SECTION A: CONTRACT AMENDMENT

1. AMENDMENT #:	2. CONTRACT #: **YH18-0001**	3. EFFECTIVE DATE OF AMENDMENT: **OCTOBER 1, 2023**	4. PROGRAM: **ALTCS E/PD**

5. CONTRACTOR NAME AND ADDRESS:

6. PURPOSE: To extend and amend the following Contract Sections for the period of October 1, 2023, through September 30, 2024: Section B, Contractor Capitation Rates and Contractor Specific Requirements, Section C, Definitions, Section D, Program Requirements, Section E, Terms and Conditions, and Section F, Attachments.

7. THE ABOVE REFERENCED CONTRACT IS HEREBY AMENDED AS FOLLOWS:

- **Section B, Capitation Rates and Contractor Specific Requirements**
- **Section C, Definitions**
- **Section D, Program Requirements**
- **Section E, Terms and Conditions**
- **Section F, Attachments**

Therefore, this Contract is hereby REMOVED IN ITS ENTIRETY, including but not limited to all terms, conditions, requirements, and pricing and is amended, restated, and REPLACED with the documents attached hereto as of the Effective Date of this Amendment.

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

9. SIGNATURE OF AUTHORIZED REPRESENTATIVE AND DATE: **DO NOT SIGN SEE SEPARATE SIGNATURE PAGE**	10. SIGNATURE OF AHCCCS CONTRACTING OFFICER AND DATE**:** **DO NOT SIGN SEE SEPARATE SIGNATURE PAGE**
11. TITLE OF AUTHORIZED REPRESENTATIVE:	12. TITLE OF AHCCCS CONTRACTING OFFICER**:**

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SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS

In consideration for these services, the Contractor will be paid Contractor-specific rates Per Member Per Month (PMPM) effective until otherwise modified by Contract amendment.

Capitation Rates: See Contractor-specific Section B

Contractor Specific Requirements: See Contractor-specific Section B

[END OF SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS]

SECTION C: DEFINITIONS

638 TRIBAL FACILITY

A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native (AI/AN) Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facilities, tribally owned and/or operated facility, 638 tribal facility, and tribally operated 638 health program.

ABUSE OF THE AHCCCS PROGRAM

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, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program [42 CFR 455.2].

ABUSE (OF A CHILD)

As specified in A.R.S. § 8-201(2), abuse of a child is defined as follows: The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. Abuse includes:

1. Inflicting or allowing sexual abuse, sexual conduct with a minor, sexual assault, molestation of a child, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, or child sex trafficking as those acts are specified in the Arizona Revised Statutes, Title 13, Chapter 14.
2. Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found, or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in section 13-3401.
3. Unreasonable confinement of a child.

ABUSE (OF A MEMBER)

Abuse of a Vulnerable Adult or the Abuse of a Child who is a member as specified in A.R.S. § 46-451(A)(1), A.R.S. § 8-201(2), A.R.S. § 46-451(A)(10).

ABUSE (OF A VULNERABLE ADULT)

As specified in A.R.S. § 46-451(A)(1), (i) an intentional infliction of physical harm, (ii) injury caused by negligent acts or omissions, (iii) unreasonable confinement, or (iv) sexual abuse or sexual assault.

ACTIVE TREATMENT

A current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.

ACTIVE TREATMENT – CHILDREN'S REHABILITATION SERVICES (CRS)

A current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22-1301).

ACTUARY

An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates [42 CFR 438.2].

ACUTE CARE ONLY (ACO)

The enrollment status of a member who is otherwise financially and medically eligible for Arizona Long Term Care Services (ALTCS) but who:

a. Refuses HCBS offered by the Case Manager,
b. Has made an uncompensated transfer that makes him or her ineligible,
c. Resides in a setting in which Long Term Services and Supports (LTSS) cannot be provided, or
d. Has an equity value in a home that exceeds $552,000.

These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive Long Term Care (LTC) institutional, alternative residential or Home and Community Based Services (HCBS).

ADJUDICATED CLAIM

A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.

ADMINISTRATIVE OFFICE OF THE COURTS (AOC)

The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director, and the staff of the AOC provide the necessary support for the supervision and administration of all State courts.

ADMINISTRATIVE SERVICES SUBCONTRACT/ SUBCONTRACTOR

An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims,
b. Pharmacy Benefit Manager (PBM),
c. Dental Benefit Manager,
d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),
e. Medicaid Accountable Care Organization (ACO),
f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and
g. CHP and DES/DDD Subcontracted Health Plan.

A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

ADULT

An individual 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.

ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)

Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).

ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS </= 106%)

Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).

AFFILIATED ORGANIZATION

A party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.

AGENT

Any individual who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].

AHCCCS AMERICAN INDIAN HEALTH PROGRAM (AIHP)

A Fee-For-Service (FFS) program administered by AHCCCS for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.

AHCCCS COMPLETE CARE (ACC) CONTRACTOR

A contracted Managed Care Organization (also known as a health plan) that is responsible for the provision of specific physical and behavioral health services to certain Title XIX/XXI populations as specified in Contract No. YH19-0001 and which does not have the expanded contractual responsibilities of an ACC-RBHA under Competitive Contract Extension (CCE) No. YH20-0002.

AHCCCS COMPLETE CARE-REGIONAL BEHAVIORAL HEALTH AGREEMENT (ACC-RBHA) OR (RBHA) CONTRACTOR	An AHCCCS Complete Care (ACC) Contractor with expanded contractual responsibilities, as specified in Competitive Contract Extension (CCE) No. YH20-0002, for the provision of Non-Title XIX/XXI services for Title XIX/XXI and Non-Title XIX/XXI members and comprehensive Title XIX/XXI physical health and behavioral health services to eligible individuals with a Serious Mental Illness (SMI) designation.
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration. The ACOM provides information to Contractors and subcontractors who have delegated responsibilities under the contract.
AHCCCS ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.
AHCCCS MANAGED CARE ORGANIZATION (MCO)	An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to A.R.S. §§ 36-2904, 36-2940, or 36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.
AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information to Contractors and Providers regarding services that are covered within the AHCCCS program. The AMPM is applicable to both Managed Care Organizations (MCOs) and Fee-For-Service (FFS) Programs and Providers.
AHCCCS MEMBER	REFER TO “MEMBER”.
AHCCCS RULES	REFER TO “ARIZONA ADMINISTRATIVE CODE”.

ALTERNATIVE HOME AND COMMUNITY BASED SERVICES (HCBS) SETTING

A living arrangement where a member may reside and receive HCBS. The setting shall be approved by the director, and either:
1. Licensed or certified by a regulatory agency of the State.
2. Operated by the Indian tribe or tribal organization, or an urban Indian organization, and has met all the applicable standards for State licensure, regardless of whether it has actually obtained the license.

The possible types of settings include:
1. For an individual with an intellectual/developmental disability:
   a. Community residential settings,
   b. Group homes,
   c. State-operated group homes,
   d. Group foster homes,
   e. Adult Behavioral health therapeutic homes (ABHTH), and
   f. Behavioral health respite homes.

2. For an individual who is Elderly and Physically Disabled (E/PD):
   a. Adult foster care homes,
   b. Assisted living homes or assisted living centers, units only,
   c. Adult Behavioral health therapeutic homes (ABHTH), and
   d. Behavioral health respite homes.

AMBULATORY CARE

Preventive, diagnostic, and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.

AMERICANS WITH DISABILITIES ACT (ADA)

The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.

ANNIVERSARY DATE

The anniversary date is 12 months from the date the member is enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.

ANNUAL ENROLLMENT CHOICE (AEC)

The opportunity for an individual to change Contractors every 12 months.

APPEAL

The request for review of an adverse benefit determination.

APPEAL RESOLUTION

The written determination by the Contractor concerning an appeal.

ARIZONA ADMINISTRATIVE CODE (A.A.C.)

The official publication of Arizona's codified Rules and published by the Administrative Rules Division.

ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)	The department established pursuant to A.R.S. § 8-451 to protect children and to perform the following: 1. Investigate reports of abuse and neglect. 2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect. 3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations. 4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family, and provide prevention, intervention, and treatment services pursuant to A.R.S. Title 8, Chapter 4.
ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)/COMPREHENSIVE HEALTH PLAN (DCS/CHP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Prior to April 1, 2021, CHP was the Comprehensive Medical and Dental Program (CMDP) (A.R.S. § 8-512).
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The State agency that has the powers and duties set forth in A.R.S. § 36-104 and A.R.S. Title 36, Chapters 5 and 34.
ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the County juvenile courts.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Demonstration Waiver, and specified in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and Case Management services as authorized by A.R.S. § 36-2931 et seq., to eligible members who are either Elderly and/or have Physical Disabilities (E/PD), and to members with Developmental Disabilities (DD), through contractual agreements and other arrangements. REFER TO "LINE OF BUSINESS."
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
ARIZONA STATE PLAN	The written agreements between the State and Centers for Medicare and Medicaid Services (CMS), which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
ASSESSMENT	An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in A.A.C. R9-10-101.

ASSESSMENT AND TRACKING SYSTEM (CATS) A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to and receive key information from ALTCS Contractors.

ATTACHMENT Any item labeled as an Attachment in the Contract or placed in the Attachments section of the Contract.

AUTHORIZED REPRESENTATIVE An individual who is authorized to apply for medical assistance or act on behalf of another individual (A.A.C. R9-22-101, A.A.C. R9-28-401).

BALANCED BUDGET ACT (BBA) REFER TO "MEDICAID MANAGED CARE REGULATIONS."

BED HOLD A 24 hour per day unit of service that is authorized by an Arizona Long Term Care System (ALTCS) member's Case Manager or the behavioral health Case Manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short-term hospitalization leave and therapeutic leave. Refer to the Arizona State Plan Amendment (SPA), 42 CFR 447.40 and 42 CFR 483.12, 9 A.A.C. 28.

BEHAVIORAL HEALTH Mental health and substance use collectively.

BEHAVIORAL HEALTH DISORDER Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance use treatment.

BEHAVIORAL HEALTH PARAPROFESSIONAL (BHPP) As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33.
2. Are provided under supervision by a behavioral health professional.

BEHAVIORAL HEALTH PROFESSIONAL (BHP)

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
   a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251, or
   b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101,
2. A psychiatrist as defined in A.R.S. § 36-501,
3. A psychologist as defined in A.R.S. § 32-2061,
4. A physician,
5. A behavior analyst as defined in A.R.S. § 32-2091,
6. A registered nurse practitioner licensed as an adult Psychiatric and mental health nurse, or
7. A registered nurse with:
   a. A psychiatric-mental health nursing certification, or
   b. One year of experience providing behavioral health services.

BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF)

As specified in A.A.C. R9-10-101, health care institution that provides treatment to an individual experiencing a behavioral health issue that:

1. Limits the individual's ability to be independent, or
2. Causes the individual to require treatment to maintain or enhance independence.

BEHAVIORAL HEALTH SERVICES

Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

BEHAVIORAL HEALTH TECHNICIAN (BHT)

An individual who is not a behavioral health professional who provides the following services to a patient to address the patient's behavioral health issue:

1. With clinical oversight by a behavioral health professional, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed under A.R.S. Title 32, Chapter 33.
2. Health-related services.

BOARD CERTIFIED

An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.

BORDER COMMUNITIES

Cities, towns, or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring States, excluding neighboring countries, due to service availability or distance.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	Eligible individuals under the Title XIX expansion program for women with income up to 250% of the Federal Poverty Level (FPL), who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. § 36-2904 and A.R.S. § 36-2907.
CARE MANAGEMENT	A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
CARE MANAGEMENT PROGRAM (CMP)	Activities to identify the top tier of high need/high-cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care Management is an administrative function performed by the health plan. Distinct from Case Management, Care Managers should not perform the day-to-day duties of service delivery.
CASE MANAGEMENT	A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
CASH MANAGEMENT IMPROVEMENT ACT (CMIA)	Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.
CENTERS OF EXCELLENCE	A facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs, and the State Children's Health Insurance Program (Title XXI).

CHANGE IN ORGANIZATIONAL STRUCTURE

Any of the following:

1. Acquisition.
2. Change in organizational documents (e.g., Amendments to Articles of incorporation, Amendments to Partnership Agreements).
3. Change in Ownership.
4. Change of MSA Subcontractor (to the extent management of all or substantially all plan functions have been delegated to meet AHCCCS contractual requirements).
5. Joint Venture.
6. Merger.
7. Reorganization.
8. State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature.
9. Other applicable changes which may cause:
    a. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN),
    b. Changes in critical member information, including the website, member or provider handbook and member ID card, or
    c. A change in legal entity name.

CHILD

An individual under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.

CHILD - KIDSCARE (TITLE XXI)

An individual under the age of 19 years who is covered under Title XXI of the Social Security Act.

CHILD AND FAMILY TEAM (CFT)

A defined group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM), a behavioral health representative, and any individuals important in the child's life who are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Department of Child Safety (DCS) or the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the child.

CLAIM DISPUTE

A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

CLEAN CLAIM

A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.

CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)

A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to and receive key information from ALTCS Contractors.

CLOSED-LOOP REFERRAL SYSTEM

The AHCCCS-approved statewide technology platform for screening and referring members to address their health-related social needs.

CODE OF FEDERAL REGULATIONS (CFR)

The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

COMMUNITY RESOURCE GUIDE

A handbook with listings of local community resources that help address Health-Related Social Needs (HRSN) and Social Determinants of Health (SDOH). The Guide contains referral resources that are specific to the region in which members are served. The Community Resource Guide serves as a supplement to the CLRS for members who are not actively engaged with health care providers that utilize the system. The Guide can be custom-made by a provider or health plan, or it can be publicly available regional handbook of resources.

COMPETITIVE BID PROCESS

A State procurement system used to select Contractors to provide covered services on a geographic basis.

COMPREHENSIVE RISK CONTRACT

A risk Contract between the State and a Managed Care Organization (MCO) that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services [42 CFR 438.2]:

1. Outpatient hospital services.
2. Rural health clinic services.
3. Federally Qualified Health Center (FQHC) services.
4. Other laboratory and X-ray services.
5. Nursing facility services.
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
7. Family planning services.
8. Physician services.
9. Home health services.

CONTINUUM OF CARE (CoC)	Both a planning process and an application required for funding from U.S. Department of Housing and Urban Development (HUD). The CoC brings together service providers in a geographic area to plan for providing housing and services for people who are homeless. The CoC controls funding for programs that target people who are homeless, specifically, Shelter Plus Care (S+C), Supportive Housing Program (SHP), and Section 8 Single Room Occupancy governed by the McKinney-Vento Homeless Assistance Act as amended by the Homeless Emergency Assistance, Rapid Transition to Housing Act (HEARTH Act) as specified in 24 CFR 91, 576, 582, and 583 and administered through the U.S. Department of Housing and Urban Development (HUD)Agency. A regional or local planning body that coordinates housing and services funding for homeless families and individuals as required by the U.S. Housing and Urban Development (HUD) Agency.
CONTRACTOR	An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to A.R.S. § 36-2904, A.R.S. § 36-2940, A.R.S. § 36-2944, or Chapter 34 of A.R.S. Title 36, to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and Federal and State law, rule, regulations, and policies.
CONVICTED	A judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	The monetary amount that a member pays directly to a provider at the time covered service is rendered (A.A.C. R9-22-711).
CORRECTIVE ACTION PLAN (CAP)	A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first- or third-party benefits before payment is made by the Contractor.
COUNTY OF FISCAL RESPONSIBILITY	The County of fiscal responsibility is the Arizona County that is responsible for paying the State's funding match for the member's ALTCS Service Package. The County of physical presence (the County in which the member physically resides) and the County of fiscal responsibility may be the same County or different Counties.
CREDENTIALING	The process of obtaining, verifying, and evaluating information regarding applicable licensure, accreditation, certification, educational, and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

DAY	A calendar day unless otherwise specified.
DAY – BUSINESS	Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or individual to perform one or more functions required to be performed by the Contractor pursuant to this Contract.
DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)	The Division of a State agency as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with an intellectual/developmental disability. AHCCCS contracts with DES/DDD to serve Medicaid-eligible individuals with an intellectual/ developmental disability.
DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD) TRIBAL HEALTH PROGRAM (DDD THP)	DES/DDD provides services to eligible individuals with developmental delays and disabilities. American Indian/Alaska Natives (AI/AN) who qualify for DDD Arizona Long Term Care System (ALTCS) receive services through one of the DDDs ALTCS Health Program (HP) or Tribal Health Program (THP). THP members receive Long Term Services and Supports (LTSS), or Home and Community Based Services (HCBS), from DDD and Effective April 1, 2022, AHCCCS Division of Fee-For-Service (FFS) Management manages acute physical and behavioral health service authorizations for enrolled DES/DDD Tribal Health Program members.
DESIGNATED REPRESENTATIVE (DR)	An individual parent, guardian, relative, advocate, friend, or other individual, designated orally or in writing by a member or guardian who, upon request of the member, assists the member in protecting the member's rights and voicing the member's service needs.

DEVELOPMENTAL DISABILITY (DD)

A strongly demonstrated potential that a child under six years of age has an intellectual/ developmental disability or will become a child with an intellectual/developmental disability, as determined by a test performed as specified in A.R.S. § 36-551 and A.R.S. § 36-694, by other appropriate tests, or a severe, chronic disability that:

1. Is attributable to Cognitive Disability, Cerebral Palsy, Epilepsy, Autism, or Down Syndrome.
2. Is manifested before age eighteen.
3. Is likely to continue indefinitely.
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
   a. Self-care,
   b. Receptive and expressive language,
   c. Learning,
   d. Mobility,
   e. Self-direction,
   f. Capacity for independent living, and
   g. Economic self-sufficiency.
5. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration.

DISENROLLMENT

The discontinuance of a member's eligibility to receive covered services through a Contractor.

DUAL ELIGIBLE MEMBER

A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

DURABLE MEDICAL EQUIPMENT (DME)

Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/ provider; is able to withstand repeated use; and is appropriate for use in the home. REFER TO "MEDICAL EQUIPMENT AND APPLIANCES".

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the Arizona State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost-effectiveness, do not apply to EPSDT services.

ELECTRONIC VISIT VERIFICATION (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
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: 1. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2. Serious impairment to bodily functions, 3. Serious dysfunction of any bodily organ or part [42 CFR 438.114(a)], or 4. Serious physical harm to another individual for behavioral health condition).
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services shall be furnished by a qualified provider and shall be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].
EMERGENCY SERVICES	Medical or behavioral health services provided for the treatment of an emergency medical condition.
ENCOUNTER	A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.2].
ENROLLMENT	The process by which an eligible individual becomes a member of a Contractor's plan.
EQUITY PARTNERS	The sponsoring organizations or parent companies of the Managed Care Organization (MCO) that share in the returns generated by the organization, both profits and liabilities.
EVIDENCE-BASED PRACTICE	An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.

EXCLUDED	Services not covered under the Arizona State Plan or the Section 1115 Demonstration Waiver, including but not limited to, services that are above a prescribed limit, experimental services, or services that are not medically necessary.
EXHIBITS	All items attached as part of the original Solicitation.
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial parent of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members, which includes informal supports.
FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate, the member directs the involvement of the family to ensure person-centered care.
FAMILY-RUN ORGANIZATION (FRO)	Family-Operated Services that are: 1. Independent and autonomous - Governed by a board of directors of which 51% or more are family members who: a. Have or had primary responsibility for the raising of a child, youth, adolescent or young adult with an emotional, behavioral, mental health or substance use need, or b. Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use need, or c. An adult who had lived experience of being a child with emotional, behavioral, mental health or substance use needs. 2. Employs Credentialed Family Support Partner (CFSP) whose primary responsibility is to provide parent/family support.
FEDERAL EMERGENCY SERVICES (FES)	A program specified in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).
FEDERAL FINANCIAL PARTICIPATION (FFP)	FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by Centers for Medicare and Medicaid Services (CMS) as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by Centers for Medicare and Medicaid Services (CMS) as meeting the definition of "health center" under Section 330 of the Public Health Service Act but does not receive grant funding under Section 330.
FEE-FOR-SERVICE (FFS)	A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.
FEE-FOR-SERVICE (FFS) MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
FIELD CLINIC	A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for Children's Rehabilitation Services (CRS)-related conditions on a periodic basis.
FISCAL AGENT	A Contractor that processes or pays vendor claims on behalf of the Medicaid agency [42 CFR 455.101].
FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, as defined in 42 CFR 455.2.
FULL BENEFIT DUAL ELIGIBLE MEMBER	A member who is enrolled with an AHCCCS Contractor for full Medicaid services and is also a Medicare beneficiary receiving Medicare Part A and Part B services. A Full Benefit Dual Eligible Member does not include those individuals who are enrolled with AHCCCS in the following population categories only through a Medicare Savings Program (and receive from AHCCCS only Medicare cost sharing assistance): Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).
GENERAL MENTAL HEATH/SUBSTANCE USE (GMH/SU)	Behavioral health services provided to adult members age 18 and older who have not been determined to have a Serious Mental Illness (SMI).

GENERALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS	Providers who configure their program operations to the needs of the Child and Family Team without arbitrary limits on frequency, duration, type of service, age, gender, population, or other factors associated with the delivery of Support and Rehabilitation Services.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.
GRIEVANCE	A member's expression of dissatisfaction with any matter, other than an adverse benefit determination.
GRIEVANCE AND APPEAL SYSTEM	A system that includes a process for member grievances and appeals including, Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) grievances and appeals, and provider claim disputes. The Grievance and Appeal system provides access to the State fair hearing process.
GRIEVANCE OR REQUEST FOR INVESTIGATION - SERIOUS MENTAL ILLNESS (SMI)	A complaint that is filed by a person with Serious Mental Illness (SMI) designation or other concerned person alleging a violation of an SMI member's rights or a condition requiring an investigation.
GUEST DOSING	A mechanism for patients who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for patients who need to travel for a period of time that exceeds the amount of eligible take-home doses.
HABILITATION	The process by which an individual is assisted to acquire and maintain those life skills that enable the individual to cope more effectively with personal and environmental demands and to raise the level of the individual's physical, mental, and social efficiency (A.R.S. § 36-551 (18)).

HEALTH CARE DECISION MAKER (HCDM)	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. § § 8-514.05, 36-3221, 36-3231 or 36-3281.
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, licensed behavior analyst, registered respiratory therapist, licensed marriage and family therapist, and licensed professional counselor.
HEALTH HOME	A provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health, and services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center, Primary Care Provider, or an Integrated Care Provider. Members may or may not be formally assigned to a Health Home.
HEALTH INFORMATION EXCHANGE (HIE)/ HEALTH INFORMATION ORGANIZATION (HIO)	A State designated non-profit Health Information Organization (HIO), that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the health information exchange organization as defined in A.R.S. § 36-3801. Pursuant to A.A.C. R9-22-701.
HEALTH INFORMATION TECHNOLOGY (HIT)	The application of information process involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
HEALTH INSURANCE	Coverage against expenses incurred through illness or injury of the individual whose life or physical well-being is the subject of coverage.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996, as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.
HEALTH PLAN	REFER TO “CONTRACTOR.”
HEALTH-RELATED SOCIAL NEEDS (HRSN)	Non-medical factors that impact health outcomes including but not limited to increasing access to safe and affordable housing, nutritious food, utility assistance, education, employment, transportation, connection to others in the community, as well as physical, environmental, and interpersonal safety. Also known as Social Determinants of Health (SDOH) or Social Risk Factors of Health (SRFOH).

HOME	A residential dwelling that is owned, rented, leased, or occupied by a member, 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 of any of these, that is licensed or certified by a regulatory agency of the State as: 1. Health care institution as specified in A.R.S. § 36-401. 2. Residential care institution as specified in A.R.S. § 36-40. 3. Community residential setting as specified in A.R.S. § 36-551. 4. Behavioral health facility as specified in A.A.C. R9-28-101.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. § 36-2931 and A.R.S. § 36-2939.
HOME HEALTH CARE	REFER TO "HOME HEALTH SERVICES."
HOME HEALTH SERVICES	Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at their place of residence and on their physician's orders, or beginning March 1, 2020, ordered by the member's nurse practitioner, physician assistant, or clinical nurse specialist, as a part of the plan of care and is reviewed by the practitioner annually as part of a written plan of care [42 CFR 440.70].
HOSPICE SERVICES	Palliative and support care for members who are certified by a physician as being terminally ill and having six months or less to live.
HOSPITALIZATION	Admission to, or period of stay in, a health care institution that is licensed as a hospital as defined in A.A.C. R9-22-101.
HOUSING SPECIALIST	A position, at the provider level, that serves as the subject matter expert for housing and homeless related services. Providing both in the office and in the field direct service to members to support them in achieving housing stability.
INCURRED BUT NOT REPORTED (IBNR)	The liability for services rendered for which claims have not been received.
INDIAN HEALTH SERVICES (IHS)	The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as specified in 25 U.S.C. 1661.
INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)	REFER TO "SERVICE PLAN."

INDIVIDUAL WITH AN INTELLECTUAL DISABILITY/ DEVELOPMENTAL DISABILITY (IID/DD)	An individual who meets the Arizona definition as specified in A.R.S. § 36-551 and is determined eligible for services through the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). Services for AHCCCS-enrolled members with intellectual/developmental disabilities determined eligible for services through DES/DDD are managed through the DES Division of Developmental Disabilities.
INFORMATION SYSTEMS	The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
IN-NETWORK PROVIDER	An individual or entity which has signed a provider agreement as specified in A.R.S. § 36-2904 and that has a subcontract or is authorized through a subcontract with an AHCCCS Contractor to provide services prescribed in A.R.S. § 36-2901 et seq. for members enrolled with the Contractor.
INSTITUTION FOR MENTAL DISEASE (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with Intellectual and Developmental Disabilities (IDD) is not an institution for mental diseases [42 CFR 435.1010].
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information is recorded to facilitate the coordination and Quality Of Care (QOC) delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary Treatment Team members to address the totality of the treatment and service plans for the member based on the most current information available.
INTERGOVERNMENTAL AGREEMENT (IGA)	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct Contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to Contract for or perform some or all of the services specified in the Contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. § 11-952.A).

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)	A facility that primarily provides health and rehabilitative services to individuals with Developmental Disabilities (DD)that are above the service level of room and board or supervisory care services or personal care services as defined in section 36-401 but that are less intensive than skilled nursing services (A.R.S. § 36-551 (28)).
JUVENILE PROBATION OFFICER (JPO)	An officer within the Arizona Department of Juvenile Corrections (ADJC) assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile's who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program (A.R.S. § 8-353).
KIDSCARE	Federal and State Children's Health Insurance Program (CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).
LIABLE PARTY	An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member as specified in A.A.C. R9-22-1001.
LIEN	A legal claim filed with the County Recorder's office in which a member resides and in the County an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
LINE OF BUSINESS (LOB)	AHCCCS Programs: AHCCCS Complete Care (ACC); AHCCCS Complete Care-Regional Behavioral Health Agreements (ACC-RBHA); Arizona Long Term Care Services Elderly and/or Physically Disabled (ALTCS E/PD); Department of Child Safety/ Comprehensive Health Plan (DCS/CHP); and Department of Economic Security/Division of Developmental Disabilities (DES/DDD).
LIMITED ENGLISH PROFICIENCY (LEP)	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter [42 CFR 457.1207, 42 CFR 438.10].
LONG -TERM SERVICES AND SUPPORTS (LTSS)	Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a Nursing Facility (NF), or other institutional setting [42 CFR 438.2].

MAJOR UPGRADE

Any systems upgrade or change to a major business component that may result in a disruption to the following: loading of contracts, providers, or members, issuing Prior Authorizations (PA) or the adjudication of claims.

MANAGED CARE

Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.

MANAGED CARE ORGANIZATION

An entity that has, or is seeking to qualify for, a comprehensive risk Contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

1. A Federally qualified Health Maintenance Organization (HMO) that meets the advance directives requirements of subpart I of 42 CFR Part 489, or
2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
   a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
   b. Meets the solvency standards of 42 CFR 438.116.

MANAGED CARE PROGRAM

A managed care delivery system operated by a State as authorized under section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].

MANAGEMENT SERVICES AGREEMENT

A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.

MANAGING EMPLOYEE

A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency [42 CFR 455.101].

MATERIAL CHANGE TO BUSINESS OPERATIONS

Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific Geographic Service Area (GSA). Changes to business operations may include, but are not limited to, policy, process, and protocol, such as Prior Authorization (PA) or retrospective review. Additional changes may also include the addition or change in:

1. Pharmacy Benefit Manager (PBM).
2. Dental Benefit Manager.
3. Transportation vendor.
4. Claims Processing system.
5. System changes and upgrades.
6. Change to Organization Name.
7. Member Identification (ID) Card vendor.
8. Call center system.
9. Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment.
10. Management Service Agreement (MSA).
11. Any other Administrative Services Subcontract.

MATERIAL CHANGE TO PROVIDER NETWORK

Any change in composition of or payments to a Contractor's provider network that affects, or can reasonably be foreseen to affect, the Contractor's adequacy of capacity and services necessary to meet the performance and/or provider network standards as specified in Contract. Changes to provider network may include but are not limited to:

1. Any change that would cause or is likely to cause more than five percent of the members in a Geographic Service Agreement (GSA) to change the location where services are received or rendered.
2. A change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.

MATERIAL OMISSION

A fact, data or other information excluded from a report, Contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, Contract, etc.

MEDICAID

A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

MEDICAID MANAGED CARE REGULATIONS

The Federal law mandating, in part, that states ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.

MEDICAL EQUIPMENT AND APPLIANCES

Item, as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and

1. Is customarily used to serve a medical purpose and is generally not useful to an individual in the absence of an illness, disability, or injury.
2. Can withstand repeated use.
3. Can be reusable by others or removable.

Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).

MEDICAL MANAGEMENT (MM)

An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the Continuum of Care (CoC) (from prevention to hospice).

MEDICAL PRACTITIONER

A physician, physician assistant or registered nurse practitioner.

MEDICAL RECORDS

All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review, or quality assurance activities (A.R.S. § 12-2291).

MEDICAL SERVICES

Medical care and treatment provided by a Primary Care Provider (PCP), attending physician, or dentist or by a nurse or other health-related professional and technical personnel at the direction/order of a licensed physician or dentist.

MEDICAL SUPPLIES

Health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury [42 CFR 440.70].

MEDICALLY NECESSARY

A covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life (A.A.C. R9-22-101).

MEDICALLY NECESSARY SERVICES

Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability, and other adverse health conditions or their progression or to prolong life.

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 Centers for Medicare and Medicaid Services (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.
MEDICATION FOR OPIOID USE DISORDER (MOUD)	An evidence-based approach that uses medication to treat individuals with Opioid Use Disorder (OUD).
MEMBER	An eligible individual who is enrolled in AHCCCS, as specified in A.R.S. § 36-2931, § 36-2901, § 36-2901.01, and A.R.S. § 36- 2981. Also referred to as Title XIX/XXI member or Medicaid member. When applicable, Member may also or alternatively refer to an enrolled individual's Health Care Decision Maker (HCDM) or Designated Representative (DR). REFER TO HEALTH CARE DECISION MAKER; REFER TO DESIGNATED REPRESENTATIVE.
MEMBER INFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes but is not limited to member handbooks, member newsletters, provider directories, surveys, on hold messages and health-related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as email and voice recorded information messages delivered to a member's phone.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
MUST	REFER TO "SHALL". Note: The term 'Must' is used interchangeably in this Contract with the term 'Shall'.
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique identification number for covered health care providers, assigned by the Centers for Medicare and Medicaid Services (CMS) contracted national enumerator.
NETWORK	A list of doctors, or other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members.
NON-CONTRACTING PROVIDER	An individual or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.
OUT-OF-NETWORK PROVIDER	An individual or entity that has a provider agreement with the AHCCCS Administration pursuant to A.R.S. § 36-2904 which does not have a subcontract with an AHCCCS Contractor, and which provides services specified in A.R.S. § 36-2901 et seq.

PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.
PARENTS/CARETAKER RELATIVES	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL).
PEER-RUN ORGANIZATION (PRO)	Peer-Operated Services that are: 1. Independent - Owned, administratively controlled, and managed by peers. 2. Autonomous - All decisions are made by the program. 3. Accountable - Responsibility for decisions rests with the program. 4. Peer – controlled - Governance board is at least 51% peers.
PERFORMANCE BOND	A written promise by a Surety to pay AHCCCS (as the obligee) an amount specified in Contract and ACOM Policy 305, if the Contractor (as the principal), fails to meet the Contractor's obligation under the Contract. A Performance Bond is also called a Surety Bond.
PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.
PERFORMANCE MEASURE PERFORMANCE STANDARDS (PMPS)	The minimal expected level of performance by the Contractor, previously referred to as the Minimum Performance Standard. Beginning Contract Year Ending (CYE) 2021, official performance measure results shall be evaluated based upon the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Medicaid Mean or Centers for Medicare and Medicaid Services (CMS) Medicaid Median (for selected CMS Core Set-Only Measures), as identified by AHCCCS, as well as the Line of Business (LOB) aggregate rates, as applicable.
PERMANENT SUPPORTIVE HOUSING (PSH)	Housing assistance (e.g., long-term leasing or rental assistance) and supportive services are provided to assist households with at least one member with a disability in achieving housing stability.
PERSON-CENTERED	An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.
PHYSICIAN SERVICES	Medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
PLAN	REFER TO "SERVICE PLAN".

POSTPARTUM	For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in maternity care quality improvement may utilize different criteria for the postpartum period.
POSTPARTUM CARE	Health care provided for a period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Family planning services are included, if provided by a physician or practitioner.
POSTSTABILIZATION CARE SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve, or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438.114(a)].
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
PREMIUM	The amount an individual pays for health insurance every month. In addition to the premium, an individual usually has to pay other costs for their health care, including a deductible, copayments, and coinsurance.
PREMIUM TAX	The tax imposed pursuant to A.R.S. § 36-2905 and A.R.S. § 36-2944.01 for all payments made to the Contractor for the Contract Year.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements.
PRESCRIPTION DRUGS	Prescription medications prescribed by an AHCCCS registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and State law including 42 U.S.C 1396r-8 and A.A.C. R9-22-209.
PRESCRIPTION DRUG COVERAGE	Prescription medications prescribed by an AHCCCS registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and State law including 42 U.S.C 1396r-8 and A.A.C. R9-22-209.
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a Nursing Facility (NF) or Intermediate Care Facility (ICF) level of care as specified in 9 A.A.C. 28 Article 1.

PRIMARY CARE All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/ gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them [42 CFR 438.2].

PRIMARY CARE PHYSICIAN A physician defined as an individual licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13, or Chapter 17 and who otherwise meets the definition of Primary Care Provider (PCP).

PRIMARY CARE PROVIDER (PCP) An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as an individual 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, or a naturopathic physician for AHCCCS members under the age of 21 receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

PRIMARY PREVENTION The focus on methods to reduce, control, eliminate, and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.

PRIOR AUTHORIZATION (PA) Process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost-effectiveness, compliance with this Article and any applicable Contract provisions. Prior Authorization (PA) is not a guarantee of payment (A.A.C. R9-22-101).

PRIOR PERIOD REFER TO "PRIOR PERIOD COVERAGE".

PRIOR PERIOD COVERAGE (PPC) For Title XIX members, the period of time prior to the member's enrollment with a Contractor, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member is made eligible via the Hospital Presumptive Eligibility (HPE) program and is subsequently determined eligible for AHCCCS via the full application process, PPC for the member will be covered by AHCCCS Fee-For-Service (FFS) and the member will be enrolled with the Contractor only on a prospective basis.

PRIOR QUARTER COVERAGE

The period of time prior to an individual's month of application for AHCCCS coverage, during which a member (limited to children under 19, individuals who are pregnant, and individuals who are in the 60-day postpartum period beginning the last day of pregnancy) may be eligible for covered services. Prior Quarter Coverage is limited to the three-month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant:

1. Received one or more covered services specified in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month.
2. Would have qualified for Medicaid at the time services were received if the individual had applied regardless of whether the individual is alive when the application is made. Refer to A.A.C. R9-22-303.

AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.

PROGRAM CONTRACTOR

REFER TO "CONTRACTOR"

PROVIDER

Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

PROVIDER GROUP

Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

PRUDENT LAYPERSON (FOR PURPOSES OF DETERMINING WHETHER AN EMERGENCY MEDICAL CONDITION EXISTS)

An individual without medical training who relies on the experience, knowledge, and judgment of a reasonable individual to make a decision regarding whether or not the absence of immediate medical attention will result in:

1. Placing the health of the individual in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily part or organ.

QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE MEMBER (QMB DUAL)

An individual determined eligible under A.A.C. R9-29- Article 2 for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in 9 A.A.C. Chapter 22 or ALTCS services provided for in 9 A.A.C. Chapter 28. A QMB Dual receives both Medicare and Medicaid services and cost sharing assistance as specified in A.A.C. R9-29-101.

QUALIFYING CLINICAL TRIAL

Any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of Section 1905(gg)(2)(A) of the Social Security Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by national organizations.

QUALITY MANAGEMENT (QM) The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.

RAPID RESPONSE A process that occurs when a child enters into Department of Child Safety (DCS) custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health needs and to refer the child for additional assessments through the behavioral health system.

RATE CODE Eligibility classification for capitation payment purposes.

REFERRAL A verbal, written, telephonic, electronic, or in-person request for health services.

REHABILITATION Physical, occupational, and speech therapies, and items to assist in improving or restoring an individual's functional level (A.A.C. R9-22-101).

REINSURANCE Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services for the Contract year. Reinsurance case types include but are not limited to regular, catastrophic, and transplant. These case types may have different qualifying criteria and reimbursement.

RELATED PARTY A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Contractor 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 individuals.

REQUEST FOR PROPOSAL (RFP) A document prepared by AHCCCS which describes the services required and which instructs a prospective Offeror how to prepare a response (Proposal).

RISK CONTRACT A Contract between the State and Managed Care Organization (MCO), under which the Contractor:

1. Assumes risk for the cost of the services covered under the Contract.
2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract [42 CFR 438.2].

RISK GROUP Grouping of rate codes that are paid at the same capitation rate.

ROOM AND BOARD (or ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual lives in an institutional setting (e.g., Nursing Facility (NF), Intermediate Care Facility [ICF]). Medicaid funds cannot be expended for room and board when a member resides in an Alternative Home and Community Based Service (HCBS) Setting (e.g., Assisted Living Facility (ALF), Behavioral Health Residential Facilities [BHRF]) or an apartment like setting that may provide meals.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.
RURAL HEALTH CLINIC (RHC)	A clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements as specified in 42 CFR 491.
SERIOUS EMOTIONAL DISTURBANCE (SED)	A designation for individuals from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.
SERIOUS EMOTIONAL DISTURBANCE (SED) ELIGIBILITY DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for receiving all medically necessary behavioral health services.
SERIOUS MENTAL ILLNESS (SMI)	A designation as defined in A.R.S. § 36-550 and determined in an individual 18 years of age or older.
SERIOUS MENTAL ILLNESS (SMI) ELIGIBILITY DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract.
SERVICE PLAN	A complete written description of all covered health services and other informal supports which includes individualized goals, peer-and-recovery support and family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
SHALL	Indicates a mandatory requirement as specified in A.A.C. R2-7-101. Note: The term 'Shall' is used interchangeably in this Contract with the term 'Must'.

SOCIAL DETERMINANTS OF HEALTH (SDOH)	The World Health Organization defines SDOH as the conditions of the community in which an individual is born, grows, works, lives, and ages, and the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems. These are also known as Social Risk Factors of Health (SRFOH).
SPECIAL HEALTH CARE NEEDS (SHCN)	Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.
SPECIALIST	A Board-eligible or certified physician who declares themself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.
SPECIALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS	Providers who provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration, or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).
SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
SPECIALTY PROVIDER	REFER TO “SPECIALIST”
STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP)	State Children’s Health Insurance Program under Title XXI of the Social Security Act (Also known as Children’s Health Insurance Program [CHIP]). The Arizona version of CHIP is referred to as “KidsCare.” REFER TO “KIDSCARE.”
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility under a category other than Adult Group due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. § 36-2907.10 and A.R.S. § 36-2907.11.

SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or individual who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract, as defined in 9 A.A.C. 22 Article 1.
SUBCONTRACTOR	1. A provider of health care who agrees to furnish covered services to members. 2. An individual, agency, or organization with which the Contractor, or its subcontractor has contracted or delegated some of its management/administrative functions or responsibilities. 3. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUBSIDIARY	An entity owned or controlled by the Contractor.
SUBSTANCE ABUSE	As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that: 1. Alters the individual's behavior or mental functioning, 2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical, and 3. Impairs, reduces, or destroys the individual's social or economic functioning.
SUBSTANCE USE DISORDER (SUD)	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the Federal Poverty Level (FPL).
THIRD-PARTY	REFER TO "LIABLE PARTY."

TITLE XIX	Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the States for medical assistance programs. Title XIX enables States to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation, and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which includes those populations specified in 42 U.S.C. 1396 a (a)(10)(A).
TITLE XIX MEMBER	Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults </= 106%), Adult Group above 106% Federal Poverty Level (Adults > 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.
TITLE XXI	Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the “Children’s Health Insurance Program” (CHIP). The Arizona version of CHIP is referred to as “KidsCare.”
TREATMENT	A procedure or method to cure, improve, or palliate an individual’s medical condition or behavioral health issue. Refer to A.A.C. R9-10-101.
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.
TRIBAL ARIZONA LONG TERM CARE SYSTEM (TRIBAL ALTCS)	A program managed by AHCCCS to provide covered, medically necessary ALTCS services to ALTCS American Indian members who reside on a Tribal reservation in Arizona or resided on a reservation immediately before being placed in a nursing facility or alternative Home and Community Based Services (HCBS) setting off reservation.

TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)	A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a TRBHA for the provision of behavioral health services to American Indian members. Refer to A.R.S. § 36-3401 and A.R.S. § 36-3407.
VIRTUAL CLINICS	Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records, and virtual interdisciplinary Treatment Team meetings.
VULNERABLE ADULT	As specified in A.R.S. § 46-451(A)(10), an individual who is 18 years of age or older and who is unable to protect themself from abuse, neglect, or exploitation by others because of a physical or mental impairment (A.R.S. § 46-451). Vulnerable adults include an incapacitated person as defined in A.R.S. § 14-1501.

[END OF SECTION C: DEFINITIONS]

SECTION D: PROGRAM REQUIREMENTS

1. PURPOSE, APPLICABILITY, AND INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Title XIX Medicaid program operating under Arizona Section 1115 Demonstration Waiver (1115 Waiver) and Title XXI program operating under Title XXI Arizona State Plan authority. In 1982, Arizona introduced its innovative Medicaid program by establishing AHCCCS, a demonstration program based on principles of managed care. In doing so, AHCCCS became the first statewide Medicaid managed care system in the nation.

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

The ALTCS E/PD (Contractor) shall be responsible for the provision of integrated care addressing physical and behavioral health needs and Long Term Services and Supports (LTSS) for the following Title XIX individuals who are E/PD including the populations below and excluding AHCCCS Complete Care (ACC), Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), Department of Child Safety (DCS)/Comprehensive Health Plan (CHP), and AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) enrolled members.

1. ALTCS qualified individuals including:
   a. Adults and children with and without General Mental Health/Substance Use (GMH/SU) needs,
   b. Adults with a Serious Mental Illness (SMI) designation,
   c. Children with a Serious Emotional Disturbance (SED) designation, and
   d. Children with Special Health Care Needs (SHCN).

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.

2. The Contractor shall comply with the requirements of the Contract as amended, unless AHCCCS and the Contractor otherwise stipulate in writing.

ALTCS services are provided in the 15 Arizona counties, either directly or indirectly, by Contractors under contract with AHCCCS. The Contractor coordinates, manages, and provides physical health care, long term care, behavioral health care, and case management services to ALTCS members.

AHCCCS Mission and Vision:
The AHCCCS mission and vision is to reach across Arizona to provide comprehensive quality health care to those in need while shaping tomorrow's managed health care from today's experience, quality, and innovation. AHCCCS supports a program that promotes the values of:

1. Choice.

2. Dignity.

3. Independence.

4. Individuality.

5. Privacy.

6. Self-determination.

Initiatives: AHCCCS' focus on continuous system improvement results in the development of initiatives aimed at building a more cohesive and effective health care system in Arizona by reducing fragmentation, structuring provider reimbursements to incentivize quality outcomes, leveraging Health Information Technology (HIT), and working with private sector partners to further innovation to the greatest extent. The Contractor shall collaborate with AHCCCS and be innovative in the implementation of these AHCCCS initiatives and focus on topics such as:

1. Health equity.

2. Telehealth services.

3. Accessing behavioral health services in schools.

4. Whole Person Care.

5. Care coordination and integration.

6. Public/private partnerships.

7. Electronic Visit Verification (EVV).

8. Emergency Triage, Treat, and Transport (ET3).

9. Payment modernization.

10. Health Information Technology (HIT).

11. Health Information Exchange (HIE)

12. Arizona Healthcare Directives Registry (AzHDR).

13. Justice System transitions.

14. Targeted Investment (TI) program.

15. Housing and Health Opportunities (H2O).

16. Home and Community Based Settings Rules.

Whole Person Care Initiative: The goal of AHCCCS' Whole Person Care Initiative (WPCI) is to address the Health-Related Social Needs (HRSN) of our members, which have a direct impact on their health outcomes. The Contractor shall implement strategies and practices to expand upon AHCCCS' efforts to address a member's whole person health care. When addressing HRSN, areas of focus can include but are

not limited to increasing access to safe and affordable housing, nutritious food, utility assistance, education, employment, transportation, connection to others in the community, as well as physical, environmental, and interpersonal safety.

The Contractor shall join the AHCCCS-Approved Closed-Loop Referral System (CLRS) and actively encourage provider network utilization of the CLRS to refer members to Community Based Organizations (CBOs) that provide services addressing HRSN. The Contractor's Care Management staff shall utilize the CLRS to screen and refer each member of their caseload annually at a minimum. Additionally, the Contractor shall partner with the Health Information Exchange/Health Information Organization (HIE/HIO) to outreach to CBOs to participate in the CLRS.

The Contractor shall actively encourage provider usage of HRSN screening and referral tools available through or compatible with the CLRS to screen and refer members for. At a minimum, the provider's tool must screen for the following HRSN regardless of the screening tools selected:

1. Homelessness/Housing Instability.

2. Food Insecurity

3. Transportation Assistance.

4. Employment Instability.

5. Utility Assistance.

6. Interpersonal Safety.

7. Justice/Legal Involvement.

8. Social Isolation/Social Support.

In conjunction with utilization of the CLRS, the Contractor and its providers shall maintain a publicly available Community Resource Guide with information on local resources that address and provide support for HRSN. The resources provided in the Community Resource Guide shall be focused on the needs and geographic area of the Contractor's member population. The Contractor shall encourage its providers to make the Community Resource Guide easily accessible to members. The Community Resource Guide shall be updated at least quarterly and made available on the Contractor's website as specified in ACOM Policy 404. A printed version of the Guide shall be made available upon member request and the website should note printed versions are available upon member request. Both electronic and printed versions of the guide shall be updated at least quarterly in alignment with ACOM Policy 404.

The Contractor shall monitor, promote, and educate providers on the use and importance of SDOH (ICD-10) codes, commonly known as "Z" codes. These codes shall be included on claims to support data collection on the HRSN experienced by AHCCCS members. To the extent feasible, the Contractor and its providers shall use the CLRS to promote health equity by leveraging data within the CLRS to identify and address health disparities across member demographic criteria.

Integrated Health Plan: The Contractor shall operate as a single entity responsible for ensuring the delivery of medically necessary covered services for members and shall provide all major administrative functions of a Managed Care Organization (MCO) including but not limited to:

1. Network Management/Provider Relations.
2. Member Services.
3. Quality Management (QM).
4. Performance Improvement (PI).
5. Medical Management (MM).
6. Systems of Care (SOC).
7. Finance.
8. Claims/Encounters.
9. Information Services.
10. Grievance and Appeal System.

The Contractor shall not delegate or subcontract key functions of health plan operations that are critical to the integration of physical and behavioral health care for members as set forth in Contract, unless one entity under subcontract provides all of the delegated functions for both the Medicaid, which includes physical and behavioral health, and Medicare Lines Of Business (LOBs). Refer to Section D, Paragraph 33 Subcontracts and ACOM Policy 438.

The Contractor shall have organizational, management, staffing and administrative systems capable of meeting all Contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within, between and among Contractor's departments, units, or functional areas of operation.

> ***Integrated Health Care Service Delivery***: The Contractor shall increase and promote the availability of integrated, holistic care for members with chronic behavioral and physical health conditions that will help members achieve better overall health and an improved quality of life.
>
> The Contractor shall develop and promote care integration activities such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. The Contractor shall consider the behavioral health needs, in addition to the primary health care needs, of members during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.

System Values and Guiding **Principles**: The following values, guiding system principles and goals are the foundation for the development of this Contract. The Contractor shall administer and ensure delivery of services consistent with these values, principles, and goals:

1. ***Accessibility of Network***: Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for aging members and members with disabilities, cultural preferences, and individual health care needs. Services are available to the same degree as services for individuals not eligible for AHCCCS.

2. ***Collaboration with Stakeholders***: Ongoing collaboration with members and families, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

3. ***Consistency of Services:*** Development of network accessibility and availability of services to ensure delivery, quality, and continuity of services in accordance with the Person-Centered Service Plan (PCSP) as agreed to by the member and the Contractor.

4. ***Member-Centered Case Management:*** Members are the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of LTSS. Services are mutually selected through person-centered planning to assist the member in attaining their individually identified goals. Education and up-to-date information about the ALTCS program, choices of options, and mix of services shall be readily available to members.

5. ***Member-Directed Options***: To the maximum extent possible, members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making informed decisions about how best to have needs met including who will provide the service and when and how the services will be provided.

6. ***Most Integrated Setting***: Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative Home and Community Based Service (HCBS) Setting rather than residing in an institution.

7. ***Person-Centered Service Planning:*** The PCSP process maximizes member-direction and supports the member to make informed decisions, so that they can lead/participate in the PCSP process to the fullest extent possible. The AHCCCS PCSP safeguards against unjustified restrictions of member rights and ensures that members are provided with the necessary information and supports r to gain full access to the benefits of community living to the greatest extent possible. The Plan ensures responsiveness to the member's needs and choices regarding service delivery and individual goals and preferences. The member and family/representative shall have immediate access to the member's PCSP. Refer to AMPM Exhibit 1620-10.

The Arizona Association of Health Plans: To assist in reducing the burden placed on providers and to enhance Contractor collaboration, the Contractor is required to be a member of the Arizona Association of Health Plans (AzAHP). AzAHP is an organization dedicated to working with elected officials, AHCCCS, MCOs, health care providers, and consumers to keep quality health care available and affordable for all Arizonans.

2. ELIGIBILITY

The Contractor is not responsible for determining eligibility.

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

Medical Eligibility: In addition to financial eligibility, an individual shall meet the medical and functional eligibility criteria as established by the Preadmission Screening tool (PAS). The PAS is conducted by an AHCCCS Registered Nurse (RN) or Social Worker (SW) with consultation by a physician, if necessary, to evaluate the person's medical status. The PAS is used to determine whether the person is at immediate risk of placement in a Nursing Facility (NF). In most cases, AHCCCS does not re-evaluate the medical status of each ALTCS member annually; however, the Contractor is responsible for notifying AHCCCS of significant changes in a member's condition, which may result in a change in eligibility. Refer to Section D, Paragraph 16, ALTCS Transitional Program and Section D, Paragraph 19, Reporting Changes in Members' Circumstances.

Serious Emotional Disturbance/Serious Mental Illness (SED/SMI) Eligibility: The Contractor shall ensure the identification and assessment of enrolled members by qualified clinicians to identify those individuals who may meet the SED or SMI eligibility criteria as specified in AHCCCS Medical Policy Manual (AMPM) Policy 320-P.

Payment for evaluations conducted for the purpose of an SED or SMI Eligibility Determination is the responsibility of the Contractor and may not be conducted by Contractor staff. The Contractor is responsible for coordinating SED and SMI eligibility evaluations, including urgent evaluations, when a member is hospitalized for psychiatric reasons, and if one has not been completed within the last six months. The Contractor shall ensure SED and SMI eligibility evaluations (including removal of designation), and all required documentation is completed accurately and referred timely and comprehensively to the AHCCCS designee authorized to render SED and SMI Eligibility Determinations.

As part of the Contractor's care management and/or high needs/high-cost program, as specified in Section D, paragraph 23, Medical Management, the Contractor shall have a robust process to identify and refer members who may meet SED or SMI eligibility criteria to receive an SED or SMI eligibility assessment as specified in AMPM Policy 320-P. The Contractor shall ensure SED and SMI Eligibility Determination Evaluation Packets include at a minimum, the following documentation:

1. SED and SMI Determination Form, as applicable. Refer to AMPM Policy 320-P.

2. Consent Form(s).

3. Comprehensive Assessment, including the Child and Adolescent Level of Care Utilization System (CALOCUS) for SED, if applicable.

4. Waiver to extend three-day SED or SMI Eligibility Determination timeframe, as applicable.

5. Additional records available for consideration.

6. Signed Release(s), if appropriate.

The Contractor shall cooperate with AHCCCS and the SED or SMI Eligibility Determination designee by establishing and implementing systems or processes for communication, consultation, data sharing, and the exchange of information. The Contractor shall immediately establish SED or SMI services and ensure effective and comprehensive care coordination based on the presenting needs of the member once an SED or SMI Eligibility Determination has been rendered that shall also include connection of member to ACC-RBHAs or other resource providers for necessary services that are not covered under the Contractor's Title XIX MCO.

The Contractor shall comply with all requirements specified in AMPM Policy 320-P.

Adherence to these requirements may be subject to review through AHCCCS audits and/or Operational Reviews (ORs).

Serious Emotional Disturbance and Serious Mental Illness Decertification *Removal of Designation*: SED and SMI Removal of Designation is the process that results in the removal of the SED or SMI behavioral health category designation from the member's record. Refer to AMPM Policy 320-P. Once an SED or SMI Eligibility Determination or Remove of Designation decision is made and submitted to AHCCCS, AHCCCS will update the member's Behavioral Health Category to add/remove SED or SMI respectively and will provide the documentation to the MCO of enrollment or American Indian Health Plan (AIHP), as applicable, via the AHCCCS Secured File Transfer Protocol (SFTP) server. The Behavioral Health Category can then be viewed in the AHCCCS Online system via the AHCCCS Online Provider Website .

3. ENROLLMENT AND DISENROLLMENT

AHCCCS has the exclusive authority to enroll and disenroll members. AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment (passive enrollment) is used pursuant to the terms of the 1115 Waiver Special Terms and Conditions [42 CFR 438.54(d)].

Members eligible for ALTCS E/PD, who are also in the custody of DCS will be enrolled with an ALTCS E/PD Contractor.

The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS [42 CFR 438.56(b)(1); 42 CFR 438.56(b)(3)].

The Contractor may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs [Section 1903(m)(2)(A)(v) of the Social Security Act, 42 CFR 438.56(b)(2)]. For disenrollment requests for medical continuity, the Contractor shall follow the procedures specified in AHCCCS Contractor Operations Manual (ACOM) Policy 403 [42 CFR 438.56(d)(2)(ii, iii, iv)].

An AHCCCS member may request disenrollment at the following times (see also ACOM Policy 403) [42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i) - (iii)]:

1. For cause at any time, which includes poor Quality Of Care (QOC), lack of access to services covered under the Contract, or lack of access to providers experienced in addressing the member's care needs [42 CFR 438.56(d)(2)(v)].

2. Without cause during the 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later.

3. Without cause at least once every 12 months.

4. Without cause upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.

An AHCCCS member may request disenrollment from the Contractor for cause at any time. Cause includes poor QOC, lack of access to services covered under the Contract, or lack of access to providers experienced in addressing the member's care needs [42 CFR 438.56(d)(2)(v)]. Consistent with the terms of the Section

1115 Waiver the Administration is waived from 42 CFR 438.52 and 438.56 to the extent necessary to permit the State to limit choice of managed care plans to a single MCO for members enrolled in the ALTCS programs outside of the Central GSA so long as members in such plans have a choice of at least two Primary Care Providers (PCPs) and may request change of PCP at least at the times specified in 42 CFR 438.56(c). Notwithstanding this authority, the State shall offer a choice of at least two MCOs to elderly and physically disabled individuals in the Central GSA.

The Contractor shall notify AHCCCS/Division of Member and Provider Services (DMPS) of disenrollment approvals.

AHCCCS will disenroll the member from the Contractor [42 CFR 438.56(d)(2)]:

1. When the member becomes ineligible for the AHCCCS program.

2. When the member moves out of the Contractor's service area (unless otherwise indicated).

3. When the member changes Contractors during the member's open enrollment and Annual Enrollment Choice (AEC) period.

4. When the Contractor does not, because of moral or religious objections, cover the service the member seeks.

5. For members who would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the Contractor and, as a result, would experience a disruption in their residence or employment. Refer to ACOM Policy 403.

6. When the member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk.

7. For cause.

8. When the member is approved for a Contractor change through ACOM Policy 403.

Member Choice of Contractor: AHCCCS members eligible for services covered under this Contract have a choice of available Contractors, except those populations specified below.

1. Previously enrolled members who have been disenrolled for less than 90 days will be automatically enrolled with the same Contractor, if still available pursuant to the terms of the 1115 Waiver Special Terms and Conditions [42 CFR 438.56(g)].

2. Members residing in a Geographic Service Area (GSA) where only one Contractor is available will be automatically enrolled with that Contractor and will be given a choice of PCPs.

Members who do not choose a Contractor prior to AHCCCS being notified of their eligibility are automatically assigned to a Contractor based on re-enrollment rules, continuity of care, or the auto-assignment algorithm. If a member is auto-assigned, AHCCCS sends a Choice notice to the member and allows the member 90 days to choose a different Contractor. Refer to Section D, Paragraph 5, Enrollment Hierarchy, for further explanation of Auto-Assignment.

Arizona Long Term Care Services Eligibility Determinations During Hospitalization: If it is determined that a member may qualify for ALTCS during an individual's acute hospitalization, AHCCCS will process an application for ALTCS eligibility. Enrollment of an applicant who is determined eligible will be effective during the hospital stay.

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

Prior Period Coverage: AHCCCS provides Prior Period Coverage (PPC) for Title XIX members for the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services. PPC refers to the timeframe from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. The Contractor receives notification from AHCCCS of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services provided to Title XIX members during PPC, including services provided prior to the Contract year in a GSA where the Contractor was not contracted at the time-of-service delivery. The Contractor is liable for costs for covered services provided during the prior period as specified in the AHCCCS Medical Assistance Eligibility Policy Manual.

Prior Quarter Coverage: Pursuant to the January 2019 Centers for Medicare and Medicaid Services (CMS) approval of 1115 Waiver, AHCCCS is waived from approving Prior Quarter Coverage eligibility (also referred to as Retroactive Coverage in the CMS 1115 Waiver Approval) for individuals who are NOT in the following three categories: children under 19, women who are pregnant, and women who are in the 60-day postpartum period beginning the last day of pregnancy. Effective July 1, 2019, only the three populations above are exempted from the waiver of prior quarter coverage eligibility, and these individuals may be determined to qualify for AHCCCS coverage during any of the three months prior to the month of application when they meet the eligibility requirements for that month. Prior Quarter Coverage eligibility expands the time period during which AHCCCS pays for covered services for eligible individuals to any of the three months prior to the month the individual applied for AHCCCS, and if the individual met AHCCCS eligibility requirements during that particular month. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter. Upon verification or notification of Prior Quarter Coverage eligibility, providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period.

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

4. ANNUAL AND OPEN ENROLLMENT CHOICE

Annual Enrollment Choice: AHCCCS conducts an AEC in GSAs that have multiple Contractors for members on their annual anniversary date [42 CFR 438.56(c)(2)(ii)]. During AEC, members may change Contractors subject to the availability of other Contractors within their GSA. AHCCCS provides enrollment and other information required by Medicaid managed Care Regulations 60 days prior to the member's AEC date. The member may choose a new Contractor by contacting AHCCCS to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made (except for approved changes under ACOM Policy 403). This holds true if a Contractor's Contract is renewed and the member continues to live in a contractor's service area.

Open Enrollment: AHCCCS may hold an open enrollment in any GSA or combination of GSAs as deemed necessary. In the event AHCCCS adds a Contractor to a GSA where choice of Contractor is currently unavailable, members currently enrolled in that GSA may be provided an open enrollment period to choose a Contractor. Members who do not elect to change Contractors will remain with the Contractor of enrollment. AHCCCS may also offer open enrollment to the members assigned to the Contractor should a change in ownership occur, refer to Section D, Paragraph 33 Subcontracts.

5. ENROLLMENT HIERARCHY

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

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

1. For the Central GSA, members will be auto-assigned equally (33%) among the three Contractors. The extra percentage point will be assigned to the Contractor with the highest overall score on the Request For Proposal (RFP).

2. For Pima County, members will be auto-assigned equally between the two Contractors.

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

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

6. PLAN CHANGES

In GSAs where the member has a choice of Contractors, the member may submit a request to change Contractor, when outside of a member's AEC, in accordance with ACOM Policy 403 for the following reasons:

1. Medical Continuity of Care Requests.
2. Erroneous network information or agency error.
3. Lack of initial enrollment choice.
4. Lack of AEC.
5. Family continuity of care.
6. Continuity of institutional or residential setting.
7. Failure to correctly apply the 90-day reenrollment policy.

A denial of any Contractor change request shall include the Contractor's reason for not approving the change and options for resolution. The notice shall advise the member of the grievance policies and timeframes for filing a grievance. The notice shall also advise the member of their right to request a hearing, including how to request a hearing and the time frame for making the request.

7. COUNTY OF FISCAL RESPONSIBILITY

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

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

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

8. PEER AND FAMILY INVOLVEMENT AND PARTICIPATION

Contractors with an Office of Individual and Family Affairs (OIFA) in a separate LOB, shall work with OIFA to embed the following principles peer and family involvement in the design and implementation of an integrated health care service delivery system by:

1. Providers sharing the same mission to place the member's whole health needs above all else.

2. Embedding member and family voice at all levels of the system.

3. Ensuring members and family members have access to peer support and family support services, utilizing peer and family support specialists. The Contractor shall report Peer/Recovery Support Specialist (PRSS) and Credentialed Family Support Partner (CFSP) Involvement in Service Delivery as specified in Section F, Attachment F3: Contractor Chart of Deliverables. Refer to AMPM Policy 963 and AMPM Policy 964 for requirements regarding the provision of PRSS and CFSP Services within the AHCCCS program.

3. Embracing services delivered by individuals with lived experience by maximizing the use of Peer Run Organizations (PROs) and Family Run Organizations (FROs).

The Contractor shall ensure behavioral health providers are creating opportunities for members and family members to participate in improving their experience at the provider site and that participation results in changes being made. Child and Family Teams (CFTs) and Adult Recovery Teams (ARTs) do not fulfill this requirement.

Committees: The Contractor is required to have meaningful peer (i.e., an individual who is receiving or has received behavioral health services), and family member participation on all Contractor committees, except for those that pertain to issues of member and/or provider confidentiality, to provide input and feedback for decision making. Every effort shall be made to include representation of council members that reflect the populations and communities served by the Contractor. Contractors with an OIFA in a separate LOB, shall work with the OIFA to include peers and family members enrolled with the Contractor-on-Contractor committees. The Contractor shall submit a Roster of Peer and Family Committee Members as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

At a minimum, the Contractor shall have a Governance Committee and Member Advocacy Council (MAC). The Contractor shall ensure that the composition of the committees is diverse and representative of the Contractor's current membership throughout the region with respect to the members' race, ethnic background, primary language, age, and Medicaid eligibility category.

> ***Governance Committee***: Contractors with an OIFA in a separate LOB shall rely on the Contractor's OIFA to assist with and participate in a formal Governance Committee. The Governance Committee membership shall include peers and family of members enrolled with the Contractor who are receiving or have received physical and behavioral health services. The Governance Committee shall meet and interact with Contractor leadership to direct strategic planning process improvement and decision making for the Contractor.
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> ***Member Advocacy Council***: Contractors with an OIFA in a separate LOB shall assemble and facilitate a MAC consisting of peers and family members enrolled with the Contractor who are receiving or have received behavioral health services, and an individual from the Contractor's Executive Management team. The MAC may also include professionals and advocates. The purpose of the MAC is to gather input, identify challenges and barriers, share information, and strategize on ways to strengthen the service delivery system. Discussion of issues and opportunities resulting from the MAC meetings are to be included on the agenda and addressed by the Contractor's Executive Management Committee and/or Governance Committee. Meeting minutes shall reflect discussion and any follow-up or activities. MAC meeting minutes shall be made available to AHCCCS upon request.

If a Contractor holds more than one LOB, the Contractor may consolidate required committees, If a Contractor elects to consolidate the required committees, the Contractor shall ensure the membership of consolidated committees are representative of all the Contractor's LOBs.

Peer-Run Organizations and Family-Run Organizations: The Contractor is expected to contract with PROs and FROs, as specified in Contract, in each of the Contractor's awarded GSA(s). The Contractor shall ensure that providers are educated on the role of the PROs and FROs and inform members on the availability of peer support and family support services at PROs and FROs. The Contractor shall ensure members have access to peer and family support services. These services assist with understanding how to effectively utilize the service delivery system to access covered benefits.

If the Contractor desires to Contract with an organization not currently recognized as a PRO or FRO by AHCCCS// Division of Community Advocacy and Intergovernmental Relations (DCAIR), OIFA and the Contractor believes the organization meets the definition and criteria, a request shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The AHCCCS/DCAIR, OIFA will review the proposed PRO or FRO and determine if the provider meets the definition and criteria, as defined in Section C, Definitions and www.SAMHSA.gov.

9. ACCOMMODATING AHCCCS MEMBERS

The Contractor shall ensure that members are provided covered services without regard to disability, race, color, national origin, age, sex, gender, sexual orientation, or gender identity, and will not use any policy or practice that has the effect of discriminating on the basis of these [42 CFR 438.3(d)(4), 42 CFR 438.206(c)(2), 45 CFR Part 92].

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

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

2. Providing to a member any medically necessary covered service which is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary.

3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in their enjoyment of any advantage or privilege enjoyed by others receiving any covered service.

4. Assigning times or places for the provision of services on the basis of disability, race, color, national origin, age, sex, gender, sexual orientation, or gender identity.

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

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

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

If the Contractor identifies a problem involving discrimination or accommodations for a member with a disability by one of its providers, the Contractor shall promptly intervene and require a Corrective Action Plan (CAP) from the provider. Failure to take prompt corrective measures may place the Contractor in default of its Contract.

10. TRANSITION ACTIVITIES

The Contractor shall comply with the AMPM and the ACOM standards for member transitions between AHCCCS programs, Contractors, or GSAs and upon termination or expiration of a Contract. The Contractor shall develop and implement policies and procedures, which comply with AHCCCS policy to address transitions of ALTCS members.

When relinquishing members, the relinquishing Contractor is responsible for timely notification to the receiving Contractor of pertinent information related to the special needs of transitioning members. Relinquishing Contractors who fail to notify the receiving Contractor or FFS Program of transitioning members with special circumstances will be responsible for covering the members' care for up to 30 days following the transition.

Appropriate medical records and case management files for the transitioning member shall be transmitted to the receiving Contractor. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor. The Contractor is responsible for coordinating care to ensure provision of uninterrupted services, Contractor and service information, emergency numbers, and instructions on how to obtain services. Refer to AMPM Policy 520 and ACOM Policies 401, 402, and 403 for additional Contractor transition requirements.

The Contractor shall implement a transition of care policy consistent with the requirements in42 CFR 438.62(b)(1)-(2), ACOM Policy 402, and AMPM Policy 520.

The Contractor shall designate a key staff person with appropriate training and experience to act as the Transition Coordinator. The Transition Coordinators for both the relinquishing and receiving Contractors shall interact closely to ensure a safe, timely, and orderly transition. Refer to Section D, Paragraph 26, Staffing Requirements and ACOM Policy 402.

The Contractor shall develop and implement member transition policies and procedures which include but are not limited to:

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

2. Children under age 19 who are blind, have disabilities, are in foster care or other out-of-home placement, or are receiving adoption assistance.

3. Members with a serious or chronic physical, developmental and/or behavioral health condition.

4. Members with an SMI designation.

5. Members with an SED designation.

6. Members who are receiving ongoing services such as daily in-home care, behavioral health, dialysis, home health, pharmacy prescriptions, medical equipment, appliances, supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy, End Of Life (EOL) care or hospice, or who are hospitalized at the time of transition.

7. Members who have received Prior Authorization (PA) for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services or nursing home admissions.

8. Continuing prescriptions, medical equipment, appliances, supplies, including enteral and nutritional supplements, and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor.

9. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth.

10. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media.

11. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the third trimester, the need for organ or tissue transplantation, the need for catastrophic reinsurance for hemophilia and high-cost biologic specialty drugs, chronic illness resulting in hospitalization or nursing facility placement.

12. Individuals who are experiencing homelessness or formerly homeless residing in Permanent Supportive Housing. Individuals experiencing homelessness includes individuals or families who do not have a fixed, sustainable, or appropriate nighttime residence including:
    a. The primary nighttime residence is a public or private place not meant for human habitation,
    b. The individual is living in a shelter designated to provide temporary living (including homeless shelters, transitional housing, hotels paid for by charitable organization or government program), or
    c. The individual is being discharged from an institution, such as a residential treatment or similar facility, a behavioral health inpatient stay, physical health hospitalization, jail/prison, and they were admitted as homeless and/or whose discharge is likely to result in returning to the street or shelter as specified in a. or b. above.

A new Contractor who receives members from another Contractor as a result of a contract award shall ensure a smooth transition for members by not discontinuing a member's service plan for 90 days after the member transition unless mutually agreed to by the member or responsible party [42 CFR 438.1].

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

Transitioning Members Due to Contract Termination: In the event the Contract or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members and shall abide by standards and protocols as specified by AHCCCS. In addition, AHCCCS reserves the right to extend the term of the Contract on a month-to-month basis to assist in any member transitions. AHCCCS may discontinue enrollment of new members with the Contractor three months prior to the

contract termination date or as otherwise determined by AHCCCS. The Contractor shall make provisions for continuing all management and administrative services until the transition of members is completed and all other requirements of this Contract are satisfied. The Contractor shall submit a detailed plan to AHCCCS for approval regarding the transition of members in the event of Contract expiration or termination. The name and title of the Contractor's Transition Coordinator shall be included in the transition plan.

The Contractor shall be responsible for providing all reports set forth in this Contract and those necessary for the transition process 42 CFR 438.610I(3), 42 CFR 434.6(a)(6)]. The Contractor shall abide by the requirements as specified in ACOM Policy 440.

Any dispute by the Contractor, with respect to termination or suspension of this Contract by AHCCCS, shall be exclusively governed by the provisions of Section E, Paragraph 19, Disputes.

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

11. SCOPE OF SERVICES

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal and State laws, 1115 Waiver, regulations, Contract, and policies, including those incorporated by reference in this Contract. The Contractor shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished [42 CFR 438.210(a)(3)(i)(iii)]. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the member [42 CFR 438.210(a)(3)(ii), 42 CFR 438.210(a)(4)]. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be reasonably expected to achieve their purpose [42 CFR 438.210(a)(3)(i), 42 CFR 438.210(a)(4)]. The Contractor shall adhere to the AMPM Chapter 300, AMPM Chapter 1200, and AMPM Chapter 1300 policies. Covered services are briefly specified below. Refer to AMPM Exhibit 300-1 and AMPM Exhibit 300-2A.

The Contractor shall ensure the coordination of services it provides with services the member receives from other entities. The Contractor shall ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, Arizona statute, and to the extent that they are applicable 42 CFR 438.208(b)(6), 42 CFR 438.208(b)(2), and (b)(4) 42 CFR 438.224.

The Contractor shall obtain consent and authorization to disclose protected health information in accordance with 42 CFR 431, 42 CFR Part 2, 45 CFR parts 160 and 164, and A.R.S. § 36-509 and shall retain consent and authorization medical records as specified in A.R.S. § 12-2297 and in conformance with AHCCCS Policy.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount

expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 [Section 1903(i) final sentence and 1903(i)(16) of the Social Security Act].

Services shall be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. The Contractor shall provide the same standard of care for all members, regardless of the member's eligibility category. The Contractor shall ensure that the services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished [42 CFR 434.6(a)(4)]. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member [42 CFR 438.210(a)(3)(ii)]. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)(3)(i), 42 CFR 438.210(a)(4)].

The Contractor shall require subcontracted providers to offer the services specified in Section D, Paragraph 18, Member Information.

The Contractor shall assure and demonstrate that it has the capacity to serve the expected enrollment in its service area in accordance with AHCCCS standards for access and timeliness of care [42 CFR 438.207(a), 42 CFR 438.68, 42 CFR 438.206(c)(1)].

The Contractor shall ensure that its providers, acting within the lawful scope of their practice, are not prohibited, or otherwise restricted from advising or advocating, on behalf of a member who is their patient, for [Section 1932(b)(3)(A) of the Social Security Act; 42 CFR 438.102(a)(1)(i)-(iv)]:

1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)].

2. Any information the member needs in order to decide among all relevant treatment options.

3. The risks, benefits, and consequences of treatment or non-treatment.

4. The member right to participate in decisions regarding the member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(iv)].

Authorization of Services: The Contractor shall have in place and follow written policies and procedures for the processing of requests for initial and continuing authorizations of services [42 CFR 438.210(b)(1), 42 CFR 438.910(d)]. The Contractor shall allow for the level of care recommendation of the Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), Early Childhood Level of Care Utilization System (ECSII), and the American Society of Addiction Medicine (ASAM) Criteria to demonstrate sufficient necessity for admission to the indicated level of care without requiring additional PA or review for a period of not less than 30 days.

The Contractor shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions [42 CFR 438.210(b)(2)(i)]. The Contractor shall consult with the requesting provider for medical services when appropriate [42 CFR 438.210(b)(2)(i), 42 CFR 438.210(b)(2)(ii)].

Any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease [42 CFR 438.210(b)(3)].

Refer to AMPM Chapter 1000 and Section F, Attachment F1, Member Grievance and Appeal System Standards for additional service authorization requirements.

General and Informed Consent: The Contractor shall adhere to General and Informed Consent requirements as specified in AMPM Policy 320-Q.

Moral or Religious Objections: The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service [42 CFR 438.10(e)(2I)(C), 42 CFR 438.102(a)(2)]. The Contractor shall submit a Proposal addressing members' access to the services [Section 1932(b)(3)(B)(i) of the Social Security Act; 42 CFR 438.102(b)(1)(i)(A)(1) and (2)]. AHCCCS does not intend to offer the services on a FFS basis to the Contractor's members. In the event the Proposal is not approved, AHCCCS will notify the Contractor. In these circumstances AHCCCS may disenroll members who are seeking these services from the Contractor and assign members to another Contractor. AHCCCS also reserves the right to withhold assignment of new members until such time as there is an approved Proposal [42 CFR 438.56]. The Proposal shall:

1. Be submitted to AHCCCS in writing prior to entering into a contract with AHCCCS or at least 60 days prior to the intended effective date of the change in the scope of services based on moral or religious grounds.

2. Place no financial or administrative burden on AHCCCS.

3. Place no significant burden on members' access to the services.

4. Be accepted by AHCCCS in writing.

5. Acknowledge an adjustment to capitation, depending on the nature of the proposed solution.

If AHCCCS approves the Contractor's Proposal for its members to access the services, the Contractor shall immediately develop a policy implementing the Proposal with a notification to members of how to access these services. The notification and policy shall be consistent with the provisions of 42 CFR 438.10 and shall be approved by AHCCCS prior to dissemination. The notification shall be provided to newly assigned members within 12 days of enrollment and shall be provided to all current members at least 30 days prior to the effective date of the Proposal [42 CFR 438.102, 42 CFR 438.102(b)(1)(i)(B), 42 CFR 438.10(g)(4)].

Notice of Adverse Benefit Determination: The Contractor shall notify the requesting provider and give the member/ written notice of any decision by the Contractor to deny, reduce, suspend, or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested [42 CFR 438.210(c), 42 CFR 438.404, 42 CFR 438.404, 42 CFR 438.400(b)]. The notice shall meet the requirements of 42 CFR 438.404, AHCCCS Rules and ACOM Policy 414. The provider shall be notified of the decision as specified in Section F, Attachment F1, Member Grievance and Appeal System Standards. The Contractor shall comply with all decision timelines specified in ACOM Policy 414. The Contractor shall conduct quarterly self-audits of Notice of Adverse Benefit Determination letters as specified in ACOM Policy 414. The Contractor shall submit a Notice of Adverse Benefit Determination Self-Audit Executive Summary as specified in the ACOM Policy 414 and Section F, Attachment F3, Contractor Chart of Deliverables. The Notice of Adverse Benefit Determination shall be sent to the AHCCCS/Office of Human Rights (OHR) for members with an SMI designation and who meet special assistance criteria.

The Contractor's ability to ensure the delivery of services requires a complete and thorough understanding of the intricate, multi-layered service delivery system in order to create an ISOC that addresses the member's needs.

The type, amount, duration, scope of services and method of service delivery depends on a wide variety of factors including:

1. Eligible populations.
2. Covered services benefit package.
3. Approach.
4. Funding.
5. Member need.

The Contractor is required to comply with all terms in this Contract and all applicable requirements in each document, guide, and manual; however, particular attention should be paid to the AMPM and ACOM with respect to requirements for effective service delivery.

PHYSICAL HEALTH SERVICES

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

American Indian Member – Service Provision: The Contractor is responsible for coverage of services under this Contract for members who are American Indians enrolled with the Contractor.

AHCCCS/Division of Fee-for-Service Management (DFSM) will reimburse for medically-necessary, acute-care services (including physical and behavioral health services) that are eligible for 100% Federal reimbursement and are provided by an Indian Health Service (IHS) or 638 tribal facility to a Title XIX member enrolled with the Contractor who is eligible to receive services through an IHS or 638 tribal facility. Encounters for Title XIX services billed by IHS or 638 tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

The Contractor is responsible for reimbursement (including physical and behavioral health services) to IHS or 638 tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. Payment rates shall be at least equal to the AHCCCS FFS rates. The Contractor may choose to subcontract with an IHS or 638 tribal facility as part of its provider network for the delivery of Title XXI covered services. Expenses incurred by the Contractor for Title XXI services billed by an IHS or 638 tribal facility shall be encountered and considered in capitation rate development.

The Contractor shall demonstrate that there are sufficient Indian Health Care Providers (IHCPs) contracted in the provider network to ensure timely access to services available under the Contract from such providers for American Indian members who are eligible to receive services [42 CFR 438.14(b)(1), 42 CFR 438.14(b)(5)]. For the purposes of this section, "IHCP" does not include health care programs operated by the IHS or a 638 tribal facility that provides services to Title XIX members enrolled with the Contractor that are reimbursed by AHCCCS/DFSM and are eligible for 100% Federal reimbursement.

The Contractor will make payment to IHCPs for covered services provided to American Indian members who are eligible to receive services through the IHCP regardless of whether the IHCP is an in-network provider. The Contractor may negotiate a rate for the services provided by an IHCP or, in the absence of a negotiated rate, the Contractor will reimburse the IHCP for its services at a rate not less than the level and amount the Contractor would pay to the same type of in-network provider that is not an IHCP [42 CFR 438.14(b)(2)(i) - (ii)]. In the event the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, AHCCCS will make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable encounter rate [42 CFR 438.14(c)(3)].

American Indian members shall be permitted to obtain covered services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services [42 CFR 438.14(b)(4)]. The Contractor shall permit an out-of-network IHCP to refer an American Indian member to a network provider [42 CFR 438.14(b)(6)].

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

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

Biomarker Testing: Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions as specified in AMPM Policy 310-KK.

Breast Reconstruction: Breast reconstruction surgery for the purposes of breast reconstruction post-mastectomy is a covered service for AHCCCS eligible members consistent with AMPM Policy 310-C.

Certified Community Health Worker/Community Health Representative Services: A certified Community Health Worker/Community Health Representative (CHW/CHR), who obtains certification through the Arizona Department of Health Services (ADHS) as specified in A.A.C. R9-16-802, may provide AHCCCS-covered member education and preventive services to eligible members.

Chiropractic Services: The Contractor shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. For members 21 years of age and older, the PCP may initially order up to 20 visits annually that include treatment and may request authorization for additional chiropractic services in that same year if additional chiropractic services are medically necessary. For Full Benefit Dual Eligible (FBDE) enrolled members, Medicare approved chiropractic services shall be covered subject to limitations specified in 42 CFR 410.21.

Dental Services: The Contractor shall adhere to the Dental Uniform List (List) and the Uniform Warranty List as specified on the Resources page of the AHCCCS website. Requests for changes to the List shall be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

For Members under the age of 21, the Contractor shall provide all members under the age of 21 with all medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services, and dental appliances in accordance with the AHCCCS Dental Periodicity

Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor shall develop processes to assign members to a dental home by six months of age or upon enrollment and communicate that assignment to the member. The Contractor shall regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventive care as specified in AMPM Policy 431. The Contractor is required to meet specific utilization rates for members as specified in Section D, Paragraph 21, Quality Management (QM) and Performance Improvement (PI). The Contractor shall ensure that members are notified in writing when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice shall be sent. Refer to AMPM Exhibit 400-3. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

For members 21 years of age and older, pursuant to A.A.C. R9-22-207, 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 as specified in AMPM Policy 310-D1.

Pursuant to A.R.S § 36-2907(A) as amended by Arizona Senate Bill 1527 (2017), the Contractor shall provide adult members 21 years of age and older with emergency dental services, limited to a $1000 per member per contract year as specified in AMPM Policy 310-D1. Dental services provided to Tribal members within an Indian Health Services (IHS) or 638 Tribal Facility are not subject to the ALTCS dental benefit $1000 limit.

Pursuant to A.R.S. § 36-2939, dental services, including dentures, are covered for persons 21 years of age or older in an amount of $1,000.00 per member for each 12-month period beginning October 1 through September 30. The Contractor shall provide dental services to members according to AMPM Policy 310-D2 and shall develop systems to monitor utilization to assure appropriate Medicaid payments.

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

Early and Periodic Screening, Diagnostic and Treatment Services: The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis, and medically necessary treatment to correct or ameliorate defects and physical or mental illnesses discovered by the screenings for members under age 21. EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, eyeglasses, (eyeglasses and other vision services, including replacement and repair of eyeglasses), for members under the age of 21 years are covered, without restrictions, by AHCCCS to correct or ameliorate conditions discovered during vision screenings for EPSDT, transportation, family planning services and supplies, and women's preventive care services, and maternity care services, when applicable. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services. The Contractor shall ensure that these members receive required health screenings and referrals as specified in AMPM Policy 430.

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention: The Contractor shall provide health care services through screening, diagnosis, and medically necessary treatment for members 21 years of age and older. These services include, but are not limited to, screening for

hypertension, elevated cholesterol, colon cancer, sexually transmitted diseases, tuberculosis, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), breast cancer, cervical cancer, and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic workups and medically necessary immunizations are also covered as specified in A.A.C. R9-28-202.

Emergency Services: The Contractor shall provide emergency services per the following [Section 1852(d)(2) of the Social Security Act, 42 CFR 438.114(b), 42 CFR 422.113(c)]:

1. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by A.A.C. R9-28 Article 1 [42 CFR 438.206(c)(1)(i)-(iii)]. Emergency medical (physical and behavioral health) services, including Crisis Intervention Services are covered without PA. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies [42 CFR 438.206(c)(1)(i)]. The Contractor shall monitor emergency services utilization (by both provider and member and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this Contract, a prudent layperson is an individual who possesses an average knowledge of health and medicine.

2. All medical services necessary to rule out an emergency condition.

3. Emergency transportation.

Per the Medicaid Managed Care regulations, 42 CFR 438.114, 42 CFR 422.113 and 42 CFR 422.133, the following conditions apply with respect to coverage and payment of emergency services. The Contractor shall cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor. The Contractor may not deny payment for treatment obtained under either of the following circumstances [Section 1932(b)(2) of the Social Security Act, 42 CFR 438.114(c)(1)(i), 42 CFR 438.114(c)(1)–ii)(A) - (B)]:

1. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition 42 CFR 438.114.

2. A representative of the Contractor (an employee or subcontracting provider) instructs the member to seek emergency medical services.

Additionally, the Contractor shall 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 [42 CFR 438.114(d)(1)(i)].

2. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of the member's presentation for emergency services. Claims submission by the hospital within 10 calendar days of the member's presentation for emergency services constitutes notice to the

Contractor. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)].

3. Require notification of Emergency Department (ED) treat and release visits as a condition of payment unless the Contractor has prior approval of AHCCCS.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient [42 CFR 438.114(d)(2)].

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination is binding on the Contractor responsible for coverage and payment. The Contractor shall comply with Medicaid Managed Care guidelines regarding the coordination of poststabilization care [42 CFR 438.114, 42 CFR 422.113].

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

Emergency Triage, Treat, and Transport: Services associated with ET3 provided by Emergency Transportation providers are covered when initiated by an emergency response system call, regardless of whether the provider that furnishes the services has a contract with the Contractor as specified in AMPM Policy 310-BB.

Experimental Services: AHCCCS does not cover experimental services (A.A.C. R9-22-203). However, as specified in AMPM Policy 320-B, the Contractor has responsibilities related to Experimental services and Qualifying Clinical Trials. A determination with respect to coverage under Section 1905(a)(30) of the Social Security Act for a member to participate in a qualifying clinical trial must be expedited and completed within 72 hours regardless of GSA or if the provider is in network. Coverage of routine member costs based on where the clinical trial is conducted, including out-of-State, or based on whether the provider treating the member is outside of the network may not be denied**.**

Family Planning Services: The Contractor shall provide family planning services and supplies in accordance with the AMPM*,* and consistent with the terms of the 1115 Waiver, 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 [42 CFR 438.210(a)(4)(ii)(C)]. If the Contractor does not provide family planning services and supplies due to moral and religious objections, it shall contract for these services through another health care delivery system or have an approved alternative in place or AHCCCS will disenroll from the Contractor members who are seeking these services and assign the members to another Contractor. Members may choose to obtain Family Planning Services and Supplies from any appropriate provider regardless of whether the Family Planning Service Providers are network providers. The Contractor shall not require PA in order to allow members to obtain family planning services and supplies from an out-of-network provider. The Contractor shall submit a Sterilization Report as specified in AMPM Policy 420 and Section F, Attachment F3, Contractor Chart of Deliverables.

Genetic Testing: Genetic testing and counseling are considered medically necessary when criteria are met as specified in AMPM Policy 310-II.

Home Health Services: This service shall be provided under the direction of a Physician or Physician Assistant, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS) to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis. Refer to AMPM for additional requirements for services provided under the home health benefit. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless AHCCCS Provider Enrollment verifies compliance with the Surety Bond requirements specified in Sections 1861(o)(7) and 1903(i)(18) of the Social Security Act. Refer to AMPM Policy 310-I. For additional information regarding Licensed Health Aide (LHA), refer to AMPM Policy 1240-G.

Hospital: The Contractor shall provide hospital services as specified in Contract and policy. Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, Obstetrics (OB) and newborn nurseries, and behavioral health emergency/. 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. Refer to AMPM Policy 310-K. For requirements regarding member transfers between facilities, Refer to AMPM Policy 530. Outpatient hospital services include any of the above services which may be appropriately provided on an outpatient or ambulatory basis (i.e., laboratory, radiology, therapies, ambulatory surgery). Observation services may be provided on an outpatient basis if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. Observation services include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability. Refer to AMPM Policy 310-S.

Hysterectomy: AHCCCS covers medically necessary hysterectomy services as authorized by Federal regulations 42 CFR 441.250 et seq. Refer to AMPM Policy 310-L.

Immunizations: The Contractor shall provide medically necessary immunizations for adults (21 years of age and older). Pharmacy and pharmacy interns and technicians under the supervision of a pharmacist, within their scope of practice, may administer AHCCCS covered immunizations to adults 19 years and older as specified in A.R.S. § 32-1974. Pharmacist, and pharmacy interns and technicians under the supervision of a pharmacist, within their scope of practice, may administer AHCCCS influenza and COVID immunizations to children who are three years through 18 years of age. Refer to AMPM Policy 310-M. The Contractor shall provide medically necessary immunizations for EPSDT members under the age of 21. The Contractor is required to meet specific immunization rates for members under the age of 21, which are specified in Section D, Paragraph 21, Quality Management and Performance Improvement. Refer to AMPM Policy 430. AHCCCS follows the recommendations established by the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP).

Incontinence Briefs: Incontinence briefs (diapers) are covered for members when unless medically necessary. For AHCCCS members over three years of age and under 21 years of age incontinence briefs, including pull-ups and incontinence pads, are covered to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances. Refer to AMPM Policy 310-P and AMPM Policy. For members in the ALTCS Program who are 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads are also covered in order to prevent skin breakdown as specified in AMPM Policy 310-P. Refer to A.A.C. R9-28-202 and AMPM Chapters 300 and 400.

Laboratory Services: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a free-standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory with Clinical Laboratory Improvement Act (CLIA) licensure or a Certificate of Waiver. Refer to AMPM Policy 310-N.

Upon written request, a Contractor may obtain laboratory test data on members from a laboratory or hospital-based laboratory subject to the requirements specified in A.R.S. § 36-2903 I and (R). The data shall be used exclusively for Quality Improvement (QI) activities and health care outcome studies required and/or approved by AHCCCS.

The Contractor shall use laboratory testing sites that have either a CLIA Certificate of Waiver or a Certificate of Registration with a CLIA identification number. Verify that laboratories satisfy all requirements in 42 CFR 493, Subpart A, General Provisions. The Contractor shall cover laboratory services for diagnostic, screening and monitoring purposes when ordered by the member's PCP, other attending physician or dentist, and provided by a CLIA approved free-standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory. The Contractor shall require all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider enrollment process. Failure to do so shall result in AHCCCS either terminating an active provider Identification (ID) number or denial of initial registration.

The Contractor shall apply the following requirements to all clinical laboratories:

1. Pass-through billing or other similar activities with the intent to avoid the requirements in Sections above is prohibited.

2. Clinical laboratory providers who do not comply with the requirements above may not be reimbursed.

3. Laboratories with a Certificate of Waiver are limited to providing only the types of tests permitted under the terms of their waiver.

4. Laboratories with a Certificate of Registration are allowed to perform a full range of laboratory tests.

The Contractor shall manage and oversee the administration of laboratory services through subcontracts with qualified services providers to deliver laboratory services, obtain laboratory test data on Title XIX/XXI eligible members from a laboratory or hospital-based laboratory subject to the requirements in A.R.S. § 36-2903(Q) (1-6) and (R), upon written request, and use the data exclusively for QI activities and health care outcome studies required and approved by AHCCCS.

Lung Volume Reduction Surgery: Lung Volume Reduction Surgery (LVRS), or reduction pneumoplasty, is covered for persons with severe emphysema when performed at a facility approved by Medicare to perform this surgery and in accordance with all of the established Medicare guidelines and in accordance with AMPM Policy 320-G.

Maternity Services: The Contractor shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, or licensed midwives. Members may select or be assigned to a PCP specializing in OB while they are pregnant. Members anticipated to have a low-risk delivery may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services.

Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by certified nurse midwives or licensed midwives, if they are in the Contractor's provider network. Members receiving maternity services from a certified nurse midwife or a licensed midwife shall also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all their primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester shall be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care. Refer to AMPM Policy 410.

For stillbirths meeting the medical criteria specified in AMPM Policy 410, the Contractor shall submit maternal and newborn delivery records as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall allow women and their newborns to receive no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with an agreement by 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 minimum 48 or 96-hour stay, whichever is applicable.

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary HIV/AIDS testing and the availability of medical counseling, as well as the benefits of treatment, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter to encourage pregnant women to be tested and instructions on where to be tested. The Contractor shall report to AHCCCS the number of pregnant women who have been newly diagnosed as HIV/AIDS-positive for each quarter during the Contract Year as specified in Section F, Attachment F3, Contractor Chart of Deliverables and AMPM Policy 410.

Medical Equipment and Medical Appliances, Medical Supplies, and Prosthetic Devices: Medical Equipment, Medical Appliances and Medical Supplies are covered under the home health benefit. Medical Equipment including Medical Appliances, Medical Supplies, and prosthetic devices are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as specified in the AMPM. Prosthetic devices shall be medically necessary and meet criteria as specified in AMPM Policy 310-JJ. For persons age 21 and older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor-controlled joints for lower limbs. Medical Equipment and Appliances may be rented or purchased only if other sources are not available to provide the items at no cost. The total cost of the rental shall 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. Refer to AMPM Policy 310-JJ, AMPM Policy 310-P, and AMPM Policy 1210.

The Contractor shall ensure the provider network includes a choice of subcontractors for customized medical equipment, medical appliances, medical supplies, and corrective appliances for members. The Contractor shall include, in the contract with the subcontractor, timeliness standards for creation, repair and delivery of medical equipment and appliances. The Contractor shall monitor the standards and take action when the subcontractor is found to be out of compliance. Refer to AMPM Policy 310-P.

Medical Marijuana: AHCCCS does not cover medical marijuana as a medical or pharmacy benefit. Refer to AMPM Policy 320-M.

Members Transitioning from Home Opioid Treatment Program to another Receiving Opioid Treatment Program and Require Guest Dosing: Guest dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support. Refer to AMPM Policy 310-V.

Metabolic Medical Foods: Medical foods are covered within the limitations defined in the AMPM for members diagnosed with a metabolic condition included under the ADHS Newborn Screening Program and as specified in the AMPM. Medical foods, including metabolic formula and modified low protein foods, shall be prescribed, or ordered under the supervision of a physician. Refer to AMPM Policy 310-GG.

Nutritional Assessments and Nutritional Therapy: Nutritional assessments are conducted as a part of the EPSDT screenings for members under age 21, and to assist members 21 years of age and older whose health status may improve with over and under-nutrition intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. AHCCCS covers nutritional therapy on an enteral, parenteral, or oral basis, when determined medically necessary, according to the criteria specified in the AMPM, to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake. Refer to AMPM Policy 310-GG and AMPM Policy 430.

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

1. The use of the orthotic is medically necessary as the preferred treatment option and consistent with Medicare guidelines.

2. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.

3. The orthotic is ordered by a physician or primary care practitioner.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental shall 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 Services: The Contractor shall provide physician services to include medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

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

Poststabilization Care Services: Pursuant to A.A.C. R9-28-202 and 42 CFR 438.114(e), 42 CFR 422.113(c)(2)(i)-(iv), 42 CFR 422.133, and 42 CFR 422.113(c)(2)(iii)(A)-(C) the following conditions apply with respect to coverage and payment of emergency and poststabilization care services, except where otherwise noted in Contract.

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

1. Poststabilization care services that were pre-approved by the Contractor.

2. Poststabilization care services that were not pre-approved by the Contractor because the Contractor did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.

3. The Contractor representative and the treating physician cannot reach agreement concerning the member's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

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

1. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care.

2. A Contractor physician assumes responsibility for the member's care through transfer.

3. A Contractor representative and the treating physician reach an agreement concerning the member's care.

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 [42 CFR 441.202, Consolidated Appropriations Act of 2008]. The attending physician shall acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination to the Contractor. This form shall be submitted to the Contractor's Medical Director and meet the requirements specified in AMPM Policy 410. The Contractor shall submit the Certificates of Necessity for Pregnancy Termination and AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request as specified in AMPM Policy 410 and Section F, Attachment F3, Contractor Chart of Deliverables. Additionally, the Contractor shall submit an AHCCCS Pregnancy Termination Report listing terminations that have been authorized by the Contractor with Supporting Documentation as specified in AMPM Policy 410 and Section F, Attachment F3, Contractor Chart of Deliverables.

Prescription Medications: Medications prescribed by a PCP, attending physician, dentist, or other AHCCCS authorized clinician and dispensed by an AHCCCS-registered Pharmacy are covered subject to the requirements of AMPM Policy 310-V.

The Contractor's Drug Lists and PA processes shall comply with AMPM Policy 310-V and AMPM Policy 1024. An Over-the-Counter medication may be prescribed as defined in AMPM Policy 310-V when it is equally effective and less costly than the same or similar prescription medication.

The Contractor's PA criteria shall not be more restrictive than the criteria used by the AHCCCS FFS Program [42 CFR Part 438].

The Contractor's medical claims prior authorization and pharmacy department, or the Contractor's Pharmacy Benefit Manager (PBM) shall follow the AHCCCS FFS criteria for Point-of-Sale and medical claims. The Contractor is required to follow the AHCCCS FFS PA criteria for all physician administered drugs including those billed on medical claims and point-of-sale prescription drug claims. The requirement to adhere to the FFS prior authorization criteria applies to Contractors that provide PA services from within their organization or use a subcontractor, i.e., a PBM.

The Contractor shall make available on the Contractor's website and in electronic or paper format, the following information [42 CFR 438.10(i)(1)-(2)]:

1. The Contractor's drug list(s) of medications shall include both the reference brand and generic names of each drug.

2. Each drug that requires PA approval shall be notated on the drug list.

3. The Contractor's Drug List shall reflect all AHCCCS approved AHCCCS Pharmacy and Therapeutics (P&T) Committee recommendations as follows:
   a. October P&T Committee approved changes shall be effective on January 1,
   b. January P&T Committee approved changes shall be effective on April 1,
   c. May P&T Committee approved changes shall be effective on October 1, and
   d. Other changes as requested by AHCCCS and specified by date.

4. The process for obtaining Federal and State reimbursable medications that are not included on the drug list.

5. The PA form with directions for non-urgent and urgent requests.

6. The PA criteria for drugs evaluated for coverage under the Contractor's PA program. The Contractor shall provide the criteria or a link to the criteria on the Contractor's website.

7. The Contractor's PBM shall communicate the above to the Contractor's Pharmacy Network.

The Contractor's drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary [42 CFR 438.10(i)(3)]. Refer to ACOM Policy 404.

The Contractor, its contracted PBM, and the PBM's Pharmacy Network shall comply with the following:

1. Pharmacies shall not charge patients, under the AHCCCS program, the cash price for a prescription, other than an applicable copayment, when the medication is Federally and State reimbursable and the prescription is ordered by an AHCCCS Registered Prescribing Clinician.

2. Pharmacies shall not split bill the cost of a prescription claim to the Contractor's PBM for a patient under the AHCCCS Program. The Contractor's PBM's Pharmacy Network shall not allow a patient under the AHCCCS Program to pay cash for a partial prescription quantity for a Federally and State reimbursable medication when the ordered drug is written by an AHCCCS Registered Prescribing Clinician.

3. Pharmacies are prohibited from auto-filling prescription medications.

4. Pharmacies shall not submit prescription claims to the contracted PBM for claims adjudication requesting reimbursement in excess of the Usual & Customary (U&C) price charged to the general public.
   a. The sum of charges for the Submitted Ingredient Cost plus the dispensing fee shall not exceed a pharmacy's U&C Price for the same prescription, and
   b. The U&C Submitted Ingredient Cost shall be the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the member to enroll or pay a fee to join the program.

5. Pharmacies that purchase drugs at a Nominal Price outside of 340B or the Federal Supply Schedule shall bill their Actual Acquisition Cost of the drug to AHCCCS and the Contractor's PBM.

6. PBM Network Pharmacies, at the discretion of the pharmacy staff, may deliver or mail prescription medications to an AHCCCS member or to an AHCCCS registered provider's office for a specific AHCCCS member.

The Contractor shall communicate the above requirements to the Contractor's PBM for inclusion in current and future Pharmacy Network contracts.

340B Drug Pricing Program: All Federally reimbursable drugs identified in the 340B Drug Pricing Program are required to be billed and reimbursed as noted below. Refer to A.R.S. § 36-2930.03, and A.A.C. R9-22-710 (C) for further details.

The Contractor is required to reimburse 340B entities and their employed, referred to, or contracted prescribing clinicians in accordance with the payment methodology below:

1. Drugs dispensed by the 340B entity pharmacy, point-of-sale system shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus a professional (dispensing) fee determined by AHCCCS.

2. Physician administered drugs shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price.

3. The professional (dispensing) fee is not reimbursed and is not permitted when a physician administered drug is administered by the prescribing clinician.

The Contractor is required to comply with any changes to reimbursement methodology for 340B entities. Effective with a future date to be determined, all 340B entities will be required to submit prescription drug point-of-sale and physician-administered drug claims at the entity's actual acquisition cost. The Contractor shall reimburse these claims in accordance with the 340B reimbursement methodology as specified above under the *340B Drug Pricing Program*.

Medicare Part D: The Medicare Modernization Act (MMA) of 2003 created the Medicare Part D prescription drug benefit for individuals enrolled in Medicare Part A and Medicare Part B coverages. Medicare Part D drug benefit plans cover prescription drugs as approved by the CMS. For FBDE members, AHCCCS covers medically necessary, Federally and State reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. CMS Medicare Part D excluded drugs, when ordered by a PCP, attending physician, dentist, or other authorized prescribing clinician, and dispensed by a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with Arizona State Board of Pharmacy Rules and Regulations, and from an AHCCCS registered pharmacy, are covered subject to the requirements of the AMPM Policy 310-V.

Prescription drugs and therapeutic classes that are eligible for coverage by a Medicare Part D drug benefit plan but are not specifically listed on the Medicare Part D Drug List, are considered to be covered by the Medicare Part D drug benefit plan and are *not covered* by AHCCCS. Refer to AMPM Policy 310-V. Additional details for coverage of Medicare Part D prescription medications are contained in Section D, Paragraph 59, Medicare Services and Cost Sharing. The Contractor is required to cover over-the-counter medications that are not covered as part of the Medicare Part D prescription drug program and when the drug meets the requirements of the AMPM Policy 310-V. The Contractor is also required to cover a drug that is excluded from coverage under Medicare Part D by CMS when the drug is medically necessary and Federally reimbursable.

Refer to Section D, Paragraph 33, Subcontracts for PBM Subcontract requirements.

Pharmaceutical Rebates: The Contractor, including the Contractor's PBM, is prohibited from collecting and negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s) or therapeutic class.

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

Therapeutic classes covered under supplemental rebate agreements are provided on the weekly National Drug Codes (NDC) file sent to contractors. The "preferred" products shall be available and notated on the Contractor's Drug Lists exactly as they are listed on the AHCCCS Drug List found on the AHCCCS website. The Contractor shall comply with AMPM Policy 310-V.

The Contractor shall ensure that all Healthcare Common Procedure Coding System (HCPCS) codes for drugs and devices billed on a medical claim shall include the NDC on the medical claim, as an example, all blood glucose testing products including finger stick and continuous glucose monitoring products. In addition, all diagnostics agents must also include the NDC of the agent on medical claims.

The Contractor shall not disadvantage one preferred agent over another when there is more than one agent in the designated preferred class and some or all of the agents have the same indications.

Refer to Section D, Paragraph 33, Subcontracts for PBM Subcontract requirements.

Pharmacy & Therapeutics Committee: Pursuant to Executive Order 2018-06 requiring Transparency and Eliminating Undue Influence by Pharmaceutical and Medical Device Companies, AHCCCS has developed and implemented a formal P&T Committee as an advisory Committee to AHCCCS. The P&T Committee is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness, and clinical appropriateness of prescription drugs. The P&T Committee makes recommendations to AHCCCS on the development and maintenance of a statewide drug list and PA criteria as appropriate. Committee members shall not participate in matters in which they have a potential conflict of interest, and they shall evaluate information regarding individual drugs and therapeutic classes of drugs in an impartial manner emphasizing the best clinical evidence and cost effectiveness. Refer to ACOM Policy 111.

Program to Monitor Antipsychotic Medications Prescribed for Children: The Contractor shall monitor and manage the appropriate use of antipsychotic medications prescribed for children. The Contractor shall adhere to the PA requirements as specified in AMPM Policy 310-V, including the submission of ad hoc requests as requested by AHCCCS.

Primary Care Provider Services: PCP services are covered when provided by a physician, physician assistant, nurse practitioner, or Clinical Nurse Specialist (CNS) 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)(1)]. The Contractor shall ensure that the PCP maintains the member's primary medical record and includes all documentation of all health risk assessments and health care services whether or not they were provided by the PCP.

Female members, or members assigned female at birth, have direct access to preventive and well care services from a gynecologist or other maternity care provider within the Contractor's network without a referral from a PCP.

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

Rehabilitation Therapy: The Contractor shall provide medically necessary occupational, physical and speech therapies. Therapies shall be prescribed by the member's PCP or attending physician for an acute condition and the member shall have the potential for improvement due to the rehabilitation. Therapies provided under the home health benefit shall adhere to the requirements specified in AMPM Policy 310-X. Occupational Therapy (OT) is covered for all members in both inpatient and outpatient settings. Therapy (PT) is covered for all members in both inpatient and outpatient settings. Outpatient PT for members 21 years of age or older is subject to visit limits per Contract year Refer to AMPM Policy 310-X. Speech therapy is covered for all members in inpatient and outpatient settings.

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

Substance Abuse Transitional Facility: A class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem (A.A.C. R9-10-101).

Therapeutic Leave and Bed Hold Days: Therapeutic leave and bed hold days are covered. Refer to AMPM Policy 1620-D.

Transplant Services and Immunosuppressant Medications: AHCCCS covers medically necessary transplant services and related immunosuppressant medications in accordance with Federal and State law and regulations. Services include pre-transplant inpatient or outpatient evaluation, donor search organ/tissue harvesting or procurement, preparation and transplantation services, and convalescent care. AHCCCS maintains specialty Contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 53, Reinsurance. The Contractor shall not make payments for organ transplants not provided for in the Arizona State Plan except as otherwise required pursuant to 42 USC 1396d(r)(5) for individuals receiving services under EPSDT. The Contractor shall follow the written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to members per Sections 1903(i) and 1903(i)(1) of the Social Security Act. Refer to AMPM Policy 310-DD and the AHCCCS Reinsurance Policy Manual.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air, or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. Refer to AMPM Policy 310-BB. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment. For information regarding Contractor reimbursement of ground ambulance and emergency care transportation when a contract does not exist between the Contractor and the transportation provider, refer to ACOM Policy 205.

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

1. Documentation of an appropriate clinical and/or social evaluation.

2. A treatment/referral plan for accessing social, behavioral, and/or health care services that address the patient's immediate needs.

3. Evidence of efforts to follow-up with the patient to ascertain adherence with the treatment plan.

4. Documentation of efforts to assess customer satisfaction with the treat and refer visit. Treat and Refer standing orders shall be consistent with medical necessity and consider patient preference when the clinical condition allows.

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

Vision Services/Ophthalmology/Optometry: The Contractor shall provide emergency eye care, and all medically necessary vision examinations, prescriptive lenses, frames, repair, or replacement of broken or lost eyeglasses without restriction, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care

for eye conditions which meet the definition of an emergency medical condition. In addition, cataract removal, medically necessary vision examinations, and prescriptive lenses and frames are covered if required following cataract removal. Members shall have full freedom to choose, within the Contractor's network, a Practitioner in the field of eye care, acting within their scope of practice, to provide the examination, care, or treatment for which the member is eligible. A "Practitioner in the field of eye care" is defined to be either an ophthalmologist or an optometrist.

Well Preventive Care: Well visits as specified in AMPM Policy 411, and prostate exams are covered for members 21 years of age and older. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program; refer to AMPM Policy 430.

LONG TERM SERVICES AND SUPPORTS

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

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

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

> ***Self-Directed Attendant Care***: A member-directed service delivery model option. The Direct Care Worker who provides these services is an employee, not of an agency, but of the member who hires, trains, and supervises the caregiver. Members selecting Self-Directed Attendant Care (SDAC) may direct their Direct Care Worker to provide certain skilled services. Refer to AMPM Chapters 1200, 1300 and 1600 for requirements pertaining to SDAC.
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> ***Spouses as Paid Caregivers***: A service delivery model option where a member may choose to have attendant care services provided by their spouse. Refer to AMPM Chapters 1200 and 1600 for requirements pertaining to Spouses as Paid Caregivers.
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> ***Agency with Choice***: A member-directed service delivery model option. Members selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations, and provide standardized training to the caregiver. Under this service delivery model option, the member or individual representative may recruit, select, and dismiss paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Community Transitional Services: A service to assist members residing in an institutional setting to reintegrate the member into the community by providing financial assistance to move from an institutional setting to their own home or apartment. Members moving from an institutional setting to an Alternative HCBS Setting such as Assisted Living Facilities (ALF) or Group Homes (GH) are not eligible for this service. This service is limited to a one-time benefit per five years per member. The Community Transition Service is funding to assist ALTCS members to reintegrate into the community by providing

goods and services to move from an ALTCS Long Term Care (LTC) institutional setting to their own Home. Refer to AMPM Policy 1240-C.

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 or would be alone for intermittent periods of time without contact with a service provider, family member, or other support systems, putting the member at risk. Refer to AMPM Policy 1240-D.

End of Life Care: A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness. Refer to AMPM Policy 310-HH.

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

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

Home Delivered Meals: A service that provides a nutritious meal containing at least one-third of the Federal recommended daily allowance for the member, delivered to the member's own home. Refer to AMPM Policy 1240-F.

Home and Community Based Services: Services as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939 provided to members with an institutional level of need who elect to receive HCBS instead of care in a NF or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). HCBS can be provided in the member's home or in other non-institutional settings that meet the definition of an Alternative HCBS Setting.

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

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

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. Refer to AMPM Policy 1240-I.

Hospice Services: Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. A participating Hospice shall meet Medicare requirements and have a written provider contract with the Contractor. Contractors are required to pay NFs 100% of the class specific contracted rate when a member elects the hospice benefit. The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. ALTCS services which are duplicative of the services included in the hospice benefit shall not be provided. If, however, the hospice agency is unable to provide or cover medically necessary services the Contractor shall provide the services. Attendant care services are not considered duplicative. Refer to AMPM Policy 310-J.

Licensed Health Aide Services: LHA services are provided by the HCDM, or DR of the ALTCS member who is under 21 years of age and eligible to receive Private Duty Nursing or skilled nursing respite care services. Refer to AMPM Policy 1240-G. The Contractor shall report on the LHA utilization and the oversight management activities including but not limited to the total number of participants, number of units of service authorized, number of units of service utilized, cost per participant, total cost of care for those participants, provider affiliation, and diagnosis categories. The Contractor shall submit an LHA Utilization Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

Private Duty Nursing: Nursing services for members who require more individual and continuous care than is available from a nurse providing intermittent care. These services are available to all ALTCS members and are provided by an RN or Licensed Practical Nurse (LPN) under the direction of the member's PCP or physician of record. Contractors who contract with independent nurses to provide private duty nursing shall develop oversight activities to monitor service delivery and QOC. Refer to AMPM Policy 1240-G.

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

Services for Members with a Dual Sensory (Vision and Hearing) Loss: Community Intervener service for members who have a dual sensory loss as specified in AMPM Policy 1240-H. Community interveners intercede between the member and the environment, allowing access to information usually gained through vision and hearing, and the development of skills to lead self-determined lives.

Supported Employment: Pre and post-employment services including short-term and ongoing supports to assist members in obtaining and/or maintaining employment. Refer to ACOM Policy 447 and AMPM Policy 1240-J.

INSTITUTIONAL SETTINGS

Nursing Facility: Refer to AMPM Policy 310-R. Members with an institutional level of need may opt to receive HCBS instead of care in a NF or ICF/IID. The Contractor shall provide Nursing Facility (NF) services, including in religious non-medical health care institutions, for members. The NF shall be licensed and Medicare/Medicaid certified by ADHS in accordance with 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Religious Nonmedical Health Care Institutions are exempt from State licensing requirements. As of October 1, 2021, there are no providers registered as religious non-medical health care institutions. The NF Services benefit is covered under 42 CFR 440.155(b).

ALTERNATIVE HCBS SETTINGS

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

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

On January 16, 2014, the CMS released final rules regarding requirements for HCBS operated under section 1915 of the Social Security Act [42 CFR 438.3(o); 42 CFR 441.301(c)(4)]. The rules mandate certain requirements for alternative residential or community settings where Medicaid beneficiaries receive LTSS. CMS states “The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.”

After a public comment period, AHCCCS submitted Arizona’s Systemic Assessment and Transition Plan to CMS in October 2015. The systemic assessment conducted by AHCCCS summarized Arizona’s current level of compliance for HCBS settings and was approved by CMS in September 2017.

The Transition Plan outlines strategies the State uses to make sure all HCBS settings came into compliance and AHCCCS received final approval of Arizona’s Transition Plan in January 2023.

All HCBS residential and non-residential settings shall comply with the HCBS Rules in order to provide services to AHCCCS members. These requirements impact ALTCS members receiving services in the following residential and non-residential settings:

Residential:

1. Assisted Living Facilities (ALFs).

2. Group Homes (GHs).

3. Nursing Supported Group Homes.

4. Adult and Child Developmental Homes.

Non-Residential:

1. Adult Day Health Programs.

2. Day Treatment and Training Programs.

3. Center-Based Employment Programs.

4. Group-Supported Employment Programs.

Contractors are primarily responsible for the following:

1. Disseminating member and family member educational materials.

2. Provider and case manager training.

3. Developing and executing provider training in collaboration with the other ALTCS Contractors and using internal resources from both QM and Workforce Development (WFD) departments.

4. Assessing and monitoring site-specific settings for compliance.

5. Reporting site-specific setting compliance to AHCCCS.

6. Assessing and ensuring compliance of new providers in the Contractor's network with the HCBS Rules prior to entering into a contract.

Visit the AHCCCS website for a copy of Arizona's Systemic Assessment and Transition Plan.

Alternative HCBS Settings include the following:

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

Adult Foster Care Home*:* An Alternative HCBS Setting that provides room and board, supervision, and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.
Assisted Living Home*:* An Alternative HCBS Setting that provides room and board, supervision, and coordination of necessary services to 10 or fewer residents.

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

Child Developmental Certified Home: An Alternative HCBS Setting for foster children (under age 18) with developmental disabilities that is licensed by DCS pursuant to A.R.S. § 8-509 and certified by DES

to provide room and board, supervision and coordination of habilitation, and treatment for up to three residents (A.R.S. § 36-593.01).

Developmental Home (Adult or Child): An Alternative HCBS Setting which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents. Refer to A.A.C. R6-6-1001 through A.A.C. R6-6-1019 and A.A.C. R6-6-1101 through A.A.C. R6-6-1119 and A.R.S. § 36-551.

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

BEHAVIORAL HEALTH SERVICES

The Contractor shall provide medically necessary behavioral health services to all members in accordance with AHCCCS policies and A.A.C. R9-28, Article 11 excluding Provider level Case Management specified in AMPM Policy 310-B, AMPM Exhibit 300-2A, and the Behavioral Health Services Matrix. Behavioral health services include but are not limited to the following:

Adult Behavioral Health Therapeutic Homes: A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan, as appropriate. Refer to AMPM Policy 320-X. The Contractor shall develop, and publish to its website, Adult Behavioral Health Therapeutic Homes (ABHTH) admission, continued stay, and discharge criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320-X. The Contractor shall submit the criteria for prior approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables.
Behavior Analysis: Behavior Analysis services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Refer to AMPM Policy 320-S.

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

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

1. Limits the individual’s ability to be independent, and

2. Causes the individual to require treatment to maintain or enhance independence (A.A.C. R9-10-101).

Refer to AMPM Policy 320-V.

The Contractor shall develop admission criteria, continued stay criteria, and discharge readiness criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320-V. The Contractor shall submit the criteria for prior approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to AMPM Policy 320-V.

The Contractor shall also ensure provider practices align with the secured Behavioral Health Residential Facility (BHRF) requirements.

The Contractor shall ensure providers adhere to all BHRF provider requirements as specified in AMPM Policy 320-V.

Case Management: All case management services are provided by the Contractor. Refer to Section D, Paragraph 17, Case Management**.**

Crisis Services: The Contractor of Enrollment shall ensure timely follow up and care coordination for assigned members after receiving crisis services, whether the member received services within, or outside the Contractor's GSA at the time services were provided, to ensure stabilization of the member and appropriate delivery of ongoing necessary treatment and services. Refer to AMPM Policy 590.

The Contractor of Enrollment is responsible for payment of all emergent transportation provided during the initial 24 hours of a crisis episode and any Non-Emergency Medical Transportation (NEMT) provided from a crisis service provider to another level of care, regardless of the timing within the crisis episode.

The Contractor of Enrollment is responsible for all other medically necessary services and continuing care related to a crisis including follow-up stabilization services, after the initial 24 hours covered by the ACC-RBHA.

The Contractor shall:

1. Ensure a robust SOC and sufficient provider network of facilities to transition a member from receiving crisis services, such as BHRFs, Residential Treatment Centers (RTCs), respite care, and other ongoing care options, when continuing services are required.

2. Ensure timely follow up and care coordination, including care coordination for Medications for Opioid Use Disorder (MOUD) for members after receiving crisis services, whether the member received services within, or outside the Contractor's GSA at the time services were provided, to ensure stabilization of the member and appropriate delivery of ongoing necessary treatment and services.

3. Ensure PA is not required for emergency behavioral health services (A.A.C. R9-22-210.01), including crisis services.

4. Develop policies and procedures to ensure timely communication with ACC-RBHAs for members that have engaged in crisis services.

5. Ensure Contractor staff are available 24 hours per day, seven days per week to receive notification of member engagement in crisis services and to provide member post-24-hour crisis stabilization services, care coordination, and discharge planning, as appropriate.

6. Ensure documented follow-up to the member within 72 hours after the member receives crisis telephone services, mobile crisis intervention, or discharges from a crisis setting as specified in AMPM Policy 590.

7. Engage peer and family support services when responding to post-crisis situations, as preferred and identified by the member.

8. Track member crisis system utilization and refer repeat and/or frequent users of crisis services to the Contractor's care management and/or high needs/high-cost program as specified in Section D, Paragraph 22, Medical Management.

9. Address preventable crisis system and inpatient psychiatric utilization through various strategies, including but not limited to, extended availability of outpatient treatment services, after hours member care options, development of member specific safety plans, and ensuring engagement of outpatient treatment providers in responding to post-crisis care and treatment.

10. Cooperate with AHCCCS, the State designated HIO, and any applicable vendors to enhance crisis-related data sharing and availability through the HIE or other applicable data or Information System (IS).

There are specific modifier(s) which shall be included on claims to identify that the service is being provided as part of a crisis episode. The Contractor and providers shall work together to ensure the modifier(s) are being included. The Contractor shall educate its providers about the crisis modifier(s) in order to ensure all appropriate costs are included in the capitation rates for the correct risk group.

Court Ordered Evaluation and Court Ordered Treatment: The Contractor is responsible for medically necessary, covered behavioral health services and treatment that are court ordered, but is not responsible for services associated with the pre-petition screening and Court Ordered Evaluation (COE). AHCCCS-covered services that are separate from COE services and medically necessary physical health services are the responsibility of the Contractor during the COE time period for AHCCCS members.
The Contractor shall develop a collaborative process with the counties to ensure coordination of care, information sharing, and timely access to pre-petition screening, COE, and Court Ordered Treatment (COT) services provided. The Contractor shall ensure the Pre-Petition Screening and COE processes are implemented and monitored in compliance with AMPM Policy 320-U and submit deliverables related to Pre-Petition Screening and COE reporting as specified in Section F, Attachment F3, Contractor Chart of Deliverables. If a county has chosen not to contract with the Contractor, the Contractor will engage in collaborative processes to ensure member services are provided and monitored for members.

Title XIX/XXI funds shall not be used to reimburse COE services. Reimbursement for pre-petition screening and COE services are the responsibility of the County pursuant to A.R.S. § 36-545. The County's financial responsibility ends with the filing of a petition for COT. Counties maintain financial responsibility of any services provided under COE until the date and time the petition for COT is actually filed. Some counties have an agreement with AHCCCS under A.R.S. § 36-545.07 to provide those services for the county. If such an agreement exists, the ACC-RBHA Contract includes those services within the scope of the ACC-RBHA responsibilities. Refer to ACOM Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE, and ACOM Policy 423 for clarification regarding the financial responsibility for the provision of specific behavioral health treatment/care when such treatment is ordered as a result of a judicial ruling, involving Driving Under the Influence (DUI), domestic violence, or other criminal offense. Refer to AMPM Policy 320-U. For additional information regarding behavioral health services refer to A.A.C. R9-22 Article 2 and Article 12.

For purposes of care coordination, the Contractor shall submit a report of all members under outpatient COT to AHCCCS. The Contractor shall submit the Outpatient Commitment COT Monitoring Report (one combined deliverable for all LOBs) as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Outpatient Commitment COT Monitoring Report shall contain the following information:

1. Health plan sub population, health plan sub population description.

2. Record number.

3. Contractor ID, Name.

4. Date by year and month.

5. Member name and demographics.

6. Member Client Information System (CIS) and/or AHCCCS identification number.

7. New or existing court order and court order description.

8. Court Ordered Treatment (COT) start date, end date, court order reason and court order reason description.

9. Re-Hospitalization, re-hospitalization description and date.

10. Date of Incarceration.

11. Court order expired.

12. Court Ordered Treatment (COT) review and court order treatment review description.

13. Transferred to IHS or Tribal 638 Facility.

14. Noncompliant.

15. Court order was amended due to noncompliance.

16. Contractor contact person, email address.

17. Behavioral health category, behavioral health category description.

18. Age, age band, age band description.

19. Funding source, funding source description.

20. Facility name, if applicable.

The Contractor and its providers shall comply with State recognized tribal court orders for members. When tribal providers are also involved in the care and treatment of court ordered tribal members, the Contractor, and its providers, shall involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT and when members are transitioned to services on the reservation, as applicable.

The Contractor is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members. Refer to AMPM Policy 320-U and ACOM Policy 423.

The Contractor shall develop policies and training that outline the Contractor's role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy shall address the processes provided for in A.R.S. Title 36, Chapter 5, Article 4:

1. Involuntary pre-petition screening, evaluation, and treatment processes.

2. Processes for tracking the status of court orders.

3. Execution of court orders.

4. Judicial review processes.

The Contractor shall develop and make available to providers information regarding specifically where a behavioral health provider would refer an individual for a voluntary or involuntary evaluation.

The Contractor shall submit a report to AHCCCS/DHCS of Members in Out-Of-State Placement as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to AMPM Policy AMPM 1620-J.

Inpatient Behavioral Health Services for Members in an Institution for Mental Diseases: The Contractor may provide members who are over the age of 21 and below the age of 65 inpatient treatment in an Institution for Mental Diseases (IMD), so long as the facility is a hospital providing psychiatric or SUD inpatient care or a sub-acute facility providing psychiatric or SUD crisis residential services, and length of stay in the IMD is for no more than 15 cumulative days during the calendar month. In accordance with 42 CFR 438.3(e)(2)(i)-(iii), the State has determined that treatment in an IMD is a medically appropriate and cost-effective substitute for the behavioral health service covered under the State plan in other settings. Contractors may, but are not required, to use an IMD in lieu of other behavioral health services. The Contractor is prohibited from requiring an enrollee to access behavioral health services at an IMD.

AHCCCS considers the following provider types to be IMDs: B1-Residential Treatment CTR-Secure (17+ Beds), B3-Residential Treatment Center – Non-Secure, B6-Subacute Facility (17+ Beds), and 71-Psychiatric Hospital. When the length of stay is no more than 15 cumulative days during the calendar month, AHCCCS shall pay the Contractor the full monthly capitation [42 CFR 438.6(e)].

When the length of stay in the IMD is more than 15 cumulative days during the calendar month, AHCCCS shall recoup the full monthly capitation from all Contractors regardless of whether the Contractor is responsible for inpatient behavioral health services and regardless of whether the Contractor authorized the IMD stay. AHCCCS shall pay all Contractors pro-rated capitation based on any days during the month the member was not an inpatient in the IMD when the IMD stay(s) exceeds 15 days.

When the length of stay in the IMD is more than 15 cumulative days during the calendar month, the Contractor shall provide the member all medically necessary services during the IMD stay that are covered under this Contract and that would be Title XIX compensable but for the IMD stay. The Contractor shall submit encounters for all services provided during the IMD stay.

The Contractor shall submit notification of an IMD Placement Exceeding 15 Days as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 109 for further information on the IMD 15-day limit.

The Contractor shall cover inpatient psychiatric services to members under the age of 21 as specified in 42 CFR 440.160 and 42 CFR Part 441, Subpart D even if the services are in a facility that meets the definition of an IMD in 42 CFR 435.1010. Under the circumstances specified in 42 CFR 441.151, these services can be provided to some members up to the age of 22. These services are not subject to the 15-day length of stay limitation on capitation applicable to enrollees over the age of 21 and below the age of 65.

The Contractor may provide behavioral health services covered under the Arizona State Plan to individuals over the age of 65 in any setting regardless of whether it meets the definition of an IMD in 42 CFR 435.1010. These services are not subject to the 15-day length of stay limitation on capitation applicable to enrollees over the age of 21 and below the age of 65. Refer to ACOM Policy 109.

Non-Title XIX/XXI Services: Service provision for Non-Title XIX/XXI services for Contractor enrolled members with behavioral health conditions is provided or coordinated by the ACC-RBHA Contractors. The Contractor shall have established processes in place to refer members to the ACC-RBHA Contractor for Non-Title XIX/XXI services. The Contractor shall inform members with how to access these services and shall assist and coordinate care for the member as appropriate, to ensure that the member is able to receive the necessary services. Refer to AMPM Policy 320-T1 and AMPM Policy 320-T2.

Out-of-State Placements for Behavioral Health Treatment: The Contractor shall notify AHCCCS of out-of-State placements, submit progress updates of members who remain in out-of-State placement for behavioral health treatment, and notify AHCCCS when a member is discharged, as specified in AMPM Policy 450 and Section F, Attachment F3, Contractor Chart of Deliverables.

Rehabilitation Services: Rehabilitation Services include:

1. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training.

2. Cognitive Rehabilitation.

3. Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion).

4. Supported Employment (Psychoeducational Service [Pre-Job Training and Job Development] and Ongoing Support to Maintain Employment [Job Coaching and Employment Support]).

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

1. Personal Care Services.

2. Home Care Training Family Services (Family Support).

3. Self-Help/Peer Services (Peer Support).

4. Therapeutic Foster Care (TFC).

5. Unskilled Respite Care.

6. Transportation.

Therapeutic Foster Care: A family-based placement option for children with serious behavioral or emotional needs who can be served in the community with intensive support. Refer to AMPM Policy 320-W. The Contractor shall develop, and publish to its website, TFC admission, continued stay, and discharge criteria for medical necessity which at a minimum includes the elements as specified in AMPM Policy 320-W. The Contractor shall submit the criteria for PA as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Treatment Services: Treatment services are provided by or under the supervision of Behavioral Health Professionals (BHPs), to reduce symptoms and improve or maintain functioning. These services include:

1. Behavioral Health Counseling and Therapy.

2. Assessment, Evaluation and Screening Services.

3. Other Professional Services.

The Contractor shall also provide behavioral health services as specified in Section D, Paragraph 13, Behavioral Health Service Delivery.

12. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its *Quality Assessment and Performance Improvement Strategy* certain populations with SHCN and the mechanisms used to identify individuals with SHCN as defined by I State [42 CFR 438.208(c)(1)].

Members with SHCN needs are those members who have serious and chronic physical, developmental, and/or behavioral conditions requiring medically necessary services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a PCP. The following populations meet this definition including, but not limited to:

1. Members with qualifying CRS conditions.

2. Members diagnosed with HIV/AIDS.

3. Members diagnosed with Opioid Use Disorder (OUD), separately tracking pregnant members and members with co-occurring pain and OUD.

4. Members who are being considered for or are actively engaged in a transplant process and for up to one-year post transplant.

5. Members enrolled in the ALTCS:
   a. Members enrolled in the ALTCS program serving individuals who are elderly and/or have a physical disability, and
   b. Members enrolled in the ALTCS program serving individuals who have a developmental disability and/or intellectual.

6. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP).

7. Members who are enrolled in the CHP.

8. Members who transition out of the CHP up to one year post transition.

9. Members with an SMI designation.

10. Any child that has a CALOCUS level of 4, 5, or 6.

11. Members with an SED diagnosis flag in the system or an SED designation.

12. Substance exposed newborns and infants diagnosed with Neonatal Abstinence Syndrome (NAS).

13. Members diagnosed with Severe Combined Immunodeficiency (SCID).

14. Members with a diagnosis of autism or at risk for autism.

Many children with SHCN typically require complex care and are medically fragile. For these children, health care service delivery involves multiple clinicians, covering the entire Continuum of Care (CoC). In addition to a PCP, these children may receive services from subspecialists who manage care related to their condition(s) and coordinate with other specialty services including but not limited to behavioral health, pharmacy, medical equipment and appliances, therapies, diagnostic services, and telemedicine visits.

Comprehensive care includes a multi-disciplinary team made up of subspecialists and caregivers such as pulmonologists, cardiologists, nutritionists, psychologists, and therapists. Because of the complexity of the needs of these children including multiple surgeries, hospitalization, and clinical care it is imperative that there be integrated health information and care coordination for the member. Services shall be provided using an integrated family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes the following elements:

1. A process for using a centralized, integrated medical record that is accessible to the Contractor and service providers consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care.

2. A process for developing and implementing a Service Plan accessible to the Contractor and service providers that is consistent with Federal and State privacy laws, and that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation.

3. Collaboration with individuals, groups, providers, organizations, and agencies charged with the administration, support, or delivery of services for persons with SHCN.

AHCCCS monitors quality and appropriateness of care/services for routine and SHCN members through Operational Reviews of Contractors and the review of required Contractor deliverables set forth in Contract, program specific performance measures, and Performance Improvement Projects (PIP).

The Contractor shall implement mechanisms to comprehensively assess each member identified as having SHCN, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring, or transition to another AHCCCS program [42 CFR 438.208(c)(2) and (c)(3)(iii) - (v), 42 CFR 438. 240(b)(4), 42 CFR 441.3010(c)(3)]. The assessment mechanisms shall use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c), and 42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(4) and (c)(3)].

The Contractor shall ensure that members with SHCN that are determined through assessment to need a course of treatment or regular care monitoring have an individualized physical and behavioral treatment or service plan. In addition, the Contractor shall conduct multi-disciplinary staffing for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

For members with SHCN determined to need a specialized course of treatment or regular care monitoring, the Contractor shall have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)]. For members transitioning, refer to Section D, Paragraph 10, Transition Activities.

The Contractor shall have a methodology to identify providers willing to provide a Patient Centered Medical Home (PCMH) for members with SHCN that offers comprehensive, continuous medical care and extended access to services with the goal of obtaining maximized health outcomes.

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

1. Accessible.

2. Continuous.

3. Coordinated.

4. Family-centered.

5. Comprehensive.

6. Compassionate.

7. Culturally effective.

13. BEHAVIORAL HEALTH SERVICE DELIVERY

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 shall be provided in a manner that respects the member and family's cultural heritage and appropriately utilizes informal support in the member's community.

The Contractor shall adhere to the following requirements with respect to delivery of behavioral health services. Regardless of the type, amount, duration, scope, service delivery method, and population served, the Contractor's behavioral health service delivery system shall incorporate the following elements:

1. The System Values and Guiding Principles as specified in Section D, Paragraph 1, Purpose, Applicability, and Introduction.

2. Service delivery by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

3. Providers, acting within the lawful scope of their practice, are not prohibited, or otherwise restricted from communicating freely with members regarding their health care, medical needs, and treatment options, even if needed services are not covered by the Contractor [Section 1932(b)(3)(A) of the Social Security Act, 42 CFR 438.102(a)(1)(i)-(iv)]:
   a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, [42 CFR 438.102 (a)(1)(i)],

b. Information the member needs in order to decide among all relevant treatment options, or
c. The risks, benefits, and consequences of treatment or non-treatment, the member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(iv)].

4. Referral processes.

5. Regular and ongoing training for Case Managers, providers, and members to assist members with how to access services, including Non-Title XIX/XXI services. Contractors shall ensure providers coordinate care for members as appropriate to ensure services are delivered upon referral.

6. Maintaining behavioral health assessments and service and treatment plans for members receiving behavioral health services, .

7. Coordinating of peer and family support services, whether delivered within or outside of the member's identified health home.

8. Adherence to General and Informed Consent requirements as outlined in AMPM Policy 320-Q.

9. Providing comprehensive care coordination across the continuum of health care and non-clinical health care-related needs and services.

10. Coordinating and providing quality health care services informed by evidence-based practice guidelines and in a cost-effective manner.

11. Coordinating and providing quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and implement a Trauma-Informed Care (TIC) approach.

12. Coordinating and providing preventive and health promotion services, including wellness services.

13. Organizing, implementing, and documenting documentation provider trainings and implementation efforts to increase outreach.

14. Providing comprehensive care coordination and transitional care across settings; follow-up after crisis episodes, discharge from inpatient to other settings; participation in discharge planning; facilitating minimally disruptive transfers between systems of care, and outreach, engagement, re-engagement, and closure for behavioral health as specified in AMPM Policy 1040.

15. Providing disease/chronic care management support, including self-management support. Refer to AMPM Policy 1023.

16. Coordinating and providing covered services to members in accordance with all applicable Federal and State laws, regulations, and policies, including those listed by reference in this Contract.

17. Coordinating and providing integrated clinical and non-clinical health-care related services.

18. Implementing HIT to link services, facilitate communication among treating professionals, and between the health team and individual and family caregivers.

Adult's Integrated System of Care: For adult members, the Contractor shall adhere to Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, that were developed to promote recovery in the adult behavioral health system; system development efforts, programs, service provision, and stakeholder collaboration shall be guided by these nine principles.

The Contractor shall ensure use of:

1. Standardized validated screening instruments by PCPs: The Contractor shall require validated screening tools for PCPs to utilize for all adults related to behavioral health needs, SDOH, and trauma.

2. Streamlined service referral mechanism for PCPs: The Contractor shall implement a streamlined mechanism for PCPs to refer adults who are screened at risk for a behavioral health need to the appropriate behavioral health provider for further assessment, if not served through an integrated care provider.

3. Psychosocial rehabilitation.

4. Centers of Excellence: Refer to Section D, Paragraph 80, Value-Based Purchasing.

5. Implementation of Assertive Community Treatment (ACT), Supported Employment, and PROs and FROs services consistent with SAMHSA Best Practices.

***Fidelity Monitoring*:** The Contractor shall participate in annual Fidelity Monitoring consistent and SAMHSA Best Practices for individuals with an SMI designation for the following:

1. Assertive Community Treatment (ACT) Teams.

2. Supported Employment.

3. Permanent Supportive Housing (PSH) support services.

4. Peer and Family Support Services.

The Contractor shall report, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, an SMI Targeted Services Report, in addition to a narrative report that includes trends, performance outcomes, lessons learned, and strategies targeted for improvement.

The Contractor shall monitor the provision of the SAMHSA Evidence-Based Practices to ensure services provided are consistent with fidelity as specified within the respective SAMHSA Toolkits. The Contractor shall engage in performance improvement planning in collaboration with all other MCOs, as applicable, for providers who have been found to not meet criteria for evidence-based practice. In the event a provider is found deficient or does not meet evidence-based practice, the Contractor shall submit the Evidence-Based Practice Remediation Plan as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Children's Integrated System of Care: For child members, the Contractor shall ensure delivery of services in conformance with Arizona Vision-12 Principles for Children Behavioral Health Service Delivery and shall abide by AHCCCS Appointment Standards as specified in ACOM Policy 417.

The Contractor shall adhere to ACOM Policy 449 with regard to adopted children in accordance with A.R.S. § 8-512.01.

The Contractor shall provide and promote Evidence-Based Practices for Transition Aged Youth (16-24 years of age) through development and monitoring of evidence-based programming.

The Contractor shall ensure transition activities begin no later than 16 years of age. Activities shall be conducted according to AMPM Policy 280, Transition to Adulthood Behavioral Health System Practice. The Contractor shall also ensure that an SMI determination is initiated as clinically indicated by age 17.5 years.

The Contractor shall ensure provision of Trauma Informed Care (TIC) service delivery approaches, including routine trauma screenings and development of a network of therapists trained and certified in trauma-focused Evidence-Based Practice.

The Contractor shall provide and promote service delivery for children ages birth through five, including screening and high need identification as directed by AHCCCS.

The Contractor shall provide and promote expansion of services for children ages birth through five through training and monitoring of specialists as directed by AHCCCS and in alignment with Evidence-Based Practices for this population [i.e., Infant Toddler Mental Health Coalition of Arizona (ITMHCA) standards].

The Contractor shall utilize SUD screening tools to identify youth with SUD and refer to SUD specialty services as appropriate.

The Contractor shall ensure the use of the CALOCUS (or other assessment, as directed by AHCCCS) by all contracted providers delivering services to enrolled children. CALOCUS assessments can be completed by any individual who has been trained to implement this assessment and is practicing within their scope. The CALOCUS shall be administered within 45 days of the initiation of behavioral health services, and re-administered at least every six months, or as significant changes occur in the life of the child. This may include but is not limited to; hospitalization, suicidal ideation or attempt, or discharge from inpatient, behavioral health short term residential treatment, or TFC.

Due to the potential for duplication of the CALOCUS assessment, scores shall be included in the clinical record, and the data file transmissions to the HIE and shared with the member's primary behavioral health provider. Treating providers shall collaborate to ensure that differences in CALOCUS levels are addressed at the clinical level and through the CFT, if applicable.

In addition to the CALOCUS (or other assessment, as directed by AHCCCS), level of acuity and high-need determination for children ages six through 17 may be assessed through clinical evaluation. Children with a CALOCUS score of 4, 5, or 6 shall be offered High Needs Case Management. The Contractor shall monitor to ensure that High Needs Case Managers collaborate with the child and family in the service planning process to offer a unique combination of formal and informal support and rehabilitation services that meets their needs. Contractors shall ensure the availability of support and rehabilitation services to all members and shall not require PA.

The Contractor shall also monitor providers administering the CALOCUS to ensure that they have completed the training. The Contractor shall engage in PI planning in collaboration with all other MCOs for providers who have been found to not be utilizing the CALOCUS as required.

The Contractor shall ensure use of:

1. Standardized validated screening instruments by PCPs:
   The Contractor shall ensure the use of validated screening tools for PCPs to utilize for all children to assess behavioral health needs, SDOH, and trauma.

2. Streamlined service referral mechanism for PCPs:
   The Contractor shall implement a streamlined mechanism for PCPs to refer children who are screened at risk for a behavioral health need to the appropriate behavioral health provider for further assessment.

3. Community-Based Behavioral Health Services:
   a. The Contractor shall develop and maintain minimum network capacity standards for Specialist Support and Rehabilitation Services Providers, and
   b. The Contractor shall develop and maintain minimum network capacity standards for TFC. The Contractor shall utilize TFC as an alternative to more restrictive levels of care when clinically indicated.

4. Centers of Excellence:
   a. Refer to Section D, Paragraph 80, Value-Based Purchasing.

5. Fidelity Monitoring:
   a. Implement AHCCCS' method for in-depth quality review including necessary practice improvement activities as directed by AHCCCS,
   b. Implement protocols for CFT training/supervision and fidelity monitoring as directed by AHCCCS, and
   c. Implement AHCCCS-approved methodology for fidelity review of CALOCUS completion and scoring.

Behavioral Health Services for School-Aged Children: The Contractor shall ensure the availability of behavioral health services for school-aged children in school settings, and the use of appropriate billing and coding for these services, including place of service codes and the use of County, Town, District, Site (CTDS) numbers by the billing provider. The Contractor shall work with schools and contracted providers to remove barriers to referral pathways and improve access to care in school settings. Contractors shall provide updates on efforts to provide resources and technical assistance for school-based services during quarterly school-based services collaborative meetings with AHCCCS. The Contractor shall ensure that behavioral health services provided as the result of a school-based referral align with guidelines for service delivery specified outlined in ACOM Policy 100 and AMPM Policy 100 including the 12 principles and all required timelines in ACOM Policy 417. The Contractor shall also provide information to enrolled members on Behavioral Health Services in schools which shall include a list of resources available to their members on school campuses, and any provider programming offered during school breaks. The Contractor shall include information on the Contractor's role in assisting school administrators to connect with behavioral health providers to meet the needs of their students and include the name, email and/or phone number for the Contractor's point of contact. Information shall be made available on the Contractor's website as specified in ACOM Policy 404. The Contractor shall submit the specific website link as part of the Website Certification deliverable as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Contractor Responsibilities: For all enrolled members, the Contractor is responsible for the following:

Arizona State Hospital Discharges: AHCCCS enrolled members who are residing in the Arizona State Hospital (ASH) and who require physical health services that are not provided by ASH during their stay, will receive services at Valleywise Health Center and/or Valleywise Medical Center. Refer to AMPM Policy 1021.

The Contractor shall provide reimbursement for medically necessary physical health services under one of the two following arrangements:

1. A contractual agreement with Valleywise Health Center clinics including Valleywise Medical Center and Valleywise Health Center physicians, to provide all medically necessary services. Valleywise Health will be assigned to provide primary care services for all members residing in ASH.

2. In the absence of a contractual agreement, the Contractor shall be responsible for coordination of care, PA processes, claims payments, and provider and member issues for all services delivered by Valleywise Health Center. The Contractor shall provide a seamless and obstacle free process for the provision of services and payment.

Emergency services for ASH residents will be provided by the Valleywise Medical Center and shall be reimbursed by the Contractor regardless of PA or notification. Physical health-related pharmacy services for ASH residents will be provided by ASH in consultation with the Contractor. The Contractor is responsible for the payment of these pharmacy services.

The Contractor shall monitor and coordinate care for enrolled members who are admitted to ASH, awaiting admission to ASH, and monitor those who have been discharged or determined discharge ready from ASH as specified in AMPM Policy 1021. The Contractor shall ensure member discharge is complete. The Contractor Care Manager shall immediately begin discharge coordination and facilitation upon ASH determination that the member is discharge ready, the member shall be safely discharged as expeditiously as possible and no later than 45 days from ASH established discharge ready date. The Contractor is required to submit an ASH Monitoring Report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Behavioral Health Clinical Chart Audit: The Contractor shall conduct a Clinical Chart Audit of the behavioral health care provided to their members. The process shall be conducted in a manner that promotes transparency and collaboration across health plans, providers, and members of the community. Further, the process will focus on continual enhancement of the existing tool to facilitate measurement of member outcomes that are meaningful and that promote alignment with nationally recognized outcome measurement.

Audits shall be conducted according to the most current version of the AHCCCS Instruction Guide for the Behavioral Health Clinical Chart Audit (BHCCA) and the corresponding BHCCA Tool available within the online AHCCCS Behavioral Health Audit portal.

The audit process shall identify at a minimum, the following expectations: (1) the extent to which the required assessment elements are identified, (2) the continuity between needs identified within the assessment and the service plan goals, objectives and services to be delivered, (3) identification of member needs that are met and unmet via the service plan goals and objectives.

The Contractor shall utilize the AHCCCS Behavioral Health Audit portal for ongoing data input and analysis.

The Contractor shall notify its providers in advance of the intent to audit. Notification shall include at minimum:

1. Start date of the audit.

2. Sample and oversample list, if applicable.

3. Audit Review Period.

4. Process by which the Contractor will provide feedback and activities related to monitoring the need for corrective action by providers based on deficient findings as a result of the audit. This should include notification of the QOC concerns or trends found as a result of the audit (with member information redacted).

5. The methods to be used to ensure member privacy.

Clinical Chart Audits are required for providers licensed under A.A.C. R9-10-10 that include Behavioral Health Outpatient Clinics (Provider Type-77) and Integrated Clinics (Provider Type IC). Additional provider types may be included, as directed by AHCCCS. The Contractor shall accept NCQA as a Patient Centered Medical Home (PCMH) with Behavioral Health Distinction as evidence that the provider has met the standards of the audit. The Contractor shall not include these providers in its chart audit sample.

The audit process should result in minimal burden to the behavioral health providers (e.g., no more than one Contractor should review the same provider within the same year, but all contracted providers, with the provider type designations identified above, should be audited at least annually). The Behavioral Health Clinical Chart Audit shall be conducted by licensed Behavioral Health Professionals (BHPs) or Behavioral Health Technicians (BHTs), with a minimum of three years' experience as a BHT and under the supervision of a BHP.

Sampling methodology shall be completed by assessing the Contractor's total population of members receiving behavioral health services within the previous twelve months, including at minimum, any of the following service codes:

- Behavioral Health Assessment (e.g., 96160, 96161, H0031, 90791, H0001, H0031)
- Therapy (e.g., 90832 - 90834, 90836-90838, 90846, 90847, 90849, 90853, H0004)
- Psychiatric Visits (e.g., 90887, 90889, 99202-99205, 99211-99215, 90791, 90792, 99341-99345, 99347-99350, 99441-99443, 99367)

Any combination of the services associated with the above codes shall have occurred within the most recent 12 months, as related to the date of the audit time frame, and for any provider type identified for audit inclusion. Contractors shall ensure samples are based on a stratified random sampling methodology that is statistically representative of the Contractor's total member population receiving services indicated above. If the Contractor has multiple LOB, providers shall be selected based upon the representative sample size required per line of business. For each provider audited during the review cycle, the sample size is not to exceed an "n" of 30 charts per provider unless otherwise approved or directed by AHCCCS. In instances of a provider having less than 30 charts, the total number of clinical charts for that provider shall be included in the audit. Relative to the contractual relationship between the provider and Contractor conducting the audit, the final sample of providers to be audited shall be adjusted to meet minimum statistical significance, even if it becomes necessary to identify additional providers that were not initially included in the provider listing for the identified health plan.

The Contractor shall submit an annual analysis of the findings and trends of its Chart Audits (Behavioral Health Clinical Chart Audit Findings and Summary Report) as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Requests for modifications to the instruction or methodology that is required in Contract, the AHCCCS Audit Instruction Guide, or the Summary Report template, shall be submitted to AHCCCS as identified in Section F, Attachment F3 Contractor Chart of Deliverables via the Behavioral Health Clinical Chart Audit Methodology deliverable. Any request for revisions will be internally reviewed by AHCCCS, and if approved, will be made by AHCCCS directly within the tool, instructions, or methodology as applicable.

The Contractor shall monitor and provide feedback on all CAPs written as a result of the findings in the case file review to ensure improved performance.

Community Service Agencies: The Contractor may contract with Community Service Agencies (CSAs) for the delivery of some covered behavioral health services. Refer to AMPM 965.

Conditional Release: The Contractor shall develop and implement policies and procedures to proactively coordinate care for members on conditional release awaiting admission to and discharge from ASH,; establish relationships with the Superior Court and ASH to support streamlined communication and collaboration between the Contractor, outpatient treatment team, ASH, and the Superior Court, and provide training to outpatient providers serving members on conditional release and assuring providers demonstrate understanding of A.R.S. § 13-3991, and A.R.S. §§ 13-3994 through 13-4000. Refer to AMPM Policy 320-Z.

The Contractor shall, in accordance with AMPM Policy 320-Z, provide high touch Care/Case Management for members on Conditional Release from the ASH consistent with the CRP issued by the assigned county Superior Court. This includes but is not limited to coordination with ASH for discharge planning; participating in the development of CRPs; member outreach and engagement to ensure compliance with the approved CRP; attendance in outpatient staffing at least once per month; care coordination with the member's treatment team and providers of both physical and behavioral health services, and routine review of administrative and clinical activities, comprehensive status reporting, and confirmation of delivery of reporting to the Superior Court, and ASH as specified in A.R.S. § 13- 3991 and A.R.S. §§ 13-3994 through 13-4000.. The Contractor shall submit a Conditional Release Monitoring Report deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables, to support an individual's conditional release into the community.

The Contractor shall also identify a key clinical single point of contact at the Contractor as specified in AMPM Policy 320-Z who is responsible for collaboration with ASH and the assigned county Superior Court and remediation of identified concerns. The Contractor may not delegate the Care/Case Management functions to a subcontracted provider.

The Contractor shall develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy shall address:

1. Involuntary evaluation/petitioning.

2. Court ordered process, including tracking the status of court orders.

3. Execution of court order.

4. Judicial review.

Coordination of Care: There shall be procedures in place for ensuring that the member's behavioral health services are appropriately provided, are documented in the member's record, are tracked by the Contractor Case Manager and included within the member's PCSP. The Contractor shall also have procedures in place for ensuring communication occurs between the Contractor Case Manager, the PCP and behavioral health providers, and other agencies and involved parties. Refer to AMPM Policy 541. The Contractor shall ensure members transitioning to the ALTCS program receive uninterrupted behavioral health services and supports and shall coordinate with the relinquishing Contractor to ensure the member is appropriately transitioned.

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

The Contractor shall ensure an effective referral process is in place for behavioral health services. The Contractor shall implement processes for referral for behavioral health service provision. The Contractor shall provide members the right to participate in decisions regarding their behavioral health care, including the right to refuse treatment. The Contractor shall implement processes regarding General and Informed Consent for behavioral health services as specified in AMPM Policy 320-Q.

In order to promote early intervention and prevent an unnecessary change of placement, the Contractor shall have a policy and process in place to timely involve a BHP to assess, develop a care plan and preserve the current placement, if possible, when a member presents new or existing challenging behaviors in a non-behavioral health setting. When attempting to place a member in a NF or Alternative HCBS Setting, the Contractor shall disclose all information that pertains to the behaviors demonstrated by members. Refer to AMPM Policy 310-R.

Evidence-Based Practice: The Contractor shall develop, manage, and monitor provider use of Evidence-Based Programs and Practices (EBPP) to ensure that services are offered and delivered in a culturally appropriate manner. The Contractor is responsible to ensure the development and use of Promising Practices if no EBPP is available. These EBPP must be specifically included at the following points in service delivery, but are not limited to:

1. Assessment.

2. Engagement.

3. Treatment planning.

4. Service delivery.
    a. Providing care and treatment to individuals based upon their unique needs, including for
        i. Individuals within the LGBTQIA+ community,
        ii. Individuals who are involved with the justice system, and
        iii. Adolescents.

5. Inclusion of recovery interventions.

6. Discharge planning.

7. Relapse prevention planning.

8. Harm reduction efforts.

9. Data and outcome collection.

10. Post-discharge engagement.

11. Gender based treatment.

EBPP shall be used by all providers for the treatment of SUD, including MOUD, and shall be integrated into all services that the member receives, as appropriate.
The Contractor shall employ a phased-in implementation approach, as directed by AHCCCS, to utilize the ASAM Criteria (most recent edition) for assessment, service planning, and level of care placement for members who have SUD or co-occurring mental health and SUD.

Mental Health Parity: CMS issued the Mental Health Parity and Addiction Equity Act (MHPAEA) final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to mental health/substance use disorder benefits than to medical/surgical benefits. The Contractor shall:

1. Not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor) [42 CFR 438.910(b)(1).

2. If a member is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits shall be provided to the member in every classification in which medical/surgical benefits are provided [42 CFR 438.910(b)(2)].

3. Not apply any cumulative financial requirements for mental health or SUD benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification [42 CFR 438.910(c)(3)].

4. Not impose Non-Quantitative Treatment Limits (NQTLs) for mental health or SUD benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

5. Refer to ACOM Policy 110 for more detailed information and requirements.

The Contractor shall demonstrate that services are delivered in compliance with mental health parity consistent with 42 CFR Part 438 and ACOM Policy 110. The Contractor may be required to submit

documentation which demonstrates compliance with mental health parity as promulgated under 42 CFR Part 438 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Additionally, the Contractor shall submit a Mental Health Parity Deficiencies Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables, identifying parity deficiencies and a plan of how the Contractor will come into compliance within the same quarter as the submission. AHCCCS may require that the mental health parity analysis is conducted in a manner consistent with the State's analysis for contracted MCOs with carved out services. The Contractor may also be required to participate with and respond to inquiries from AHCCCS and/or an AHCCCS contracted consultant regarding Contractor policies and procedures requiring review to determine compliance with mental health parity regulations.

In the event that a Contract modification, amendment, novation or other legal act changes, limits, or impacts, compliance with the mental health parity requirement, the Contractor agrees to conduct an additional analysis for mental health parity in advance of the execution of the Contract change. Further, the Contractor shall provide documentation of how the requirements of 42 CFR 438 are met with submission of the Contract change; and how sustained compliance shall be achieved. The Contractor shall certify compliance with mental health parity requirements before Contract changes become effective.

The Contractor may be required to cover, in addition to services covered under the Arizona State Plan, any services necessary for compliance with the requirements for parity in mental health and SUD benefits in 42 CFR part 438, subpart K. The Contract identifies the types and amount, duration, and scope of services consistent with the analysis of parity compliance conducted by either the State or the MCO.

Monitoring of Behavior Analysis: The Contractor shall monitor and coordinate care for members receiving Behavior Analysis. The Contractor shall collaborate with all MCOs in partnership to ensure that the contracted network of providers of Behavior Analysis services are utilizing the Applied Behavioral Analysis (ABA) code set, and to streamline system wide processes for PA and c monitoring the utilization of appropriate service codes, billing, and supervision practice for services delivered under the supervision of a Behavior Analyst. The Contractor shall maintain a sufficient network to ensure the needs of the population are met. The Contractor shall include information related to the monitoring of these activities in the Provider Network Development and Management Plan as required under ACOM Policy 415, and submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Monitoring, Training, and Education: The Contractor is responsible for training all staff who will have contact with members, staff who will be involved in any coordination of care for members, and providers, in sufficient detail and frequency, to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding:

1. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems.

2. The Arizona Vision-12 Principles for Children Behavioral Health Service Delivery.

3. The 10 Principles of Wraparound.

4. Covered behavioral health services and referrals.

5. How to access services.

6. Petitioning and COE processes provided for in A.R.S. Title 36 Chapter 5, Article 4.

7. How to involve the member and their family in decision-making and service planning.

The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Training for staff and providers may be provided through employee orientation, clinical in-services, and/or information sharing via newsletters, brochures, etc. The Contractor shall maintain documentation of the behavioral health trainings in accordance with AMPM Policy 1630.

Non-Title XIX/XXI Behavioral Health Services: Refer to Section D, Paragraph 11, Scope of Services.

Opioid Use Disorder Treatment Programs: The Contractor shall monitor the availability of OUD treatment services for network sufficiency.

Outreach: For Services pertaining to outreach refer to Section D, Paragraph 22, Medical Management.

Permanent Supportive Housing Coordination: Safe, stable, and affordable housing aligned and coordinated with an individual's behavioral health, medical, and other supportive services, consistent with the member's needs and goals in the least restrictive community setting, is a critical component of an individual's overall well-being and care. Any of these services may be medically necessary if those services assist members to secure or maintain PSH placement. The Contractor shall be responsible for complying with all ACOM Policy 448 requirements related to assessment of, coordination with, and supports to, assist members in attaining and maintaining housing as part of their independent living goals and service planning. The Contractor shall ensure housing needs are evaluated by providers as part of identifying independent living goals and service planning and that all members have information about, and assistance securing, available housing resources including market rate, mainstream subsidy, and the AHCCCS Housing Program.

The Contractor shall enter into an agreement with the Statewide Housing Administrator for the sharing of information and data related to:

1. Member referrals and prioritization.

2. Service coordination of housing subsidies and supportive services.

3. Member-specific reporting related to Contractor's members referred and/or being served in the AHCCCS Housing Program.

The Contractor shall attend the AHCCCS Quarterly Housing Meeting and submit Housing deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall submit quarterly a Supportive Housing Report for all members who have requested or been referred for housing assistance as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Supportive Housing Report shall include information regarding members who have been identified by Contractor's Housing Specialist (or Coordinator) and/or its network of providers with housing need. Reported information includes the referral or intervention provided as well as the outcome of that referral or intervention if known. Referrals and interventions include referrals to apply to the AHCCCS Housing Program for Non-Title XIX/XXI supportive housing services (rent/utility subsidies and relocation services) as well as other mainstream housing or homeless programs for which they may be eligible for including but not limited to Public Housing Authority Housing Choice or other voucher programs, eviction prevention, and/or transitional or emergency shelter programs. Additionally, the Support Housing Report shall include the following:

1. Date of Referral.

2. Member Name.

3. AHCCCS ID.

4. Homeless Management Information System (HMIS) ID Number, if available.

5. Member included on Contractor High-Cost High Needs Roster.

6. SMI Indicator.

7. Needs assessment score from Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT), LOCUS, or other AHCCCS approved screening tool, if available.

8. If the member has designated housing navigation or supportive services.

9. Member's current housing situation including homelessness.

10. Referral or Intervention Provided and Outcomes (up to two).

11. Date of housing placement or resolution.

12. Include CoC meeting attendance and MCO representative in attendance.

13. Include criteria used to determine members in need of PSH, total number of members in need within GSA, and number of Housing Specialists at the provider level to meet the need.

14. Include the criteria used to determine the number of Housing Specialists working for the health plan, to meet the need and the total number of Housing Specialist staff working for the plan.

Homeless Management Information System: AHCCCS encourages coordination and collaboration with other systems of care that serve its members in order to improve health outcomes. Because of the documented intersection between AHCCCS members with acute mental and physical health needs and homelessness, AHCCCS intends to coordinate with the Lead Agencies and HMIS Administrators in all three HUD-recognized Homeless CoC (Maricopa Regional CoC, the Tucson-Pima CoC and the Balance of State CoC) to develop data sharing between AHCCCS and their HUD-mandated HMIS. Through this data sharing and coordination, AHCCCS intends to improve member access to resources, improve health and housing outcomes, improve provider service delivery, and enhance intra and inter system coordination for AHCCCS and the CoCs.

AHCCCS requires all contracted MCOs to support this effort by ensuring key program and operational staff participate in the planning and implementation of data sharing structure and protocols. The Contractor shall participate in any additional activities to support this such as:

1. Enrollment/participation in the CoC HMIS system for all GSAs in which the MCO is providing services.

2. Ensure Housing Specialists complete timely entry and upload designated AHCCCS member data into HMIS and/or AHCCCS systems using defined standards.

3. Ensure compliance with all AHCCCS and HUD HMIS legal standards around data releases and confidentiality.

4. Participation in discussion with local CoC to support the coordinated entry system process and development of CoC by-name-lists.

5. Commitment to improved case coordination based on data informed approaches through data sharing.

6. Participation in any shared reporting and evaluation related to HMIS/AHCCCS data sharing.

7. Support of training and ongoing participation of designated provider staff in HMIS protocols.

8. Covering any agency or user fees associated with HMIS usage.

9. Any other necessary duties and tasks identified in the planning process.

Primary Care Provider Medication Management Services: In addition to treating physical health conditions, the Contractor shall allow PCPs to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tests necessary for diagnosis, and treatment. For the antipsychotic class of medications, PA may be required. For PCPs prescribing medications to treat SUDs, the PCP shall refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MOUD model and coordinate care with the behavioral health provider. The Contractor is responsible for these services both in the prospective and PPC timeframes.

Quality Management: QM processes for behavioral health services shall be included in the Contractor's QM Plan and shall meet the QM requirements of AHCCCS as specified in the AMPM Policy 910. The Contractor shall ensure that its QM program incorporates monitoring of the PCP's referral to, coordination of care with, and transfer of care to behavioral health providers as well as usage of Arizona's Controlled Substances Prescription Monitoring Program (CSPMP) as required under this Contract.

The Contractor shall have procedures in place for ensuring communication occurs between prescribers when controlled substances are used and include provider-mandated usage of the CSPMP.

Referrals: The Contractor shall develop, monitor, and continually evaluate its processes for timely referral, assessment, service, and treatment planning for behavioral health services, including services provided out-of-State. The Contractor shall have identified staff members to assist the member in coordinating necessary services and ensure that requests for behavioral health services may be initiated by the member, family, or guardian or any health care professional are referred within one business day to ensure that the request for services results in the member receiving a referral to a behavioral health provider A direct referral for a behavioral health assessment may be made by the member or any health care professional. For referrals received from a PCP requesting a member receive a psychiatric evaluation or medication management, an appointment with a behavioral health medical professional shall be provided according to the needs of the member and within AHCCCS appointment standards with appropriate interventions to prevent a member from experiencing a lapse in medically necessary psychotropic medications.

Special Assistance: For members with an SMI designation, the Contractor shall require its staff, subcontractors, and service providers to identify individuals who meet criteria for special assistance and submit notification to AHCCCS/ OHR. The Contractor shall ensure consistency with the requirements as specified in AMPM Policy 320-R. Additionally, the Contractor shall cooperate with the Independent Oversight Committee (IOC) in meeting its obligations as specified in AMPM Policy 320-R and submit the

deliverables related to Special Assistance Services reporting as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Specific Requirements for Behavioral Health Services for Members in Legal Custody of the Department of Child Safety and Adopted Children: Upon notification by DCS that a child has been taken into custody, the Contractor shall ensure that each child and family is referred for ongoing behavioral health services for a period of at least six months unless services are refused by the guardian or the child is no longer in DCS custody. A minimum of one monthly documented service is required. Services shall be provided to:

1. Mitigate and address the child's trauma.

2. Support the child's temporary caretakers.

3. Promote stability and well-being.

4. Address the permanency goal of the child and family.

The Contractor shall obtain from DCS a monthly listing of children placed in DCS custody. The Contractor shall reconcile the DCS report with the Contractor list of children who have received a rapid response. For any identified members placed in DCS custody, the Contractor shall comply with requirements for children in DCS custody as specified in ACOM Policy 449 including submission of the following deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables:

1. Behavioral Health Utilization & Timeframes for Members in DCS Custody.

2. DCS and Adopted Children Services Reporting: Access to Services.

3. DCS and Adopted Children Services Reporting: Calls and Emails and Rapid Response Reconciliation Report.

Specific Requirements for Services to American Indians: The Contractor shall ensure that all covered behavioral health services are available to American Indian members living off reservation who are enrolled with the Contractor.

Transfer of Care: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be transferred to a behavioral health provider for evaluation and/or continued medication management services, the Contractor shall require and ensure that the PCP coordinates the transfer of care. All affected subcontracts shall include this provision. The Contractor shall establish policies and procedures for the transition of these members for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members. Refer to AMPM Policy 510 and 520.

14. AHCCCS GUIDELINES, POLICIES, AND MANUALS

All AHCCCS guidelines, policies, and manuals, including but not limited to, ACOM, AMPM, and Reporting Guides are hereby incorporated by reference into this Contract. Guides and manuals are available on the AHCCCS website. Refer to ACOM Policy 100 and AMPM Policy 100 for an overview of the principles of service delivery; an outline of the ACOM and AMPM layout; and processes for policy development. The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to the AHCCCS guidelines, policies, and manuals. The Contractor is responsible for complying with the requirements set forth within. In addition, links to AHCCCS Rules, Statutes and other resources are

available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available to Contractors on the AHCCCS website.

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

ALTCS members who are temporarily out of the Contractor's service area may be provided LTSS, including HCBS, while out of the service area. The Contractor is not expected to set up special contractual arrangements to provide LTSS out of the service area, however, should consider authorization when member-specific providers, such as family Attendant Care, are available during the temporary absence. ALTCS members temporarily absent from Arizona without authorization from the Contractor are eligible for services in accordance with 42 CFR 431.52. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Contractor shall report absences of more than 30 days from the State to the ALTCS eligibility office for a determination of continued eligibility as specified in AMPM Policy 1620. The Contractor shall submit a written request to AHCCCS/DHCS as specified in the AMPM Policy 1620-J, before placing a member in a residential facility outside the State to facilitate a coordinated review with AHCCCS/DMPS for any potential eligibility impact.

16. 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 LTSS. For those members who are living in a medical institution when determined eligible for the ALTCS Transitional program, the Contractor shall arrange for home and community-based placement as soon as possible, but not later than 90 consecutive days after the effective date of eligibility for the ALTCS Transitional Program.

ALTCS Transitional members are entitled to all ALTCS covered services except for institutional custodial care (services provided at an institutional level in a NF or ICF). When institutional custodial care is determined to be medically necessary, the period of institutionalization may not exceed 90 consecutive days. If institutional care is expected to exceed 90 consecutive days, the Contractor shall request a medical eligibility reassessment PAS within 45 days of institutional admission. ALTCS Transitional members determined by the PAS to be at risk of institutionalization will be transferred from the ALTCS Transitional Program to the regular ALTCS program effective the disposition date of the PAS reassessment.

Contractor compliance is monitored through AHCCCS/DHCS via the monthly Transitional Program Report.

17. CASE MANAGEMENT

Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes. The Case Management process involves reviewing and assessment of the ALTCS member's strengths, preferences, and service and support needs with the member and the planning team. The review shall result in an individualized, mutually agreed upon, appropriate and cost effective PCSP that meets the medical, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting [42 CFR 438.208(c)(3)(i) - (v), 42 CFR 441.301(c)(1) - (3)].

The PCSP is a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs,

individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

A basic tenet of case management is to ensure involvement of the member and the member's family in making informed decisions and the involvement of the member and the planning team in identifying strengths and needs of the member. The foundation of case management is respect for the member interests, needs, culture, language, and belief system. The planning team is an integral part of the development of the PCSP.

A Case Manager shall be an Arizona licensed RNs in good standing, SWs, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience, or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or with an SMI designation. Refer to AMPM Policy 1630. Case managers shall not provide direct services to members but shall authorize appropriate services and/or refer members to appropriate services.

A SW is defined as an individual who possesses a baccalaureate or master's degree in social work from a school or program accredited by the Council on Social Work Education (CSWE). SWs shall comply with the licensing supervision, and certification requirements of the State(s) or jurisdiction(s) in which they practice and shall possess the skills and professional experience necessary to practice social work.

Case management experience is defined as human service-related experience requiring care coordination across service delivery systems and work involving assessing, evaluating, and monitoring services for individuals with SHCN related but not limited to conditions such as physical and/or intellectual disabilities, aging, physical and/or behavioral health disorders, and SUD.

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

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

1. Respect the member and the member's rights.

2. Support the member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible.

3. Provide adequate information and teaching to support the member and family/representative to make informed decisions and choices.

4. Be available to answer questions and address service issues raised by the member or family/representative, including between regularly scheduled PCSP meetings.

5. Provide a continuum of service options that supports the expectations and agreements established through the PCSP process.

6. Educate the member and family/representative on how to report unavailability or other problems with service delivery to the Contractor to ensure unmet service needs can be addressed as quickly as possible, as specified in AMPM Policy 1620-D and AMPM Policy 1620-E regarding requirements.

7. Facilitate access to non-ALTCS supports and services available throughout the community, as well as Non-Title XIX services for members with an SED or SMI designation.

8. Advocate for the member and/or family/significant others as the need occurs.

9. Allow the member and family/representative to identify their role in interacting with the service delivery system including the extent to which the family/informal supports will provide uncompensated care.

10. Provide members with flexible and creative service delivery options.

11. Educate members about member directed options for delivery of designated services in accordance with AMPM Chapter 1300. These options shall be reviewed with members living in their own homes at every PCSP meeting. The ALTCS Member Service Options Decision Tree found in AMPM Chapter 1600, Exhibit 1620-18, is a tool that may be used by Case Managers to have discussions with members.

12. Educate members on the option to choose a spouse as the member's paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs.

13. Provide necessary information to providers about any changes in member's goals, functioning and/or eligibility to assist the provider in planning, delivering, and monitoring services.

14. Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member.

15. Educate members on EOL care, person-centered planning, and services and supports including covered services and assist members in accessing those services, in accordance with AMPM Policy 310-HH.

16. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education, and employment, including volunteer opportunities (refer to the section below which outlines additional requirements for individualized member goals).

17. Refer member cases, via Electronic Member Change Report (EMCR), to the AHCCCS/DMPS services for a medical eligibility reassessment if a member is assessed to no longer require an institutional level of care. Refer to the AHCCCS ALTCS Member Change Report Guide for MCR instructions.

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

The Case Manager shall make initial contact and periodic PCSP meetings with the member within the appropriate timeframes and locations specified in AMPM Policy 1620-A and AMPM Policy 1620-E. The purpose of these PCSP meetings is to assess the continued suitability and cost effectiveness of the services/supports and placement in meeting the member's needs as well as to evaluate the member's living environment, identify potential barriers to quality of the care delivered by the member's service providers and to assess for any unmet needs. The Case Manager shall be responsible for assessing and documenting the member's overall functional, physical, and behavioral health status at each PCSP meeting. Additionally, at the PCSP meetings, the member and family/representative shall be asked to sign the PCSP that indicates whether the member and family/representative agrees or disagrees with the services to be authorized. If the member disagrees, the case manager shall follow appropriate procedures

for providing the member written notice of Adverse Benefit Determination and the member's right to appeal the decision**.**

For ALTCS members who received HCBS after the effective date of Title XIX eligibility but prior to enrollment in the ALTCS MCO, HCBS are covered if: 1) that individual had been receiving HCBS prior to the date of the ALTCS eligibility determination for a time frame covered by the period of ALTCS eligibility and 2) a written plan of care for that individual was in existence at the time the HCBS were furnished. Payment responsibility for HCBS does not precede the effective date of Title XIX eligibility which typically is the first day of the month of application. The written plan of care shall be developed by a qualified individual based upon an assessment of that individual, and the written plan shall describe the HCBS to be provided, the frequency, and the providers responsible for furnishing the services. In the event that the individual is determined to be eligible for prior quarter coverage, coverage of HCBS will also extend to the prior quarter coverage eligibility period if the written plan of care for HCBS for that individual was in existence during the prior quarter coverage timeframe.

For members utilizing the SDAC member-directed option, case managers shall facilitate contingency planning with members in order to mitigate risks of a disruption in the delivery of authorized services as specified in AMPM Policy 1320-A.

The Contractor shall ensure complete, correct, and timely entry of data related to placement history and cost effectiveness studies into the Client Assessment and Tracking System (CATS). "Timely" shall mean within 14 days of an event (e.g., assessment, service approval, placement change, discontinuance of a service), unless otherwise specified in AMPM Exhibit 1620-1. Unless the Contractor is currently transmitting data to CATS electronically, all data entry shall be directly entered into CATS. If the Contractor is not currently entering data directly into CATS, it shall have a systems interface in place so it can update the case management information no less than twice per month with an error rate of 5% or less. The Contractor is not required to enter service authorizations into the CATS.

The Contractor is, however, expected to maintain a uniform tracking system in each member chart documenting the begin and end date of services inclusive of renewal of services and the number of units authorized for services as required by the AMPM Chapter 1600. Refer to the AHCCCS Tutorial for Pre-Paid Medical Information Systems (PMMIS) Interface for ALTCS Case Management for a tutorial on access to and data entry into CATS.

The Contractor shall implement a systematic method of monitoring its Case Management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations [Inter-Rater Reliability (IRR)]. The Contractor shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. Refer to AMPM Policy 1630. This information shall be made available upon request by AHCCCS.

The Contractor shall implement a process for ensuring, tracking, and monitoring, the new PCSP Performance Standards at minimum on a quarterly basis. The Contractor shall provide AHCCCS, within the timeline specified in Section F, Attachment F3, Contractor Chart of Deliverables, the Contractor's internal PCSP Performance Standards Audit Results. Refer to AMPM Policy 1630.

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

assigning and monitoring case management caseloads. The Case Management Plan shall also include an evaluation of the Contractor's Case Management Plan from the prior year, to include lessons learned and strategies for improvement. Refer to AMPM Policy 1630 and AMPM Attachment 1630-A.

Caseload Ratios: The Contractor shall ensure adequate staffing to meet Case Management requirements. Each case manager's caseload may not exceed a weighted value of 96. The Contractor may assign a weighted value lower than those specified below. However, the Contractor shall obtain authorization from AHCCCS/DHCS prior to implementing caseloads whose values exceed these AHCCCS standards.

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

1. For members in an institutional setting, a weighted value of **1.0** is assigned. Case managers may have up to 96 members (96 x 1.0 = 96).

2. For members in an HCBS (own home) setting, a weighted value of **2.2** is assigned. Case managers may have up to 43 members (43 x 2.2 = 96 or less).

3. For members in an Alternative HCBS setting, a weighted value of **1.8** is assigned. Case managers may have up to 53 members (53 x 1.8 = 96 or less).
4. For members in Acute Care Only (ACO) status, a weighted value of **1.0** is assigned. Case managers may have up to 96 members (96 x 1.0 = 96).

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

(# of members in an institutional setting x 1.0)
+
(# of members in an HCBS (own home) setting x 2.2)
+
(# of members in an Alternative HCBS setting x 1.8)
+
(# of members in Acute Care Only (ACO) status x 1.0)

= 96 or less

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

1. For members in an institutional setting determined to have an SMI, a weighted value of **1.4** is assigned. Case managers may have up to **68** members with an SMI designation (68 x 1.4 = 96 or less).

2. For members in an HCBS (own home) setting determined to have an SMI, a weighted value of **3.0** is assigned. Case managers may have up to **32** members with an SMI designation (32 x 3.0 = 96).

3. For members in an Alternative HCBS setting determined to have an SMI, a weighted value of **1.9** is assigned. Case managers may have up to **50** members with an SMI designation (50 x 1.9 = 96 or less).

4. For members in Acute Care Only (ACO) status determined to have an SMI, a weighted value of **1.0** is assigned. Case managers may have up to **96** ACO members with an SMI designation (96 x 1.0 = 96).

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

(# of members in an institutional setting x 1.0)
+
(# of members with an SMI designation who are in an institutional setting x 1.4)
+
(# of members in an HCBS (own home) setting x 2.2)
+
(# of members with an SMI designation who are in an HCBS (own home) setting x 3.0)
+
(# of members in an Alternative HCBS setting x 1.8)
+
(# of members with an SMI designation who are in an Alternative HCBS setting x 1.9)
+
(# of members in Acute Care Only (ACO) status x 1.0)
+
(# of members with an SMI designation who are in Acute Care Only (ACO) status x 1.0)

= 96 or less

Monitoring, Training, and Education: The Contractor shall conduct Case Management orientation for new staff and on-going training programs for all Case Management staff that includes Case Management standards (as specified in AMPM Policy 1630), the ALTCS guiding principles and subjects relevant to the population served (e.g., geriatric and/or disability issues, behavioral health, member rights, Case Manager's QM role). The Contractor is responsible for training staff and providers, in sufficient detail and frequency, to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services and referrals, how to access services, including the pre-petition screening, COE processes provided for in A.R.S. Title 36 Chapter 5, Article 4), how to involve the member and their family in decision-making and service planning, and information regarding initial and quarterly behavioral health consultation requirements. The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Training for staff and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. The Contractor shall maintain documentation of the behavioral health trainings in accordance with AMPM Policy 1630.

18. MEMBER INFORMATION

In addition to compliance with other pertinent Federal laws and regulations, the Contractor shall ensure its member communications comply with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (ACA), 45 CFR Part 92, 42 CFR Part 438 and related State requirements including ACOM Policy 404, ACOM Policy 406 and ACOM Policy 433. The Contractor shall ensure that it takes reasonable steps to provide meaningful access to each individual with Limited English Proficiency (LEP) eligible to be served or likely to be encountered in its health programs and activities. As part of this obligation, the Contractor shall identify the prevalent non-English languages spoken by members in its service area and develop and implement an effective written language access plan as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Language assistance services shall be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with LEP [45 CFR 92.201I]. For significant communications and publications, the Contractor shall comply with the nondiscrimination notice provisions in 45 CFR 92.8. In addition to the general requirements set forth in Section D, Paragraph 18, Member Information, the Contractor shall implement all other activities necessary to comply with Federal and State requirements [42 CFR 438.408(d)(1), 42 CFR 438.10].

The Contractor shall provide members with the Contractor's toll free and Text Telephone Devices (TTY/TDY) telephone numbers for customer service which shall be available during normal business hours. In addition, the Contractor shall provide members with the Contractor's toll-free TTY/TDY nurse triage line telephone number which shall be available 24 hours a day, seven days a week. The Contractor is prohibited from having separate phone numbers for physical and behavioral health services or issues.

All informational materials prepared by the Contractor shall be approved by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 404 and 406 for further information and requirements for member communications.

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

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

1. That oral interpretation is available for any language.

2. That written translation is available in each of the prevalent non-English languages in the Contractor's service area.

3. That auxiliary aids and services are available for members with disabilities.

4. How members may access the services above [42 CFR 438.10(d)(5)].

All written materials to members shall be written in easily understood language, use font size of at least 12 points, and be available in alternative formats and through provision of auxiliary aids and services that take into account the special needs of members with disabilities or LEP [42 CFR 438.10(d)(6)].

The Contractor shall make its written materials that are critical to obtaining services (also known as vital materials) available in the prevalent non-English language spoken for each LEP population in the Contractor's service area [42 CFR 438.3(d)(3)].

These vital materials shall also be made available in alternate formats upon request at no cost. Additionally, the materials shall include taglines in the prevalent non-English languages in Arizona in a conspicuously visible font size, explaining how to request auxiliary aids and services, the availability of written translation or oral interpretation services to understand the information, and provide the Contractor's toll free and TTY/TDD telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials.

Vital materials include, at a minimum, the following:

1. Member Handbooks.

2. Provider Directories.

3. Consent forms.

4. Appeal and Grievance Notices.

5. Denial and Termination Notices.

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

For consistency in the information provided to members, the Contractor is required to utilize the AHCCCS-developed definitions for managed care terminology [42 CFR 438.10]. Refer to ACOM Policy 406.

Maternal Child Health and Early and Periodic Screening, Diagnostic, and Treatment Member Outreach: The Contractor shall conduct written and other member educational outreach related to Maternal Child Health (MCH) and EPSDT as specified in AMPM Chapter 400 and AMPM Exhibit 400-3.

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

1. A **Member Handbook** which serves as a summary of benefits and coverage. The Contractor is required to use the State developed model Member Handbook (refer to ACOM Policy 406). The content of the Member Handbook shall include information that enables the member to understand how to effectively use the managed care program and at a minimum, shall include the information provided in ACOM Policy 406 [42 CFR 438.10(g)(1), 42 CFR 438.10(g)(2), 42 CFR 438.10(c)(4)(ii)), and 45 CFR 147.200(a)]. The Contractor shall review and update the Member Handbook at least once a year. The Handbook shall be submitted to AHCCCS for approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Upon the initial case management assessment, and annually thereafter, the case manager will review the contents of the Member Handbook with the member or authorized representative.

   The Contractor shall include information in the Member Handbook and other printed documents to educate members about the availability and accessibility of covered services and that behavioral health conditions may be treated by the member's PCP within their scope of practice. The Contractor shall have information available for potential members as specified in ACOM Policy 404 and ACOM Policy 406, and 42 CFR 438.10(e)(2).

2. A **Provider Directory**, which at a minimum, includes those items listed in ACOM Policy 406 [42 CFR 438.10]. The Contractor has the option of providing the Provider Directory in paper format or providing written notification of how the Provider Directory information is available on the Contractor's website, via electronic mail, or via postal mailing as specified in ACOM Policy 406 [42 CFR 438.10(g)(3)(i)–(iv)]. The written notification shall be sent to members within 12 business days of receipt of notification of the enrollment date. The Provider Directory shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary [42 CFR 438.10(h)(4)].

The Contractor shall make a good faith effort to give written notice to Members who received their primary care from, or who are seen on a regular basis by, a provider who is terminated from the network. Written notice shall be provided to the member within the latter of 30 calendar days prior to the effective date of the provider termination or 15 calendar days after the receipt or issuance of the provider termination notice [42 CFR 438.10(f)(1)].

The Contractor shall have information available for potential members as specified in ACOM Policy 404 and ACOM Policy 406 [42 CFR 438.10(f)(4)].

Member Identification Cards: The Contractor is responsible for the production, distribution, and cost of AHCCCS Member ID Cards and the AHCCCS Notice of Privacy Practices as specified in ACOM Policy 433 and Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

1. An updated Member Handbook at no cost to the member.

2. The Provider Directory as specified in ACOM Policy 406.

The Contractor shall ensure compliance with any applicable Federal and State laws that pertain to member rights and ensure that its staff and subcontractors take those rights into account when furnishing services to members [42 CFR 438.100 et. seq].

The Contractor shall ensure that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the Contractor or its subcontractors treat the member [42 CFR 438.100(a)(1) and 42 CFR 438.100(c)].

Social Networking Activities: The Contractor shall participate in Social Networking Activities to support learning and engagement. The Contractor shall adhere to the requirements for Social Networking Activities as specified in ACOM Policy 425 and submit deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Website Requirements: The Contractor shall develop and maintain a website that is focused, informational, user-friendly, functional, and provides the information as required in ACOM Policy 404 and submit deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

As required by 42 CFR 438.10(c)(3), AHCCCS provides a direct Uniform Resource Locator (URL) website hyperlink to the below information to members via the AHCCCS website under Available Health Plans. The Contractor shall provide notification to AHCCCS when there is a change in a URL for this information as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

1. Contractor's main Arizona Medicaid website.

2. Contractor's Member Handbook.

3. Contractor's Formulary.

The Contractor shall publish a listing of individual providers, on its website who are formally trained in or specialize in the diagnosis of ASD on its website. The web pathway for the members accessing this list shall be easily available and navigable within the Contractor's website, using a simple keyword search for autism or other similar term. This webpage shall include information for members and their families on how to access specialized diagnostic services including which diagnostics meet the requirements for

eligibility under the DES/DDD. At a minimum, the listing shall include the following fields: Group Practice Name or Agency Name, Address, Phone Number, Provider Name(s), Type of Provider, and Specialized Age Range. The type of provider shall be based on formal licensure (e.g., MD, Psychologist), and may list additional specialty information for the practitioner (e.g., psychiatrist, developmental pediatrician, neuropsychologist, etc.). The Contractor shall ensure that any licensure type listed is based on Arizona Administrative Code (A.A.C. R4-6, A.A.C. R4-16, A.A.C. R4-26). The Contractor shall submit the specific website link as part of its Website Certification deliverable as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall also publish a listing of providers who specialize in the treatment of individuals with ASD on its website. The web pathway for the members accessing this list shall be easily available and navigable within the Contractor's website, using a simple keyword search for autism or other similar term. This webpage shall include information for members and their families on how to access specialized treatment services. At a minimum the listing shall include the following fields: Group Practice Name or Agency Name, Address, Phone Number, Provider Name, Treatment Type and Specialized Age Range. The treatment type may include more than Behavior Analysis. Reference types of services that can be offered within AMPM Policy 310-B. The Contractor shall submit this information as part of its Website Certification deliverable as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall have a process in place to identify and verify that any and all agencies or providers listed on their website can deliver the services as listed to meet the needs of individuals who may need access to these specialized services. AHCCCS may, at its discretion, request evidence that the Contractor verify the accuracy of website provider information and services as listed.

19. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS EMCR provides the Contractor with a method for complying with notification to the ALTCS eligibility offices and AHCCCS of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, living arrangements, share of cost, income, or resources; a change in medical condition which could affect eligibility; no LTSS provided; demographic changes or the member's death. Refer to the ALTCS Member Change Report User Guide for MCR instructions.

20. PRE-ADMISSION SCREENING AND RESIDENT REVIEW

The Contractor shall ensure that, prior to admission of a member to a NF, the NF has performed a Pre-Admission Screening and Residential Review (PASRR) Level I screening and, when indicated, that the appropriate entity has performed a PASRR Level II evaluation as specified in the AMPM Policy 680-C. When the result of the PASRR Level I screening indicates that the member has an intellectual disability, DES conducts the Level II evaluation. When the result of the PASRR Level I screening indicates that the member has a mental illness, the ACC-RBHA conducts the Level II evaluation. The purpose of the PASRR Level II evaluation is to determine whether a member who has a mental illness or an intellectual disability needs the level of care provided in a NF and/or needs specialized services. When the PASRR Level II evaluation determines that the member needs a different level of care than can be provided in a NF, the Contractor shall arrange for the provision of other covered services appropriate to the member's needs. When the PASRR Level II evaluation determines that the member needs specialized services while in the NF, the Contractor shall arrange for the provision of covered specialized services appropriate to the member's needs. Failure to have the proper PASRR screening prior to placement of members in a NF may result in Federal Financial Participation (FFP) being withheld from AHCCCS.

Should withholding of FFP occur, AHCCCS will recoup the withheld amount from a Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the NF, that admitted the member without the proper PASRR [42 CFR Part 483, Subpart C].

21. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

General Requirements: The Contractor shall provide quality care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the QOC provided to enrolled members through established QM/PI Program processes. The Contractor shall execute processes to monitor, analyze, plan, implement, evaluate, and report QM/PI activities, as specified in the AMPM [42 CFR 438.330(a)(1) and (e), 42 CFR 438.330(a)(3), 42 CFR 438.330(b), 42 CFR 438.330(e)(1), 42 CFR 438.330(e)(2)].

The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 438.320, 42 CFR 438.350]. AHCCCS utilizes an External Quality Review Organization (EQRO) for purposes of conducting an independent External Quality Review (EQR) review of its Contractors [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.

The Contractor shall ensure that the Contractor's QM/PI Program Unit (or department) is separate and distinct from any other units or departments within its organizational structure, such as MM or Contractor Care Management; however, the Contractor may have separate but coordinated QM and Performance/QI Units under the QM/PI Program. The Contractor is expected to integrate QM/PI Program processes, such as tracking and trending of issues, throughout all areas of the organization, with the ultimate responsibility for QM/PI Program processes and activities residing within the Contractor's QM/PI Unit(s).

QM/PI Program staff positions that perform work functions related to the Contract shall fall under the QM/PI Program Unit and have a direct reporting relationship to the local Chief Medical Officer (CMO)/Medical Director. The local CMO/Medical Director and Administrator/CEO shall have the ability to direct, implement, and prioritize interventions related to QM/PI Program activities and investigations. The Contractor's local Medical Director/CMO and Administrator/CEO shall direct and prioritize the QM/PI Program work conducted by Contractor staff, including Administrative Services Subcontractors' staff which perform functions under this Contract related to the QM/PI Program.

Should the Contractor experience staff inadequacy which prevents the Contractor from meeting contractual requirements, the Contractor shall notify AHCCCS/DHCS QM of the staffing concerns, including a description of the concern and a plan to remedy the inadequacy. The Contractor shall submit Staffing Concern Notification as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall maintain and execute policies/procedures related to the implementation of a comprehensive, coordinated delivery system for integrated physical health, behavioral health, and LTSS services, including the administrative and clinical integration of health care service delivery. Integration strategies and activities shall focus on improving individual health outcomes and increasing member satisfaction.

The Contractor shall submit QM/PI Program deliverables in accordance with AHCCCS Instructions as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

At a minimum, the Contractor's QM/PI Program shall comply with the requirements specified in this section, AMPM, ACOM, and Federal and State requirements.

Quality Management/Performance Improvement Program: The Contractor shall have an ongoing QM/PI Program for the services it furnishes to members, regardless of payor source or eligibility category [42 CFR 438.330(a)(1), 42 CFR 438.330(a)(3)].

The Contractor's QM/PI program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement (in the areas of clinical and nonclinical care) which is expected to have a favorable effect on health outcomes and member satisfaction, as specified in this section and AMPM Chapter 900 [42 CFR 328.330(a)(1), 42 CFR 438.330(b)(1-2)].

The Contractor shall:

1. Measure and report to the State, its performance, using standard measures (performance measures) as required by the State or CMS [42 CFR 438.330(c)(2)(i)].

2. Submit specified data to the State that enables the State to measure the Contractor's performance using standardized measures (performance measures), as specified by the State [42 CFR 438.330(c)(2)(ii)]

3. Perform a combination of the above activities [42 CFR 438.330(c)(2)(iii)].

The Contractor's QM/PI Program shall include, but is not limited to:

1. Implementation, monitoring, evaluation, and compliance with applicable requirements in the ACOM and AMPM.

2. Provision of quality care and services to eligible members, regardless of payor source or eligibility category.

3. Contractor written policies and training regarding preventing abuse, neglect, and exploitation, ensuring incident stabilization [member(s) immediate health and safety is secured and immediate care and recovery needs are identified and provided], reporting incidents, and conducting investigations.

4. Monitoring for provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in the AHCCCS Minimum Subcontract Provisions (MSPs) and Contract. Refer also to the Report of the Abuse & Neglect Prevention Task Force to Governor Douglas A. Ducey (November 1, 2019) developed in response to Executive Order 2019-03.

5. Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN as specified in Contract [42 CFR 438.330(b)(4), and 42 CFR 438.340].

6. Demonstration of improvement in the QOC and services provided to members through established QM/PI processes.

7. Analysis of the effectiveness of implemented interventions, to include targeted interventions, to address the unique needs of populations and subpopulations served [42 CFR 438.330(e)(2)].

8. Attendance and/or participation in applicable community initiatives, events, and/or activities as well as implementation of specific interventions to address overarching community concerns (including applicable activities related to chronic disease management, EPSDT, dental, behavioral health, LTSS,

and HCBS justice population, opioid and substance use, suicide, veterans, and SDOH including, but not limited to, homelessness, employment, and community engagement, etc.)

9. Written policies regarding member rights and responsibilities [42 CFR 438.100(b)(1)].

10. Protection and confidentiality of medical records and any other personal health/enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements, AMPM, and the Medical Records Contract section [42 CFR 438.224].

11. Compliance with requirements to assure member rights and responsibilities conform with AHCCCS policies on Title XIX/XXI Notice and Appeal Requirements, Special Assistance for Persons Determined to have a SMI, Notice and Appeal Requirements (SMI and Non-SMI), Member Grievance Resolution Process, and AMPM [42 CFR 438.100(a)(2), 42 CFR 438-228(a), 42 CFR 438.400(a), 42 CFR 438.402(a)]. The Contractor shall also comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964), including other laws regarding privacy and confidentiality [42 CFR 438.100(d)].

12. Development and maintenance of mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to:
    a. Monitor service quality, and
    b. Develop strategies to improve member outcomes and QI activities related to QOC and system performance.

13. Employment of sufficient, knowledgeable, and qualified local staff and utilization of appropriate resources to achieve Contractual compliance. The Contractor's resource allocation shall be adequate to achieve quality outcomes. Staffing adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS Policy requirements.

14. Local staff that are available 24 hours per day, seven days per week, to work with AHCCCS and/or other State agencies on urgent issue resolutions, such as Arizona Department of Health Services (ADHS)/Bureau of Medical Facilities. Urgent issue resolutions include Immediate Jeopardies (IJ), fires, or other public emergency situations. These staff shall have:
    a. Access to information necessary to identify members who may be at risk, including the identified members' current health/service status,
    b. The ability to initiate new placements/services,
    c. The ability to perform status checks at affected facilities, and
    d. Perform ongoing monitoring, if necessary.

15. Uniform provisional credentialing, initial credentialing, recredentialing and organizational credentialing for all provider types that shall comply with the requirements specified in AMPM, ACOM, Federal and State requirements, and this section [42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b)].

16. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of QOC concerns, related to abuse, neglect, exploitation, suicide attempts, SUD/opioid-related concerns, alleged human rights violations, and unexpected deaths. The Contractor shall comply with requirements, as specified in AMPM Policy 960.

17. Submission of IRR metrics and evidence of completed IRR activities, reflective of the previous quarter reporting, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, for each of the following areas, at a minimum: triage, case leveling, and corrective actions.

18. Submission of any cases involving Medicaid fraud, waste, or abuse reported to the AHCCCS Office of the Inspector General (OIG). Refer to Section D, Paragraph 64, Corporate Compliance.

19. Requirement for any ADHS licensed or certified provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints, and other pertinent information that is available and considered to be public information from oversight agencies.

20. The Contractor shall monitor contracted providers for compliance with QM measures including supervisory visits conducted by an RN when a home health aide or an LHA is providing services.

21. Monitoring of services and service sites, as specified in AMPM Policy 910. The Contractor shall submit a Contractor Monitoring Summary, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall not delegate functions of the review/auditing and monitoring of services and service sites.

22. QM/PI program monitoring and evaluation activities, which include:
    a. Peer Review and QM/PI Committees that meet at least quarterly or more frequently, as needed (e.g., Ad Hoc Meeting or more frequently recurring meetings), and are chaired by the Contractor's local CMO/designated Medical Director. AHCCCS reserves the right to be in attendance as a silent witness to requested Peer Review Committee Meetings, and
    b. Other subcommittee(s) under the QM Committee, as required, or as a need is identified.

23. Requirements for its QM Committee to proactively and regularly review member grievance and appeal data to identify:
    a. Outlier members who have filed multiple complaints, grievances, or appeals regarding services, or against the Contractor, or
    b. Members who contact governmental entities for assistance, including contacting AHCCCS, for the purposes of assigning a care coordinator to assist the member in navigating the health care system.

24. Collection and submission of performance measure data, including any required by the State or CMS [42 CFR 438.330(a)(2), 42 CFR 438.330(b)(2), 42 CFR 438.330(c)],

25. Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)].

26. Implementation of processes to assess, plan, implement, and evaluate QM/PI activities related to the care and services provided to members, in conformance with AMPM requirements [42 CFR 438.330(a)(1), (b)(1) and (b)(2)].

27. Performance measurement and PIPs, as specified in this section, AMPM Policies 910, 970, and 980 [42 CFR 438.330(a)(2), 42 CFR 438.330(b)(1), 42 CFR 438.330(c), 42 CFR 438.330(d), 42 CFR 438.330(a)(2)].

28. Routine, and ad hoc, dissemination of subcontractor and provider QI related information including performance metrics, dashboard indicators, and member outcomes to the State and key stakeholders, inclusive of members and family members.

29. A written QM/PI Program Plan in accordance with 42 CFR 438.330, AMPM Policy 920, and Section F, Attachment F3, Contractor Chart of Deliverables.

30. Timely, accurate, and complete submission of QM/PI Program deliverables that address strategies and performance for program activities, as specified in this section, AMPM, and Section F, Attachment F3, Contractor Chart of Deliverables. Information included within the Contractor's QM/PI Program deliverable submissions and/or deliverable submissions and utilized as part of AHCCCS' External Quality Review Reporting may become public information and/or available to all interested parties on the AHCCCS website.

Health Care-Acquired Conditions and Other Provider-Preventable Conditions: Federal regulation prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider–Preventable Condition (OPPC). OPPC refers to a condition occurring in any health care setting and that meets the following criteria [42 CFR 434.6(a)(12)(i), 42 CFR 438.3(g), 42 CFR 447.26(a), 42 CFR 447.26(b), 42 CFR 447.26(c)]:

1. Is identified in the Arizona State Plan.

2. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

3. Has a negative consequence for the beneficiary.

4. Is auditable.

5. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient [42 CFR 447.26(b)].

If an HCAC or OPPC is identified, the Contractor shall conduct a QOC investigation as specified in AMPM Chapter 900 [42 CFR 438.3(g), 42 CFR 434.6(a)(12)(ii), 42 CFR 447.26(d)].

Seclusion and Restraint: The Contractor shall adhere to Federal and State laws that govern member rights when delivering services, including (at a minimum) the protection and enforcement, of a person's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation [42 CFR 438.100(a)(1),42 CFR 100(b)(2)(v)]. The Contractor shall follow local, Federal and State regulations and requirements related to seclusion and restraint. Reports regarding incidents of seclusion and restraint shall be submitted to AHCCCS as specified in AMPM Policy 962 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables (A.R.S. § 36-513, A.R.S. § 41-3804).

Incident, Accident, and Death Reporting**:** The Contractor shall develop and implement policies and procedures that require individual and organizational providers to report to the Contractor, AHCCCS, and other appropriate authorities, Incident, Accident, and Death (IAD) Reports in conformance with the requirements established by AHCCCS and as specified in AMPM Policy 961. IAD Reports shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Quality of Care Concerns and Investigations: The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with SHCN, [42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)].

The Contractor shall assess incidents for potential QOC concerns and develop a process that delineates between concerns not meeting QOC criteria (which includes incidents of: HCAC, OPPC, abuse, neglect, exploitation, injuries, high profile cases, suicide attempts, SUDs/opioid-related concerns, alleged human

rights violations, and unexpected death). The Contractor shall develop a process to report incidents to the AHCCCS/DHCS, QM Team as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall also report the Communications of Adverse Actions to Provider as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall develop and implement policies and procedures that analyze QOC concerns through identifying the concern(s), initial assessment of the severity of the concern(s), and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff (including subcontractor and delegated entity staff, when applicable) and providers are trained on how to refer suspected QOC concerns to the Contractor's QM/PI Program QM QOC concern staff. This training shall be provided during new employee orientation (within 30 days of hire) and annually, thereafter.

The Contractor shall monitor contracted providers for compliance with the Contractor's QM requirements, as well as member health and safety; the Contractor's QM QOC concern staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider concerns. The Contractor shall comply with requirements, as specified in Contract and AMPM Policy 960.

Credentialing: The Contractor shall demonstrate that its providers are reviewed and credentialed through the Contractor's Credentialing Committee [42 CFR 438.206(b)(6)]. The Contractor shall refer to AMPM Chapter 900 and Section F, Attachment F3, Contractor Chart of Deliverables for related reporting requirements.

The Contractor shall comply with the uniform temporary/provisional credentialing, initial credentialing, and recredentialing practices for all provider types as specified below [CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b)]:

1. Maintain documentation of temporary/provisional credentialing, initial credentialing, and recredentialing for individual and organizational providers who have signed contracts or participation agreements with the Contractor or those that meet the requirements of AMPM Policy 950 [42 CFR 438.206(b)(1)-(2)].

2. Demonstrate that its providers are reviewed and credentialed through the Contractor's Credentialing Committee which is chaired by the Contractor's local Medical Director/CMO.

3. Comply with the requirements, including the submission of the Credentialing Report, specified in AMPM Policy 950 and Section F, Attachment F3, Contractor Chart of Deliverables.

4. Does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

5. Does not employ or contract with providers excluded from participation in Federal health care programs [42 CFR 438.214].

Credential Verification Organization Contract: The AzAHP has established a Contract with a Credential Verification Organization (CVO) that is responsible for performing credentialing activities:

1. Receiving completed applications, attestations, and primary source verification documents.

2. Conducting annual audits of the AzAHP-contracted CVO to ensure compliance with AHCCCS requirements.

The AHCCCS Contractor shall utilize the AzAHP-contracted CVO as part of its credentialing and recredentialing process, regardless of the Contractor's membership in the AzAHP. This requirement eases the administrative burden for providers that contract with AHCCCS Contractors which often results in duplicative submission of information used for credentialing purposes. The Contractor shall follow the AHCCCS recredentialing timelines for providers that submit their credentialing data and forms to the AzAHP CVO.

The Contractor is responsible for completing the credentialing process. The Contractor shall continue to include utilization, performance, compliance, and QOC documentation, as specified in the AMPM, to complete the credentialing or recredentialing files that are brought to the Credentialing Committee for a decision. In addition, the Contractor shall also meet AMPM Policy 950 requirements for temporary/provisional credentialing.

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of temporary/provisional and initial credentialing, a Contractor shall:

1. Notify providers of credentialing decisions (approved or denied).

2. Calculate and report to AHCCCS as specified in AMPM Policy 950.

3. Report the credentialing information with regard to all credentialing applications, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Additionally, the Contractor shall ensure that they have a process in place to monitor occurrences which may have jeopardized the validity of the credentialing process, at a minimum, on an annual basis.

Subcontractor Monitoring: The Contractor shall develop and submit a Subcontractor Performance Monitoring Plan as a component of its QM/PI Program Plan, to include language that addresses, at a minimum, the timely handling, completion, and submission of (in accordance with Contract and Policy requirements) the following QM/PI functions:

1. Incident, Accident, and Death (IAD) Report.

2. Quality Of Care (QOC) Concerns and investigations.

3. AHCCCS required Performance Measure calculations and reporting.

4. Performance Improvement Projects (PIPs).

5. Provisional, initial, organizational, and recredentialing processes and requirements.

6. Medical Record Reviews.

7. Peer Review processes.

AHCCCS will accept the AzAHP review process to meet this audit requirement. A CAP shall be developed and implemented when provider monitoring activities reveal poor performance, as follows:

1. When performance falls below the minimum performance level.

2. Shows a statistically significant decline from previous period performance.

Provider Quality Monitoring: Provider Quality Monitoring functions include, but are not limited to, the service site assessments of all providers as specified in AMPM Policy 910. The Contractor shall conduct comprehensive quality audits of each location where members receive services. Quality Monitoring reviews and functions including annual onsite visits, reviews/audits, shall not be delegated to subcontracted providers or third-party entities. These functions shall be completed by the Contractor's QM/PI Program QM team. Contractors are encouraged to collaborate with one another to avoid undue burden and reduce duplication of effort.

The Contractor shall ensure:

1. Corrective actions are implemented in order to bring the provider into compliance in instances where concerns are identified.

2. Any identified potential Individual and/or Systemic QOC concerns, and IJ and/or Health and Safety concerns shall be immediately triaged by the Contractor's QM/PI Program QM QOC staff as specified in AMPM Policy 960.

3. Utilization of standardized monitoring tools by provider type, as required by AHCCCS.

4. IRR of quality monitoring processes that includes documented testing and results of individuals completing provider quality monitoring activities.

Accreditation: The Contractor is required to inform the AHCCCS QI Team as to whether it has been accredited by a private independent accrediting entity. If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide AHCCCS with a copy of its most recent accreditation review documents received from the accreditation body, including the following [42 CFR 438.332(a) and [42 CFR 438.332(b)(1)-(3)]:

1. Accreditation status, survey type, and level (as applicable).

2. Accreditation results including summaries of findings, recommended/required actions or improvements, and CAPs as provided/made available through the accreditation entity.

3. The expiration date of the accreditation.

The Contractor's accreditation status (inclusive of the name of the accrediting entity, accreditation program, and accreditation level, when applicable) shall be made available on the AHCCCS website [42 CFR 438.332(c)(1)]. Should the Contractor renew or lose its accreditation (either due to non-renewal or revocation), the Contractor shall provide AHCCCS written notification (in the case of losing its accreditation) or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity.

> ***National Committee for Quality Assurance Accreditation***: The Contractor shall achieve NCQA First Health Plan Accreditation, inclusive of the NCQA Medicaid Module by October 1, 2023. The Contractor shall also obtain the NCQA LTSS Distinction by October 1, 2024. The Contractor shall also achieve NCQA Health Equity Accreditation by October 1, 2025.

Accreditation Administrative Actions:

First Surveys

First Survey Provisional Status: For First Surveys, if the Contractor receives a **Provisional** status the Contractor shall:

1. Notify AHCCCS of the Provisional status.

2. Work with NCQA timely to resolve any corrective actions in order to obtain Accredited status.

3. Undergo a Resurvey within 12 months of the accreditation decision.

4. Provide AHCCCS all relevant documentation related to the Provisional status including, but not limited to, NCQA's written decision, related report(s), any related NCQA corrective action(s), Contractor CAPs developed to address the deficiencies, CAP Survey timeline and results.

***First Survey Denied Status*:** For First Surveys, if the Contractor receives a **Denied** status, the Contractor may be subject to Administrative Actions. Additionally, the Contractor shall re-apply for accreditation status within one year from the date of the initial Denied status.

Renewal Surveys

***Renewal Survey Provisional* Status**: For Renewal Surveys, if the Contractor receives a **Provisional** accredited status the Contractor shall:

1. Notify AHCCCS of the Provisional status.

2. Work with NCQA timely to resolve any corrective actions in order to obtain Accredited status.

3. Undergo a Resurvey within 12 months of the accreditation decision.

4. Provide AHCCCS all relevant documentation related to the Provisional status including, but not limited to, NCQA's written decision, related report(s), any related NCQA corrective action(s), Contractor CAPs developed to address the deficiencies, CAP Survey timeline, and results.

5. Be subject to Administrative Actions.

***Renewal Survey Denied* Status**: For Renewal Surveys, if the Contractor receives a **Denied** status, the Contractor shall be subject to Administrative Actions. Additionally, the Contractor shall apply for an Expedited Survey with NCQA within six months of the date of the initial Denied status. If NCQA denies the request for an Expedited Survey, the Contractor shall submit the denial to AHCCCS and shall re-apply for accreditation status within one year from the date of the initial Denied status.

Upon request from AHCCCS, the Contractor shall provide any and all documents related to Accreditation.

Accreditation and Nonduplication/Deeming: Pursuant to 42 CFR 438.360, CMS provides a mechanism for states to use to prevent duplication of the mandatory external quality review activities described in 438.358(b)(1)(i) through (iii) for its Contractors, when a Contractor has had a similar review performed by an approved Medicare or national accrediting organization. If AHCCCS identifies an item as duplicative, pursuant to 42 CFR 438.360, the item is considered "deemed" and compliant if it is also found to meet accreditation standards by the AHCCCS-approved Medicare or private accrediting organization's review, the NCQA. AHCCCS retains the right to reinstitute any monitoring activity considered "deemed" for any oversight process.

AHCCCS has identified components of the AHCCCS operational review standards required under 42 CFR 438.358(b)(1)(iii) as deemable, in conformance with 42 CFR 438.360, and will be modifying standards based upon on this evaluation. AHCCCS retains the ability to resume an OR requirement that is removed or modified as part of nonduplication efforts.

In addition to reviewing operational review standards to identify duplicative OR requirements, AHCCCS has reviewed deliverables to identify which may be addressed through the Contractors' accreditation requirements to further reduce administrative burden. AHCCCS retains the ability to resume any Contractor deliverable that is removed or reduced as part of nonduplication efforts at any time for any reason.

The Contractor shall meet and maintain the below requirements in order for the identified components operational review standards and deliverables) to remain deemed by AHCCCS:

1. The Contractor shall obtain accreditation from an approved Medicare or private accrediting organization recognized by CMS as applying standards at least as stringent as Medicare under the procedures in 42 CFR 422.158. AHCCCS requires Contractors to obtain accreditation from the NCQA.

2. The Contractor shall meet and maintain full accreditation status as required by this Contract.

3. NCQA's review standards shall be comparable to standards established through the EQR protocols, as outlined in 42 CFR 438.352, for the EQR activities specified in 42 CFR 438.358(b)(1)(i) through (iii).

4. The Contractor shall provide to AHCCCS all reports, findings, and other results of NCQA's review activities applicable to the standards for the EQR activities.

5. The Contractor shall ensure that all information is furnished to AHCCCS or its External Quality Review Organization, as applicable, for analysis and inclusion in the External Quality Review annual technical reports described in 42 CFR 438.364(a).

6. The Contractor shall maintain sufficient compliance with Contractual requirements.

AHCCCS will identify in its Quality Strategy, described in 42 CFR 438.340, the EQR activities for which it has exercised the nonduplication option described above.

Performance Improvement Projects: The Contractor shall implement PIPs designed to achieve and sustain significant improvement, through ongoing measurements and interventions, in clinical and non-clinical focus areas, as specified in AMPM Chapter 900, that include the following [42 CFR 438.330(d)(i)-(iv)]:

1. Measurement of performance using objective quality indicators.

2. Implementation of interventions to achieve improvement in access to and QOC.

3. Evaluation of the effectiveness of the interventions based on measures/indicators collected as part of the PIP.

4. Planning and initiation of PIP activities for increasing or sustaining improvement.

PIPs are mandated by AHCCCS; however, the Contractor shall also identify and implement additional PIPs meaningful to the population served, based on self-identified opportunities for improvement, as supported by root cause analysis, internal/external data, surveillance of trends, or other information available to the Contractor. If the Contractor holds AHCCCS Contracts for more than one population/LOB, the Contractor shall:

1. Submit separate reports for each population/LOB.

2. Submit rates and results specific to population/LOB for which the submission pertains.

3. Ensure the inclusion of applicable subpopulation data and disparity analysis within its reporting, with the identification of targeted interventions to be implemented specific to the analysis findings.

Upon notification and direction from AHCCCS, the Contractor shall:

1. Participate in mandatory technical assistance sessions. The Contractor may also request technical assistance, as needed.

2. Participate in AHCCCS workgroup sessions aimed to identify barriers and implement interventions, including any interventions mandated by AHCCCS, to address system performance.

3. Propose and implement Contractor-specific CAPs for identified deficiencies.

The Contractor shall report the status and results of each PIP to AHCCCS, no less than once per year and as requested, using the AHCCCS Performance Improvement Project (PIP) Reporting Template(s) included on the AHCCCS QM/PI Reporting Templates & Checklist webpage, and as specified in AMPM Policy 980, the AHCCCS QM/PI Reporting Templates & Checklist webpage, and Section F, Attachment F3, Contractor Chart of Deliverables. Performance for each PIP shall be monitored by the Contractor (minimally) on an annual basis, or more frequently, so information related to the Contractor's performance can be reviewed and evaluated, with interventions revised accordingly [42 CFR 438.330(d)(1), 42 CFR 438.330(d)(3)]. The Contractor's PIP report submissions may be provided to AHCCCS' EQRO for review, evaluation, and potential inclusion within the AHCCCS EQR Annual Technical Reports and findings. In addition, AHCCCS may elect to require validation of the Contractor's AHCCCS-Mandated and Contractor Self-Selected PIP reports by AHCCCS' EQRO.

Performance Measures: To meet QM/PI Program and reporting requirements, standardized performance measures shall be calculated and reported on an annual basis or more frequently, as determined by AHCCCS [42 CFR 438.330 (c)]. Performance measures shall be monitored and evaluated in accordance with Contract, AHCCCS instruction and AMPM Chapter 900. AHCCCS may utilize/require administrative, hybrid, or other methodologies for calculating and reporting performance measure rates, as defined by the CMS for Core Set of Adult and/or Child Health Care Quality Measures for Medicaid (Adult and Child

Core Sets), measures NCQA for selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures, other entities for nationally recognized measure, or as determined by AHCCCS.

For Contract Year Ending (CYE) 2024 (10/1/2023 through 9/30/2024) performance measures shall be reflective of the Calendar Year (CY)/Measurement Year (MY) 2024 (1/1/2024 through 12/31/2024) measurement period in alignment with the applicable CMS (Adult and Child) Core Set and NCQA HEDIS® technical specification requirements.

AHCCCS Performance Measures (Statewide Aggregate Rates): Statewide aggregate performance measure rate calculations are conducted by AHCCCS' EQRO utilizing the Adult and Child Core Set technical specifications. Performance measure selection and methodologies utilized for calculating the measures align with that outlined in the CMS Adult and Child Core Set Lists and associated specifications. AHCCCS may utilize other performance measures and/or methodologies, such as NCQA HEDIS®, or develop methodologies for measurement that are reflective of the Arizona system of care delivery model.

Performance is evaluated annually using the official performance measure rates described in the preceding paragraph; these rates are considered the official measurements for statewide reporting. In lieu of AHCCCS-calculated statewide aggregate rates, AHCCCS may elect to utilize Contractor-calculated performance measure rates (e.g., administrative, hybrid, or other methodologies) that have undergone validation by AHCCCS' EQRO and have been aggregated for official statewide reporting.

Official statewide performance measure rates shall be compared with the CMS Child and Adult Health Care Quality Measures, national Medicaid Median (CMS Medicaid Median), and/or the NCQA HEDIS® Medicaid Mean for selected HEDIS®-Only measures, that aligns with the CY/MY for which the data reflects.

CMS-416: AHCCCS utilizes the methodology established within the CMS Instructions for Completing Form CMS-416: Annual EPSDT Participation Report for reporting EPSDT Participation. The aggregate rate for Title XIX, as well as the aggregate rate for Title XXI, are generated one time per year and reported to CMS within specified timeframes. AHCCCS may, in lieu of generating the rates, opt to utilize CMS-generated rates for reporting purposes. AHCCCS may require the Contractor to implement a CAP or participate in mandatory workgroup activities when statistically significant declines in the Title XIX and/or Title XXI aggregate rates are identified.

Hybrid Performance Measures: AHCCCS may conduct hybrid performance measure reviews/audits for any CMS Child or Adult Core Set measure, NCQA HEDIS®, or other standardized performance measure to monitor and evaluate performance for performance measures and/or PIPs. AHCCCS-conducted hybrid performance measure reviews/audits shall be reflective of statewide performance; however, AHCCCS reserves the right to conduct/require hybrid performance measure reviews/audits to monitor Contractor, LOB, population, and/or program performance. Contractor reported rates may be reported publicly, and the Contractor may be required to implement a CAP when:

1. Deficiencies are identified within hybrid performance measure rates.

2. Hybrid performance measure rates do not meet performance requirements.

3. Declines in hybrid performance measure rates occur.

Hybrid Data Collection Procedures: AHCCCS may require the Contractor to submit data for standardized performance measures and/or PIPs within specified timelines in accordance with

AHCCCS instructions for collecting and reporting the data. AHCCCS may elect to utilize AHCCCS' EQRO for conducting hybrid performance measure review/audit activities.

Contractor Performance Measures (Contractor Specific-Rates): The Contractor shall comply with AHCCCS QM/PI Program requirements to improve the care, coordination, and services provided to AHCCCS members as demonstrated through performance metrics and performance measure reporting. The Contractor shall calculate and report (in accordance with AHCCCS instruction) all measures (inclusive of all associated submeasure rates and required reporting stratifications) included as part of the CMS (Adult and Child) Core Set List for the associated measurement period, as well as select NCQA HEDIS® or other AHCCCS-required performance measures as listed below.

HEDIS® OR OTHER ADULT MEASURES
Inpatient Utilization (IPU)
Diagnosed Mental Health Disorders (DMH)
Use of Opioids at High Dosage (HDO)
Long-Term Services and Supports - Comprehensive Assessment and Update (LTSS-CAU)
Long-Term Services and Supports - Comprehensive Care Plan and Update (LTSS-CPU)
Long-Term Services and Supports - Shared Care Plan with Primary Care Practitioner (LTSS-SCP)

As measure sets are updated, the performance measures required by AHCCCS may also be updated to reflect the changes. In addition, AHCCCS may require the Contractor submit performance measure rate data (inclusive of numerator and denominators for any required measures, submeasures, and reporting stratifications) for performance measures required by NCQA as part of its accreditation process.

As part of the Contractor's performance measure data calculations, reporting, monitoring, and analysis activities, the Contractor shall:

1. Ensure qualified staff and personnel are utilized in the data collection, calculation, monitoring, evaluation, and reporting process.

2. Calculate, monitor, analyze, and report performance measure rates (including all submeasure and stratified rate reporting required as part of the associated performance measure technical specifications as required by CMS). Reporting shall be specific to population/LOB.

3. Analyze (and report in accordance with AHCCCS instruction and request) performance measure data specific to applicable subpopulations (e.g., members with SHCN, including, but not limited to EPSDT, maternal, and behavioral health category).

4. Analyze (and report in accordance with AHCCCS instruction and request) performance measure data by placement (e.g., HCBS vs. NF), SOC delivery model, GSA, county, applicable member designations, and/or other applicable demographic and SDOH factors.

5. Conduct routine monitoring and implement population/subpopulation-specific targeted interventions, meant to ameliorate or eliminate identified disparities, which are based on an analysis of previous performance.

The Contractor is responsible for collecting valid and reliable data in accordance with associated measure specifications, as well as the technical guidance and instructions provided by AHCCCS and/or AHCCCS' EQRO when conducting performance measure validation activities. Responsibility for validation and oversight of performance measure data collection and rate reporting in alignment with AHCCCS requirements remains with the Contractor, despite utilization of a vendor or subcontractor to conduct performance measure calculations or hybrid reviews on its behalf. The Contractor shall comply with all manuals, documents, and guides referenced within the Contract and AMPM Chapter 900, in accordance with AHCCCS instructions and CMS mandatory reporting requirements. In addition, the Contractor shall be required to utilize allowable supplemental data sources that meet the criteria outlined within the associated performance measure technical specifications and utilize the data collection methodology as instructed or required by AHCCCS.

Hybrid Performance Measures: The Contractor shall participate in hybrid performance measure reviews/audits for all measures identified by AHCCCS, at the intervals specified by AHCCCS.

The number of records that each Contractor collects will be based on CMS (Adult and Child) Core Set measure specifications, NCQA HEDIS® specifications, EQRO, or other sampling guidelines in accordance with instructions provided by AHCCCS. The number of records that each Contractor collects may be affected by the Contractor's previous performance rate for the associated measure. The Contractor shall comply with and implement the hybrid methodology data collection as directed by AHCCCS or AHCCCS' EQRO. If records are missing for more than 5% of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS.

Hybrid Data Collection Procedures: When requested by AHCCCS, the Contractor shall submit data for standardized performance measures and/or PIPs (when applicable) within specified timelines and according to AHCCCS instructions for collecting and reporting the data. The Contractor shall collect data from medical records, Electronic Health Records (EHRs), or through other AHCCCS approved mechanisms in accordance with the technical specifications and/or methodology identified by AHCCCS. Data collected for performance measures and/or PIPs shall be completed in accordance with the instructions and timelines provided by AHCCCS and/or AHCCCS' EQRO, when applicable. For AHCCCS-directed hybrid studies, data shall be reported utilizing a standardized format for each hybrid measure, with allowable supporting documentation submitted, in accordance with AHCCCS provided instructions.

The Contractor shall also ensure that data collected by multiple parties/individuals for performance measures and PIP reporting is consistent and comparable through an implemented IRR process, as specified in AMPM Policy 970 and 980. Failure to follow the data collection and reporting instructions that accompany the data request may result in regulatory actions including, but not limited to, sanctions imposed on the Contractor.

The Contractor shall implement a process for internally monitoring, evaluating, and reporting all performance measure rates, utilizing a standardized methodology. The Contractor shall evaluate performance, based on the unique population/LOB and applicable subpopulations. The Contractor shall have a mechanism for its QM/PI Committee to report the Contractor's performance on an ongoing basis to its Administrator/CEO, stakeholders, and other key staff.

The Contractor shall calculate, evaluate, and report performance measure rates in accordance with AHCCCS instructions. Contractor-calculated performance measure/submeasure rates that have been validated by AHCCCS' EQRO are the official rates utilized for determination of Contractor compliance with performance requirements. AHCCCS reserves the right to calculate and report rates, in lieu of Contractor calculated rates, which may be utilized as the official rates when determining Contractor compliance with

performance measure requirements. Contractor-calculated rates that have been validated and compiled by AHCCCS' EQRO are the official rates utilized for the population/LOB aggregate rates; however, AHCCCS may elect to utilize performance measure rates that have been calculated by AHCCCS' EQRO as the official population/LOB rates.

Contractor Performance Measure Reporting: The Contractor shall include all Medicaid Managed Care enrolled members within its performance measure reporting and report rates specific to population/LOB, and/or as directed by AHCCCS. The Contractor shall adhere to the continuous enrollment criteria as outlined in the associated measure specifications, and/or as directed by AHCCCS.

The Contractor shall analyze (and report, in accordance with AHCCCS instruction and request), performance measure data specific to:

1. Applicable subpopulations (e.g., members with SHCN, including, but not limited to: EPSDT, maternal, behavioral health diagnosis, and disability status).

2. Placement (e.g., HCBS vs. NF).

3. System Of Care (SOC) delivery model.

4. Geographic Service Area (GSA) or County.

5. Applicable member designations.

6. Other applicable demographic and SDOH factors that may not be required as part of the associated performance measure specifications.

Based on the evaluation and analysis of current and previous performance, the Contractor shall conduct and report disparity analysis findings and activities meant to ameliorate or eliminate identified disparities.

The Contractor is responsible for monitoring and reporting the status of, and any discrepancies identified in encounters, received by AHCCCS including paid, denied, and pended for purposes of performance measure monitoring. Reporting shall be directed to the AHCCCS QI Manager and communicated upon identification and prior to the official statewide rate calculations being conducted.

The Contractor's performance measure monitoring shall be reported to AHCCCS as part of its QM/PI Program Plan (inclusive of Work Plan and Work Plan Evaluation) and Performance Measure Monitoring Report in accordance with this section; Section F, Attachment F3, Contractor Chart of Deliverables; AMPM Chapter 900; and as required by AHCCCS.

Quality Improvement Performance Requirements: Contractor performance is evaluated annually using the official rates specified in the Contractor Performance Measures (Contractor-Specific Rates) section above. These rates are considered the official measurements for each performance measure. Contractor specific official rates will be compared with the population/LOB aggregate rates, as applicable, and the NCQA HEDIS® Medicaid Mean or the CMS Medicaid Median [for selected CMS (Adult and Child) Core Set-Only Measures], as identified by AHCCCS. The Contractor shall perform in accordance with established standards, as specified in this section. Contractor performance that does not meet established standards, per official reporting, may be subject to regulatory action (which may include sanctioning) for each deficient measure (measure/submeasure) rate.

The Contractor shall meet and sustain, as well as ensure that each subcontractor meets and sustains, the NCQA HEDIS® Medicaid Mean/CMS Medicaid Median for each performance measure (measure/ submeasure) rate [42 CFR 438.330(b)(1)-(2) and (d)(1)]. It is equally important that, in addition to meeting the NCQA HEDIS® Medicaid Mean/CMS Medicaid Median, the Contractor continually improves performance measure outcomes from year to year.

The Contractor shall meet and sustain, as well as ensure that each subcontractor meets and sustains, the NCQA HEDIS® Medicaid Mean/CMS Medicaid Median for each performance measure (measure/ submeasure) rate [42 CFR 438.330(b)(1)-(2) and (d)(1)]. It is equally important that, in addition to meeting the NCQA HEDIS® Medicaid Mean/CMS Medicaid Median, the Contractor continually improves performance measure outcomes from year to year.

The Contractor shall show demonstrable and sustained improvement toward meeting (or maintaining, if above) the associated population/LOB aggregate measure/submeasure rate, as applicable, and the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median. AHCCCS will require the Contractor to implement a CAP for performance measure/submeasure rates that do not meet the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median. AHCCCS may require the implementation of a CAP for performance measure/submeasure rates that are below the associated population/LOB aggregate rates. AHCCCS may require the implementation of a CAP for performance measure/submeasure rates that show a statistically significant decline in one or more of its rates. This includes measures that show a statistically significant decline in one or more of its (measure/submeasure) rates even when the rate(s) meet or exceed the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median, as well as those that meet or exceed the associated population/LOB aggregate rate. In addition, AHCCCS may require the Contractor to implement a CAP or participate in mandatory workgroup activities when statistically significant declines in the aggregate population/LOB-specific rate(s) performance measure/submeasure rates are identified even when the rate(s) meets or exceeds the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median.

AHCCCS may impose sanctions on the Contractor if it does not show statistically significant improvement in its official performance measure/submeasure rates. Sanctions may also be imposed for:

1. Statistically significant declines in official rates, even if they meet or exceed the associated population/LOB aggregate rate, as applicable, and/or the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median.

2. Any rate that does not meet the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median.

3. A rate that has a significant impact to the population/LOB or statewide aggregate rate, and (including a significant impact to the population/LOB or statewide aggregate rate based on the Contractor's failure to utilize the performance measure calculation methodology required by AHCCCS).

4. Any rate that falls from a higher to lower performing percentile/quartile based on the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median benchmark data.

AHCCCS may require the Contractor to demonstrate that they are allocating increased administrative resources to improve rates for a particular measure or service area.

Upon notification and direction from AHCCCS, the Contractor shall:

1. Participate in mandatory technical assistance sessions. The Contractor may also request technical assistance as needed.

2. Participate in AHCCCS workgroup sessions and initiatives aimed to identify barriers and develop action plans to address system performance.

3. Propose and implement Contractor-specific CAPs for official statewide aggregate rates on the CMS Scorecard that:
   a. Do not meet the published NCQA HEDIS® Medicaid Mean/CMS Medicaid Median, or
   b. Demonstrate a significant decline for the applicable measurement period.

4. Propose and implement Contractor-specific CAPs, for measures demonstrating statistically significant disparities based on AHCCCS' evaluation and analysis of measure performance, inclusive of targeted interventions meant to ameliorate or eliminate identified disparities.

Quality Improvement Corrective Action Plans: An evidence-based CAP, inclusive of elements specified in AMPM Policy 920, shall be received by AHCCCS within 30 days of the notification of deficiency(ies) from AHCCCS. Proposed CAPs shall be approved by AHCCCS prior to implementation and CAP updates shall be submitted at intervals specified by AHCCCS. AHCCCS may conduct one or more follow-up desktop or on-site reviews to verify compliance with a CAP. The Contractor shall also identify and implement additional CAPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the Contractor. Self-implemented CAPs and associated CAP updates shall be submitted upon AHCCCS request.

Quality Improvement Deliverable Extension Requests: If an extension of time is needed to complete the submission, the Contractor shall submit a formal request for AHCCCS' consideration via email communication sent at least two business days prior to the deliverable due date to the AHCCCS/DHCS, Operations Compliance Officer (OCO) and QI Team Manager, in accordance with AMPM Policy 920 requirements.

Member Satisfaction Surveys: The Contractor shall, as requested by AHCCCS, participate in member satisfaction surveys in accordance with CMS' External Quality Review Protocol [42 CFR 438.340(a), 42 CFR 438.340(b)(4)]. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool which shall be approved in advance by AHCCCS and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Member satisfaction survey findings or performance rates for survey questions may result in Administrative Action. The results of the surveys may become public information and available to all interested parties on the AHCCCS website. The Contractor may be required to participate in workgroups and other efforts that are initiated based on the survey results. The Contractor may participate in or conduct additional surveys based upon findings from the previously conducted member satisfaction survey, as approved by AHCCCS, as part of designing its QI or CAP activities.

Refer to Section D, Paragraph 61, Surveys for additional information specific to member survey requirements.

Health Disparity Summary & Evaluation Report: The Contractor shall develop and implement a strategic plan that includes an analysis of the effectiveness of implemented strategies and interventions in meeting its health equity goals and objectives during the previous CY, a detailed overview of the Contractor's identified health equity goals/objectives for the upcoming CY, and targeted strategies/interventions planned for the upcoming CY to achieve its goals**.** The Contractor shall submit the Health Disparity Summary & Evaluation Report as specified in AMPM Policy 920 and Section F, Attachment F3, Contractor Chart of Deliverables.

Engaging Members through Technology Executive Summary: The Contractor shall develop and implement a strategic plan for the upcoming CY to engage and educate its membership, as well as improve access to care and services, through telehealth services and web-based applications intended to assist members with self-management of health care needs. Within its plan, the Contractor shall identify web/mobile-based applications utilized in its outward-facing communication with members. The Contractor shall also identify subpopulations that can benefit from web/mobile based applications used to assist members with self-management of health care needs (e.g., chronic conditions, pregnancy, SDOH resources, or other health-related topics the Contractor considers to be most beneficial to members), implementing and evaluating targeted Engaging Members through Technology (EMTT) related activities specific to these areas. The Contractor shall submit an EMTT Executive Summary, in report format and as a component of the Contractor's QM/PI Program Plan submission, as specified in AMPM Policy 920 and Section F, Attachment F3, Contractor Chart of Deliverables.

Contractor's Best Practices and Follow Up on Previous Year's External Quality Review Report Recommendations: The Contractor shall submit its Best Practices and Follow Up on Previous Year's EQR Report Recommendations deliverable, as specified in AMPM Policy 920 and Section F, Attachment F3, Contractor Chart of Deliverables.

Targeted Investments: AHCCCS' TI program, including the 2016 1115 Waiver program and the 2023 1115 Waiver program, outlines performance measures and process requirements that participating providers agree to achieve, to support, and demonstrate their ability to address members' medical, behavioral, and HRSN. These annual requirements, identified as process milestones and performance measure targets, are found at: www.azahcccs.gov/PlansProviders/TargetedInvestments/. The Contractor shall consider alignment with these milestones and performance measures when developing and implementing strategies to support integration efforts, such as value-based purchasing arrangements, with participating providers.

Ambulatory Medical Record Review Audit: The Contractor shall conduct an Ambulatory Medical Record Review (AMRR) audit according to the requirements outlined below, as well as within AMPM 940. The audit shall include the following provider types, including PCPs that serve children (i.e., children defined as less than 21 years of age) and obstetricians/gynecologists. The Medical Record review process shall consist of monitoring a group practice based on the following number of practitioners within the group practice:

- Group practice with one to two practitioners, eight charts per practitioner.
- Group practice with three to six practitioners, four charts per practitioner.
- Group practice with seven-15 practitioners, two charts per practitioner.
- Group practice with 16+ practitioners, a maximum of 30 charts shall be reviewed.

1. If the score after review of the required number of charts identified above, is less than 85%, technical assistance shall be provided to the practitioner, and the practitioners shall also be audited the following year.

2. If the score after eight charts is 85% or greater, yet areas of deficiency are found, technical assistance shall be given to the practitioner.

3. For providers that do not treat children or pregnant members, the following process shall occur unless a different methodology is reviewed and approved by AHCCCS:
   a. A random sample of 30 providers per GSA will be pulled for audit each year. Eight charts will be audited per provider,

b. If the score after eight charts is less than 85%, technical assistance shall be given to the provider, and the provider shall also be re-audited the following year,
c. If the score after eight charts is 85% or greater, yet areas of deficiency are found, technical assistance shall be given to the provider, and
d. If, after all the audits are completed and noted trends are identified around deficiencies or improvement opportunities, the entire network shall receive education and guidance on the issues identified.

For the AMRR AzAHP maintains oversight of the administrative processes through regular collaboration with the Contractors, including development and maintenance of the audit tool, data analysis, assistance with provider identification and audit rotation schedule. Any additional processes that have been established prior to October 1, 2020, by way of agreement between a Contractor and AzAHP may continue as is. Any alteration to these established processes will require AHCCCS approval.

For completion of the AMRR, an RN or an LPN with current Licensure under the Arizona State Board of Nursing (BON) shall be utilized to conduct the audit.
In addition, the Contractor shall:

1. Follow local, Federal and State regulations and requirements related to seclusion and restraint. Reports regarding incidents of seclusion and restraint shall be submitted to AHCCCS as specified in AMPM Policy 962 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables (A.R.S. § 36-513).

2. Submit deliverables related to Actions Reported to the National Provider Data Bank (NPDB) or a Regulatory Board, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

3. Submit deliverables related to QM as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

22. MEDICAL MANAGEMENT

The Contractor shall ensure an integrated MM process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the CoC (from preventive care to hospice care).

The Contractor shall have a process to report MM data and management activities through the Contractor's MM Committee. The Contractor's MM committee shall utilize the Plan, Do, Study, Act (PDSA) cycle to analyze the data, make recommendations for action, monitor the effectiveness of actions, and report these findings back to the MM committee for review and ongoing process improvement.

The Contractor shall assess, monitor, and report quarterly through the Contractor's MM Committee, medical decisions to assure compliance with timeliness, language, and Notice of Adverse Benefit Determination intent, and that the decisions comply with all Contractor coverage criteria.

The Contractor shall maintain a written MM Program Plan that addresses the monitoring of MM activities. Refer to AMPM Policy 1010. The Contractor shall develop a plan outlining short and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the Contractor shall develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination

and the outcome measurement shall be reported in the MM Program Plan submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall implement processes to assess, plan, implement, evaluate, and as mandated, report MM monitoring activities as specified in AMPM Chapter 1000 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall evaluate, interpret variances, and monitor required MM activities, as specified in the AMPM Chapter 1000, including [42 CFR Part 457 and 42 CFR Part 438]:

1. Utilization Data Analysis and Data Management. Refer to AMPM Policy 1020.

2. Concurrent Review. Refer to AMPM Policy 1020.

3. AMPM Policy for Discharge Planning. Refer to AMPM Policy 1020.

4. Prior Authorization (PA) and Service Authorization. Refer to AMPM Policy 1020.

5. Inter-Rater Reliability (IRR). Refer to AMPM Policy 1020.

6. Retrospective Review. Refer to AMPM Policy 1020.

7. Clinical Practice Guidelines developed in consultation with network providers [42 CFR Part 438.236(b)(3)]. Refer to AMPM Policy 1020.

8. New Medical Technologies and New Uses of Existing Technologies. Refer to AMPM Policy 1020.

9. Contractor Care Management and Coordination. Refer to AMPM Policy 1021.

10. Disease/Chronic Care Management. Refer to AMPM Policy 1023.

11. Drug Utilization Review. Refer to AMPM Policy 1024.

AHCCCS will provide a new Contractor (including an Incumbent Contractor new to a GSA) with three years of historical encounter data for members enrolled with the Contractor as of December 1, 2013. Contractors should use this data to assist with identifying members in need of MM.

The Contractor shall ensure that each member has a designated individual or entity that is primarily responsible for coordinating services for the member. The Contractor shall have procedures to ensure that each member has an assigned PCP that provides care appropriate to the member's needs. The Contractor is required to provide the member with information on how to contact their designated individual or entity [42 CFR 438.208(b)(1)].

The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with SHCN [42 CFR 438.240(b)(4)]. The Contractor shall implement procedures to deliver primary care to and coordinate health care service for members. These procedures shall ensure that each member has an ongoing source of primary care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member [42 CFR 438.208].

The Contractor shall make a best effort to conduct an initial screening of each member's needs as specified in AMPM Policy 910 [42 CFR 438.208(b)(3)]. The Contractor shall share with the State or other contracted entities serving the member the results of any identification and assessment of the member's needs to

prevent duplication of services and activities [42 CFR 438.208(b)(4)]. The Contractor shall have procedures to coordinate the services for members between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)].

The Contractor shall have procedures to coordinate the services provided for members between services provided by the Contractor and services received from other AHCCCS Contractors, from FFS Medicaid or from the community and social support providers [42 CFR 438.208(b)(2)(i)-(iv)]. The Contractor shall coordinate care with other AHCCCS Contractors and PCPs that deliver services to Title XIX/XXI members [42 CFR 438.208(b)(3)-(4)].

24 Hours Post Medical Clearance Emergency Department Report: The Contractor shall monitor the length of time adults and children wait to be discharged from the ED while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member needs behavioral health placement or wrap around services is in the ED the Contractor shall coordinate care with the ED and the member's treatment team to discharge the member to the most appropriate placement or wrap around services. Additionally, the Contractor shall submit the 24 Hours Post Medical Clearance ED Report utilizing the standardized AHCCCS reporting template as required in Section F, Attachment F3, Contractor Chart of Deliverables.

Care Coordination for Survivors of Sex Trafficking: The Contractor is responsible for providing outreach to members identified by the Arizona Child Abuse Hotline who are assessed as survivors of sex trafficking. Once notification is received by AHCCCS from the Hotline, AHCCCS will forward the notification to the Contractor. The Contractor or its contracted provider shall outreach to the member's guardian to provide trauma-informed resources, including but not limited to a description of how to access behavioral health assessment services and subsequent treatment if medically necessary. The Contractor shall ensure the results of the outreach and activities are communicated back to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Outreach activity results shall include the date of contact with the member's guardian and a description of services referred and/or delivered.

Care Management Program: The Contractor shall ensure the provision of care management to assist members who may or may not have a chronic disease but have physical or behavioral health needs or risks that need immediate attention. Refer to AMPM Policy 1021. This care management shall assure members get the services they need to prevent or reduce an adverse health outcome. Care management includes a comprehensive assessment of the member and development and implementation of a care plan as specific in AMPM Policy 1021. Care management should be short term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the member's immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention. The Contractor shall ensure the provision of care management to assist members experiencing barriers transition to a different level of care (e.g., discharge from an ED or inpatient hospital, admission to a residential setting) and assist members in accessing necessary services to ensure successful transition.

Care Management is designed to cover a wide spectrum of episodic and chronic health care conditions for members in the top tier of high need/high-cost members, including those with SHCN, with an emphasis on health disparities, proactive health promotion, health education, and disease management including consultation with a member's Treatment Team and direct engagement with members; and self-management resulting in improved physical and behavioral health outcomes. These activities are performed by the Contractor's Care Managers.

The Contractor shall employ care managers to perform Contractor care management functions as required in AMPM Chapters 500 and 1000. Contractor care managers should have expertise in member self-management approaches, member advocacy, navigating complex systems and communicating with a wide spectrum of professional and laypersons including family members, physicians, specialists, and other health care professionals.

The Contractor shall have multiple methods a member can be referred to the Care Management program including but not limited to referrals from the member/caregiver, internal sources (e.g., customer service, quality management, case management) and/or a provider as specified in AMPM Policy 1021.

The Contractor shall develop member selection criteria for the Contractor Care Management model to determine the service intensity or targeted interventions a member may require to help achieve improved health outcomes and reduce risk and cost. The Contractor shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMR), health services programs within the organization, or other advanced data sources to develop the selection criteria. The Contractor shall stratify members for their Care Management program for targeted interventions, on at least an annual basis.

If the Contractor intends to delegate a portion of the Care Management functions to an Administrative Services Subcontractor, prior approval is required. Requests for approvals shall be submitted as specified in ACOM Policy 438.

The Contractor shall assure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and referral of QOC/service concerns.

Collaboration with System Stakeholders: The Contractor shall work in partnership with all Contractors and TRBHAs in its GSA(s) to meet, agree upon and reduce writing MOUs and/or joint Collaborative Protocols. Protocols and/or MOUs shall represent robust and meaningful collaborative processes and relationships, as necessary to meet member's needs based on the LOB and subpopulation (e.g., adult, child, SMI, GMH/SU, justice-involved), as specified in AMPM Policy 541, AMPM Policy 590, AMPM Policy 1021, and AMPM Policy 1022.

1. The Contractor shall address in each Collaborative Protocol, at a minimum, the following:
    a. Procedures for each entity to coordinate the delivery of covered services to members served by both entities.
    b. Mechanisms for resolving problems.
    c. Information sharing.
    d. Resources each entity commits for the care and support of members mutually served.
    e. Procedures to identify and address joint training needs.
    f. Where applicable, procedures to have providers co-located with jails, prisons, and detention facilities or other agency locations as directed by AHCCCS.

2. All MOUs and/or joint Collaborative Protocols shall be fully executed with required signatures and dates by all parties.

3. The Contractor shall review and update all written protocols and MOUs as needed, but no less than every 36 months. AHCCCS may, at its discretion, request current Collaborative Protocols and MOUs.

The Contractor shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements under 42 CFR 431.300 et seq. To the extent permitted by law, treatment data may be shared without the permission of the member and are **not** subject to 42 CFR Part 2. Data may consist of:

1. Individual's Name (First Name, Middle Initial, Last Name).
2. Date Of Birth (DOB).
3. AHCCCS ID.
4. Social Security Number.
5. Gender.
6. Court Ordered Treatment (COT) status.
7. Public Fiduciary/Guardianship status.
8. Assigned Behavioral Health Provider Agency.
9. Assigned Behavioral Health Provider's Phone Number.
10. Name of AHCCCS Contractor.
11. Primary Care Provider (PCP) Name and Phone Number
11. Diagnoses (Medical and Behavioral Health).
13. Medications.

Concurrent Review: The Contractor shall ensure consistent application of review criteria that governs the utilization of services in institutional settings, provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply as specified in AMPM 1020.

The Contractor shall have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into acute care facilities, Behavioral Health Inpatient Facilities (BHIFs), BHRFs, and TFC facilities. The intent of the discharge planning policy and procedure would be to increase the utilization management of inpatient admissions and decrease readmissions within 30 days of discharge.

Refer to AMPM Policy 320-O for provisions regarding behavioral health assessment and treatment/service planning.

In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a HCAC or an OPPC (refer to AMPM Chapter 1000). If an HCAC or OPPC is identified, the Contractor shall report the occurrence to AHCCCS and conduct a QOC investigation as specified in AMPM Chapter 900 [42 CFR 438.3(g), 42 CFR 438.6(f)(2)(ii), and 42 CFR 434.6(a)(12)(ii)].

Require admission and continued stay authorizations for members in acute care facilities, BHIFs, BHRFs, TFC facilities are to be conducted by a physician or other qualified health care professional. Under 42 CFR 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, will render decisions to deny if the criteria for admission or continued stay is not met.

Coordination with AHCCCS Contractors and Primary Care Providers: The Contractor shall forward behavioral health records including copies or summaries of relevant information of each member to the member's PCP as needed to support quality MM and prevent duplication of services.

The Contractor shall establish a process to ensure care coordination for pharmaceutical needs for members based on early identification of health risk factors or special care needs and ensure the following information, for all members referred by the PCP, is communicated to the PCP, upon request, no later than 10 days from the request [42 CFR 438.208(b)(3)]:

1. Critical laboratory results as defined by the laboratory and required by specific medication(s).

2. Prescriptive changes of a member's medication(s) within the same therapeutic class or a change to a new drug from a different therapeutic class.

Drug Utilization Review: The Contractor shall perform Drug Utilization Review (DUR) activities in accordance with the CMS requirements in the Social Security Act Section 1927 (g) Drug Use Review and the Federal Opioid Legislation (42 USC 1396A(OO). The Contractor shall report on its DUR management activities as specified in AMPM Policy 1024 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall complete the annual CMS DUR Survey which will be emailed when CMS releases the annual survey. The Contractor shall submit the DUR Survey as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

High Need/High Cost: The Contractor shall identify, monitor, and implement interventions for providing appropriate and timely care to members with high needs and/or high costs who have physical and/or behavioral health needs. Refer to AMPM Policy 1021.

> ***High-Cost Behavioral Health Needs***: The Contractor shall submit counts of distinct members that are considered to have High-Cost Behavioral Health Needs based on Contractor criteria. For the identified members the Contractor shall submit the number of PA and Notice of Adverse Benefit Determinations issued, as well as the concurrent and retrospective reviews of these for members identified within the State Fiscal Year (July 1-June 30). The Contractor shall submit the High-Cost Behavioral Health Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Inappropriate Emergency Department Utilization: The Contractor shall identify and track members who utilize ED services inappropriately four or more times within a six-month period. Interventions shall be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service. The Contractor shall submit an ED Diversion Summary as specified in AMPM Policy 1021 and Section F, Attachment F3, Contractor Chart of Deliverables.

Justice System Reach-in Care Coordination: To facilitate care coordination for members transitioning from correctional institutions, AHCCCS is engaged in data sharing agreements with most jails, prisons, and detention facilities providing a mechanism for a member's program eligibility to remain unaffected by incarceration in most cases. Rather than discontinuing program eligibility for incarceration, AHCCCS instead suspends a member's health plan enrollment temporarily to a "no pay" status during the period of incarceration and, upon release, immediately reinstates the previous enrollment to promote continuity of care. In support of this enrollment suspense initiative, the Contractor is required to engage in Justice System Reach-in Care Coordination activities.

The Contractor shall conduct reach-in care coordination for members incarcerated for 20 or more days and shall commence upon the knowledge of an anticipated release date. The contractor shall collaborate with justice system stakeholders (e.g., jails/prisons/detention facilities, courts, law enforcement, and community supervision agencies) to identify justice involved members with chronic and/or complex physical and/or behavioral health care needs prior to the member's release. Additionally, the Contractor shall conduct reach-in care coordination for incarcerated members who have SUD and/or meet medical necessity criteria to receive MOUD.

The Contractor shall report a Justice System Reach-In Plan and outcome summaries as part of its MM Program Plan. The Contractor shall monitor progress throughout the year and submit a Justice System Reach-In Monitoring Report including the number of members involved in reach-in activities and as specified in AMPM Policy 1022 and Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

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

Maternal Child Health: The Contractor shall monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries, utilization of Long-Acting Reversible Contraceptives (LARC)/Immediate Postpartum Long-Acting Reversible Contraception (IPLARC), prenatal, and postpartum visits. The Contractor shall implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation and implement interventions to decrease the incidence of occurrence.

Monitoring Controlled and Non-Controlled Medication Utilization: The Contractor shall engage in activities to monitor controlled and non-controlled medication use as specified in AMPM Policy 310-FF to ensure members receive clinically appropriate prescriptions. The Contractor is required to report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, a Pharmacy and/or Prescriber - Member Assignment report which includes the members who are restricted to using a specific Pharmacy or Prescriber/Providers due to excessive use of prescription medications (narcotics and non-narcotics). The Contractor is also required to report to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables when the Contractor makes changes to interventions and parameters to the Contractor's Exclusive Pharmacy and/or Single Prescriber Process as specified in AMPM Policy 310-FF.

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

The Contractor shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is their patient, for [Section 1932(b)(3)(A) of the Social Security Act, 42 CFR 438.102(a)(1)(i)-(iv)]:

1. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)].

2. Any information the member needs in order to decide among all relevant treatment options.

3. The risks, benefits, and consequences of treatment or non-treatment.

4. The member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(iv)].

5. Deliver covered health services in accordance with the requirements of any other funding source.

The Contractor shall conduct quarterly self-audits of Notice of Adverse Benefit Determination letters as specified in ACOM Policy 414. The Contractor shall submit a Notice of Adverse Benefit Determination Self-Audit Executive Summary as specified in the ACOM Policy 414 and Section F, Attachment F3, Contractor Chart of Deliverables.

Out-of-State Placements for Behavioral Health Treatment: The Contractor shall notify AHCCCS of placement or pending placement of a member in an out-of-State placement, submit progress updates of members who remain in out-of-State placement for behavioral health treatment, and notify AHCCCS when a member is discharged, including those members waiting for out-of-State placement, as specified in AMPM Policy 450 and Section F, Attachment F3, Contractor Chart of Deliverables.

Outreach: The Contractor is responsible for the organization of provider level training and the development of informational materials to increase outreach, eligibility identification, referrals, and tracking of referral outcomes, including for under and uninsured individuals. Refer to AMPM Policy 1040 for provisions regarding community and member Outreach, Engagement, and Re-engagement for behavioral health services. The Contractor shall provide and participate in outreach activities to inform the public of the benefits and availability of behavioral health services and how to access those services as specified in AMPM Policy 1040. The Contractor shall provide outreach and dissemination of information to the general public and other human service providers, including but not limited to, county and State governments, school administrators, first responders, teachers, those providing services for military veterans and other interested parties about the availability and accessibility of services, and coordinate with AHCCCS in promoting its outreach initiatives.

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

23. GRIEVANCE AND APPEAL SYSTEM

The Contractor shall have in place a written Title XIX/XXI Grievance and Appeal System process for members who are Title XIX/XXI eligible, subcontractors, and providers, which defines their rights regarding disputed matters with the Contractor. The Contractor's Grievance and Appeal System for members includes a grievance process (the procedures for addressing member grievances), an appeals process, and access to the State's fair hearing process as specified in Section F, Attachment F1, Member Grievance and Appeal System Standards.

The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as specified in Section F, Attachment F2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Section F, Attachment F1, Member Grievance and Appeal System Standards, Section F, Attachment F2, Provider Claim Dispute Standards, 42 CFR Part 438 Subpart F and any other requirements related to the Grievance and Appeal System under Federal, State or local law, statute, ordinance, rule, regulation, or court decree.

The Contractor may delegate the Grievance and Appeal System process to Administrative Services Subcontractors; however, the Contractor shall 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. The Contractor shall remain responsible for compliance with all requirements. The Contractor is not permitted to delegate the Grievance and Appeal System requirements to its providers.

Information to members shall meet cultural competency and LEP requirements as specified in Section D, Paragraph 18, Member Information and Section D, Paragraph63, Cultural Competency.

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

The Contractor shall indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including, but not limited to, attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, lawsuits challenging the Contractor's failure to conform to any requirements related to the Grievance and Appeal System under Federal, State, or local law, statute, ordinance, rule, regulation, or court decree.

The Contractor shall also ensure that it timely provides written information to both members and providers, which clearly explains the Grievance and Appeal System requirements.

This information shall include:

1. The right to a State fair hearing, the method for obtaining a State fair hearing.

2. The Rules that govern representation at the hearing.

3. The right to file grievances, appeals and claim disputes.

4. The requirements and timeframes for filing grievances, appeals and claim disputes.

5. The availability of assistance in the filing process.

6. The toll-free numbers that the member can use to file a grievance or appeal by phone.

7. That benefits will continue when requested by the member in an appeal or State fair hearing request concerning certain actions which are timely filed.

8. That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the member.

9. That a provider may file an appeal on behalf of a member with the member's written consent.

The future enrollment of a Contractor's member to another Contractor and/or the member's subsequent loss of AHCCCS eligibility are not valid reasons to deny or limit a member's service authorization request submitted to the Contractor during the time period in which the member was enrolled with that Contractor. Contractors shall not take the position during the grievance and appeals process that a former member's subsequent enrollment with another Contractor or that member's subsequent loss of AHCCCS eligibility are valid reasons for the Prior Contractor to deny or dismiss an appeal of the adverse benefit determination if the member submitted the service authorization request to the Prior Contractor during a period of enrollment with the Prior Contractor. The Prior Contractor is required to substantiate that the denial or reduction of the service authorization request is based upon medical necessity, the exclusion of the service from the scope of AHCCCS covered services, and/or cost effectiveness. If the authorization decision of the Prior Contractor is overturned on appeal, the Prior Contractor is financially responsible for coverage of those services notwithstanding the member's subsequent enrollment with a different Contractor or the member's subsequent loss of AHCCCS eligibility.

The Contractor shall provide reports on the Grievance and Appeal System as specified in the AHCCCS Grievance and Appeal System Reporting Guide and Section F, Attachment F3, Contractor Chart of Deliverables.

In addition to the above Title XIX/XXI Grievance and Appeal System processes, the Contractor is also required to adhere to the SMI Grievance and Appeal System requirements specified below.

Grievance and Appeal Process for Members with Serious Mental Illness Designation: The following applies to members who have been designated as Seriously Mentally Ill (refer to A.R.S. § 36-550(4):

The Contractor shall implement grievance and appeal processes as described in Arizona Administrative Code Title 9, Chapter 21, Article 4 for members with a SMI designation, hereinafter "the SMI grievance and appeal processes." The Contractor shall ensure that the SMI grievance and appeal processes comply with all applicable requirements in Arizona State laws and administrative regulations including the ACOM, AMPM, A.A.C. Title 9, Chapter 21, Article 4, and the requirements specified in this Contract.

The Contractor's SMI grievance and appeal department and personnel shall be available to members and other stakeholders via a published, direct telephone number or by a telephone prompt on the Contractor's primary messaging system.

The Contractor shall provide written notification of the Contractor's SMI grievance and appeal processes to all subcontractors and providers at the time of entering into a subcontract or other agreement with a provider. The Contractor shall provide written notification with information about the Contractor's SMI grievance and appeal processes to members in its Member Handbook. The Contractor shall provide

written notification to members at least 30 days prior to the effective date of a change in any part of a SMI grievance or appeal policy.

The Contractor shall administer all of the SMI grievance and appeal processes competently, expeditiously, and equitably for all members, subcontractors, and providers to ensure that SMI grievances and SMI appeals are efficiently and effectively adjudicated and/or resolved. The Contractor shall not engage in conduct to prohibit, discourage, or interfere with a member's right to assert an SMI grievance or SMI appeal.

The Contractor shall regularly review data regarding SMI grievances and SMI appeals to identify trends and opportunities for system improvement, take action to correct identified deficiencies, and otherwise implement modifications which improve SMI grievance and SMI appeal operations and efficiency. The Contractor shall regularly review SMI grievance and SMI appeal data to identify members who utilize SMI grievance and SMI appeal processes at a significantly higher rate than other members and shall take appropriate clinical interventions where appropriate.

The Contractor shall provide all professional, paraprofessional, and clerical/administrative resources to represent the Contractor's in any of its SMI cases that rise to the level of an administrative or judicial hearing or proceeding. Absent written agreement to the contrary, the Contractor shall be responsible for payment of attorney fees and costs awarded to a claimant in any administrative or judicial proceeding. The Contractor shall:

1. Upon request from and within the time specified by AHCCCS, provide any SMI grievance and/or SMI appeal information, report, or document.

2. Fully cooperate with AHCCCS in the event AHCCCS decides to intervene in, participate in, or reviews any Notice, SMI grievance, or SMI appeal process or proceeding.

3. Comply with and/or implement any AHCCCS directive within the time specified pending formal resolution of the issue.

4. At all relevant times take into consideration the best clinical interests of the member when addressing provider or member SMI grievance and/or SMI appeal related concerns.

Appeals for Members with Serious Mental Illness: An SMI Appeal is an appeal filed pursuant to the provisions of Arizona Administrative Code (A.A.C.) R9-21-401 et seq. regarding decisions pertaining to behavioral health services for SMI members (or to eligibility decisions for those members seeking to become SMI eligible), including fees and waivers; assessments and further evaluations; service and treatment plans and planning decisions; and the implementation of those decisions. The SMI Appeals process may be utilized only by those members who already have an SMI designation or who are seeking to become SMI eligible. It is important to note that a person designated as SMI who is also Title XIX/XXI eligible may appeal an adverse benefit determination (defined under 42 CFR 438.400 to include the denial or limited authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; and/or the failure to provide a service in a timely manner) under either the SMI Appeals process or the Title XIX/XXI appeal process.

The SMI appeals process is a mediated process consisting of one or more appeal conferences at which the parties to the appeal discuss the appeal and seek a mediated resolution. If resolution is not achieved, the appellant may request an administrative hearing to decide the issue on appeal. The Contractor shall require all staff facilitating SMI Appeal conferences to have training in mediation, conflict resolution, or problem-solving techniques. Refer to A.A.C. R9-21-401 et seq. for further detail.

Grievances for Members with a Serious Mental Illness Designation: An SMI Grievance is an allegation of a rights violation against a member with an SMI Determination relating to the provision of behavioral health services by a mental health agency, pursuant to A.A.C. R9-21-201 et seq. and A.A.C. R9-21-403 et seq. Anyone may file an SMI Grievance, but this process is limited to allegations of rights violations by a mental health agency against an SMI member relating to behavioral health services only. An SMI Grievance for the purposes of this paragraph is not the same as a Title XIX/XXI member grievance as specified in 42 CFR Part 438 subpart F which is defined as a member's expression of dissatisfaction with any matter, other than an adverse benefit determination, and may also be referred to as a complaint. A member designated SMI may file both an SMI Grievance and a complaint about any issue and shall not be required to exhaust the complaint process prior to filing an SMI Grievance.

The Contractor shall require investigators who conduct SMI Grievance investigations to be certified by the Council on Licensure, Enforcement, and Regulation (CLEAR) or by an equivalent certification program identified by the Contractor, which shall be submitted to AHCCCS for prior approval.

The Contractor shall submit an SMI Grievance and Appeal Report as specified in Section F, Attachment F3, of the Contractor Chart of Deliverables.

The Contractor is responsible for responding to requests from the AHCCCS Clinical Issue Resolution Unit involving member complaints, concerns, and issues brought to AHCCCS' attention by AHCCCS members, family members, providers, and other concerned parties. Upon request, the Contractor shall provide the Clinical Resolution Unit with a written summary that describes the steps taken to resolve the issue, including findings, the resolution, and if indicated, a need for corrections. The Contractor shall acknowledge receipt of an issue referral expeditiously and according to the urgency and response timeframe identified by the AHCCCS/DHCS, Clinical Resolution Unit as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

24. MATERNITY CARE PROVIDER REQUIREMENTS

The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with AMPM Chapter 400.

The following are provider types who may provide maternity care when it is within their training and scope of practice:

1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers.

2. Practitioners:
   a. Physician Assistants,
   b. Nurse Practitioners, and
   c. Certified Nurse Midwives.

3. Licensed Midwives.

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife shall also be assigned to a PCP for other health care and

medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Per AMPM Policy 410 labor and delivery services rendered through Free Standing Birthing Centers shall be provided by a physician or by a certified nurse midwife who has hospital admitting privileges for labor and delivery services, or a licensed midwife who is following licensing and practice requirements as specified in A.A.C. R9-16-111 through 113 Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, certified nurse midwives, and licensed midwives who include such services within their practice. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, certified nurse midwives, and licensed midwives who include such services within their practice.

25. MEMBER COUNCILS

To promote a collaborative effort to enhance the integrated service delivery system (physical health, behavioral health and LTSS) in local communities while maintaining a member focus, the Contractor shall establish an ALTCS Member Council that participates in providing input on policy and programs [42 CFR 438.110(a)]. The Contractor shall establish at least one ALTCS Member Council in each GSA. However, the Contractor should consider expanding its ALTCS Member Council structure to establish a Council by County or Counties rather than GSA in order to ensure Council participation in consideration of County population, travel requirements, and/or unique community needs.

Every effort shall be made to include a cross representation of ALTCS members and families/representatives, member advocacy groups and providers that reflect the population and community served. The ALTCS Member Council should consist of at least 10 Council members.

ALTCS members and families/representatives and member advocacy groups shall make up at least 50**%** of the membership. The Contractor shall assist in recruiting an ALTCS E/PD member of the Council who will serve on the AHCCCS ALTCS Advisory Council [42 CFR 438.110(b)].

The Contractor shall provide council members with orientation and ongoing training that includes sufficient information and ensures understanding of Council member responsibilities. The Council shall be chaired by the Contractor's Administrator/CEO or designee and will meet at least quarterly with a quorum of members in attendance when Council recommendations or approvals are required. Council agendas and meeting minutes shall be provided to the Contractor's Executive Management Committee to address issues and opportunities for improvements to the integrated service delivery system.

The Contractor shall submit an ALTCS Member Council Plan to AHCCCS/DHCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The ALTCS Member Council Plan shall include:

1. Justification for Council by GSA/County(ies).

2. Meeting schedule.

3. Membership.

4. Trainings.

5. Goals and objectives.

6. An evaluation of the prior year's plan.

All ALTCS Member Council agendas, meeting minutes, and list of attendees shall be submitted to AHCCCS upon request.

AHCCCS may require the Contractor to pursue additional stakeholder engagement processes to address design, implementation, and oversight of the AHCCCS Long Term Care program [42 CFR 438.70].

26. STAFFING REQUIREMENTS

The Contractor shall have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all Contract requirements. For the purposes of this Contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610, 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The Contractor is obligated to screen employees and subcontractors to determine whether they have been excluded from participation in Federal health care programs, as specified in Section D, Paragraph 64, Corporate Compliance.

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

The Contractor shall have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies such as ADHS/Bureau of Medical Facilities on urgent issue resolutions. Urgent issue resolutions include IJ, fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, ability to initiate new placements/services, and have the availability to perform status checks at affected facilities and perform ongoing monitoring, if necessary. Additionally, the Contractor shall have processes in place to assure limited member disruption of care/services in the case of an emergency; examples include but are not limited to mechanisms for service authorization and/or pharmacy overrides and transportation to support evacuation efforts. The Contractor shall provide contact information, for primary and back-up staff members who will handle Urgent Issue Resolution (non-business hours) with its annual Key Staff deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. AHCCCS/DHCS, OCO shall be notified and provided with back up contact information when the primary contact individual will be unavailable, or when the primary contact information changes.

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

A staff member is prohibited from occupying more than two positions, regardless of whether the staff member occupies two positions within a single LOB or one position across two lines of business (including non-AHCCCS LOBs) unless prior approval is obtained by AHCCCS. The following Staff positions are exempt from this limitation:

1. Chief Financial Officer (CFO).
2. Communications/Public Administrator.
3. Continuity of Operations and Recovery Coordinator.
4. Contract Compliance Officer *(Only when the individual staff person filling this position does not also hold the Corporate Compliance Officer position)*.
5. Credentialing Coordinator.
6. Cultural Competency Coordinator.
7. Dental Director.
8. DES/Adult Protective Services (APS) Liaison.
9. Encounter Manager.
10. Information Systems Administrator.
11. Justice System Liaison.
12. Medical Management (MM) Program Behavioral Healthcare Practitioner.
13. Member Services Manager.
14. Management Services Agreement (MSA) Administrator.
15. Network Administrator.
16. Provider Claims Educator.
17. Provider Services Manager.
18. Quality Improvement (QI) Program Behavioral Healthcare Practitioner.
19. Transplant Coordinator.
20. Work Force Development (WFD) Administrator.

21. The Administrator/CEO is limited to holding one position which is either:
    a. The Administrator/CEO of the ALTCS E/PD LOB, or
    b. The Administrator/CEO of the ALTCS E/PD and Medicare Dual Eligible-Special Needs Plan (D-SNP) LOB. Otherwise, the Administrator/CEO is prohibited from holding any other position in any other LOB.

22. The QM Manager is limited to holding one position for the ALTCS EPD LOB. The QM Manager is prohibited from holding any other position in any other LOB.

23. AHCCCS prohibits the Corporate Compliance Officer from holding any other position other than the Contract Compliance Officer position.

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

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

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

AHCCCS has the discretion to review all submitted Key Staff positions and reserves the right to direct Contractor actions regarding staffing decisions it deems are in the best interest of the State. AHCCCS will not permit any Contractor staff to hold positions which may present a conflict of interest.

At a minimum, the following staff is required:

Key Staff Positions

1. **Administrator/CEO** who is located in Arizona and shall directly oversee the entire operation of the Contractor on a day-to-day basis, including actively directing and prioritizing work and operations of the organization, regardless of where that work is performed or the site of operations. The Contractor's Administrator/CEO is accountable to AHCCCS for compliance with the requirements and obligations under this Contract.

2. **Behavioral Health Coordinator** who is a BHP as specified in Health Services Rule, A.A.C. R9-10-101, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are met, including but not limited to coordination of behavioral health care and physical health care between all providers, review network to reduce out-of-State placements, active involvement in out-of-State placements. This position shall also serve as the Liaison for children in DCS custody.

3. **Case Management Administrator/Manager** who is an Arizona licensed RN in good standing with a minimum of three years of management experience or a SW with a minimum of three years of

management experience; or who has a degree in psychology, special education, or counseling, with a minimum of three years of case management experience and three years of management experience. The Case Management Administrator/Manager shall be located in Arizona to oversee all functions of case management.

4. **Chief Financial Officer (CFO)** who is responsible for oversight of the budget, accounting systems and financial reporting requirements.

5. **Chief Medical Officer (CMO)/Medical Director** who is located in Arizona and who is an Arizona-licensed physician in good standing. The CMO/Medical Director shall actively provide oversight and management of the QM, QI, and MM Programs. The CMO/Medical Director shall not hold any other position other than the QM Program Behavioral Health Practitioner and/or the MM Program Behavioral Health Practitioner.

6. **Claims Administrator** who shall ensure prompt and accurate provider claims processing. Sufficient staffing under this position shall be in place to ensure the timely and accurate processing of original claims, resubmissions, and overall adjudication of claims. The primary functions of the Claims Administrator are:
   a. Develop and implement claims processing systems capable of paying claims in accordance with Federal and State requirements,
   b. Develop processes for cost avoidance,
   c. Ensure minimization of claims recoupments, and
   d. Ensure claims processing timelines are met.

7. **Communications Administrator** who is responsible for media inquiries, public relations, policy development, and implementation and oversight of all social networking and marketing activities.

8. **Continuity of Operations and Recovery Coordinator** who is located in Arizona and is responsible for the coordination and implementation of the Contractor's Continuity of Operations and Recovery Plan, and training and testing of the Plan, as specified in ACOM Policy 104.

9. **Corporate Compliance Officer** who is located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS/OIG. Refer to Section D, Paragraph 64, Corporate Compliance. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position.

10. **Cultural Competency Coordinator** who is responsible for implementation and oversight of the Contractor's Cultural Competency Program and the Cultural Competency Plan.

11. **Contract Compliance Officer** who is located in Arizona and who serves as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer include, but are not limited to, coordination of the tracking and submission of all Contract deliverables, fielding and coordinating responses to AHCCCS inquiries, coordinating the preparation and execution of Contract requirements such as ORs, random and periodic audits and ad hoc visits**.**

12. **Credentialing Coordinator** who is located in Arizona and who has appropriate education and/or experience to effectively complete all requirements of the position. The primary functions of the Credentialing Coordinator are:
   a. Serve as the single point of contact to AHCCCS for credentialing-related questions and concerns,

b. Responsible for timely and accurate completion of all credentialing-related deliverables,
c. Ensure all credentialing requirements, including timeframes, are adhered to by the Contractor, and
d. Provide a detailed, transparent description of the credentialing process to providers and serve as the single point of contact for the Contractor to address provider questions about the credentialing process.

13. **Dental Director** who is located in Arizona, is an Arizona licensed general or pediatric dentist in good standing, and who is responsible for leading and coordinating the dental activities of the Contractor including review and denial of dental services, provider consultation, utilization review, and participation in tracking and trending of QOC concerns as related to dental services. The Dental Director may be an employee or subcontractor of the Contractor but may not be from the Contractor's delegated dental subcontractor.

14. **Dispute and Appeal Manager** who is located in Arizona, is responsible for managing Grievance and Appeal System processes and for forwarding all requests for hearing to AHCCCS/Office of the General Counsel (OGC) with the required information. This individual shall collaborate with AHCCCS to address provider or member SMI grievance and SMI appeal process concerns. This qualified individual shall collect necessary information, consult with the member's treatment team and consult with the Contractor's Medical Director/CMO or a care manager for clinical recommendations when applicable, develop communication strategies in accordance with confidentiality laws, and develop a written plan to address and resolve the concern, to be approved by AHCCCS prior to implementation. Any staff reporting to this position who manage and adjudicate disputes and appeals shall also be located in Arizona.

15. **Encounter Manager** who shall ensure AHCCCS encounter reporting requirements are met. Sufficient staffing under this position shall be in place to ensure timely and accurate processing and submission of encounter data and reports to AHCCCS.

16. **EPSDT Coordinator** who is located in Arizona and who is an Arizona licensed nurse, physician or physician's assistant in good standing; or has a master's degree in health services, public health, health care administration or other related field, and/or a Certified Professional in Healthcare Quality (CPHQ) or Certified in Health Care Quality and Management (CHCQM) certification. Staff reporting to this position shall be appropriate to meet the AHCCCS Maternal and Child Health (MCH)/EPSDT contractual and policy requirements, and quality and performance measure goals, and shall be located in Arizona. EPSDT staff shall either report directly to the EPSDT Coordinator or the EPSDT Coordinator shall have the ability to ensure that AHCCCS EPSDT requirements are met. The EPSDT Coordinator may also serve as the MCH Coordinator.

    The primary functions of the EPSDT Coordinator are:
    a. Ensure receipt of EPSDT services,
    b. Promote preventive health strategies,
    c. Promote access to oral health care services,
    d. Identify and coordinate assistance for identified member needs, and
    e. Interface with community partners.

17. **Information Systems Administrator** who is responsible for IS management including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all data and data exchange elements. Sufficient staffing reporting to this position shall be in place to ensure timely and accurate ISs management to meet system and data exchange requirements.

18. **Justice System Liaison** who is located in Arizona and is the single point of contact for justice system stakeholders (e.g., jails/prisons/detention facilities, courts, law enforcement, and community supervision agencies). This position is responsible for ensuring care coordination of justice-involved members and for oversight and reporting of Justice System Reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system. This includes, but is not limited to, sequential intercept modeling, crisis system utilization, specialty court programs (e.g., opioid/drug, mental health, homeless, domestic violence, and veteran's courts), and conducting outreach and specialized training to local law enforcement accommodating, interacting, and communicating with individuals who, due to the nature of their condition, may have an atypical response to law enforcement including individuals who are elderly and/or individuals with intellectual and developmental disabilities.

19. **Management Services Agreement Administrator** who is responsible for oversight of the MSA subcontractor and who is the Contractor's Key Contact for AHCCCS coordination and who is not employed by the MSA. This position is only required when the Contractor operates under a subcontract with an MSA.

20. **Maternal Child Health Coordinator** who is located in Arizona and is an Arizona licensed nurse, physician, or physician's assistant in good standing, or who has a master's degree in health services, public health, or health care administration or other related field and/or a Certified Professional in Healthcare Quality (CPHQ) or Certified Professional in Healthcare Quality Management (CHCQM) certification. Staff reporting to this position shall be appropriate to meet the AHCCCS MCH contractual and policy requirements, and quality and performance measure goals, and shall be located in Arizona. MCH staff shall either report directly to the MCH Coordinator or the MCH Coordinator shall have the ability to ensure that AHCCCS MCH requirements are met. The MCH Coordinator may also serve as the EPSDT Coordinator.

    The primary functions of the MCH/EPSDT Coordinator are:
    a. Ensure receipt of maternal and postpartum care,
    b. Promote family planning services,
    c. Promote preventive health strategies,
    d. Promote access to oral health care services,
    e. Identify and coordinate assistance for identified member needs, and
    f. Interface with community partners.

21. **Medical Management Manager** who is located in Arizona and is an RN, physician, or physician's assistant in good standing. This position manages all MM requirements under AHCCCS policies, State regulations and Contract, including but not limited to: application of appropriate medical necessity criteria, concurrent review, discharge planning, care coordination, disease/chronic care management, and PA functions, care management functions, monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services, and monitor PA functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards. MM shall have sufficient local staff reporting to this position with appropriate physical and behavioral health knowledge and expertise to support whole-person health and to comply with AHCCCS MM contractual and policy requirements.

22. **Member Services Manager** who is located in Arizona and who coordinates communications with members, coordinates issues with appropriate areas within the organization, resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times.

23. **Network Administrator** who is located in Arizona and who manages and oversees network development, network sufficiency, and network reporting functions. This position ensures network adequacy and appointment access, develops network resources in response to identified unmet needs, and ensures a member's choice of providers.

24. **Performance/QI Manager** who is located in Arizona, has a direct reporting relationship (or direct hierarchical reporting relationship) to the Contractor's CMO/Medical Director and:
    a. Is a CPHQ through the National Association for Health Care Quality (NAHQ),
    b. Is CHCQM through the American Board of Quality Assurance and Utilization Review Physicians, or
    c. Has comparable education and experience in health plan data and outcomes measurement.

    The Performance/QI Manager is responsible for QI activities as well as staff conducting QI work as outlined in Contract and policy. Staff reporting to this position shall be located in Arizona, have knowledge of both physical and behavioral health service delivery, and be appropriately qualified (education/certification/ professional experience) to meet the AHCCCS QI contractual and policy requirements. The Performance/QI Manager shall not hold any other position other than the Performance/QI Manager position but is able to oversee multiple LOB should the Contractor hold multiple Contracts.

    The primary functions of the Performance/QI Manager are:
    a. Focus organizational efforts on improving quality measure performance,
    b. Develop and implement PIPs and QI related CAPs,
    c. Utilize data to develop interventions/strategies to improve quality outcomes and member satisfaction, and
    d. Report QI/performance outcomes.

25. **Pharmacy Coordinator/Pharmacy Director** who is an Arizona licensed pharmacist or physician in good standing, who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or subcontractor of the Contractor.

26. **Provider Claims Educator** who is located in Arizona and who facilitates the exchange of information between the grievances, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator are:
    a. Educate contracted and non-contracted providers (professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer,
    b. Educate contracted and non-contracted providers on available Contractor resources such as provider manuals, website, fee schedules, etc.,
    c. Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls,
    d. Identify trends and guide the development and implementation of strategies to improve provider satisfaction, and
    e. Frequently communicate with providers, including conducting on-site visits, to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.

27. **Provider Services Manager** who is located in Arizona and coordinates communications between the Contractor and providers. This position ensures that providers receive prompt resolution to their problems and inquiries and appropriate education about participation in the AHCCCS Program. Sufficient local staffing under this position shall be in place to ensure providers receive assistance and appropriate and prompt responses. Refer to Section D, Paragraph 29, Network Management.

28. **Quality Management Manager** who is located in Arizona, and an Arizona-licensed RN, physician or physician's assistant in good standing or is a CPHQ by the NAHQ and/or CHCQM by the American Board of Quality Assurance and Utilization Review Providers. The QM Manager shall have experience in QM and clinical investigations. QM shall have sufficient local staffing who are licensed clinical or BHP, to meet the requirements of the QM program. The QM Manager shall have a direct reporting relationship to the Contractor's CMO/Medical Director. The QM Manager shall not hold any other position other than the QM Manager position but is able to oversee multiple lines of business should the Contractor hold multiple Contracts. QM shall have sufficient local staffing who are licensed clinical or behavioral health professionals to meet the requirements of the QM program. Staff shall report directly to the QM Manager.

    The primary functions of the QM Manager position are:
    a. Ensure individual and systemic QOC,
    b. Conduct comprehensive quality-of-care investigations,
    c. Conduct onsite quality management visits/reviews ,
    d. Conduct Care Needed Today/IJ investigations,
    e. Integrate quality throughout the organization,
    f. Implement QI as it pertains to QM related focus areas, and
    g. Resolve, track, and trend QOC grievances.

29. **Transition Coordinator** who is a health care professional or who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all member transition issues, responsibilities, and activities. The Transition Coordinator shall ensure safe, timely, and orderly member transitions. Refer to ACOM Policy 402.

30. **Transplant Coordinator** who is an Arizona licensed RN in good standing and who is responsible for the timely review and authorization of transplant services in accordance with AHCCCS policy and State regulations. Refer to AMPM Policy 310-DD.

31. **Workforce Development Administrator** who is responsible for coordinating and overseeing contractually required WFD activities. The WFD Administrator shall have a professional background, authorities, and ongoing training and development needed to lead the Workforce Development Operation (WFDO) as specified in Contract. These elements include but are not limited to the following:
    a. Experience in workforce recruitment, selection, training and development, deployment, and retention,
    b. Experience and or training in WFD functions such as workforce forecasting, assessment, planning, and the provision of technical assistance in WFD matters, and
    c. If not ordinarily required by the Contractor, the WFD Administrator, shall have a Professional Development Plan containing workforce related training and development objectives. All personnel directly reporting to the WFD Administrator having WFD roles (e.g., training managers, coordinators, specialists) shall have a Professional Development Plan.

Additional Required Staff:

31. **Case Managers** who are Arizona licensed RNs in good standing, SWs, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of case management experience management experience definition; or individuals with a minimum of two years' experience in providing case management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or individuals with an SED or SMI designation.

    For case managers who will serve individuals who are elderly and/or individuals with physical or developmental disabilities and with an SED or SMI designation, the requirement is as follows (Refer to AMPM Policy 1630):
    a. One year of case management experience serving elderly and/or persons with physical or developmental disabilities, and
    b. Two years of case management experience serving members determined to have an SMI.

    Case managers shall be sufficient in numbers and located in Arizona to perform assessment and care planning services for all enrolled members.

32. **Case Management Supervisor(s)** who is an Arizona licensed RN in good standing or a SW with a minimum of three years of case management experience; or who has a degree in psychology, special education, or counseling, with a minimum of three years of case management experience and three years of management experience. The Case Management Supervisor shall be located in Arizona to oversee case management staff. AHCCCS will permit Case Managers being promoted to Case Management Supervisors to have a degree in a similar or related field with discretion given to the Contractor to make this determination, as long as the Case Managers also meet the necessary experience required.

33. **Concurrent Review staff** who conducts inpatient medical necessity reviews. This staff shall include but is not limited to Arizona-licensed nurses and/or Arizona-licensed BHPs in good standing. The staff will work under the direction of an Arizona-licensed physician.

34. **DES/APS Liaison** who is responsible for coordinating with DES/APS for adult members. The Contractor shall provide the contact information for this staff position with the Key Staff deliverables, as outlined below, and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

35. **Employment Staff** designated as the subject matter expert on employment supports, services, and resources within the Contractor's service area. The staff designated as the employment expert shall be available to assist providers with up-to-date information designed to aid members in making informed decisions about employment, including but not limited to ADES/RSA and ARIZONA@WORK. Employment staff are responsible for providing technical assistance to Case Managers to support availability and access to employment service for members and overseeing the Contractor's adherence to the AMPM Policy 1240-J. Furthermore, this individual is responsible for educating Case Managers on how to incorporate the Arizona Disability Benefits 101 resource tool into personal goal development planning discussions with members and developing and implementing strategies to educate members on the resource tool. The Contractor shall attend ad hoc technical assistance meetings for the purpose of enhancing program delivery to increase successful employment outcomes for members.

36. **Housing Specialist** designated as the subject matter expert(s) on the provision of housing and housing resources to members within the Contractor's service area. Refer to Section D, Paragraph 17, Case Management. The Contractor shall ensure that it has a designated staff person(s) as a Housing Specialist. The Housing Specialist is required to reside in Arizona within the Contractor's assigned GSA. The Housing Specialist is an expert(s) on PSH and resources within the Contractor's service area. The Housing Specialist may be designated as the expert in other areas as well as housing, but they shall be clearly identified and function as the Housing Specialist. While the Contractor shall have at least one designated Housing Specialist, the Contractor shall have sufficient dedicated housing staffing reporting to the Housing Specialist to ensure there is coverage in each GSA the MCO operates out of, and based on a formula to ensure there is coverage based on size and member enrollment numbers in order to adequately meet contractual and policy housing service requirements. Key duties of the Housing Specialist include:
    a. Assist provider network's support staff (e.g., case managers) with up-to-date information designed to aid members in making informed decisions about and accessing their independent living housing options including AHCCCS Non-Title Housing Programs (e.g., scattered site vouchers, Community Living Programs), mainstream housing subsidy programs (e.g., HUD Housing Choice Vouchers, local Public Housing Authority Programs); and market rate housing options,
    b. Provide education and training to providers and support staff on supportive housing and evidence-based practices related to housing services,
    c. Supporting case managers and network support staff with identifying members with housing needs, making appropriate housing referrals to AHCCCS Housing Programs mainstream supportive housing programs and other housing resources for individuals with housing needs,
    d. Assisting members and case managers to support transition or post-transition activities including, but not limited to, requests and referrals, assistance with eligibility documentation and verification, transition wait times, transition barriers and special needs/accommodations, rent amount, monthly income amounts, location of housing options chosen, and counties chosen for transition,
    e. As specified in the Network Development and Management Plan, the Contractor shall report annually on the status of any affordable housing networking strategies and innovative practices/initiatives it elects to implement,
    f. Act as the Contractor's liaison to the quarterly AHCCCS Quarterly Housing Meeting led by the AHCCCS Director of Housing as well as other ad hoc AHCCCS Housing Workgroups and initiatives,
    g. Serve as the Contractor's liaison to local HUD approved CoC for the Contractor's service area. The Housing Specialist or the Housing Specialist's designee shall attend appropriate CoC meetings, participate in CoC coordinated entry and HMIS systems, and assist CoC in identifying, engaging, and securing appropriate housing and services for members experiencing homelessness,
    h. Advocate, plan, and coordinate with provider supportive services to ensure members in independent, AHCCCS, and mainstream subsidized supportive housing programs, receive appropriate services to maintain their housing, and
    i. The Housing Specialist is responsible for identifying housing resources and building relationships with contracted Housing Providers and mainstream public housing authorities for the purposes of developing innovative practices to expand housing options, assisting, and coordinating. This may include assisting providers in identifying and applying for AHCCCS SMI Housing Trust Fund projects.

    The Contractor shall ensure Housing Specialists are familiar with the following standards and practices related to Permanent Supportive Housing, including but not limited to:

    a. Federal Fair Housing, Equal Opportunity, Non-Discrimination and other Federal and State Housing laws Fair housing,
    b. The Arizona Residential Landlord Tenant Act (ARLTA),

c. Use of the needs assessment tools such as Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), Level of Care Utilization System (LOCUS), or other housing assessment and/or housing prioritization tools in the Housing Specialist's service area,
d. Fundamentals of Housing First and the SAMHSA Permanent SHP, and
e. Current and emerging tools and best practices in permanent supportive housing and services.

37. **Legal Counsel,** including both in-house and outside (as applicable) Legal Counsel, who are responsible for providing legal advice to, and/or representation of~~,~~ the Contractor for any matters that may arise related to this Contract. The Contractor shall provide the contact information for outside counsel and other related documentation regarding in-house counsel with the Key Staff deliverables, as specified below, and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

38. **Medical Management Program Behavioral Healthcare Practitioner** who reviews any behavioral healthcare denials of care based on medical necessity and advises or participates on the behavioral health aspects in the MM Committee. The MM Program Behavioral Healthcare Practitioner shall be a medical doctor or have a clinical Doctor of Philosophy or Doctor of Psychology degree; the MM Healthcare Practitioner may be a staff person within the Contractor's organization such as a participating practitioner, or a behavioral healthcare delegate but, must meet the aforementioned credentials.

39. **Prior Authorization staff** to authorize health care services. This staff shall include but is not limited to Arizona-licensed nurses and/or Arizona- licensed BHPs in good standing. The staff will work under the direction of an Arizona-licensed physician.

40. **Quality Improvement Program Behavioral Healthcare Practitioner** who advises or participates in the QM/PI Committee, or a behavioral healthcare subcommittee reporting to the QM/PI Committee. The QI Program Behavioral Healthcare Practitioner shall be a medical doctor or have a clinical Doctor of Philosophy or Doctor of Psychology degree; the QI Program Behavioral Healthcare Practitioner may be a staff person within the Contractor's organization such as a participating practitioner, or a behavioral healthcare delegate, but must meet the aforementioned credentials.

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

1. An organization chart with the Key Staff positions. The chart shall include the person's name, title, location, and portion of time allocated to each Medicaid Contract and other non-Medicaid lines of business.

2. A functional organization chart of the key program areas, responsibilities, and reporting lines.

3. A listing of all Key Staff to include the following:
   a. Individual's name,
   b. Individual's title,
   c. Individual's telephone number,
   d. Individual's email address,
   e. Individual's location(s),
   f. Documentation confirming applicable Key Staff functions are filled by individuals who are in good standing (for example, a printout from the Arizona Medical Board web page showing the CMO's active license), and
   g. A list of all Key Staff functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past Contract year.

4. An attestation adhering to staffing requirements/limitations for all staff.

The Contractor is responsible for maintaining a significant local presence within the State of Arizona.

Positions performing functions related to this Contract shall have a direct reporting relationship to the local Administrator/CEO. The local Administrator/CEO shall have the authority to direct, implement and prioritize work to ensure compliance with Contractor requirements. The local Administrator/CEO shall have the authority and ability to prioritize and direct work performed by the Contractor staff and work performed under this Contract through a management service agreement or through a delegated agreement.

Staff Training and Meeting Attendance: The Contractor shall ensure that all staff, whether employed or under contract, have appropriate training, education, experience, orientation, and credentials, as applicable, to perform assigned job duties and fulfill the requirements of the Contract.

The Contractor shall provide initial and ongoing staff training that includes an overview of AHCCCS, AHCCCS Policy and Procedure Manuals, Contract requirements, and Federal and State requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of QOC/service concerns. The Contractor shall ensure that procedures are developed, which include scripts that guide staff through the process of addressing QOC and/or service concerns. These procedures may include, but are not limited to:

1. Internal subject matter experts that can address member concerns.

2. Available resources (e.g., stakeholder resources, Contractor webpages) that can assist members to know what services are available, how to access available services and where they are available.

3. How to file complaints regarding quality or service concerns.

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

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

Contractor personnel who investigate alleged incidents in ICF/IIDs, Skilled Nursing Facilities (SNFs), ALFs, and GHs are required to receive training on how to conduct required investigations and on the specific special needs of individuals with Intellectual and Developmental Disabilities (I/DD). Per ACOM Policy 407 the Contractor is required to work collaboratively with other Contractors to select, develop (or adapt), and implement a single training program for investigators that complies with the requirements set forth by AHCCCS. AHCCCS reserves the right to audit these processes at any time, including during OR of the Contractor. [Refer to the Report of the Abuse & Neglect Prevention Task Force to Governor Douglas A. Ducey (November 1, 2019) developed in response to Executive Order 2019-03].

Suicide Prevention: The Contractor shall require its staff who have direct contact with members (e.g., Contractor case and care managers, customer/member service staff) to be trained in identification of suicide risk using nationally recognized training materials (e.g., SafeTalk) within 90 days from the start of employment.

27. WRITTEN POLICIES AND PROCEDURES

The Contractor shall develop and maintain written policies and procedures for each functional area, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing, and approving all policies and procedures. All policies and procedures shall be reviewed by the Contractor at least annually to ensure that the Contractor's written policies reflect current practices. All medical and QM policies shall be approved and signed by the Contractor's CMO/Medical Director. All other policies shall be dated and signed by the Contractor's Administrator or appropriate executive officer, or minutes shall be held on file reflecting the review and approval of the policies by an appropriate committee, chaired by the Contractor's Administrator/CEO, CMO/Medical Director or CFO.

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

28. NETWORK DEVELOPMENT

The provider network shall be a foundation that supports an individual member's needs as well as the membership as a whole.

The Contractor shall develop, maintain, and monitor a comprehensive provider network that is diverse and supports the unique needs of the AHCCCS members. The Contractor's network shall be supported by written agreements which are sufficient to provide all covered services to AHCCCS members, including those with LEP or physical or cognitive disabilities [42 CFR 438.206(b)(1)]. The network shall include in-home care services and Alternative HCBS Settings.

The Contractor shall ensure covered services are accessible in terms of location and hours of operation as required by AHCCCS Network requirements. The Contractor shall provide a comprehensive provider network that ensures its membership has access at least equal to community standards [42 CFR 438.206(b)(1)]. Priority shall be placed on allowing members to live in the most integrated and least restrictive setting and ensuring members have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

Regardless of the setting, the Contractor shall develop and implement organizational structures and procedures that promote collaboration and consultation among multi-specialty treatment team members and community providers.

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

1. Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (NF, ALFs and at home) including the ALTCS Guiding Principles as specified in Section D, Paragraph 1, Purpose, Applicability, and Introduction:
   a. Member-Centered Case Management,
   b. Member-Directed Options,

c. Person-Centered Service Planning,
d. Consistency of Services,
e. Accessibility of Network,
f. Most Integrated Setting, and
g. Collaboration with Stakeholders.

2. Ensuring support of the member's informal support system (e.g., family caregivers).

3. Developing HCBS settings to meet the needs of members who are elderly or have a physical disability and those who have cognitive impairments, behavioral health needs, and other SHCN.

4. Promoting the delivery of services in a culturally competent manner to all members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity [42 CFR 438.206]. Refer to ACOM Policy 405 and Section D, Paragraph 63, Cultural Competency.

5. A network of community-based providers including physicians, preventive, primary care, family planning, dental, behavioral health (including adult and child psychiatrists), laboratory, x-ray, therapy services, and other specialty providers through a network of community-based providers in accordance with network standards and which maximize member choice and ensure timely access to covered services [42 CFR 438.206(b)(7)].

6. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, mobile providers in rural or under-served areas, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State.

7. Community-based, family support providers in urban, suburban, and rural areas of the State.

The Contractor is prohibited from utilizing as a placement setting for members, Group Homes for the Developmentally Disabled, as administered under Arizona Administrative Code, Title 9, Chapter 33.

The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for behavioral health or SUD benefits that are comparable to, and applied no more stringently than, any processes, strategies, evidentiary standards, or other factors used to determine access to out-of-network providers for medical/surgical benefits in the same classification [42 CFR 438.910(d)(3) and (5)].

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers to maximize member choice. The Contractor shall allow each member to choose their network provider to the extent possible and appropriate [42 CFR 438.3(l)]. Services shall be accessible to members in terms of timeliness, amount, duration, and scope as those are available to beneficiaries under FFS Medicaid [42 CFR 438.210(a)(2)].

The Contractor shall ensure its provider network provides physical access, accessible equipment, reasonable accommodations, culturally competent communications, for all members including those with physical or cognitive disabilities [42 CFR 438.206(c)(3)]. The Contractor shall meet Network Standards as specified in ACOM Policy 436. The Contractor may request an exception to these network standards; it shall submit such a request for AHCCCS approval as specified in ACOM Policy 436 and Section F, Attachment F3, Chart of deliverables. The Contractor shall maintain a sufficient network in accordance with the requirements specified in ACOM Policy 436, 42 CFR 438.68, 42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42

CFR 438.207(c). In the event a Contractor is not able to meet network standards, AHCCCS may review requested exceptions as specified in ACOM Policy 436 [42 CFR 438.68].

The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population, and to promote health equity for members served. The Contractor shall design its provider network to maximize the availability of community based primary care and specialty care access, including specialists that treat individuals with qualifying medical conditions under A.A.C. R9-22-1303, to ensure a reduction in utilization of emergency services, one day hospital admissions, hospital-based outpatient surgeries (when lower cost surgery centers are available) and hospitalization for preventable medical problems.

The Contractor's network of behavioral health providers shall include, at a minimum the following:

1. Locally established, Arizona-based, independent PROs and FROs. The Contractor shall provide technical assistance and support to PROs and FROs as necessary.

2. Master's and doctoral level trained clinicians in the fields of social work, counseling, marriage and family therapy, psychology and substance use counseling, who are trained in, and implement nationally recognized best practices for medically and behaviorally complex conditions, including intellectual/cognitive disabilities, trauma-related disorders, SUD, sexual offenders, sexual abuse victims, dialectical behavior therapy, members who are pregnant or postpartum, and specialized populations or age groups, including transition age youth and members aged birth to five years old

The Contractor shall develop incentive plans to recruit and retain locally based BHPs and Behavioral Health Medical Professionals.

There shall be sufficient providers for the provision of all covered services, including emergency medical care on a 24-hour-a-day, seven-day-a-week basis [42 CFR 438.206(c)(1)(iii)]. The development of HCBS shall include provisions for the availability of services on a seven-day-a-week basis and for extended hours, as dictated by member needs [42 CFR 438.206(b)(1)]; [42 CFR 438.206(c)(1)(i), (ii) and (iii)]. The Contractor is required to have available non-emergent after-hours physician or primary care services within its network. If the Contractor's network is unable to provide medically necessary services required under Contract, the Contractor shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement, or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the Contractor shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.12(a)(2) and 42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities under this Contract nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)-(3)]. If the Contractor declines to include individuals or groups of providers in its network, it shall give the affected providers timely written notice of the reason for its decision [42 CFR 438.12(a)(1)]. The Contractor may not employ or contract with providers who are excluded from participation in Federal healthcare programs, under either Section 1128 or Section 1128A of the Social Security Act [42 CFR 438.214(d)].

Alternative HCBS Settings: To ensure members are residing in the most appropriate, least- restrictive non-institutional setting, the Contractor shall, on an ongoing basis, monitor and evaluate member placement data. The Contractor shall develop and implement proactive strategies to increase the percentage of members residing in their own homes. The strategies that are developed and/or implemented shall not infringe upon members' choices and preferences. Upon identification that 20% or more of the Contractor's membership are residing in Alternative HCBS Settings, in any GSA, the Contractor will be required to reevaluate and provide evidence of interventions utilized to reduce the percentage. The strategies that are developed and/or implemented shall not lead to or incentivize an increase in the percentage of members residing in nursing facilities and shall not infringe upon members' choices and preference. Refer to AMPM Policies 1230-A, 1230-C, 1240-B, and 1240-J.

Arizona Early Intervention Program: The Contractor shall comply with the requirements of the AzEIP. The AzEIP is implemented through the coordinated activities of the ADES, ADHS, DCS, Arizona State Schools for the Deaf and Blind (ASDB), AHCCCS, and Arizona Department of Education (ADE). The AzEIP Program is governed by the Individuals with Disabilities Act (IDEA), Part C (P.L.105-17). AzEIP, through Federal regulation, is stipulated as the payor of last resort to Medicaid, and is prohibited from supplanting another entitlement program, including Medicaid. The Contractor shall pay all AHCCCS registered AzEIP providers, regardless of their contract status with the Contractor, when service plans identify and meet the requirement for medically necessary EPSDT covered services. Refer to AMPM Policy 430. AHCCCS has developed an AzEIP Speech Therapy Fee Schedule and rates incorporating one procedure code, with related modifiers, settings, and group sizes. The Contractor shall utilize this methodology for payment for the speech therapy procedure when provided to an AHCCCS member who is a child identified in the AHCCCS system as an AzEIP recipient. Irrespective of services covered by AzEIP, the Contractor remains responsible for timely coverage of all medically necessary services as specified in this Contract. Consistent with A.A.C. R9-22-705 K., in the absence of a contract, Contractors shall pay claims at rates not less than the AHCCCS AzEIP FFS rates. In the event the Contractor intends to contract for AzEIP services at rates that are lower than the AHCCCS AzEIP rates, the Contractor shall notify AHCCCS of the proposed rates at least 90 days in advance of implementation. The Contractor shall provide the proposed rates with an explanation of how it intends to track, evaluate, and mitigate any potential negative impacts to access to care. AHCCCS will review the proposed rates to consider if an adjustment to the Contractor's capitation rates may be warranted.

Centers of Excellence: The Contractor shall contract with Centers of Excellence which implement evidence-based practices and track outcomes for members with specialized health care needs. Refer to Section D, Paragraph 13, Behavioral Health Service Delivery and Section D, Paragraph 80, Value-Based Purchasing.

Durable Medical Equipment Service Delivery: Durable Medical Equipment (DME) (e.g., wheelchairs, walkers, hospital beds, and oxygen equipment) is critical in optimizing the member's independence and functional level, both physically and mentally, and to support service delivery in the most integrated setting and foster engagement in the community. The Contractor is required to provide medically necessary DME to members in a timely manner consistent with AHCCCS Policy. The Contractor shall track and report the timeliness of DME Service Delivery as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Graduate Medical Education (GME) Residency Training Programs: AHCCCS is committed to WFD and support of the medical residency and dental student training programs in the State of Arizona. AHCCCS expects the Contractor to support these efforts. AHCCCS encourages plans to contract with or otherwise support the many GME Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in Contractor MM and committee activities. In the event of a contract termination between the Contractor and a Residency Training Program or training site, the Contractor may not remove members from that program in such a manner as to harm the stability of the

program. AHCCCS reserves the right to determine what constitutes risk to the program. Further, the Contractor shall attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas (A.A.C. R9-22-712.05, A.R.S. § 36-2903.01(G)(9), A.R.S. § 36-2903.01(G)(9)(d), A.R.S. § 36-2907.06).

Multi-Specialty Interdisciplinary Clinics: For members with SHCN, covered services shall be delivered through a combination of established MSICs, Field Clinics, Virtual Clinics, and in community settings. The Contractor is expected to contract with all MSICs in the awarded GSA(s) and attempt to contract with any additional MSICs which have provided services to the Contractor's members.

In the event the Contractor and an MSIC fail to negotiate a contract, the Contractor shall continue to allow members to utilize the MSIC. In the absence of a contract, consistent with A.A.C. R9-22-705 K., the Contractor shall reimburse the MSIC at the AHCCCS MSIC fee schedule.

With regard to procedure code T1015 and its application in the MSIC, the MCO shall not make payments for T1015 unless: it is billed by an MSIC and it is for a CRS member, a former CRS member, or any member enrolled with an ALTCS MCO.

The MSIC may include all services provided to a member on a single date of service on one claim form or multiple claim forms. If multiple claim forms, the MSIC National Provider Identifier (NPI) shall be used as the rendering provider on each claim. A single MSIC is eligible for only one T1015 code payment per member/per day.

The use of procedure code T1015 and its application to Federally Qualified Health Care Center/Rural Health Clinic (FQHCs/RHCs) remains unchanged.

If the Contractor fails to negotiate contracts with all currently established MSICs in each of the Contractor's awarded GSAs, the Contractor shall establish contracts for multispecialty interdisciplinary care provided at one location by a variety of providers. At a minimum, access to the following providers at each multispecialty interdisciplinary care site shall be available:

1. Physicians.
2. Nurse Practitioners.
3. Physician Assistants.
4. Licensed BHPs.
5. Rehabilitation providers.

The Contractor shall take appropriate steps to include the availability of the following specialty providers at the single location:

1. Cardiologist.
2. Dentist.
3. Social Worker (SW).
4. Nutritionist.

5. Physiatrist.
6. Otolaryngologists.
7. Gastroenterologist.
8. Neurologist.
9. Ophthalmologist.
10. Surgeon.
11. Orthopedist.
12. Plastic surgeon.
13. Urologist.
14. Audiologist.

In the event the Contractor and an MSIC fail to negotiate a contract, the Contractor shall submit a description outlining the alternative delivery model, including proposed multispecialty interdisciplinary care providers, to AHCCCS for review and approval as specified in ACOM Policy 436 and Section F, Attachment F3, Contractor Chart of Deliverables.

In addition to the clinic settings specified above, the Contractor shall also ensure a network of community-based providers to include primary care, dental, and other specialty providers throughout the awarded GSA(s). Members shall not be restricted from receiving services from these community-based providers.

The Contractor shall establish a process to ensure coordination of care for members turning 21 the choice to continue being served by an MSIC that is able to provide services and coordinate care for adults with SHCN.

Network Development and Management Plan: The Contractor shall develop and maintain a Provider Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)]. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP shall be evaluated, updated annually, and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The NDMP shall include the requirements specified in ACOM Policy 415. The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, QI data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible [42 CFR 438.604(a)(5); 42 CFR 438.606; 42 CFR 438.207(b); 42 CFR 438.206]. AHCCCS may impose Administrative Actions for material deficiencies in the Contractor's provider network.

Treat and Refer: The Contractor is required to seek contract(s) with Treat and Refer providers registered in any and all areas served by the Contractor.

Telehealth: Telehealth is defined as health care services delivered via asynchronous (store and forward), remote patient monitoring, teledentistry, telemedicine (interactive audio and video), or telephone (audio-only). Telehealth shall not replace provider choice and/or member preference for physical delivery of services. The Contractor shall be responsible for the oversight, administration, and implementation of telehealth services in compliance with Federal and State laws and the requirements of this Contract and all incorporated references. The Contractor shall ensure that telehealth is available and utilized, when appropriate, to ensure geographic accessibility of services to members. The Contractor shall be responsible for developing and expanding the use and availability of telehealth services, when indicated and appropriate. Refer to AMPM Policy 320-I.

Workforce Development: In accordance with ACOM Policy 407, the Contractor shall establish and maintain a WFDO. The WFDO works together with the Contractor's Network and QM functions to ensure the provider network has:

1. Sufficient workforce capacity - An appropriate number of qualified workers needed to provide services.

2. Required level of workforce capability – Workers who are interpersonally, clinically, culturally, and technically competent in the skills needed to provide services.

3. Connected workplaces – Providers with an internal capacity for developing their workforce and or are connected to external workforce development resources.

The Contractor's WFDO shall consist of the following components:

1. A WFD Administrator.

2. A WFDO that is organizationally aligned with the Contractor's Network Management and QM functions. The WFDO is the organizational structure, personnel, processes and resources, the Contractor implements to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities and when indicated, deliver technical assistance to provider organizations to strengthen their WFD programs.

3. A Professional Development Plan for the WFD Administrator.

4. Data collection and information processing resources for assessing the current level of workforce capacity and capability strengths and deficits as well as forecasting and planning strategies that address future workforce requirements.

The WFDO performs the following functions:

1. Leads the Contractors internal WFD efforts and represent the Contractor as a member of the AZAHP WFD Alliance as well as other workforce related workgroups and committees.

2. Produces the Contractor's Network WFD Plan and contributes to the WFD Alliance's Annual Collaborative Assessment and Forecast of WFD Priorities of system wide WFD needs and solutions for addressing them.

3. Ensures that providers comply with all AHCCCS required workforce training and competency requirements and practices.

4. Ensures that providers have access to and comply with all training programs and practices required by the Report of the Abuse & Neglect Prevention Task Force to Governor Douglas A. Ducey (November 1, 2019):
   a. Resources and training programs to assist professionals and family caregivers prevent and manage stress and burnout,
   b. Training for all personnel in the prevention and detection of all forms of abuse and neglect, and
   c. Routine exercises and drills to test the reactions of staff to simulated conditions where abuse and neglect could potentially occur are incorporated into the providers' ongoing workforce/staff training and development plan.

5. Ensures that providers have completed trainings related to the specific needs of the population that they serve, and as indicated on the scope of services included within the facility's license.

6. Ensures that staff in residential settings treating the following populations have completed specific certification, training program(s), or otherwise demonstrate competency in:
   a. Individuals with or at risk for autism,
   b. Individuals with dementia or related disorders,
   c. Individuals with traumatic brain injury,
   d. Individuals with persistent aggressive behavior, and
   e. Other specialized populations as identified by the Contractor.

7. Ensures that staff providing community-based services treating the following populations have completed specific certification, training program(s), or otherwise demonstrate competency in:
   a. Individuals with or at risk for autism,
   b. Individuals with dementia or related disorders,
   c. Individuals with traumatic brain injury,
   d. Individuals with persistent aggressive behavior,
   e. Individuals who are pregnant or postpartum, and
   f. Other specialized populations as identified by the Contractor.

8. Collects and analyzes workforce data needed to prepare required and ad hoc workforce assessment reports, forecasts, and plans.

9. In recognition of the interconnected relationships that providers have with multiple health plans, coordinates the provision of technical assistance to Network Providers on WFD processes such as recruitment, selection, training, deployment, and retention.

10. Participates in routine and ad hoc WFD meetings with the AHCCCS Administrator of Healthcare WFD as well as with the AZAHP WFD Alliance.

The Contractor shall submit deliverables related to WFD as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

29. NETWORK MANAGEMENT

The Contractor shall have written policies and procedures on how the Contractor will [42 CFR 438.12(a)(2) and 42 CFR 438.214(a)]:

1. Communicate and negotiate with the network regarding contractual and/or program changes and requirements.

2. Monitor network compliance with policies and Rules of AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes.

3. Evaluate the quality of services delivered by the network.

4. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.

5. Monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.

6. Process provisional credentials.

7. Recruit, select, credential, recredential and contract with providers in a manner that incorporate QM, utilization, office audits and provider profiling.

8. Provide training for its providers and maintain records of such training.

9. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

10. Ensure that provider calls are acknowledged within three business days of receipt; resolved and the result communicated to the provider within 30 business days of receipt (this includes referrals from AHCCCS).

Contractor policies are subject to approval by AHCCCS/DHCS and are monitored through ORs.

The Contractor shall monitor providers to demonstrate compliance with all network requirements in this Contract.

Material Change to the Provider Network: The Contractor is responsible for evaluating all provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's provider network. These changes could include, but would not be limited to, changes in services, covered benefits, GSAs, composition of or payments to its provider network, or eligibility of a new population. Material changes to the provider network shall be approved in advance by AHCCCS. The Contractor shall submit the required documentation as specified in ACOM Policy 439 and Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.604(a)(5), 42 CFR 438.606, 42 CFR 438.608(a)(4), 42 CFR 438.207(b)-(c), 42 CFR 438.206].

Refer to Section D, Paragraph 42, Material Changes to Business Operations regarding material changes by the Contractor that may impact business operations.

Refer to Section D, Paragraph 54, Capitation Adjustments regarding material changes by the Contractor that may impact capitation rates.

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

Opioid Use Disorder Real-Time Service Availability Locator: The Real-Time Service Availability Locator is a service locator built to assist the public and others in locating real-time information about the availability of OUD services throughout the State.

The Contractor shall require Opioid Treatment Programs (OTPs), Office-Based Opioid Treatment (OBOTs), and Opioid Residential Treatment Program providers to supply data feeds to the AHCCCS-contracted vendor for the Real-Time Service Availability Locator. The Contractor shall require its providers to comply with the AHCCCS reporting requirements. The following data elements are required for initial reporting, within a timeline identified by AHCCCS and shall be updated as frequently as the data field value changes.

1. Agency and location specific information:
    a. Agency name,
    b. Address,
    c. Phone,
    d. Website,
    e. Hours of operation,
    f. Logo,
    g. Counties served, and
    h. Contracted health plans.

2. Populations served:
    a. Gender, and
    b. Age.

3. Services provided:
    a. Residential,
    b. Methadone maintenance,
    c. Buprenorphine maintenance,
    d. Naltrexone maintenance,
    e. Peer support, and
    f. Psychosocial.

4. Capacity (as applicable to provider type):
    a. Available beds,
    b. Methadone maintenance,
    c. Buprenorphine maintenance, and
    d. Naltrexone maintenance.

Provider Forums: The Contractor shall hold a provider forum no less than semi-annually. The forum shall be chaired by the Contractor's Administrator/CEO or designee. The purpose of the forum is to improve communication between the Contractor and its providers and hear any concerns from the provider community. The forum shall be open to all providers including dental and ALTCS providers. The Provider Forum shall not be the only venue available to providers to communicate and participate in issues affecting the provider network. Provider Forum meeting agendas and minutes shall be made available to AHCCCS upon request. The Contractor shall create a plan to address any concerns heard in these meetings and report information discussed during these forums to executive management within the organization. In addition to the provider forum, the Contractor shall coordinate a semi-annual meeting with a broad spectrum of behavioral health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the health care service delivery.

30. PROVIDER MANUAL

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

31. PROVIDER ENROLLMENT/TERMINATION

The Contractor shall ensure that all its subcontractors register with AHCCCS as an approved service provider (i.e., AHCCCS registered provider) consistent with provider disclosure, screening, and enrollment requirements [42 CFR 438.608, 42 CFR 455.100-106, 42 CFR 455.400 – 470]. This includes, but may not be limited to, the Contractor ensuring that all subcontractors provide to AHCCCS their identifying information such as name, specialty, DOB, Social Security number, NPI, Federal taxpayer identification number, and the State license or certification number of the provider.

For specific requirements on Provider Enrollment refer to the AHCCCS website.

The NPI, for all providers eligible for an NPI, is required on all claim submissions from providers and subsequent MCO encounters to AHCCCS. The Contractor shall work with providers to obtain their NPI. AHCCCS reserves the right to withhold all payments for services where a provider who is eligible for enrollment with AHCCCS has not become an AHCCCS registered provider. AHCCCS further reserves the right to recoup or recover all payments made to such a provider who was eligible for enrollment with AHCCCS but has not become an AHCCCS registered provider.

AHCCCS Provider Enrollment Portal: The AHCCCS Provider Enrollment Portal (APEP) is an online, electronic portal, launched by AHCCCS August 31,2020, which streamlines and expedites the provider enrollment process for providers. APEP allows providers a means to electronically submit a new enrollment or modify an existing provider ID anytime of the day. The Contractor shall ensure providers register through APEP and continue to maintain the provider ID as required by AHCCCS. The Contractor shall encourage providers to update their provider registration data with any changes to their demographic data, including the current population group sets served for those provider types asked to enter the population group sets during their AHCCCS registration.

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

AHCCCS will screen and enroll, and periodically revalidate all of the Contractor's subcontracted providers as Medicaid providers as specified by 42 CFR 438.602(b)(1).

32. PROVIDER AFFILIATION TRANSMISSION

The Contractor shall collect and submit information regarding its entire contracted provider network in the format specified in the AHCCCS Provider Affiliation Transmission (PAT) User Manual which can be found on the AHCCCS website.

The Contractor shall also validate its compliance with minimum network requirements against the network information provided in the PAT through the submission of a completed Minimum Network Requirements Verification Template as specified in ACOM Policy 436, Attachment A. The PAT and the Minimum Network Requirements Verification Template shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

33. SUBCONTRACTS

The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as specified in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1); 42 CFR 438.3(k)].

The Contractor shall oversee, and is accountable for, any functions and responsibilities that it delegates to any subcontractor [42 CFR 438.230(a)]. All such subcontracts shall be in writing [42 CFR 438.230(c)(1)(i) – (ii), 42 CFR 438.6(l)].

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

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

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

The Contractor may not employ or contract with providers who are 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)(1)].

The Contractor shall require subcontracted providers to adhere to the requirements of the Arizona Opioid Epidemic Act SB1001, Laws 2018. First Special Session.

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

Delegated agreements for operational functions which are determined by AHCCCS to inhibit integrated service delivery for the Medicaid or Medicare D-SNP LOBs are prohibited.

The Contractor shall not delegate the QOC investigations processes or onsite QOC visits to Administrative Services Subcontractors or providers.

Before entering into an Administrative Services Subcontract which delegates duties or responsibilities to a subcontractor, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities, then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the Administrative Services Subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the Administrative Services Subcontractor's performance is inadequate.

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies shall be communicated to the Administrative Services Subcontractor in order to establish a CAP [42 CFR 438.230(b)]. The results of the performance review and the CAP shall be communicated to AHCCCS upon completion as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

Additionally, if at any time during the period of the Administrative Services Subcontract the subcontractor is found to be in noncompliance, the Contractor shall notify AHCCCS and comply with ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

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

DUGless Data Reporting Requirements: For those demographic elements with no identified alternative data source or Social Determinant identifier, AHCCCS created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members.

The Contractor shall require that all providers who might typically document or provide these types of data provide the required data via the DUGless portal.

The requirements, definitions, and values for submission of the identified data elements are specified in the AHCCCS DUGless Portal Guide (DPG). The required information collected by AHCCCS health care providers are recorded and reported to MCOs to assist in monitoring and tracking of the following:

1. Access and utilization of services.

2. Community and stakeholder information.

3. Compliance with Federal, State, and grant requirements.

4. Health disparities and inequities.

5. Member summaries and outcomes.

6. Quality and MM activities.

7. Social Determinants Of Health (SDOH).

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

If there is an ownership change in the management services subcontractor, the assignment of the MSA shall be approved by AHCCCS prior to the assignment to the new subcontractor. Refer to ACOM Policy 317. AHCCCS may impose enrollment caps in any or all GSAs as a result of a change in ownership. AHCCCS may also offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two Contractors within the same LOB to utilize the same management service company in the same GSA.

The performance of management service subcontractors shall be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 33, Subcontracts and Section F, Attachment F3, Contractor Chart of Deliverables and as specified in ACOM Policy 438

Minimum Subcontract Provisions: All subcontracts shall reference and require compliance with the AHCCCS MSPs. Refer to the AHCCCS MSPs on the AHCCCS website.

All Minimum Subcontract Provisions shall apply to Management Services Agreements unless otherwise stated.

The Contractor shall collaboratively and proactively work with providers to ensure and monitor compliance with requirements of the Report of the Abuse & Neglect Prevention Task Force to Governor Douglas A. Ducey (November 1, 2019) developed in response to Executive Order 2019-03 as specified in the AHCCCS MSPs and Contract.

In addition, each subcontract shall contain the following:

1. Subcontractor activities and obligations, and related reporting responsibilities [42 CFR 438.230(c)(1)(i)-(iii), 42 CFR 438.3(k)].

2. A provision requiring subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with contract obligations [42 CFR 438.230(c)(2), 42 CFR 438.230(c)(1)(ii), 42 CFR 438.3(k)].

3. A provision that requires the subcontractor to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions [42 CFR 438.230(c)(2), 42 CFR 438.3(k)].

4. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.

5. Identification of the name and address of the subcontractor.

6. Identification of the population, to include patient capacity, to be covered by the subcontractor.

7. The amount, duration, and scope of services to be provided, and for which compensation will be paid.

8. The term of the subcontract including beginning and ending dates, methods of extension, termination, and re-negotiation.

9. The specific duties of the subcontractor relating to coordination of benefits and determination of Third-Party Liability (TPL).

10. The specific duties of the subcontractor relating to coordination of care for all members.

11. A provision that the subcontractor agrees to identify Medicare and other TPL coverage and to seek such Medicare or TPL payment before submitting claims to the Contractor.

12. A description of the subcontractor's patient, medical, dental, and cost record keeping system.

13. Specification that the subcontractor shall cooperate with QM programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.

14. A provision stating that a Change in Organizational Structure of an Administrative Services Subcontractor shall require a Contract amendment and prior approval by AHCCCS.

15. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population.

16. 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.

17. A provision that the subcontractor shall obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members.

18. A provision that the subcontractor shall comply with encounter reporting and claims submission requirements as specified in the subcontract.

19. Provision(s) that allow the Contractor to suspend, deny, refuse to renew, or terminate any subcontractor in accordance with the terms of this Contract and applicable law and regulation.

20. A provision for revocation of the delegation of activities or obligations or specifies other remedies in instances where AHCCCS or the Contractor determines that the subcontractor has not performed satisfactorily [42 CFR 438.230(c)(1)(iii), 42 CFR 438.3(k)].

21. A provision that the subcontractor may provide the member with factual information but is prohibited from recommending or steering a member in the member’s selection of a Contractor.

22. 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 member [42 CFR 438.210(e)].

23. A provision that the State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor, or of the

subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State [42 CFR 438.230(c)(3)(i)-(iv)].

24. A requirement that the subcontractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member [42 CFR 438.210(a)(3)(ii)].

25. A provision that requires the subcontractor to assist members in understanding their right to file grievances and appeals in conformance with all AHCCCS Grievance and Appeal System and member rights policies.

26. A provision that the subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 CFR 438.230, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid members [42 CFR 438.230].

27. For subcontractors licensed as an inpatient facility, BHRF or TFC facility, a requirement to comply with Contractor's QM and MM programs.

28. A provision that the right to audit under paragraph (c)(3)(i) of 42 CFR 438.230, will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later [42 CFR 438.230(c)(3)(iv)].

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

Opioid Treatment Program Requirements: Pursuant to A.R.S. § 36-2907.14, in addition to all Federal or State licensing and registration requirements, any OTP (including New and Existing OTP sites) receiving reimbursement from AHCCCS or its Contractors shall develop and submit Plans as specified in statute, and any relevant documentation, for review and approval by AHCCCS. The Contractor shall ensure OTP providers are educated on these requirements, as specified in AMPM Policy 660.

Pharmacy Benefit Manager Subcontracts Pass-Through Pharmacy Benefit Manager Pricing Model and Discrete Administrative Fee: The Contractor shall amend the subcontract between the Contractor and its PBM to reflect a pass-through pricing model, defined as a PBM subcontract in which:

1. The Contractor shall reimburse the PBM the exact amount of the actual payments made to pharmacies inclusive of the ingredient costs and the dispensing fees for prescription claims.

2. The Contractor shall submit encounters to AHCCCS for prescription drug claims that are the exact amount of the actual payments made to the pharmacies inclusive of ingredient costs and the dispensing fees for prescription claims.

3. The Contractor and PBM shall ensure that no additional direct or indirect remuneration fees, any membership fees or the like may be imposed on a pharmacy as a condition of claims payment or network inclusion. No additional retrospective remuneration or recoupment models including, but not limited to, Generic Effective Rates (GERs) or Brand Effective Rates (BERs) shall be permitted. However, nothing shall preclude the reprocessing of claims due to claims adjudication error of the

Contractor or its agent or claim related pharmacy audit adjustments for incorrectly billed pharmacy claims.

4. The Contractor shall ensure that encounters submitted to AHCCCS are payments issued by the MCO's PBM and/MCO PBM's contractors or subcontractors and are the exact amounts allowed under the reimbursement methodology delineated in the contract between the MCOs PBM and the pharmacy or the Pharmacy Services Administrative Organization (PSAO) and the pharmacy.

5. All revenues including direct and indirect payments and credits received by the PBM related to services provided for the Contractor are passed through to the Contractor, including but not limited to: pricing discounts/credited paid to the PBM, inflationary payments, clawbacks, fees, credits, grants, chargebacks, reimbursements, all rebates, administrative fees paid by manufacturers or other related entities, and any other payments received by the PBM on behalf of or related to the Contractor.

6. The Contractor shall not accept any credits or funding offered by the PBM, as an example but not limited to, implementation credits or ongoing credits that are proposed in the contract.

7. The Contractor shall pay the PBM an all-inclusive administrative fee, on a fixed and/or per script basis, for all services provided under the PBM subcontract. The PBM shall not charge the Contractor for other services, as an example, but not limited to, additional fees for a “flu vaccine program”. The administrative fee shall not be funded directly or indirectly with revenues associated with credits, rebates, or other payments made to the PBM.

8. For all Contractors, including those contracting with a PBM that subcontracts with another PBM, the submitted encounter to AHCCCS by the Contractor shall be the actual payment to the pharmacy. The contracts, between the Contractor and the PBM or the PBM and its subcontracted PBM or any other identified subcontracts associated with the delivery or administration of the pharmacy benefit shall be submitted to AHCCCS upon request.

9. For Contractors whose PBMs subcontract with a PSAO, the submitted pharmacy encounter to AHCCCS shall include the actual payment to the pharmacy that provided the service, including the paid ingredient cost and dispensing fee.

10. The Contractor’s PBM contract shall be updated to exclude any waiting period for a pharmacy to be added to the PBM’s pharmacy network, as an example, but not limited to, the PBM shall not require the pharmacy to wait six months prior to adding the pharmacy to the Contractor’s PBM pharmacy network.

The PBM may charge a discrete administrative fee to the Contractor. AHCCCS recommends this fee not be greater than the average of two dollars per paid prescription, including any fixed administrative charges. The discrete administrative fee shall be reported to AHCCCS in the quarterly financial reporting packages as directed in the AHCCCS Financial Reporting Guide. Refer to Section F, Attachment F3, Contractor Chart of Deliverables. Contractor pharmacy encounters shall be submitted in accordance with the requirements in Section D, Paragraph 68, Encounter Data Reporting. The Contractor shall submit the PBM subcontract to AHCCCS in order to demonstrate that it complies with the above provisions as stated in Section F, Attachment F3, Contractor Chart of Deliverables.

Reimbursement Requirements: The Contractor shall include the specific content below in the PBM subcontracts for reimbursement.

Brand Name Drugs: The Contractor's contract with the PBM shall provide a Guaranteed Brand Name Drug Discount Rate and require the reimbursement of Brand Name Prescription claims, in aggregate, at a minimum, to be the following:

1. 84-Day Supply or Less: The lesser of the Average Wholesale Price (AWP) less 18% , the Submitted Ingredient Cost, or the U&C price plus a Dispensing Fee.

2. Greater than an 84-Day Supply: The lesser of the AWP less 19.50% , the Submitted Ingredient Cost, or the U&C price plus a Dispensing Fee.

The Guaranteed Discount Rate shall be calculated for branded legend and Over-the-Counter branded drugs on a cumulative six-month basis, beginning with the period October 1 through March 31 and followed by the period April 1 through September 30.
The PBM shall evaluate and calculate each six-month time period and determine if the performance guarantee was met. The guarantee shall be calculated within 30 days after the end of each cumulative six-month time period.

If the guarantee was not met, the PBM shall issue payment to the Contractor to meet the performance guarantee after each six-month time period within 60 days after the close of the six-month time period.

The Contractor shall audit the PBM to ensure the reimbursements paid to pharmacies are in accordance with the contract reimbursement terms between the Contractor and the PBM and are equal to the encounter values submitted to AHCCCS. The Contractor shall report the audit findings to AHCCCS every six months for the time periods of October 1 through March 31 and April 1 through September 30.

Generic Drugs: The Contractor's contract with the PBM shall require the reimbursement of generic drugs to be guaranteed, in aggregate, at a minimum, at AWP less 84% for all Days Supplies dispensed. The calculation of the aggregate guarantee shall include all generic drugs, including single source, multisource and Over-the-Counter generic drugs, and generic drug claims reimbursed at U&C pricing or the Submitted Ingredient Cost.

All generic drug prescription claims shall be reimbursed to network pharmacies at the lesser of the Maximum Allowable Cost, AWP less 18%, the submitted ingredient cost, or U&C pricing plus a Dispensing Fee.

The Generic Drug Guarantee shall be calculated for generic drugs on a cumulative six-month basis, beginning with the period October 1 through March 31 and followed by the period April 1 through September 30.

The PBM shall evaluate and calculate each six-month time period and determine if the performance guarantee was met. The guarantee shall be calculated within 30 days after the end of each cumulative six-month time period.

If the guarantee was not met, the PBM shall issue payment to the Contractor to meet the performance guarantee after each six-month time period within 60 days after the close of the six-month time period.

The Contractor shall audit the PBM to ensure the reimbursements paid to pharmacies are in accordance with the contract reimbursement terms between the Contractor and the PBM and are equal to the encounter values submitted to AHCCCS. The Contractor shall report the audit findings to AHCCCS their findings every six months for the time periods of October 1 through March 31 and April 1 through September 30.

Mail Order Prescriptions Services: The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate for all Mail Order Pharmacy Prescriptions Claims, in aggregate, at a minimum, of AWP less 24% and the Mail Order Prescription Claims shall be reimbursed, at a minimum, the lesser of the AWP less 24%, the Submitted Ingredient Cost, Maximum Allowable Cost, or the U&C price. This is applicable to Contractors providing mail order services when the pharmacy is owned or operated under the same corporate umbrella of companies as the PBM. This does not apply to the retail pharmacy networks not owned or operated under the same corporate umbrella that includes the PBM.

The Guaranteed Discount Rate shall be calculated for mail order prescription drugs on a cumulative six-month basis, beginning with the period October 1 through March 31 and followed by the period April 1 through September 30.

The PBM shall evaluate and calculate each six-month time period and determine if the performance guarantee was met. The guarantee shall be calculated within 30 days after the end of each cumulative six-month time period.

If the guarantee was not met, the PBM shall issue payment to the Contractor to meet the performance guarantee after each six-month time period within 60 days after the close of the six-month time period.

Other- Miscellaneous: The PBM subcontract shall include:

1. A clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy.

2. Language requiring the Contractor's PBM to monitor and update the Maximum Allowable Cost for generic drugs and other pricing benchmarks on a schedule at least as consistent with market changes, including additions and changes as the cost of generic drugs increase or decrease. Upon request from the Contractor or a network pharmacy, the PBM shall provide at least one source where a non- 340B network pharmacy is able to purchase the drug at the PBM's Maximum Allowable Cost rate for that drug, or lower. The PBM shall provide a reasonable and direct process for network pharmacies to communicate with the PBM and report the pharmacy's inability to purchase at the PBM's Maximum Allowable Cost price and receive instructions from the PBM as to where to purchase the drug at the Maximum Allowable Cost price. The language shall include a specific response time for pricing resolution when inquiries are brought to the attention of the PBM by the Contractor or Network Pharmacy.

3. Language with performance guarantees that address adherence to the AHCCCS Drug List Preferred Agents for the AHCCCS Supplemental Rebate Classes Preferred Agents.

4. Language that allows the Contractor to terminate the PBM subcontract without cause and without penalty.

5. Language that upon termination of the PBM's Contract the following, at a minimum, will be transferred to the PBM at no charge:
   a. Claims History File,
   b. PA File,
   c. Mail Order Open Refills File,
   d. Specialty Drug Open Refills File,
   e. Accumulators File (if the Contractor has a corresponding Medicare Advantage Plan for Dual Eligible members),

f. Adjustments, and
g. Other requests by AHCCCS.

Rebate Payments: The Contractor shall include the content below in PBM subcontracts for reimbursement when the PBM is paying a flat fee rebate, a percentage rebate, or a market share rebate to the Contractor for prescription utilization:

1. Rebate guarantees based on a minimum flat rate fee, a percentage or market share rebate shall be compared, in total, to the collected rebates by the PBM from the manufacturer or an entity on behalf of the manufacturer. The PBM shall provide the Contractor with the minimum flat rate rebate, the percentage rebate, the market share rebate, or 100% of the collected rebates, whichever is greater for all prescription utilization.

2. The PBM subcontractor shall include language that requires the PBM to report rebates and administrative fees to the Contractor in the AHCCCS requested format.

3. The PBM subcontract shall include language that does not allow administrative costs to be collected and kept by the PBM for utilization that is related to the Contractor. All monies, including but not limited to, rebates and administrative fees collected by the PBM from a manufacturer, or other company representing the manufacturer, that relate to the prescription utilization under the MCO/PBM contract, shall be passed through to the Contractor.

4. The Contractor shall not apply monies received for rebates or the administration of rebates against the administrative fees of the PBM contract.

Specialty and Biosimilar Drugs: The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate, in aggregate, at a minimum, of AWP less 18.25% for all Specialty and Biosimilar Drugs. Specialty and Biosimilar Prescription claims, in aggregate, shall be reimbursed to pharmacies at the lesser of AWP less 18.25%, Maximum Allowable Cost, the Submitted Ingredient Cost, or the U&C price plus a Dispensing Fee. The Dispensing Fee for non-compounded and compounded prescriptions shall not be greater than what is listed in the Arizona State Plan. Limited and exclusive distribution, biosimilars, and specialty drugs are included in the guarantee.

The Guaranteed Discount Rate shall be calculated for limited distribution, biosimilars and specialty drugs on a cumulative six-month basis, beginning with the period October 1 through March 31 and followed by the period April 1 through September 30.

The PBM shall evaluate and calculate each six-month time period and determine if the performance guarantee was met. The guarantee shall be calculated within 30 days after the end of each cumulative six-month time period.

If the guarantee was not met, the PBM shall issue payment to the Contractor to meet the performance guarantee after each six-month time period within 60 days after the close of the six-month time period.

Specialty Medications that can be purchased and dispensed by a retail pharmacy shall not be reimbursed to the Specialty Pharmacy for a greater amount than the amount that would be reimbursed under the PBM/Contractor Retail Pharmacy Drug Reimbursement rates.

The Contractor shall audit the PBM to ensure the reimbursements paid to pharmacies are in accordance with the contract reimbursement terms between the Contractor and the PBM and are equal to the encounter values submitted to AHCCCS. The Contractor shall report the audit findings to AHCCCS their

findings every six months for the time periods of October 1 through March 31 and April 1 through September 30.

Provider Agreements: The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Furthermore, the Contractor shall not prohibit a provider from providing services for any other AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category. In addition, the Contractor shall require subcontracted providers to adhere to the requirements specified in AMPM Chapter 600.

The Contractor shall make reasonable efforts to enter into a written agreement with any provider providing services at the request of the Contractor more than 25 times during the previous Contract year and/or are anticipated to continue providing services for the Contractor. The Contractor shall follow ACOM Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the adequacy of its network.

In all contracts with network providers, the Contractor shall comply with any additional provider selection requirements established by the State [42 CFR 438.12(a)(2), 42 CFR 438.214(e)].

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

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

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

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

If the Contractor delegates the collection of member Share of Cost to a provider, the provider contract shall spell out complete details of both parties' obligations in share of cost collection.

34. ADVANCE DIRECTIVES

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

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

2. The Contractor shall require PCPs which have agreements with the entities specified in paragraph a. above, to comply with the requirements of subparagraph 1.(a.) through 1.(e.) above.

3. The Contractor shall require health care providers specified in subparagraph 1 above to provide a copy of the member's executed advance directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record and, provide education to staff on issues concerning advance directives.

4. The Contractor shall provide written information to adult members and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. § 36-3231, regarding the following [42 CFR 422.128]:
   a. A member's rights regarding advance directives under Arizona State law,
   b. The organization's policies regarding the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience,
   c. A description of the applicable State law and information regarding the implementation of these rights,
   d. The member's right to file complaints directly with AHCCCS,
   e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum shall do the following:
      i. Clarify institution-wide conscientious objections and those of individual physicians,
      ii. Identify State legal authority permitting such objections, and
      iii. Describe the range of medical conditions or procedures affected by the conscience objection, and
   f. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.3(j)(4)].

5. Written information regarding advance directives shall be provided to members at the time of enrollment with the Member Handbook. Refer to ACOM Policy 404 for member information and Member Handbook requirements.

6. The Contractor is not relieved of its obligation to provide the above information to the individual once they are no longer incapacitated or unable to receive such information. Follow-up procedures shall be in place to provide the information to the individual directly at the appropriate time.

35. SPECIALTY CONTRACTS

AHCCCS may at any time negotiate or contract on behalf of the Contractor and AHCCCS for specialized hospital and medical services. AHCCCS will consider existing Contractor resources in the development and execution of specialty contracts. AHCCCS may require the Contractor to modify its delivery network to accommodate the provisions of specialty contracts. AHCCCS may consider waiving this requirement to utilize the specialty contract if such action is determined to be in the best interest of the State; however, in no case shall AHCCCS be held responsible for reimbursement exceeding that payable under the relevant AHCCCS specialty contract including, but not limited to, reinsurance payments.

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

AHCCCS has specialty contracts, including but not limited to, transplant services, anti-hemophiliac agents, and pharmaceutical related services. AHCCCS shall provide at least 60 days advance written notice to the Contractor prior to the implementation of any specialty contract. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.
Refer to Section D, Paragraph 53, Reinsurance.

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

In the absence of a contract between the Contractor and a hospital providing otherwise, the Contractor shall reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. § 36-2904, § 36-2905.01, § 36-2905.03, and 9 A.A.C. 22, Article 7, which set forth requirements for: reimbursement of the majority of inpatient hospital services using the Patient Refined-Diagnostic Related Group (APR-DRG) payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81; reimbursement of limited inpatient hospital services using per diem rates specified in A.A.C. R9-22-712.61; reimbursement of inpatient services provided by non-contracted hospitals in Pima and Maricopa counties at 95% of the amounts otherwise payable for inpatient services; and reimbursement of inpatient behavioral health services provided by non-contracted behavioral health inpatient facilities at 90% of the AHCCCS FFS rates.

The Contractor may conduct prepayment, concurrent and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims may be subject to recoupment. If the Contractor fails to identify lack of medical necessity through prepayment and/or concurrent medical review, lack of medical necessity shall not constitute a basis for recoupment of paid hospital claims, including outlier claims, unless the Contractor identifies the lack of medical necessity through a post-payment medical review of information that the Contractor could not have discovered during a prepayment and/or concurrent medical review through the exercise of due diligence. The Contractor shall comply with Section D, Paragraph 43, Claims Payment/Health Information System.

For information on Differential Adjusted Payments (DAPs) refer to Section D, Paragraph 51, Compensation.

37. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this Contract [42 CFR 438.206(b)(2)].

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to the PCP. The Contractor shall adjust the size of the PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. AHCCCS, using the PAT Report, shall inform the Contractor when a PCP has a panel of more than 1800 AHCCCS members (i.e., 1800 report), to assist in the assessment of the size of their panel. This information will be provided on a semi-annual basis.

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP who serves as a coordinator in referring the member for specialty medical services and that the Contractor's data regarding PCP assignments is current. The Contractor shall provide information to the member on how to contact the member's assigned PCP [42 CFR 438.208(b)(1)].

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

The Contractor shall ensure that primary care services are available and accessible in the communities in which members would access routine health care services. In addition, the Contractor shall have a network of specialty providers available to provide care and services in the community in addition to those specialty and multidisciplinary services that are available through the MSIC, thereby maximizing member choice.

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m), 438.52(d), 438.14(b)(3) and this Contract. Any American Indian who is enrolled with the Contractor and who is eligible to receive services from an Urban Indian Health Program PCP participating as a Contractor's network provider, is permitted to choose that Urban Indian Health Program as their PCP as long as that provider has capacity to provide the services [American Reinvestment and Recovery Act (ARRA) Section 5006(d) and State Medicaid Director Letter (SMDL) 10-001, 42 CFR 438.14(b)(3), 42 CFR 447].

The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information specified in ACOM Policy 404 and ACOM Policy 406 for member information requirements. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

1. Supervising, coordinating, and providing care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral).

2. Initiating referrals for medically necessary specialty care.

3. Maintaining continuity of care for each assigned member.

4. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health.

5. Utilizing the AHCCCS approved EPSDT Clinical Sample Template or electronic equivalent.

6. Providing clinical information regarding member's health and medications to the treating provider including behavioral health providers, within 10 business days of a request from the provider.

7. If serving children, enrolling as a Vaccines for Children (VFC) provider.

8. Checking the Arizona State Board of Pharmacy CSPMP when prescribing controlled medications in accordance with A.R.S § 36-2606.

Refer to requirements specified in AMPM Policy 510.

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

38. APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING, AND REPORTING

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

The Contractor 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.

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

The Contractor shall ensure members have timely access to medically necessary non-emergent transportation for routine appointments. Additionally, the Contractor shall have a process in place for members to request and receive medically necessary transportation for urgent appointments. The Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. The Contractor shall meet a performance target of 95% of all completed pick-up and drop off trips in a quarter to be completed timely. The Contractor shall develop and implement performance auditing protocol to

evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

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

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

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

39. PHYSICIAN INCENTIVES

The Contractor shall ensure compliance with all applicable physician incentive requirements, including but not limited to Section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 438.10(f)(3), 42 CFR 438.3(i), 42 CFR 422.208(c)(1)-(2), and 42 CFR 422.210. These regulations, in part, prohibit Contractors from operating any physician incentive plan that directly or indirectly makes payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a member.

The Contractor shall not enter into contractual arrangements that place providers at substantial financial risk as specified in 42 CFR 422.208 unless prior written approval of the contractual arrangement is received by AHCCCS. For those proposed contractual arrangements which meet the definition of substantial financial risk, the following shall be submitted to AHCCCS for review and approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables [Section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 422.208(c)(2), 42 CFR 438.3(i), and 42 CFR 438.6(g)]:

1. The type of incentive arrangement.

2. A plan for a member satisfaction survey.

3. Details of the stop-loss protection provided.

4. A summary of the compensation arrangement that meets the substantial financial risk definition.

5. Any other items as requested by AHCCCS.

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

Any Contractor-selected and/or developed physician incentive that meets the requirements of 42 CFR 417.479 shall be approved by AHCCCS prior to implementation as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

The Contractor shall establish written criteria and procedures for accepting and acting upon referrals to specialists, including emergency referrals, to include, at a minimum, the following:

1. Definition of a referral as any oral, written, faxed, or electronic request for services made by the member or member's legal guardian, family member, an AHCCCS Contractor, PCP, hospital, court, Tribe, IHS, Tribal 638 Facility, school, or other State or community agency.

2. Use of Contractor's referral process.

3. 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.

4. 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, or other third-party health coverages such as Medicare as applicable.

5. Requirements for referral in order to ensure member access to behavioral health services. Refer to AMPM Policy 1021.

6. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners [42 CFR 438.206(b)(2)].

7. For members with SHCN determined to need a specialized course of treatment or regular care monitoring, the Contractor shall 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.

Disposition of Referrals: The Contractor shall require that providers, when appropriate, communicate the final disposition of each referral to the referral source and Health Plan within 30 days of the member receiving an initial assessment.

Referral for a Second Opinion: The Contractor shall allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

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

1. Clinical laboratory services.

2. Physical Therapy (PT) services.

3. Occupational Therapy (OT) services.

4. Outpatient speech-language pathology services.

5. Radiology and certain other imaging services.

6. Radiation therapy and supplies.

7. Medical equipment and appliances and medical supplies.

8. Parenteral and enteral nutrients, equipment, and supplies.

9. Prosthetics, orthotics and prosthetic devices and supplies.

10. Home health services.

11. Outpatient prescription drugs.

12. Inpatient and outpatient hospital services.

The Contractor shall accept and respond to emergency referrals 24 hours a day, seven days a week. Emergency referrals do not require PA.

The Contractor shall ensure that training and education are available to PCPs regarding behavioral health referrals and consultation procedures.

The Contractor shall ensure emergency referrals include those initiated for Title XIX/XXI eligible SMI members admitted to a hospital or treated in the emergency room.

41. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

The Contractor is encouraged to use FQHCs/RHCs and FQHC Look-Alikes in Arizona to provide covered services. FQHCs/RHCs and FQHC Look-Alikes are paid unique, cost-based Prospective Payment System (PPS) rates for the majority of non-pharmacy ambulatory Medicaid-covered services. The PPS rate is an all-inclusive per visit rate.

To ensure compliance with the requirement of 42 USC 1396b(m)(2)(A)(ix) that the Contractor's payments, in aggregate, will not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC or FQHC Look-Alike, the Contractor shall pay the unique PPS rates to FQHCs/RHCs and FQHC Look-Alike for PPS-eligible visits. Reimbursement of case management, behavioral health group therapy, and telehealth services provided by a FQHC or RHC shall be in accordance with AMPM Policy 670. For services not eligible for PPS reimbursement, the Contractor shall negotiate rates of payment with FQHCs/RHCs and FQHC Look-Alikes for non-pharmacy services that are comparable to the rates paid to providers that provide similar services.

The Contractor shall be required to submit member month information for members for each FQHC/RHC/FQHC Look-Alike as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS may perform periodic audits of the member information submitted. Refer to the AHCCCS Financial

Reporting Guide, for further guidance. The FQHCs/RHCs and FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website.

Refer to Section D, Paragraph 11, Scope of Services, *Prescription Medications*.

42. MATERIAL CHANGE TO BUSINESS OPERATIONS

The Contractor is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to business operations [42 CFR 438.207 (c)]. All material changes to business operations shall be approved in advance by AHCCCS.

The Contractor shall submit the request for approval of a material change to business operations as specified in ACOM Policy 439 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor may be required to conduct meetings with providers to and/or members to address issues related changes to business operations, changes in policy, reimbursement matters, PAs and other matters as identified or requested by AHCCCS.

Refer to Section D, Paragraph 29, Network Management regarding material changes by the Contractor that may impact the provider network.

Refer to Section D, Paragraph 67, System and Data Exchange Requirements for additional submission requirements regarding system changes and upgrades.

43. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes and systems that ensure the accurate collections and processing of claims, analysis, integration, and reporting of data [Section 6504(a) of the ACA, Section 1903(r)(1)(F) of the Social Security Act, and 42 CFR 438.242(a) and (b)]. These processes and systems shall result in information on areas including, but not limited to, service utilization, claim disputes, member grievance and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 438.242(a)].

Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. § 36-2904. Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim, or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse.

The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)(5) and (6), 42 CFR 447.46, Sections 1932(f) and 1902(a)(37)(A) of the Social Security Act].

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

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgical Center (ASC), and Outpatient services.

2. Multiple Procedure/Surgical Reductions.

3. Global Day E & M Bundling standards.

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

1. Benefit Package Variations.

2. Timeliness Standards.

3. Data Accuracy.

4. Adherence to AHCCCS Policy.

5. Provider Qualifications.

6. Member Eligibility and Enrollment.

7. Over-Utilization Standards.

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

1. The reason(s) for denials and adjustments.

2. A detailed explanation/description of all denials, payments, and adjustments.

3. The amount billed.

4. The amount paid.

5. Application of COB and copays.

6. Provider rights for claim disputes.

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

The related remittance advice shall be sent with the payment unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT shall be sent to the provider, no later than

the date of the EFT. Refer to Section D, Paragraph 67, Systems and Data Exchange Requirement, for specific standards related to remittance advice and EFT payment.

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

In accordance with A.R.S. § 36-2904 the Contractor is required to reimburse providers of hospital and non-hospital services at the AHCCCS fee schedule in the absence of a contract or negotiated rate.

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

The Contractor is required to reimburse AHCCCS registered providers that are county departments of health for adult immunization services at the AHCCCS fee schedule in the absence of a Contract or negotiated rate.

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

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

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

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

Refer to ACOM Policy 203 for additional requirements regarding the adjudication and payment of claims.

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

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

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

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

1. Verification that provider contracts are loaded correctly.

2. Accuracy of payments against provider contract terms.

Audits of provider contract terms shall 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 shall be documented in policy and the Contractor shall review the Contract loading of both large groups and individual practitioners at least once every five-year period in addition to any time a Contract change is initiated during that timeframe. The findings of the audits specified above shall be documented and any deficiencies noted in the resulting reports shall be met with corrective action.

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

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

Any individual recoupment in excess of $50,000 per provider or Tax Identification Number (TIN) within a Contract Year or greater than 12 months after the date of the original payment shall be approved as specified in Section F, Attachment F3, Contractor Chart of Deliverables and as further specified in ACOM Policy 412. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a Contract Year (based on recoupment date), the Contractor shall report the cumulative recoupment monthly to the designated AHCCCS/DHCS Operations and Compliance Officer as specified in the AHCCCS Claims Dashboard Reporting Guide and Section F, Attachment F3, Contractor Chart of Deliverables.

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

44. PERFORMANCE BOND OR BOND SUBSTITUTE

In addition to the initial minimum capitalization or Equity Per Member requirements, the Contractor shall be required to establish and maintain a Performance Bond, in accordance with ACOM Policy 305 for as long as the Contractor has AHCCCS-related liabilities of $50,000 or more outstanding including contingent liabilities reported in the Contractor's financial statements, or 15 months following the termination date of this Contract, whichever is later, and will be in the amount and for the term determined by AHCCCS, to

guarantee payment of the Contractor's obligations under this Contract including but not limited to payments due to contracted providers, non-contracted providers, any other entity that subcontracts for the performance of the Contractor's obligations under this Contract whether related to coverage for services to enrollees or for the administration of this Contract [A.R.S. § 36-2903(M), 42 CFR 438.116].

In lieu of a Performance Bond, AHCCCS, in its sole discretion, may accept a Bond Substitute or combination of Bond Substitutes of the types specified in ACOM Policy 305. The Contractor agrees to perform any and all acts and execute any and all documents including, but not limited to, security agreements and necessary filings pursuant to the Arizona Uniform Commercial Code, necessary to grant AHCCCS an enforceable security interest in such Bond Substitute to secure performance of the Contractor's obligations under this Contract. The Contractor is solely responsible for establishing the creditworthiness of all forms of Bond Substitutes. AHCCCS may, after written notice to the Contractor, withdraw its permission for a Bond Substitute or Bond Substitutes, in which case the Contractor shall provide AHCCCS with Performance Bond or an alternate form of Bond Substitute acceptable to AHCCCS as specified in ACOM Policy 305.

For each year that the Contractor has actual or contingent liabilities of $50,000 or more, the Contractor shall provide documentation of the Performance Bond or bond substitutes in a form acceptable to AHCCCS as specified in ACOM Policy 305. The Contractor shall provide a written attestation, through the Performance Bond Annual Attestation Statement, consistent with 42 CFR 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond is accurate, complete, and truthful as specified in ACOM Policy 305 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

A Contractor that fails to maintain or renew the Performance Bond or Bond Substitute is considered in material breach of this Contract and is subject to Administrative Action.

Following a merger/acquisition of a Contractor or a Contractor's parent company, AHCCCS reserves the right to require additional Performance Bond assurances on behalf of the new entity, including, but not limited to, expanding the Performance Bond or Bond Substitute to include service dates prior to the merger/acquisition.

In the event of a default by the Contractor, AHCCCS shall, in addition to any other remedies it may have under this Contract, obtain payment under the Performance Bond or Bond Substitute to remedy the breach, including but not limited to one or more of the following purposes:

1. Paying any damages sustained by providers, non-contracting providers, and other subcontractors by reason of a breach of the Contractor's obligations under this Contract.

2. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor.

3. Reimbursing AHCCCS for any administrative expenses incurred by reason of a breach of the Contractor's obligations under this Contract, including, but not limited to, expenses incurred after termination of this Contract for reasons other than for the convenience of AHCCCS under Section E, Paragraph 48, Termination for Convenience, of this Contract.

4. Reimbursing expenditures incurred by AHCCCS in the direct operation of the Contractor under section E, Paragraph 43, Temporary Management/Operations of a Contractor of this Contract.

5. Paying any sanctions imposed under Section D, Paragraph 74, Administrative Actions, to the extent the sanctions are not offset against payments due from AHCCCS to the Contractor as provided for under Section E, Paragraph 38, Right of Offset, of this Contract.

Compliance with the requirements of this Section does not relieve the Contractor from the obligation to pay AHCCCS for any damages resulting from breach of this Contract if the Performance Bond or Bond Substitute is insufficient to fully indemnify AHCCCS.

The Contractor may not change the amount, duration, scope, or type of the Performance Bond or Bond Substitute without prior approval from AHCCCS/DBF, Health Care Finance.

The Contractor shall not pledge any bond substitute as collateral for a loan or security for any other loan, or debt or obligation of the Contractor, or pledge the Bond Substitute as security to creditors. The Contractor shall be in material breach of this Contract if it fails to maintain or renew the Performance Bond or Bond Substitute as required by this Contract and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

45. AMOUNT OF PERFORMANCE BOND OR BOND SUBSTITUTE

The Contractor shall provide a Performance Bond or Bond Substitute in an amount equal to 100% of the total capitation payment (excluding premium tax), including acute care only members, due to the Contractor in the first month of the Contract year. The Contractor shall provide the Performance Bond or Bond Substitute no later than 30 days following notification by AHCCCS of the amount. It is the Contractor's responsibility to self-monitor the required Performance Bond or Bond Substitute amount and notify AHCCCS of the need to increase the amount when necessary, and whether a rider to the existing Performance Bond will be used to increase the amount. If a new Performance Bond will be used to increase the amount, AHCCCS shall approve the new Performance Bond prior to execution. When the amount of the Performance Bond or Bond Substitute falls below 90% of the monthly capitation amount (excluding premium tax), the amount of the Performance Bond or Bond Substitute shall be increased to at least 100% of the monthly capitation amount (excluding premium tax). If AHCCCS notifies the Contractor of a needed change in Performance Bond or Bond Substitute amount, the Contractor shall do so no later than 30 days following notification by AHCCCS.

The Contractor may not change the amount, duration, scope, or type of the Performance Bond or Bond Substitute without prior written approval from AHCCCS/DBF, Health Care Finance. Refer to ACOM Policy 305.

46. ACCUMULATED FUND DEFICIT

The Contractor and its owners shall review financial statements for accumulated fund deficits on a quarterly and annual basis. In the event the Contractor has a fund deficit, the Contractor and its owners shall fund the deficit through capital contributions in a form acceptable to AHCCCS. The capital contributions shall 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 may, at its sole discretion impose a different timeframe than the 30 days required in this paragraph. AHCCCS may, at its sole discretion, impose sanctions and/or enrollment caps in any or all GSAs, if applicable, and/or sanction the Contractor as a result of an accumulated deficit, even if unaudited.

47. ADVANCES, EQUITY DISTRIBUTIONS, LOANS, AND INVESTMENTS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, equity distributions, loans, loan guarantees, profit sharing agreements, or investments, including, but not limited to those to related parties or affiliates including another fund or line business within its organization. The Contractor shall not, without prior approval of AHCCCS, make individual or cumulative loans, loan guarantees, or advances to providers equal to or in excess of $50,000 per Provider TIN within a contract year. The Contractor is required to report all repayment of advances, loans, loan guarantees, or investments as

specified in Section F, Attachment F3, Contractor Chart of Deliverables and ACOM Policy 418. All requests for prior approval are to be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 418 for further information.

48. FINANCIAL REPORTING AND VIABILITY STANDARDS

The Contractor shall comply with the AHCCCS established financial viability standards or any revisions or modifications of the standards, in conformance with the AHCCCS Financial Reporting Guide. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Current Ratio, Equity per Member, Contract Year to Date Medical Loss Ratio (MLR), and Contract Year to Date Administrative Cost Percentage [42 CFR 438.116 (a) and (b)]. These same standards will be reviewed for the financial statements applicable to the Contractor's Medicare LOB if the Contractor is certified by AHCCCS.

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

The Contractor shall cooperate with AHCCCS reviews of the ratios and financial viability standards below. The ratios and financial viability standards are as follows:

FINANCIAL VIABILITY STANDARDS – ALTCS EPD	
CURRENT RATIO	Current assets, less due from affiliates, divided by current liabilities. "Current Assets" includes any investments that can be converted to cash within three business days without significant loss of value (i.e., more than 10%). All components of the calculation should include annual audit adjustments. Other Assets deemed restricted by AHCCCS are excluded from this ratio. Refer to the AHCCCS Financial Reporting Guide. Standard: At least 1.00

FINANCIAL VIABILITY STANDARDS – ALTCS EPD	
EQUITY PER MEMBER	The Contractor shall self-monitor for compliance with the Equity Per Member amount every 30 days at a minimum to ensure equity per member does not fall below the required amount. The Contractor shall infuse capital to meet the Equity Per Member within 30 days of falling below the required amount. Unrestricted equity, less on-balance sheet Performance Bond or Bond Substitute, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted by AHCCCS (Refer to ACOM Policy 305), divided by the number of members at the end of the period. All components of the calculation should include annual audit adjustments. The Contractor shall self-monitor for compliance with the Equity Per Member amount every 30 days at a minimum to ensure Equity Per Member does not fall below the required amount. The Contractor shall infuse capital to meet the Equity Per Member within 30 days of falling below the required amount. The Contractor may request a waiver from AHCCCS to include the portion of the due from affiliates balance resulting from a qualifying cash sweep arrangements or a qualifying centralized cash management with or for other Arizona Medicaid lines of business (including the Non-Title XIX/XXI Contract). Additional information regarding the Equity Per Member Requirement may be found in the Performance Bond and Equity Per Member Requirements Policy in ACOM Policy 305 [42 CFR 438.604(a)(4); 42 CFR 438.606; 42 CFR 438.116]. If the Contractor fails to monitor for compliance every 30 days, and/or fails to infuse capital within 30 days of identification of noncompliance (to bring Equity Per Member back into compliance and remain in compliance), AHCCCS will review the causes for the lack of compliance. AHCCCS may require the Contractor to comply with one or more of the *"Remediation when the contract fails to meet the Equity Per member requirement"* specified in ACOM Policy 305. Standard: At least $2,000
MEDICAL LOSS RATIO	Incurred claims plus expenditures for activities that improve health care quality, divided by premium revenue less Federal, State, and local taxes and licensing and regulatory fees. Refer to the AHCCCS Financial Reporting Guide. Standard: At least 85%
ADMINISTRATIVE COST PERCENTAGE	Total administrative expenses divided by total payments received from AHCCCS less Reinsurance premium tax. All components of the calculation should include annual audit adjustments. Standard: No greater than 8%

FINANCIAL VIABILITY STANDARD – MEDICARE ADVANTAGE PLAN CERTIFIED BY AHCCCS	
EQUITY PER MEMBER	Unrestricted equity, less on-balance sheet Performance Bond or Bond Substitute, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted by AHCCCS (Refer to ACOM Policy 305), divided by the number of Medicare Advantage Plan dual eligible members enrolled at the end of the period. All components of the calculation should include annual audit adjustments. Standard: At least $350

Additional information regarding the Equity Per Member Requirement may be found in ACOM Policy 305.

Financial Reports: The Contractor shall provide clarification of accounting issues found in financial reports identified by AHCCCS upon request and provide annual Financial Reports audited by an independent Certified Public Accountant prepared in accordance with Generally Accepted Auditing Standards (GAAS) and the Cost Allocation Plan. The Contractor shall have the annual Supplemental Reports audited and signed by an independent Certified Public Accountant. [42 CFR 438.3(m)].

The Contractor shall comply with all financial reporting requirements specified in Section F, Attachment F3, Contractor Chart of Deliverables, and the AHCCCS Financial Reporting Guide [42 CFR 438.3(m)] a copy of which may be found on the AHCCCS website. The required reports are subject to change during the Term of the Contract and are summarized in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall prepare deliverables in accordance with Generally Accepted Accounting Principles (GAAP) in electronic copy form. Where specific guidance is not found in authoritative literature or where multiple acceptable methods to record accounting transactions are available, the Contractor shall, when directed by AHCCCS, comply with the requirements in conformance with the AHCCCS Financial Reporting Guide [42 CFR 438.3(m)].

Medical Loss Ratio Annual Requirement: The Contractor shall submit an MLR Report and Attestation in compliance with 42 CFR 438.8 as specified in Section F, Attachment F3, Contractor Chart of Deliverables. All components of the calculation should include annual audit adjustments and true up of any estimates to present on an incurred date of service basis. Any retroactive changes to capitation rates after the Contract Year End will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to AHCCCS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by AHCCCS. Refer to the AHCCCS Financial Reporting Guide.

The Contractor shall submit annual audit adjustments with the Draft and Final Audit Financial Reporting Packages and comply with all financial reporting requirements contained in Section F, Attachment F3, Contractor Chart of Deliverables and the AHCCCS Financial Reporting Guide. Reporting is required for both the ALTCS E/PD and Medicare LOBs, regardless of the licensing or certifying entity for the Medicare Advantage Plan. If the Contractor is a Medicare Advantage Plan licensed through the Department of Insurance and Financial Institutions, quarterly reporting to AHCCCS is required for informational purposes only. The required reports are subject to change during the Term of the Contract and are summarized in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 106 [42 CFR 438.3(m)].

The Contractor shall comply with the financial viability standards, or any revisions or modifications of the standards, in conformance with the AHCCCS Financial Reporting Guide, Financial Ratios and Standards [42 CFR 438.116 (a) and (b), 42 CFR 438.3(m)].

The Contractor shall submit unaudited financial information, including financial statements, in an Excel file through SharePoint via the Financial Reporting Package as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall utilize the AHCCCS prepared Excel template as specified in the AHCCCS Financial Reporting Guide.

The Contractor shall submit unaudited financial information, including financial statements, of any entity with a controlling interest in the Contractor (balance sheet and statement of revenues and expenses only) and shall also submit complete audited financial statements of any entity with a controlling interest in the Contractor via the Financial Reporting Package as specified in Section F, Attachment F3, Contractor Chart of Deliverables. For purposes of this Contract requirement, an entity is considered to have a controlling interest when that entity, directly or through one or more subsidiaries, has the authority to direct the operational or financial activities of the Contractor.

49. AFFILIATED CORPORATION

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

50. CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

A change in Contractor organizational structure shall require prior approval of AHCCCS, as specified in ACOM Policy 317 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall submit notification and a detailed transition plan to AHCCCS 180 days prior to the effective date as specified in ACOM Policy 317. The purpose of the transition plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to perform the Contract requirements, ensure that services to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by any change in organizational structure. AHCCCS reserves the right to obtain stakeholder input on proposed changes in a Contractor's organizational structure through a public notice and feedback process. In addition, AHCCCS reserves the right to temporarily suspend a Contractor's new member enrollment including, but not limited to, auto-assignment pending AHCCCS review and final determination regarding a Contractor's Change in Organizational Structure.

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

51. COMPENSATION

The method of compensation under this Contract for Title XIX members will be PPC and prospective capitation, special provisions for payments, and reinsurance as specified in this Contract, and appropriate laws, regulations, and policies [42 CFR 438.6(b)(1)].

Final capitation rates are identified and developed, and payment is made in accordance with 457.1201(c) and 42 CFR 438.3(c). Capitation payments may only be made by the State and retained by the Contractor for Medicaid-eligible members [42 CFR 438.3(c)(2)].

The Contractor will not receive compensation for value-added services and shall not report the cost of value-added services as allowable medical or administrative costs.

The Contractor shall comply with Rates and Reimbursement Guidance as directed by AHCCCS and subsequently made available on the AHCCCS website at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/

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

Where payments are made by EFT, AHCCCS shall not be liable for any error or delay in transfer, nor indirect or consequential damages arising from the use of the EFT process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor. Except for adjustments made to correct errors in payment, and as otherwise specified in this Contract, any savings remaining to the Contractor as a result of favorable claims experience and efficiencies in service delivery at the end of the Term of Contract may be kept by the Contractor.

All funds received by the Contractor pursuant to this Contract shall be separately accounted for in accordance with GAAP.

Except for monies received from the collection of TPLs, the only source of payment to the Contractor for the services provided hereunder is the ALTCS Fund or other AHCCCS designated or appropriated funding sources. An error discovered by the State, with or without an audit, in the amount of fees paid to the Contractor will be subject to adjustment or repayment by AHCCCS via a recoupment from future payment(s) to the Contractor, or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS shall be notified and reimbursed within 30 days of identification [42 CFR 438.608(c)(3)].

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

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn Federal authority, or which is the subject of a legislative repeal), the Contractor shall do no work on that part after the effective date of the loss of program authority. The State will adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work.

If the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to the State. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority [CMS, Medicaid, and CHIP Operations Group Letter Dated September 4, 2020].

Capitation Payments: The Contractor will be paid capitation for all prospective and PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members. Capitation is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

The Contractor will be denied payment for newly enrolled members when, and for so long as, payment for those members is denied by CMS under 42 CFR 438.730(e) [42 CFR 438.726(b), 42 CFR 438.700(b)(1)-(6), 42 CFR 438.730(e)(1)(i), 42 CFR 438.730(e)(1)(ii), Section 1903(m)(5)(B)(ii) of the Social Security Act].

The Contractor shall develop and maintain internal controls and systems to separately account for both AHCCCS-related revenue and expenses and non-AHCCCS-related revenue and expenses by type and program and develop and maintain internal controls to prevent and detect fraud, waste, and program abuse. The Contractor shall separately account for all funds received under this Contract in conformance with the requirements in the AHCCCS Financial Reporting Guide [42 CFR 438.3(m)].

Capitation Rate Development: Capitation rates are developed by AHCCCS according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice and following generally accepted actuarial principles and practices. AHCCCS provides the following data to its actuaries to establish rates for the purposes of rebasing and/or updating the capitation rates:

1. Utilization and unit cost data derived from fully adjudicated and approved encounters, as well as individual encounter level detail as needed.

2. Both unaudited and audited financial statements reported by the Contractors.

3. Home and Community Based Services (HCBS) and Institutional inflation trends.

4. AHCCCS FFS schedule pricing adjustments (if applicable).

5. Market Basket Inflation Trends.

6. Member specific statistics, e.g., member acuity, member choice.

7. Historical and projected enrollment by risk group.

8. Programmatic or Medicaid covered service changes that effect reimbursement.

9. Additional administrative requirements for the Contractor.

10. Other changes to medical practices that affect reimbursement.

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

1. Reinsurance (as specified in Section D, Paragraph 53, Reinsurance).

2. Medicare enrollment.

3. Geographic Service Area (GSA) adjustments.

4. Home and Community Based Services (HCBS) member mix.

5. Member share of cost amounts.

6. Member specific statistics, e.g., member acuity, member choice.

7. Supplemental information requested from Contractors.

Information is reviewed by AHCCCS' actuaries each year to determine if adjustments are necessary. A Contractor may cover services that are not covered under the Arizona State Plan or the 1115 Waiver Special Terms and Conditions approved by CMS; however, those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)] (Section 1903(i) and 1903(i)(17) of the Social Security Act). GME payments are not included in the capitation rates but are paid out separately consistent with the terms of the Arizona State Plan.

The Contractor will receive dual and non-dual capitation rates. Each capitation rate covers both full long-term care and acute care only members. Full long-term care members are those members who are receiving LTSS and reside in a NF, a certified home and community-based setting or in their own home. At a minimum, the member shall receive LTSS at least once every 30 days.

Acute care only members are those members who:

1. Reside in a living arrangement in which LTC Service benefits cannot be provided.

2. Refuse LTC services.

3. Have equity value in a home that exceeds the allowable amount.

4. Have made an uncompensated transfer that makes him or her ineligible to receive LTC Services.

5. Have not received LTC services in a full calendar month due to the following:
   a. Refusal of LTC services,
   b. Departure from the State for more than 30 days, or
   c. LTC provider not available.

Community Reinvestment: The Contractor shall demonstrate a commitment to the communities served by the Contractor through community reinvestment activities including contributing 6% of its annual profits to community reinvestment. The Contractor shall submit a plan, detailing its anticipated community reinvestment activities, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall submit a Community Reinvestment Report of actual expenditures as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 303.

Federally Qualified Health Centers and Rural Health Clinics: The Contractor shall pay each FQHC and RHC the unique, all-inclusive per visit rate as established by AHCCCS for all visits eligible to receive the PPS rate, except for instances in which Medicaid is not the primary payer of the claim, in which case established system logic to pay the lesser of amount may prevail.

Premium Tax: A.R.S. § 36-2905 and A.R.S. § 36-2944.01 require that the Contractor report and pay premium tax quarterly to Department of Insurance and Financial Institutions (DIFI) based on Title XIX/XXI payments received from AHCCCS during the quarter being reported. Capitation payments, reinsurance payment, reconciling payments/recoupments, supplemental payments, and cost settlements have the Premium Tax included in the payments/recoupments. Premium tax report(s) shall be due to AHCCCS/DBF,

Health Care Finance as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 304.

Provider Rate Requirements

Practitioner/Dentist Rates: As required by Laws 2020, Ch.46, Sec.2, AHCCCS increased base reimbursement rates for services reimbursed under the AHCCCS dental fee schedule and physician fee schedule effective October 1, 2020. AHCCCS expects the Contractor to maintain the fee schedule adjustments to the contracted rates that were in place three months prior to the effective date of the fee schedule increases required by Laws 2020, Ch. 46, Sec 2. If the Contractor does not intend to maintain the increase to the dental and physician rates by at least the fee schedule rate increases, the Contractor shall notify AHCCCS of the proposed rates and adjustments 60 days in advance of implementation and provide an explanation of how it intends to track, evaluate, and mitigate any potential negative impacts to access to care that could result. AHCCCS will review the proposed rates to consider if an adjustment to the Contractor's capitation rates may be warranted.

Provider Rate Requirements: AHCCCS expects that Contractor rates for individual NFs are at least equal to the AHCCCS FFS rates. AHCCCS also expects that AHCCCS FFS Fee Schedule rate adjustments should apply to all MCO fee schedules and contracted NF rates that are in place three months prior to the effective date of the FFS rate changes, including those rates for which AHCCCS does not establish an FFS rate, such as specialty and add-on rates. For specialty and add-on rates, the aggregate NF rate increase should apply. If the Contractor intends to contract with individual NFs at rates that are less than the FFS rates or does not intend to adjust rates in an amount at least equal to the FFS rate adjustment, the Contractor shall notify AHCCCS of the proposed rates and adjustments 60 days in advance of implementation and provide an explanation of how it intends to track, evaluate, and mitigate any potential negative impacts to access to care that could result. AHCCCS will review the proposed rates to consider if an adjustment to the Contractor's capitation rates may be warranted. AHCCCS may verify that these requirements for NF providers have been met.

AHCCCS expects the Contractor to apply the aggregate HCBS FFS schedule rate adjustment to the MCO ALF Fee Schedule rates and all contracted ALF rates that are in place three months prior to the effective date of the FFS rate adjustment for NF providers. If the Contractor does not intend to increase ALF rates at least equal to the FFS rate adjustment for NF providers, the Contractor shall notify AHCCCS of the proposed rates and adjustments 60 days in advance of implementation and provide an explanation of how it intends to track, evaluate, and mitigate any potential negative impacts to access to care that could result. AHCCCS will review the proposed rates to consider if an adjustment to the Contractor's capitation rates may be warranted. AHCCCS may verify that these requirements for ALF providers have been met.

AHCCCS expects the Contractor to apply the HCBS FFS fee schedule rate adjustments to the MCO Fee Schedule and all contracted HCBS rates that are in place three months prior to the effective date of the HCBS FFS rate adjustment. If the Contractor does not intend to increase HCBS rates minimally by the HCBS FFS rate increase, the Contractor shall notify AHCCCS of the proposed rates and adjustments 60 days in advance of implementation and provide an explanation of how it intends to track, evaluate, and mitigate any potential negative impacts to access to care that could result. AHCCCS will review the proposed rates to consider if an adjustment to the Contractor's capitation rates may be warranted. AHCCCS may verify that these requirements for HCBS providers have been met.

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

For information on VBP DAPs refer to Section D, Paragraph 51, Compensation.

Reconciliations

Cost Settlement for COVID Vaccine: The Contractor is responsible for COVID vaccine cost, if not covered by the Federal Government, and the vaccine administration and submitting those expenses as encounters. If the vaccine cost is not covered by the Federal Government, it will also be cost settled. AHCCCS will make cost-settlement payments to the Contractor based upon adjudicated/approved encounter data. Refer to ACOM Policy 302. These payments will continue through CYE 24.

Reconciliation of Costs to Reimbursement: AHCCCS will reconcile the Contractor's medical cost expenses to medical revenue paid excluding expenses which fall under the Cost Settlement for COVID Vaccine , to the Contractor. Refer to ACOM Policy 301. AHCCCS intends to review the limitation of profit and loss on an annual basis using a data driven approach. This Contract will limit the Contractor's profits and losses as follows:

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 2%	100%	0%	2%	2%
> 2% and <= 6%	50%	50%	2%	4%
> 6%	0%	100%	0%	4%
Loss	**MCO Share**	**State Share**	**Max MCO Loss**	**Cumulative MCO Loss**
<= 2%	100%	0%	2%	2%
> 2%	0%	100%	0%	2%

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

Special Provisions for Payment

In accordance with 42 CFR 438.6, the Contractor shall be subject to a withhold arrangement, shall be eligible for incentive payments, shall participate in delivery system and provider payment initiatives, and shall direct payments to providers as specified by AHCCCS. These provisions are specified below.

Delivery System and Provider Payment Initiatives

42 CFR Sections 438.6(c) and 438.6(d) provide the State flexibility to implement delivery system and provider payment initiatives. AHCCCS reserves the right to utilize this flexibility to require Contractor participation in initiatives that may require certain payment levels and/or certain directed payments to providers to support State actions that are critical to ensuring timely access to high-quality care. AHCCCS will obtain written approval from CMS prior to implementation, if applicable, and Contractors will be required to implement, as directed by AHCCCS guidance. AHCCCS anticipates that most initiatives will involve payments to the Contractor outside of the monthly base capitation payments, made as a separate lump sum payment. AHCCCS will compute directed payment amounts and ensure the associated payments and/or capitation rates meet actuarial soundness requirements, as applicable.

These delivery system reform initiatives [42 CFR 438.6(c)]:

1. Make participation in the delivery system reform initiative available, using the same terms of performance, to a class of providers providing services under the contract related to the reform initiative.

2. Use a common set of performance measures across all payers and providers.

3. Does not set the amount or frequency of the expenditures.

4. Does not allow AHCCCS to recoup any unspent funds allocated for these arrangements from the Contractor [42 CFR 438.6(c)(1)(ii)].

Access to Professional Services Initiative: Access to Professional Services Initiative (APSI) is a program to preserve and promote access to medical services through a uniform percentage increase to the contracted rates between the qualified practitioners and the Contractors. Contractors shall supplement, not supplant, contracted reimbursement rates with payments made under the APSI directed payment program. For professional services provided by qualified practitioners affiliated with designated hospitals as specified in ACOM Policy 330.

Federal regulation mandates that APSI payments be approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the APSI preprint. AHCCCS will compute the Qualified Practitioners rate increase and will make available to the Contractor a fifth of the estimated annual payment amounts on a quarterly basis. Interim payments are calculated using projected experience for the CY. The Contractor will be paid outside of the monthly capitation payments through a separate quarterly lump sum payment. No sooner than nine months after the contract year end there will be an adjustment to the prior year's costs based on a reconciliation of lump sum payments compared to the actual encounters. The final payment is based on actual experience from the CY being reconciled.

AHCCCS may amend the APSI components annually or during the contract year and will provide guidance to the Contractor as applicable.

American Rescue Plan Act Directed Payments

Home and Community Based Services and Rehabilitation Providers: AHCCCS seeks to provide enhanced support to HCBS and Rehabilitation providers in order to support direct care workers and enhance, expand, or strengthen HCBS through a lump sum directed payment methodology. The payments are a uniform percentage increase to the contracted rates between the qualified practitioners and the Contractors. Contractors shall supplement, not supplant, contracted reimbursement rates with ARP payments made. AHCCCS will compute the increase and will make available to the Contractor the associated amounts of payments owed to providers. The Contractor will be paid outside of the monthly capitation payments through a single separate payment. Federal regulation mandates that these payments be approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the HCBS directed payment.

Other American Rescue Plan Act Home and Community Based Services Provider Directed Payments: AHCCCS seeks to provide enhanced support to HCBS providers in order to enhance, expand, or strengthen home and community-based services through a lump sum directed payment methodology. AHCCCS will compute the increase and will make available to the Contractor the associated amounts of payments owed to providers. The Contractor will be paid outside of the

monthly capitation payments through a single separate payment. Federal regulation mandates that these payments be approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the HCBS directed payment.

Differential Adjusted Payments: AHCCCS has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. Federal regulation mandates that these payments be approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the DAPs. AHCCCS may amend the DAP components annually, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The Contractor will support the Rate Differential in accordance with 42 CFR 438.6(c)(1)(iii)(B). Contractors shall supplement, not supplant, contracted reimbursement rates with payments made under the DAP directed payment program. The DAPs require that the Contractor shall adjust payments for specific qualifying providers, in addition to any AHCCCS fee for service rate changes adopted by the Contractor, to the qualifying providers. This DAP increase to rates shall be included in all payments made to qualifying providers (including sub-capitation and block payment arrangements). These DAP payments are specified in the public notice documents on the AHCCCS website; refer to *Public Notices and Opportunities for Public Comment – Rates and Supplemental Payments, Rates Section Notice of Differential Adjusted Payments*:
https://www.azahcccs.gov/AHCCCS/PublicNotices/.

Qualifying Providers: AHCCCS will provide a reference file that will contain the qualifying DAP providers, or a provider file for individual provider flags, for applicable DAP categories. In addition, AHCCCS will post listings of the qualifying providers by DAP category on the AHCCCS –FFS Fee Schedules - –DAPs - "Qualifying Provider" web page on the AHCCCS website.
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/qualifyingproviders.html

The Contractor shall utilize these files with information specified in the DAP public notice on the AHCCCS website to increase the rates that the Contractor would otherwise pay by the appropriate percentage for contracted and non-contracted providers. For contracted providers, the DAP category is reflected as an increase in the provider contracted rates. For non-contracted providers not reimbursed at a provider-specific rate, the applicable AHCCCS MCO fee schedule (also supplied as a reference file extract) shall be used as the default base rate to which the applicable increase or increase percentages shall be applied for the qualified providers. For non-contracted providers reimbursed at a provider-specific rate, the AHCCCS supplied rates are reflective of the percent increase.

Hospital Enhanced Access Leading to Health Improvements Initiative: AHCCCS seeks to provide enhanced support to hospitals in order to preserve and enhance access to these facilities that deliver essential services to Medicaid members in Arizona. The Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII) is a program to preserve and promote access to medical services through an increase in the amounts specified by AHCCCS to the Contractor's reimbursement to contracted hospitals. Federal regulation mandates that these payments be approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the HEALTHII preprint. Contractors shall supplement not supplant contracted hospital reimbursement rates with payments made under the HEALTHII directed payment program. AHCCCS will compute the annual interim HEALTHII rate increase using projected experience for the Contract Year and will pay out 25% of the total on a quarterly basis. Lump sum payments made outside of monthly capitation will be sent to the Contractor with payment directions. No later than 12 months after the end of the contract period, AHCCCS intends to calculate final HEALTHII payment amounts by Contractor and provider based on actual utilization incurred and will direct Contractors to adjust payments. AHCCCS may

amend the HEALTHII components annually or during the contract period and will provide guidance to the Contractor as applicable.

Nursing Facility Enhanced Payments: AHCCCS seeks to provide enhanced support to NFs in order to preserve access to these providers who deliver essential services to Medicaid members in Arizona. Federal regulation mandates that these payments be prior approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the NF Enhanced Payments.

The Contractor shall participate in ensuring enhanced support by providing quarterly payments to network providers that provide NF services. In accordance with A.A.C R9-28-703(B) - *Payment to facilities by contractors*, AHCCCS shall compute the uniform dollar increase and will communicate the amount of the increase by facility to the Contractor. On at least a quarterly basis, the Contractor shall make lump sum payments to NF providers as directed by AHCCCS equal to 98% of the amount received from AHCCCS. The Contractor shall make payments within 20 calendar days from the date that funds are received. As specified in A.A.C. R9-28-703(E) - *General requirements for all payments*, a facility shall be open on the date the supplemental payment is made to be eligible for the payment. As specified in A.A.C. R9-28-703(E) - *General requirements for all payments*, a facility shall be open on the date the supplemental payment is made to be eligible for the payment. AHCCCS will work to ensure that these supplemental payments are only made to open facilities, to the extent that the closure is reported to AHCCCS. In the event that a payment is made to a closed facility, it will be the responsibility of the Contractor to recoup the payment from the provider and return 100% of the funds to AHCCCS. Refer to ACOM Policy 412.

The uniform increase is intended to supplement, not supplant, payments to eligible providers [42 CFR 438.6(c)(1)(iii)(B)].

Pediatric Services Initiative: AHCCCS seeks to provide enhanced support to ensure the financial viability of the State's Qualified Children's Hospitals as defined in ACOM Policy 327. Pediatric Services Initiative (PSI) is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractor's rates for inpatient and outpatient services provided by Qualified Children's Hospitals. Federal regulation mandates that these payments be approved by CMS before they shall be implemented. Annually, AHCCCS will notify the Contractor when CMS approves the PSI initiative. The rate increase is intended to supplement, not supplant, payments to Qualified Children's Hospitals as defined in ACOM Policy 327. AHCCCS will compute the interim rate increase and will make available to the Contractor the associated amounts of payments owed on a quarterly basis. Interim payments are calculated using projected experience for the Contract Year. The Contractor will be paid outside of the monthly capitation payments through a separate quarterly interim lump sum payment. No sooner than nine months after the contract year end there will be an adjustment to the prior year's costs based on a reconciliation of lump sum payments compared to the actual encounters. The final payment is based on actual experience from the CY being reconciled. Requirements are further specified in ACOM Policy 327.

AHCCCS may amend the PSI components annually or during the contract period and will provide guidance to the Contractor as applicable.

Incentive Arrangements: This Contract provides for the following incentive arrangements between AHCCCS and the Contractor:

Alternative Payment Model Initiative-Withhold and Quality Measure Performance Incentive: The Alternative Payment Model (APM) Withhold and Quality Measure Performance (QMP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the

capitation rates for performance on select performance measures identified in ACOM Policy 306. AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year and the computation of the performance measures.

Alternative Payment Model Initiative-Performance Based Payments: The Alternative Payment Model-Performance Based Payment (APM-PBP) incorporates an incentive arrangement under which the Contractor may receive additional funds over and above the capitation rates for implementing APM arrangements with providers who successfully meet targets established by the Contractor that are aimed at QI, such as reducing costs, improving health outcomes, or improving access to care. In accordance with ACOM Policy 307, for those APM arrangements which result in PBP to providers, AHCCCS will make a lump-sum payment to the Contractor after the completion of the contract year.

The Contractor shall submit the APM Quality Reporting Checklist and APM Quality Reporting Attachment as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall submit data for the prior Contract periods as requested by AHCCCS. Refer to ACOM Policy 307.

The Contractor shall submit the APM Strategic Plan Template and the APM Strategic Plan Attachment as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall not receive incentive payments in excess of 5% of the approved capitation payments attributable to the members or services covered by the incentive arrangements.

These incentive arrangements:

1. Are for a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

2. Are not to be renewed automatically.

3. Are made available to both public and private contractors under the same terms of performance.

4. Do not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

5. Are necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at 42 CFR 438.340 [42 CFR 438.6(b)(2)].

Withhold Arrangement: The APM Initiative – Withhold and QMP incorporates a withhold arrangement of 1% of the Contractor's capitation and a portion of, or all of, the withheld amount will be paid to the Contractor for performance on select performance measures identified in ACOM Policy 306. AHCCCS will apply the withhold after the completion of the contract year by recouping the full amount of the annual withhold. Also, after the completion of the contract year and the computation of the performance AHCCCS will reconcile the Contractor's earned portion of the withhold against the withheld funds and will make a lump sum payment to the Contractor. The Contractor will not be paid greater than 100% of the withhold.

This withhold arrangement is:

1. For a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied.

2. Not to be renewed automatically.

3. Made available to both public and private contractors under the same terms of performance.

4. Does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

5. Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the AHCCCS quality strategy under 42 CFR 438.340 [42 CFR 438.6(b)(3)].

52. MEMBER BILLING AND LIABILITY FOR PAYMENT

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

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

1. The Contractor's or any subcontractor's debts in the event of the Contractor's or the subcontractor's insolvency [42 CFR 438.106(a), 42 CFR 438.606, 42 CFR 438.116, Section 1932(b)(6) of the Social Security Act].

2. Covered services provided to the member except as permitted under A.A.C. R9-28-701.10(2) [42 CFR 438.106(b)(1)(2) and (c); 42 CFR 438.3(k), 42 CFR 438.230 (c)(1)-(2), Section 1932(b)(6) of the Social Security Act].

3. Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly [42 CFR 438.106(c), 42 CFR 438.3(k), 42 CFR 438.230, Section 1932(b)(6) of the Social Security Act].

53. REINSURANCE

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

AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level and subject to coinsurance percentages and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. PPC and prospective expenses are included under the reinsurance

program. For reimbursement of reinsurance encounters in subcapitated arrangements, refer to the AHCCCS Reinsurance Policy Manual.

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

Reinsurance as specified in this paragraph applies to all members covered under this Contract.

The table below represents deductible and coinsurance levels. Refer to the specific case type below for coverage details. The deductible level for regular reinsurance is based on the Contractor's statewide ALTCS enrollment as of October 1st of each contract year.

REINSURANCE CASE TYPE	STATEWIDE PLAN ENROLLMENT	DEDUCTIBLE WITH MEDICARE PART A	DEDUCTIBLE WITHOUT MEDICARE PART A	COINSURANCE
REGULAR REINSURANCE	0-1,999	$150,000	$75,000	75%
REGULAR REINSURANCE	2,000 +	$150,000	$75,000	75%
CATASTROPHIC REINSURANCE	N/A	N/A	N/A	85%
TRANSPLANT AND OTHER CASE TYPES	Refer to specific paragraphs below	Refer to specific paragraphs below	Refer to specific paragraphs below	Refer to specific paragraphs below

Annual deductible levels apply to all members except for State Only Transplant.

Regular Reinsurance: Regular reinsurance coverage covers partial reimbursement of covered inpatient hospital services. Inpatient services are those services provided in acute care hospitals (provider type 02), Specialty per diem hospital (provider type C4), and accredited psychiatric hospitals (provider type 71) only. Same day admit-and-discharge services do not qualify for Reinsurance. Regular reinsurance does not cover services provided by any other inpatient provider type, including but not limited to RTCs and subacute facilities. Refer to the AHCCCS Reinsurance Policy Manual for further details.

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

For all reinsurance case types, for services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation/policy limiting 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.

Encounters for claims which cross over reinsurance contract years will not be eligible for reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.

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

The Contractor shall 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, the replacement encounter shall be submitted and reach adjudicated/approved status within 15 months of end date of service to receive adjusted reinsurance benefits. The Contractor should refer to Section D, Paragraph 68, Encounter Data Reporting, for encounter reporting requirements. Refer to the AHCCCS Reinsurance Policy Manual for further details.

When a member changes Contractors within a reinsurance contract year, costs incurred for that member do not follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current reinsurance contract year) will not be applied toward the receiving Contractor's deductible level.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biologics/high-cost specialty drugs, as well as those members who are diagnosed with Hemophilia, von Willebrand's Disease, or Gaucher's Disease, as follows:

> ***Biologics/High-Cost Specialty Drugs***: Catastrophic reinsurance is available to cover the cost of certain biologics/high-cost specialty drugs when medically necessary, including other high cost, low frequency drugs identified by AHCCCS on a case-by-case basis. Refer to the AHCCCS Reinsurance Policy Manual for a complete list of the approved biologics/high-cost specialty drugs. When a biosimilar (generic equivalent) of a biologic/high-cost specialty drug is available, and AHCCCS has determined that the biosimilar is more cost effective than the brand name biologic/high-cost product, AHCCCS will reimburse 85% of the lesser of the biologic/high-cost specialty drug or its biosimilar equivalent for reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific member. If the AHCCCS P&T Committee mandates the utilization of only the brand name biologic/high-cost specialty drug rather than the biosimilar, AHCCCS will reimburse 85% of the paid amount of the branded biologic/high-cost specialty drug. All biologic/ high-cost specialty drugs must be encountered on a Form C pharmacy claim to be eligible for reinsurance. Members transitioning to different biologics and/or high-cost specialty drugs or receiving multiple biologics and/or high-cost specialty drugs must request authorization from AHCCCS/DHCS, MM for each separate drug in order to receive Reinsurance.
>
> ***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.
>
> ***Hemophilia***: Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia or Von Willebrand's. AHCCCS holds a specialty contract for anti-hemophilic agents and related services for Hemophilia or Von Willebrand's. The Contractor shall exclusively utilize the AHCCCS contract for Hemophilia Factor and Blood Disorders as the authorizing payor. As such, the Contractor will provide PA, care coordination, and reimbursement for all components covered under the Contract for their members. The Contractor will comply with the terms and conditions of the AHCCCS Contract. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower.

***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.

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

Gene therapies will be evaluated on a case-by-case basis for members with hemophilia, Von Willebrand's, Gaucher's and all other disease states.

The Contractor shall notify AHCCCS of cases identified for catastrophic reinsurance coverage (Catastrophic Reinsurance Request), as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. For continuation of previously approved catastrophic reinsurance, the Contractor shall submit the Catastrophic Reinsurance Request and Catastrophic Reinsurance Crossover Member List as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

Members considered by AHCCCS/DHCS to be high-cost behavioral health will be covered under catastrophic reinsurance using separate guidelines. In order to qualify for reinsurance reimbursement these members shall have been approved by AHCCCS prior to October 1, 2007, and active on September 30, 2007. Behavioral health reinsurance will cover the institutional or HCBS setting only. Acute care services and all other ALTCS services are not covered by catastrophic behavioral health reinsurance. The Contractor will be reimbursed at 75% of allowable payments with no deductible. Refer to AMPM Policy 1620-I. The Contractor shall submit their NF Contracted Rates for Reinsurance as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Other Catastrophic Reinsurance: For all reinsurance case types other than transplants, the Contractor is reimbursed 100% for all medically necessary covered expenses provided in a reinsurance contract year, after the reinsurance case reaches $1,000,000. It is the responsibility of the Contractor to notify the AHCCCS/DBF, Health Care Finance, Reinsurance Supervisor and Reinsurance Analyst once a reinsurance case reaches $1,000,000. Failure to notify AHCCCS or failure to adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters for 100% reimbursement consideration.

Regular and Catastrophic Reinsurance Cases Payment: AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/ TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. For reimbursement of reinsurance encounters in subcapitated arrangements, refer to the AHCCCS Reinsurance Policy Manual.

All catastrophic claims are subject to medical review by AHCCCS.

Transplant Reinsurance: This program covers members who are eligible to receive AHCCCS covered major organ and tissue transplants. Refer to AMPM Policy 310-DD and the AHCCCS Reinsurance Policy Manual for covered services and types of organ and tissue transplants. The Contractor shall notify AHCCCS when a member is referred to a transplant facility for evaluation for an AHCCCS covered organ transplant. Transplant reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. In order to qualify for reinsurance benefits, the Transplant Reinsurance Request shall be received by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. For continuation of previously approved transplant reinsurance, the Contractor shall submit the Transplant Reinsurance Crossover Member List with members that have a component that crosses the contract year as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

If a Contractor intends to use a non-contracted transplant facility for a covered transplant and AHCCCS already holds a contract for that transplant type, or a non-contracted transplant type at a contracted transplant facility, the Contractor must obtain prior approval from the AHCCCS/DHCS, MM. An approved transplant performed at a non-contracted facility will be reimbursed at 85% of the lesser of 1) the AHCCCS transplant contracted rate for the same organ or tissue, if available, or 2) the health plan paid amount. Depending on the unique circumstances of each approved non-contracted transplant, AHCCCS/DBF, Health Care Finance, Finance/Reinsurance may consider, on a case-by-case basis, reinsurance coverage at 85% of the Contractor's paid amount for comparable case/component rates. If no prior approval is obtained, and the Contractor incurs costs at the non-contracted facility or for a noncontracted transplant type , those costs are not eligible for either transplant or regular reinsurance.

Transplant Reinsurance Cases Payment: Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplant services rendered, or 85% of the Contractor's paid amount. Transplant contracts include per diem rates for inpatient follow-up care post-transplant (day 11+ for kidneys and day 61+ for all other transplants). Reinsurance for inpatient follow-up care post-transplant follows the regular reinsurance reimbursement, including a deductible requirement. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplant rates may be found on the AHCCCS website.

Reinsurance payments are linked to transplant encounter submissions. The Contractor is required to submit all supporting encounters for transplant services and additional documentation as identified in the AHCCCS Reinsurance Policy Manual. In order to receive reinsurance payment for transplant stages, billed amounts and Contractor paid amounts for adjudicated encounters shall equal the amounts on the required documentation submitted to AHCCCS. Timeliness for each component payment will be calculated based on the latest adjudication date for the complete set of encounters related to the component. Clean claims shall be received no later than 15 months from the end date of service for each particular transplant stage. Refer to the AHCCCS Reinsurance Policy Manual for the appropriate billing of transplant services.

Transplant Extended Eligibility Option One and Option Two: Individuals who are currently on the transplant waiting list and subsequently lose eligibility may become eligible for and select one of two eligibility options. Extended eligibility is authorized only for members who have met all of the following conditions:

1. The individual has been determined ineligible due to excess income.

2. The individual was on the transplant waitlist before AHCCCS eligibility expired.

3. The individual entered into a contractual arrangement with the transplant facility to pay the amount of income, which is in excess of the eligibility income standards (referred to as transplant share of cost).

   Option One: Extended eligibility is for one 12-month continuous period of time. During that time, the member is eligible for all AHCCCS covered services including transplant as long as they continue to remain on the transplant waiting list. All medically necessary covered services provided to Option one members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters. The member must be enrolled under rate code 3100 or 310z. If determined medically ineligible for a transplant at any time during the period, eligibility for AHCCCS covered services will terminate at the end of the calendar month in which the determination is made.

   Option Two: Extended eligibility covers transplant services only. At the time that the transplant is scheduled to be performed, the transplant candidate will reapply and will be re-enrolled with their previous Contractor to receive all covered transplant services. The member must be enrolled under rate code 3200 or 320z.

Reinsurance coverage for State Only Option one and Option two members (as specified in Section D, Paragraph 2, Eligibility) for transplants received at an AHCCCS contracted facility is paid at the lesser of 1) 100% of the AHCCCS contract amount for the transplantation services rendered, less the transplant share of cost; or 2) 100% of the Contractor paid amount, less the transplant share of cost, refer to the AHCCCS Reinsurance Manual. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplant services rendered less the transplant share of cost, or 100% of the Contractor paid amount, less the transplant share of cost. All Option one and Option two transplants are subject to the terms regarding non-contracted facility transplants set forth above and in the AHCCCS Reinsurance Policy Manual. The AHCCCS contracted transplant rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCS as specified in the AMPM Policy 310-DD Attachments A.

Disputed Matters: For encounters which are the subject of a member appeal, provider claim dispute, grievance, or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the longer of: 1) 90 days from the date of the final decision in that proceeding/action or 2) 15 months from the end date of service/date of eligibility posting to file the reinsurance encounter AND for the reinsurance encounters to reach adjudicated/approved status. Therefore, reinsurance encounters for disputed matters will be considered timely if both the Notice of Decision letter is received and the encounters reach adjudicated/approved status no later than 90 days from the date of the final decision in that proceeding/action even though the 15-month deadline may have expired. Failure to submit the Notice of Decision and the encounters within the applicable timeframes specified above will result in the denial of reinsurance.

54. CAPITATION ADJUSTMENTS

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

Rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles. Capitation rates may be modified during the term of the Contract when changes to provisions in the Contract require adjustment to maintain actuarially sound rates.

In addition, AHCCCS, at its sole discretion, may adjust capitation rates to address fundamental changes in circumstances such as:

1. Program changes.

2. Legislative requirements.

3. Updated encounter experience.

4. Rate setting assumptions.

5. Centers for Medicare and Medicaid Services (CMS) mandates.

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

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

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

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

1. Death of a member.

2. Inmate of a public institution.

3. Institution for Mental Diseases (IMD) stays greater than 15 cumulative days during the calendar month for members aged 21-64.

4. Duplicate capitation to the same Contractor.

5. Adjustment based on change in member's contract type.

6. Voluntary withdrawal.

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

Inmate of a Public Institution Reporting: The Arizona Department of Corrections Rehabilitation and Reentry (ADCRR) and several Counties are submitting a daily file of inmates entering or being released from their custody. AHCCCS matches these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration or their eligibility period if shorter. AHCCCS will provide the Contractor

with incarceration information for the member on the Contractor's 834 file. The file will indicate an "IE" code for ineligible associated with the disenrollment. The file will also include a data element indicating "CTYPRI" (with the County of jurisdiction) or "DOCMAT" (DOC Matched Recipient) as the new health plan of enrollment due to incarceration. Upon release from incarceration, the member will be re-enrolled with their previous Contractor unless that plan is no longer available to the member. If the plan the member was enrolled in prior to incarceration is no longer available, the member will be auto-assigned using the current enrollment rules. A member is eligible for covered services until the effective date of the member's "no-pay" status.

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

1. AHCCCS ID.

2. Name.

3. DOB.

4. When incarcerated.

5. Where incarcerated.

Refer to the AHCCCS Medical Assistance Eligibility Policy Manual Chapter 500, 525 Not an Inmate and section MA1502J of the EPM; AHCCCS Medical Assistance Eligibility Policy Manual Chapter 1500, 1502 Types of Changes, V. Incarcerated

55. MEMBER SHARE OF COST

ALTCS E/PD members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the share of cost, have a share of cost in the amount of $0.00. Generally, only institutionalized ALTCS members have a share of cost. 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]. Refer to AHCCCS Medical Assistance Eligibility Policy Manual on the AHCCCS website for a complete list of share of cost adjustments.

The Contractor receives monthly capitation payments which incorporate an assumed deduction for the share of cost members contribute to the cost of care. Refer to Section D, Paragraph 51, Compensation, for details on the share of cost reconciliation. The Contractor or its subcontractors has sole responsibility for collecting members' share of cost. The Contractor has the option of collecting the share of cost or delegating this responsibility to the provider. The Contractor may transfer this responsibility to NFs, IMD for those 65 years of age and older, Inpatient Psychiatric Facilities for those under 21 years of age, and HCBS Providers and compensate these facilities net of the share of cost amount. If the Contractor delegates this responsibility to the provider, the provider contract shall spell out complete details of both parties' obligations in share of cost collection. The Contractor or its subcontractors shall not assess late fees for the collection of the share of cost from members.

56. COPAYMENTS

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

57. PEDIATRIC IMMUNIZATIONS AND THE VACCINE FOR CHILDREN PROGRAM

Through the VFC Federal and State governments purchase, and make available to providers at no cost, vaccines for AHCCCS children under age 19. Therefore, the Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Contractor shall contact AHCCCS/DHCS, QM for guidance. Any provider licensed by the State to administer immunizations may "enroll with ADHS as a "VFC provider" to receive these vaccines. Providers shall enroll and re-enroll annually with the VFC program. The Contractor shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS. The Contractor shall comply with all VFC requirements and monitor contracted providers to ensure that providers are registered as VFC providers when acting as PCPs for members under the age of 19 years.

Whenever possible, members shall be assigned to VFC providers within the same or a nearby community within the respective GSA. When it is not possible, the Contractor shall develop processes to ensure vaccinations are available through a VFC enrolled provider or through the appropriate County Health Department. In all instances, the antigens are to be provided through the VFC program. The Contractor shall develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

Arizona State law requires the reporting of all immunizations given to children under the age of 19. Immunizations shall be reported at least monthly to the ADHS Immunization Registry. Reported immunizations are held in a central database known as Arizona State Immunization Information System (ASIIS), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor shall educate its provider network about these reporting requirements and the use of this resource. Refer to AMPM Policy 430.

58. COORDINATION OF BENEFITS AND THIRD-PARTY LIABILITY

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

If the Contractor verifies the existence of a liable third party that is not known to AHCCCS, or identifies any change in coverage, the Contractor shall report the information as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 74, Administrative Actions.

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

The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. § 36-2903, and A.A.C. Title 9, Chapter 28, Article 9., so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this Contract. The two methods used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as specified in A.A.C. Title 9, Chapter 28, Article 9., Federal and State law, and ACOM Policy 434. For Contractor cost sharing responsibilities for members covered by both Medicare and Medicaid refer to ACOM Policy 201 [42 CFR 433 Subpart D, 42 CFR 447.20].

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

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

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

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

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

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

***Medicare Fee-for-Service Crossover Claims Payment Coordination*:** AHCCCS delegates to Contractor's coordination of benefits payment activities with legally liable third parties, including Medicare.

For dual eligible members, Contractors shall coordinate Medicare FFS crossover claims payment activities with the Medicare Benefits Coordination and Recovery Center (BCRC) in accordance with 42 CFR 438.3(t).

The Contractor shall be registered with the BCRC as an AHCCCS trading partner to electronically process Medicare FFS crossover claims. An Attachment to the existing AHCCCS Medicare FFS Coordination of Benefits Agreement (COBA) shall be executed by Contractors and AHCCCS to register with the BCRC as a trading partner. Upon completion of the registration process, the BCRC shall issue each Contractor a unique COB ID number upon completion of BCRC readiness review activities.

Upon receipt of its BCRC COB ID number, the Contractor shall coordinate with BCRC regarding the electronic exchange and transmission of necessary BCRC-provided data files and file layouts, including eligibility and claim data files to coordinate payment of Medicare FFS crossover claims only.

Further information and resources for Contractors regarding the Medicare FFS cross-over claims process and BCRC requirements are available on the BCRC web page: www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html

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

Post-Payment Recoveries: Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, the Contractor shall adjudicate the claim and then utilize post-payment recovery processes which include pay and chase, retroactive recoveries involving commercial insurance payor sources, and other TPL recoveries. Refer to ACOM Policy 434.

Pay and Chase: The Contractor shall pay the full amount of the claim according to the AHCCCS Capped FFS Schedule or the contracted rate and then seek reimbursement from any third party if the claim meets the requirements specified in ACOM Policy 434.

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

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

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

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

Upon identification of a potentially liable third party for any of the above situations, the Contractor shall, within 10 business days, report the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in

one of the remedies specified in Section D, Paragraph 74, Administrative Actions. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tort-feasor(s) to recover damages arising from the same or similar set of circumstances (e.g., class action lawsuits) regardless of whether any reinsurance or FFS payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or FFS payments are involved. By contrast, a "joint" case is one where FFS payments and/or reinsurance payments are involved. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

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

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

1. Total collections received do not exceed the total amount of the Contractor's financial liability for the member.

2. There are no payments made by AHCCCS related to FFS, reinsurance, or administrative costs (e.g., lien filing).

3. Such recovery is not prohibited by Federal or State law.

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

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

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

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

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

59. MEDICARE SERVICES AND COST-SHARING

Medicare Services: Dual eligible members shall have choice of all providers in the Contractor's network. The Contractor shall coordinate Medicare services based on a dual eligible member's coverage choices through Original Medicare (FFS), a Medicare Advantage Plan, or a State-contracted Medicare Advantage (D-SNP) with prescription drug coverage (a Medicare Advantage D-SNP with prescription drug coverage (a Medicare Advantage Part C D-SNP that covers Medicare Parts A, B and D services).

Certain Medicare covered Part B preventive services are available to dual eligible members at little or no out of pocket cost. Refer to www.medicare.gov for further information.

Medicare Cost Sharing: The Contractor shall pay Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost-sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor shall limit their cost sharing responsibility according to A.A.C. R9-29-301 and A.A.C. R9-29-302 and as further specified in ACOM Policy 201. Refer to Section D, Paragraph 11, Scope of Services, *Prescription Medications,* regarding coverage of Medicare Part D medications.

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

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible member is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to CMS, the Contractor shall notify AHCCCS pursuant to ACOM Policy 201 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

60. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including ACOM Policy 101 [42 CFR 438.104]. The Contractor shall submit all proposed marketing for approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables and as specified in ACOM Policy 101. All marketing materials that have been approved by the AHCCCS Marketing Committee may be distributed by the Contractor for a period of two years from the date of approval and shall be re-approved after that time. Pursuant to 42 CFR 438.104, the AHCCCS Marketing Committee will consult with the Arizona State Medicaid Advisory Committee (SMAC) in reviewing submitted marketing materials.

The Contractor shall submit a Marketing Activities Report of pre-approved events the Contractor participated in within the past six months, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The AHCCCS Marketing Committee will review the Contractor's submission to determine if the Contractor's participation in the events complies with ACOM Policy 101. If AHCCCS determines a violation occurred, the Contractor may be subject to Administrative Action.

61. SURVEYS

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

Survey findings or performance rates for survey questions may result in regulatory action including, but not limited to, the Contractor being required to develop a CAP, the Contractor being required to participate in technical assistance or AHCCCS-led workgroups to improve any areas of concern noted by AHCCCS, and/or sanctions. Failure to effectively develop and/or implement AHCCCS-approved CAPs and drive improvement may result in additional Administrative Action by AHCCCS.

AHCCCS Required Surveys: The Contractor may be required to perform annual surveys. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. The Final Survey Tool and Results, including any related analysis, shall be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Survey results are to be reported separately by Title XIX and Title XXI categories and in aggregate, as applicable or as directed by AHCCCS. The Contractor shall utilize member survey findings to improve care for Title XIX and Title XXI members.

As specified in Section F, Attachment F3, Contractor Chart of Deliverables, the Contractor is required to perform periodic surveys of its membership, as specified in ACOM Policy 424, in order to verify that members have received services that have been paid for by the Contractor and to identify potential service/claim fraud [42 CFR 455.20, 42 CFR 433.116]. The Contractor, or its subcontractor if the Contractor has delegated its responsibilities for coverage of services and payment of claims, shall perform these surveys [42 CFR 438.608(a)(5)].

The Contractor shall participate in conducting and/or reviewing the results of the member surveys as requested by AHCCCS. Surveys may include HCBS member experience surveys, HEDIS® Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, and/or any other tool that AHCCCS determines will benefit QI efforts.

Non-AHCCCS Required Surveys: For non-AHCCCS required surveys, including surveys required by NCQA to meet NCQA requirements, the Contractor shall provide notification as specified in Section F, Attachment F3, Contractor Chart of Deliverables, prior to conducting any Contractor initiated member or provider survey. The notification shall include a project scope statement, project timeline, and a copy of the survey. Survey results are to be reported separately by Title XIX and Title XXI categories and in aggregate, as applicable. The Contractor shall utilize member survey findings to improve care for Title XIX and Title XXI members. The results and analysis of the results for any Contractor initiated surveys, including identification of the population(s) surveyed, shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Surveys performed by the Contractor to evaluate health plan satisfaction for previous members (exit surveys), are subject to the above notification requirement for non-AHCCCS required surveys and are not subject to AHCCCS Marketing Committee approval.

Surveys are not subject to the file and use review process.

62. PATIENT TRUST ACCOUNT MONITORING

The Contractor shall have a policy regarding on-site monitoring of trust fund accounts for institutionalized members to ensure that expenditures from a member's trust fund comply with Federal and State regulations. Suspected incidents of fraud involving the management of these accounts shall be reported in accordance with Section D, Paragraph 64, Corporate Compliance. If the Contractor identifies that a patient trust account combined with other resources will exceed the allowable resource limit specified in A.A.C R9-28-407, or a balance nearing that limit, they shall submit an MCR to the ALTCS eligibility office.

63. CULTURAL COMPETENCY

The Contractor shall participate in AHCCCS' efforts to promote, and shall implement a program that promotes, the delivery of services in a culturally competent manner to all members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity and meets the requirements of ACOM Policy 405 [42 CFR 438.3(d)(4), 42 CFR 438.206(c)(2), 45 CFR Part 92].

The Contractor shall develop and implement a Cultural Competency Plan which meets the requirements of ACOM Policy 405. An annual assessment of the effectiveness of the Cultural Competency Plan, with any modifications to the Plan, shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

64. CORPORATE COMPLIANCE

Corporate Compliance Program: The requirements of 42 CFR 438.608 are imposed on the Contractor and the Contractor shall ensure compliance with those provisions. The Contractor shall have a mandatory Corporate Compliance Program that is designed to guard against fraud and abuse and is supported by other administrative procedures including a Corporate Compliance Plan.

The Contractor shall appoint a Corporate Compliance Officer in accordance with Section D, Paragraph 26, Staffing Requirements. The Contractor's written Corporate Compliance Plan shall adhere to Contract and ACOM Policy 103 and shall be submitted to AHCCCS/OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Corporate Compliance Program shall be designed to prevent, detect, and report fraud, waste, or abuse. The compliance program shall 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 rules, regulations, guidelines, and standards.

2. The Corporate Compliance Officer shall be an onsite or virtual management official who reports directly to the Contractor's CEO and Board of Directors, if applicable. If working virtually, the Corporate Compliance Officer shall do so within the same county as the Contractor's local office. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract.

3. Effective lines of communication between the Corporate Compliance Officer and the Contractor's employees.

4. Enforcement of standards through well-publicized disciplinary guidelines.

5. Establishment and implementation of procedures that include provision for the prompt referral of any potential fraud, waste, or abuse to AHCCCS/OIG.

6. Establishment and implementation of procedures and a system with dedicated staff for routine monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly to reduce the potential for recurrence, ongoing compliance with requirements under the Contract, and external monitoring and auditing of subcontractors.

7. Submission of an External Audit Plan/Schedule, and Audit Report of all individual provider audits to AHCCCS/OIG as specified in ACOM Policy 103 and Section F, Attachment F3, Contractor Chart of Deliverables.

8. Establishment of a Regulatory Compliance Committee involving the Board of Directors and the Contractor's senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements of the Contract.

9. Compliance with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 438.608(a)(6)]. As a condition for receiving payments, the Contractor shall establish written policies, and shall ensure adequate training and ongoing education for, all of its employees (including management), members, and of any subcontractors and/or agents of the Contractor regarding the following:
   a. Detailed information about the Federal False Claims Act,
   b. The administrative remedies for false claims and statements,
   c. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and
   d. The whistleblower protections under such laws.

10. Establishment of a system for training and education for the Corporate Compliance Officer, the Contractor's senior management, all staff and new hires on the Federal and State standards and requirements under the Contract, including the items in number 9 above. All training shall be conducted in such a manner that can be verified by AHCCCS.

11. Notification to AHCCCS/Office of Data Analytics (ODA), as specified in Section F, Attachment F3, Contractor Chart of Deliverables of any CMS compliance issues related to Health Insurance Portability and Accountability Act (HIPAA) transaction and code set complaints or sanctions.

12. Reporting to AHCCCS of description of transactions between the Contractor and a party in interest as defined in Section 1318(b) of the Social Security Act, including the following transactions as specified in Section F, Attachment F3, Contractor Chart of Deliverables [Section 1903(m)(4)(B) of the Social Security Act]:
   a. Any sale or exchange, or leasing of any property between the organization and such a party,
   b. Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment, and
   c. Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported regarding an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

The Contractor shall make the information reported available to its members upon reasonable request.

Disclosure Information: The Contractor shall submit all disclosure Information requested in ACOM Policy 103 and its attachments, and as required by Federal and State law, including but not limited to the following: Disclosure of Ownership or Control Interest; fiscal agents; business transactions; persons convicted of crimes as specified in regulation, ACOM Policy 103, and in Section F, Attachment F3, Contractor Chart of Deliverables; and creditors [42 CFR 455, Subpart B, 42 CFR 455.436, 42 CFR 438.602(c), 42 CFR 438.604(a)(6), 42 CFR 438.606, 42 CFR 438.608(c)(2), SMDL 08-003 and 09-001, Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act]. Disclosures shall be made in accordance with ACOM Policy 103, as directed by regulation, and upon request from AHCCCS or CMS [42 CFR 455, Subpart B].

The Contractor shall provide the above-listed disclosure information to AHCCCS at any and all of the following times [Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act, 42 CFR 438.608(c)(2), 42 CFR 455.100–103, and 42 CFR 455.104(c)(3)]:

1. Upon the Contractor submitting the Proposal in accordance with the State's procurement process.

2. Upon the Contractor executing the Contract with the State.

3. Upon renewal or extension of the Contract.

4. 45 days prior to the effective date of commencement of operations for a change in Contractor Organizational Structure. Refer to ACOM Policy 317.

5. Within 35 days after any change.

6. Upon request by AHCCCS.

The Contractor shall immediately notify AHCCCS/OIG of any person who has been excluded through these checks as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

FFP is not available for any amounts paid to a Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

1. The Contractor is controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(1), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09].

2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as specified in Section 1128(b)(8)(B) of the Social Security Act [42 C FR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09].

3. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual or entity that is, or is affiliated with a person/entity that is, debarred, suspended, or

excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [Section 1932(d)(1) of the Social Security Act, 42 CFR 438.608(c)(1), 42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(a)(1)-(2), (b), (c)(1)-(4), and (d)(2), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549].

4. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09].

5. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:
   a. Any individual or entity that is, or was affiliated with a person/entity that is, excluded from participation in any Federal health care programs [42 CFR 438.808, 42 CFR 438.610, Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549], and
   b. Any entity that would provide those services through an excluded individual or entity excluded from participation in any Federal healthcare program [42 CFR 438.808, 42 CFR 438.610, Section 1903(i)(2) of the Social Security Act, 42 CFR 431.55(h), 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, and SMDL 1/16/09].

Should AHCCCS learn that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act, AHCCCS may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation [Executive Order No. 12549, 42 CFR 438.610].

The Contractor shall require Fiscal Agents and Administrative Services Subcontractors to adhere to the requirements specified above regarding disclosure Information requested in ACOM Policy 103 and its attachments, and as required by Federal and State law, including but not limited to the following: Disclosure of Ownership or Control Interest; fiscal agents; business transactions; persons convicted of crimes [42 CFR 455, Subpart B, 42 CFR 455.436, 42 CFR 438.608(c), 42 CFR 455.436, SMDL 09-001, Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act]. Administrative Services Subcontractors shall disclose to AHCCCS/OIG the identity of any excluded person [42 CFR 438.604(a)(6), 42 CFR 438.606, 42 CFR 455.104, 42 CFR 438.230, 42 CFR 438.608(c)(2)]. Refer to ACOM Policy 103 and its attachments.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) and (1903(i) and 1903(i)(2)(A)) of the Social Security Act.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical

direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) (Sections 1903(i) and 1903(i)(2)(B))of the Social Security Act).

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the State has failed to suspend payments during any period in which the State has notified the Contractor of a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments (Section 1903(i) and 1903(i)(2)(C)) of the Social Security Act).

Reporting Alleged Fraud, Waste, or Abuse of the AHCCCS Program: In accordance with A.R.S. § 36-2918.01, § 36-2932, § 36-2905.04 and ACOM Policy 103, the Contractor, its subcontractors, and providers are required to notify the AHCCCS/OIG regarding all allegations of fraud, waste, or abuse involving the AHCCCS Program. The Contractor shall promptly notify AHCCCS when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member [42 CFR 438.608(a)(3)]. The Contractor shall not conduct any investigation or review of the allegations of fraud, waste, or abuse involving the AHCCCS Program. Notification to AHCCCS/OIG shall be in accordance with ACOM Policy 103 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall also report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, any credentialing denials including, but not limited to those which are the result of licensure issues, QOC concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS/OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.17, 42 CFR 455.1(a)(1)].

The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS/OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic, or written requests for information within the timeframe specified by AHCCCS/OIG. The Contractor agrees to provide documents, including original documents, to AHCCCS/OIG upon request and at no cost. The AHCCCS/OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 30 calendar days from the date of the AHCCCS/OIG request.

Once the Contractor has referred a case of alleged fraud, waste, or abuse to AHCCCS/OIG, the Contractor shall take no action to audit, investigate, recoup, or otherwise offset any suspected overpayments. This includes subcontractors working on behalf of the Contractor. In the event that AHCCCS/OIG, either through a criminal restitution order, civil monetary penalty or assessment, a global civil settlement or judgment, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity/individual, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. The Contractor hereby assigns to AHCCCS each, every, any and all of its rights to recover overpayments due to fraud, waste or abuse including any and all monetary recoveries in connection with, related to, or otherwise arising out the overpayment(s). In the event that the Contractor has recovered an overpayment, the Contractor shall notify AHCCCS/OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS/OIG will notify the Contractor when the investigation concludes. If it is determined by AHCCCS/OIG to not be a fraud, waste, or abuse case, the Contractor shall adhere to the applicable AHCCCS policy manuals for disposition.

Termination of Provider From Contractor Network of Providers: The Contractor shall ensure, for itself and require of any subcontractor(s), that any provider of services or person terminated (as defined in 42 CFR 455.101) from participation in the AHCCCS Medicaid Program, other XIX programs, Title XVIII or XXI programs, shall be terminated from participating with Contractor as a provider in any of Contractor's network of providers who render services to individuals eligible to receive medical assistance pursuant to Title XIX.

65. RECORD RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the QOC, medical records, prescription files and other records specified by AHCCCS.

The Contractor 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, Federal or State government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this Contract unless a longer period of time is required by law.
The Contractor shall comply with the record keeping requirements specified in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the Contractor shall ensure compliance with A.R.S. § 12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient's medical records for at least six years after the last date the adult patient received medical or health care services from that provider.

2. If the patient is under 18 years of age, the provider shall retain the patient's medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the Contractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If this Contract is completely or partially terminated records shall be retained as specified above.

66. MEDICARE REQUIREMENTS

Medicaid members also enrolled in Medicare are referred to as dual eligible members. To improve care coordination for dual eligible members, the State requires the Contractor or its affiliated organization (Contractor) to provide Medicare benefits to dual eligible members through a CMS and State-contracted Medicare Advantage D-SNP for all counties in the Contractor's contracted GSAs. To match the population served, the D-SNP Type shall be a D-SNP subset that matches this Contract.

The Contractor's D-SNP shall provide care coordination as well as information and data reporting as required by AHCCCS, and as detailed in its executed Medicare Advantage D-SNP Health Plan Agreement with AHCCCS,

which outlines requirements that aim to improve care coordination and timely information sharing for enrolled dual eligible members consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 Medicare Improvements for Patients and Provider Act (MIPPA), and the ACA. State-Contracted D-SNP MIPPA Agreements are available on the AHCCCS website. Further information regarding execution of a D-SNP MIPPA Agreement with AHCCCS is available in ACOM Policy 107.

Activities to Enhance Alignment: State-contracted D-SNPs not previously approved by CMS for Default Enrollment activities shall submit to CMS an initial application to perform such activities, subject to the requirements of 42 CFR 422.66 and applicable CMS regulatory guidance. CMS approval of an initial application to perform default enrollment activities shall be obtained from CMS.

D-SNPs currently authorized by CMS to perform default enrollment activities shall renew such authorizations in accordance with the requirements and timeframes of 42 CFR 422.66 and applicable CMS regulatory guidance.

D-SNP shall coordinate default enrollment of newly Medicare eligible individuals who are currently enrolled only in its companion Medicaid Plan. Default enrollment procedures are detailed by CMS in 42 CFR 422.66 and *Medicare Managed Care Manual*, Chapter 2, Section 40.1.4to include individuals who are aging-in to Medicare, as well as those qualifying for Medicare upon the completion of the 24-month waiting period due to a disability. D-SNP shall report default enrollment statistics to AHCCCS, as specified in its State-contracted Medicare Advantage D-SNP Health Plan Agreement.

AHCCCS will continue to establish requirements to improve alignment and enhance care coordination for dual eligible members. State-contracted D-SNPs shall collaborate with AHCCCS, and CMS as applicable, in developing and implementing additional strategies that enhance alignment of dual eligible members enrolled in D-SNPs and companion Medicaid Plans.

Medicaid Eligibility: D-SNPs are responsible for coordinating care on behalf of enrolled full benefit dual eligible members who are defined as:

1. Qualified Medicare Beneficiary with full AHCCCS medical assistance benefits (QMB Plus).

2. Specified Low Income Medicare Beneficiary (SLMB) with full AHCCCS medical assistance benefits (SLMB Plus).

3. Other FBDE Beneficiary, to include Freedom to Work waiver members.

Medicare Branding: The Contractor shall establish and implement appropriate CMS-approved branding for offered Medicare D-SNP product(s) that is readily identifiable by members and providers as an integrated plan for both Medicare and Medicaid covered services.

Medicare State Certification: Medicare Advantage plans are required to be licensed under State law. As specified in A.R.S 36-2903(B)(2) AHCCCS has the authority to certify its Contractors for Medicare purposes. The Contractor may apply for its companion Medicare Advantage D-SNP certification through AHCCCS or apply and obtain such licensure through the Arizona Department of Insurance. The AHCCCS certification process is detailed in ACOM Policy 106.

Medicare Structure: The Contractor shall ensure the integration of Medicare and Medicaid services. As required by A.R.S. § 36-2906.01, the Contractor shall establish an affiliated corporation whose only authorized business is to provide services under this Contract to AHCCCS eligible persons enrolled with the Contractor. This affiliated corporation shall be established within 120 days of contract award. In

addition, the Contractor shall operate a CMS and State-contracted D-SNP serving beneficiaries eligible for both Medicare and Medicaid. The Contractor shall have, and assure AHCCCS it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this Contract and the Medicare product to the extent necessary to ensure integration of AHCCCS and Medicare services for persons enrolled with the Contractor for both programs. The State-contracted D-SNP shall be an affiliated organization of or a part of the same legal entity of the Contractor as defined at 42 CFR 422.2(4)(iii) for a fully integrated dual eligible special needs plan (FIDE SNP) serving E/PD enrolled dual eligible members.

Member Transition: The Contractor is required to participate in all activities as directed by AHCCCS which pertain to member transitions as a result of (not inclusive): a termination of a D-SNP contract with CMS, an AHCCCS contract termination or GSA change arising from a procurement or other program administration activity, or such contract termination initiated by the D-SNP. Within five (5) calendar days of identification, the Contractor shall notify AHCCCS in the case of significant changes to the terms of its contract with CMS to protect beneficiary and State interests including, but not limited to: D-SNP contract non-renewals, service area changes and reductions, proposed member transitions to another D-SNP product offered in the same CMS contract by the State-contracted Medicare Improvements for Patients and Provider Act (MIPPA) Medicare Advantage Organization, terminations, deficiencies, notices of intent to deny, and novation agreements.

State Contracting with Dual Eligible Special Needs Plans: AHCCCS shall not contract with any D-SNP to serve the Contractor's dual eligible population outside of awarded contracts. Contractors who fail to maintain a D-SNP for all counties in awarded GSAs will be subject to Administrative Action. D-SNPs are subject to the AHCCCS (VBP/APM) Policy; refer to ACOM Policy 307 for current contract year requirements. Detailed D-SNP responsibilities are specified in Medicare Advantage D-SNP Health Plan Agreement available on the AHCCCS website.

The Contractor shall notify AHCCCS/DHCS of all received D-SNP related CMS warning letters, notices of intent to deny, imposed civil monetary penalties, or CAPs as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

67. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

AHCCCS supports new and evolving technologies that create efficiencies, improve QOC and lead to better health care outcomes while containing costs. Examples of such technologies, supported, in part, by the Health Information Technology for Economic and Clinical Health Act (HITECH) include the use of health information technology in EHRs, e-prescribing, and a HIE infrastructure. Expanding technological capability is expected to reduce total spending on health care by diminishing the number of inappropriate tests, duplicate procedures, paperwork, and administrative overhead, which will result in fewer adverse events. The use of health information technology for health care service delivery and health care management is critical to the effectiveness in the following areas:

1. Access to care.

2. Care coordination.

3. Prescribing practices, for example, polypharmacy.

4. Evidence-based care.

5. Medical Management (MM) programs.

6. Early and Periodic Screening Diagnosis and Treatment (EPSDT) services.

7. Coordination with community services.

8. Referral management.

9. Discharge planning.

10. Performance measures.

11. Performance Improvement Projects (PIPs).

12. Medical record review.

13. Quality Of Care (QOC) review processes.

14. Quality Improvement (QI).

15. Claims processing.

16. Claims review.

17. Prior Authorization (PA).

The Contractor is required to exchange data with AHCCCS relating to the information requirements of this Contract and as required to support the data elements to be provided to AHCCCS. All data exchanged shall be in the formats prescribed by AHCCCS which includes those required/covered by the HIPAA. Details for the formats may be found in the HIPAA Transaction Companion Guides & Trading Partner Agreements, the AHCCCS Encounter Manual and in the AHCCCS TIG available on the AHCCCS website.

The information exchanged with AHCCCS shall be in accordance with all procedures, policies, Rules, or statutes in effect during the term of this Contract. If any of these procedures, policies, Rules, regulations, or statutes are hereinafter changed both parties agree to conform to these changes following notification by AHCCCS.

Claims Data: This system shall be capable of collecting, storing, and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. § 36-2903 and § 36-2904 and A.A.C. R9-28-701.10. The system shall be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

In addition, the Contractor shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

1. Receive 85% of total claims (e.g., professional, institutional, and dental), with a minimum 60% requirement by form type, based on volume of actual claims excluding claims processed by PBMs electronically,

2. Produce and distribute 75% of remittances electronically,

3. Provide 85% of claims payments via EFT.

AHCCCS intends to increase the percentage requirements over the term of the Contract.

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations, and control documents are required, including the completion and submission of the Electronic Data Interchange (EDI) Trading Partner Agreement in order to exchange data with AHCCCS.

With the completion of required documents as specified in the AHCCCS Encounter Manual, each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

Contractor Responsibilities: The Contractor is responsible for any incorrect data, delayed submission, or payment (to the Contractor or its subcontractors), and/or penalty applied due to any error, omission, deletion, or incorrect data submitted by the Contractor. Any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS.

The Contractor is required to provide attestation that any data transmitted is accurate, complete, and truthful, to the best of the Contractor's CEO, CFO, or designee's knowledge under penalty of perjury as specified by AHCCCS in the HIPAA Transaction Companion Guides and Trading Partner Agreements [42 CFR 438.606].

The Contractor is required to verify the accuracy and timeliness of data reported by providers, including data from network providers the Contractor is compensating on the basis of capitation payments. Including the screening of data from providers for completeness, policy compliance and consistency.

Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's subcontractors resulting from error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

Data Security: The Contractor is required to have a security audit performed by an independent third party on an annual basis. The annual audit report shall be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The audit shall include, at a minimum, a review of Contractor compliance with all security requirements as specified in the AHCCCS Security Rule Compliance Summary Checklist, as specified in ACOM Policy 108. In addition, the audit shall include a review of Contractor policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Contractor's business practices, and the production processing systems.

The audit shall result in a findings report and as necessary a CAP, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The CAP shall also include timelines for corrective actions related to all issues or discrepancies identified. The annual report shall include the findings and CAP and shall be submitted to AHCCCS for review and approval.

AHCCCS will verify that the required audit has been completed and the appropriate approved remediation plans are in place and being followed.

Electronic Transactions: The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or PA requests; or the receipt of electronic remittance. The Contractor shall be able to make claims payments via EFT and have the capability to accept electronic claims attachments.

Electronic Visit Verification: Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement EVV for non-skilled in-home services and home health services. The Contractor is required to monitor member access to care and provider compliance standards as directed by AHCCCS. The Contractor shall implement policies and procedures to monitor, analyze, and take appropriate action to ensure member access to care to services and to support provider compliance with requirements covered under the EVV program as specified in AMPM Policy 540 and AMPM Policy 1320-A.

Health Information Exchange: The Contractor is required to Contract with the qualifying State designated HIO, a non-profit organization which provides the secure HIE network for the exchange of clinical health information. The Contractor shall sign a participation agreement with the HIO, to ensure each Contractor has access to the HIE for any permitted uses, as described in the HIE Participation Agreement. To further the integration of technology-based solutions and the promotion of interoperability of EHR within the ISOC, AHCCCS will increase opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption and use of HIT may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor is expected to actively participate in offering information and providing provider support and education to further expand provider adoption and use of HIT.

It is AHCCCS' expectation that the Contractor will review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing EHRs and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals, and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates accelerating statewide HIE participation for all Medicaid providers and Contractors by:

1. Requiring that behavioral health and physical health providers use the HIE for the secure sharing of clinical information between physical and behavioral health providers.

2. Ensuring providers utilize ADT alerts to facilitate timely follow up with members after admission or discharge from hospitals and emergency rooms.

3. Supporting the acceleration of electronic prescribing by Arizona Medicaid providers.

4. Joining the HIO's Board of Directors and advisory councils to enable and provide input into governance and policy making, and the availability of information technology service offerings.

5. Identifying value-based purchasing opportunities that link with a provider's adoption and use of HIT.

The Contractor shall encourage providers that are participating in the Medicaid Promoting Interoperability Program (formerly the EHR Incentive Program) (i.e., eligible hospitals and eligible professionals) to continue to promote interoperability, accelerate the participation of other provider types in their network, and participate in planning activities that will result in improved care coordination and health care delivery for members.

The Contractor is expected to collaborate with AHCCCS and the HIO to support projects and initiatives in areas where HIT and HIE can bring significant change and progress including efforts focused on:

1. Coordinating the secure sharing of clinical health information between providers and across the CoC facilities.

2. Identifying l partnerships for integrated care among other health care delivery participants.

3. Identifying and implementing strategies that improve care coordination and health outcomes for high need/high-cost members.

4. Coordinating care for members who are enrolled in the AIHP.

5. Coordinating care for members who are transitioning between AHCCCS and Qualified Health Plans.

6. Coordinating care for AHCCCS eligible and enrolled members involved in transitioning in or out of the Justice system.

7. Improving Care coordination and care transitions between providers and members.

8. Improving Pharmacy management.

9. Collaborating with the HIO on recruitment and outreach strategies that target providers in each Contractor's network and that encourages those providers to join the HIE.

10. Participating in QI activities and reporting as identified by the Contractor or AHCCCS.

11. Other activities as identified by AHCCCS and that are allowed under the Permitted Use Policy of the HIO.

To support outreach to the providers in each Contractor's network, each Contractor is recommended to develop, with the HIO a recruitment plan that can achieve a 10% increase in the number of providers that join the HIE.

Health Insurance Portability and Accountability Act: The Contractor shall comply with the Administrative Simplification requirements of 45 CFR Parts 160 and 162 that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

Interoperability for Payers: The Contractor shall implement requirements applicable to payers in the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers" final rule (CMS-9115-F) as published in the Federal Register on May 1, 2020 (85 FR 25510). The Contractor shall implement Section III-Patient Access Application Programming Interface (API), Section IV-Provider Directory API, and Section V-Payer to

Payer Data Exchanges in accordance with AHCCCS effective dates. The Contractor shall implement the API in accordance with 42 CFR 431.60 and 42 CFR 431.70, which must include all of the provider directory information specified in 42 CFR 438.10(h)(1) and (2).

The Contractor shall implement these interoperability requirements in accordance with the applicable specifications of the Office of the National Coordinator's (ONC's) "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule as published in the Federal Register on May 1, 2020 (85 FR 25642), effective June 30, 2020.

Member Data: The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in the AHCCCS prescribed electronic data exchange formats. Upon request, the Contractor shall provide to AHCCCS PCP assignments in an AHCCCS prescribed electronic data exchange format.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned to the Contractor after Contract award.

The Contractor shall ensure that changing or making major upgrades to the IS s affecting claims processing, payment, or any other major business component, is accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to AHCCCS for review and comment as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

68. ENCOUNTER DATA REPORTING

Complete, accurate, and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set FFS and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. Furthermore, increased emphasis on encounter data is highlighted in the Medicaid Managed Care Regulations published on May 6, 2016. The Contractor shall submit encounter data to AHCCCS for all services for which a Contractor incurred financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred including services provided during PPC [42 CFR 438.242(c)(1)-(4), 42 CFR 438.604(a)(1)-(4), 42 CFR 438.606, 42 CFR 438.8, 42 CFR 438.818]. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1) and 42 CFR 455.1(a)(2)].

New Contractors shall successfully exchange encounter data for all applicable form types with AHCCCS no later than 120 days after the start of the Contract or be subject to possible corrective actions up to and including sanctions.

***Encounter Corrections*:** The Contractor is required to monitor and resolve pended encounters, and encounters denied by AHCCCS.

The Contractor if further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits, or investigations conducted by AHCCCS or the Contractor. The Contractor shall void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters shall be submitted. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced, or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters, including, approved, pended, denied, and voided encounters, impact completeness, accuracy, and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days for example), or poor encounter performance overall, may result in CAPs and/or sanctions.

Encounter Reporting: The Contractor shall produce reports for the purposes of tracking, trending, reporting process improvement, and monitoring submissions and revisions of encounters. The Contractor shall submit these reports to AHCCCS as required per the AHCCCS Encounter Manual, TIG, or as directed by AHCCCS and as further specified in Section F, Attachment F3, Contractor Chart of Deliverables.

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 30 months of approved, voided, plan-denied, pended and AHCCCS-denied encounters received and processed by AHCCCS. These files shall be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

Encounter Submissions: Encounters shall be submitted in the format prescribed by AHCCCS. Encounter data shall be provided to AHCCCS as specified in the HIPAA Transaction Companion Guides & Trading Partner Agreements, the AHCCCS TIG and the AHCCCS Encounter Manual, including, but not limited to, inclusion of data to identify the physician who delivers services to patients per Section 1903(m)(2)(A)(xi)) of the Social Security Act.

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS no later than 210 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Failure to submit encounters within 210 days may result in sanctions as specified in the AHCCCS Encounter Manual.

Covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act; the State shall collect such rebates from manufacturers. (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMDL 10-006). To ensure AHCCCS' compliance with this requirement, pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing shall be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. The Contractor shall report information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed (other than covered outpatient drugs that under subsection (j)(1) of Section 1927 of the Social Security Act [42 USCS § 1396r-8] are not subject to the requirements of that Section) and such other data as required by AHCCCS (Section1903(m)(2)(A)(xiii) of the Social Security Act and SMDL 10-006).

The Contractor's health plan paid amount per pharmacy encounter that is submitted to AHCCCS shall be equal to the adjudicated and approved reimbursement amount between the PBM and the PBM's network pharmacy or in an emergent situation, a reimbursement made to a non-network pharmacy. A network pharmacy includes hospital outpatient, retail, compounding, specialty, long-term care pharmacies, or any other pharmacy type included in the PBM's Pharmacy Network.

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor shall attest that the services listed were actually rendered.

The Contractor shall be subject to sanctions for noncompliance with encounter submission completeness, accuracy, and timeliness requirements.

Encounter Supporting Data Files: AHCCCS provides the Contractor with periodic (no less than twice monthly) full replacement files containing provider and medical coding information as stored in PMMIS. These files shall be used by the Contractor in conjunction with the Contractor's data to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual or TIG for further information regarding the content and layouts of these files.

Encounter Validation Studies: Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. These studies may result in sanctions of the Contractor and/or require a correction action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS Encounter Data Validation Technical Document for further information.

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

Sharing of Data: On a recurring basis, monthly based on adjudication date, AHCCCS shall provide the Contractor an electronic file of claims and encounter data, for members enrolled with the Contractor who have received services, that adjudicated from another Contractor or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

69. PERIODIC REPORTING REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions specified in Section D, Paragraph 74, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows:

1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.

2. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.

3. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

The Contractor shall comply with all reporting requirements contained in this Contract. The Contractor shall submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the State or Secretary [42 CFR 438.604(b), and 42 CFR 438.606]. AHCCCS requirements regarding reports, including but not limited to, report content, report frequency, and report submission, are subject to change at any time during the term of the Contract. The Contractor shall comply with all changes

specified by AHCCCS, including those pertaining to subcontractor reporting requirements. The Contractor shall be responsible for continued reporting beyond the term of the Contract.

70. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this Contract, request financial, clinical, or other information from the Contractor. Responses shall fully disclose all financial, clinical, or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information to AHCCCS as requested no later than 10 business days after the receipt of the request unless otherwise specified in the request itself.

If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed statement to AHCCCS, within the timeframe designated by AHCCCS, setting forth the reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

71. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS, or the Federal government, to its members and subcontractors. All costs shall be the responsibility of the Contractor.

72. READINESS REVIEWS

The purpose of a Readiness Review is to assess a Contractor’s readiness and ability to provide covered services to members in accordance with this Contract. A Readiness Review is conducted at the discretion of AHCCCS to review programmatic operations of the Contractor. Programmatic operations subject to readiness reviews include but are not limited to service delivery changes, IT system modifications, and change of Contractor. The Contractor shall satisfy AHCCCS’ requirements on all Readiness Review elements in order to continue operating under this Contract [42 CFR 438.66(d)(3)].

73. MONITORING AND OPERATIONAL REVIEWS

The Contractor shall comply with all reporting requirements contained in this Contract and AHCCCS Policy. In accordance with CMS requirements, AHCCCS has in effect procedures for monitoring the Contractors’ operations and performance to ensure program compliance and identify best practices, including, but not limited to, evaluation of submitted deliverables, ad hoc reporting, and periodic focused and ORs [42 CFR 438.66(a)].

These monitoring procedures will include, but are not limited to, operations related to the following [42 CFR 438.66(c)(1) – (12)]:

1. Member enrollment and disenrollment.

2. Processing member grievances and appeals.

3. Processing Provider Claim Disputes and Appeals.

4. Findings from the State's EQR process.

5. Results of member satisfaction surveys conducted by the Contractor.

6. Performance on required quality measures.

7. Medical Management (MM) committee reports and minutes.

8. Annual QI plan.

9. Audited financial and encounter data.

10. Medical Loss Ratio (MLR) summary reports.

11. Customer service performance data.

12. Any other data related to the provision of LTSS.

13. Violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438.

14. Violations of the conditions for receiving FFP, as set forth in Subpart J of 42 CFR 438.

15. All other provisions of the Contract, as appropriate.

Operational Reviews: In accordance with CMS requirements 42 CFR 434.6 (a)(5) and A.A.C. Title 9, Chapter 28, Article 5, AHCCCS, or an independent agent, will conduct periodic operational reviews of the Contractor to ensure program compliance and identify best practices [42 CFR 438.204].

The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements and provide the Contractor with technical assistance when necessary. The type and duration of the review will be solely at the discretion of AHCCCS.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled operational review. AHCCCS reserves the right to conduct reviews without notice to monitor Contractual requirements and performance as needed.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out-of-State locations and will coordinate travel arrangements and accommodations with the Contractor.

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

The Contractor will be furnished a copy of the draft operational review Report and will be given the opportunity to comment on any operational review findings prior to AHCCCS issuing the final operational review Report. AHCCCS reserves the right to publish information related to the results of any operational

review. The Contractor shall develop CAPs based on recommendations provided in the final operational review Report. The CAPs and modifications to the CAPs shall be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial operational review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the operational review Tool, draft operational review Report or final operational review Report to other AHCCCS Contractors.

74. ADMINISTRATIVE ACTIONS

Notice to Cure: AHCCCS may provide a written Notice to Cure to the Contractor outlining the details of the noncompliance and timeframe to remedy the Contractor's performance. If, at the end of the specified time period, the Contractor has complied with the Notice to Cure requirements, AHCCCS may choose not to impose a sanction.

Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-28-606, ACOM Policy 408, ACOM Policy 440, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [45 CFR 74.48, 42 CFR Part 455, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]. Refer to Section E, Paragraph 43, Temporary Management/Operation of a Contractor, and Paragraphs 45 through 48 regarding Termination of the Contract.

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process specified in A.A.C. R9-34-401 et seq.

Technical Assistance: For Technical Assistance, the Contractor shall note the following Technical Assistance Provisions:

1. Recognize AHCCCS' technical assistance to help the Contractor achieve compliance with any relevant contract terms or Contract subject matter issues does not relieve the Contractor of its obligation to fully comply with all terms in this Contract.

2. Recognize that the Contractor's acceptance of AHCCCS' offer or provision of technical assistance shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue.

3. Recognize that AHCCCS not providing technical assistance to the Contractor as it relates to compliance with a Contract requirement or any and all other terms, shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue.

4. Recognize that a Contractor's subcontractor's participation in a technical assistance matter, in full or in part, does not relieve the Contractor of its contractual duties nor modify the Contractor's contractual obligations.

75. MEDICAID SCHOOL-BASED CLAIMING PROGRAM

Pursuant to an Intergovernmental Agreement (IGA) with the Department of Education, and a contract with a Third Party Administrator, AHCCCS pays participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.. The Medicaid services shall be identified in the member's IEP as medically necessary for the child to obtain a public-school education. Refer to AMPM Policy 710.

Medicaid School-Based (MSB) services are provided in a school setting or other approved setting specifically to allow children to receive a public-school education. They do not replace medically necessary services provided outside the school setting or other MSB approved alternative setting. Currently, services include audiology, therapies (OT, PT, and speech/language), behavioral health evaluation and counseling, nursing and attendant care (health aid services provided in the classroom), and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSB service.

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

The Contractor and its providers shall coordinate with schools and school districts that provide MSB services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with children who have special needs, shall coordinate with the appropriate school staff working with these members. Transfer of member medical information and progress toward treatment goals between the Contractor and the member's school or school district is required as appropriate and shall be used to enhance the services provided to members.

76. PENDING ISSUES

The following constitute pending items that may be resolved after the issuance of the Contract or during the Term of Contract. Any program changes due to the resolution of the issues will be reflected in future amendments to the Contract. Capitation rates may also be adjusted to reflect the financial impact of program changes. The Contractor may be subject to program changes that are a result of:

1. Legislative mandates.
2. Federal or State Directives.
3. Regulatory changes.
4. Executive orders.
5. Court orders.
6. AHCCCS initiatives.
7. Committee decisions.

8. Stakeholder input.

9. Quality management.

10. Performance improvement.

11. Modernization efforts.

The items in this paragraph are subject to change and should not be considered all-inclusive.

1115 Waiver: As part of the Agency's initiatives to improve and modernize the Medicaid program, AHCCCS continues to work with CMS on various pending waiver requests. Waiver approvals may necessitate changes to the terms of this Contract which will be executed through a Contract amendment or other guidance, as necessary. On October 14, 2022, CMS approved AHCCCS' request for a five-year extension of its 1115 Waiver; the CMS approval is effective from October 14, 2022 through September 30, 2027. In addition to renewing current waiver and expenditure authorities, AHCCCS is seeking to implement additional authorities which are subject to CMS approval. Refer to the AHCCCS website for pending Waiver proposals and amendments.

CMS Managed Care Regulations: On April 27, 2023, CMS released two proposed rules impacting both the Medicaid and CHIP programs. The proposed rules include significant changes to numerous areas including access to care, transparency, and oversight of provider payment rates, engagement of members, quality measurement, and program accountability:

1. Managed Care Access, Finance, and Quality (or the "Managed Care Proposed Rule"), which focuses on managed care delivery systems.
2. Ensuring Access to Medicaid Services (or the "Access Proposed Rule"), which focuses on the FFS delivery system and program improvements for HCBS across delivery systems.

The Contractor shall participate with AHCCCS in implementation strategies for the finalized Rules. The Contract shall comply with the applicable sections of the Rules and any modifications thereafter.

Coronavirus Disease of 2019 Information: AHCCCS is responding to an outbreak of respiratory illness, called Coronavirus Disease of 2019 (COVID-19), caused by a novel (new) coronavirus. On March 11, 2020 Governor Doug Ducey issued a Declaration of Emergency and an Executive Order regarding the COVID-19 outbreak in Arizona, and subsequent Executive Orders with further administrative actions. On March 17, 2020, and March 24, 2020, AHCCCS submitted requests to the CMS to waive certain Medicaid and KidsCare requirements in order to ensure ongoing access to care over the course of the COVID-19 outbreak. As of March 23, AHCCCS has received Federal approval to implement programmatic changes to help ensure access to health care for vulnerable Arizonans. Temporary Changes made in response to the COVID-19 emergency are presented in CMS-approved flexibilities and the AHCCCS-developed Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19). The CMS-approved flexibilities and FAQs may not align with various provisions set forth in the AMPM, the ACOM Policies; the AHCCCS billing requirements; and/or other AHCCCS directives. In these instances, the CMS-approved flexibilities and FAQs take precedence and are controlling. The Contractor may refer to the COVID-19 FAQs at the following link: https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html.

Health Equity: AHCCCS remains committed to identifying and addressing health disparities among its members and reviewing opportunities to promote equitable care for its members. AHCCCS is considering the following strategies to advance health equity for its members:

1. Using the CLRS, through the AHCCCS WPCI, to promote health equity by leveraging data within the CLRS to identify and address health disparities across member demographic criteria.

2. Requiring NCQA Health Equity Accreditation to be achieved by October 1, 2025.

3. Establishing a Health Equity Administrator role responsible for promoting health equity and addressing identified health disparities amongst the Contractor's members.

4. Enhancing the Network development and planning requirements to capture how the Contractor's provider network delivers equitable care and requiring the Contractor to collect data on and address the diversity of its provider network.

5. Including performance measure stratifications (in alignment with measure steward reporting requirements, or as required by AHCCCS), within the Withhold and Quality Measure Performance Incentive initiative as described in ACOM Policy 306.

6. Enhancing the Health Disparity Summary & Evaluation Report to include additional requirements such as identifying health disparities through direct member engagement, conducting disparity analyses related to member placement and demographics, and attesting to the development of provider-facing tool kits to promote health equity.

77. CONTINUITY OF OPERATIONS AND RECOVERY PLAN

The Contractor shall develop a Continuity of Operations and Recovery Plan, as detailed in ACOM Policy 104, to manage unexpected events and the threat of such occurrences, that which may negatively and significantly impact business operations, and the ability to deliver services to members. All staff shall be trained on, and be familiar with, the Plan.

The Continuity of Operations and Recovery Plan shall be updated annually. The Contractor shall submit a summary of its Continuity of Operations and Recovery Plan to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

78. MEDICAL RECORDS

The member's medical record shall be maintained by the provider who generates the record. Medical records include those maintained by PCPs or other providers including but not limited to, medical records kept in placement settings such as NFs, ALFs, other home, and community-based providers, and TFC licensing agencies.

The Contractor 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. The Contractor shall have written policies guaranteeing each member's right to request and receive a copy of their medical records, and to request that the medical record be amended or corrected [45 CFR Part 160, 164, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi)]. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

The Contractor is responsible for ensuring that a medical record (paper or electronic format) is established when information is received about a member. If the provider 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 shall be associated with the member's medical record as soon as one is established.

The Contractor shall require subcontracted service providers to create a medical record 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 shall be associated with the member's medical record as soon as one is established.

Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment. The Contractor shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information and which comply with AMPM Policy 940. The Contractor shall ensure that providers maintain and share a member health record in accordance with professional standards [42 CFR 438.208(b)(5)].

The Contractor shall retain consent and authorization for medical records as prescribed in A.R.S. § 12-2297 and in conformance with AHCCCS Policy.

The Contractor shall have written policies and procedures to ensure that the MSICs have an integrated electronic medical record for each member that is maintained and available for the multi-specialty treatment team and community providers.

An integrated electronic medical record shall contain all information necessary to facilitate the coordination and QOC delivered by multiple providers in multiple locations at varying times.

The Contractor shall create written plans for providing training and evaluating providers' compliance with the Contractor's medical records' standards comply with medical record review requirements as specified in AMPM Policy 940 and comply with record retention requirements as specified in Section D, Paragraph65, Record Retention.

For care coordination purposes, medical records shall be shared with other care providers, such as the multi-specialty interdisciplinary team.

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

The Contractor shall comply with medical record review requirements as specified in AMPM Policy 940.

The Contractor shall comply with record retention requirements as specified in Section D, Paragraph 65, Record Retention.

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other organization or agency. The Contractor may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper format within 20 business days of receipt of request or more quickly if necessary.

The Contractor shall comply with Federal and State confidentiality statutes, rules, and regulations to protect medical records and any other personal health information that may identify a particular member or subset of members and shall establish and implement policies and procedures consistent with the confidentiality requirements in 42 CFR 431.300 et. Seq., 42 CFR 438.208(b)(2) and (b)(4), 42 CFR 438.224, 45 CFR parts 160

and 164, 42 CFR part 2, and A.R.S. § 36-509, for medical records and any other health and member information that identifies a particular member.

The Contractor shall have the discretion to 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 service delivery. The Contractor shall have the discretion to release information related to fraud, waste and program abuse so long as protected HIV-related information is not disclosed A.R.S. § 36-664, and substance abuse information shall only be disclosed consistent with Federal and State law, including but not limited to [42 CFR 2.1 et seq].

79. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data as specified in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS TIG available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, as specified in the TIG, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A daily capitation transaction, as specified in the HIPAA Transaction Companion Guides, and Trading Partner Agreements, will be produced to provide Contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as specified in the TIG, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor shall reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS/Information Services Division (ISD).

80. VALUE-BASED PURCHASING

VBP is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value-based health care systems where members' experience and population health are improved and there is a commitment to continuous QI and learning. The Contractor shall participate in VBP efforts.

Alternative Payment Model Initiatives: The purpose of APM initiatives are to encourage Contractor activity in the area of QI by aligning the incentives of the Contractor and provider through APM strategies in the Health Care Payment Learning and Action Network (LAN) APM Framework with a focus on Categories 3 and 4. Requirements are further specified in ACOM Policy 307 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Centers of Excellence: Centers of Excellence are facilities and/or programs that are recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Identification of a Centers of Excellence shall be based on provider certification, accreditation, or other specific recognition as performing with fidelity to locally or nationally recognized and established criteria for the population being served. Identification as a Center of Excellence by a Contractor shall include tracking and reporting of outcome data demonstrating efficacy in treatment and adherence to established benchmarks for outcome data for the population served.

Adult's System of Care: The Contractor shall contract with providers which adhere to nationally recognized criteria as a Centers of Excellence, and demonstrate in annual reporting how these providers implement evidence-based practices in adherence with nationally recognized criteria and shall present outcome data for the following groups of adults with special health care needs:

1. Members with chronic pain with or without co-occurring SUD.

2. Dementia and related disorders.

Children's System of Care: The Contractor shall contract with providers which adhere to nationally recognized criteria as a Centers of Excellence, and demonstrate in annual reporting how these providers implement evidence-based practices in adherence with nationally recognized criteria and shall present outcome data for the following groups of children with special health care needs:

1. Children aged birth to five with behavioral health needs: Staffed with specialists who are endorsed by the ITMHCA or other Endorsement program recognized under the Alliance for the Advancement of Infant Mental Health (formerly the League of States using the Michigan Association for Infant Mental Health Endorsement®).

2. Children with or at risk of ASD.

3. Adolescents with SUD, for example:
   a. Adolescent Community Reinforcement Approach (A-CRA),
   b. Assertive Community Care, and
   c. Global Appraisal of Individual Needs (GAIN).

4. Transition Aged Youth, for example:
   a. First episode psychosis programs, and
   b. Transition to Independence (TIP) Model.

E-Prescribing: E-prescribing is an effective tool to improve members' health outcomes and reduce costs as specified in ACOM Policy 321. Benefits afforded by the electronic transmission of prescription-related information include but are not limited to reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, and increased prescription accuracy. The Contractor shall increase its E-Prescribing rate of original prescriptions in accordance with ACOM Policy 321. The National Council for Prescription Drug Program (NCPDP) Prescription Origin Code and Fill Number (Original or Refill Dispensing) shall be submitted on all pharmacy encounter records, as specified in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

Value-Based Providers: The Contractor shall develop strategies that ensure that members are directed to providers who participate in APM initiatives and who offer value as determined by measurable outcomes. The Contractor shall submit a Centers of Excellence Report describing its strategies to direct members to valued providers The report shall be submitted with the Provider Network Development and Management Plan as required under ACOM 415, and submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

81. THE AMERICAN RESCUE PLAN ACT

Section 9187 of the American Rescue Plan (ARP) Act of 2021 (Pub. L. 117-2) provides qualifying States with a temporary 10 percentage point increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures for HCBS. AHCCCS submitted and received CMS approval of an HCBS Spending Plan, which allows the Agency to leverage this enhanced FMAP to improve and expand the State's HCBS and behavioral health programs. CMS extended the deadline for States to use the State funds received through enhanced 10% FMAP on qualifying home and community-based and behavioral health services to March 31, 2025; however, AHCCCS may limit ARP spending to September 30, 2024. The HCBS Spending Plan targets delivery of member-centric strategies to support strengthening and enhancing care and advancing technology to promote greater independence and community connection for their HCBS-based populations. AHCCCS is in the process of implementing its Spending Plan, which targets four key populations: seniors; individuals with disabilities; with an SMI designation; and children with behavioral health needs.

To be eligible for additional Federal funding under ARP Section 9817, participating States must submit a quarterly HCBS spending plan to provide information on the amount of funds attributable to the increase in FMAP that the State is claiming. States must also report on the cost of the activities they are implementing to enhance, expand, or strengthen HCBS. In addition, every other quarter, States must provide an updated spending plan narrative describing the State's activities to enhance, expand, or strengthen HCBS.

The Contractor shall collaborate with AHCCCS on select initiatives specified in the State's HCBS Spending Plan. Several initiatives improve and expand services provided to AHCCCS members, such as the provision of home-delivered meals, acute care services, and reimbursement for parents as paid caregivers. Services expanded under the HCBS Spending Plan will continue to be delivered as defined by their service description for this contract period. The Contractor is also expected to support additional HCBS Spending Plan initiatives, as identified by AHCCCS, and as agreed upon by the Contractor. These initiatives will target activities that support the HCBS workforce and develop or enhance existing training to support career development of direct care workers, behavioral health technicians, or behavioral health paraprofessionals. A description of all HCBS Spending Plan initiatives is available on the AHCCCS ARP website: American Rescue Plan.

Over the term of the Contract, the Contractor shall support AHCCCS to review, develop, and define administrative and operational processes necessary for implementation of applicable HCBS Spending Plan initiatives. The Contractor shall provide regular updates, at a minimum every 90 days, to AHCCCS on the status of these initiatives. Activities under the HCBS Spending Plan are evolving and dependent on Federal and State programmatic and expenditure authority. If revisions or modifications to the HCBS Spending Plan are required, AHCCCS will document and communicate any impact to the Contractor accordingly.

AHCCCS reserves the right to audit the HCBS Spending Plan initiatives funds distributed to Contractors and may require reporting to verify funds were distributed or spent in the manner defined in the HCBS Spending Plan and SMDL MD # 21-003 (SMD).

Refer to Section D, Paragraph 51, Compensation for ARP-related Directed Payments.

82. LEGISLATIVE, LEGAL, AND REGULATORY ISSUES

The Contractor shall comply with Legislative changes, directives, regulatory changes, or court orders related to any term in this Contract.

The Contractor shall comply with program changes based on Federal or State requirements that are unknown, pending or that may be enacted after Contract Award Date. Any program changes due to new or changing Federal or State requirements will be reflected in future Contract amendments.

The Contractor shall agree to an adjustment of capitation rates prior to Contract Performance Start Date or at any time during the Contract term for trend updates, impact cause by health care reform, Medicare Integration, and program, and other changes that affect expected service delivery or administrative costs.

The Contractor shall recognize that AHCCCS will comply 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:

1. Use of evidence-based guidelines.

2. Identification and publication of top performing Contractors.

3. Identification and publication of top performing providers.

4. Program pay for performance payouts.

5. Mandated publication of guidelines.

6. Mandated publication of outcomes.

7. Identification of Centers of Excellence for specific conditions, procedures, or member populations.

8. Establishment of Return on Investment goals.

The following, which is not an all-inclusive list, are examples of issues that could result in program changes, for the Contractor's required compliance: Compliance with the applicable sections of the Patient Protection and Affordable Care Act (PPACA) and provisions as adopted by AHCCCS in the Arizona State Plan.

The Contractor shall:

1. Meet other requirements as stipulated including increased provider reimbursement up to Medicare levels for select primary care services.

2. Participate in care coordination data sharing as specified by AHCCCS between Medicaid MCOs and Exchange Qualified Health Plans for those members that transition between Medicaid and Exchange health care coverage.

3. Comply with the Center for Medicare and Medicaid policies, directives, and guidelines.

The Contractor shall comply with Legislative changes:

1. To the State's budget.

2. That affect covered services.

3. That modify, alter, or create obligations that affect programs, policies, or requirements in this Contract.

4. That establishes a HIE as required by the ACA and any resulting modifications to Medicaid eligibility as contemplated under the ACA that may impact the benefit package and service delivery structure for members.

The Contractor shall comply with Executive Orders, regulatory changes affecting licensing, privileging, certification, and credentialing.

The Contractor shall comply with CMS' approval or denial of any request by AHCCCS for an 1115 Waiver Demonstration amendment, the Arizona State Plan Amendment or permission to participate in a demonstration project. This includes the waiver of member choice of acute health plan that was submitted to CMS by AHCCCS in 2014, which would provide the State with the flexibility to require one Contractor(s) to provide integrated health care services to SMI members.

The Contractor shall comply with Court orders, related to services provided or other obligations agreed to under this contract, in existing or future litigation in which the State is a defendant and participate in any demonstration projects or activities to plan, promote, and implement integrated health care service delivery and care coordination for dual eligible members.

[END OF SECTION D: PROGRAM REQUIREMENTS]

[

SECTION E. CONTRACT TERMS AND CONDITIONS

1. ADVERTISING AND PROMOTION OF CONTRACT

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

2. APPLICABLE LAW

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

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

3. ARBITRATION

The parties to this Contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. § 12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this Contract, without the prior written consent of AHCCCS. Delegation of less than all of the duties of this Contract shall conform to the requirements of Section D, Paragraph 33, Subcontracts.

5. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code or assigning rights or obligations under this Contract without the prior written consent of AHCCCS.

6. AUDIT AND INSPECTION

The Contractor shall comply with all provisions specified in applicable A.R.S. § 35-214 and § 35-215 and AHCCCS Rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.3(h)].

The Contractor's or any subcontractor's books and records shall be subject to audit at any time by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.3(h), Section 1903(m)(2)(A)(iv) of the Social Security Act].

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

The right to audit under this section exists during the term of this Contract and for 10 years from the termination of this Contract or the date of completion of any audit, whichever is later [42 CFR 438.3(h)].

7. AUTHORITY

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

8. CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this Contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this Contract, the Contractor may request an adjustment in compensation paid under this Contract. The Contractor shall request an adjustment within 30 days from the date of receipt of the change notice.

Contract amendments are subject to approval by CMS, and approval is withheld until all amendments are signed by the Contractor. When AHCCCS issues an amendment to modify the contract, the Contractor shall ensure Contract amendments are signed and submitted to AHCCCS by the date specified by AHCCCS. The provisions of such amendment will be deemed to have been accepted even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

9. CHOICE OF FORUM

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

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act of 1990 as amended; section 1557 of the Patient Protection and Affordable Care Act (PPACA); Equal Employment Opportunity (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 [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]. The Contractor shall maintain all applicable licenses and permits.

In accordance with 42 CFR 438.3(d)(3),42 CFR 438.3(d)(4), A.R.S. § 41-1461 et seq., and Executive Order 2023-01, the Contractor will not discriminate against individuals eligible to enroll on the basis of health status or need for healthcare services, race, color, national origin, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or

expression, ancestry, age, military service or veteran status, marital status, or disability and the Contractor will not use any policy or practice that has the effect of discriminating on any of these bases.

The Contractor accepts individuals eligible for enrollment in the order in which they apply without restriction (except as otherwise specified by CMS), up to the limits set under the Contract [42 CFR 438.3(d)(1)].

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall safeguard information in accordance with Federal and State statutes and regulations, including but not limited to: the HIPPA of 1996 (Public Law 104-191); 45 CFR Parts 160 and 164; 42 CFR Part 431, Subpart F; 42 CFR Part 2; 42 CFR Part 438 A.R.S. § 36-664; A.R.S. § 36-2903; A.R.S. § 36-2932; A.R.S. § 41-1959; A.R.S. § 46-135; and any rules implanting those State statutes (e.g., A.A.C. R9-22-503, A.A.C. R9-22-512 and A.A.C. R9-28-514).

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

The Contractor shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any individual other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

12. CONFLICT OF INTEREST

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

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

14. CONTRACT

The Contract between AHCCCS and the Contractor shall include: 1) the RFP including AHCCCS policies and procedures incorporated by reference as part of the RFP, 2) the Proposal submitted by the Contractor in response to the RFP including any Best and Final Offers, and 3) any Contract amendments.

In the event of a conflict in language between the Proposal (including any Best and Final Offers) and the RFP (including AHCCCS policies and procedures incorporated by reference), the provisions and requirements set forth and/or referenced in the RFP(including AHCCCS policies and procedures incorporated by reference) shall govern.

The Contract shall be construed according to the laws of the State of Arizona.

15. CONTRACT INTERPRETATION AND AMENDMENT

Administrative Changes - The AHCCCS Procurement Officer, or authorized designee, reserves the right to correct any obvious clerical, typographical or grammatical errors, as well as errors in party contact information (collectively, "Administrative Changes"), prior to or after the final execution of an Agreement or Agreement Amendment. Administrative Changes subject to permissible corrections include misspellings, grammar errors, incorrect addresses, incorrect Agreement Amendment numbers, pagination and citation errors, mistakes in the labeling of the rate as either extended or unit, and calendar date errors that are illogical due to typographical error. The AHCCCS Procurement Office shall subsequently notice the contractor of corrections to administrative errors in a written confirmation letter with a copy of the corrected Administrative Change attached.

No Parole 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 AHCCCS Procurement Officer on behalf of the State and signed by a duly authorized representative of the Contractor.

16. COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other Contracts for additional work related to this contract and Contractor shall fully cooperate with such other Contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by AHCCCS employees.

17. COVENANT AGAINST CONTINGENT FEES

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

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful [42 CFR 438.604, 42 CFR 438.606(b)]. Certification of financial and encounter

data shall be submitted concurrently with the data [42 CFR 438.606(c), 42 CFR 438.604(a)-(b)]. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who reports directly to the CEO or CFO [42 CFR 438.604, 42 CFR 438.606(a)].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by A.A.C. Title 9, Chapter 28, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process specified in 9 A.A.C. Chapter 34 and A.R.S. § 36-2932. All disputes except as provided under A.A.C. Title 9, Chapter 28, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall State the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this Contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S § 41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. § 23-214, Subsection A.

21. EFFECTIVE DATE

The effective date of this Contract shall be the date referenced on the offer and award page of this Contract or any subsequent amendments.

22. EMPLOYEES OF THE CONTRACTOR

All employees of the Contractor employed in the performance of work under the Contract shall be considered employees of the Contractor at all times, and not employees of AHCCCS or the State. The Contractor shall comply with the Social Security Act, Workman's Compensation laws and Unemployment laws of the State of Arizona and all State, local and Federal legislation relevant to the Contractor's business.

23. FEDERAL IMMIGRATION AND NATIONALITY ACT

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

24. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the

procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

25. INCORPORATION BY REFERENCE

This Solicitation and all attachments and amendments, the Contractor's Proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the Contract.

26. INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency):

The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including, but not limited to, attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, from and against attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, from and against the operational and the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

Notwithstanding the foregoing, the Contractor shall be responsible for claims, losses, liability, costs, and expenses, including, but not limited to, attorney's fees and costs, arising out of the Contractor's failure to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, court decree or contract requirement, including, but not limited to, the Contractor's failure to make payments to providers on a timely and/or transparent basis, even if a court finds that AHCCCS has a duty to monitor the Contractor or to ensure compliance. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, from and against the expenses incurred by AHCCCS to address Contractor deficiencies arising out of the failure to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, court decree or contract requirement including, but not limited to, administrative and operational costs associated with compliance and monitoring systems, corrective action plans, reporting and data analytics, auditing, data collection, inspection and oversight activities, procurement, staffing and personnel expenses, contractor management services, vendor services, consultant services, performance plans, appeals, and sanctions.

27. INDEMNIFICATION - PATENT AND COPYRIGHT

To the extent permitted by applicable law the Contractor shall defend, indemnify, and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work

performed under this Contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

28. INSURANCE

The Contractor is required to maintain insurance, at a minimum, as specified in Standard Professional Service Contract - Working with Children or Vulnerable Adults.

STANDARD PROFESSIONAL SERVICE CONTRACT - WORKING WITH CHILDREN AND/OR VULNERABLE ADULTS

INDEMNIFICATION CLAUSE:

To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of, or recovered under, the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State, or local law, statute, ordinance, rule, regulation, or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense, and judgment costs where this indemnification is applicable. In consideration of the award of this Contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents, and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor shall procure and maintain, until all of their obligations have been discharged, including any warranty periods under this Contract, insurance against claims for injury to persons or damage to property arising from, or in connection with, the performance of the work hereunder by the Contractor, its agents, representatives, employees or subcontractors.

The *Insurance Requirements* herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or subcontractors, and the Contractor is free to purchase additional insurance.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE**: Contractor shall provide coverage with limits of liability not less than those stated below.

1. Commercial General Liability (CGL) – Occurrence Form

Policy shall include bodily injury, property damage, and broad form contractual liability coverage.

• General Aggregate	$2,000,000
• Products – Completed Operations Aggregate	$1,000,000
• Personal and Advertising Injury	$1,000,000
• Damage to Rented Premises	$50,000
• Each Occurrence	$1,000,000

a. The policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor.
b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.
c. The policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should it be included with the Professional Liability.
d. Contractor shall provide the following statement on their Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

2. Business Automobile Liability

Bodily Injury and Property Damage for any owned, hired, and/or non-owned automobiles used in the performance of this Contract.

• Combined Single Limit (CSL)	$1,000,000

a. Policy shall be endorsed, as required by this written agreement, to include the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by, or on behalf of, the Contractor involving automobiles owned, hired and/or non-owned by the Contractor.
b. Policy shall contain a waiver of subrogation endorsement as required by this written agreement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

3. Workers' Compensation and Employers' Liability

• Workers' Compensation	Statutory
• Employers' Liability	
Each Accident	$1,000,000
Disease – Each Employee	$1,000,000
Disease – Policy Limit	$1,000,000

a. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.
b. This requirement shall not apply to each Contractor or subcontractor that is exempt under A.R.S. § 23-901, and when such Contractor or subcontractor executes the appropriate waiver form (Sole Proprietor or Independent Contractor).

4. Professional Liability (Errors and Omissions Liability)

Each Claim	$ 2,000,000
Annual Aggregate	$ 2,000,000

a. If SAM coverage is being provided under this policy then Contractor shall provide the following statement on their Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded." This coverage may be sub-limited to no less than $500,000.
b. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.
c. Policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of this Contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS**: The policies shall include, or be endorsed to include, as required by this written agreement, the following provisions:

1. The Contractor's policies, as applicable, shall stipulate that the insurance afforded the Contractor shall be primary and that any insurance carried by the Department, its agents, officials, employees or the State of Arizona shall be excess and not contributory insurance, as provided by A.R.S. § 41-621 (E).

2. Insurance provided by the Contractor shall not limit the Contractor's liability assumed under the indemnification provisions of this Contract.

C. **NOTICE OF CANCELLATION**: Applicable to all insurance policies required within the Insurance Requirements of this Contract, Contractor's insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without 30 days prior written notice to the State of Arizona. Within two business days of receipt, Contractor shall provide notice to the State of Arizona if they receive notice of a policy that has been or will be suspended, canceled, materially changed for any reason, has expired, or will be expiring. Such notice shall be sent to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables, of this Contract.

D. **ACCEPTABILITY OF INSURERS**: Contractor's insurance shall be placed with companies licensed in the State of Arizona or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers. Insurers shall have an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE**: Contractor shall furnish AHCCCS with certificates of insurance (valid ACORD form or equivalent approved by the State of Arizona) evidencing that Contractor has the insurance as required by this Contract. An authorized representative of the insurer shall sign the certificates.

The State's receipt of any certificates of insurance or policy endorsements that do not comply with this written agreement shall not waive or otherwise affect the requirements of this agreement.

Each insurance policy required by this Contract shall be in effect at, or prior to, commencement of work under this Contract. Failure to maintain the insurance policies as required by this Contract, or to provide evidence of renewal, is a material breach of contract.

The AHCCCS contract number and project description shall be noted on the certificate of insurance.

All Certificates of Insurance, Policy Endorsements and Insurance Material Changes shall be sent to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The State of Arizona reserves the right to require complete copies of all insurance policies required by this Contract at any time.

F. **SUBCONTRACTORS**: Contractor's certificate(s) shall include all subcontractors as insureds under its policies or Contractor shall be responsible for ensuring and/or verifying that all subcontractors have valid and collectable insurance as evidenced by the certificates of insurance and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the relevant insurance section of the AHCCCS MSPs located on the AHCCCS website. AHCCCS reserves the right to require, at any time throughout the life of the Contract, proof from the Contractor that its subcontractors

have the required coverage. All subcontractors are required to maintain insurance and to provide verification upon request.

G. **APPROVAL AND MODIFICATIONS**: AHCCCS, in consultation with State Risk, reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the life of this Contract, as deemed necessary. Such action will not require a formal Contract amendment but may be made by Administrative Action.

H. **EXCEPTIONS**: In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a certificate of self-insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

[END INSURANCE REQUIREMENTS]

29. IRS W9 FORM

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

30. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in Federal and State Law and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from an individual who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the system.

31. LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the individuals and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

32. NO GUARANTEED QUANTITIES

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

33. NON-EXCLUSIVE REMEDIES

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

34. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are specified 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. No claims paid by the Contractor to a network provider, out-of-network provider, subcontractor or financial institution located outside of the United States are considered in the development of actuarially sound capitation rates [42 CFR 438.602(i)].

35. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the Section 1115 Demonstration Waiver for the State of Arizona; the Arizona State Plan; the Constitution and laws of Arizona, and applicable State Rules;

the terms of this Contract which consists of the RFP, the Proposal of the Successful Offeror, and any Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

36. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this Contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this Contract, as otherwise allowed under this Contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information, and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this Contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable Federal and State laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS/Office of the Director (OOD). For purposes of this subsection, the term “data” shall not include member medical records.

Except as otherwise provided in this Section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this Contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for Federal or State government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 75.

37. RELATIONSHIP OF PARTIES

The Contractor under this Contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the Contract.

38. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any sums due the Contractor any expenses or costs incurred by AHCCCS or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the Contract, including but not limited to expenses, costs and damages.

39. RIGHT TO ASSURANCE

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

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this Contract, in accordance with A.R.S. § 41-2547.

41. SEVERABILITY

The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the contract.

42. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended, or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended, or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at www.oig.hhs.gov/fraud/exclusions.asp.

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

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

43. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR Part 438, Subpart I, and A.R.S. § 36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on members premiums or charges that exceed those permitted by AHCCCS, discrimination among members 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 member 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 members' health or that temporary management is necessary to ensure the health of members while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor.

Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Pursuant to 42 CFR 438.706, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction [42 CFR 438.706(a)-(d), Section 1932(e)(2)(B)(ii) of the Social Security Act].

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

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

44. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this Contract, starting October 1, 2017, shall be for an initial period of three years with three renewal periods: one renewal of two years, and two renewals of one year each. The Contract Year is October 1 through September 30 with an annual October 1 renewal. The terms and conditions of any such contract extension shall remain the same as the original Contract except, as otherwise amended. Any Contract extension or renewal shall be through Contract amendment and shall be at the sole option of AHCCCS.

If the Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCS may renew the Contractor's contract in one GSA, but not in another. In the event AHCCCS determines there are issues of noncompliance by the Contractor in one GSA, AHCCCS may request an enrollment cap for the Contractor's contracts in all other GSAs. Further, AHCCCS may require the Contractor to renew all currently awarded GSAs or may terminate the contract if the Contractor does not agree to renew all currently awarded GSAs.

Contract amendments, including renewals, are subject to approval by the CMS. When the Contracting Officer issues an amendment to extend or renew the contract, the provisions of such extension or renewal will be deemed to have been accepted 30 days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension or renewal amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension or renewal amendment. Failure of an existing Contractor to accept an amendment to extend or renew may result in immediate suspension/termination of member assignment. If the Contractor provides such notification, the Contracting Officer may initiate contract termination proceedings.

If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor. The Contractor is required to provide 180 days advance written notice to the AHCCCS Procurement Officer of its intent not to renew the contract. If the Contractor provides the AHCCCS Procurement Officer Written notice of its intent not to renew this contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

45. TERMINATION

AHCCCS reserves the right to terminate this contract in whole or in part by reason of force majeure, due to the failure of the Contractor to comply with any term or condition of the contract, including, but not limited to, circumstances which present risk to member health or safety, and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. The term force majeure means an occurrence that is beyond the control of AHCCCS and occurs without its fault or negligence. Force majeure includes acts of God and other similar occurrences beyond the control of AHCCCS which it is unable to prevent by exercising reasonable diligence.

AHCCCS reserves the right to terminate this Contract and transition members to a different Contractor or provide Medicaid benefits through other Arizona State plan or Section 1115 Demonstration Waiver, if the State determines that the Contract has failed to carry out the substantive terms of its Contract or has failed to meet the applicable requirements of sections 1932, 1903(m) or 1905(t) of the Social Security Act. [42 CFR 438.708(a), 42 CFR 438.708(b), sections 1903(m), 1905(t), and 1932 of the Social Security Act]

If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested [Section 1932(e)(4) of the Social Security Act; 42 CFR 438.722(a)-(b)]. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.710, 42 CFR 438.10, AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the Contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS immediately on demand.

The Contractor shall retain, preserve, and make records available, within the timeframes required by Federal and State law, including but not limited to, those records related to member grievances and appeal records, litigation, base data, MLR reports, claims settlement and those covered under HIPAA, as required by Contract, Federal and State law, including but not limited to 45 CFR 164.530(j)(2) and 42 CFR 438.3(u). Refer to ACOM Policy 440.

AHCCCS may, upon termination of this Contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

46. TERMINATION - AVAILABILITY OF FUNDS

If, funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS for any payment may arise under this Contract until funds are made available for performance of this Contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

47. TERMINATION FOR CONFLICT OF INTEREST

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

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R.S. § 38-511.

48. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination, and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS immediately upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed, and materials accepted before the effective date of the termination.

49. THIRD-PARTY ANTITRUST VIOLATIONS

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

50. TYPE OF CONTRACT

Fixed-Price, stated as capitated Per Member Per Month (PMPM), except as otherwise provided.

51. WARRANTY OF SERVICES

The Contractor warrants that all services provided under this Contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty.

In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this Contract in the manner and to the same extent as the services originally furnished.

[END OF SECTION E: CONTRACT TERMS AND CONDITIONS]

SECTION F: ATTACHMENTS

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

The Contractor shall have a written policy delineating its Grievance and Appeal System which shall be in accordance with applicable Federal and State laws, regulations, and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall also furnish this information to members within 12 days after the Contractor receives notice of the enrollment and annually thereafter. The Contractor shall provide this information to subcontractors at the time of contract and make this information available in its provider manual and on its website. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to members describing the Grievance and Appeal System as well as Contractor appeal and grievance notices, including denial and termination notices, shall be available in the prevalent non-English language spoken for each LEP population in the Contractor's service area [42 CFR 438.3(d)(3)]. These written materials shall also be made available in alternate formats upon request at no cost. Auxiliary aids and services shall also be made available upon request and at no cost. These written materials shall include taglines in the prevalent non-English languages (font size of at least conspicuously visible font size) explaining the availability of written translation or oral interpretation services to understand the information and include the Contractor's toll free and TTY/TDD telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials. Refer to ACOM Policy 404 and ACOM Policy 406 for additional information and requirements [42 CFR 438.408(d)(1), 42 CFR 438.10].

The Contractor shall inform members, at a minimum, through the Contractor's member handbook and website, that oral interpretation services are available in any language and alternative communication formats are available for members who are deaf or hard of hearing or are blind or have low vision.

For additional information regarding the member Notice of Adverse Benefit Determination process and State developed notice templates, refer to ACOM Policy 414 and 42 CFR Part 438 [42 CFR 438.10(c)(4)(ii)]. For additional information regarding member information requirements, refer to ACOM Policy 404 and ACOM Policy 406.

Failure to comply with any of these provisions may result in an imposition of sanctions.

At a minimum, the Contractor shall comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

1. The Contractor shall maintain accurate records of all grievances and appeals in a manner accessible to the State and available upon request to CMS and which shall contain at a minimum the following [42 CFR 438.416 (a), 42 CFR 438.416(b)(1)–(6), 42 CFR 438.416(c)]:
   a. A general description of the reason for an appeal or grievance,
   b. The date received,
   c. The date of each review or, if applicable, review meeting,
   d. The resolution at each level of appeal or grievance,
   e. The date of resolution at each level,

f. The name of the member for whom the appeal or grievance was filed, and
g. The name of the individual filing the appeal or grievance on behalf of the member, if applicable, and
h. The date the request for hearing was received, if applicable.

2. The Contractor has an effective mechanism in place for tracking receipt, acknowledgement, investigation, and resolution of grievances and appeals, and for tracking requests for hearing within the required timeframes.

3. The Contractor shall thoroughly investigate grievances and appeals using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.

4. The Contractor shall track and trend Grievance and Appeal System information in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.

5. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance, appeal, or request for hearing [42 CFR 438.414, 42 CFR 438.10(g)(2)(xi)(A)-(C)].

6. The Contractor shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to the grievance and appeal process. This included but is not limited to auxiliary aids and services upon request, such as interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability [42 CFR 438.406(a), 42 CFR 438.406(a), 42 CFR 438.228(a)].

7. The availability of toll-free numbers that a member can use to file a grievance or appeal by phone if requested by the member.

8. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as standard appeals unless the member or the provider requests expedited resolution [42 CFR 438.406(b)(3)].

9. The Contractor shall permit both oral and written appeals and grievances [42 CFR 438.402(c)(3)(i), 42 CFR 438.402(c)(3)(ii)].

10. The Contractor shall acknowledge receipt of each grievance and appeal. For grievances, an oral grievance shall be considered acknowledged at the time it is made. The Contractor is not required to acknowledge receipt of the grievance in writing, however, if the member requests written acknowledgement, the acknowledgement shall be made within five business days of receipt of the request.

11. For appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one day of receipt for expedited appeals [42 CFR 438.406(b)(1), 42 CFR 438.228(a)].

12. The Contractor shall ensure individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making, or a subordinate of such individuals. The Contractor shall also ensure individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) grievances regarding denials of expedited resolutions of appeals, or 3) grievances or appeals involving clinical issues have the same or similar clinical specialty in treating the member's condition or disease [42 CFR 438.406(b)(2)(ii)(A)-(C), 42 CFR 438.228(a)]. Decisions makers on grievance and appeals of adverse benefit determinations shall take into account all comments, documents, records, and other information submitted by the member or their representative as well as providers without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 438.406(b)(2)(iii), 42 CFR 438.228(a)]. AHCCCS does not offer or arrange for an external medical review as specified in 42 CFR 438.402(c)(1)(i)(B).

13. The Contractor shall not delegate the Grievance and Appeal System requirements to its providers.

14. Define a grievance as a member's expression of dissatisfaction with any matter, other than an adverse benefit determination [42 CFR 438.400(b)]. There are no time limits for filing a member grievance.

15. A member shall file a grievance with the Contractor and the member is not permitted to file a grievance directly with the AHCCCS [42 CFR 438.402(c)(3)(i)].

16. The Contractor shall address identified issues as expeditiously as the member's condition requires and shall resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].

17. The Contractor shall provide a written explanation of the resolution to a grievance, and the response shall be mailed within 10 business days of resolution of the grievance [42 CFR 438.408 (b)].

18. If resolution to a grievance or appeal of an adverse benefit determination is not completed when the timeframe expires, the member is deemed to have exhausted the Contractor's grievance process and the can file a request for hearing [42 CFR 438.408, 42 CFR 438.402(c)(1)(i)(A)].

19. For appeals involving issues of medical necessity when a decision is not reached within the required time frame or when there is insufficient or conflicting information regarding medical necessity, the Contractor must extend the timeframe for resolution of an appeal, by up to 14 days, and shall document efforts to consult with the ordering provider (peer to peer), to obtain clinical information to assist in resolving the appeal. Obtaining an extension and peer to peer consultation in these circumstances is in the member's best interest. [42 CFR 438.210 (b)(2),42 CFR 438.408(b)(1)-(3), 42 CFR 438.408(c)(1)(i)-(iii)]. The Contractor shall allow the provider sufficient time for a peer-to-peer to occur before the Contractor issues its decision.

20. If the Contractor extends the timeframe for resolution of an appeal not at the request of the member, the Contractor shall make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice within two calendar days of the reason for the decision to extend the

timeframe and inform the member of the right to file a grievance if the member disagrees with that decision [42 CFR 438.408(c)(2)(i)-(ii), 42 CFR 438.408(b)(1)-(3)].

21. Define a service authorization request as a request by the member, the representative, or a provider for a physical or behavioral health service for the member which requires PA by the Contractor [42 CFR 438.210]. The Contractor shall ensure completion of the service authorization request decision within the timeframe applicable to the particular type of the authorization request: 1) authorization requests for medications and 2) authorization requests that do not involve medications. The Contractor shall process standard and expedited authorization requests as service authorization requests that do not involve medications. The Contractor shall process service authorization requests pertaining to medications according to the timeframes applicable to medication requests and not according to the standard or expedited timeframes used for non-medication service authorization requests. For service authorization requests lacking sufficient clinical information necessary to render the decision or that require clarification, the Contractor shall make sufficient attempts to obtain the information or clarification and document all attempts.

22. Define a standard authorization request for standard authorization decisions not involving medications: A standard authorization request is a request for a service that is not a medication, and which does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the Contractor receives the request is considered the date of receipt and is used to determine the due date for completion of the decision. For standard authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's best interest [42 CFR 438.210(d)(1)(i)-(ii), 42 CFR 438.404(c)(3)-(4)]. The Notice of Adverse Benefit Determination shall 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.

23. Define an expedited authorization request for expedited authorization decisions not involving medications: An expedited authorization request is a request for a service that is not a medication in which either the requesting provider indicates, or the Contractor determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. For expedited authorization decisions (those not involving medications), the Contractor shall provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 72 hours following the receipt of the authorization request, regardless of whether the 72 hour deadline falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's interest [42 CFR 438.210(d)(2)(i)-(ii), 42 CFR 438.404(c)(6)].

24. For service authorization decisions for medications, the Contractor shall provide a Notice of Adverse Benefit Determination no later than 24 hours from receipt of the authorization request regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. If the PA request for the medication lacks sufficient information for the Contractor to render a decision for the medication, the Contractor shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request. The Contractor shall provide the Notice of Adverse Benefit Determination no later than seven business days from the initial date of the authorization request [42 CFR 438.3(s)].

25. The Contractor shall ensure that the date/hour it receives the request, whichever is applicable, is considered the date/time of receipt of the service authorization request. The Contractor may use electronic date stamps or manual stamping for logging the receipt.

26. Define an Adverse Benefit Determination as set forth below 42 CFR 438.400(b) and permit a member, or their DR, to file an appeal of an Adverse Benefit Determination taken by the Contractor. Adverse Benefit Determinations are any of the following:
    a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit,
    b. Reduction, suspension, or termination of a previously authorized service,
    c. A denial, in whole or in part, of a payment for a service. A denial, in whole or in part, of a payment for a service because the claim does not meet the definition of a clean claim at 42 CFR 447.45(b) is not an adverse benefit determination,
    d. Failure to provide services in a timely manner, as defined by the State,
    e. Failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) required for standard resolution of appeals and standard disposition of grievances,
    f. Denial of a rural member's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area, or
    g. Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.

27. For decisions involving issues of medical necessity when a decision is not reached within the required time frame or when there is insufficient or conflicting information regarding medical necessity, the Contractor must extend the timeframe to render a decision, by up to 14 days, and shall document efforts to consult with the ordering provider (peer to peer), to obtain clinical information to assist in a decision. Obtaining an extension and peer to peer consultation is in these circumstances is in the member's best interest [42 CFR 438.210 (b)(2), 42 CFR 438.408(b)(1)-(3), 42 CFR 438.408(c)(1)(i)-(iii)]

28. The Notice of Adverse Benefit Determination for a service authorization decision that is not completed within the standard, expedited, or medication authorization request timeframes, whichever is applicable, will be made on the date that the timeframes expire, and the decision constitutes as a denial [42 CFR 438.404(c)(5). If the decision has not been completed within the time and in the best interest of the member, for expedited or standard requests an extension of up to 14 days is required to obtain additional information.

29. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the Contractor shall give the member written notice of the reason to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with the decision. The Contractor shall issue and carry out its decision as expeditiously as the member's health condition requires and no later than the date the extension expires [42 CFR 438.210(d)(1)(ii), 42 CFR 438.404(c)(4)(i)-(ii)].

30. The Contractor shall notify the requesting provider, in writing, of the decision to deny or reduce a service authorization request. Electronic notification is acceptable.

31. The Contractor shall provide a Notice of Adverse Benefit Determination: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least five days before the date of adverse benefit determination in the case of suspected fraud; 3) at the time of any adverse benefit determination affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 calendar days from receipt of a standard service authorization request, within 72 hours from receipt of an expedited service authorization request, unless an extension is in effect, or within 24 hours from receipt of a medication authorization request, unless additional information is needed from the prescriber in which case the determination shall be provided no later than seven business days from the receipt of the initial request. For service authorization decisions, the Contractor shall also ensure that the Notice of Adverse Benefit Determination provides the member with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service [42 CFR 438.404(c)(1), 42 CFR 431.211, 42 CFR 431.214, 42 CFR 438.404(c)(2)].

32. As specified below, the Contractor may elect to mail a Notice of Adverse Benefit Determination no later than the date of Adverse Benefit Determination when [42 CFR 438.404(c)(1), 42 CFR 431.213, 42 CFR 431.231(d), Section 1919(e)(7) of the Social Security Act, 42 CFR 483.12(a)(5)(i)-(ii),]:
    a. The Contractor receives notification of the death of a member,
    b. The member signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information),
    c. The member is admitted to an institution where they are ineligible for further services,
    d. The member's address is unknown, and mail directed to the member has no forwarding address, or
    e. The member has been accepted for Medicaid in another local jurisdiction.

33. The Notice of Adverse Benefit Determination shall explain:
    a. The adverse benefit determination the Contractor has taken or intends to take,
    b. The requested service and the reason for the requested service,
    c. The reasons for the adverse benefit determination which include an explanation of the specific facts that pertain to the decision and the legal basis for the determination, including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable. If citing medical necessity as a reason for denial, the Notice of Adverse Benefit Determination must provide a clear and specific

explanation of why the service is not medically necessary. The Contractor shall also include potential alternative options to consider and not merely refer the member back to the provider,

d. The effective date of a service denial, limited authorization, reduction, suspension, or termination,
e. The right of the member to be provided upon request, and at no charge, reasonable access to copies of all documents, records and other information related to the adverse benefit determination; this information includes medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits, and any documentation, records, and other information relevant to the member request as specified in 42 CFR 438.404(b)(2),
f. A listing of legal aid resources,
g. The member's right to request an appeal and the procedures for filing an appeal of the Contractor Adverse Benefit Determination, including information on exhausting the Contractor's appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c), including if the Contractor fails to make a decision in a timely manner regarding the member's appeal request,
h. The procedures for exercising these rights,
i. Circumstances when expedited resolution is available and how to request it,
j. The member's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay for the cost of these services. The Notice of Adverse Benefit Determination shall comply with ACOM Policy 414 [42 CFR 438.404(b)(1)-(b)(6) 42 CFR 438.402(b)-(c)], and
k. A statement that the provider who requested the service authorization request has the option to request a peer-to-peer discussion with the Contractor's Medical Director. The Contractor shall allow at least 10 business days from the date the provider has been made aware of the denial for the provider to request a peer-to-peer.

34. Define an appeal as the request for review of an Adverse Benefit Determination, as defined above [42 CFR 438.400(b)].

35. The Contractor shall resolve standard appeals as expeditiously as the member's health condition requires no later than 30 calendar days from the date of receipt of the appeal unless an extension is in effect [42 CFR 438.408(a), 42 CFR 438.408(b)(2)]. If a Notice of Appeal Resolution (NOAR) 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 [42 CFR 438.402(b), 42 CFR 438.228(a)].

36. Define an expedited appeal as an appeal in which the Contractor determines (for a request from a member) or the Provider indicates (when making the request for the member or in support of the member's request) that taking the time for standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor shall resolve all expedited appeals as expeditiously as the member's health condition requires but not later than 72 hours from the date the Contractor receives the expedited appeal (unless an extension is in effect) [42 CFR 438.408(a), 42 CFR 438.408(b)(3)]. The Contractor shall make reasonable efforts to provide oral notice to a member regarding an expedited resolution appeal [42 CFR 438.408(d)(2)(ii)]. If a NOAR 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 [42 CFR 438.402(b), 42 CFR 438.228(a)].

37. A member shall be given 60 calendar days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal [42 CFR 438.402(c)(2)(ii)].

38. Explain that a provider or authorized representative acting on behalf of a member and with the member's written consent, may file an appeal, grievance, or request a State fair hearing request [42 CFR 438.402(c)(1)(i)-(ii); 42 CFR 438.408]. The provider or authorized representative acting on behalf of the member shall be given 60 calendar days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal either orally or in writing, unless an expedited resolution is requested [42 CFR 438.402(c)(1)(ii), 42 CFR 438.402(c)(2)(ii), 42 CFR 438.402(c)(3)(ii)].

39. The Contractor includes, as parties to the appeal, the member, the member's legal representative, or the legal representative of a deceased member's estate [42 CFR 438.406(b)(6)].

40. The Contractor shall ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal [42 CFR 438.410(b)].

41. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 calendar days if the member requests the extension or if the Contractor establishes a need for additional information and that the delay is in the member's interest [42 CFR 438.408(c), 42 CFR 438.408(b)].

42. If the Contractor extends the timeframe for resolution of an appeal when not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice and follow-up within two calendar days with a written notice of the reason for the decision to extend the timeframe and the member's grievance rights [42 CFR 438.408(c)(2)(i)-(iii), 42 CFR 438.408(b)(2) and (3)].

43. The Contractor shall establish and maintain an expedited review process for appeals when 1)the Contractor determines (for a request from a member) the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function or 2)the provider indicates (in making the request on behalf of the member or in support of the member's request) the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function [42 CFR 438.210(d)(2)(i), 42 CFR 438.404(c)(6), 42 CFR 438.410(a)].

44. If the Contractor denies a request for expedited resolution, it shall transfer the appeal to the 30-calendar day timeframe for a standard appeal [42 CFR 438.410(c), 42 CFR 438.408(b)(2), 42 CFR 438.408(c)(2)]. The Contractor shall make reasonable efforts to give the member prompt oral notice and follow-up within two calendar days with a written notice of the denial of expedited resolution and the member's grievance rights.

45. The Contractor shall have policies and procedures outlining documentation requirements related to appeals that include but are not limited to:
    a. The reason the member is appealing the previous decision,
    b. Additional clinical or other information provided with the appeal request,
    c. Actions taken that relate to the appeal including previous denial or appeal history, and
    d. Follow-up activities associated with the denial of any prior appeal and before the current appeal.

Policies and procedures must state that the Contractor fully investigates the content of the appeal and documents the findings. The Contractor shall ensure that all documentation pertinent to the appeal is included in the appeal file.

46. For appeals, the Contractor provides the member a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing [42 CFR 438.406(b)(4), 42 CFR 438.408(b), 42 CFR 438.408(c)]. The Contractor shall inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe [42 CFR 438.406(b)(4), 42 CFR 438.408(b), 42 CFR 438.408(c)].

47. For appeals, the Contractor provides the member and their representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal. This information shall be provided at no charge to the member and sufficiently in advance of the resolution timeframe [42 CFR 438.406(b)(5)].

48. The Contractor shall provide written NOAR to the member and the member's representative or the representative of the deceased member's estate which shall contain:
    a. The results of the resolution process in easily understood language, and the date it was completed. As part of the resolution process, the Contractor shall perform a thorough and independent review of the appeal and the issues presented by the authorization request as specified in more detail below. The Contractor's NOAR shall not be a "cut and paste" from the Notice of Adverse Benefits Determination and shall discuss the particular facts of the appeal and the legal basis for the determination, including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable. For appeals which are denied based upon medical necessity or due to the experimental nature of the service, the Notice of Appeal Resolution must provide a clear and specific explanation of why the service is not medically necessary or why it is considered experimental. The Contractor shall also include potential alternative options to consider and not merely refer the member back to the provider,
    b. Title and specialty of the practitioners who participated in the appeal decision,
    c. For appeals not resolved wholly in favor of members the Notice must include and describe in detail the following:
    d. Specific reasons for the Contractor denial,
    e. Specific criteria used in making the decision and that the criteria used to make the decision is available upon request,
    f. The right of the member to be provided upon request, and at no charge, reasonable access to copies of all documents, records, and other information related to the appeals,
    g. Specific factual and legal basis to support the decision, and an explanation of:
        i. How the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision. For determinations which deny the service request due to lack of medical necessity, the notice must include a clear and specific explanation of why the service is not medically necessary. The Contractor shall also include potential alternative options for consideration,
        ii. The applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable,

iii. The member's right to request a State fair hearing (including the requirement that the member shall file the request for a hearing in writing to the Contractor) no later than 90 days after the date the member receives the Contractor's NOAR and how to do so,
iv. The right to receive continued benefits pending the hearing when the member has requested a hearing within ten calendar days from the date the notice of resolution was sent and how to request continuation of benefits, and
v. Information explaining that the member may be held liable for the cost of benefits if the hearing decision upholds the Contractor [42 CFR 438.408(d)(2)(i)-(ii), 42 CFR 438.10, 42 CFR 438.408(e)(1)-(2)].

Refer to the AHCCCS Guide to Language in Notice of Adverse Benefit Determination.

49. The Contractor shall continue benefits if all of the following occur: [42 CFR 438.420, 42 CFR 438.402(c)(2)(ii)]
    a. The member files the request for an appeal within 60 calendar days following the date on the Adverse Benefit Determination notice.
    b. The appeal involves:
        i. The termination, suspension, or reduction of a previously authorized service.
        ii. A denial and the physician asserts that the requested service/treatment is a necessary continuation of the previously authorized service.
    c. The member's services were ordered by an authorized provider.
    d. When the appeal was filed, the period covered by the original authorization has not expired, AND
    e. The member files a request for continuation of benefits on or before the later of the following:
        i. Within 10 calendar days of the Contractor sending the notice of adverse benefit determination, or
        ii. The intended effective date of the Contractor's proposed adverse benefit determination.

50. If at a member's request benefits are continued or are reinstated while the appeal or State fair hearing is pending, the Contractor shall continue benefits until one of the following occur [42 CFR 438.420(c)(1)-(3); 42 CFR 438.408(d)(2)]:
    a. The member withdraws the appeal or request for State fair hearing.
    b. The member does not request a State fair hearing and continuation of benefits within 10 calendar days from the date the Contractor sends the notice of an adverse appeal resolution.
    c. A State fair hearing decision adverse to the member is issued.

51. The Contractor shall continue benefits regardless of the period of the initial PA, if all of the requirements are met.

52. The Contractor may, consistent with AHCCCS policy on recoveries and as specified in Contract, recover the cost of continued services furnished to the member while the appeal or State fair hearing was pending if the final resolution of the appeal or State fair hearing upholds the Contractor's Adverse Benefit Determination [42 CFR 438.420(d), 42 CFR 431.230(b)].

53. If the member files a request for hearing the Contractor shall ensure that the hearing request and supporting documentation is submitted to the AHCCCS/OGC as specified by ACOM Policy 445 and **Section F,** Attachment F3, Contractor Chart of Deliverables. State fair hearing notices will be issued by the AHCCCS Administration and are not delegated to the Contractor [42 CFR 438.228(b)].

54. If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal or the pendency of the hearing process, the Contractor shall authorize or provide the services as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 438.424(a)]. Services shall be authorized within the above timeframe irrespective of whether the Contractor contests the decision.

55. If the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation [42 CFR 438.424(b)].

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

57. If the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending the appeal or State fair hearing decision, the Contractor may recover the cost of those services from the member.

58. The future enrollment of a Contractor’s member to another Contractor and/or the member’s subsequent loss of AHCCCS eligibility are not valid reasons to deny or limit a member’s service authorization request submitted to the Contractor during the time period in which the member was enrolled with that Contractor. The Contractor shall not take the position during the grievance and appeals process that a former member’s subsequent enrollment with another Contractor or that member’s subsequent loss of AHCCCS eligibility are valid reasons for the Prior Contractor to deny or dismiss an appeal of the adverse benefit determination if the member submitted the service authorization request to the Prior Contractor during a period of enrollment with the Prior Contractor. The Prior Contractor is required to substantiate that the denial or reduction of the service authorization request is based upon medical necessity, the exclusion of the service from the scope of AHCCCS covered services, and/or cost effectiveness. If the authorization decision of the Prior Contractor is overturned on appeal, the Prior Contractor is financially responsible for coverage of those services notwithstanding the member’s subsequent enrollment with a different Contractor or the member’s subsequent loss of AHCCCS eligibility.

59. In addition to the grievance and appeals procedures specified herein, the Contractor shall also make available the grievance and appeals processes specified in Arizona Administrative Code Title 9, Chapter 21, Article 4 for persons determined under Arizona law to be Seriously Mentally Ill.

[END OF ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS]

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

The Contractor shall have in place a written claims dispute policy for its subcontractors and non-contracted providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies.

Failure to comply with any of these provisions may result in the imposition of sanctions.

The Contractor shall comply with the following provisions:

1. The Provider Claim Dispute Policy shall stipulate that all claim disputes shall be adjudicated in Arizona, including those claim disputes arising from claims processed by an Administrative Services Subcontractor.

2. The Provider Claims Dispute Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the Contractor shall send a copy of its Provider Claims Dispute Policy within 45 days of receipt of a claim. The policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.

3. The Provider Claim Dispute Policy shall specify that all claim disputes challenging claim payments, denials or recoupments shall be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

4. The Provider Claim Dispute Policy shall specify a physical local address in Arizona for the submission of all provider claim disputes and hearing requests.

5. That specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.

6. The Contractor shall develop and maintain a tracking log for all claims disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claims dispute, resolution of the claim dispute, and the date of resolution.

7. That claim disputes are acknowledged in writing and within five business days of receipt.

8. Claims disputes are thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.

9. All documentation received by the Contractor during the claim dispute process is dated upon receipt.

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

11. The Provider Claim Dispute Policy shall specify a copy of the Contractor's Notice of Decision (Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor unless the provider and Contractor agree to a longer period. The Decision shall include and describe in detail the following:
    a. The nature of the claim dispute,
    b. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member's name, pertinent dates of service, dates and specific reasons for the Contractor denial/payment of the claim, and whether or not the provider is a contracted provider,
    c. An explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable,
    d. The provider's right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Contractor's decision, and
    e. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

12. If the Provider files a written request for hearing, the Contractor shall ensure that the hearing request and supporting documentation is submitted to AHCCCS/OGC, as specified by ACOM Policy 445 and Section F, Attachment F3, Contractor Chart of Deliverables.

13. If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor shall review the matter to determine why the request for hearing was filed and resolve the matter when appropriate.

14. If the Contractor's Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision, with any applicable interest, within 15 business days of the date of the Decision.

15. If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 438.424]. Services shall be authorized within the above timeframe irrespective of whether the Contractor contests the decision.

[END OF ATTACHMENT F2: PROVIDER CLAIMS DISPUTE STANDARDS]

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and are subject to change at any time during the term of the Contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. The submission of late, inaccurate, or incomplete data shall be subject to the penalty provisions described in Section D, Paragraph 74, Administrative Actions.

The deliverables are due by 5:00 PM Arizona Time on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM Arizona Time on the next business day.

All deliverables which are noted to be submitted via SharePoint are to be submitted to the SharePoint Contract Compliance Site at: compliance.azahcccs.gov. Should AHCCCS modify any deliverables, or the submission process for deliverables, AHCCCS shall provide a notice of instruction to the Contractor outlining changes to the deliverable.

AHCCCS has identified which deliverables are addressed through the Contractors' NCQA Accreditation requirements and can be removed to further reduce administrative burden. These deliverables will remain listed in the Contract Chart of Deliverables and are marked as fully deemed and do not require submission to AHCCCS unless the Contractor has not met accreditation requirements or AHCCCS has determined to resume the deliverable.

Refer to Section F, Attachment F3, Contractor Chart of Deliverables in the separately attached Excel document.

[END OF ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES]

[END OF SECTION F: ATTACHMENTS]

SECTION G: RESERVED

SECTION H: RESERVED

SECTION I: RESERVED