ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

801 EAST JEFFERSON STREET
PHOENIX, ARIZONA  85034

MEDICARE ADVANTAGE ORGANIZATION AGREEMENT
BETWEEN AHCCCS AND
Participant: Banner – University Care Advantage
AHCCCS AGREEMENT # YH20-0010-02

This AGREEMENT is entered into by the Arizona Health Care Cost Containment System (AHCCCS), the Arizona State Medicaid Agency, having its principal office at 801 East Jefferson Street, Mail Drop 4100, Phoenix, Arizona 85034, and hereafter referred to as “AHCCCS”, and the Participant: Banner – University Care Advantage hereafter referred to as “Medicare Advantage Organization (MAO)”.

The purpose of this Agreement is to coordinate care for individuals in Arizona who are enrolled in Medicare and receive assistance under Medicaid, known as “Dual Eligible Members.” This Agreement outlines requirements which aim to improve care coordination and timely information sharing by both parties for Dual Eligible Members enrolled in an AHCCCS-certified or State-licensed MAO, consistent with the requirements of 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the Patient Protection and Affordable Care Act of 2010 and as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA). As required in its AHCCCS contract, each AHCCCS Complete Care (ACC or Medicaid MCO) or ALTCS Health Plan is required to also operate an MAO offering a Dual Eligible Special Needs Plan (D-SNP) product(s) in all Geographic Service Areas (GSAs) in which it holds a Medicaid contract. Per the requirements of AHCCCS Contractor Operations Manual (ACOM) Policy 107, AHCCCS shall execute an Agreement only when an MAO holds a companion AHCCCS program contract that covers the requested county(ies) and AHCCCS population(s).

As required by Arizona Revised Statutes (A.R.S.) §36-2906.01, each contracted Medicaid MCO or ALTCS Health Plan shall establish an affiliated corporation whose only authorized business is to provide services to enrolled AHCCCS eligible persons. Each contracted Medicaid MCO shall have, and assure AHCCCS it does have, the legal and actual authority to direct, manage, and control the operations of both the corporation established under its AHCCCS contract and its companion MAO to the extent necessary to ensure integration of Medicare and AHCCCS services for individuals enrolled for both programs. The AHCCCS-contracted MAO shall be an affiliated organization of the companion Medicaid MCO as defined.

1. DEFINITIONS

1.1 Affiliated Organization: A party that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with or of an entity.
1.2 Arizona Long Term Care System (ALTCS) Program: A Title XIX program administered by AHCCCS as authorized by A.R.S. Title 36, Chapter 29, Article 2. The ALTCS Program provides long term care, acute care, behavioral health care and case management services to two distinct populations: eligible individuals who are elderly and physically disabled, and eligible individuals who are developmentally disabled. In order to qualify for the ALTCS Program, applicants shall be determined to need an institutional Level of Care, as well as meet other financial and eligibility criteria.

1.3 Centers for Medicare and Medicaid Services (CMS): An organization within the United States Department of Health and Human Services responsible for administering the Medicare (Title XVIII) and Medicaid (Title XIX) programs.

1.4 Dual Eligible Member: An individual enrolled with an AHCCCS Medicaid MCO for full Medicaid services (AHCCCS benefits) who also receives both Part A and Part B Medicare benefits. These individuals are considered to be Full Benefit Dual Eligible Members, and include Qualified Medicare Beneficiary Plus (QMB+), Specified Low-Income Medicare Beneficiary Plus (SLMB+) and Other Full Benefit Dual Eligible (Other FBDE) populations. A Full Benefit Dual Eligible Member does not include those persons enrolled in a Medicare Savings Program population: Qualified Medicare Beneficiary only (QMB only), Specified Low-Income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).

1.5 Dual Eligible Special Needs Plan (D-SNP): A type of Medicare Advantage health benefit plan product offered by a CMS-contracted MAO that limits its enrollment to those individuals who are eligible for benefits under both Medicare (Title XVIII) and Medicaid (Title XIX) programs. This type of Medicare plan is authorized to target its enrollment activities to only those beneficiaries who are dually eligible for Medicare and Medicaid.

1.6 Medicare Advantage (MA): Medicare’s managed care program (Part C) as administered by CMS.

1.7 Medicare Advantage Organization (MAO): An entity contracted with CMS to provide integrated Medicare Part A, Part B, and Part D benefits to Medicare beneficiaries.

1.8 Qualified Medicare Beneficiary with AHCCCS Benefits (QMB+): An individual who is entitled to Medicare, meets the Federal income standard of equal to or less than 100 percent of the Federal Poverty Level (FPL), and is determined eligible for full AHCCCS benefits. For a QMB+ Dual Eligible Member, AHCCCS shall provide payment of the applicable Medicare Part A premium, the applicable Medicare Part B premium, Medicare coinsurance amounts, and Medicare deductibles for Medicare covered services.

1.9 Specified Low-Income Medicare Beneficiary with AHCCCS Benefits (SLMB+): An individual who is entitled to Medicare, meets the Federal income standard of greater than 100 percent but less than 120 percent of the FPL, and is determined eligible for full AHCCCS benefits. For a SLMB+ Dual Eligible Member, AHCCCS shall provide payment of the applicable Medicare Part B premium only.

1.10 Other Full Benefit Dual Eligible: An individual who is entitled to Medicare, does not meet either QMB+ or SMB+ categorical income criteria, but is determined eligible for full AHCCCS benefits. For an Other Full Benefit Dual Eligible Member, AHCCCS does not provide payment...
2. PROGRAM REQUIREMENTS

2.1. MAO RESPONSIBILITIES TO COORDINATE MEDICAID BENEFITS

The MAO is responsible for the coordination of both Medicare and Medicaid integrated health care benefits, regardless of whether a Dual Eligible Member is enrolled with the MAO’s companion AHCCCS Complete Care, ALTCS or RBHA health plan for Medicaid benefits.

2.1.1 If a Dual Eligible Member is enrolled with the MAO for both Medicare and Medicaid benefits, the MAO is responsible for coordinating all benefits covered by both Medicare and AHCCCS.

2.1.2 If a Dual Eligible Member is enrolled with the MAO for both Medicare and Medicaid benefits, the MAO shall utilize Medicare Parts A, B and D data, and Medicaid health care and other data received from AHCCCS, to coordinate all aspects of the Dual Eligible Member’s integrated health care benefits, including, but not limited to discharge planning, disease management, and care management.

2.1.3 If a Dual Eligible Member is not enrolled with the MAO’s companion Medicaid MCO for Medicaid benefits, the MAO shall coordinate AHCCCS only benefits with the Dual Eligible Member’s assigned AHCCCS Complete Care, ALTCS or RBHA health plan. Coordination of integrated Medicaid benefits is not the Dual Eligible Member’s responsibility.

2.1.4 The MAO shall coordinate behavioral health benefits with the Dual Eligible Member’s AHCCCS Complete Care, ALTCS or RBHA health plan, when necessary and appropriate.

2.1.5 The MAO shall submit to AHCCCS its Medicare Health Risk Assessment tool annually as specified in Attachment 1: Chart of Deliverables.

2.1.6 AHCCCS will ensure that MAO has access to the Dual Eligible Member’s AHCCCS Complete Care, ALTCS or RBHA health plan enrollment through daily enrollment files and the AHCCCS Online web portal.

2.1.7 The MAO shall establish a designated Care Coordination Contact Person at each AHCCCS Complete Care, ALTCS, or RBHA health plan who will be responsible at a minimum to timely share, communicate and coordinate inpatient hospital, emergency department, and chronic illness information to assist an enrolled Dual Eligible Member’s assigned AHCCCS Complete Care, ALTCS, or RBHA health plan (whether a companion affiliated or non-companion organization) coordinate care – including when benefits change either to or from Medicare or Medicaid coverage – in accordance with, but not limited to, the applicable terms and
requirements of *AHCCCS Medical Policy Manual (AMPM)* Chapter 500: Care Coordination Requirements. Within ten (10) calendar days of a change in the MAO’s designated Care Coordination Contact Person(s), MAO shall notify each AHCCCS Complete Care, ALTCS, or RBHA health plan of such change.

2.1.8 The MAO shall provide AHCCCS with the name of its designated Care Coordination Contact Person who is responsible for coordinating the care of enrolled Dual Eligible Members as per paragraph 2.1.7. The name and contact information of this person shall be listed in paragraph 3.16.3. AHCCCS shall be notified within ten (10) calendar days of a change in the MAO’s designated Care Coordination Contact Person.

2.1.9 MAO shall participate in any AHCCCS meetings (by telephone, Internet or in person) relating to the care for Dual Eligible Members.

MAO shall timely provide any necessary information and data as requested by AHCCCS or CMS to further Medicare-Medicaid care coordination activities.

In addition, MAO shall provide necessary information and participate as requested in the U.S. General Accountability Office (GAO) study on state-level integration between D-SNPs and Medicaid, a requirement of Section 50311, part (e) of the Bipartisan Budget Act of 2018.

2.1.10 The MAO shall provide AHCCCS with necessary and timely information in response to requested quality of care inquiries. Responses to quality of care cases referred by AHCCCS shall address the appropriate investigative and resolution processes for benefits and care coordinated through both the Medicare and Medicaid programs.

2.1.11 *Default Enrollment Process* – On behalf of currently enrolled AHCCCS categorically eligible members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and that such Medicare eligibility results in Full Benefit Dual Eligible status for such members, MAO shall perform the default enrollment process as provided by 42 CFR 422.66 and 422.68.

Through this Agreement, in conformance with 42 CFR 422.66(c)(2)(i)(B) and 42 CFR 422.107, AHCCCS approves MAO’s implementation of the default enrollment process subject to CMS’ prior approval as per the requirements of 42 CFR 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable.

MAO shall be responsible for timely obtaining initial default enrollment process approval from CMS no later than 120 calendar days prior to the Effective Date of this Agreement as specified in paragraph 3.1: Term of Agreement. MAO shall coordinate with AHCCCS regarding those activities necessary to obtain such CMS prior approval. MAO shall forward to AHCCCS a copy of CMS’ default enrollment process prior approval notification or correspondence to the MAO within 10
calendar days of receipt, in accordance with the requirements of Attachment 1: Chart of Deliverables.

MAO shall also be responsible for coordinating those necessary activities to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. MAO shall coordinate with AHCCCS regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. MAO shall forward to AHCCCS copies of its default enrollment process renewal notification and materials to CMS, and CMS’ renewal approval(s) notification or correspondence to the MAO, within 10 calendar days of receipt, in accordance with the requirements of Attachment 1: Chart of Deliverables.

MAO shall maintain a minimum 3.0 overall plan Star rating as assigned by CMS to implement the default enrollment process. MAO implementation of the default enrollment process shall be revoked by CMS if a minimum 3.0 overall plan Star rating is not maintained, and default enrollment cannot be re-applied for with CMS until the MAO has subsequently achieved this minimum Star rating. See paragraph 2.11: Medicare Star Ratings for additional Star rating requirements.

Through implementation of the default enrollment process, AHCCCS shall provide MAO with information necessary to prospectively identify those AHCCCS categorically eligible members who are or will be in their Medicare Initial Coverage Election Period.

On an informational basis only, MAO shall report monthly to AHCCCS of its default enrollment process activities and results, as specified in Attachment 1: Chart of Deliverables and Attachment 5: Default Enrollment Process Reporting Requirements.

2.1.12 Passive Enrollment Process – When determined in the best interest of a Dual Eligible Member to maintain continuity of integrated care through aligned enrollment between their companion Medicaid MCO and selected MAO, each as offered by the same parent/affiliated organization, it is AHCCCS’ sole option to request the opportunity of and consult with CMS for implementing the applicable passive enrollment requirements of 42 CFR 422.60(g) to address the circumstances described at 42 CFR 422.60(g)(1)(iii).

MAO shall implement passive enrollment requirements and procedures only as directed or instructed by CMS or AHCCCS, in accordance with but not limited to, such terms, conditions, or requirements as provided by 42 CFR 422.60(g)(3), 422.60(g)(4)(ii), 422.60(g)(5), and applicable regulatory guidance.

MAO shall provide CMS or AHCCCS with any data or information within the timeframes or specifications requested, as determined necessary, to facilitate passive enrollment activities.
2.1.13 **Alignment Efforts** – AHCCCS will continue to work with stakeholders to establish practices which improve alignment for Dual Eligible Members. The beneficiary’s choice of MAO shall be fully respected, and consequently, misalignment may occur. MAO shall maximize care coordination for AHCCCS Complete Care, ALTCS, and RBHA health plan members who are Dual Eligible Members (see ACOM Policy 107).

2.2. **MEDICAID BENEFITS COVERED BY THE MAO**

MAO is not responsible for providing or reimbursing any Medicaid benefits. The MAO shall maintain current knowledge and familiarity of AHCCCS Complete Care, ALTCS and RBHA health plan benefits through ongoing reviews of AHCCCS laws, rules, policies, AHCCCS Complete Care, ALTCS and RBHA health plan contracts, and further guidance as posted on the AHCCCS website. The MAO shall timely coordinate AHCCCS Complete Care, ALTCS and/or RBHA health plan benefits for its enrolled Dual Eligible Members as described in Attachments 2, 3 and 4 of this Agreement. Paragraph 2.1 et seq. details the MAO’s specific Medicare-Medicaid care coordination requirements.

AHCCCS Medicaid covered services are described in Title XIX of the Social Security Act, 42 CFR 440 and 441; A.R.S. §36-2901 et seq.; AHCCCS regulations Arizona Administrative Code (A.A.C.) Title 9, Chapters 22 and 28; the **AHCCCS Medical Policy Manual (AMPM)**; AHCCCS policies and procedures; applicable AHCCCS Complete Care, ALTCS or RBHA health plan contracts; the AHCCCS website; and other relevant materials.

2.3. **MEDICAID COST-SHARING PROTECTIONS COVERED UNDER MAO**

Section 1902(n)(3)(B) of the Social Security Act prohibits a Medicare provider from balance billing a QMB+ Dual Eligible Member for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments. A QMB+ Dual Eligible Member has no legal obligation to make further payment to a provider or to the MAO for Medicare Part A or Part B cost sharing amounts. MAO provider agreements shall specify that a contracted Medicare provider agrees to accept MAO Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill the appropriate AHCCCS Complete Care (ACC), ALTCS or RBHA health plan as applicable for any additional Medicare payments that may be reimbursed by Medicaid. Dual Eligible Members shall be responsible for any applicable Medicaid copayments.

For further information about AHCCCS’ cost sharing policy, see **ACOM Policy 201**. Cost sharing rules on behalf of Dual Eligible Members as administered by the MAO’s companion AHCCCS Complete Care, ALTCS or RBHA health plan are included at A. A. C. paragraphs R9-29-101 to R9-29-601.
2.4. IDENTIFYING AND SHARING OF INFORMATION ON MEDICAID NETWORK PROVIDERS

MAO shall develop a network of providers which includes an overlap of providers in its network that are also contracted with its companion AHCCCS Complete Care, ALTCS or RBHA health plan. On its website, MAO shall maintain a link to its applicable companion AHCCCS Complete Care, ALTCS or RBHA health plan’s provider search capabilities to assist an enrolled Dual Eligible Member in determining a provider’s participation in the MAO’s provider network.

AHCCCS health plan provider networks can also be accessed online through respective individual websites at https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx.

2.5. VERIFYING ELIGIBILITY FOR MEDICARE AND MEDICAID

The MAO shall accurately verify both potential and enrolled Dual Eligible Members’ Medicare and Medicaid eligibility status.

The MAO shall have access to real-time Medicaid eligibility data for Dual Eligible Members enrolled in its companion AHCCCS Complete Care, ALTCS or RBHA health plan. AHCCCS transmits electronic eligibility files to its contracted Medicaid MCOs daily.

For a Dual Eligible Member not enrolled in the MAO’s companion AHCCCS Complete Care, ALTCS or RBHA health plan, the MAO shall verify eligibility using the AHCCCS Online real-time web portal at: https://azweb.statemedicaid.us/Home.asp.

2.6. ENCOUNTER SUBMISSION

The MAO shall submit Medicare encounter data to AHCCCS in accordance with the requirements of Attachment 1: Chart of Deliverables. AHCCCS has a data use Agreement with CMS to receive Medicare data for care coordination. This data will provide AHCCCS with information on services paid for by Medicare.

2.7. FINANCIAL STANDARDS AND REPORTING

The MAO shall meet the financial standards and reporting requirements as follows.

2.7.1 MAO Certified by AHCCCS

If the MAO is certified by AHCCCS as authorized to bear financial risk, then the following requirements apply.

2.7.1.1 Financial Standards – The MAO shall meet AHCCCS’ minimum Equity Per Member and Performance Bond financial solvency standards for MAOs, as detailed in ACOM Policy 305: Performance Bond and Equity Per Member Requirements. This policy is available on the AHCCCS website.

2.7.1.2 Financial Reporting – The MAO shall submit to AHCCCS all required quarterly financial reports in accordance with the applicable financial
2.7.1.3 **Transactions Requiring AHCCCS Prior Approval** – Certain transactions, such as distributions of MAO equity to a parent or other affiliated organization(s), that may impact Equity Per Member, Performance Bond, and other financial solvency standards, require AHCCCS prior approval. Requests for AHCCCS’ prior approval of such transactions shall be made in accordance with the requirements of ACOM Policy 305: Performance Bond and Equity Per Member Requirements, ACOM Policy 418: Provider and Affiliate Advance and Loan Request, and the AHCCCS Financial Reporting Guide as applicable. Such requests shall be directed to the AHCCCS Division of Health Care Management’s (DHCM’s) Operations Compliance Officer for Medicare.

2.7.2 **MAO Licensed by Arizona Department of Insurance (ADOI)**

If the MAO is licensed by the ADOI as authorized to bear financial risk, then the following requirements apply.

2.7.2.1 **Financial Standards** – The MAO shall meet the ADOI’s applicable minimum financial solvency standards for state-licensed Health Care Service Organizations (HCSOs).

2.7.2.2 **Financial Reporting** – The MAO shall submit required quarterly and annual NAIC format financial reports to the ADOI. The MAO shall also provide, for informational purposes only, in the same format(s) for the same time periods, unconsolidated, separate financial reports representing solely the financial results of the MAO’s D-SNP offered only to Arizona Dual Eligible Members as detailed in Section 4 of this Agreement. Copies of these unconsolidated, AHCCCS-only MAO D-SNP financial reports in ADOI format(s) are to be provided to the AHCCCS DHCM-Finance Unit in accordance with the requirements of Attachment 1: Chart of Deliverables.

2.7.2.3 **Financial Notifications** – Within 10 calendar days of the date of such correspondence with the ADOI, the MAO shall also provide AHCCCS DHCM-Finance Unit with informational copies of requests to and approvals received from the ADOI for distributions of equity or other similar financial transactions that affect the MAO’s financial solvency.

2.8. **MARKETING AND ADVERTISING OF AGREEMENT**

To increase Dual Eligible Members’ enrollment in aligned MAOs and companion Medicaid MCOs, AHCCCS encourages the MAO to directly market its Medicare Advantage product(s) only to those Dual Eligible Members currently enrolled in the MAO’s companion AHCCCS Complete Care, ALTCS or RBHA health plan as applicable. The MAO shall only enroll an eligible Dual Eligible Member in accordance with the terms, service
area counties and plan benefit packages listed for each of the respective AHCCCS companion contracts, programs and populations as specified in Section 4 of this Agreement.

The MAO shall not advertise or publish information regarding this Agreement for commercial benefit without the express written prior approval of the AHCCCS Chief Procurement Officer, in accordance with the requirements of Attachment 1: Chart of Deliverables.

2.9. GRIEVANCES AND APPEALS
The MAO shall implement the applicable requirements of 42 CFR 422.562(a)(5), and any subsequent regulatory guidance relating to assistance with Medicaid covered service grievances and appeals as detailed in paragraph 2.13 of this Agreement.

The MAO shall submit Grievances and Appeals reports in accordance with the requirements of Attachment 1: Chart of Deliverables and the AHCCCS Grievance System Reporting Guide. AHCCCS shall use these reports for informational purposes only.

The MAO shall provide AHCCCS with the following information:

- A quarterly summary of Part C and Part D pre-service member appeals received and the outcomes of those appeals,
- A quarterly summary of Medicare Independent Review Entity (IRE) decisions received, and
- Service level detail on those appeals upheld and overturned (including a description of the action that was appealed).

2.10. MEMBER TRANSITION
The MAO is required to participate in all activities as directed by the State which relate to member transition as a result of termination of this contract. This applies to terminations directed from AHCCCS, CMS or MAO.

The MAO is required to notify AHCCCS in the case of significant changes to the terms of the contract with CMS to protect beneficiary and state interests including, but not limited to: MAO SNP non-renewals, service area changes, plan benefit package (PBP) changes, terminations, deficiencies, notices of intent to deny, and novation agreements. MAO must submit any CMS warning letters or corrective action plans within ten (10) calendar days of receipt to the AHCCCS Operations Compliance Officer for Medicare.

2.11. MEDICARE STAR RATINGS
The MAO shall notify AHCCCS within five (5) calendar days of receiving notification from CMS of a Part C or Part D annual overall Medicare Star quality rating of less than 3.0 for the coming contract year.
The MAO shall submit to AHCCCS an outline of the steps it proposes or has implemented to improve the low Star quality rating score received.

These notifications shall be submitted to AHCCCS in accordance with the requirements of Attachment 1: Chart of Deliverables.

2.12 FULLY INTEGRATED DUAL ELIGIBLE (FIDE) SPECIAL NEEDS PLAN STATUS

This paragraph is applicable only to an MAO contracted under this Agreement that shall offer a separate and distinct Plan Benefit Package (PBP) of coverage, consistent with State policy, to Dual Eligible Members enrolled in its companion ALTCS Health Plan in accordance with the terms and requirements of Section 4 of this Agreement.

MAO serving ALTCS program Dual Eligible Members through an ALTCS Health Plan shall be designated annually by CMS as a FIDE-SNP according to the following CMS requirements:

2.12.1 Enroll special needs individuals entitled to medical assistance under a Medicaid State Plan, as defined in Section 1859(b)(6)(B)(ii) of the Act and 42 CFR Section 422.2 and described in detail in Section 40.5.3 of Chapter 16b of the Medicare Managed Care Manual;

2.12.2 Provide Dual Eligible Members-access to Medicare and Medicaid benefits under a single managed care organization;

2.12.3 Have a CMS-approved, MIPPA compliant contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;

2.12.4 Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and

2.12.5 Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

2.12.6 In addition, in determining whether MAO meets the FIDE-SNP definition, CMS will allow Long Term Care benefit carve-outs or exclusions only if the MAO can demonstrate that it meets the following criteria:

2.12.6.1 The plan must be at risk for substantially all of the services under the capitated rate;

2.12.6.2 The plan must be at risk for nursing facility services for at least six months (180 days) of the plan year;

2.12.6.3 The individual must not be disenrolled from the plan as a result of exhausting the service covered under the capitated rate; and,

2.12.6.4 The plan must remain responsible for managing all benefits, including any carved-out service benefits, notwithstanding the method of
payment (e.g., fee-for-service, separate capitated rate) received by the plan.

2.12.7 The MAO shall notify AHCCCS annually of CMS approved or non-approved FIDE Special Needs Plan status, as applicable, in accordance with the requirements Attachment 1: Chart of Deliverables.

2.13. MAO ASSISTANCE WITH MEDICAID COVERAGE, APPEALS AND GRIEVANCES

The MAO shall implement the requirements of 42 CFR 422.562(a)(5) to assist an enrolled Dual Eligible Member with obtaining Medicaid covered services, and with Medicaid grievance and appeals procedures, regardless of whether or not such Dual Eligible Member is enrolled in the MAO’s companion ACC, ALTCS or RBHA health plan, or an AHCCCS fee-for-service health coverage program.

The MAO shall make available and offer such assistance when it becomes aware of a Dual Eligible Member’s need to utilize these Medicaid procedures, and not only when directly requested by the Dual Eligible Member. This assistance may include but not be limited to:

- Explaining how to make a request for a Medicaid covered service prior authorization,
- Appealing a Medicaid adverse benefit determination,
- Identifying and providing specific instructions for contacting their enrolled ACC MCO, ALTCS or RBHA health plan, or AHCCCS fee-for-service point(s) of contact,
- Coordinating in making such contacts,
- Assisting in obtaining documentation to support a Medicaid prior authorization request, grievance or appeal,
- Assisting in filing either a Medicaid grievance or appeal.

Attachment 6 of this Agreement includes contact information for each ACC, ALTCS and RBHA health plan, and the AHCCCS fee-for-service program applicable to a Dual Eligible Member’s potential AHCCCS health plan. The Care Coordination Contact Person listed in paragraph 3.16.3, or his/her designee, shall reference Attachment 6 when assisting a Dual Eligible Member with applicable Medicaid coverage, grievance, or appeals processes.

When a Dual Eligible Member accepts such assistance with these proposed Medicaid procedures, the MAO shall provide it through multiple methods, including but not limited to:

- Self-advocate coaching services, education and/or outreach,
- Completion of necessary forms for and explanation of the Medicaid grievance and appeals process.
The MAO’s obligation to provide assistance with these procedures does not require representation on behalf of an enrolled Dual Eligible Member at a Medicaid appeal.

Upon request from CMS or AHCCCS, the MAO shall provide documentation of its compliance with the requirements of 42 CFR 422.562(a)(5).

2.14. PENDING ISSUES

2.14.1 Highly Integrated Dual Eligible Special Needs Plan (HIDE) Status – The MAO shall collaborate with AHCCCS and CMS to achieve HIDE status beginning CY2021 for its participating contracted companion ACC Medicaid MCO, subject to the requirements of the Balanced Budget Act of 2018 and applicable subsequent regulatory guidance issued by CMS.

2.14.2 Supplemental Benefits – The MAO shall collaborate with AHCCCS regarding discretionary health-related supplemental benefits to be offered under the Balanced Budget Act of 2018 and Special Supplemental Benefits for the Chronically Ill (SSCBI) to be offered beginning CY2020 under authority provided by CMS in the Medicare Advantage CY2020 Final Call Letter issued April 1, 2019. Such coordination shall include proposed prospective SSCBIs that have a reasonable expectation of improving or maintaining the health or overall function of such an AHCCCS Dual Eligible Member as tailored to the individual’s needs, for those such who are enrolled with the MAO. AHCCCS seeks to improve Medicare-Medicaid program coordination of such SSCBIs so as to reduce service delivery fragmentation and promote improved health outcomes. Examples of such coordinated SSCBIs include, but are not limited to home delivered foods/meals, home environmental modifications, transportation for non-medical needs, and other identified social determinant of health needs on a per identified and defined chronically ill Dual Eligible Member basis as documented in their care management/care treatment plan.

2.14.3 Interoperability for Payers – The MAO shall participate with AHCCCS in determining and effecting necessary implementation strategies and solutions to address CMS’ and The Office of the National Coordinator for Health Information Technology’s (ONC’s) issued proposed rules, technical requirements and timelines encompassing the interoperability of electronic health record and patient access to protected health information, as initially published in the Federal Register of March 4, 2019. Such participation shall also include collaboration as a payer “participant” in and through the ONC’s proposed Trusted Exchange Framework and Common Agreement (TEFCA) proposed Draft 2 requirements and timelines, as initially published on the ONC’s website on April 19, 2019.

2.14.4 Primary Cares Initiative – The MAO shall participate with AHCCCS in due diligence activities regarding the future potential of furthering care coordination and integration opportunities on behalf of Dual Eligible Members beginning CY2021
3. TERMS AND CONDITIONS

3.1. TERM OF AGREEMENT

The term of this Agreement is for the period January 1, 2020 ("Effective Date") through December 31, 2020, inclusive.

3.2. AUTHORITY

This Agreement, and any subsequent Amendments issued thereto in accordance with paragraphs 3.5 and 3.6, is issued under the authority of the undersigned AHCCCS Chief Procurement Officer.

3.3. RELATIONSHIP OF PARTIES

Under this Agreement, the contracted MAO is an independent contractor. Neither party to this Agreement shall be deemed to be an employee or agent of the other party.

3.4. CONFLICT OF INTEREST

The MAO 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 MAO shall fully and completely disclose any situation that may present a conflict of interest. If the MAO is now performing or elects to perform during the term of this Agreement any services for any AHCCCS contractor, provider or Contractor or an entity owning or controlling same, the MAO shall disclose this relationship prior to accepting any assignment involving such party.

3.5. CONTRACT / AGREEMENT INTERPRETATION AND AMENDMENT

3.5.1. No Parole Evidence - This Agreement 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 Agreement. No other understanding, either oral or in writing, shall be binding.

3.5.2. No Waiver - Either party's failure to insist on strict performance of any term or condition of the Agreement 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.

3.5.3. **Written Amendments** - This Agreement shall be modified only through a written amendment to the Agreement within the scope of the Agreement as signed by the AHCCCS Chief Procurement Officer and counter-signed by a duly authorized representative of the MAO.

3.6. **CHANGES AND AMENDMENTS TO THIS AGREEMENT**

AHCCCS may at any time, by written notice to the MAO, make changes within the general scope of this Agreement.

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

When AHCCCS issues an amendment to modify the Agreement, the provisions of such amendment will be deemed to have been accepted thirty (30) calendar days after the date of notification to MAO by AHCCCS through U.S. Postal Service postmark date or date of electronic mail (e-mail) transmission, even if the amendment has not been signed by the MAO, unless within that time the MAO notifies AHCCCS in writing that it refuses to sign the amendment. If the MAO provides such notification, then AHCCCS will initiate applicable termination proceedings.

3.7. **SEVERABILITY**

The provisions of this Agreement are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Agreement.

3.8. **COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS**

The MAO shall comply with all applicable Federal and State laws and regulations including but not limited to Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The MAO shall maintain all applicable licenses and permits.
3.8.1. IMPLIED AGREEMENT TERMS

Each provision of law and any terms required by law to be in this Agreement are a part of this Agreement as if fully stated in it.

3.8.2. NON-DISCRIMINATION

The MAO shall comply with State Executive Order No. 2009-09 and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act.

3.8.3. FEDERAL IMMIGRATION AND NATIONALITY ACT

The MAO 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 Agreement. Further, the MAO shall flow down this requirement to all subcontractors utilized during the term of the Agreement. The State shall retain the right to perform random audits of MAO and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the MAO 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 Agreement for default and suspension and/or debarment of the MAO.

3.8.4. E-VERIFY REQUIREMENTS

In accordance with A.R.S. § 41-4401, the MAO 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.

3.9. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The MAO shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to: 42 CFR 431 Subpart F; A.R.S. §§36-107, 36-2903 (for AHCCCS Complete Care members); 36-2932 (for ALTCS members); 41-1959; and 46-135; the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936); 45 CFR Parts 160 and 164; and AHCCCS rules and policies.

The MAO 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 Agreement shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the Agreement. Except as required or permitted by law, the MAO also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the MAO as needed for the performance of duties under the Agreement, unless otherwise agreed to, in writing, by AHCCCS.

The MAO shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this Agreement, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know,
any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this Agreement. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the MAO by AHCCCS.

3.10. **PROPERTY OF THE STATE**

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

3.11. **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 MAO or subcontractor that is related to the performance of this Agreement, in accordance with A.R.S. §41-2547.

3.12. **OFF SHORE PERFORMANCE OF WORK PROHIBITED**

   Any services that are described in the Program Requirements 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.

3.13. **DISPUTE RESOLUTION**

3.13.1. **General Agreement of the Parties**

   The parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the parties employ all reasonable and informal means to resolve any dispute under this Agreement. The parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this section.

3.13.2. **Duty to Negotiate in Good Faith**

   Any dispute that in the judgment of any party to this Agreement may materially or substantially affect the performance of this Agreement will be reduced to writing and delivered to the other party. The parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the parties shall not resort
3.13.3. 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 (Title 41).

3.13.4. Non-Exclusive Remedies
The rights and the remedies of AHCCCS under this Agreement are not exclusive. Such rights and remedies for non-compliance with the terms and conditions of this Agreement include, but are not limited to, those in the MAO’s AHCCCS companion health coverage program contract(s), each of which is applicable at AHCCCS’ sole discretion:

- AHCCCS Complete Care (ACC) paragraph D.68: Administrative Actions,
- ALTCS Health Plan paragraph D.74: Administrative Actions,
- Integrated RBHA (Maricopa County) paragraph 19.7: Administrative Actions, and
- Integrated RBHA (Greater Arizona) paragraph 19.23: Administrative Actions.

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

3.14. TERMINATION OF AGREEMENT
This Agreement may be terminated under the following conditions:

3.14.1. The State may terminate the Agreement in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of the State of Arizona. The termination will be effective on the date specified in the State’s notice of termination. The State will provide the MAO written notice of such termination at least thirty (30) calendar days prior to the effective date of termination, unless the State determines that circumstances warrant a shorter notice period.

3.14.2. In addition to the reasons set forth above, the State reserves the right to terminate this Agreement, in whole or in part, upon the following conditions:

3.14.2.1. The State may terminate this Agreement at any time if a court of competent jurisdiction finds MAO failed to adhere to any laws,
ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MAO’s duties under this Agreement.

3.14.2.2. The State may terminate the Agreement at any time if the MAO: files for bankruptcy; becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it; makes an assignment for the benefit of all or substantially all of its creditors; or enters into an Agreement for the composition, extension, or readjustment of substantially all of its obligations.

3.14.2.3. The State may terminate the Agreement at any time and in whole or in part if it determines, at its sole discretion, that the MAO has materially breached the Agreement.

3.14.3. The MAO may terminate this Agreement by providing the State written notice at least 30 calendar days prior to termination. The termination will be effective on the date specified in the MAO’s notice of termination.

3.15. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

3.16. NOTICES

All notices and other communications regarding this Agreement shall be delivered to the following contact persons. The parties may change the contact information set forth by giving written notice to the other party.

3.16.1. For AHCCCS:

Name  Meggan LaPorte
Title   AHCCCS Chief Procurement Officer
Address  701 East Jefferson Street, Mail Drop 5700
          Phoenix, Arizona 85034
Telephone  (602) 417-4538
Email     Meggan.LaPorte@azahcccs.gov
3.16.2. For the MAO:

Name  Jon Savary
Title  Medicare Administrative Director
MAO  Banner – University Care Advantage
Address  2701 East Elvira Road
         Tucson, Arizona 85756
Telephone  (480) 827-5929
Email  jon.savary@bannerhealth.com

3.16.3. For the MAO Care Coordination Contact Person:

Name  Viki Alexander
Title  Interim Medical Management Director
MAO  Banner – University Care Advantage
Address  2701 East Elvira Road
         Tucson, Arizona 85756
Telephone  (480) 827-5956
Email  viki.alexander@bannerhealth.com
4. CONTRACTOR SPECIFIC SECTION

The MAO shall enroll an eligible Dual Eligible Member only in accordance with the terms, service area counties and plan benefit packages (PBPs) listed for each of the respective AHCCCS companion contracts, programs and populations as designated by specific contracts or as otherwise specified in paragraphs 4.1 through 4.5 inclusive of this Section.

MAO is a Dual Eligible Subset which is authorized to enroll Dual Eligible Members with eligibility only in the following AHCCCS programs (check all that apply):

4.1 AHCCCS Complete Care (ACC) (companion AHCCCS contract YH19-0001)
4.2 Integrated RBHA (companion AHCCCS contract YH17-0001)
4.3 ALTCS Elderly and Physically Disabled (companion AHCCCS contract YH18-0001)
4.4 ALTCS Developmentally Disabled (DD) (companion AHCCCS contract YH6-0014)
4.5 Children’s Rehabilitative Services (CRS) (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.1. AHCCCS Complete Care (ACC) (companion AHCCCS contract YH19-0001)

4.1.1. Member Eligibility:
☒ AHCCCS Complete Care (ACC) ☒ QMB+
☐ Integrated RBHA ☒ SLMB+
☐ ALTCS Elderly and Physically Disabled ☒ FBDE (non-QMB)
☐ ALTCS Developmentally Disabled (DD)
☐ Children’s Rehabilitative Services (CRS) (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.1.2. Service Area:
☐ Apache County ☐ Mohave County
☒ Coconino County ☐ Navajo County
☐ Gila County ☒ Pima County
☒ Graham County ☒ Pinal County
☒ Greenlee County ☒ Santa Cruz County
☒ La Paz County ☐ Yavapai County
☒ Maricopa County ☒ Yuma County
4.2. Integrated RBHA (not applicable)

4.2.1. Member Eligibility:
- ☐ AHCCCS Complete Care (ACC)
- ☐ Integrated RBHA
- ☐ ALTCS Elderly and Physically Disabled
- ☐ ALTCS Developmentally Disabled (DD)
- ☐ Children’s Rehabilitative Services (CRS)
  (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.2.2. Service Area:
- ☐ Apache County
- ☐ Cochise County
- ☐ Coconino County
- ☐ Gila County
- ☐ Graham County
- ☐ Greenlee County
- ☐ La Paz County
- ☐ Maricopa County
- ☐ Mohave County
- ☐ Navajo County
- ☐ Pima County
- ☐ Pinal County
- ☐ Santa Cruz County
- ☐ Yavapai County
- ☐ Yuma County

4.3. ALTCS Elderly and Physically Disabled (companion AHCCCS contract YH18-0001)

4.3.1. Member Eligibility:
- ☒ AHCCCS Complete Care (ACC)
- ☒ Integrated RBHA
- ☒ ALTCS Elderly and Physically Disabled
- ☒ ALTCS Developmentally Disabled (DD)
- ☒ Children’s Rehabilitative Services (CRS)
  (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.3.2. Service Area:
- ☐ Apache County
- ☒ Cochise County
- ☐ Coconino County
- ☒ Gila County
- ☒ Graham County
- ☒ Greenlee County
- ☒ La Paz County
- ☒ Maricopa County
- ☐ Mohave County
- ☐ Navajo County
- ☒ Pima County
- ☒ Pinal County
- ☒ Santa Cruz County
- ☐ Yavapai County
- ☒ Yuma County
4.4. **ALTCS Developmentally Disabled (DD) (not applicable)**

4.4.1. **Member Eligibility:**

- [ ] AHCCCS Complete Care (ACC)  
- [ ] QMB+
- [ ] Integrated RBHA  
- [ ] SLMB+
- [ ] ALTCS Elderly and Physically Disabled  
- [ ] FBDE (non-QMB)
- [ ] ALTCS Developmentally Disabled (DD)
- [ ] Children’s Rehabilitative Services (CRS) (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.4.2. **Service Area:**

- [ ] Apache County  
- [ ] Mohave County
- [ ] Cochise County  
- [ ] Navajo County
- [ ] Coconino County  
- [ ] Pima County
- [ ] Gila County  
- [ ] Pinal County
- [ ] Graham County  
- [ ] Santa Cruz County
- [ ] Greenlee County  
- [ ] Yavapai County
- [ ] La Paz County  
- [ ] Yuma County
- [ ] Maricopa County

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4.5. **Children’s Rehabilitative Services (CRS) (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only, as per paragraph 4.4 only) (not applicable)**

4.5.1. **Member Eligibility:**

- [ ] AHCCCS Complete Care (ACC)  
- [ ] QMB+
- [ ] Integrated RBHA  
- [ ] SLMB+
- [ ] ALTCS Elderly and Physically Disabled  
- [ ] FBDE (non-QMB)
- [ ] ALTCS Developmentally Disabled (DD)
- [ ] Children’s Rehabilitative Services (CRS) (for the ALTCS Developmentally Disabled [DD] CRS subpopulation only)

4.5.2. **Service Area:**

- [ ] Apache County  
- [ ] Mohave County
- [ ] Cochise County  
- [ ] Navajo County
- [ ] Coconino County  
- [ ] Pima County
- [ ] Gila County  
- [ ] Pinal County
- [ ] Graham County  
- [ ] Santa Cruz County
- [ ] Greenlee County  
- [ ] Yavapai County
- [ ] La Paz County  
- [ ] Yuma County
- [ ] Maricopa County
4.6. CMS-APPROVED SERVICE AREA. The CMS approved Service area(s) for the MAO’s offered CMS-approved Plan Benefit Package(s) (PBPs) aligning with the companion AHCCCS contract service area county(ies) in paragraphs 4.1 through 4.5 inclusive as applicable, is/are as follows:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Apache County</th>
<th>Cochise County</th>
<th>Coconino County</th>
<th>Gila County</th>
<th>Graham County</th>
<th>Greenlee County</th>
<th>La Paz County</th>
<th>Maricopa County</th>
</tr>
</thead>
<tbody>
<tr>
<td>H4931-001</td>
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<td>☐</td>
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<tr>
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<td>☐</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>H4931-007</td>
<td>☐</td>
<td>☐</td>
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<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>
4.6.4. **H4931-008 Service Area (aligning with paragraph 4.1.2 Service Area only):**
- [ ] Apache County
- [ ] Cochise County
- [ ] Coconino County
- [ ] Gila County
- [ ] Graham County
- [ ] Greenlee County
- [ ] La Paz County
- [ ] Maricopa County
- [ ] Mohave County
- [ ] Navajo County
- [ ] Pima County
- [ ] Pinal County
- [ ] Santa Cruz County
- [ ] Yavapai County
- [ ] Yuma County

4.6.5. **H4931-013 Service Area (aligning with paragraph 4.3.2 Service Area only):**
- [ ] Apache County
- ☒ [ ] Cochise County
- [ ] Coconino County
- ☒ [ ] Gila County
- ☒ [ ] Graham County
- ☒ [ ] Greenlee County
- [ ] La Paz County
- [ ] Maricopa County
- [ ] Mohave County
- [ ] Navajo County
- [ ] Pima County
- [ ] Pinal County
- [ ] Santa Cruz County
- [ ] Yavapai County
- [ ] Yuma County

4.6.6. **H4931-014 Service Area (aligning with paragraph 4.3.2 Service Area only):**
- [ ] Apache County
- [ ] Cochise County
- [ ] Coconino County
- [ ] Gila County
- [ ] Graham County
- [ ] Greenlee County
- [ ] La Paz County
- [ ] Maricopa County
- [ ] Mohave County
- [ ] Navajo County
- ☒ [ ] Pima County
- [ ] Pinal County
- [ ] Santa Cruz County
- [ ] Yavapai County
- [ ] Yuma County

4.6.7. **H4931-015 Service Area (aligning with paragraph 4.3.2 Service Area only):**
- [ ] Apache County
- [ ] Cochise County
- [ ] Coconino County
- [ ] Gila County
- [ ] Graham County
- [ ] Greenlee County
- [ ] La Paz County
- ☒ [ ] Maricopa County
- [ ] Mohave County
- [ ] Navajo County
- [ ] Pima County
- ☒ [ ] Pinal County
- [ ] Santa Cruz County
- [ ] Yavapai County
- [ ] Yuma County
4.6.8. **H4931-016 Service Area (aligning with paragraph 4.3.2 Service Area only):**

- [ ] Apache County
- [ ] Cochise County
- [ ] Coconino County
- [ ] Gila County
- [ ] Graham County
- [ ] Greenlee County
- [ ] La Paz County
- [ ] Maricopa County
- [ ] Mohave County
- [ ] Navajo County
- [ ] Pima County
- [ ] Pinal County
- [ ] Santa Cruz County
- [☐] Santa Cruz County
- [ ] Yavapai County
- [ ] Yuma County

4.7. **SPECIFIC PLAN OFFERINGS**

MAO shall operate eight (8) Dual Eligible Special Needs Plans under CMS contract number H4931. MAO shall enroll individuals into offered Plan Benefit Packages (PBPs) in accordance with federal and state guidelines, and the terms of this Agreement.

A Dual Eligible Member’s eligibility for each particular plan benefit package (PBP) is described below:

4.7.1. **H4931-001** is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

- 4.7.1.1. The individual must be currently enrolled in the AHCCCS Complete Care (ACC) companion program in accordance with paragraph 4.1.1;

- 4.7.1.2. The individual must live within the appropriate county that corresponds with the specific service area of their AHCCCS Complete Care (ACC) companion program enrollment in accordance with paragraph 4.1.2;

- 4.7.1.3. The individual must be entitled to participate in Medicare; and

- 4.7.1.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.1.

4.7.2. **H4931-006** is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

- 4.7.2.1. The individual must be currently enrolled in the AHCCCS Complete Care (ACC) companion program in accordance with paragraph 4.1.1;

- 4.7.2.2. The individual must live within the appropriate county that corresponds with the specific service area of their AHCCCS Complete Care (ACC) companion program enrollment in accordance with paragraph 4.1.2;

- 4.7.2.3. The individual must be entitled to participate in Medicare; and

- 4.7.2.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.2.
4.7.3. H4931-007 is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.3.1. The individual must be currently enrolled in the AHCCCS Complete Care (ACC) companion program in accordance with paragraph 4.1.1;

4.7.3.2. The individual must live within the appropriate county that corresponds with the specific service area of their AHCCCS Complete Care (ACC) companion program enrollment in accordance with paragraph 4.1.2;

4.7.3.3. The individual must be entitled to participate in Medicare; and

4.7.3.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.3.

4.7.4. H4931-008 is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.4.1. The individual must be currently enrolled in the AHCCCS Complete Care (ACC) companion program in accordance with paragraph 4.1.1;

4.7.4.2. The individual must live within the appropriate county that corresponds with the specific service area of their AHCCCS Complete Care (ACC) companion program enrollment in accordance with paragraph 4.1.2;

4.7.4.3. The individual must be entitled to participate in Medicare; and

4.7.4.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.4.

4.7.5. H4931-013 is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.5.1. The individual must be currently enrolled in the ALTCS Elderly and Physically Disabled companion program in accordance with paragraph 4.3.1;

4.7.5.2. The individual must live within the appropriate county that corresponds with the specific service area of their ALTCS Elderly and Physically Disabled companion program enrollment in accordance with paragraph 4.3.2;

4.7.5.3. The individual must be entitled to participate in Medicare; and

4.7.5.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.5.
4.7.6. **H4931-014** is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.6.1. The individual must be currently enrolled in the ALTCS Elderly and Physically Disabled companion program in accordance with paragraph 4.3.1;

4.7.6.2. The individual must live within the appropriate county that corresponds with the specific service area of their ALTCS Elderly and Physically Disabled companion program enrollment in accordance with paragraph 4.3.2;

4.7.6.3. The individual must be entitled to participate in Medicare; and

4.7.6.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.6.

4.7.7. **H4931-015** is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.7.1. The individual must be currently enrolled in the ALTCS Elderly and Physically Disabled companion program in accordance with paragraph 4.3.1;

4.7.7.2. The individual must live within the appropriate county that corresponds with the specific service area of their ALTCS Elderly and Physically Disabled companion program enrollment in accordance with paragraph 4.3.2;

4.7.7.3. The individual must be entitled to participate in Medicare; and

4.7.7.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.7.

4.7.8. **H4931-016** is a Dual Eligible Subset plan open to only those individuals eligible to enroll pursuant to the following eligibility requirements:

4.7.8.1. The individual must be currently enrolled in the ALTCS Elderly and Physically Disabled companion program in accordance with paragraph 4.3.1;

4.7.8.2. The individual must live within the appropriate county that corresponds with the specific service area of their ALTCS Elderly and Physically Disabled companion program enrollment in accordance with paragraph 4.3.2;

4.7.8.3. The individual must be entitled to participate in Medicare; and

4.7.8.4. The individual must reside within the CMS-approved service area county for this PBP in accordance with paragraph 4.6.8.
### IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT:

<table>
<thead>
<tr>
<th>5. NAME OF MAO:</th>
<th>6. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Banner – University Care Advantage</td>
<td></td>
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<table>
<thead>
<tr>
<th>SIGNATURE OF AUTHORIZED INDIVIDUAL:</th>
<th>SIGNATURE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Oestreich</td>
<td>Mark</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPED NAME:</th>
<th>TYPED NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathleen Oestreich</td>
<td>Meggan LaPorte, CPPO, MSW</td>
</tr>
</tbody>
</table>

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<tr>
<th>TITLE:</th>
<th>TITLE:</th>
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<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>Chief Procurement Officer</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE:</th>
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<tbody>
<tr>
<td>6/17/2019</td>
<td>06/13/2019</td>
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## ATTACHMENT 1: CHART OF DELIVERABLES

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<thead>
<tr>
<th>Area</th>
<th>Timeframe</th>
<th>Report</th>
<th>When Due</th>
<th>Agreement Section</th>
<th>Agreement Paragraph</th>
<th>Reference/Policy</th>
<th>Send To</th>
<th>Submitted Via</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCM OPERATIONS</td>
<td>Upon execution of initial Agreement</td>
<td>Default Enrollment Process – Initial Approval</td>
<td>120 days prior to Effective Date of Agreement</td>
<td>Section 2: Program Requirements</td>
<td>2.1.11</td>
<td>42 CFR 422.66(g)</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Email notification</td>
</tr>
<tr>
<td>DHCM OPERATIONS</td>
<td>Minimum every 5 years after most recent approval</td>
<td>Default Enrollment Process – Renewal Approval</td>
<td>Within 10 calendar days of receipt</td>
<td>Section 2: Program Requirements</td>
<td>2.1.11</td>
<td>42 CFR 422.66(g)</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Email notification</td>
</tr>
<tr>
<td>DHCM CLINICAL QUALITY MANAGEMENT</td>
<td>Annually</td>
<td>Medicare Health Risk Assessment Tool</td>
<td>January 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Section 2: Program Requirements</td>
<td>2.1.5</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Email notification</td>
</tr>
<tr>
<td>DHCM OPERATIONS</td>
<td>Monthly</td>
<td>Default Enrollment</td>
<td>30 calendar days after month end</td>
<td>Section 2: Program Requirements</td>
<td>2.1.12</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Email notification</td>
</tr>
<tr>
<td>DHCM FINANCE</td>
<td>Quarterly</td>
<td>Financial Reporting</td>
<td>60 days after the end of the quarter</td>
<td>Section 2: Program Requirements</td>
<td>2.7.1.2</td>
<td>AHCCCS Financial Reporting Guide(s)</td>
<td>DHCM-Finance Program Compliance Auditor</td>
<td>FTP server with email notification</td>
</tr>
</tbody>
</table>

---

Page 30 of 42
<table>
<thead>
<tr>
<th>Area</th>
<th>Timeframe</th>
<th>Report</th>
<th>When Due</th>
<th>Agreement Section</th>
<th>Agreement Paragraph</th>
<th>Reference/Policy</th>
<th>Send To</th>
<th>Submitted Via</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHCM OPERATIONS</td>
<td>Monthly</td>
<td>Member Appeals Summary and Outcomes</td>
<td>First day of the second month following the month being reported</td>
<td>Section 2: Program Requirements</td>
<td>2.9</td>
<td>AHCCCS Grievance System Reporting Guide</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Secure email notification</td>
</tr>
<tr>
<td>DHCM OPERATIONS</td>
<td>Annually</td>
<td>CMS Notification of MAO FIDE Status (as applicable)</td>
<td>10 calendar days of receipt</td>
<td>Section 2: Program Requirements</td>
<td>2.12.7</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Secure email notification</td>
</tr>
<tr>
<td>DHCM OPERATIONS</td>
<td>Annually</td>
<td>CMS Notification of MAO Star Ratings</td>
<td>10 calendar days of receipt</td>
<td>Section 2: Program Requirements</td>
<td>2.11</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Secure email notification</td>
</tr>
<tr>
<td>DHCM OPERATIONS</td>
<td>Per Occurrence</td>
<td>Change of Designated Care Coordinator</td>
<td>10 calendar days of change</td>
<td>Section 2: Program Requirements</td>
<td>2.1.8</td>
<td>N/A</td>
<td>DHCM Operations Medical Management Unit and Compliance Officer for Medicare</td>
<td>FTP server with email notification</td>
</tr>
</tbody>
</table>
## MEDICARE ADVANTAGE ORGANIZATION AGREEMENT
**BETWEEN AHCCCS AND**
Participant: Banner – University Care Advantage
AHCCCS AGREEMENT # YH20-0010-02

<table>
<thead>
<tr>
<th>Area</th>
<th>Timeframe</th>
<th>Report</th>
<th>When Due</th>
<th>Agreement Section</th>
<th>Agreement Paragraph</th>
<th>Reference/Policy</th>
<th>Send To</th>
<th>Submitted Via</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DHCM CLINICAL QUALITY MANAGEMENT</strong></td>
<td>Per Occurrence</td>
<td>Quality of Care Inquiry Responses</td>
<td>When requested</td>
<td>Section 2: Program Requirements</td>
<td>2.1.10</td>
<td>N/A</td>
<td>DHCM Clinical Quality Management Unit</td>
<td>FTP server with secure email notification to <a href="mailto:CQM@azahcccs.gov">CQM@azahcccs.gov</a> with notification to CQM Administrator</td>
</tr>
<tr>
<td><strong>CONTRACTS AND PURCHASING</strong></td>
<td>Per Occurrence</td>
<td>Advertising, Property of the State</td>
<td>Advance written approvals</td>
<td>Section 3: Terms and Conditions</td>
<td>2.8, 3.10</td>
<td>N/A</td>
<td>Contracting Officer</td>
<td>Email notification</td>
</tr>
<tr>
<td><strong>DHCM OPERATIONS</strong></td>
<td>Per Occurrence</td>
<td>MAO Contract Changes with and Notifications from CMS</td>
<td>10 calendar days of notice or change</td>
<td>Section 2: Program Requirements</td>
<td>2.10</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Secure email notification</td>
</tr>
<tr>
<td><strong>DHCM OPERATIONS</strong></td>
<td>Per Occurrence</td>
<td>Notification of Potential Conflict(s) of Interest</td>
<td>Advance written approval</td>
<td>Section 3: Terms and Conditions</td>
<td>3.8</td>
<td>N/A</td>
<td>DHCM Operations Compliance Officer for Medicare</td>
<td>Secure email notification</td>
</tr>
<tr>
<td><strong>CONTRACTS AND PURCHASING</strong></td>
<td>Per Occurrence</td>
<td>Notices to AHCCCS</td>
<td>Per schedule</td>
<td>Section 3: Terms and Conditions</td>
<td>4.8</td>
<td>N/A</td>
<td>Contracting Officer</td>
<td>Email notification</td>
</tr>
<tr>
<td><strong>DHCM DATA ANALYSIS AND RESEARCH UNIT (DAR)</strong></td>
<td>Per Schedule</td>
<td>Medicare Encounter Data</td>
<td>Per schedule</td>
<td>Section 2: Program Requirements</td>
<td>2.6</td>
<td>N/A</td>
<td>DHCM DAR designated Sr. Business Analyst</td>
<td>Established PMMIS transmission protocols with email notification</td>
</tr>
</tbody>
</table>
### ATTACHMENT 2 – AHCCCS COVERED SERVICES – PHYSICAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>PHYSICAL HEALTH SERVICES</th>
<th>TITLE XIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IN ACCORDANCE WITH APPLICABLE CONTRACT AND POLICY TERMS, CONDITIONS AND LIMITATIONS)</td>
<td>&lt;21</td>
</tr>
<tr>
<td>Audiology</td>
<td>X</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Breast Reconstruction After Mastectomy</td>
<td>X</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>X</td>
</tr>
<tr>
<td>Cochlear Implants</td>
<td>X</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Preventive &amp; Therapeutic Dental Services</td>
<td>X</td>
</tr>
<tr>
<td>Limited Medical and Surgical Services by a Dentist (for Members Age 21 and older)</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Eye Exam</td>
<td>X</td>
</tr>
<tr>
<td>Vision Exam/Prescriptive Lenses</td>
<td>X</td>
</tr>
<tr>
<td>Lens Post Cataract Surgery</td>
<td>X</td>
</tr>
<tr>
<td>Treatment for Medical Conditions of the Eye</td>
<td>X</td>
</tr>
<tr>
<td>Health Risk Assessment &amp; Screening Tests (for Members Age 21 and Older)</td>
<td></td>
</tr>
<tr>
<td>Preventive Examinations in the Absence of any Known Disease or Symptom</td>
<td>X</td>
</tr>
<tr>
<td>HIV/AIDS Antiretroviral Therapy</td>
<td>X</td>
</tr>
<tr>
<td>High Frequency Chest Wall Oscillation Therapy</td>
<td>X</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>X</td>
</tr>
<tr>
<td>Hospice</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Observation</td>
<td>X</td>
</tr>
</tbody>
</table>
## Physical Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Title XIX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Outpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Hysterectomy (Medically Necessary)</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Laboratory</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Early and Periodic Screening, Diagnosis and Treatment</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Medical Foods</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Medical Equipment and Appliances</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Prosthetic</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Orthotic Devices</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Negative Pressure Wound Therapy</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Nursing Facilities (up to 90 days)</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Non-Physician First Surgical Assistant</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Foot and Ankle Services</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Primary Care Provider Services</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Radiology and Medical Imaging</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Occupational Therapy – Inpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Occupational Therapy – Outpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Physical Therapy – Inpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Physical Therapy – Outpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Sleep Studies (Polysomnography)</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Speech Therapy – Inpatient</strong></td>
<td>X</td>
</tr>
<tr>
<td>PHYSICAL HEALTH SERVICES (IN ACCORDANCE WITH APPLICABLE CONTRACT AND POLICY TERMS, CONDITIONS AND LIMITATIONS)</td>
<td>TITLE XIX</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Speech Therapy – Outpatient</td>
<td>X</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>X</td>
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<tr>
<td>Total Outpatient Parental Nutrition</td>
<td>X</td>
</tr>
<tr>
<td>Non-Experimental transplants approved for Title XIX reimbursement (See Policy Regarding Specific Transplant Coverage)</td>
<td>X</td>
</tr>
<tr>
<td>Transplant Related immunosuppressant drugs</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Emergency</td>
<td>X</td>
</tr>
<tr>
<td>Transportation - Non-emergency</td>
<td>X</td>
</tr>
<tr>
<td>Triage</td>
<td>X</td>
</tr>
</tbody>
</table>
ATTACHMENT 3 – AHCCCS COVERED BEHAVIORAL HEALTH SERVICES

| Behavioral Health Services (In accordance with applicable contract and policy terms, conditions and limitations, including those services listed in the AHCCCS Behavioral Health Services Matrix on the AHCCCS website) | ACC | ALTCS |
|---|---|---|---|---|---|
| | Title XIX | Title XIX |
| | <21 | ≥21 | <21 | ≥21 |
| Behavioral Health Counseling and Therapy - Individual | X | X | X | X |
| Behavioral Health Counseling and Therapy – Group and Family | X | X | X | X |
| Behavioral Health Screening Services | X | X | X | X |
| Behavioral Health Assessment Services | X | X | X | X |
| Behavioral Health Testing Services | X | X | X | X |
| Behavioral Health Evaluation Services | X | X | X | X |
| Other Professional Services – Alcohol and/or Drug Services | X | X | X | X |
| Other Professional Services – Multisystemic Therapy for Juveniles | X | X |
| Other Professional Services – Mental Health Services (fka Traditional Healing) | Non-TXIX funds if available | Non-TXIX funds if available | Non-TXIX funds if available | Non-TXIX funds if available |
| Other Professional Services – Auricular Acupuncture | Non-TXIX funds if available | Non-TXIX funds if available | Non-TXIX funds if available | Non-TXIX funds if available |
| Skills, Training and Development, and Psychosocial Rehabilitation (Living Skills Training) | X | X | X | X |
| Cognitive Rehabilitation | X | X | X | X |
| Health Promotion Services (Behavioral Health Prevention/Promotion Education, Medication Training, and Support Services) | X | X | X | X |
| Psycho Educational Services and Ongoing Support to Maintain Employment | X | X | X | X |
| Medical Services | X | X | X | X |
### BEHAVIORAL HEALTH SERVICES

*(In accordance with applicable contract and policy terms, conditions and limitations, including those services listed in the AHCCCS Behavioral Health Services Matrix on the AHCCCS website)*

<table>
<thead>
<tr>
<th>Service</th>
<th>ACC</th>
<th>ALTCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory, Radiology and Medical Imaging</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical Management</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electro-Convulsive Therapy</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Case Management</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Care Training – Family</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Care Training – to Home Care Client</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Self-Help/Peer Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Unskilled Respite Care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>Non-TXIX funds if available</td>
<td>Non-TXIX funds if available</td>
</tr>
<tr>
<td>Sign Language or Oral Interpretation Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Emergency</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transportation – Non-Emergency</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Crisis Intervention Services – Mobile</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Crisis Intervention Services – Facility-Based</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital Services</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sub-Acute Facility</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential Treatment Center</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Behavioral Health Residential Facility (without Room and Board)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental Health Services NOS (Room and Board)</td>
<td>Non-TXIX funds if available</td>
<td>Non-TXIX funds if available</td>
</tr>
<tr>
<td>Supervised Behavioral Health Treatment and Day Programs</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
### Behavioral Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>ACC Title XIX</th>
<th>ALTCS Title XIX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Behavioral Health Services and Day Programs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community Psychiatric Supportive Treatment and Medical Day Programs</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community Psychiatric Supportive Treatment and Medical Day Programs – by telephone</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## ATTACHMENT 4 – ALTCS COVERED SERVICES

### INSTITUTIONAL SERVICES
- Intermediate Care Facility (DD Dual Eligible Members only)
- Nursing Facility – Level I
- Nursing Facility – Level II
- Nursing Facility – Level III
- Nursing Facility – Level IV
- Nursing Facility – Respite
- Bed Hold – Therapeutic Leave
- Bed Hold – Hospital Admission

### ALTERNATIVE RESIDENTIAL SETTINGS
- Assisted Living Home
- Assisted Living Center
- Adult Foster Care
- Habilitation – Residential (DD Group Homes only)
- Level II Behavioral Health Residential
  - (May be appropriate for stays of any length)

- Behavioral Health Therapeutic Home
  - Home Care Training to Home Care Client (Child)
  - Home Care Training to Home Care Client (Adult)
  - Home Care Training to Home Care Client (Adult Geriatric)

### HOSPICE SERVICES
- Routine Home Care
- Continuous Home Care
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Respite Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>General Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HOME AND COMMUNITY BASED SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Adult Day Health Care</td>
<td></td>
</tr>
<tr>
<td>Attendant Care</td>
<td></td>
</tr>
<tr>
<td>Companion Care</td>
<td></td>
</tr>
<tr>
<td>Community Transition Service</td>
<td></td>
</tr>
<tr>
<td>Emergency Alert System</td>
<td></td>
</tr>
<tr>
<td>Habilitation</td>
<td></td>
</tr>
<tr>
<td>- Day Treatment &amp; Training</td>
<td></td>
</tr>
<tr>
<td>- Supported Employment</td>
<td></td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td></td>
</tr>
<tr>
<td>Home Health Services/Nursing</td>
<td></td>
</tr>
<tr>
<td>Home Health Services/Home Health Aide</td>
<td></td>
</tr>
<tr>
<td>Homemaker</td>
<td></td>
</tr>
<tr>
<td>Home Modification</td>
<td></td>
</tr>
<tr>
<td>Personal Care</td>
<td></td>
</tr>
<tr>
<td>Respite</td>
<td></td>
</tr>
<tr>
<td>- Short Term In-Home</td>
<td></td>
</tr>
<tr>
<td>- Continuous In-Home</td>
<td></td>
</tr>
<tr>
<td>- Group Respite</td>
<td></td>
</tr>
</tbody>
</table>
ATTACHMENT 5 – DEFAULT ENROLLMENT PROCESS REPORTING REQUIREMENTS

MAO shall report monthly each of the following six (6) default enrollment process data elements to AHCCCS, as per the requirements of Attachment 1: Chart of Deliverables.

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Number of individuals (potential Dual Eligible Members) identified by MAO as eligible for default enrollment based on age or disability.</td>
</tr>
<tr>
<td>b. Number of beneficiaries (potential Dual Eligible Members), separated by eligibility based on age or disability, that were noticed by MAO at least sixty (60) calendar days prior to the effective date of default enrollment.</td>
</tr>
<tr>
<td>c. Number of beneficiaries (potential Dual Eligible Members) who opt out of (decline) default enrollment prior to the effective date. Differentiate between those who opt out by telephone or in writing, as well as eligibility based on age or disability.</td>
</tr>
<tr>
<td>d. At the end of the first month of enrollment, specify the number of rapid disenrollments (the number of Dual Eligible Members who disenroll within their first month of default enrollment). Continue to track for rapid disenrollments within the first three months of a Dual Eligible Member’s default enrollment effective date.</td>
</tr>
<tr>
<td>e. Provide information regarding any complaints received internally, including grievances relating to default enrollment. For complaints with a Medicare Advantage Complaint Tracking Module (CTM) identification number, please also list the CTM number with the complaint. Provide this information in an Excel spreadsheet.</td>
</tr>
<tr>
<td>f. Indicate if MAO has identified any individuals (potential Dual Eligible Members) for which it was unable to identify for default enrollment in the required timeframe (minimum 60 calendar days prior) for notification of default enrollment, and an explanation of why they were excluded from the default enrollment process.</td>
</tr>
</tbody>
</table>
ATTACHMENT 6 – AHCCCS HEALTH PLAN REFERENCE TABLE FOR MAO ASSISTANCE WITH MEDICAID COVERAGE, APPEALS AND GRIEVANCES

<table>
<thead>
<tr>
<th>HEALTH PLAN</th>
<th>WEBSITE</th>
<th>TELEPHONE</th>
<th>EMAIL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Complete Care (ACC) Health Plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AZ Complete Health</td>
<td><a href="http://www.azcompletehealth.com/contact-us.html">www.azcompletehealth.com/contact-us.html</a></td>
<td>1-888-788-4408 TTY 711</td>
<td>Contact Us Form at <a href="http://www.azcompletehealth.com/contact-us.html">www.azcompletehealth.com/contact-us.html</a></td>
</tr>
<tr>
<td>Banner-University Family Care</td>
<td><a href="http://www.bannerufc.com/acc/about-us/contact-us">www.bannerufc.com/acc/about-us/contact-us</a></td>
<td>1-800-582-8686 TTY 711</td>
<td></td>
</tr>
<tr>
<td>Care1st Health Plan Arizona</td>
<td><a href="http://www.care1staz.com/az/aboutus/contact.asp">www.care1staz.com/az/aboutus/contact.asp</a></td>
<td>1-866-560-4042 TTY 711</td>
<td>Email Form at <a href="http://www.care1staz.com/az/aboutus/contact.asp">www.care1staz.com/az/aboutus/contact.asp</a></td>
</tr>
<tr>
<td>Magellan Complete Care</td>
<td><a href="http://www.mccofaz.com/utility/contact-us/">www.mccofaz.com/utility/contact-us/</a></td>
<td>1-800-424-5891</td>
<td>Email Form at <a href="http://www.mccofaz.com/utility/contact-us/">www.mccofaz.com/utility/contact-us/</a></td>
</tr>
<tr>
<td>Mercy Care (1)</td>
<td><a href="http://www.mercycareaz.org/members/completecare-formembers/contact">www.mercycareaz.org/members/completecare-formembers/contact</a></td>
<td>1-800-624-3879 TTY 711</td>
<td>Contact Us Form at <a href="http://www.mercycareaz.org/members/completecare-formembers/contact">www.mercycareaz.org/members/completecare-formembers/contact</a></td>
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<tr>
<td>Steward Health Choice Arizona</td>
<td><a href="http://www.stewardhealthchoiceaz.com/contact">www.stewardhealthchoiceaz.com/contact</a></td>
<td>1-800-322-8670 TTY 711</td>
<td>Link: <a href="mailto:comments@steward.org">comments@steward.org</a></td>
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<tr>
<td>UnitedHealthcare Community Plan (1)</td>
<td><a href="http://www.uhcommunityplan.com/az/medicaid/ahcccs.html">www.uhcommunityplan.com/az/medicaid/ahcccs.html</a></td>
<td>1-800-348-4058 TTY 711</td>
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**ALTCS Health Plans**

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<tr>
<td>Banner-University Family Care LTC</td>
<td><a href="http://www.bannerufc.com/ltc/about-us/contact-us">www.bannerufc.com/ltc/about-us/contact-us</a></td>
<td>1-833-318-4146 TTY 711</td>
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<tr>
<td>Mercy Care LTC</td>
<td><a href="http://www.mercycareaz.org/members/ltc-formembers/contact">www.mercycareaz.org/members/ltc-formembers/contact</a></td>
<td>1-800-624-3879 TTY 711</td>
<td>Contact Us Form at <a href="http://www.mercycareaz.org/members/ltc-formembers/contact">www.mercycareaz.org/members/ltc-formembers/contact</a></td>
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<td>UnitedHealthcare Community Plan LTC</td>
<td><a href="http://www.uhcommunityplan.com/az/medicaid/long-term-care.html">www.uhcommunityplan.com/az/medicaid/long-term-care.html</a></td>
<td>1-800-293-3740 TTY 711</td>
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**RBHA Health Plans**

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<td>AZ Complete Health</td>
<td><a href="http://www.azcompletehealth.com/contact-us.html">www.azcompletehealth.com/contact-us.html</a></td>
<td>1-888-788-4088 TTY 711</td>
<td>Contact Us Form at <a href="http://www.azcompletehealth.com/contact-us.html">www.azcompletehealth.com/contact-us.html</a></td>
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<td>Mercy Care RBHA</td>
<td><a href="http://www.mercycareaz.org/members/rbha-formembers/contact">www.mercycareaz.org/members/rbha-formembers/contact</a></td>
<td>1-800-564-5465 TTY 711</td>
<td>Contact Us Form at <a href="http://www.mercycareaz.org/members/rbha-formembers/contact">www.mercycareaz.org/members/rbha-formembers/contact</a></td>
</tr>
<tr>
<td>Steward Health Choice Arizona</td>
<td><a href="http://www.stewardhealthchoiceaz.com/health-wellness/behavioral-health/">www.stewardhealthchoiceaz.com/health-wellness/behavioral-health/</a></td>
<td>1-800-640-2123 TTY 711</td>
<td>Link: <a href="mailto:comments@steward.org">comments@steward.org</a></td>
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**Other Contact Information**

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<tr>
<td>AHCCCS Fee-for Service Programs</td>
<td><a href="http://www.azahcccs.gov/shared/AHCCCScontacts.html">www.azahcccs.gov/shared/AHCCCScontacts.html</a></td>
<td>1-855-432-7587</td>
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<tr>
<td>State Health Insurance Assistance Program (SHIP)</td>
<td><a href="https://des.az.gov/services/older-adults/medicare-assistance">https://des.az.gov/services/older-adults/medicare-assistance</a></td>
<td>1-800-432-4040</td>
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(1) Available also to Dual Eligible Members enrolled in respective DD health plan.