposed in accordance with paragraph 80 (of this section) if DES/DDD does not meet these financial viability standards. AHCCCS will take into account DES/DDD's unique programs for managing care and improving the heath status of members when analyzing medical expense and administrative ratio results. However, if a critical combination of the Financial Viability Standards are not met, or if DES/DDD's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

Financial Viability Standards:

Medical Expense Ratio Total medical expense (including case management) divided by total payments received by 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%

DES/DDD shall comply with all financial reporting requirements contained in Attachment D, Chart of Deliverables Requirements and the ALTCS Financial Reporting Guide; a copy of which may be found on the AHCCCS website. The required reports are subject to change during the contract term and are summarized in Attachment D, Chart of Deliverables.

53. RESERVED

54. RESERVED

55. RELATED PARTY TRANSACTIONS

Any proposed subcontract involving a related party or entity requires prior approval from AHCCCS, Division of Health Care Management. The minimum information required on ownership and control in related party transactions is set by federal law (42 CFR 455.100 through 455.106) and DES/DDD shall disclose all required information, justify all related party transactions reported, and certify the accuracy and completeness of the disclosures made. DES/DDD shall demonstrate that transactions occurring between the provider and a related party-in-interest are reasonable, will not adversely affect the fiscal soundness of DES/DDD, and do not present a conflict of interest.

56. COMPENSATION

Capitation Payments: DES/DDD shall be compensated on a capitated basis. Actuaries established the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purposes of rebasing the capitation rates:

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

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis of the capitation rates.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary to maintain actuarially sound rates. DES/DDD may cover services for members that are not covered under the State Plan; however those services are not included in the data provided to actuaries for setting capitation rates.

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

Subject to the availability of funds, AHCCCS shall make payments to DES/DDD in accordance with the terms of this contract provided that DES/DDD's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of ARS Title 36..

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

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

Targeted Case Management: DES/DDD will be paid monthly on a capitated basis. This payment will be based on the number of recipients matched as of the first of each month. The targeted case management capitation payment will be made no later than 10 business days after receipt of the DES/DDD data transmission. AHCCCS will make payments to DES/DDD in accordance with the terms as outlined in Attachment E provided that DES/DDD's performance is in compliance with the terms and conditions.

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

DES/DDD receives legislative appropriations for DD Title XIX services and a 100% state-funded DD services program. DES/DDD shall, by July 1st on an annual basis, transfer to AHCCCS the total amount appropriated for the state match for Title XIX ALTCS expenditures, the DES/DDD share of Medicare phase-down payments to CMS as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and the total estimated amount sufficient to provide the required state match for Title XIX eligible targeted case management expenditures. This transfer shall be made, in its entirety, prior to the first Title XIX disbursement. AHCCCS shall deposit the monies transferred into an Intergovernmental Agreement (IGA) Fund of which AHCCCS shall have sole disbursement authority.

When AHCCCS draws FFP for qualifying DES/DDD disbursements, AHCCCS will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to DES/DDD.

AHCCCS also will use monies in the IGA Fund to make monthly disbursements to CMS for the DES/DDD share of Medicare phase-down payments made in accordance with the MMA for drug benefit costs assumed by Medicare for full dual eligible members. Payment amounts will be made in a manner specified by CMS and will be funded prior to monthly capitation if insufficient funds are remaining in the IGA Fund.

If AHCCCS determines that additional monies are required, AHCCCS shall notify DES/DDD that additional monies must be deposited into the IGA Fund prior to making additional Title XIX disbursements. If at the end of a fiscal year, and after the close of any administrative adjustments as defined in ARS § 35-190 - 191, monies remain in the IGA Fund, AHCCCS shall notify DES/DDD and transfer these monies back to DES/DDD. If it is determined that excessive funds exist in the IGA Fund, DES/DDD may request a

withdrawal of monies prior to the end of a state fiscal year and/or prior to the close of the administrative adjustment period.

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

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

57. ANNUAL SUBMISSION OF BUDGET

DES/DDD shall submit to AHCCCS, by August 10th of each renewal year, a copy of the DDD budget submittal to the Office of Strategic Planning and Budget (OSPB) due the following September related to the prior year actual expenditures, the current year expenditure estimate, and the subsequent year expenditure request. Any changes to these documents shall be submitted to AHCCCS upon submission to OSPB. These documents will be utilized by AHCCCS in preparation of the request of Federal Funds Expenditure Authority for the DES/DDD program in the AHCCCS HCFA-37.

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

58. REINSURANCE

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*:** Reinsurance is a stop-loss program provided by AHCCCS to DES/DDD 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 and is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percent is the rate at which AHCCCS will reimburse DES/DDD for covered services incurred above the deductible. The deductible is the responsibility of the DES/DDD. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates.

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

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with hemophilia, and non-DDAVP responding Von Willebrand's Disease and Gaucher's Disease. For additional detail and restrictions refer below and to the AHCCCS Reinsurance Processing Manual and the AMPM. There are no deductibles for catastrophic reinsurance cases. For members receiving Biotech drugs outside of specific conditions mentioned in this

paragraph, 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 contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or DES/DDD's paid amount, whichever is lower, depending on the subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or DES/DDD's paid amount, whichever is lower. All catastrophic claims are subject to medical review by AHCCCS.

AHCCCS holds a specialty contract for anti-hemophilic agents and related services for hemophilia. DES/DDD 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, DES/DDD is the authorizing payor. As such, DES/DDD 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.

DES/DDD must notify AHCCCS, Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of initial diagnosis and/or enrollment with DES/DDD, and annually 30 days prior to the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria: 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.

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

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

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

Biotech Drug Reinsurance: Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor unless the member is CRS enrolled, the medications are related to the management of a CRS covered condition, and CRS is providing coverage. Catastrophic reinsurance will cover the drug cost only. Refer to the AHCCCS Reinsurance Processing Manual for a list of covered drugs. The Biotech Drugs covered under reinsurance will be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug or its generic equivalent for reinsurance purposes.

Transplant Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the AMPM for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is to be paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of DES/DDD's paid amount. 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 transplantation rates may be found on the AHCCCS website. DES/DDD must notify AHCCCS Division of Health Care Management, Medical Management Unit 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 Medical Management Unit 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. If no prior approval is obtained, and the Contractor incurs costs at the out of state facility, those costs will not be eligible for either transplant or regular reinsurance.

***Other Reinsurance*:** For all reinsurance case types other than transplants, DES/DDD will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case reaches $650,000. It is the responsibility of DES/DDD to notify AHCCCS, Division of Health Care Management, Reinsurance Supervisor, once a case reaches $650,000. DES/DDD is required to split encounters as necessary once the reinsurance case reaches $650,000. Failure to notify AHCCCS or failure to split and 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

a) Encounter Submission: All reinsurance associated encounters, except as provided below for "Disputed Matters," must reach a clean status within fifteen months from the end date of service, or date of eligibility posting, whichever is later.

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 claim AND for the reinsurance claim to reach clean claim status. Therefore, reinsurance claims for disputed matters will be considered timely if the Contractor files such claims in clean claim 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 in clean claim status 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.

DES/DDD 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 74, Encounter Data Reporting, for encounter reporting requirements.

b. Payment of Regular and Catastrophic Reinsurance Cases: AHCCCS will reimburse DES/DDD for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/TPL, payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the DES/DDD, minus the coinsurance and Medicare/TPL payment unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, the 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.

c. ***Payment of Transplant Reinsurance Cases:*** Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the DES/DDD's paid amount, subject to coinsurance percentages. DES/DDD is required to submit all supporting service encounters for transplant services. Reinsurance payments will be linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage. Please refer to the Reinsurance Processing Manual for appropriate billing of transplant services.

Reinsurance Audits:
AHCCCS may, at a later date, perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits and DES/DDD will be given appropriate advance notice.

59. CAPITATION ADJUSTMENTS

Rate Adjustments:
Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review the effect of program changes, legislative requirements, Contractor experience, actuarial assumptions, and/or Contractor specific capitation factors to determine if a capitation adjustment is needed. In these instances the adjustment and assumptions will be discussed with DES/DDD prior to modifying capitation rates. DES/DDD may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review.

DES/DDD is responsible for notifying AHCCCS of program and/or expenditure changes initiated by the DES/DDD during the contract period that may result in material change to the current or future capitation rates.

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

a. death of a member
b. inmate of a public institution
c. duplicate capitation paid for the same member
d. adjustment based on change in member's contract type
e. voluntary withdrawal

Upon becoming aware that a member may be an inmate of a public institution, DES/DDD must notify AHCCCS for an eligibility determination. Notifications must be sent via email to one of the following two email addresses as applicable:

For children under age 18: DMSJUVENILEIncarceration@azahcccs.gov
For adults age 18 and older: DMSADULTIncarceration@azahcccs.gov

Notifications must include:

- AHCCCS ID
- Name

- Date of Birth (DOB)
- When incarcerated
- Where incarcerated

DES/DDD does not need to report members incarcerated with the Arizona Department of Corrections.

Several Counties are submitting daily files 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 DES/DDD and placed in a "no-pay" status for the duration of their incarceration. DES/DDD will see the "IE" code for ineligible associated with the disenrollment. Upon release from jail, the member will be re-enrolled with DES/DDD. A member is eligible for covered services until the effective date of the member's "no-pay" status.

60. MEMBER SHARE OF COST

ALTCS members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the share of cost, have a share of cost in the amount of $0.00. Generally, only institutionalized ALTCS members have a share of cost; however, certain HCBS ALTCS members may be liable for a share of cost, particularly those who become eligible through a special treatment income trust [42 CFR 438.108]. See the ALTCS Eligibility Policy Manual for a complete list of SOC adjustments on the AHCCCS website.

DES/DDD receives monthly capitation payments which incorporate an assumed deduction for the share of cost which members contribute to the cost of care. DES/DDD is responsible for collecting their members' share of cost. DES/DDD has the option of collecting the share of cost or delegating this responsibility to the provider. DES/DDD may transfer this responsibility to nursing facilities, Institutions for Mental Disease for those 65 years of age and older, or Inpatient Psychiatric Facilities for those under 21 years of age, and HCBS Providers and compensate these facilities net of the share of cost amount. If DES/DDD delegates this responsibility to the provider, the provider contract must spell out complete details of both parties' obligations in share of cost collection. . DES/DDD or its subcontractors shall not assess late fees for the collection of the share of cost from members.

61. COPAYMENTS

DES/DDD is required to apply copayments as per ACOM and other direction by AHCCCS. There are currently no copayments for ALTCS members for ALTCS covered services [42 CFR 438.108].

62. PEDIATRIC IMMUNIZATION AND THE VACCINE FOR CHILDREN PROGRAM

Through the Vaccine for Children (VFC) program the federal and state governments purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. Therefore, DES/DDD shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, DES/DDD shall contact AHCCCS, Division of Health Care Management, Clinical Quality Management Unit for guidance. Any provider licensed by the State to administer immunizations may register with ADHS as a "VFC provider" and receive free vaccines. DES/DDD shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS found in the AHCCCS fee schedule. DES/DDD shall comply with all VFC requirements and monitor its providers to ensure that, a physician acting as primary care physician (PCP) to members under the age of 19, is registered with ADHS/VFC.

In some Counties, providers may choose not to provide vaccinations due to low numbers of children in their panels, etc. DES/DDD must develop processes to ensure that vaccinations are available through a VFC enrolled provider or through the county Health Department. In all instances, the antigens are to be provided

through the VFC program. The Contractor must 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. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. Contractors must educate their provider network about these reporting requirements and the use of this resource and monitor to ensure compliance.

63. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. DES/DDD shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by DES/DDD are cost avoided or recovered from a liable party. DES/DDD may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

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

Cost Avoidance*:* DES/DDD shall take reasonable measures to determine the legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. DES/DDD shall cost-avoid a claim if it establishes the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when DES/DDD 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 third party liability cannot be established DES/DDD must adjudicate the claim. If the probable existence of a party's liability cannot be established DES/DDD must adjudicate the claim. DES/DDD must then utilize post payment recovery which is described in further detail below. If the Administration determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions in an amount not less than **three times** the amount that could have been cost avoided.

DES/DDD shall not deny a claim for untimeliness if the untimely claim submission results from a provider's efforts to determine the extent of the liability.

If a third party insurer (other than Medicare) requires the member to pay any copayment, coinsurance or deductible, then DES/DDD is responsible for making these payments under the method described below even if the services are provided **outside** of the DES/DDD network.

A. If the provider is **CONTRACTED** with DES/DDD:

DES/DDD shall pay the **lesser** of the **difference** between:
1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance
OR
2) The Primary Insurance Paid amount and DES/DDD's Contracted Rate

The lesser of methodology applies unless DES/DDD's contract with the provider requires a different payment scheme.

B. If the provider is **NOT CONTRACTED** with DES/DDD:

DES/DDD shall pay the **lesser** of the **difference** between:
1) The Primary Insurance Paid amount and the Primary Insurance Rate, i.e., the member's copayment required under the Primary Insurance
OR
2) The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate

Examples

Scenario 1 AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $45 Primary Paid $30	
Contractor Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $45-$30 vs. $55 - $30)
Contractor Payment to Non-Contracted Provider in this example	$15 (this is calculated from the lesser of: $45-30 vs. $50-30)

Scenario 2 AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $60 Primary Paid $40	
Contractor Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $60 - $40 vs. $55-$40)
Contractor Payment to Non-Contracted Provider in this example	$10 (this is calculated from the lesser of: $60-$40 vs. $50-$40)
Scenario 3 AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $70 Primary Paid $60	
Contractor Payment to Contracted Provider in this example	$0 (this is calculated from the lesser of: $70 - $60 vs. $55-$60)
Contractor Payment to Non Contracted Provider in this example?	$0 (this is calculated from the lesser of: $70-$60 vs. $50-$60)

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

Members with CRS condition:

See Section D, Paragraph 13 for CRS related information

***Postpayment Recoveries**:* Postpayment recovery is necessary in cases where DES/DDD has not established the probable existence of a liable party at the time services were rendered or paid for, or was unable to cost-avoid. The following sections set forth requirements for Contractor recovery actions including recoupment activities, other recoveries and total plan case requirements.

Recoupments: DES/DDD must follow the protocols established in the ACOM Policy 412. DES/DDD must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the Contractor must submit replacement encounters.

Other Recoveries: DES/DDD shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 799.9 and 800 to 999.9 (excluding code 994.6) and other procedures. DES/DDD shall not pursue recovery in the following circumstances unless the case has been referred to DES/DDD by AHCCCS or AHCCCS' authorized representative:

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

Upon identification of any of the above situations, DES/DDD shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of DES/DDD; no reinsurance or fee-for-service payments are involved. By contract, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, DES/DDD he shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions. The Program Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Joint Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by DES/DDD. In joint cases AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement in joint cases and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. DES/DDD will be responsible for their prorated share of the contingency fee. DES/DDD's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to DES/DDD.

Total Plan Case Requirements: In "total plan" cases, DES/DDD 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. DES/DDD shall use the AHCCCS approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery.

DES/DDD may retain up to 100% of its third-party collections if all of the following conditions exist:

a. Total collections received do not exceed the total amount of DES/DDD financial liability for the member
b. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e. lien filing etc.) and
c. Such recovery is not prohibited by State or Federal law

Prior to negotiating a settlement on a total plan case, DES/DDD shall notify AHCCCS to ensure that there is no reinsurance or fee for service payments that have been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

For total Contractor cases, DES/DDD shall report settlement information to AHCCCS utilizing the AHCCCS approved casualty recovery Notification of Settlement form within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

Other Reporting Requirements*:* If DES/DDD discovers the probable existence of a liable party that is not known to AHCCCS, DES/DDD must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. In addition, DES/DDD shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the *Technical Interface Guidelines*. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

Upon AHCCCS' request, DES/DDD shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to DES/DDD. AHCCCS will provide DES/DDD with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the *Technical Interface Guidelines.*

Cost Avoidance/Recovery Report:
DES/DDD shall report on a quarterly basis a summary of their cost avoidance/recovery activity. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

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

64. MEDICARE SERVICES AND COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligible". Generally, DES/DDD is responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within DES/DDD's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. Unless prior approval is obtained from AHCCCS, DES/DDD must limit their cost sharing responsibility according to ACOM Policy 201 and Policy 202. DES/DDD shall have no cost sharing obligation if the Medicare payment exceeds what DES/DDD would have paid for the same service of a non-Medicare member. Please refer to Section D, Paragraph 10, Covered Services, for information regarding prescription medication for Medicare Part D.

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay co-payments for their Medicare covered prescription medications for the remainder of the calendar year regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

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

To ensure appropriate information is communicated for these members to the Center for Medicare and Medicaid Services (CMS), the following processes will be utilized:

1. DES/DDD must ensure that member placement information on the CA 161 screen is timely and as accurate as possible. Information regarding members placed in medical institutions funded by Medicaid for a full calendar month will be submitted to CMS.

2. DES/DDD will complete the ALTCS Medical Institution Notification form for Dual Eligible members who are placed in the medical institutions listed below to the AHCCCS Member Database Management Administration, via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month:

    a. Acute hospital
    b. Psychiatric Hospital – Non IMD
    c. Psychiatric Hospital – IMD

65. MEMBER BILLING AND LIABILITY FOR PAYMENT

AHCCCS registered providers may charge AHCCCS members for services which are excluded from AHCCCS coverage or which are provided in excess of AHCCCS limits according to the guidelines set forth in A.A.C R9-22-702.

Liability for Payment: Except for permitted calculated share of costs, DES/DDD or its subcontractors must ensure that members are not held liable for:

a. DES/DDD or subcontractor's debts in the event of DES/DDD or subcontractor's insolvency;
b. covered services provided to the member, for which AHCCCS does not pay DES/DDD and DES/DDD does not pay subcontractors; or
c. payments to DES/DDD or 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 DES/DDD or the subcontractor provided the services directly.

66. SURVEYS

DES/DDD may be required to perform its own annual general or focused member survey. All such surveys, along with a timeline for the project, must be approved in advance by AHCCCS. Results, analysis and improved strategies shall be communicated to AHCCCS Division of Health Care Management, DHCM Operations Unit within 45 days of completion. AHCCCS may require inclusion of certain questions. DES/DDD is required to include questions related to case manager performance, appointment waiting time, transportation wait times and culturally competent treatment on member surveys and to use personnel other than the case manager to administer the survey.

For non AHCCCS required surveys, DES/DDD shall provide AHCCCS notification 15 days prior to conducting any DES/DDD initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and the analysis of the results of any DES/DDD initiated surveys shall be submitted to the DHCM Operations Unit within 45 days of the completion of the project.

AHCCCS may periodically conduct a survey of a representative sample of DES/DDD's membership. AHCCCS will consider suggestions from DES/DDD for questions to be included in this survey. The draft reports from the surveys will be shared with DES/DDD prior to finalization. The results of these surveys will become public information and available to all interested parties on the AHCCCS website.

At least quarterly, DES/DDD is required to survey a sample of its membership that have received services to verify that services DES/DDD paid for were delivered as outlined in the ACOM Policy [42 CFR 455.20].

67. PATIENT TRUST ACCOUNT MONITORING

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

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

68. AMERICAN WITH DISABILITIES ACT (ADA) COMPLIANCE

DES/DDD shall meet all applicable ADA requirements when providing services to members.

69. CULTURAL COMPETENCY

DES/DDD shall have a Cultural Competency Plan which meets the requirement of the ACOM Cultural Competency Policy. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the AHCCCS Division of Health Care Management, DHCM Operations Unit, no later than 45 days after the start of each contract year. The Plan should address all services and settings, *i.e.*, attendant care, assisted living facilities, *etc*. [42 CFR 438.206(c)(2)]

DES/DDD shall ensure compliance with the cultural competency plan and all requirements pertaining to Limited English Proficiency.

70. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01 and the ACOM, Chapter 100, DES/DDD and their subcontractors and providers are required to immediately notify the AHCCCS, Office of the Inspector General (OIG) regarding any suspected fraud or abuse [42 CFR 455.17]. DES/DDD agrees to immediately (within ten business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)] by completing the confidential AHCCCS Referral for Preliminary Investigation form. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, contractors or sub-contractors.

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

DES/DDD agrees to permit and cooperate with any onsite review. A review by the OIG may be conducted without notice and for the purpose of ensuring program compliance. DES/DDD also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by the AHCCCS. DES/DDD agrees to provide documents, including original documents, to representatives of the OIG upon request. The 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 OIG request.

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

The compliance program shall be designed to both prevent and detect suspected fraud or abuse. The compliance program must include:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to and processes for complying with all applicable federal and state standards.
2. The written designation of a compliance committee who are accountable to DES/DDD's top management.
3. The Compliance Officer must be an onsite management official who reports directly to DES/DDD's top management. Any exceptions must be approved by AHCCCS.
4. Effective training and education.
5. Effective lines of communication between the compliance officer and the organization's employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Provision for internal monitoring and auditing.
8. Provision for prompt response to problems detected.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), DES/DDD, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. DES/DDD must establish a process for training existing staff and new hires on the compliance program and on the items in section 10. All training must be conducted in such a manner that can be verified by AHCCCS.
12. DES/DDD must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions;
    a. The administrative remedies for false claims and statements;
    b. Any state laws relating to civil or criminal penalties for false claims and statements;
    c. The whistleblower protections under such laws.
13. DES/DDD must notify AHCCCS of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

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

71. RECORDS RETENTION

DES/DDD shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. DES/DDD 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.

DES/DDD shall 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. DES/DDD shall be responsible for any costs associated with the production of requested information.

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

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

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

72. DATA MANAGEMENT

DES/DDD shall have the capability for all required technical interfaces with AHCCCS. Refer to the *AHCCCS Technical Interface Guidelines* in the Bidder's Library for further information. A copy of these guidelines are available online at www.azahcccs.gov.

73. DATA EXCHANGE REQUIREMENT

DES/DDD is authorized to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided AHCCCS in the formats prescribed by AHCCCS which includes formats prescribed by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the draft *HIPAA Transaction Companion Documents & Trading Partner Agreements*, the AHCCCS Encounter Manual and in the AHCCCS *Technical Interface Guidelines*, available online.

The information so recorded and submitted to 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 appropriate notification by AHCCCS.

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

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

DES/DDD shall accept from AHCCCS original evidence of eligibility and enrollment in a form appropriate for electronic data exchange. Upon request by AHCCCS, DES/DDD shall provide to AHCCCS updated date-sensitive PCP assignments in a form appropriate for electronic data exchange.

DES/DDD shall be provided with a DES/DDD -specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by the DES/DDD shall include DES/DDD's security code. DES/DDD agrees that by use of its security code, it certifies that any data transmitted is accurate and truthful, to the best of DES/DDD's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606].

The costs of software changes are included in administrative costs paid to DES/DDD. There is no separate payment for software changes. A PMMIS systems contact will be assigned after contract award. AHCCCS will work with DES/DDD as Electronic Data Interchange options are examined.

Health Insurance Portability and Accountability Act (HIPAA): DES/DDD shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of DES/DDD by the dates required by the implementing Federal regulation as well as all subsequent requirements and regulations as published.

74. ENCOUNTER DATA REPORTING

Encounter Submission:
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. DES/DDD shall submit encounter data to AHCCCS for all services for which DES/DDD incurred financial liability and claims for services eligible for processing by the DES/DDD 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)].

DES/DDD shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, DES/DDD certifies that the services listed were actually rendered. The encounters must be submitted in the format prescribed by AHCCCS.

Encounter data must be provided to AHCCCS as outlined in the X12 and NCPDP *Transaction Companion Documents & Trading Partner Agreements* and the AHCCCS Encounter Manual and should 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 DES/DDD, whichever date is later. Requirements for encounter data are described in the AHCCCS Encounter Manual and the AHCCCS Encounter Companion Documents.

To support Federal Drug Rebate processing, pharmacy related encounter data must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. For the purposes of this requirement, pharmacy encounter data is defined as retail pharmacy encounters until such time AHCCCS expands Federal Drug Rebate processing to include all other pharmaceuticals reported on professional and outpatient facility encounters.

DES/DDD will be assessed sanctions for noncompliance with encounter submission requirements.

Encounter Reporting:
DES/DDD must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounters and encounter revisions. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual.

At least twice each month AHCCCS provides DES/DDD with full replacement files containing provider and medical procedure coding information. These files should be used to assist DES/DDD to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information.

***Encounter Corrections*:**
DES/DDD is required to monitor and resolve pended encounters, encounters denied by AHCCCS, and encounters voided and voided/replaced. AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. In addition to adjudicated approved encounters, pended, denied and voided encounters affect completeness, accuracy and timeliness rates. Rates below the established standards

(pended encounters that have pended for more than 120 days), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

DES/DDD is required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission as described below. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or DES/DDD. DES/DDD 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 or adjustments that result in an increased claim value, replacement encounters must be submitted. For those recoupments requiring approval from AHCCCS, replacement encounters must be submitted within 120 days of the recoupment approval from AHCCCS. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected encounters.

***Encounter Validation Studies*:**
Per the CMS requirement, AHCCCS will conduct encounter validation studies of DES/DDD's encounter submissions, and may sanction DES/DDD and/or require a corrective action plan for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with DES/DDD's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria use in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS 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. DES/DDD will be notified in writing of any significant change in study methodology.

75. REPORTING REQUIREMENTS

AHCCCS, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data, and other information from DES/DDD. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 80, Sanctions and Attachment D, Chart of Deliverables. Standards applied for determining adequacy of required reports are as follows:

a. *Timeliness:* Reports or other required data shall be received on or before scheduled due dates.
b. *Accuracy:* Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
c. *Completeness:* All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

DES/DDD shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. DES/DDD shall comply with all changes specified by AHCCCS.

DES/DDD shall be responsible for continued reporting beyond the term of the contract.

76. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from DES/DDD. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such written requests for information, DES/DDD shall provide complete information as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself.

77. DISSEMINATION OF INFORMATION

Upon request, DES/DDD shall assist AHCCCS in the dissemination of information prepared by AHCCCS, or the federal government, to its members. The cost of such dissemination shall be borne by DES/DDD. All advertisements, publications and printed materials which are produced by DES/DDD and refer to covered services shall state that such services are funded under contract with AHCCCS.

78. RESERVED

79. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS requirements and AHCCCS Rule 9 A.A.C. 28, Article 5, AHCCCS, or an independent agent, will conduct periodic operational and financial reviews for the purpose of (but not limited to) identifying best practices and ensuring program compliance [42 CFR 438.204]. The type and duration of the review will be solely at the discretion of AHCCCS. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give DES/DDD at least three weeks advance notice of the scheduled Operational and Financial Review. AHCCCS reserves the right to conduct reviews without notice. AHCCCS may conduct a review without notice in the event DES/DDD undergoes reorganization, or makes changes in three or more key staff positions within a 12-month period, or to investigate complaints received by AHCCCS. DES/DDD shall comply with all other medical audit provisions as required by AHCCCS.

AHCCCS may request, at the expense of DES/DDD, to conduct on-site reviews of functions performed at out of state locations. AHCCCS will coordinate travel arrangements and accommodations with DES/DDD at their request.

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

DES/DDD will be furnished a copy of the draft Operational and Financial Review report and given the opportunity to comment on any review findings prior to AHCCCS issuing the final report. Recommendations made by the Review Team to bring DES/DDD into compliance with federal, state, AHCCCS, and/or contract requirements, must be implemented by DES/DDD. Modifications to the correction action plan must be approved in advance by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational and Financial Review to determine DES/DDD's progress in implementing recommendations and achieving program compliance.

DES/DDD shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report or final report to other AHCCCS Contractors. DES/DDD may share the Operational and Financial Review Tool with their subcontracted acute care plans.

In addition to the annual Operational and Financial Review AHCCCS may conduct unannounced site visits to monitor contractual requirements and performance as needed.

80. SANCTIONS

In accordance with applicable Federal and State laws and regulations, AHCCCS Rules R9-22-606 and R9-28-608, ACOM Policy 408 and the terms of this contract, AHCCCS may impose sanctions, including but not limited to: temporary management of DES/DDD; monetary penalties; withholding of payments; and suspension, refusal to renew, or termination of the contract, or any related subcontracts [42 CFR 422.208.42; 42 CFR 438.700, 702, 704, and CFR 92.36(i)(1); 45 CFR 74.48]. Written notice will be provided to DES/DDD specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. DES/DDD may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. R9-34-401 et seq.

Intermediate sanctions may be imposed, but are not limited to:

a. Substantial failure to provide medically necessary services that the DES/DDD is required to provide under the terms of this contract to its enrolled members.
b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
c. Discrimination among enrollees on the basis of their health status or need for health care services.
d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider.
f. Failure to comply with the requirement for physician incentive plan as delineated in Paragraph 39, Physician Incentive/Pay for Performance.
g. Distribution directly, or indirectly through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
h. Failure to meet AHCCCS Financial Viability Standards.
i. Material deficiencies in the DES/DDD's provider network.
j. Failure to meet quality of care and quality management requirements.
k. Failure to meet AHCCCS encounter standards.
l. Violation of other applicable State or Federal laws or regulations.
m. Failure to fund accumulated deficit in a timely manner.
n. Failure to comply with any provisions contained in this contract
o. Failure to report third party liability cases as defined in paragraph 63, Coordination of Benefits/Third Party Liability..
p. Submitting late, incomplete or inaccurate deliverables.

AHCCCS may impose the following types of intermediate sanctions:

a. Civil monetary penalties
b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and for violations defined in 42 CFR 438.706 and A.R.S.§36-2903 and §36-2932.
c. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
d. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process: Prior to the imposition of a sanction for non-compliance, AHCCCS shall provide a written cure notice to the DES/DDD regarding the details of the non-compliance. If a notice to cure is provided to DES/DDD, the cure notice will specify the period of time during which the DES/DDD must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, DES/DDD has complied with the cure notice requirements, AHCCCS will not impose a sanction. If, however, the DES/DDD has not complied with the cure notice requirements, AHCCCS may proceed with the imposition of sanctions.

Refer to the ACOM Policy 408 for details.

81. MEDICAID SCHOOL BASED CLAIMING PROGRAM, (MSB)

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

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

DES/DDD's evaluations and determinations of medical necessity shall be made independent of the fact that the child is receiving MSBC services. If a request is made for services that also are covered under the MSB program for a child enrolled with DES/DDD, the request shall be evaluated on the same basis as any request for a covered service.

DES/DDD and its providers must coordinate with schools and school districts that provide MSBC services to DES/DDD'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 DES/DDD and the member's school or school district is required as appropriate and should be used to enhance the services provided to members.

82. PENDING LEGISLATION AND PROGRAM CHANGES

The following constitute pending items that may be resolved after the initial issuance of the contract amendment. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract. Final capitation rates may also be adjusted to reflect the financial impact of program changes. The items in this paragraph are subject to change and should not be considered all-inclusive.

Community First Choice:
The Patient Protection and Affordable Care Act, Section 2401, Community First Choice (CFC) provides states an option that will allow the member, or where appropriate, the member's representative, to direct the services provided by the home and community-based attendant , regardless of who acts as the employer of record. AHCCCS is expecting to implement CFC using an Attendant Agency of Choice model, where the attendant is an employee of the agency but with the consumer retaining control. To obtain guidance on the implementation of CFC, AHCCCS has established a Development and Implementation Council that includes a majority of members with disabilities, elderly individuals, and their representatives. AHCCCS will include DES/DDD in the implementation of the Agency of Choice model.

Federal and State Legislation: AHCCCS and DES/DDD are subject to legislative mandates 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.

Health Information Technology for Economic and Clinical Health Act (HITECH): In February 2009, as part of the federal stimulus package, Congress enacted the Health Information Technology for Economic and Clinical Health Act (HITECH). The legislation included a number of provisions designed to encourage the adoption and use of health information technology including electronic health records (EHRs) and the development of a health information exchange (HIE) infrastructure. The underlying rationale for the Act is the belief that the adoption on a nationwide basis would reduce total spending on healthcare 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 Health Information Technology for Economic and Clinical Health Act (HITECH) includes provisions designed to encourage the adoption and use of health information technology including electronic health records (EHRs), e-prescribing and the development of a health information exchange (HIE) infrastructure. AHCCCS and its Contractors support these new evolving technologies, designed to create efficiencies and improve effectiveness of care resulting in improved patient satisfaction with the health care experience, the provision of optimal care outcomes and cost efficiencies.

To further the integration of technology based solutions and the meaningful use of electronic health records within provider offices, AHCCCS anticipates increasing opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption 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. Contractors 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 Contractors 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 expanding utilization of health information technology as it relates to health care management and Contractor deliverables in the following, but not limited to, areas:

- Access to care
- Care coordination
- Pharmacy, including but not limited to polypharmacy
- Evidence based care
- Disease management
- EPSDT services
- Coordination with community services
- Referral management
- Discharge planning
- Performance measures
- Performance improvement projects
- Medical record review
- Quality of care review processes
- Quality improvement
- Claims review
- Prior authorization
- Claims

83. BUSINESS CONTINUITY AND RECOVERY PLAN

DES/DDD shall develop a Business Continuity and Recovery Plan, as detailed in the ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. This plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at DES/DDD's main place of ALTCS business
- Complete loss of use of the main site and satellite offices out of state
- Loss of primary computer system/records
- Communication between DES/DDD and AHCCCS in the event of a business disruption
- Periodic testing

The Business Continuity and Recovery Plan shall be updated annually. DES/DDD shall submit a summary of the Plan to AHCCCS 15 days after the start of the contract year. All staff shall be trained and familiar with the Plan.

84. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Medical records include those maintained by 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 free of charge annually. DES/DDD shall have written policies and procedures to maintain the confidentiality of all medical records.

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

DES/DDD 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.

DES/DDD shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with the AMPM.

DES/DDD shall have written plans for providing training and evaluating providers' compliance with the DES/DDD medical records standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

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

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other agency. DES/DDD 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.

Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed [A.R.S. §36-664(I)].

85. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to members' demographic, eligibility and enrollment data, which DES/DDD shall use to update its member records. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction update, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. DES/DDD shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

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

The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for DES/DDD 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. DES/DDD will reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, DES/DDD will record the results of the reconciliation, which will be made available upon request, and 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 into the next month. If DES/DDD detects an error through the monthly update process, DES/DDD shall notify AHCCCS, Information Services Division.

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

86. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its Quality Strategy certain populations with special health care needs including members enrolled in DDD, CRS and those receiving behavioral health services. DES/DDD must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring [42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals [42 CFR 438.240(c)(2)] [42 CFR 438.208(c)(2)]. DES/DDD shall share with other entities providing services to that member the results of its identification and assessment of that member’s needs so that those activities need not be duplicated [42 CFR 438.208(b)(3) and (c)(3)]. Members enrolled in the ALTCS Program who are elderly or physically disabled or are developmentally disabled are automatically identified as having special health care needs.

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

DES/DDD shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation and chemotherapy, 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.

87. TECHNOLOGICAL ADVANCEMENT

DES/DD must have a website with links to the information as described in ACOM Policy 404 and Policy 416.

[END OF SECTION D]

SECTION E - CONTRACT TERMS AND CONDITIONS

1. APPLICABLE LAW

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

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

2. AUTHORITY

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

3. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract, including all attachments and executed amendments and modifications; AHCCCS policies and procedures.

4. CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State and signed by a duly authorized representative of the Contractor.

5. SEVERABILITY

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

6. RELATIONSHIP OF PARTIES

DES/DDD under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

7. ASSIGNMENT AND DELEGATION

DES/DDD shall not assign any rights nor delegate any duties under this contract. Delegation of less than all of the duties of this contract must conform to the requirements of Section D, Paragraph 33, Subcontracts.

8. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

DES/DDD 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. DES/DDD shall maintain all applicable licenses and permits.

9. 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.

10. THIRD PARTY ANTITRUST VIOLATIONS

DES/DDD 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 DES/DDD toward fulfillment of this contract.

11. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that DES/DDD does not intend to perform or continue performing this contract, the procurement officer may demand in writing that DES/DDD give a written assurance of intent to perform. The demand shall be sent to DES/DDD by certified mail, return receipt required. Failure by DES/DDD 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.

12. 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 DES/DDD receives written notice of the cancellation unless the notice specifies a later time.

13. GRATUITIES

AHCCCS may, by written notice to DES/DDD, immediately terminate this contract if it determines that employment or a gratuity was offered or made by DES/DDD or a representative of DES/DDD 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 DES/DDD.

14. SUSPENSION OR DEBARMENT

DES/DDD shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity 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)]. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. DES/DDD is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of the individuals. The database can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp.

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

15. 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, return receipt requested, to DES/DDD of the termination at least 90 days before the effective date of the termination. In the event of termination under this paragraph, all documents, data and reports prepared by DES/DDD under the contract shall become the property of and be delivered to AHCCCS. DES/DDD 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.

16. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR TERMINATION

Temporary Management/Operation by AHCCCS: Pursuant to the Balanced Budget Act of 1997, 42 CFR 438.700 et seq. and State Law ARS §36-2903, AHCCCS is authorized to impose temporary management for DES/DDD under certain conditions. Under federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by DES/DDD, including but not limited to the following: substantial failure to provide medically necessary services DES/DDD 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 DES/DDD is correcting the deficiencies noted above or until there is an orderly transition or reorganization of DES/DDD. Under federal law, temporary management is mandatory if AHCCCS determines that DES/DDD has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

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

Termination: AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of DES/DDD to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If DES/DDD is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require DES/DDD 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 DES/DDD by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide DES/DDD with a pre-termination hearing before termination of the contract.

17. 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 DES/DDD, 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, DES/DDD shall have no further obligation to AHCCCS.

18. RIGHT OF OFFSET

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

19. NON-EXCLUSIVE REMEDIES

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

20. NON-DISCRIMINATION

In accordance with ARS 41-1461 et seq. and Executive Order 2009-09, the Contractor shall provide equal employment opportunities for all persons, regardless of race, color, religion, creed, sex, age, national origin, disability or political affiliation. The Contractor shall comply with the Americans with Disabilities Act.

21. EFFECTIVE DATE

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

22. TERM OF CONTRACT AND OPTION TO RENEW

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

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days after the date of mailing by the Contracting Officer, even if the extension amendment has not been signed by the Program Contractor, unless within that time the Program Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. If the Contractor provides such notification, the Contracting Officer will 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.

23. DISPUTES

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

Except as provided by 9 A.A.C. Chapter 22, Article 6 the exclusive manner for DES/DDD to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and ARS §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, 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, DES/DDD 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.

24. 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.

25. CONTRACT
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.

26. COVENANT AGAINST CONTINGENT FEES
DES/DDD 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.

27. CHANGES
AHCCCS may at any time, by written notice to DES/DDD, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, DES/DDD may assert its right to an adjustment in compensation paid under this contract. DES/DDD must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 26, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by AHCCCS, even if the amendment has not been signed by DES/DDD, unless within that time DES/DDD notifies AHCCCS in writing that it refuses to sign the amendment. If DES/DDD provides such notification, AHCCCS will initiate termination proceedings.

28. TYPE OF CONTRACT
Firm Fixed-Price stated as capitated per member per month except as otherwise provided.

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

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

31. NO GUARANTEED QUANTITIES
AHCCCS does not guarantee DES/DDD any minimum or maximum quantity of services or goods to be provided under this contract.

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

33. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

DES/DDD 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 DES/DDD by AHCCCS.

34. COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this contract and DES/DDD shall fully cooperate with such other contractors and AHCCCS employees or designated agents DES/DDD shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees.

35. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this contract are the sole property of AHCCCS. DES/DDD 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, DES/DDD 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 DES/DDD in the course of performing its duties and obligations under this contract shall not be used by DES/DDD for any independent project of DES/DDD or publicized by DES/DDD 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, DES/DDD 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 DES/DDD 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. DES/DDD shall additionally be subject to the applicable provisions of 45 CFR Part 92.

36. AUDITS AND INSPECTIONS

DES/DDD 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 DES/DDD’s facilities. DES/DDD shall fully cooperate with AHCCCS staff and allow them reasonable access to DES/DDD’s staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, DES/DDD’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 438.242(b)(3)].

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.

37. LOBBYING

No funds paid to DES/DDD 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. DES/DDD shall disclose if any funds paid to DES/DDD 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.

38. 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.

39. DATA CERTIFICATION

DES/DDD 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 DES/DDD Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO. 42 CFR 438.604 et. seq.

40. 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. Offerors shall declare all anticipated offshore services in the proposal.

41. FEDERAL IMMIGRATION AND NATIONALITY ACT

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.

42. IRS W9 FORM

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

43. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

DES/DDD 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.

44. 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.

45. 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.

46. SCRUTINIZED BUSINESSES

In accordance with A.R.S. 35-391 and A.R.S. 35-393, Contractor certifies that the Contractor does not have scrutinized business operations in Sudan or Iran.

SECTION F - ATTACHMENTS

ATTACHMENT A: RESERVED

The Minimum Subcontract Provisions are now on the AHCCCS Website at:

http://www.azahcccs.gov/commercial/MinimumSubcontractProvisions.aspx

ATTACHMENT B(1): ENROLLEE GRIEVANCE SYSTEM

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

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

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

At a minimum, DES/DDD's Grievance System Standards and Policy shall specify:

1. That DES/DDD shall maintain records of all grievances and appeals and requests for hearings.

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

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

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

5. That DES/DDD shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

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

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

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

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

10. That an enrollee must file a grievance with DES/DDD and that the enrollee is not permitted to file a grievance directly with the AHCCCS.

11. That DES/DDD must dispose of each grievance in accordance with the Grievance System Reporting Guide, but in no case shall the timeframe exceed 90 days.

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

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

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

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

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

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

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

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

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

21. The definition of a standard appeal and that DES/DDD shall resolve standard appeals no later than 30 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.

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

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

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

25. That DES/DDD shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 5 days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:

    a. DES/DDD receives notification of the death of an enrollee;
    b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
    c. The enrollee is admitted to an institution where he is ineligible for further services;

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

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

27. That the Notice of Action must explain: 1) the action DES/DDD has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with DES/DDD, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.

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

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

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

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

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

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

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

34. That if the enrollee files a request for hearing , DES/DDD must ensure that the case file and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS) no later than five business days from when DES/DDD receives the provider's written hearing request. The file provided by DES/DDD must contain a cover letter that includes:
    a. Enrollee's name

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

35. The following material shall be included in the file sent by DES/DDD:
    a. the Enrollee's written request for hearing
    b. copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
    c. DES/DDD's Notice of Appeal Resolution
    d. other information relevant to the resolution of the appeal

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

37. That if DES/DDD or the Director's Decision reverses a decision to deny, terminate, reduce or suspend 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 DES/DDD or Director's Decision and applicable statutes, rules, policies and contract terms. The Contractor shall not deny the provider's request for reimbursement on the same basis as the reversed decision or for lack of prior authorization. The Contractor shall allow the provider the longer of 1) the timeframes described in ARS §36-2904 or 2) 60 days from the date of the decision to submit a clean claim to the Contractor unless the Director's Decision specifies otherwise. 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.

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

ATTACHMENT B(2): PROVIDER CLAIMS DISPUTE SYSTEM STANDARDS AND POLICY

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

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

2. The Provider Claims Dispute System Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with DES/DDD 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 whichever is later.

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

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

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

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

7. All documentation received by DES/DDD during the claims dispute process is dated upon receipt.

8. All claim disputes are filed in a secure designated area and are retained for five years following DES/DDD's decision, the Administration's decision, judicial appeal or close of the claims dispute, whichever is later, unless otherwise provided by law.

9. A copy of DES/DDD's Notice of Decision (hereafter referred to as Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute 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 grievance
    b. the issues involved
    c. the reasons supporting DES/DDD's Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
    d. the Provider's right to request a hearing by filing a written request for hearing to DES/DDD no later than 30 days after the date the Provider receives DES/DDD's decision.
    e. If the claim dispute is overturned, the requirement that the DES/DDD shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

10. If the Provider files a written request for hearing , DES/DDD must ensure that all supporting documentation is received by the DES, Division of Services and Support, Appellate Services Administration (DES/DSS/ASA), no later than five business days from the date DES/DDD receives the provider's written hearing request. The file sent by DES/DDD must contain a cover letter that includes:

a. Provider's name
b. Provider's address
c. Member's name and AHCCCS Identification Number
d. Provider's phone number (if applicable)
e. The date of receipt of claim dispute
f. A summary of DES/DDD's actions undertaken to resolve the claim dispute and basis of the determination

11. The following material shall be included in the file sent by DES/DDD:

    a. Written request for hearing filed by the Provider
    b. Copies of the entire file which includes pertinent records; and DES/DDD's Decision
    c. Other information relevant to the Notice of Decision of the claim dispute

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

ATTACHMENT C: RESERVED

ATTACHMENT D: CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for DES/DDD 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 DES/DDD'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 on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM on the next business day.

If DES/DDD is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Program Contractor may request to submit data on a quarterly basis. However, if DES/DDD is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, DES/DDD must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

CONTRACTS

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Initial contracts with AHCCCS and any amendments and renewals (Section E, ¶22)	Within 60 days of receipt from AHCCCS	Contracts & Purchasing Administrator (DBF)	Email signature page
Request to assign any right or delegate any duty(Section E, ¶7)	Approval required prior to assignment	Contracts & Purchasing Administrator (DBF)	Email signature page
Subcontracts for: • Delegated Agreements • Management Services Agreements • Service Level Agreements • (Section D, ¶ 33) • RFP for Medical Services	60 days prior to start date	DHCM Operations Manager	FTP server with email notification

BEHAVIORAL HEALTH

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Annual Case Review of Behavioral Health Services to Members (Section D, ¶12)	August 30	Clinical Quality Management Unit (DHCM)	FTP server with email notification

DATA ANALAYSIS AND RESEARCH

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Corrected Pended Encounter Data (Section D, ¶74)	Monthly, according to established schedule	Encounter Administrator (DHCM)	FTP server with email notification
New Day Encounter (Section D, ¶74 and Encounter Manual)	Monthly, according to established schedule	Encounter Administrator (DHCM)	FTP server with email notification
Medical Records for Data Validation (Section D, ¶ 74, Data Validation User Manual)	90 days after the request received from AHCCCS	Encounter Administrator (DHCM)	FTP server with email notification

EXECUTIVE MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Cultural Competency Annual Evaluation (Section D, ¶69)	45 days after the start of the contract year	DHCM Operations (DHCM)	FTP server with email notification
Network Development and Management Plan (Section D, ¶28)	November 15	DHCM Operations (DHCM)	FTP server with email notification
Resignation and addition of any key staff (Section D, ¶25)	Within 7 days of learning of resignation	DHCM Operations (DHCM)	FTP server with email notification
All physician incentive agreements upon contract renewal, prior to initiation of new contract or upon request from AHCCCS or CMS (Section D, ¶39)	45 days prior to implementation	ALTCS Financial Manager (DHCM)	FTP server with email notification
Provider Fraud/Abuse Report (Section D, ¶70)	Within 10 business days of discovery	Office of Inspector General (OIG)	Secure email or web portal
Eligible Person Fraud/Abuse Report (Section D, ¶70)	Within 10 days of discovery	Office of Inspector General (OIG)	Secure email or web portal
Modifications of Operational & Financial Review Corrective Action Plan (Section D, ¶79)	Prior to implementation of modification	DHCM Operations (DHCM)	FTP server with email notification
Related party subcontracts (Section D, ¶55)	Prior approval required	DHCM Operations (DHCM)	FTP server with email notification
Key Staff Demographics for Staff listed in a., b. & c. (Section D, ¶25)	July 15	Valarie Noor, HC Health Program Manager III, OIG/Provider Relations; MD 4500, 701 E. Jefferson, Phoenix, AZ 85034	Hardcopy
Staff functions located outside of Arizona (Section D, ¶25)	August 15	DHCM Operations (DHCM)	FTP server with email notification

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Organizational Chart with "Key Staff" positions (Section D, ¶25)	August 15	DHCM Operations (DHCM)	FTP server with email notification
Functional Organizational Chart with key program areas, responsibilities and reporting lines. (Section D, ¶25)	August 15	DHCM Operations (DHCM)	FTP server with email notification
Administrative Services Annual Subcontractor Assignment and Evaluation Report (Section D, ¶ 33)	Annually 90 days after start of contract year	DHCM Operations (DHCM)	FTP server with email notification
Business Continuity and Recovery Plan Summary (Section D, ¶83)	15 days after the start of the contract year	DHCM Operations (DHCM)	FTP server with email notification
Administrative Directives (Section D, ¶26)	10 days after the end of each quarter (October, January, April, July)	DHCM Operations (DHCM)	FTP server with email notification
Website Certification (Section D, ¶17)	45 days after the start of the contract year.	DHCM Operations (DHCM)	FTP server with email notification

FINANCE

REPORT	**DATE DUE**	**SEND TO:**	**SUBMITTED VIA:**
Monthly Financial statement (not including months that are also a quarter end) in DES/DDD standard format (Section D, ¶52)	30 days after month end	Finance Manager (DHCM)	FTP server with email notification
Monthly Claims Dashboard Report (Section D, ¶44)	15 days after month end	Finance Manager (DHCM)	FTP server with email notification
Quarterly Financial Statement (Section D, ¶52)	60 days after quarter end	Finance Manager (DHCM)	FTP server with email notification
FQHC Member Month Information (Section D, ¶42)	60 days after quarter end	Finance Manager (DHCM)	FTP server with email notification
Draft Audited Financial Statement (Section D, ¶52)	120 days after year end	Finance Manager (DHCM)	FTP server with email notification
Annual Submission of Budget (Section D, ¶57)	August 10th	Finance Manager (DHCM)	FTP server with email notification
Final Audited Financial Statement (Section D, ¶75)	150 days after year end	Finance Manager (DHCM)	FTP server with email notification
Final Management Letter (Section D, ¶75)	150 days after year end	Finance Manager (DHCM)	FTP server with email notification
Annual Disclosure Statement (Section D, ¶75)	150 days after year end	Finance Manager (DHCM)	FTP server with email notification
Annual Reconciliation (Section D, ¶75)	150 days after year end	Finance Manager (DHCM)	FTP server with email notification
Advances, Distributions, Loans (Section D, ¶50)	Prior approval required	Finance Manager (DHCM)	FTP server with email notification

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Claims recoupments exceeding $50,000 per provider within a contract year (Section D, ¶44)	Prior approval required	Finance Manager (DHCM)	FTP server with email notification
Summary of contract rates for long term care and home and community based services (See Financial Reporting Guide for format)	December 1	Finance Manager (DHCM)	FTP server with email notification
Quarterly Verification of Receipt of Paid Services (Section D, ¶66 and ACOM Policy 424)	Due the 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	Finance Manager (DHCM)	FTP server with email notification
Quarterly Cost Avoidance/Recovery Report (Section D, ¶ 63 and the AHCCCS Program Integrity Reporting Guide)	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 November 14	Finance Manager (DHCM)	FTP server with email notification

GRIEVANCE SYSTEM

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Grievance Systems Reports (Section D, ¶22)	Tenth Day of 2nd Month Following Month Being Reported	Division of Health Care Management (DHCM)	FTP server with email notification
Request for Hearing Files (Section F, ¶Attachment B)	5 business days from the date appeal is received	Office of Legal Assistance	Hardcopy

MEMBER SERVICES/CASE MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
All Member Informational Materials (Newsletters, Brochures, etc.) (Section D, ¶17)	Prior to Distribution	DHCM Operations (DHCM)	FTP server with email notification
Annual Member Survey (Section D, ¶ 66)	Prior to Distribution	DHCM Operations (DHCM)	FTP server with email notification
Annual Member Survey results analysis and improvement strategies (Section D, ¶ 66)	45 days after completion	DHCM Operations (DHCM)	FTP server with email notification

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Member Handbook (Section D, ¶ 17)	Within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution	DHCM Operations (DHCM)	FTP server with email notification
Placement outside the state (Section D, ¶14)	Prior approval required	DHCM Operations (DHCM)	FTP server with email notification
Changes or corrections to member's circumstances (income, living arrangements, TPL, services, etc.) (Section D, ¶18)	ALTCS electronic member change report requirements	AHCCCS Electronic Submission	Web portal
Case Management Plan (Section D, ¶16)	November 15	ALTCS Case Management Manager (DHCM)	FTP server with email notification
Targeted Case Management Plan (Attachment E)	November 15	ALTCS Case Management Manager (DHCM)	FTP server with email notification
Case management internal monitoring process, results, and continuous improvement strategies (Section D, ¶16)	As requested	ALTCS Case Management Manager (DHCM)	FTP server with email notification

NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Network Summary (Section D, ¶32)	10/15, 5/15	ALTCS Unit (DHCM)	FTP server with email notification
All material changes in provider network (Section D, ¶29)	In advance of the change	ALTCS Unit (DHCM)	FTP server with email notification
Ball v. Betlach Semi-Annual Report (Section D, ¶28)	May 15 (Oct, Nov, Dec, Jan, Feb, Mar) Nov 15 – (Apr, May, Jun, Jul, Aug, Sep)	ALTCS Unit (DHCM)	FTP server with email notification
Unexpected major network changes (Section D, ¶29)	Within 1 day of change	ALTCS Unit (DHCM)	FTP server with email notification
Provider who refuses to sign a contract (if providing more than 25 services in the contract year) (Section D, ¶33)	Document refusal within 7 days of final attempt to gain contract	ALTCS Unit (DHCM)	FTP server with email notification
Non-Provision of Services Log (Section D, ¶ 28 and ACOM *Gap-In-Services Policy*)	10th business day following the reporting month	DHCM Operations *(DHCM)*	Secure email
Gap in Services Log (Section D, ¶ 28 and ACOM *Gap-In-Services Policy*)	10th business day following the reporting month	DHCM Operations (DHCM)	Secure email
Quarterly Provider Terminations Due to Rates (ACOM *Provider Network Development and Management Plan Policy*)	15 days after the end of each quarter	DHCM Operations (DHCM)	FTP server with email notification

THIRD PARTY LIABILITY

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Report the following cases of Third Party Liability (Section D, ¶63): • Uninsured/underinsured motorist insurance • First and third-party liability insurance • Tortfeasors, including casualty • Trust recovery • Restitution recovery • Estate recovery • Worker's Compensation	Upon Identification	AHCCCS TPL Subcontractor	HMS web portal or Hardcopy to TPL section in DBF
Report all joint liability cases (Section D, ¶63)	Within 10 business days of identification	AHCCCS TPL Subcontractor	HMS web portal or Hardcopy to TPL section in DBF

CLINICAL QUALITY MANAGEMENT (QM)

REPORT	DATE DUE	SEND TO	SUBMITTED VIA:
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with the Document) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Maternity Care Plan (Section D, ¶20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Stillbirth Report (Section D, ¶ 20) (AMPM Chapter 400)	Immediately following procedure	Clinical Quality Management Unit (DHCM)	Secure email to CQM Administrator or fax to 602-417-4162
EPSDT Monitoring Report (Section D, ¶ 20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Monthly Pregnancy Termination Report (Section D, ¶20) (AMPM Chapter 400)	End of the month following pregnancy termination.	Clinical Quality Management Unit (DHCM)	Secure email to CQM Administrator or fax to 602-417-4162
EPSDT Improvement and Adult Quarterly Monitoring Report (Template must be used) (Section D, ¶ 20) (AMPM Chapter 400)	30 days after the end of each quarter See Suspension list for specific items being suspended	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Credentialing Quarterly Report (Section D, ¶20)	30 days after the end of each quarter	Clinical Quality Management Unit (DHCM)	FTP server with email notification

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA:
Semi-annual report of number of pregnant women who are HIV/AIDS positive (Section D, ¶10 - Maternity)	30 days after the end of each quarter of the contract year	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Performance Improvement Project Baseline Report(Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Performance Improvement Project Re-measurement Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Performance Improvement Project Final Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	Clinical Quality Management Unit (DHCM)	FTP server with email notification
QM Quarterly Report (Section D, ¶20)	45 days after end of each quarter	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Pediatric Immunization Audit (Section D, Paragraph 20)	As Requested	Clinical Quality Management Unit (DHCM)	FTP server with email notification

MEDICAL MANAGEMENT

REPORT	DATE DUE	SEND TO	SUBMITTED VIA:
Quarterly Inpatient Hospital Showing (Section D, ¶21and the AMPM Chapter 1000)	15 days after the end of each quarter	Medical Management Unit	FTP server with email notification
Medical Management Plan and Evaluation (AMPM Chapter 900)	Annually on December 15th	Medical Management Unit	FTP server with email notification
MM Quarterly Report (Section D, ¶21)	60 Days after the end of each quarter	Medical Management Unit	FTP server with email notification
HIV Specialty Provider List (AMPM Chapter 300)	Annually, on December 15th	Medical Management Unit	FTP server with email notification
Transplant Report (AMPM, Chapter 1000)	15 days after the end of each quarter	Medical Management Unit	FTP server with email notification
Non-Transplant and Catastrophic Reinsurance covered Diseases and Biological Medications (Section D, ¶58)	Annually, within 30 days of the beginning of the contract year, and when newly enrolled in the plan or newly diagnosed.	Medical Management Unit	FTP server with email notification

Suspensions
The following describes suspensions made during the current contract or renewal period. Suspensions are defined as a temporary release from the deliverable requirement as presented in Contract for the term shown in this Attachment. The following suspensions will be in effect for the period from July 1, 2012 through June 30, 2013.

Section D, Paragraph 20, Quality Management
PEDS tracking and Obesity Tracking reporting in the EPSDT Quarterly Report are suspended.

Section D, Paragraph 21, Medical Management
The report of Prior Authorization is suspended.
The Medical Management Quarterly Report is suspended.

Section D, Paragraph 44, Claims Payment/Health Information System
Signed Agreement with an independent auditing firm with a schedule of completion for the independent audits of the Claims Payment/Health Information System (Section D, ¶ 44)

Independent Audits of Claims Payment/Health Information Systems (Section D, ¶ 44)

Claims Review Report (Section D, ¶ 44)

ATTACHMENT E: TARGETED CASE MANAGEMENT

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

1. TARGETED CASE MANAGEMENT SERVICES FOR NON-ALTCS RECIPIENTS

The case management responsibilities as described in Chapter 1600, Section 1640 of the AHCCCS Medical Policy Manual shall apply to DES/DDD recipients enrolled with an AHCCCS acute care contractor (non-ALTCS members). DES/DDD shall submit, annually, with their ALTCS Case Management Plan to AHCCCS a written plan describing the implementation and monitoring of Targeted Case Management.

"Case manager" means a person who is either a degreed social worker, licensed registered nurse, or one with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. DES/DDD shall ensure adequate staffing to meet case management requirements. If case management staffing is not adequate to meet the needs of the recipients, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must be sufficient to cover case manager absenteeism and turnover. AHCCCS will review caseload sizes during the annual Targeted Case Management Services Review.

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

2. PAYMENT

Payment to DES/DDD for targeted case management services must not duplicate payments made to public agencies or private entities under other program for this same purpose and will be made by AHCCCS on a capitated basis as a pass through of federal funds received by AHCCCS. See Section 56 – Compensation for a description of the pass-through process

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

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

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

3. ON-SITE REVIEWS

In accordance with AHCCCS Rule 9 A.A.C 28, Article 5, AHCCCS will conduct an operational review of targeted case management services every year for the purpose of, but not limited to, ensuring program compliance. The type and duration of the review will be solely at the discretion of AHCCCS and will include, but not be limited to, Case Management Services Review. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give DES/DDD at least four weeks advance notice of the date of the on-site review. AHCCCS may conduct a review in the event DES/DDD undergoes a reorganization or makes changes in three or more key staff positions within a 12-month period.

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

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

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

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

4. ANNUAL SUBMISSION OF BUDGET

DES/DDD shall submit to AHCCCS, by July 31st of each year, an estimate of the costs of providing targeted case management services pursuant to this contract. The cost estimates must be fully supported by documentation stating the nature of the costs and the methods and data used to develop the estimates.
If at any time during the term of this contract DES/DDD determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. AHCCCS, with DES/DDD, may request additional money from the Governor’s Office of Strategic Planning and Budgeting.

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

5. SANCTIONS

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