DEPARTMENT OF ECONOMIC SECURITY Your Partner For A Stronger Arizona	**CONTRACT AMENDMENT**	**Arizona Department of Economic Security** 1789 W Jefferson Street, Mail Drop 1541, Phoenix, AZ 85007

SECTION A: CONTRACT AMENDMENT PAGE

CONTRACT NUMBER:	AMENDMENT NUMBER:
CTR047021	**9**

DESCRIPTION/ LABEL:	**DDD Health Plans**
CONTRACTOR NAME:	**Arizona Physician IPA Inc. dba UnitedHealthcare Community Plan**

THE ABOVE REFERENCED CONTRACT IS HEREBY MODIFIED AS FOLLOWS:

1. Pursuant to Uniform Terms and Conditions, Provision Five (5) Contract Changes, Section 5.1 Amendments, **Section D** entitled "Scope of Work", and **Exhibit F3** entitled "Contractor Chart of Deliverables", are revised and replaced as delineated in this Amendment Nine (9).

ALL OTHER REQUIREMENTS, SPECIFICATIONS, AND TERMS AND CONDITIONS REMAIN UNCHANGED

ACKNOWLEDGEMENT AND AUTHORIZATION

This Amendment shall be fully executed upon signature of both parties.

Contractor hereby acknowledges receipt and acceptance of the above-referenced Contract Amendment and that a signed copy must be filed with the Procurement Officer.	The above-referenced Contract Amendment is hereby executed this ____ day of Oct 31, 2023, 2023 at Phoenix, Arizona Tracy Chisler
Signature / Date **10/30/2023**	Procurement Officer Signature
	
Authorized Signatory's Name	
Jean Kalbacher	
Title **CEO**	Cc: Contract File

TABLE OF CONTENTS
(REVISED AS OF OCTOBER 2023)

Table of Contents

Contract No: **CTR047021**

Description: **DDD Health Plans**

Table of Contents

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SECTION B: CAPITATION RATES AND GEOGRAPHIC SERVICE AREA

Contractor Capitation Rates:

DDD Health Plans - Capitation Rate from 10/1/2023 to 9/30/2024	
Contractor: Arizona Physician IPA Inc. dba UnitedHealthcare Community Plan	
	Per Member Per Month
Dual Eligible	$279.95
Non-Dual Eligible	$1,198.44

The Contractor shall provide services as described in this Contract. In consideration for these services, the Contractor will be paid rates per member per month, unless otherwise modified by Contract amendment.

Capitation rates are payable to the Contractor until such time new rates are established as described in Section D, Scope of Work, Paragraph 56, Compensation.

Contractor Specific Requirements:

Geographic Service Area: The Contractor shall serve eligible members statewide.

SECTION C: DEFINITIONS

638 TRIBAL FACILITY

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

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 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), and 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.
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 Medicaid 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 Medicaid program as defined by 42 CFR 455.2.
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 the Arizona Long Term Care System (ALTCS) but who: 1) refuses Home and Community Based Services (HCBS) offered by the Support Coordinator; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Services and Support (LTSS) cannot be provided; or 4) has equity value in a home that exceeds $552,000. These members enrolled in ALTCS are eligible to receive acute medical services but not eligible to receive Long Term Care (LTC) institutional services, alternative residential services or 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: 1. Claims processing, including pharmacy claims, 2. Pharmacy Benefit Manager (PBM), 3. Dental Benefit Manager, 4. Credentialing, including those for only primary source verification, (i.e., Credential Verification Organization), 5. Medicaid Accountable Care Organization (ACO), 6. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and

	7. Comprehensive Health Plan (CHP) and DDD Subcontracted Health Plan. 8. A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. 9. Providers are not Administrative Services Subcontractors.
ADMINISTRATIVE SERVICES SUBCONTRACTORS OF THE DIVISION (AdSS)	See "CONTRACTOR."
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.
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 person 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 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 (ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM)	See "ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM."
AHCCCS COMPLETE CARE (ACC) CONTRACTOR	A contracted Managed Care Organization (MCO), also referred to herein as a "health plan" that, except in limited circumstances, is responsible for the provision of both physical and behavioral

	health services to eligible Title XIX/XXI persons enrolled by AHCCCS.
AHCCCS COMPLETE CARE - REGIONAL BEHAVIORAL HEALTH AUTHORITY (ACC-RBHA)	An AHCCCS Complete Care (ACC) Contractor with expanded contractual responsibilities, as specified in 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 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 with 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 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 MANAGED CARE ORGANIZATION	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 Statute and Rules, and Federal law and regulations.
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, or

(2) operated by the IHS, an 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 a 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),
    f. Behavioral health respite homes, and
    g. Substance abuse transitional facilities.

2. For an individual who is Elderly and Physically Disabled (EPD):
    h. Adult foster care homes,
    i. Assisted living homes or assisted living centers, units only,
    j. Adult Behavioral Health Therapeutic Homes (ABHTH),
    k. 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.
AMERICAN INDIAN HEALTH FACILITY (ITUs)	Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs may be referred to as American Indian Health Facilities (ITUs) (ARRA Section 5006(d), State Medicaid Director [SMD] letter 10-001).
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and

	telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
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 ADULT PROTECTIVE SERVICES (APS)	The program within the ADES which facilitates services and supports that help protect vulnerable adults from abuse, neglect or exploitation, and help them live as independently as possible. A.R.S. § 46-451 et. seq.
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 State agency 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 CORRECTIONS (ADOC)	The State agency that has the powers and duties set forth in A.R.S. § 41-1601 et. seq. to provide the supervisory staff and administrative functions at the state level of all matters relating to the institutionalization, rehabilitation and community supervision functions of all adult offenders.

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 CORRECTIONS (ADJC)	The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.
ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)	A program established by Part C of the Individuals with Disabilities Act managed within the DDD which provides eligible children and their families access to services to enhance the capacity of families and caregivers to support the child's development between the ages of birth until the child reaches the age of three (3).
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, physical health, behavioral health and support coordination (case management) services as authorized by A.R.S. § 36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with intellectual/developmental disabilities (DD), through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
ARIZONA STATE HOSPITAL (AzSH)	A service setting that provides long-term inpatient psychiatric care to individuals with mental illnesses who are under a court order for treatment.
ARIZONA STATE IMMUNIZATION INFORMATION SYSTEM (ASIIS)	Arizona's information system that is the repository for immunization information.

ARIZONA STATE PLAN	The written agreements between the State and Centers for Medicare and Medicaid (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.
AUTHORIZED REPRESENTATIVE	An individual who is authorized to apply for medical assistance or act on behalf of another person (A.A.C. R9-22-101, A.A.C. R9-28-401).
BALANCED BUDGET ACT (BBA)	Refer to "MEDICAID MANAGED CARE REGULATIONS."
BEHAVIORAL HEALTH	Term used to describe mental health (MH) 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, and

	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, or 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: a. Limits the individual's ability to be independent; or b. 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, or 2. Health-related services.
BENEFITS COORDINATION AND RECOVERY CENTER	Centers for Medicare and Medicaid Services (CMS) resource dedicated to the coordination of benefits for individuals dually eligible for Medicaid and Medicare for States that have entered into a Coordination of Benefits Agreement.
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective medical 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 whose residents typically receive primary or emergency care in neighboring states, excluding neighboring countries, due to service availability or distance.
CAPITATION	Payment to a Contractor by the Division of a fixed monthly payment per person in advance, for which the Contractor provides a full range of Covered Services as authorized under A.R.S. § 36-2904 and § 36-2907.
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)	Program 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. The Care Management Program is an administrative function performed by the health plan. Distinct from support coordination, Care Managers should not perform the day-to-day duties of service delivery.
CARE MANAGER	A Care Manager employed by the Contractor performs care management activities 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 support coordination, Care Management does not include 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.
CENTER 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).
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.

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, or 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	A person under the age of eighteen (18), unless the term is given a different definition by statute, rule or policies adopted by the Division or AHCCCS.
CHILD AND FAMILY TEAM (CFT)	A defined group of individuals that includes, at a minimum, the child and their family, or healthcare decision maker, 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 or mosques, or other places of worship/faith, agents from other service systems like the

	Department of Child Safety (DCS), or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
CHILD – KIDSCARE (TITLE XXI)	An individual under the age of 19 years who is covered under Title XXI of the Social Security Act.
CHILDREN'S REHABILITATIVE SERVICES (CRS)	A designation of Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive services as specified in A.A.C. R9-22.
CHOICE NOTICE	A written notice to a Medicaid enrollee that clearly and fully explains the enrollee's right, and process to follow, to disenroll from the assigned MCO and select a different MCO.
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.
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 RESOURCES 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. A risk contract between the Division and an 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]: Outpatient hospital services; b. Rural health clinic (RHC) services; c. Federally Qualified Health Center (FQHC) services; d. Other laboratory and X-ray services; e. Nursing facility (NF) services; f. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; g. Family planning services; h. Physician services; and/or i. Home health services.
CONDITIONAL RELEASE PLAN (CRP)	If the Superior Court finds that a person, who was placed under the jurisdiction of the PSRB pursuant to A.R.S. § 13-3994 and committed to a secure state MH facility, still suffers from a mental disease or defect or that the mental disease or defect is in stable remission but the person is no longer dangerous, the Superior Court shall order the person's conditional release. The person shall remain under the board's jurisdiction. The Superior Court in conjunction with the state MH facility and behavioral health community providers shall specify the conditions of the person's

	release. The Superior Court shall continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan shall be in place, including the necessary funding to implement the plan as outlined in A.R.S. § 13.3994(F)(3).
CONTRACT YEAR	A Contract Year is October 1 through September 30.
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, rules, 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.
CO-OCCURRING DIAGNOSIS	An additional physical condition, MH or substance use diagnosis experienced by an individual with a developmental disability.
COPAYMENT	A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in A.A.C. R9-22, Article 7.
COORDINATION OF BENEFITS AGREEMENT (COBA)	The new COBA Program establishes a standardized contract between the CMS and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data.
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.
COURT ORDERED TREATMENT (COT)	A court order for involuntary treatment under A.R.S. Title 36, Chapter 5, Article 5, as a result of a determination that an individual is, as a result of a mental disorder, a danger to self or others or has a persistent or acute disability or a grave disability and requires involuntary treatment.
COVERED SERVICES	The health and medical services to be delivered by the Contractor as specified in Section D, Scope of Work.
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.
CULTURE	The integrated pattern of human behavior that includes language, thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
CULTURAL COMPETENCY	A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, which enables that system, agency or those professionals to work effectively in cross-cultural situations. Culture refers to integrated

	patterns of human behavior that include the language, thoughts, communications, actions, customs beliefs, values, and institutions of racial, ethnic, religious or social groups. The culture of disability shall be included as one of many cultures addressed by the Contractor in its cultural competency initiatives. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors and needs presented by members and their communities.
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 person 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 OR DIVISION)	The Division of a State agency as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with an intellectual/developmental disability.
DES/DDD TRIBAL HEALTH PROGRAM (THP)	A Fee-For-Service (FFS) program administered by DES/DDD for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by any AHCCCS registered provider, and for Title XIX members, that are not provided by or through the Indian Health Services tribal health programs operated under 638. This Program was previously referred to as DDD-AIHP (DDD American Indian Health Plan) or DES-AIHP (DES American Indian Health Plan). The DDD Tribal

	Health Program (THP) name became effective beginning October 1, 2021.
DEVELOPMENTAL DISABILITY (DD)	As defined in A.R.S. § 36-551, a strongly demonstrated potential that a child under six (6) years of age has an intellectual/ developmental disability or will become a child with an intellectual/developmental disability as determined by a test performed pursuant to A.R.S. § 36-694 or by other appropriate tests, or a severe, chronic disability that: a. Is attributable to cognitive disability, cerebral palsy, epilepsy, autism, or Down Syndrome b. Is manifested before age eighteen (18); c. Is likely to continue indefinitely; d. Results in substantial functional limitations in three or more of the following areas of major life activity: i. Self-care, ii. Receptive and expressive language, i. Learning, ii. Mobility, iii. Self-direction, iv. Capacity for independent living, or e. 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.
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.
DISENROLLMENT	The discontinuance of a member's eligibility to receive covered services through a Contractor.

DIVISION ADMINISTRATIVE SERVICES SUBCONTRACTORS OPERATIONS MANUAL (AdSS OPERATIONS MANUAL)	This manual provides information related to Administrative Services Subcontractors operations and is available on the Division's website.
DIVISION ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the eligibility criteria for the DDD (A.R.S. § 36-559 and 560).
DIVISION MEDICAL POLICY MANUAL	This manual provides information regarding covered health care services and is available on the Division's website.
DIVISION OF MEMBER and PROVIDER SERVICES (DMPS)	The division within AHCCCS responsible for providing Member Services for AHCCCS and determining eligibility for CRS.
DIVISION RULES	See "ARIZONA ADMINISTRATIVE CODE." Division Rules are State regulations which have been promulgated by the DES for the DDD and published by the Arizona Secretary of State.
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).
DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)	A Dual Eligible Special Needs Plan (D-SNP) is a type of Medicare Advantage plan that enrolls beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offers the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able

	to withstand repeated use; and is appropriate for use in the home. See also, “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 members under the age of twenty-one (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 HEALTH RECORDS (EHR)	An EHR, or electronic medical record (EMR), refers to the systematized collection of patient and population electronically-stored health information in a digital format. These records can be shared across different health care settings.
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 conditions.
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 the Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.2].
ENROLLMENT	The process by which an eligible person becomes a member of the Contractor's plan.
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 person receiving services.
EXHIBITS	All items attached as part of this solicitation.
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 members. When appropriate, the member directs the involvement of the family to ensure person-centered care.

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 members may also include siblings, grandparents, aunts and uncles.
FAMILY-RUN ORGANIZATION (FRO)	Family-Operated Services that: a. Are independent and autonomous - Governed by a board of directors of which 51% or more are family members who: i. 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 ii. Have the lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use need, or iii. An adult who had lived experience of being a child with emotional, behavioral, mental health or substance use needs. b. Employ credentialed parent/family support providers 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 & Services Administration (HRSA) and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
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.
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 to provide a specific set of services including evaluation, monitoring, and treatment for 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].
FQHC LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of “health center” under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal and State law, as defined in 42 CFR 455.2.
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 DES/DDD within which a DES/DDD Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record.
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.
GUARDIAN	A guardian is the person who, under court order, is appointed to fulfill the powers and duties prescribed in A.R.S. § 14-5312. The term "guardian" does not include the appointment of a guardian pursuant to A.R.S. § 14-5312.01, § 14-5209, and § 8-871.
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 a person is assisted to acquire and maintain those life skills that enable the person to cope more effectively with personal and environmental demands and to raise the level of the person's physical, mental and social efficiency, as defined by A.R.S. § 36-551(25). Habilitation services focus on mentoring and teaching, not on caregiving.
HABILITATION THERAPY	A service that seeks to help individuals keep, learn, or improve skills and functioning that they are otherwise unable to develop on

	their own. Habilitation Therapy services include Occupational Therapy, Physical Therapy and Speech Therapy.
HEALTH CARE DECISION MAKER	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 un-emancipated 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 Behavioral Analyst, licensed social worker, 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 “qualifying health information exchange (HIE) organization” is 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 person whose life or physical well-being is the subject of coverage.
HEALTH INSURANCE PROVIDER FEE (HIPF)	An annual fee on the health insurance industry nationwide, including most Medicaid health plans effective January 1, 2014, pursuant to the Affordable Care Act (ACA).
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	HIPAA (P.L. 104-191); 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 NEED	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, 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, 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)	HCBS, as defined in A.R.S. § 36-2931 and A.R.S. § 36-2939(B)(2) and (C).
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 his 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].
HOMEMAKER	A direct care service in which assistance is provided for the performance of routine household activities, such as shopping, cooking, and cleaning within a member's own or family home.
HOSPICE SERVICES	Palliative and support care for members who are certified by a physician as being terminally ill and having six (6) 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 AND URBAN DEVELOPMENT (HUD), SECTION 811, SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES	The Section 811 program allows persons with disabilities to live as independently as possible in the community by subsidizing rental housing opportunities which provide access to appropriate supportive services. Section 811 program is authorized to operate in two ways: (1) the traditional way, by providing interest-free capital advances and operating subsidies to nonprofit developers of affordable housing for persons with disabilities; and (2) providing project rental assistance to state housing agencies. The assistance to the state housing agencies can be applied to new or existing multifamily housing complexes funded through different sources, such as Federal Low-Income Housing Tax Credits, Federal HOME funds, and other State, Federal, and local

	programs. The last appropriation was appropriated for traditional 811 capital advances made in FY 2011. Section 811 of the National Affordable Housing Act of 1990 (P.L. 101-625) as amended, and 24 CFR Part 891.
HOUSING SPECIALIST	A position, at the provider level that serves as the subject matter expert for housing and homeless-related services. Providing direct service to members in the office and in the field to support them in achieving housing stability.
INCURRED BUT NOT REPORTED (IBNR)	The liability for services rendered for which claims have not been received.
INDEPENDENT OVERSIGHT COMMITTEE	Public bodies established pursuant to A.R.S. § 41-3801 to promote the rights of members who receive services as individuals with developmental disabilities from DES pursuant to A.R.S. Title 36, Chapter 5.1.
INDIAN HEALTH SERVICES (IHS)	The operating division within the U.S. DHHS, 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 WITH AN INTELLECTUAL/DEVELOPMENTAL DISABILITY (I/DD)	An individual who meets the Arizona definition as outlined in A.R.S. § 36-551 and is determined eligible for services through the DES/DDD. Services for members who are AHCCCS-enrolled LTC with I/DD are managed through the DES/DDD and their Contractors. Services for members with I/DD who are not AHCCCS enrolled are managed by DES/DDD. See “DD” and “INTELLECTUAL DISABILITY.”
INFORMATION SYSTEMS	The component of the Offeror’s organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).

IN-NETWORK PROVIDER	A person or entity which has signed a provider agreement as specified in A.R.S. § 36-2904 and is authorized through a subcontract with a Division Contractor to provide services prescribed in A.R.S. § 36-2901 et seq. for members enrolled with the Contractor.
INSTITUTION FOR MENTAL DISEASES (IMD)	A hospital, NF, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an IMD 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 Disabilities (IID) is not an IMD. [42 CFR 435.1010].
INSTITUTIONAL SETTINGS	For purposes of this Contract, Institutional Settings means a Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
INTEGRATED CLINICS (ICS)	Providers registered with AHCCCS as ICS and licensed by the ADHS as Outpatient Treatment Centers which provide both behavioral health services and physical health services.
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information listed in Chapter 900 of the AdSS Medical Policy Manual is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTELLECTUAL DISABILITY (ID)	A condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before the age of eighteen (18). [A.R.S. § 36-551(14), 42 CFR 483.102 and related conditions as defined by 42 CFR 435.1010].

INTERDISCIPLINARY CARE	Meetings of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and Planning Documents 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 non-profit 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 and A.R.S. § 11-952(A)].
INTERMEDIATE CARE FACILITY (ICF)	A health care institution, Medicaid certified through ADHS and monitored by the ADES, providing room and board and with the primary purpose to provide health, active treatment and rehabilitative services to individuals with developmental disabilities (Division Medical Policy Manual, Policy 1210). An ICF primarily provides health and rehabilitative services to persons with developmental disabilities that are above the service level of room and board or supervisory care services or personal care services as defined in A.R.S. § 36-401 but that are less intensive than skilled nursing services [A.R.S. §36-551 (28)].
KIDSCARE	Federal and State Title XXI — 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 nineteen (19), in households with income between one hundred and thirty-three percent (133%)

	and two hundred percent (200%) of the Federal Poverty Level (FPL).
LIABLE PARTY	An individual, insurer, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of a 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.
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, or other institutional setting [42 CFR 438.2].
MAJOR UPGRADE	Any systems upgrade or changes to a major business component that may result in a disruption to the following: loading of contracts, providers, or members, issuing prior authorizations or the adjudication of claims.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers;

	have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, Medical Management (MM), and the coordination of care.
MANAGED CARE ORGANIZATION (MCO)	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]: a. A Federally qualified health maintenance organization that meets the advance directives and requirements of Subpart I of 42 CFR Part 489; or b. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions: ○ 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. ○ 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 Act [42 CFR 438.2].
MANAGEMENT SERVICES AGREEMENT (MSA)	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 five percent (5%) of total membership and/or provider network in a specific Geographic Region. Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Additional changes may also include the addition or change in: a. Pharmacy Benefit Manager, b. Dental Benefit Manager, c. Transportation vendor, d. Claims processing system, e. System changes and upgrades, f. Member Identification Card vendor, g. Call center system, h. Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment, i. MSA, j. 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 sufficiency 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: a. Any change that would cause or is likely to cause more than five percent (5%) of the members in a Geographic Region to change the location where services are received or rendered. b. Any change impacting five percent (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. Known in Arizona as AHCCCS.
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 BBA.
MEDICAL EQUIPMENT AND APPLIANCES	Item, as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and a. 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; b. Can withstand repeated use; and c. Can be reusable by others or removable. Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).
MEDICAL INSTITUTION	For purposes of the Institutional Status Reporting for Medicare Part D Copays, medical institutions are defined as: a. Acute hospitals, b. Psychiatric hospital – Non IMD, c. Psychiatric hospital – IMD, d. Residential treatment center – Non IMD, e. Residential treatment center – IMD, f. Skilled nursing facilities, or g. ICF/IID.
MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to hospice).

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 Physician (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	As defined in A.A.C. R9-22-101. Medically Necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability and other adverse conditions or their progression, or to prolong life.
MEDICALLY NECESSARY SERVICES	Those Covered Services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
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.
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
NETWORK	A list of doctors or other health care providers, nursing facilities and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide care to its members.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with the Contractor.
NON-QUANTITATIVE TREATMENT LIMIT (NQTL)	A limitation on the scope or duration of benefit coverage for treatment that is not expressed numerically. Examples include but are not limited to: Medical Management (MM) standards that apply to deny or limit coverage; fail-first policies or step therapy

	protocols; provider participation requirements; network restrictions and formulary design.
NURSING FACILITY (NF)	A facility that is licensed and Medicare/Medicaid certified by the ADHS in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician (Division Medical Policy Manual, Policy 310-R and 1210).
OFFEROR	A person, organization or entity that responds to this Solicitation.
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.
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, and 4. Peer Controlled - Governance board is comprised of at least fifty-one percent (51%) peers.
PERFORMANCE BOND	A written promise by a Surety to pay the Division (as the obligee) an amount specified in Contract and AdSS Operations Manual, 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 CYE 2021, official performance measure results shall be evaluated based upon the NCQA HEDIS® Medicaid Mean or 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 SUPPORTING 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 CARE	Ways of planning, providing, and monitoring care rooted in listening to what members need and want in order to help them live in communities of their choice. Inherent in person-centered care is an emphasis on seeing members as equal partners in their care and transforming the options available to the member, rather than on "fixing" or changing the person.
PHYSICIAN SERVICES	Medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
PLANNING DOCUMENTS	A Planning Document is developed and maintained by the Division's Support Coordinator with input from the Planning Team to identify needed services.

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.
POST STABILIZATION 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)].
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in A.A.C. R9-28, Article 1.
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)	Integrated information infrastructure that supports Medicaid 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.
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 PROVIDER (PCP)	An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15, or a naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services. The PCP shall be an individual, not a group or association of persons, such as a clinic.
PRIMARY PREVENTION	The focus on methods to reduce, control, eliminate and prevent the incidence or onset of physical or MH disease through the application of interventions before there is any evidence of disease or injury.
PRIOR AUTHORIZATION (PA)	Process by which the Division 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 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 the member is enrolled with the Contractor. Refer to 9 A.A.C. 22 Article 1. The time period for PPC does not include the time period for prior quarter coverage.
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 nineteen (19) years of age, individuals who are pregnant, and individuals who are in the 60-day-post-partum 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: a. Received one or more covered services specified in A.A.C. R9-22, Articles 2 and 12, and A.A.C. R9-28, Article 2 during the month; and b. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made. Refer to A.A.C. R9-22-303. **The Contractor is not responsible for payment for Covered Services received during the prior quarter.**
PROGRAM CONTRACTOR	Refer to “CONTRACTOR.”

PROVIDER	Any person 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)	A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions or 3) serious dysfunction of a bodily part or organ.
PSYCHIATRIC SECURITY REVIEW BOARD (PSRB)	The PSRB maintains jurisdiction over individuals who have committed a violent or dangerous criminal offense and are determined to be guilty except insane, consistent with the powers and duties articulated under A.R.S. § 31-502. Persons who are placed under the jurisdiction of the PSRB under A.R.S. § 13-3994 are committed to a secure state MH facility and may be released to a program of treatment in the community, under conditions determined by the PSRB.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE MEMBER (QMB DUAL)	A person determined eligible under A.A.C. R9, Chapter 29, Article 2 for QMB and eligible for acute care services provided for in A.A.C. R9, Chapter 22 or ALTCS services provided for in A.A.C. R9, Chapter 28. A QMB Dual receives both Medicare and Medicaid services and cost sharing assistance as specified in A.A.C. R9-29-101.
QUALITY MANAGEMENT	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 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 a person'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).
RESPONSIBLE PERSON	The parent or guardian of a minor with a DD, the guardian of an adult with a DD or an adult with a DD who is a client or an applicant for whom no guardian has been appointed. [A.R.S. § 36-551(37)]
RISK CONTRACT	a. A contract between the Division and an MCO, under which the Contractor: Assumes risk for the cost of the services covered under the contract. b. Incurs loss if the cost of furnishing the services exceeds the payments under the contract [42 CFR 438.2].
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., NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting (e.g., Assisted Living Home, Behavioral Health Residential Facilities) or an apartment-like setting that may provide meals.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of A.A.C. R9-22, Article 7 is considered roster billing.
RURAL HEALTH CLINIC (RHC)	A clinic that is located in a rural area designated r as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatmentof mental diseases, and meets all other requirements as specified 42 CFR 491.
SANCTION	Any action or remedy specified under Section G1, Special Terms and Conditions, Paragraph 44.
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 for individuals eighteen (18) years of age or older.
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 the Division 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.
SHARE OF COST (SOC)	The SOC is the amount the DMPS/ALTCS has determined, based on the member's income and expenses, what the member would have to pay monthly if she/he was placed in a nursing home or ICF.
SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA)	Eligible pregnant women under Section 9401 of the SOBRA of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below one hundred and fifty percent (150%) of the FPL, and children in families with individually budgeted incomes ranging from below one hundred percent

	(100%) to one hundred and forty percent (140%) of the FPL, depending on the age of the child.
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 services for the SMI.
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.
SPECIAL HEALTH CARE NEEDS	Serious and chronic physical, developmental or behavioral health 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 (1) year or longer and may require ongoing care not generally provided by a PCP. All ALTCS-DD members are considered members with special health care needs.
SPECIALIST	A Board-eligible or certified physician who declares himself or herself 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.
SPEECH GENERATING DEVICE (SGD)	Represent aided forms of high-technology AAC systems, defined as DME, that allow a member with a significant expressive speech-language disorder to electronically represent vocabulary and express thoughts or ideas in order to meet the member's functional speech needs.
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)	State CHIP under Title XXI of the Social Security Act. The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."
STATE FISCAL YEAR	The budget year — State fiscal year: July 1 through June 30.
SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to the Division under the terms of this Contract.
SUBCONTRACTOR	a. A provider of health care who agrees to furnish covered services to members. b. A person, agency or organization with which the Contractor, or its subcontractor, has contracted or delegated some of its management/administrative functions or responsibilities. c. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under this Contract with the Division.
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: a. Alters the individual's behavior or mental functioning. b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical. c. Impairs, reduces, or destroys the individual's social or economic functioning.
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)	An agency within the United States Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.
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.
SUCCESSFUL INCUMBENT CONTRACTOR	A Contractor under contract with the Division through September 30, 2019, that is awarded an ALTCS-DD Program contract for physical and behavioral health services effective October 1, 2019.
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 one hundred percent (100%) of the FPL.
SUPPORT COORDINATION	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.
SUPPORT COORDINATOR	An individual from DES/DDD assigned, or selected by a member, to provide Support Coordination.
THIRD PARTY	Refer to "LIABLE PARTY."

TITLE XIX	Known as Medicaid, or in Arizona as AHCCCS, 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, SSI, SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program (BCCTP) 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 Aid For Families With Dependent Children [AFDC]), SSI or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below one hundred and six percent (106%) FPL (Adults </= 106 percent), Adult Group above one hundred and six percent (106 percent) FPL (Adults > 106 percent), BCCTP, 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	A member eligible for 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.
TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)	A tribal entity that has an IGA with the AHCCCS administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a 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 himself/herself from abuse, neglect, or exploitation by others because of a physical or mental impairment (A.R.S. § 46-451). Vulnerable adult includes an incapacitated person as defined in A.R.S. § 14-1501.

[END OF SECTION C: DEFINITIONS]

SECTION D: SCOPE OF WORK

1. PURPOSE, APPLICABILITY AND INTRODUCTION

The purpose of the Contract between DES/DDD and the Contractor is to implement, manage and provide integrated services and supports for members enrolled in the ALTCS-DD Program as approved under the Arizona Revised Statutes (A.R.S.) § 36-2901 et. seq. and § 36-2932 et. seq. Individuals determined to have a qualifying I/DD as specified in A.R.S. § 36-551 who apply and meet the eligibility criteria for ALTCS (A.R.S. § 36-260, § 36-550.4, § 36-2901, § 36-2932) including:

a. Adults and children with General Mental Health/Substance Use (GMH/SU) needs,
b. Adults determined to have Serious Mental Illness (SMI),
c. Children with a Serious Emotional Disturbance (SED) designation
d. Children, including those with special health care needs.

Under the Contract, the Contractor will be responsible for the provision and administration of all physical health services and behavioral health services, as well as the following LTSS: nursing facility, emergency alert system services, habilitative physical therapy for members twenty-one (21) years of age and older, and Augmentative and Alternative Communication (AAC) services, supplies, and accessories. The Division will provide and manage all other LTSS and Support Coordination. Effective October 1, 2020, the Contractor will also be responsible for the provision of Behavior Analysis services. Service integration across physical health services, behavioral health services and LTSS provided to members will be achieved through a close collaboration and care coordination between the Contractor, the Division and their respective providers.

In the event 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:

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

INTRODUCTION

DES' True North, or vision statement, is "All Arizonans who qualify receive timely DES services and achieve their potential." It is the mission of the Division to empower Arizonans with developmental disabilities to lead self-directed, healthy and meaningful lives.
Individuals with intellectual and developmental disabilities face health care disparities and inequities in health care access, communication to make informed health care decisions, service quality to meet their unique needs, levels of service utilization, health status and often have unmet health care needs. The Contractor shall mitigate these health care disparities, using best practices for individuals with intellectual and developmental disabilities when providing members necessary services and supports. Services shall be accessible and provided in an integrated, flexible, and member-driven manner, resulting in improved health status, functional capabilities and quality of life. The goal is for all members to achieve the highest level of independent decision-making, self-sufficiency and engagement in the community.

The Contractor's provision of services and supports shall reflect the Division's ALTCS-DD program values of member:

- Choice,
- Dignity,
- Independence,
- Individuality,
- Privacy, and
- 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, and working with private sector partners to further innovation to the greatest extent. The Contractor shall collaborate with the Division and be innovative in the implementation of these initiatives. AHCCCS initiatives can be found on the AHCCCS website at www.azahcccs.gov, under the *AHCCCS Info* tab 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),
    Health Information Exchange (HIE) Arizona Healthcare Directives Registry (AzHDR),
11. Justice System transitions,
12. Targeted investments.

***Whole Person Care Initiative**:* The goal of AHCCCS and DDD 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 healthcare. 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 shall also maintain a publicly available Community Resource Guide with information on local resources that address and provide support for HRSN. The Community Resource Guide shall be kept up to date and available on the Contractor's website. 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 AdSS 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 AdSS Policy 404. 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 Contractor shall monitor, promote, and educate providers on 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 Division 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.

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.

Member-Centered Services

The member is the primary focus. The member and family/representative, as appropriate, are active participants in the planning, identification and evaluation of physical, behavioral, and long-term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goal(s) for achieving or maintaining his/her highest level of self-sufficiency. Up-to-date information about the ALTCS-DD program, choices of options and a mix of services is readily available to members and presented in a manner that facilitates the member's ability to understand the information.

Employment First Philosophy

The Division supports Employment First Principles, Policy and Practice, which include the following:

a. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.
b. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.
c. Employment First supports an overarching goal that eligible individuals with disabilities will have access to integrated work settings most appropriate for them, including the supports necessary to help them succeed in the workplace.
d. Employment First does not mean employment only and does not deny individual choice.
e. Employment First does not eliminate service options currently available, but is intended to increase employment opportunities.

Member-Directed Options for Accessing Cost-Effective, Covered Services

Members are afforded the opportunity to manage their personal health and development by making informed decisions to the maximum extent possible about how best to have needs met including who will provide the service and when and how the services will be provided.

Person-Centered Service Planning

Person-Centered Planning is a continuous problem-solving process used to assist members to plan for their future. The focus is on helping members to develop personal relationships, participate in the

community, increase control and autonomy over their own lives and develop the skills and abilities needed to achieve their goals. Person-Centered Planning maximizes member-direction and supports the member to make informed decisions, so that he/she can lead/participate in the process to the fullest extent possible. The Planning Document developed through this process, safeguards against unjustified restrictions of member rights, and ensures members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible. The Contractor, in collaboration and coordination with the member's Support Coordinator, ensures responsiveness to the member's needs and choices regarding service delivery, personal goals, and preferences. The member and family/representative, as appropriate, and providers involved in the support, care and treatment of the member have immediate access to the member's Planning Documents to promote coordinated, integrated care.

Consistency of Services and Supports

An accessible and consistently available network of services and supports is developed to ensure the delivery, quality and continuity of services. Services and supports are provided in accordance with the Planning Document as agreed to by the member and as authorized by the Division or Contractor, consistent with coverage responsibility.

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 members with disabilities, cultural preferences, and individual health care needs. Services are available to members to the same extent that services are available to individuals who are not receiving services through the Medicaid system.

Most Integrated Setting

Members live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are afforded the choice of living in their own home or choosing an alternative HCBS setting rather than residing in an institution. Members receive comprehensive services in the most integrated and least restrictive setting, allowing them to be fully integrated into their communities. To that end, members shall be afforded the choice to receive HCBS in community settings where individuals who do not have disabilities spend their time.

Collaboration with Stakeholders

Ongoing collaboration with members and family/representatives, service providers, community advocates, other member-serving agencies, and the Division facilitates continuous improvement of the ALTCS-DD Program.

Alignment of Care

Increasing the availability of well-coordinated, integrated care for members with developmental disabilities is a critical need. The Division and stakeholders have established that reducing or eliminating fragmentation of care for members requires focused efforts to coordinate physical and behavioral health care with LTSS and community supports.

Several key components of this Contract are designed to create greater alignment and care coordination:

a. Historically, ALTCS-DD members received their physical health care, behavioral health care and long-term care from three distinct health plans. Under this Contract, members will receive their physical and behavioral health services from the Contractor and their Support Coordination and LTSS from the Division.

b. The Contractor shall have a Care Management Program with qualified staff experienced in working with individuals with intellectual and developmental disabilities and other special health care needs to support care management and care coordination efforts.

c. A single, shared Planning Document, developed by the Support Coordinator with the participation of the Contractor's care management staff as appropriate, serves as the foundation for care and shall be made available to all involved providers.

d. For members with high needs or members who would benefit from care management, the Contractor's Care Manager is required to closely collaborate with the member's Support Coordinator to facilitate timely referral, access, coordination, and outcomes monitoring of all services in a manner that does not duplicate service, efforts or activities.

e. The Contractor, or its corporate affiliate, must be a Medicare Advantage Dual Eligible Special Needs Plan to support and promote coordinated care for dual eligible (Medicare and Medicaid eligible) members.

f. The Contractor shall mitigate disparities in health care access for members, to provide members with equal access to the physical and behavioral health care it is responsible for providing.

Integrated Services

The Contractor's ability to successfully ensure the delivery of integrated services and supports requires the Contractor to have a thorough understanding of the intricate, multi-layered service delivery system designed to address the needs of its members.

Health care integration is more than consolidating the administrative responsibility for providing physical and behavioral health benefits, or co-locating service delivery. Rather, the Contractor's integrated care system shall operate to holistically assess and seamlessly provide needed services within existing community programs. The Contractor's service delivery system shall reflect that successful member outcomes are a shared responsibility for all involved in the care and treatment of the member, leveraging the strengths of the respective provider disciplines.

The Contractor shall develop a comprehensive integration strategy focused on improving individual health outcomes, enhancing care coordination and increasing member satisfaction. The Contractor shall develop specific strategies to promote the integration of physical and behavioral health services and coordination with the Division's delivery of LTSS.

Strategies are expected to focus on, but not be limited to:

a. Implementing care coordination and care management best practices for providing physical health care, behavioral health care and coordinating these services with LTSS;

b. Proactive identification of members for engagement in care management;

c. Providing the appropriate level of care management/coordination of services to members with co-occurring conditions and/or comorbid physical health and behavioral health conditions while collaborating on an ongoing basis with the member's Support Coordinator, the member and other individuals involved in the member's care;

d. Ensuring continuity and coordination of physical and behavioral health services with the member's LTSS, and collaboration/communication between the member's Support Coordinator and providers;

e. Operating a single member services toll-free phone line available to all members for all services covered under the scope of this Contract;

f. Operating a single nurse triage line available for all members for all services covered under the scope of this Contract;

g. Developing strategies to assist members and/or their families in connecting with other supports and services delivery networks (e.g., childcare, Supplemental Nutrition Assistance Program (SNAP) and Head Start);

h. Considering the behavioral and physical health care needs of members during network development and contracting practices that consider providers and settings with an integrated service delivery model to improve member care and health outcomes;

i. Organizational structure and operational systems and practices that support the delivery of integrated services for members; and

j. Collaborating with community service providers to ensure members are integrated into existing programs in the communities in which they live.

2. ELIGIBILITY

All members served under this Contract must meet both ALTCS eligibility criteria and the Division's eligibility criteria. The Contractor shall: 1) defer to the Division, which has exclusive authority throughout the term of this Contract, to determine DES/DDD eligibility; and 2) accept the Division's roster of individuals who are identified by the Division to be both ALTCS and DES/DDD eligible.

DES/DDD Eligibility

The Division supports individuals with a diagnosis of cerebral palsy, epilepsy, autism, down's syndrome and intellectual/cognitive disability and with at least three substantial functional limitations in the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency, and individuals under six (6) years old who are at risk for becoming developmentally disabled. See "Developmental Disability" definition in Section C, Definitions. Eligible DD diagnoses are defined in A.R.S. § 36-551 and the Division's policy manuals. The Contractor is responsible for notifying the Division if it believes that a member no longer meets the Division's eligibility criteria.

ALTCS 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 AHCCCS' website.

Medical Eligibility

In addition to financial eligibility, an individual shall meet the medical and functional eligibility criteria as established by the PAS. The PAS is conducted by a registered nurse or social worker with consultation by a physician, if necessary, to evaluate the person's medical status. The PAS is used to determine whether the person is at immediate risk of placement in an institution for Individuals with Intellectual/Cognitive Disabilities. In most cases, the medical status of each member will not be re-evaluated annually; however, the Contractor is responsible for notifying the Division of significant changes in a member's condition, which may result in a change in eligibility.

ALTCS Transitional Program Eligibility

The ALTCS Transitional Program is available for members (both institutional and HCBS) who, at the time of medical reassessment, have improved either medically, functionally or both, to the extent that they no longer need institutional care, but who still need significant long-term care services and supports. 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 care is determined medically necessary, the period of institutionalization may not exceed ninety (90) consecutive days.

Members living in a medical institution when determined eligible for the ALTCS Transitional Program shall be transitioned to a home and community-based placement as soon as possible, but no later than ninety (90) days after the effective date of eligibility for the ALTCS Transitional Program. The Contractor is responsible for assisting the Support Coordinator with the member's transition to a home and community-based placement and coordinating the services for which the Contractor is responsible for coverage.

For members in the ALTCS Transitional Program, if institutional care is expected to exceed ninety (90) consecutive days, the Contractor shall collaborate with the Support Coordinator, as outlined in the AdSS Medical Policy Manual, Policy 310-R.

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.

Arizona Long Term Care Services Eligibility Determinations During Hospitalization
If it is determined that a member may qualify for Arizona Long Term Care Services (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.

Other Eligibility Categories
In addition to meeting ALTCS and DES/DDD eligibility criteria, a subset of members may have CRS-qualifying medical conditions (A.R.S. § 36-260 et. seq.) and/or have been determined to meet eligibility as individuals with a SMI (A.R.S. § 36-550.4).

Serious Emotional Disturbance/Serious Mental Illness (SED/SMI) Eligibility
The Contractor shall ensure persons who may meet the Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) eligibility criteria are identified and assessed by qualified clinicians in accordance with AHCCCS Policy on SMI Eligibility Determinations. Refer to requirements in Section D, Behavioral Health Service Delivery Requirements. American Indian members determined to meet SMI criteria can choose to receive behavioral health services through the Contractor, TRBHA, IHS or 638 tribal facility.

The Contractor shall provide medically necessary covered services for members who have been determined SED or SMI eligible, based upon available funding.

The Contractor shall ensure persons who may meet the SED or SMI eligibility criteria and persons requesting SED or SMI decertification are identified and assessed by qualified clinicians as specified in AdSS Medical Policy Manual, Policy 320-P. Payment for evaluations conducted for the purpose of an 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, which will be reviewed by the AHCCCS designee who conducts SMI eligibility determinations to determine member SMI eligibility status. The Contractor shall ensure the 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 27, 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 AdSS Medical Policy 320-P. The contractor shall ensure the SED and SMI eligibility determination evaluation Packets include, at a minimum, the following documentation:

a. AdSS Medical Policy Manual 320-P, Attachment A,

b. Serious Mental Illness Determination Form,

c. Consent Form(s),

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

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

f. Additional records available for consideration, and

g. 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 a determination for SED or SMI eligibility 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 TXIX plan..

ACC-RBHAs are responsible for coordinating SED or SMI evaluations for Non-Title XXI members and members who are incarcerated and have suspended Medicaid eligibility.

Adherence to these requirements may be subject to review through Division audits and/or reviews.

Serious Emotional Disturbance and Serious Mental Illness 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.

Once an SED or SMI Eligibility Determination or Removal of Designation decision is made and submitted to the AHCCCS, AHCCCS will update the member's Behavioral Health Category to add/remove SED or SMI respectively and will provide the documentation to the AdSS of enrollment , as applicable, via the AHCCCS SFTP server. The Behavioral Health Category can then be viewed in the AHCCCS Online system via the AHCCCS Online Provider Website.

Members who have been decertified will continue to receive their services through the Contractor; however, will no longer be eligible to receive non-Title XIX services and benefits, nor the entitlements (i.e., Special Assistance) or due process (i.e., SMI Notice and Grievance and Appeals rights) that are available to individuals with a serious mental illness.

CRS Eligibility

Members who have a CRS designation and are in need of current or continued (active) treatment as defined in A.A.C. R9-22-1301 for one (or more) CRS qualifying medical condition(s) shall receive services through the Contractor. Refer to Section D, Paragraph 9, Scope of Services. The Contractor shall provide covered medically necessary services, including services to treat the CRS qualifying condition(s), as described within this Contract.

The Contractor shall refer members under the age of twenty-one (21) years who do not have a CRS designation but are potentially in need of services related to CRS qualifying conditions, as specified in A.A.C. R9-22 Article 13, and A.R.S. Title 36, to DMPS. (See AdSS Operations Manual, Policy 426 for the processes used to process referrals for a CRS designation.) In addition, the Contractor shall notify the member, or his/her parent/guardian/authorized representative, when the referral to a specialist for an evaluation of a CRS condition will be made. The Contractor shall provide covered services necessary to treat the CRS qualifying condition as well as other services described within this Contract.

The Contractor shall establish a process for the identification of members under the age of twenty-one (21) years with a CRS designation who have completed treatment for the CRS condition, and do not have any other CRS-qualifying conditions. The Contractor is responsible for notifying the AHCCCS DMPS of the date when a member with a CRS designation is no longer in need of treatment for the CRS qualifying condition(s) as specified in the AdSS Operations Manual, Policy 426. The notification requirements described above are applicable only to members under twenty-one (21) years of age. The Contractor shall accept historical CRS identification numbers (ID's) as alternative member ID's for claims processing, as applicable.

3. ENROLLMENT AND DISENROLLMENT

The Division has the exclusive authority to enroll and disenroll members with the Contractor. The Division will assign members to Contractors consistent with Division Policy Manuals (see the AdSS Medical Policy Manual, Policy 520 and AdSS Operations Manual, Policy 314). The Contractor shall not disenroll any member for any reason unless directed to do so by the Division. 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 services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs [42 CFR 438.56(b)(2)].

For children with an I/DD who qualify for both CHP and DES/DDD, the member is enrolled with DES/DDD for provision of physical and behavioral health services.

Initial Enrollment

Effective October 1, 2019, the Division will assign members to the Contractor, consistent with the Division Policy Manuals.

All members enrolled in the ALTCS-DD program at the time of Contract start will be given an opportunity to select a Contractor to provide services covered under this Contract at least thirty (30) days prior to Contract start. Members who do not take action during the transitional open enrollment will be auto-assigned to a Contractor by the Division as follows:

a. Members enrolled with a successful incumbent contractor will be auto-assigned (re-enrolled) with the successful incumbent contractor for continuity of care purposes.

b. All other members will be auto-assigned to the awarded Contractor(s) with the lowest membership, alternating between the available Contractors until numerical distribution is equitable.

The Division will send a Choice Notice to members who select a Contractor or are auto-assigned, allowing the member ninety (90) days to select a different Contractor.

Newly Enrolled Members

Newly enrolled members after Contract start date will be auto-assigned by the Division to a Contractor by alternating between the available Contractors.

The Division will send a Choice Notice to newly enrolled members who are auto-assigned, allowing the member ninety (90) days to select a different Contractor.

Enrollment Change Requests

Members may submit Contractor change requests to the Division. The Division makes member enrollment changes in accordance with Division Policy. Questions and requests regarding Contractor changes should be referred to the Division's Transition Coordinator via mail at: 3443 North Central Avenue, Suite 600, Phoenix, AZ 85012, or by phone at 1-602-771-8080 or 1-844-770-9500. For medical continuity and coordination of care requests, the Contractor shall follow the procedures outlined in the AdSS Medical Policy Manual, Policies 520, 530 or 540 when a member changes Contractors available under this Contract or other health plans.

A member may request Contractor changes at the following times (see also the AdSS Operations Manual, Policy 401) [42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]:

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

b. Without cause ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later;

c. Without cause at least once every twelve (12) months; or

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

When a member requests a Contractor change for cause, the member must use the Division's Grievance and Appeal System process for the request and the Division shall issue a decision no later than thirty (30) days from the date of the request. If the Division approves a request for a Contractor change, the effective date of an approved change must be no later than the first day of the second month following the month in which the member or Contractor files the request [42 CFR 438.56(e)(1)]. If, as a result of the appeal process, the Division denies the request for change, the Division shall notify the member of their right to request a State Fair Hearing no later than thirty (30) days from the date of the adverse determination.

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

a. When the member becomes Medicaid ineligible;

b. When the member changes Contractors during the member's open enrollment period;

c. When the Contractor does not, because of moral or religious objections, cover the service the member seeks unless the Contractor offered a solution that was accepted by the Division in accordance with the requirements in Section D, Paragraph 9, Scope of Services;

d. When the member is approved for a Contractor change;

e. For members who would have to change their residential or institutional provider, based upon 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;

f. 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; or

g. For cause.

Prior Quarter Coverage

Pursuant to the January 2019 CMS Approval of 1115 Waiver, AHCCCS is waived from approving Prior Quarter Coverage eligibility (also referred to as Retroactive Coverage in the 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 post-partum 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, if the individual met AHCCCS eligibility requirements during that particular month. The Contractor is not responsible for payment for covered services received during the prior quarter. Upon verification or notification of Prior Quarter Coverage eligibility, providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period.

Prior Period Coverage

*Prior Period Coverage (*PPC) is available 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 the Division of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services provided to members during PPC. This may include services provided prior to the Contract year 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.

Provider Refund Payments

NFs shall refund any payment received from a member/resident, or family member (in excess of SOC) for the period of time from the effective date of Medicaid eligibility, to the member/resident, or family member who made the payment.

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

Disenrollment to AHCCCS Complete Care Program

When a member becomes ineligible for ALTCS DDD but remains eligible for the AHCCCS Complete Care (ACC) Program, the member shall choose an ACC Contractor. In such cases, the Division 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 Pre-Admission Screening (PAS), obtaining the member's choice of ACC Contractor is part of transition planning. Refer to AMPM Policy 520.

Newborns Born to Mothers Enrolled in ALTCS-DD Program

The Contractor shall notify AHCCCS and the Division of a child's birth to an enrolled member no later than one (1) calendar day from the date of birth. AHCCCS is available to receive notification 24 hours a day, seven days a week via the AHCCCS website. The Contractor shall ensure that newborns born to a member enrolled with the Contractor are not enrolled with the Contractor for the delivery of health care services. Babies born to mothers enrolled with the Contractor are auto-assigned to an AHCCCS

Complete Care Contractor when no family continuity exists. Mothers of these newborns are sent a Choice Notice advising them of their right to choose a different ACC Contractor for their child, which allows them ninety (90) days to make a choice.

American Indians

American Indians who become ALTCS-DD eligible can choose to receive the services described within this Contract either through the managed care network and structures, or through the Division's FFS unit at any time. Changes for an American Indian member are subject to annual enrollment choice (AEC) requirements in Section D, Paragraph 4, Annual Enrollment, and "Enrollment Change Requests" requirements above. American Indian members, Title XIX, on- or off-Nation, eligible to receive services, may choose to receive services at any time from an ITU. The Contractor shall not impose enrollment fees, premiums, or similar charges on American Indians served by an ITU.

4. ANNUAL ENROLLMENT

The Division conducts an AEC for members every twelve (12) months as designated by the Division. During AEC, members may change Contractors. The Division provides enrollment and other information required by Medicaid Managed Care Regulations sixty (60) days prior to the Division-established annual enrollment. The member may choose a new Contractor by contacting the Division to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made. The Contractor shall comply with AdSS Operations Manual, Policy 402. The Division at any time may hold an open enrollment as deemed necessary.

5. PEER AND FAMILY INVOLVEMENT AND PARTICIPATION

The Contractor shall embed the following principles of 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 within the AHCCCS program.

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

The Contractor's Office of Individual and Family Affairs (OIFA) shall ensure that behavioral health provider sites create 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 and Adult Recovery Teams do not fulfill this requirement.

The Contractor shall submit a summary of common activities of member and family participation at identified provider sites, including but not limited to: quality improvement and enhanced customer service developed through the engagement and collaboration of member and family member participation. Summary shall include the submission of agendas, meeting minutes and attendance sheets as applicable. The Contractor shall submit the overview of activities as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Collaboration with Peers and Family Members: At least every six months, the Contractor's OIFA shall meet with a broad spectrum of peers, family members, and providers including PROs and FROs, advocacy organizations, and or any other individuals that have an interest in creating system enhancements. These meetings will be utilized to gather input, identify challenges and barriers, share information, and strategize ways to strengthen the service delivery system The Contractor and shall invite OIFA to participate at these meetings.

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. Each Committee shall work with the Contractor's OIFA to include peers and family members enrolled with the Contractor. The Contractor shall submit a Roster of Peer and Family Committee Members as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall ensure that the composition of the committees is diverse and representative of the Contractor' current

membership throughout the region with respect to the members' race, ethnic background, primary language, age, and Medicaid eligibility category.

Peer-Run Organizations (PRO) and Family-Run Organizations (FRO): The Contractor is expected to contract with PROs and FROs, as specified in Contract, in each of the Contractor's awarded statewide. 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 provide access to peer and family support services for members to assist with understanding and coping with the stressors of a member's disability and how to effectively, and efficiently, utilize the service delivery system for covered benefits. If the Contractor desires to contract with an organization not currently recognized by AHCCCS/DCAIR OIFA and the Contractor believes the organization meets the definition of a PRO or FRO a request shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS will review the proposed PRO or FRO and determine if the provider meets the definition and criteria for a PRO or FRO, as defined in Section D, Definitions and www.SAMHSA.gov.

Peer and Family Support Specialists and Family Involvement

The Contractor shall embed the following principles, with respect to peer and family involvement, in the design and implementation of an integrated health care service delivery system:

a. Behavioral, physical, peer and family support providers shall share the same mission to place the member's whole-health needs above all else as the focal of point of care;

b. Utilize peer and family delivered support services/specialists and embed peer and family voice at all levels of the system. The Contractor shall submit information noting Peer/Recovery Support Specialist (PRSS) and Credentialed Parent/Family Support Specialist involvement in service delivery as specified in Section F, Exhibit F3: Contractor Chart of Deliverables;

c. Refer to AdSS Policy 963 and AdSS Policy 964 for requirements regarding the provision of Peer/Recovery Support Specialists and Credentialed Parent/Family Support Services within the DDD program; and

d. Maximize the use of existing behavioral and physical health infrastructure including PROs and FROs.

6. MEMBER IDENTIFICATION CARDS

The Contractor is responsible for obtaining the Division's prior approval regarding the production, distribution and costs of AHCCCS/DDD member identification cards in accordance with AdSS Operations Manual Policy 433 and Exhibit F3, Contractor Chart of Deliverables. Member identification cards shall contain the ADES/DDD and Contractor logos, and shall specify the member's enrollment consistent with the following naming standard: "DDD Health Plan by [insert Contractor Name]".

7. ACCOMMODATING MEMBERS

The Contractor shall ensure that members are provided covered services without regard to race, color, national origin, age, sex, gender, sexual orientation, or gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, or gender identity [42 CFR 457.1201(d), 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:

a. Denying or not providing a member any covered service or access to an available facility or treatment room that ensures privacy;

b. Denying a covered service or access to a service in a community location because behavior may be disruptive in an office environment or medical equipment is difficult to navigate in an office environment;

c. Denying access to an examination room because wheelchair is too large to fit through a doorway, or examination table due to lack of equipment that meets member needs;

d. 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;

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

f. 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; and

g. Limiting or excluding medically necessary, cost-effective, EPSDT services.

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

The Contractor shall eliminate access to care barriers to ensure services are provided in a way that members can 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 communication/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 subcontractor to implement barriers to care (e.g., the terms of the subcontract act to discourage the full utilization of services by some members) the Contractor shall be in default of its Contract. If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, it shall promptly intervene and require a CAP from the provider, notifying the Division of the problem and CAP within 30 calendar days from the date the issue was identified as required in Section F, Exhibit F3, Contractor Chart of Deliverables. Failure to take prompt corrective measures may place the Contractor in default of this Contract.

8. MEMBER TRANSITION ACTIVITIES

The Contractor shall comply with the Division's standards for member transitions between Division Contractors, AHCCCS Plans, changes in health care providers or other providers, and upon implementation, termination or expiration of this Contract.

Members often require care over extended periods of time. Therefore, transitions are common and may include transitions from the neonatal intensive care unit (NICU) to home; the pediatric to the adult system of care; from an AHCCCS Plan to a Division Contractor; between Division Contractors; between levels of inpatient and outpatient care; and from physician to physician. All members are designated as individuals with special health care needs (see Section D, Paragraph 15, Special Health Care Needs) pursuant to the Division Medical Policy Manual, Policy 540, requiring additional assistance during care transitions. Accordingly, the Contractor shall implement specific policies and procedures to preserve the continuity of care during such transitions. The Contractor's policies and

procedures shall be consistent with the AdSS Medical Policy Manual, Policy 520, and shall include, but shall not be limited to, standards related to the transitions of:

a. Members with significant medical conditions such as a high-risk pregnancy or pregnancy that is within the third trimester, the need for organ or tissue transplantation, the need for catastrophic reinsurance for hemophilia and high-cost biologic specialty drugs, the need for communication devices, wheelchair dependency, ventilator dependency, chronic illness, resulting in hospitalization or NF placement;

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

c. Members under age nineteen (19) years who are blind, have disabilities, have a CRS-qualifying condition, are in foster care or other out-of-home placement, or are receiving adoption assistance;

d. Members determined to have a serious or chronic physical, developmental and/or behavioral health condition such as a SMI, SED, Autism Spectrum Disorder, ID;

e. Member with an SMI designation.

f. Members who are receiving ongoing services such as daily in-home care, behavioral health, dialysis, home health, chemotherapy and/or radiation therapy, end of life care or hospice, or who are hospitalized at the time of transition;

g. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;

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

i. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, residential treatment, out-of-area specialty services, or nursing home admission;

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

k. Medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing AHCCCS Contractor;

I. Individuals 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:

1. The primary nighttime residence is a public or private place not meant for human habitation;

2. 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

3. The individual is being discharged from an institution, such as a residential treatment, an acute care or a behavioral health inpatient stay, jail/prison, and was admitted as homeless, upon discharge, is likely to return to the street or shelter as specified in 1. or 2. above.

The cost, if any, of reproducing and forwarding medical records of the transitioning member shall be the responsibility of the relinquishing Contractor/AHCCCS Plan.

The Contractor shall designate a key staff person with appropriate training and experience as described under Section D, Paragraph 19, Staff Requirements, 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 19, Staff Requirements and the AdSS Operations Manual, Policy 402.

Member Transitions from an ACC or LTC Plan to the Division

Members who transition from an ACC or LTC Plan to the Division are considered newly enrolled; accordingly, initial contact and member engagement requirements and timeframes shall apply to the Contractor.

The Division will notify the Contractor of a member enrollment resulting from the transition of a member from an AHCCCS Complete Care or LTC Plan to a Division Contractor. The Division shall act as the primary point of contact for member transitions from ACC or LTC Plans, and the Contractor shall coordinate the transition as required by the Division.

The Division, when receiving a transitioning member, shall ensure care is coordinated either directly, or indirectly through the Contractor, with the relinquishing ACC or LTC Plan in order to ensure that services are not interrupted, and for providing the new member with service information, emergency numbers and instructions on how to obtain services. The Division will transmit appropriate medical

records and care management information received from the relinquishing ACC or LTC Plan to the Contractor. The Contractor shall maintain members' current providers and service authorizations in place for a period of at least ninety (90) days unless mutually agreed to by the member or member's responsible person. The Contractor shall reimburse a non-emergent, non-contracted provider in accordance with Section D, Paragraph 44, Claims Payment/Health Information System.

When members transition to the Contractor, members currently in treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed course of treatment.

Member Transitions from the ALTCS-DD Program to an ACC or LTC Plan:
The Division will notify the Contractor of a member disenrollment and will lead the coordination transition activities to the receiving ACC or LTC Plan. The Contractor shall support the Division as required and shall be responsible for providing pertinent information related to any special or particular care needs for the seamless transition of members. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the Contractor.

Member Transitions during Implementation of this Contract:
To ensure service continuity during the implementation of this Contract, the Contractor shall maintain members' current providers and service authorizations in place for a period of at least 180 days unless mutually agreed to by the member or member's responsible person. Implementation, for purposes of determining service continuity, is defined as any member transition that occurs within the first three months of the Contract. Additionally, for members with CRS-qualifying conditions and have an established relationship with a PCP that does not participate in the Contractor's provider network, the Contractor shall provide, at a minimum, a 180-day transition period in which the member may continue to seek care from their established PCP while the member/responsible person, the Contractor's Care Manager, and the member's Support Coordinator finds an alternative PCP within the Contractor's provider network.

When members transition to the Contractor, members currently in treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed course of treatment.

Member Transitions for Member Enrollment Changes between Contractors:
The relinquishing Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special or particular care needs for the seamless transition of members. The receiving Contractor, when receiving a transitioning member, is responsible to coordinate care with the relinquishing Contractor in order to ensure that services are not interrupted, and for providing the member with instructions on how to obtain services. Appropriate medical records of the transitioning member shall also be transmitted. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the relinquishing entity.

The receiving Contractor shall ensure a smooth transition for members by maintaining their current providers and service authorizations in place for a period of at least ninety (90) days unless mutually agreed to by the member or member's representative.

Contractors shall ensure that transitioning members currently in treatment with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

Pediatric to Adult Member Transition
The Contractor shall participate in the development of a Pediatric to Adult Transition Plan for each member at least twelve (12) months prior to a member's eighteenth (18th) birthday. The Pediatric to Adult Transition Plan shall be developed by the member's Support Coordinator (as part of the Planning Document) with members, their families, the Contractor's Care Manager (if applicable), and providers involved in the member's care and treatment. The Contractor's responsibility in the transition planning process shall include assisting the Division in educating the member and their family regarding the need to change from pediatric to adult services and provide the necessary information to inform choices when making transition-related decisions.

The Pediatric to Adult Transition Plan should identify an adult-care PCP, be developmentally appropriate and be periodically updated to address the member's current needs. In addition to health care, discussions related to employment, education, recreation, and social needs should be part of the planning for adulthood. All teens, including those with cognitive disabilities, should be included in planning for adulthood in a way that is meaningful to them. Furthermore, the Pediatric to Adult Transition Plan shall include strategies to address barriers to transitioning from a pediatric to an adult-oriented system of care. The Contractor shall adhere to policies in the Division Medical Policy Manual, Policy 520.

Contract Termination

In the event that the Contract or any portion thereof is terminated pursuant to Section G2, Uniform Terms and Conditions, Paragraph 9, is suspended or expires, the Contractor shall assist the Division in the transition of its members to other Contractor(s). In addition, the Division reserves the right to extend the term of the Contract on a month-to-month basis to assist in any transition of members. The Division may discontinue enrollment of new members with the Contractor ninety (90) days prior to the Contract termination date. The Contractor shall make provisions for continuing all management and administrative services until the transition of all members is completed and all other requirements of this Contract are satisfied. The Contractor shall submit a detailed plan to the Division for approval regarding the transition of members in the event of Contract expiration or termination. The name and title of the Contractor's Transition Coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this Contract and necessary for the transition process [42 CFR 434.6(a)(6)].

Any dispute by the Contractor, with respect to termination or suspension of this Contract by the Division, shall be exclusively governed by the provisions of Section G2, Uniform Terms and Conditions, Paragraph 10, Contract Claims.

9. SCOPE OF SERVICES

The Contractor is responsible for managing, covering, and providing all medically necessary physical health services and behavioral health services, as well as the following LTSS: Nursing Facility, Emergency Alert System Services and Habilitative Physical Therapy for members twenty-one (21) years of age and older. All other LTSS and Support Coordination are managed, covered and provided by the Division. The Contractor shall assure and demonstrate that it has the capacity to serve the expected enrollment in accordance with the Division's standards for access and timeliness of care [42 CFR 457.1230(b), 42 CFR 438.207(a), 42 CFR 438.68, 42 CFR 438.206(c)(1)].

The Contractor is responsible for providing all services as required under this Contract. Medicaid covered services shall be provided in accordance with all applicable Federal and State laws, regulations and policies. 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 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 457.1230(d), 42 CFR 438.210(a)(3)(ii)]. The Contractor may place appropriate limits

on a service based on criteria such as evidence-based practice or medical necessity; or for utilization control, provided the services furnished can be reasonably expected to achieve their purpose [42 CFR 457.1230(d), 42 CFR 438.210(a)(3)(i); 42 CFR 438.210(a)(4)]. The Contractor is prohibited from avoiding costs for services covered in its Contract by referring members to publicly supported health care resources [42 CFR 457.1201(p)].

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

The Contractor shall assure and demonstrate that it has the capacity to serve the expected enrollment in its service area in accordance with the Division's standards for access and timeliness of care [42 CFR 457.1230(b), 42 CFR 438.207(a), 42 CFR 438.68, 42 CFR 438.206(c)(1)].

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 shall ensure that services are rendered by providers that are appropriately licensed and/or certified, operating within their scope of practice, and registered as AHCCCS providers. The Contractor shall provide the same standard of care for all members. Services shall be accessible and provided by service providers trained in providing services to the population covered under this Contract. The individual strengths and needs of the member and, when appropriate, their family shall determine the type, modality and intensity of services. Services shall be provided in a manner that respects the member's cultural needs and, when appropriate, family's cultural needs. Services shall be developmentally and linguistically appropriate, meet effective communication requirements under the ADA Section 504, and shall be community-based to the extent possible.

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 457.1230(d), 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 457.1230(d), 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 15, Member Information.

The Contractor shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is his or her patient, for [Section 1932(b)(3)(A) of the Social Security Act; 42 CFR 457.1222; 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. Any information the member needs in order to decide among all relevant treatment options;

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

d. The member's 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 457.1220, 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(iv)]; and

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

   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 NOA Self-Audit Executive Summary as specified in the ACOM Policy 414 and Section F, Attachment F3, Contractor Chart of Deliverables.

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 including, but not limited to, 45 CFR Parts 160 and 164, Subparts A and E, and Arizona statute, to the extent that they are

applicable [42 CFR 438.208 (b)(2) and (b)(6); 42 CFR 457.1230(c); 42 CFR 438.208; 42 CFR 438.224].

The services are described in detail in A.A.C. R9-22 Article 2, Division Policy Manuals, AMPM and ACOM, all of which are incorporated herein by reference. [42 CFR 400(a)(1)].

Moral or Religious Objections

The Contractor shall notify the Division if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service [Section 1932(b)(3)(B)(i) of the Social Security Act, 42 CFR 457.1222; 42 CFR 457.1207; 42 CFR 438.10(e)(2)(v)(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 Act; 42 CFR 457.1222, 42 CFR 438.102(b)(1)(i)(A)(1) and (2)]. If the Division does not approve the Contractor's proposal, the Division will notify the Contractor. The proposal shall:

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

b. Place no financial or administrative burden on the Division;

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

d. Be accepted by the Division in writing; and

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

If the Division approves the Contractor's proposal for its members to access the services, the Contractor shall immediately develop a policy implementing the proposal along 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 the Division prior to dissemination. The notification shall be provided to newly assigned members within twelve (12) days of enrollment and shall be provided to all current members at least thirty (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)].

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 457.1230(d); 42 CFR

438.210(b)(1); 42 CFR 438.910(d)]. The Contractor's policies and procedures shall include the Contractor's timely notification to the Division of requests for services that are provided by the Division. The Contractor shall not provide a Notice of Adverse Benefit Determination for services that are provided by the Division.

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 prior authorization 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 457.1230(d); 42 CFR 438.210(b)(2)(i)]. The Contractor shall consult with the requesting provider for medical services when appropriate [42 CFR 457.1230(d); 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 457.1230(d); 42 CFR 438.210(b)(3)]. Refer to the AdSS Medical Policy Manual, Chapter 1000, and Exhibit F1, Member Grievance and Appeal System Standards for additional service authorization requirements. The services listed below require the Division's review for approval or denial of the services in compliance with the Division's second level review process under AdSS Medical Policy Manual:

a. Admission to the AzSH,

b. Behavioral Health Residential Facility (BHRF) [denials only],

c. Enclosed or partially enclosed beds,

d. Hysterectomy,

e. Sterilization,

f. Termination of pregnancy, and/or

g. Transplant or any transplant immunosuppressant medication (denials only)

h. Participation in experimental services and clinical trials.

i. Electroconvulsive Therapy

For these services, the Contractor must submit to the Division the request for prior authorization with medical/clinical documentation that supports medical necessity for the requested services. The Contractor shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven (7) business days, for review and response for standard service authorization requests, and two (2) business days for expedited service authorization requests. Refer to AdSS Medical Policy Manual, Policy 320-V for BHRF timely requirements.

The Contractor is responsible for ensuring compliance with the requirements for timeliness of service authorization decisions under 42 CFR 438.404, AHCCCS rules, AdSS Operations Manual, Policy 414 and Exhibit F1, Member Grievance and Appeal System Standards of this Contract. Such notifications include issuing a Notice of Extension when additional time is needed to obtain the medical and/or clinical supporting documentation to provide to the Division, or when additional time is needed for the Division's review of the request for authorization.

General and Informed Consent

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

Notice of Adverse Benefit Determination

The Contractor shall notify the requesting party, which may include a provider, the member's Support Coordinator and/or the member/responsible person, and give the member/responsible person 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 457.1260; 42 CFR 457.1230(d); 42 CFR 438.210(c); 42 CFR 438.404; 42 CFR 438.400(b)]. The notice shall meet the requirements of 42 CFR 438.404, AHCCCS rules, AdSS Operations Manual, Policy 414 and Exhibit F1, Member Grievance and Appeal System Standards of this Contract. The provider shall be notified of the decision as specified in Section F, Exhibit F1, Member Grievance and Appeal System Standards of this Contract [42 CFR 438.210(c)]. The Contractor shall comply with all decision timelines outlined in the AdSS Operations Manual, Policy 414. The Notice of Adverse Benefit Determination shall be sent to the DDD/OIFA for members with an SMI designation and 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 a system of care 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 or AdSS Medical and Operations Manuals with respect to requirements for effective service delivery.

CONTRACTOR COVERED SERVICES

The Contractor shall cover and provide the physical and behavioral health services, as well as the limited set of LTSS [Nursing Facility, Emergency Alert System Services and Habilitative Physical Therapy for members twenty-one (21) years of age and older] and Augmentative and Alternative Communication (AAC) services, supplies, and accessories, as described below. Refer to the AdSS Medical Policy Manual and AHCCCS' Medical Policy Manual and AHCCCS' Behavioral Health Covered Services Guide for a more comprehensive list and description of Covered Services.

Adaptive Aids/Assistive Technology

The Contractor shall provide certain medically necessary adaptive aids which includes assistive technology, consistent with the requirements in the AdSS Medical Policy Manual, Policy 1250-F, if prescribed by a specialist physician, practitioner or dentist. Documentation from therapists who have treated the member may be required. Medical documentation shall comply with the CMS medical record documentation requirements, establish the need for equipment and provide a comprehensive explanation of how the member will benefit from the equipment. Covered adaptive aids include but are not limited to: traction equipment; aids for eating (including adaptive utensils and trays for wheelchairs); helmets; standers, prone and upright; voice activated aids (including switches and buttons); toileting aids; wedges and custom seating (positioning); transfer aids; car seats; and, other items as determined medically necessary by joint consultation of the Medical Director(s) of the Contractor and the Division.

For members who reside in an ICF/IID, the Contractor shall cover all medically necessary adaptive aids prescribed by a physician (see CMS State Operations Manual, Appendix J, Guidance to Surveyors).

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

American Indians who become DES/DDD eligible can choose to receive the services described within this Contract either through the managed care network and structures, or through the DES/DDD Tribal Health Program, at any time.

American Indian members who do not have a designation as an individual with a SMI have a choice of receiving services based upon one of four (4) service delivery options as shown in the table below:

	PH SERVICES	CRS SERVICES	BH SERVICES	LTSS
Option 1	Contractor	Contractor	Contractor	Division
Option 2	DDD-THP	DDD-THP	DDD-THP	Division
Option 3	DDD-THP	DDD-THP	TRBHA	Division
Option 4	Contractor	Contractor	TRBHA	Division

American Indian members with a designation as an individual with a SMI have a choice of receiving services based upon one of two service delivery options as shown in the table below:

	PH SERVICES	CRS SERVICES	BH SERVICES	LTSS
Option 1	Contractor	Contractor	Contractor	Division

Option 2	DDD-THP	DDD-AIHP	TRBHA	Division

The Contractor is responsible for coverage of services under this Contract for members who are American Indians enrolled with the Contractor.

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 457.1209, 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 Indian Health Service or a 638 tribal facility that provide services to members eligible for Title XIX enrolled with the Contractor that are reimbursed by the AHCCCS Division of Fee-For-Service Management and are eligible for one hundred percent (100%) Federal reimbursement.

The Contractor shall 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 457.1209, 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 457.1209, 42 CFR 438.14(c)(3)]. For the purposes of this section, “IHCP” does not include health care programs operated by the Indian Health Service or a 638 tribal facility that provides services to Title XIX members enrolled with the Contractor that are reimbursed by the AHCCCS Division of Fee-For-Service Management and are eligible for one hundred percent (100%) Federal reimbursement.

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 457.1209, 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 457.1209, 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. See Section D, Paragraph 59, 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 twenty-one (21) years receiving the EPSDT services.

For members who reside in an ICF/IID, the Contractor shall cover hearing aids prescribed by a physician (see CMS State Operations Manual, Appendix J, Guidance to Surveyors).

Augmentative and Alternative Communication (AAC) Services, Supplies, and Accessories
AAC systems represent services, supplies, and accessories as durable medical equipment (DME) components used to enhance communication which are aided speech generating devices (SGD). SGDs are further classified as digitized speech devices and synthesized speech devices, and both represent a covered benefit of Arizona Medicaid Title XIX Services for eligible members.
The scope of AAC services includes diagnostic, screening, preventive, and corrective services provided by or under the direction of a speech-language pathologist. Specific activities include evaluation for a recommendation of design, set-up, customization, and treatment related to the use of AAC systems. Provision of the AAC System includes installation, training, and device modification, repair and replacement as authorized.

AAC – Medical Necessity and Cost Effectiveness
The provision of AAC systems benefit includes coverage for all eligible members of all ages if the services, supplies, and accessories are considered medically necessary as defined in AHCCCS Rule R9-28-101 & R9-28-201. The Contractor shall provide medically necessary, cost effective and federally reimbursable AAC systems consistent with the requirements in rule, the Augmentative and Alternative Communication User Guide, the Augmentative and Alternative Communication Provider Guide, and the AdSS Medical Policy Manual, Policy 310-P Medical Equipment, Medical Appliances and Medical Supplies.

AAC – Prior Authorization
Prior authorization is required for AAC systems provided through the Contractor as specified in the AdSS Medical Policy Manual, Policy 310-P Medical Equipment, Medical Appliances and Medical Supplies.

Requests for authorization for Speech Language Pathologist (SLP) Assessments, on or before 12.31.20 as well as the authorization for and the provision of DME, DME installation, and the initial training hours will be completed by the Division.

Requests for any AAC service or system occurring after 12.31.20 will be completed by the Contractor.

The Contractor shall submit a report of the timeliness access standards for prior authorization determinations as specified in the AAC Utilization, Grievance, and Appeals Report in Section F, Exhibit F3, Contractor Chart of Deliverables.

Behavioral Health Services

Behavioral Health Service coverage is described in more detail in the AMPM Policy 310-B, AMPM Exhibit 300-2A, and AHCCCS' Behavioral Health Services Matrix. The Contractor shall provide medically necessary Behavioral Health Services to all members in accordance with AHCCCS and Division policies, A.A.C. R9-28 Article 11, and as described in Section D, Paragraph 11, Behavioral Health Services Program Requirements. The Contractor shall ensure all behavioral health services are delivered to members in an age and developmentally appropriate manner. Covered behavioral health services include, but are not limited to:

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 Exhibit F3, Contractor Chart of Deliverables.

Behavior Analysis: Behavior Analysis services are covered benefits for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Refer to the AMPM Policy 320-S.

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

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

a. Limits the individual's ability to be independent, and/or

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

Refer to the AdSS Medical Policy Manual, Policy 320-V.

The Contractor shall develop admission criteria for medical necessity which at a minimum includes the elements as outlined in the AdSS Medical Policy Manual, Policy 320-V. The Contractor shall submit the criteria for prior approval as specified in Exhibit F3, Contractor Chart of Deliverables. The Contractor shall publish the approved criteria as specified in AMPM Policy 320-V.

The Contractor shall also ensure provider practices align with the Secured BHRF requirements.

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.

Crisis Services**:** Crisis services must be accessible for individuals with Intellectual/Developmental Disabilities (I/DD).The Contractor is responsible for emergent transportation provided during the initial 24 hours of a crisis episode and any NEMT provided from a crisis service provider to another level of care, regardless of the timing within the crisis episode.

The Contractor is responsible for all other medically necessary services under this Contract related to a crisis episode, which may include follow-up stabilization services, after the initial 24 hours covered by the ACC-RBHA. The Contractor shall:

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

b. 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;

c. Ensure prior authorization is not required for emergency behavioral health services (A.A.C. R9-22-210.01), including crisis services;

d. Develop policies and procedures to ensure timely communication with ACC-RBHA and the Division for members who have engaged in crisis services;

e. Ensure timely follow-up and care coordination, including care coordination for MOUD for members after receiving crisis services to ensure stabilization of the member and appropriate delivery of ongoing necessary treatment and services;

f. Ensure Contractor staff are available twenty-four (24) hours per day, seven (7) days per week to receive notification of member engagement in crisis services and to provider member post-twenty-four (24) hour crisis stabilization services, care coordination and discharge planning, as appropriate;

g. Ensure documented follow up for the member within 72 hours after the member receives crisis telephone services, mobile crisis intervention, or discharges from a crisis setting as specified in AdSS Medical Manual Policy 590.

h. 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;

i. 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 crisis and safety plans, and ensuring engagement of outpatient treatment providers in responding to post-crisis care and treatment; and

j. 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.

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

There is a specific modifier(s) that 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 included. The Contractor shall educate its providers about the crisis modifiers(s) in order to ensure all appropriate costs are included in the capitation rates for the correct risk group.

Court Ordered Evaluation (COE) and Court Ordered Treatment (COT): : The Contractor is responsible for medically necessary, covered behavioral health services and treatment that is court ordered, but is not responsible for services associated with the pre-petition screening and COE. 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 Division 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 COT services provided. 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. The Contractor shall ensure the Pre-Petition Screening and COE processes are implemented and monitored in compliance with AdSS Medical Manual 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.

Refer to the AdSS Operations Manual, Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE, and the AdSS Operations Manual, Policy 423 for clarification regarding the financial responsibility for the provision of specific MH 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 See also the AdSS Medical Policy Manual, 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 Court Ordered Treatment (COT) to the Division. The Contractor shall submit the Outpatient Commitment COT Monitoring Report as required in Exhibit F3, Contractor Chart of Deliverables. The Outpatient Commitment COT Monitoring Report shall contain the following information:

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

b. Record number,

c. Contractor ID, Name,

d. Date by year and month,

e. Member name and demographics,

f. Member CIS and/or AHCCCS identification number,

g. New or existing court order and court order description,

h. COT start date, end date, court order reason and court order reason description,

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

j. Date of Incarceration ,

k. Court order expired,

l. COT review and court order treatment review description,

m. Transferred to IHS or Tribal 638 Facility,

n. Non-compliant,

o. Court order amended due to non-compliance,

p. Contractor contact person, email address,

q. Behavioral health category, behavioral health category description,

r. Age, age band, age band description, and/or

s. Funding source, funding source description,

t. 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 Nation, as applicable. The Contractor is encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for members of the tribes. See also, the AdSS Medical Policy Manual, Policy 320-U and the AdSS Operations Manual, Policy 423.

The Contractor shall develop policies, procedures 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 (Ch. 5, Article 4):

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

b. Processes for tracking the status of court orders,

c. Execution of court orders,

d. Judicial review processes.

The Contractor shall develop information that specifies where a behavioral health provider would refer an individual for a voluntary or involuntary evaluation, making it available to providers.

Out-of-State Placements for Behavioral Health Treatment: The Contractor shall notify the Division of out of state placements, or pending placements, and shall submit monthly progress updates of members who remain in out of state placement for behavioral health treatment and notify the Division when a member is discharged as specified in the AdSS Medical Policy Manual, Policy 450 and Section F, Exhibit F3, Contractor Chart of Deliverables, AdSS Medical Policy Manual.

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 fifteen (15) cumulative days during the calendar month. In accordance with 42 CFR 457.1201(e) and 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 access to behavioral health services at an IMD.

AHCCCS establishes the provider types AHCCCS recognizes as IMDs. AHCCCS has determined 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.

The Division will pay the Contractor the full monthly capitation for a member when the length of stay is no more than fifteen (15) cumulative days during the calendar month [42 CFR 438.6(e)]. The Contractor is prohibited from requiring a member to use an IMD. When the length of stay in the IMD is more than fifteen (15) cumulative days during the calendar month, the Division 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. The Division 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 fifteen (15) days.

When the length of stay in the IMD is more than fifteen (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, Exhibit F3, Contractor Chart of Deliverables. Refer to the AdSS Operations Manual, Policy 109 for further information on the IMD fifteen (15) day limit.

Inpatient Services: 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 age 22. These services are not subject to the fifteen (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 fifteen (15) day length of stay limitation on capitation applicable to enrollees over the age of 21 and below the age of 65.

Inpatient Hospital Service: In accordance with 42 CFR 438.3(e)(2)(i) through (iii), the Contractor may provide services in alternative inpatient settings that are licensed by the Arizona Department of Health Service/Division of Licensing Services (ADHS/DLS), in lieu of services in an inpatient hospital. Alternative settings shall be cost effective compared to non-IMD settings and provide developmentally appropriate services to individuals with I/DD and co-occurring behavioral health conditions.

The Contractor's policies and procedures shall ensure that in the event a covered behavioral health services or LTSS identified in a member's discharge plan is temporarily unavailable to a discharge-ready member in an inpatient or residential facility, the Contractor shall: 1) allow the member to remain in that setting until the behavioral health or LTSS service is available when the identified service is necessary for the safe discharge of the member from the facility; or 2) ensure that Contractor care management, intensive outpatient services, provider behavioral health case management, and/or peer service are available to the member while waiting for the desired service, if the identified covered service is not necessary to the safe discharge of the member from an inpatient or residential facility.

Rehabilitation Services: The Contractor shall provide rehabilitation services as described below.

Rehabilitation Services include:

a. Skills Training and Development and Psychosocial Rehabilitation Living Skills Training, Cognitive Rehabilitation;

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

c. Supported Employment. [Psychoeducational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)]. The Division similarly offers LTSS employment supports. To avoid the duplication of efforts, the member's Support Coordinator and Planning Team shall determine the service provider that best meets the member's needs for employment support. The determination and coverage responsibility will be documented in the member's Planning Document. Members' Support Coordinators are responsible for making any Vocational Rehabilitation referrals.

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:

a. Provider Behavioral Health Case Management;

b. Home Care Training Family Services (Family Support);

c. Self-Help/Peer Services (Peer Support);

d. Therapeutic Foster Care (TFC);

e. Unskilled Respite Care (the Contractor must report member utilization of Respite services to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables);

f. Transportation; and

g. Personal Care Services.

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, Therapeutic Foster Care (TFC) admission, continued stay, and discharge criteria for medical necessity which at a minimum includes the elements as outlined in AMPM Policy 320-W. The Contractor shall submit the criteria for prior approval as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

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

a. Behavioral Health Counseling and Therapy;

b. Assessment, Evaluation and Screening Services; and/or

c. Other Professional Services

The Contractor shall also provide behavioral health services as described in Section D, Paragraph 11, Behavioral Health Service Delivery Requirements.

Breast Reconstruction

The Contractor shall cover breast reconstruction surgery for the purposes of breast reconstruction post-mastectomy for members consistent with AMPM Policy 310-C.

Children's Rehabilitative Services

Members shall receive treatment for one or more of the CRS qualifying medical conditions in A.A.C. R9-28-203 through the Contractor. The Contractor shall refer members who are potentially in need of services related to CRS qualifying conditions, as specified in A.A.C. R9-22 Article 13, and A.R.S. Title 36 to AHCCCS/Division of Member and Provider Services (DMPS). The Contractor shall notify the member, or their parent/guardian/DR, when a referral to a specialist for an evaluation of a CRS condition will be made. Refer to ACOM Policy 426 for the processes used to process referrals for a CRS designation. The Contractor shall provide covered services necessary to treat the CRS qualifying condition as well as other services specified within this Contract.

The Contractor shall establish a process for the identification of members under the age of 21 with a CRS designation who have completed treatment for the CRS condition, and do not have any other CRS eligible conditions. The Contractor is responsible for notifying the Division of the date when a member with a CRS designation is no longer in need of treatment for the CRS qualifying condition(s) as specified in Section F, Attachment F3, Contractor Chart of Deliverables and AdSS Operations Policy Manual 426. The notification requirements specified above are applicable only to members under 21 years of age. In addition, the Contractor shall consider members with a CRS qualifying condition as members with special health care needs. Refer to Section D, Special Health Care Needs section. The Contractor shall accept historical CRS Identification (ID) numbers as alternative member IDs for claims processing, as applicable.

The Contractor shall ensure that individuals with a CRS qualifying condition(s) are identified, that a CRS referral is submitted to the Division, and that the member is assigned to a Multi-Specialty Interdisciplinary Clinic (MSIC) as the PCP as specified in A.A.C. R9-22 Article 13, and A.R.S. Title 36. A member may choose a different PCP other than the MSIC; however, the PCP must comply with AdSS Medical Policy 560. The Contractor shall notify the member when a referral to a specialist for an evaluation of a CRS condition is made. Refer to AdSS Medical Policy 426 for the processes used to process referrals for a CRS designation.

The Contractor shall provide covered services necessary to treat the CRS qualifying condition as well as other services specified within this Contract. The Contractor shall establish a process for the identification of members under the age of 21 with a CRS designation who have completed treatment for the CRS condition and do not have any other CRS-eligible conditions. The Contractor is responsible for notifying the Division of CRS Members With Completed Treatment, including the date when a member with a CRS designation is no longer in need of treatment for the CRS qualifying condition(s) as specified in Section F, Attachment F3, Contractor Chart of Deliverable and ACOM

Policy 426. The notification requirements specified above are applicable only to members under 21 years of age. In addition, the Contractor shall consider members with a CRS qualifying condition as members with SHCN. Refer to Section D, Paragraph 82, Special Health Care Needs. The Contractor shall accept historical CRS identification numbers as alternative member IDs for claims processing, as applicable.

Chiropractic Services

The Contractor shall provide chiropractic services to members under the age twenty-one (21) years when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. For members over the age of 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 enrolled members, Medicare approved chiropractic services shall be covered subject to limitations specified in 42 CFR 410.21.

Dialysis

The Contractor shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified End Stage Renal Disease 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.

EPSDT 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 twenty-one (21) years. Early and Periodic Screening, Diagnostic and Treatment (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, and family planning services, 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. A service does not need to *cure* a condition in order to be covered under EPSDT. Services that *maintain or improve* the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. This is particularly important for children with developmental disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly and chronic illnesses and conditions. Other, less common examples include items of durable medical equipment, such as decubitus cushions and bed rails. Such services are a crucial component of a good, comprehensive child-focused health benefit.

While rehabilitative services can meet a range of children's treatment needs, they can be particularly critical for children with developmental disabilities and co-occurring MH and SUD issues. Rehabilitative services are defined to include any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual *to the best possible functional level*.

Like other services covered under EPSDT, rehabilitative services need not actually cure a disability or completely restore an individual to a previous functional level. Rather, such services are covered when they ameliorate a physical or mental disability, as discussed above. Moreover, determinations of whether a service is rehabilitative shall take into consideration that a child may not have attained the ability to perform certain functions due to his/her developmental stage. That is, a child's rehabilitative services plan of care should reflect goals appropriate for the child's developmental stage.

Depending on the interventions that the individual child needs, services that can be covered as rehabilitative services include: community-based crisis services, such as mobile crisis teams, and intensive outpatient services; individualized MH and substance use treatment services, including in non-traditional settings such as a school, a workplace or at home; medication management; counseling and therapy, including to eliminate psychological barriers that would impede development of community living skills; and rehabilitative equipment such as daily living aids. For additional information, see:

https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention

The Contractor shall provide health care services through screening, diagnostic and medically necessary treatment for members twenty-one (21) years of age and older. These services include, but are not limited to, screening and treatment for hypertension; pneumonia; swallowing dysfunction; neurological disorders; 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 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 Title 9, Chapter 28, Article 2.

Emergency Alert System

The Contractor is responsible for providing monitoring devices or systems for members who are unable to access assistance in an emergency 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.

Emergency Services

The Contractor shall provide emergency services per the following [Section 1852(d)(2) of the Social Security Act, 42 CFR 457.1228, 42 CFR 438.114(b), 42 CFR 422.113(c)]:

a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a twenty-four hours a day, seven days a week (24/7) basis, for an emergency medical condition as defined by R9-22, Article 1[42 CFR 438.206(c)(1)(i)-(iii)]. Emergency medical services (physical and behavioral health) services, including Crisis Intervention Services, are covered without prior authorization.

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

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

d. Emergency transportation.

Per the Medicaid Managed Care regulations, 42 CFR 438.114, 422.113, 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 457.1228, 42 CFR 438.114(c)(1)(i), 42 CFR 438.114(c)(1)(ii)(A) – (B)]:

a. 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 under 42 CFR 438.114, or

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

Additionally, the Contractor shall not:

a. Limit what constitutes an emergency medical condition as defined in 42 CFR 457.1228 and 42 CFR 438.114, on the basis of lists of diagnoses or symptoms [42 CFR 457.1228, 42 CFR 438.114(d)(1)(i)-(ii)];

b. 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 ten (10) calendar days of presentation for emergency services. Claims submission by the hospital within ten (10) calendar days of the member's presentation for the emergency services constitutes notice to the Contractor. This notification stipulation is only related to the provision of emergency services; and

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

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 457.1228, 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 post-stabilization care [42 CFR 457.1228, 42 CFR 438.113 and 42 CFR 438.114(d)(3)].

For additional information and requirements regarding emergency services, refer to A.A.C. R9-22-201 et seq. and 42 CFR 438.114.

Emergency Triage, Treat, and Transport
Services associated with Emergency Triage, Treat and Transport (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.

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. The Contractor shall provide end of life care consistent with the AdSS Medical Policy Manual, Policy 310-HH.

Experimental Services
Neither the Division nor the Contractor covers 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 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 AdSS Medical Policy Manual, and consistent with the terms of the Section 1115 Demonstration 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 457.1230(d), 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. 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. Members do not require a prior authorization from the Contractor to receive family planning services and supplies from an out-of-network provider. However, the provider must be registered with AHCCCS. The Contractor shall submit a Sterilization Report as specified in AdSS Medical Policy Manual, Policy 420 and Section F, Exhibit F3, Contractor Chart of Deliverables.

Genetic Testing

The Contractor shall cover genetic testing and counseling when medically necessary. Genetic testing and counseling if medically necessary when criteria are met as delineated in AMPM Policy 310-II.

Home Health

The Contractor shall provide home health. This service shall be provided under the direction of a physician 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 the AdSS Medical Policy Manual 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. See the AdSS Medical Policy Manual, Policy 310-I.

Hospice Services

Hospice services provide palliative care for members and supportive care for 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. The Contractor is required to cover hospice, as well as to pay NF one hundred percent (100%) of the class-specific contracted rate when a member elects the hospice benefit. These services are covered for members who are certified by a physician as being terminally ill and having six (6) months or less to live.

A participating Hospice provider shall meet Medicare requirements and have a written provider contract with the Contractor. The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice qualifying condition. 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 services shall be provided by the Contractor. Attendant care services are covered by the Division and are not considered duplicative. The Contractor shall notify the Division when a member is referred for Hospice services.

Hospital

The Contractor shall provide hospital services as outlined in the Contract and policy. Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health emergency/crisis services. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services, and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, are also covered. Refer to the AdSS Medical Policy Manual, Policy 310-K for limitations on hospital stays.

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.

Hysterectomy

The Contractor shall cover medically necessary hysterectomy services as authorized by federal regulations 42 CFR 441.250 et seq. Refer to AMPM Policy 310-L and AdSS Medical Manual Policy 1001.

Immunizations

The Contractor shall provide medically necessary immunizations for adults twenty-one (21) years of age and older. Pharmacists and pharmacy interns 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. Pharmacists, 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. Refer to the AdSS Medical Policy Manual, Policies 310-M and 430 for current immunization requirements. The Contractor is required to meet specific immunization rates for members under the age of twenty-one (21) years, which are described in Section D, Paragraph 26, Quality Management and Performance Improvement. AHCCCS/DDD follows the recommendations established by the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP).

Laboratory Services

Laboratory services for diagnostic, screening and monitoring purposes shall be covered by the Contractor 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 licensure or a Certificate of Waiver.

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

The Contractor shall use laboratory testing sites that have either a Clinical Laboratory Improvement Amendments (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 ID number or denial of initial registration.

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

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

b. Clinical laboratory providers who do not comply with the requirements in Sections above, may not be reimbursed,

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

d. 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, Contractor shall use the data exclusively for quality improvement activities and health care outcome studies required and approved by AHCCCS.

Lung Volume Reduction Surgery (LVRS)

The Contractor shall cover LVRS, or reduction pneumoplasty, 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 obstetrics while they are pregnant. Members who are 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 the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. 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.

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

The Contractor shall inform all assigned pregnant members of voluntary prenatal HIV/AIDS testing and the availability of medical counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter, to encourage pregnant members to be tested and instructions about where to be tested. Semi-annually, the Contractor shall report to the Division the number of pregnant women who have been newly diagnosed as HIV/AIDS-positive for each quarter during the Contract year. This report is due as specified in Section F, Exhibit F3, Contractor Chart of Deliverables and Division Medical Policy Manual, Policy 410.

Medical Foods

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

Medical Marijuana

The Division does not cover medical marijuana as either a medical or pharmacy benefit. See AMPM Policy 320-M.

Medical Equipment and Appliances, Medical Supplies*, *and Prosthetic Devices

Medical equipment, including appliances and medical supplies, are covered under the home health benefit. Medical equipment including appliances, medical supplies and prosthetic devices shall be covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the AdSS Medical Policy Manual, Policy 310-P. Provision of medical equipment includes the equipment itself and completion of installation and training to the Member, as applicable.

The assessed need for medical equipment may include significant improvement of the quality of life for a member when accompanied by a comprehensive explanation of how the member will benefit from the equipment. Coverage of this service is based on assessed need, not a member's or the family's stated desires regarding specific services. Documentation of medical need submitted shall meet CMS medical record documentation requirements. Prosthetic devices shall be medically necessary and meet criteria as described in the AdSS Medical Policy Manual, Policy 310-P. Prosthetic devices must be medically necessary and meet criteria as specified in AdSS Medical Policy 310-JJFor individuals age twenty-one (21) years or older, the Division 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 which 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. See the AdSS Medical Policy Manual, Policy 1210.

Incontinence briefs shall be provided by the Contractor. For members over three (3) years of age and under twenty-one (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. In addition, for members who are twenty-one (21) years of age and older, incontinence briefs, including pull-ups and incontinence pads are covered in order to prevent skin breakdown as outlined in AdSS Medical Policy Manual 310-P and AdSS Medical Manual Policy 430. See A.A.C. R9-28-202 and the AdSS Medical Policy Manual, Chapters 300 and 400. Six (6) months prior to the member's twenty-first (21st) birthday, the Contractor shall notify members receiving incontinence briefs of the change in benefit, including steps to request the benefit continue at the previous level.

The Contractor shall ensure the provider network includes a choice of subcontractors for medical e equipment, medical appliances, medical supplies, and corrective appliances for members. The Contractor shall include, in the contract with the subcontractor, timeliness standards for the 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.

Members Transitioning from Home Opioid Treatment Program (OTP) to another Receiving OTP Requiring Guest Dosing

Guest dosing is consistent with SAMHSA's guidance regarding medication safety and recovery support.

Nursing Facility (NF) Services

The Contractor shall be responsible for identification of the need for placement in NF when the need for services is rehabilitative. While convalescent care should be considered short-term, the Contractor shall extend NF coverage as medically necessary. The Division will assess and identify the member's need for placement in NF and authorize NF services. If the Contractor disagrees with the Division's authorization decision, the Contractor may request a peer-to-peer review with the Division.

The Support Coordinator will communicate with the Contractor and the Contractor shall be responsible for providing a list of available contracted NF options. Add Refer to AMPM Policy 310-R. Members with an institutional level of need may opt to receive Home and Community Based Services (HCBS) instead of care in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID). The Contractor shall provide services in NFs, including religious non-medical health care institutions. NFs must meet DES insurance standards, including sexual abuse and molestation coverage refer to AMPM Policy 310-R. As of October 1, 2021, there are no providers registered as religious non-medical health care institutions.

The Nursing Facility Services benefit is covered under 42 CFR 440.155(b).

In lieu of a NF, when clinically appropriate, the member may receive HCBS, an alternative HCBS setting or an Assisted Living Facility. Community based services should be utilized to promote community integration for members. The Contractor shall coordinate with the Division for coverage when the member may require a Division covered HCBS in lieu of a NF, alternative residential setting or placement in an Assisted Living Facility.

NF services must be provided in a dually-certified Medicare/Medicaid NF, which includes in the per-diem rate: nursing services; basic patient care, including specialized supervision if required for member safety; enhanced behavioral supports; equipment and sickroom supplies; dietary services; administrative physician visits; non-customized DME; necessary maintenance and rehabilitation therapies; over the counter medications; social, recreational and spiritual activities; and administrative, operational medical direction services.

The Contractor shall ensure that, prior to admission of a member to a nursing facility, the nursing facility has performed a 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 nursing facility and/or needs specialized services. When the PASRR Level II evaluation determines that the member does not need the level of care provided in a nursing facility, 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 nursing facility, 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 nursing facility may result in Federal Financial Participation (FFP) being withheld from AHCCCS. Should withholding of FFP occur, AHCCCS will recoup the withheld amount from a Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the nursing facility, which admitted the member without the proper PASRR [42 CFR Part 483, Subpart C].

Nutritional Assessments and Nutritional Therapy

The Contractor shall provide nutrition services. Nutritional assessments are conducted as a part of the EPSDT screenings for members under age twenty-one (21) years, and to assist members twenty-one (21) years of age and older whose health status may improve with over- and under- nutritional intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. The Contractor shall cover nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary, according to the criteria specified in the AdSS Medical Policy Manual, Policy 310-GG to provide either complete daily dietary requirements or to supplement a member's daily nutritional and caloric intake. The Contractor shall report medically necessary nutritional supplements to the Division on a quarterly basis as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Oral Health/Dental Services

The Contractor shall adhere to the Dental Uniform Prior Authorization List and the Uniform Warranty List as outlined in the AdSS Medical Policy Manual, Policy 431. Requests for changes to the Dental Uniform Prior Authorization List shall be submitted to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

The Contractor shall provide all members under the age of twenty-one (21) years with all medically necessary dental services, including emergency dental services, dental screening, preventive services, therapeutic services, and dental appliances in accordance with the Dental Periodicity Schedule. The Contractor shall monitor compliance with the 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 whose members have been assigned to the provider's dental home for routine preventative care as outlined in the AdSS Medical Policy Manual, Policy 431. The Contractor must meet specific utilization rates for members as described in Section D, Paragraph 26, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified in writing when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice shall be sent. Members under the age of twenty-one (21) years may request dental services without a referral and may choose a dental provider from the Contractor's provider network.

For members twenty-one (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 dentist. These services would be considered physician services if furnished by a physician. Limited dental services are covered as described in the AdSS Medical Policy Manual, 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 twenty-one (21) years of age and older with emergency dental services, limited to $1,000 per member per contract year as outlined in the AdSS Medical Policy Manual, Policy 310-D1. Dental services provided to Tribal members within an 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 individuals twenty-one (21) years of age or older in an amount of $1,000.00 per member for each twelve (12) month period beginning October 1 through September 30. The Contractor shall provide dental services to

members according to the AdSS Medical Policy Manual and shall develop systems to monitor utilization to assure appropriate Medicaid payments.

For members who reside in an ICF/IID, the Contractor shall provide all standard and comprehensive medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services and dental appliances in accordance with 42 CFR 438.460. See CMS State Operations Manual Appendix J – Guidance to Surveyors: ICF/IIDs.

Orthotics

Orthotics shall be covered by the Contractor for members under the age of twenty-one (21) years as outlined in the AdSS Medical Policy Manual, Policy 430. Orthotics are covered for members twenty-one (21) years of age and older if all of the following apply:

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

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

c. 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 twenty-one (21) years 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.

Pursuant to 42 CFR 483.460(a) and (b), for members who reside in an ICF/IID, the Contractor shall cover all physician services, including annual physical, vision and hearing evaluations and, as ordered, eyeglasses and hearing aids. Limits may not be placed on these benefits for members

residing in an ICF/IID. Additionally, referrals to specialists and any subsequent physician orders will be covered by the Contractor for these members regardless of limits that may be imposed by AHCCCS, and regardless of the setting appropriate for the member, which may include where they reside. (See CMS State Operations Manual, Appendix J, Guidance to Surveyors.)

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. The Contractor is responsible for the coverage of podiatry services.

Post-stabilization Care Services

Pursuant to A.A.C. R9-28-202 and 42 CFR 457.1228; 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 of post-stabilization care services, except where otherwise noted in the Contract:

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

    i. Post-stabilization care services that were pre-approved by the Contractor;

    ii. Post-stabilization 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 (1) hour after being requested to approve such care or could not be contacted for pre-approval; and

    iii. 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.

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

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

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

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

iv. The member is discharged.

Pregnancy Terminations

Pregnancy termination shall be covered by the Contractor 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 2008].

The attending physician shall acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This certificate shall be submitted to the Contractor's Medical Director and meet the requirements specified in the AdSS Medical Policy Manual, 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 a 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 AdSS Medical Policy Manual, Policy 310-V.

The Contractor's Drug Lists and prior authorization processes shall comply with the AdSS Medical Policy Manual, Policy 310-V and the AdSS Medical Policy Manual, Policy 1024. An Over-the-Counter medication may be prescribed as defined in the AdSS Medical Policy Manual, Policy 310-V when it is equally effective and less costly than the same or similar prescription medication shall use the criteria as it is posted on the AHCCCS website [42 CFR Part 438].

The Contractor's pharmacy, 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 drug list information [42 CFR 457.1207, 42 CFR 438.10(i)(1)-(2)]:

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

b. Each drug that requires prior authorization approval shall be notated on the drug list;

c. The Contractor's Drug List shall reflect all AHCCCS approved AHCCCS Committee recommendations as follows:

   i. October P&T Committee approved changes shall be effective on January 1,

   ii. January P&T Committee approved changes shall be effective on April 1,

   iii. May P&T Committee approved changes shall be effective on October 1, and

   iv. Other changes as requested by AHCCCS and specified by date.

d. The process for obtaining F ederal and S tate reimbursable medications that are not included on the drug list;

e. The prior authorization form with directions for non-urgent and urgent requests; and

f. The prior authorization criteria for drugs evaluated for coverage under the Contractor's prior authorization program. The Contractor shall provide the criteria, or a link to the criteria, on the Contractor's website.

g. 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)]. See the AdSS Operations Manual, Policy 416.

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

a. Pharmacies shall not charge members 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.

b. Pharmacies shall not split bill the cost of a prescription claim to the Contractor's PBM for a member. The Contractor's PBM's Pharmacy Network shall not allow a member 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.

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

d. 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.

    i. 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

    ii. 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.

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

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

Pharmacy & Therapeutics Committee

Pursuant to Executive Order 2108-06 requiring Transparency and Eliminating Undue Influence by Pharmaceutical and Medical Device Companies; AHCCCS has developed and implemented a formal

Pharmacy & Therapeutics (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 prior authorization 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.

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. Refer to AdSS Medical Policy Manual 310-V.

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 see Section D, Paragraph 69, Encounter Data Reporting.

Therapeutic classes covered under supplemental rebate agreements are provided on the weekly NDC file sent to Contractors. The "preferred" products shall be available and notated on the Contractors' Drug Lists exactly as they are listed on the AHCCCS Drug List. The Contractor shall comply with the AdSS Medical Policy Manual, Policy 310-V. The Contractor shall ensure that all HCPCS codes for drugs and devices billed on a medical claim shall include the National Drug Code (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.

Medicare Part D

The Medicare Modernization Act of 2003 created the 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 full benefit dual eligible members, the Division 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, are covered subject to the requirements of the AdSS Medical Policy Manual, 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 in 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 AdSS Medical Policy Manual, Policy 310-V. Additional detail for coverage of Medicare Part D prescription medications is 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 and State reimbursable.

340B Drug Pricing Program

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

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

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

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

c. 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*.

PCP Services

PCP services are covered by the Contractor when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services and behavioral health [42 CFR 457.123(c), 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 primary care provider.

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 prior authorization requirements as specified in in the AdSS Medical Policy Manual, Policy 310-V, including the submission of ad hoc requests as requested by the Division.

Radiology and Medical Imaging

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

Rehabilitative and Habilitative Therapies

The Contractor is responsible for covering the following 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 outlined in the AdSS Medical Policy Manual, Policy 1250-E.

a. Occupational therapy is covered for all members in both inpatient and outpatient settings. Outpatient occupational therapy for members twenty-one (21) years of age or older are subject to visit limits per Contract year as described in the AdSS Medical Policy Manual, Policy 1250-E.

b. Physical therapy is covered for all members in both inpatient and outpatient settings. The Contractor is also responsible for coverage of Habilitative Physical Therapy for all members (21) years of age or older. Outpatient physical therapy for members twenty-one (21) years of age or older are subject to visit limits per Contract year as specified in AdSS Medical Policy Manual, Policy 1250-E.

c. Speech therapy is covered for all members in inpatient and outpatient settings as described in AdSS Medical Policy Manual, Policy 1250-E.

The Contractor shall also cover Habilitative Therapies provided by an MSIC.

Respiratory Therapy

Respiratory therapy is covered by the Contractor 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 Substance Abuse Transitional Facility is a class of health care institution that provides behavioral health services to an individual over eighteen (18) years of age who is intoxicated or may have a substance abuse problem (A.A.C. R9-10-101). The Contract shall cover medically necessary services provided by a Substance Abuse Transitional Facility.

Transplant Services and Immunosuppressant Medications

The Contractor shall cover 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. The Contractor shall maintain 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

The Contractor is responsible for coverage of transportation services. 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 a 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. Members with special mobility, sensory, or behavior needs shall be provided transportation in a vehicle adapted to those needs as required to facilitate adequate access to service. 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. Refer to the AMPM Policy 310-BB. 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 Services

The Contractor is responsible for coverage of treat and refer services. Treat and refer services are service interactions with a member who has accessed 911 or a similar public emergency dispatch number, but whose illness or injury does not require ambulance transport to an emergency department based on the clinical information available at that time. The interaction shall include: 1) documentation of an appropriate clinical and/or social evaluation, 2) a treatment/referral plan for accessing social, behavioral, and/or healthcare services that address the patient's immediate needs, 3) evidence of efforts to follow-up with the member to ascertain adherence with the treatment plan, and 4) documentation of efforts to assess member satisfaction with the treat and refer visit. Treat and Refer standing orders shall be consistent with medical necessity and shall consider member preference when the clinical condition allows.

Contracts with Treat and Refer Providers

The Contractor is required to enter into a contract(s) with Treat and Refer providers registered with AHCCCS to ensure statewide coverage.

Triage/Screening and Evaluation of Emergency Medical Conditions

These are Contractor covered services when provided by an acute care hospital, an IHS or 638 tribal facility and urgent care centers 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. The Division is committed to supporting AHCCCS' implementation of the Emergency Triage, Treat, and Transport (ET3) project payment model. The Contractor shall participate in the payment model and contract with at least one registered provider.

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 twenty-one (21) years. For members who are twenty-one (21) years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition. In addition, cataract removal, and medically necessary vision examinations, prescriptive lenses, and frames are covered if required following cataract removal.

Members shall have full freedom to choose, within the Contractor's network, a practitioner in the field of eye care, acting within the scope of their 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.

For members who reside in an ICF/IID, referrals to specialists and any subsequent physician orders will be covered by the Contractor, regardless of limits imposed above for Vision Service/Ophthalmology/Optometry noted above for members twenty-one (21) years of age and older. See CMS State Operations Manual Appendix J – Guidance to Surveyors: ICF/IIDs.

Well Preventative Care

Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams shall be covered by the Contractor for members twenty-one (21) years of age and older [refer to AMPM, Policy 411]. For members under twenty-one (21) years of age, the Contractor shall cover medically necessary services under the EPSDT Program [refer to AdSS Medical Policy Manual, Policy 430].

For members who reside in an ICF/IID, referrals to specialists and any subsequent physician orders will be covered by the Contractor, regardless of limits imposed above for Well Exams noted above for

members twenty-one (21) years of age and older. See CMS State Operations Manual Appendix J – Guidance to Surveyors: ICF/IIDs.

LONG TERM SERVICES AND SUPPORTS COVERED BY THE DIVISION

The Contractor shall understand the full array of LTSS the member may receive from the Division in order to collaborate effectively with the Support Coordinator in service planning and care coordination for members. The Division covers and provides Support Coordination and the LTSS briefly listed and described below. More detailed descriptions of LTSS listed below can be found in the AdSS Medical Policy Manual and in A.A.C. Title 9, Chapter 28, Article 2.

Attendant Care

This is a direct care service provided by a direct care worker for members who reside in their own or family's homes and includes homemaker services, personal care, general supervision and assistance, socialization and skills development, depending upon the member's assessed need. Attendant care services are not considered duplicative of hospice services. Attendant Care services are considered duplicative of Personal Care Services as outlined in Section D, Paragraph 9, Scope of Services, Behavioral Health Services, Support Services.

Spouses as Paid Caregivers: A service delivery model option where a member may choose to have attendant care services provided by his/her spouse.

Agency with Choice

A member-directed service delivery model option. Member's 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 will recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Independent Provider Model

A service delivery model option where Independent Providers contract directly with the Division via an Independent Provider Agreement (IPA). This model requires the use of a fiscal agent to manage the tax responsibilities and other employer obligations related to Independent Provider selection. The member or responsible person hires, orients, and trains each Independent Provider to deliver the support as authorized in the member's Planning Documents. The Division currently has a moratorium

on expansion of the Independent Provider Model, except in cases in which the Division approves the expansion to meet Network Standards.

Career Preparation Readiness

A service that provides assistance to eligible individuals to obtain community integrated employment. This service provides members currently participating in Center-Based Employment with the services and supports to assist them in making a progressive move into competitive and/or integrated employment. The Support Coordinator is responsible for Vocational Rehabilitation referrals for appropriate members prior to authorizing Career Preparation Readiness.

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 Group Homes or Assisted Living Facilities are not eligible for this service. This service is limited to a one-time benefit per five (5) 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.

Day Treatment and Training for Adult, Child (After School) and Child (Summer)

A service that provides specialized sensory-motor, cognitive, communicative, social interaction and behavioral training to promote skill development for some portion of a twenty-four (24)-hour day.

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. Behavioral and Occupational, Physical (for members under the age of twenty-one (21) years) or Speech Therapies may be provided as a part of or in conjunction with habilitation services. This includes habilitation services such as Day Treatment and Training (also known as day program) for individuals with I/DD and Supported Employment.

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.

Habilitative Therapies

The following habilitative therapies are available for members of any age. Habilitative therapy directs the member's participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Planning Document and is based on needs identified in these respective documents. Occupational, Physical (for members under the age of twenty-one [21] years) and Speech habilitative therapies are provided consistent with the AdSS Medical Policy Manual, Policy 1250-E. The Division delegates the provision of Habilitative Therapies to the Contractor, when delivered by an MSIC.

Occupational, Physical, and Speech Therapy

Therapy services provide medically necessary activities to develop, improve, or restore functions/skills. Therapy services require a prescription, are provided or supervised by a licensed therapist, and are not intended to be long term services. Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement and eating. Physical therapy, covered by the Division for members under the age of twenty-one (21) years, may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting and other movements. Speech therapy may address receptive and expressive language, articulation, fluency, eating and swallowing.

Focused Behavioral Treatment ("Habilitation Consultation," also known as "Hab C") and Comprehensive Behavioral Treatment ("Habilitation, Early Childhood Autism Specialized," also known as "ECM")

Consultative services and a variety of behavioral interventions are covered consistent with the requirements under the AdSS Medical Policy Manual, Policy 1250-E. While consultative services and behavioral interventions can be provided in a number of settings as identified in the AdSS Medical Policy Manual, Policy 1250-E, the Division makes every effort to provide the services necessary to assist a member to remain in his/her home or the family/caregiver's home and to participate in community activities. These are consultative services that are intended to complete an assessment and develop an intervention plan. The plan identifies strategies to strengthen the skills of the member and his/her family/caregivers.

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 Nursing Facility (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.

Home Health Services

This service includes nursing (i.e., private duty nursing for continuous nursing services), therapies, supplies and home health aide services are provided under the direction of a physician or Physician Assistant, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS) to prevent hospitalization or institutionalization. Home health services are provided on a part-time or intermittent basis, refer to AMPM 310-I.

Home Modifications

Home Modifications are services to physically modify the home setting that enables the member to function with greater independence and that has a specific adaptive purpose. An individualized home modifications plan is developed following the completion of a home assessment. The individualized home modifications plan will ensure that only appropriate medically necessary modifications are completed to the home. This plan also provides for a cost effective, predictable and medically beneficial service for the member. Physical modifications to the home are covered as determined through an assessment of the member's needs and as identified in the member's Planning Document. Home modifications must be medically necessary with the purpose of deterring the risk of increased utilization of HCBS or institutionalization, refer to AMPM Policy 1240-I.

Homemaker

This service is 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.

Medallion Program

The Medallion Program provides a member identification system for individuals who become separated from caregivers, including after-hours contact numbers. The identification items may be necklaces, bracelets, shoe slides or similar products worn on a person.

Private Duty Nursing
A service that provides nursing intervention that may include patient care, coordination, facilitation and education. These services are available to all members and are provided by a registered nurse or licensed practical nurse under the direction of the ALTCS member's PCP or physician of record [AMPM, Policy 1240-G].

Respite Care
The service is a direct care 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 twenty-four (24)-hours per day and is limited to 600 hours per benefit year.

Services for Members with a Dual Sensory (Vision and Hearing) Loss
Community Intervener service for members who have a dual sensory loss. 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. Supported Employment services are also available for behavioral health services covered by the Contractor. To avoid duplication of efforts, the member's Support Coordinator and Planning Team is responsible to decide if the Supported Employment service provider contracted with the Contractor or the Division best meets the member's needs for employment support. This decision will be documented by the Support Coordinator in the member's Planning Document. The Support Coordinator is responsible for Vocational Rehabilitation referrals for appropriate members prior to authorizing Supported Employment.

Center-based Employment
A service that provides paid work and vocational skill building at a facility-based, non-integrated setting where members are supervised and paid by the provider. Paid work is typically at a sub-minimum wage rate. The service may be provided on a time-limited or on an ongoing basis.

Employment Support Aid
A service that provides members with the one-to-one supports needed for the member to remain in his/her employment. These supports could include one or more of the following three (3) options:

personal care services, behavioral supports, and/or follow-along supports needed to maintain stable employment. The actual supports provided will be dependent upon member need; however, this service will primarily be used to provide on-the-job follow-along supports for members in competitive employment.

ALTERNATIVE HOME- AND COMMUNITY-BASED (HCBS) SETTINGS

Members may receive services in Alternative HCBS Settings as defined in A.A.C. R9-28 Article 1. Members will live in the most integrated and least restrictive setting possible and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

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

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final rules regarding requirements for Home and Community Based Services (HCBS) operated under section 1915 of the Social Security Act [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 long term services and supports (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 will use 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 members. These requirements impact ALTCS members receiving services in the following residential and non-residential settings:

Residential:

1. Nursing Supported Group Homes, and
2. Adult and Child Developmental Homes.

Non-Residential:

1. Adult Day Health Programs,
2. Day Treatment and Training Programs,
3. Center-Based Employment Programs, and
4. Group-Supported Employment Programs.

Contractors will be primarily responsible for the following, where applicable and as activities pertain to Contractor Covered Services:

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 quality management and workforce development departments,
4. Assessing and monitoring site-specific settings for compliance,
5. Reporting site-specific setting compliance to AHCCCS, and
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.

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 (3) residents. Refer to A.A.C. R6-6-1001 through R6-6-1019 and R6-6-1101 through R6-6-1119 and A.R.S. § 36-551.

Group Home for Individuals with I/DD
A community residential facility licensed by ADHS for up to six (6) residents that provides room, board, personal care, supervision and habilitation. The DD Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs for members who cannot physically or functionally live independently in the community. Refer to A.A.C. Title 9, Chapter 33, Article 1 and A.R.S. § 36-551.

Licensed Health Aide Services (LHA): LHA services are provided by the parent, guardian, or family member 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.

Nursing Supported Group Home for Individuals with Intellectual/Developmental Disabilities: A community residential facility contracted with DES for up to six residents that provides room, board, personal care, daily habilitation, supervision, and continuous nursing support and intervention. Refer to A.A.C. Title 9, Chapter 33, Article 1 and A.R.S. § 36-551.

Assisted Living Facility (ALF)
A residential care institution that provides supervisory care services, personal care services or direct 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:

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

b. *Assisted Living Centers*: 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 eleven (11) or more residents.

INSTITUTIONAL SETTINGS

For purposes of this Contract, Institutional Settings are Intermediate Care Facilities for ICFs/IID or NF.

Intermediate Care Facilities for Persons with Intellectual/Developmental Disabilities
A facility whose primary purpose is to provide physical and behavioral health, active treatment and rehabilitative services to IIDs.

10. SUPPORT COORDINATION

Support Coordination (also known as DDD case management) is the responsibility of the Division. Support Coordination is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates supports and services to meet a member's needs. The Support Coordination process involves review 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, Person-Centered Service Plan (PCSP) that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting [42 CFR 457.1230(c), 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 Support Coordination is to ensure involvement of the member/responsible person 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 Support Coordination is respect for the member's interests, needs, culture, language, and belief system. The planning team is an integral part of the development of the PCSP.

Support Coordination provided to members follows the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her

life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life shall be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, culture, language, preferences, strengths and needs. For members, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support.

Support Coordinators do not provide direct services to members but do authorize appropriate services and/or refer members to appropriate services.

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

Support Coordinators shall:

a. Respect the member and the member's rights;

b. Support the member to have a meaningful role in planning and directing his/her own supports and services to maximum extent possible;

c. Provide adequate information and teaching to support the member/responsible person to make informed decisions and choices;

d. Be available to answer questions and address service issues raised by the member or responsible person, including between regularly scheduled Person-Centered Service Plan (PCSP) meetings;

e. Provide a continuum of service options that support the expectations and agreements established through the PCSP process;

f. Educate the member/responsible person on how to report to the Contractor or Division the lack of availability of services or other problems with service delivery so that unmet needs can be

addressed as quickly as possible, as specified in AMPM Policy 1620-D and AMPM Policy 1620-E regarding requirements;

g. 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;

h. Advocate for the member/responsible person/significant others as the need occurs;

i. Allow the member and responsible person to identify their role in interacting with the service delivery system, including the extent to which the family/informal supports will provide uncompensated care;

j. Provide members with flexible and creative service delivery options;

k. Educate members/Health Care Decision Makers and Designated Representatives about member-directed options for delivery of designated services in accordance with AMPM Chapter 1300. These options shall be reviewed with members/Health Care Decision Makers for members living in their own homes at every PCSP meeting.

l. 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;

m. Educate members/responsible persons about abuse awareness and self protection;

n. 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;

o. 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;

p. Educate members/responsible person on End of Life care, person centered planning, services and supports including covered services and assist members in accessing those services in accordance with the AdSS Medical Policy Manual, Policy 310-HH;

q. 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); and

r. 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.

Housing

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. The Housing Specialist is an expert(s) on housing programs 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 statewide, and 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. Assisting 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 XIX/XXI Housing Subsidy Programs (e.g., scattered site vouchers, Community Living Programs), mainstream House Subsidy Programs (e.g., HUD Housing Choice Vouchers, local Public Housing Authority Programs); and market rate housing options;

b. Providing education and training to providers and support staff on housing programs 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 Subsidy Programs mainstream 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, reporting annually on the status of any affordable housing networking strategies and innovative practices/initiatives the Contractor elects to implement;

f. Acting as the Contractor's liaison to the AHCCCS Quarterly Housing Coordination Meeting led by the AHCCCS Director of Housing Programs as well as other ad hoc AHCCCS Housing Workgroups and initiatives;

g. Collaborating with the Division's Housing Specialist who serves as the liaison to local HUD approved Continuum of Care (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 Continuum of Care in identifying, engaging, and securing appropriate housing and services for members experiencing homelessness;

h. Advocating, planning, and coordinating with provider supportive services to ensure members in independent, AHCCCS, and mainstream subsidized housing programs, are offered appropriate services to maintain their housing; and

i. 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. 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 Act, Equal Opportunity, Non-Discrimination and other Federal and State housing laws;

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 Supportive Housing program; and

e. Current and emerging tools and best practices in permanent supportive housing and services.

11. BEHAVIORAL HEALTH SERVICE DELIVERY REQUIREMENTS

The Contractor shall ensure that all behavioral health services provided are medically necessary as determined by a qualified behavioral health professional. The Contractor's network shall include Master's and Doctoral level trained clinicians in the fields of social work, counseling, and psychology that are trained in implementation of best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma-related disorders, SUDs, sexual disorders, and special age groups such as transition age youth and members aged birth to five (5) years old.

Psychiatrists, psychologists, physician assistants, certified psychiatric nurse practitioners, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed behavior analysts, and licensed independent substance abuse counselors may bill independently. Other behavioral health professionals must be employed by or contracted with and bill through an AHCCCS registered behavioral health provider.

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 as outlined in the AMPM Policy 1050. Services shall be accessible and provided by competent individuals who are adequately trained and supervised, including treatment modalities for individuals with intellectual and developmental disabilities. 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, are linguistically appropriate, supports members in achieving their maximum level of independence and appropriately utilizes natural supports in the member's community. Members with developmental disabilities may not be denied access to these services based on their level of cognitive ability, their need for personal care, or other factors associated with the developmental disability.

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 sub-population of members served, the Contractor's behavioral health service delivery system shall incorporate the following elements:

a. The System Values and Guiding Principles;

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

c. 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 457.1222, 42 CFR 438.102(a)(1)(i)-(iv)] and the following:

   i. 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)];

   ii. Information the member needs in order to decide among all relevant treatment options;

   iii. The risks, benefits, and consequences of treatment or non-treatment, the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, [42 CFR 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(iv)];

d. Referral processes;

e. Regular and ongoing training for 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;

f. Behavioral health assessment and provide service and treatment planning as specified in AMPM Policy 320-O;

g. Coordination and provision of peer and family delivered support services, whether delivered within or outside of the member's identified health home;

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

i. Access to comprehensive care coordination across the continuum of healthcare and non-clinical healthcare-related needs and services;

j. Coordination and provision of quality health care services informed by evidence-based practice guidelines and in a cost-effective manner;

k. Coordination and provision of quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and implement a trauma-informed care approach;

l. Coordination and provision of preventative and health promotion services, including wellness services;

m. Organization, training, implementation, and documentation of provider involved trainings/implementation to increase outreach, identification, referrals, and provision of services to under and uninsured individuals;

n. Coordination and provision of 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 in as specified in AMPM Policy 1040;

o. Coordination and provision of disease/chronic care management support, including self-management support (refer to AMPM Policy 1023);

p. Provision of covered services to members in accordance with all applicable Federal and State laws, regulations, and policies, including those listed by reference in this Contract;

q. Coordination and provision of integrated clinical and non-clinical health-care related services; and

r. Implementation of health information technology to link services, facilitate communication among treating professionals, and between the health team and individual and family caregivers.

The Contractor shall employ a phased-in implementation approach, as directed by AHCCCS, to utilize the American Society of Addiction Medicine (ASAM) Criteria (Third Edition, 2013) for assessment, service planning, and level of care placement for members who have SUD or co-occurring mental health and SUD.

The Contractor shall submit, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, a Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child members. The Provider Case Management Plan shall include performance outcomes, lessons learned, and strategies targeted for improvement. Following the initial submission, subsequent submissions shall include an evaluation of the Contractor's Provider Case Management Plan from the previous year. Refer to AMPM Policy 570. For provider Case Management using the Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR approach, the appropriate modifier must be utilized. The Contractor and providers shall work together to ensure the modifier(s) are being included. For information on modifiers, see the Behavioral Health Services Matrix.

The Contractor shall adhere to the following Adult and Children's System of Care requirements, Guiding Principles and clinical guidance documents outlined below when providing services to adults and children:

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 system; system development efforts, programs, service provision, and stakeholder collaboration shall be guided by these nine principles.

The Contractor shall ensure use of:

Standardized validated screening instruments by PCPs. The Contractor shall implement validated behavioral health screening tools for PCPs to utilize for all adults to determine if further assessment for behavioral health services is necessary.

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.

Provider Case Management Services: Shall be based upon a member's acuity and service needs. The Contractor shall comply with the requirements for provider Case Management standards and caseload ratios as specified in AMPM Policy 570.

Psychosocial rehabilitation. The Contractor shall provide behavioral supports and living skills training to members and/or their families in order to maximize the member's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, protection against exploitation, budgeting, recreation, development of social support networks and use of community resources.

Centers of Excellence. The Contractor shall contract with Centers of Excellence which implement evidence-based practices and track outcomes for adult members with specialized healthcare needs, including Integrated Pain Management Center of Excellence that address behavioral and physical healthcare needs and opioid use disorder.

Implementation of Assertive Community Treatment (ACT), Supported Employment, and Peer-Run Organizations and Family-Run Organization services consistent with Substance Abuse and Mental Health Services Administration (SAMHSA) Best Practices.

Fidelity Monitoring: The Contractor shall complete annual Fidelity Monitoring consistent with (SAMHSA) Best Practices for the following:

a. ACT Teams,

b. Supported Employment,

c. Permanent Supportive Housing support services, and

d. Peer and Family Support Services.

The reviews shall be completed within the AHCCCS Fidelity Monitoring process.

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

The Contractor shall monitor the provision of the SAMHSA Evidence-Based Practices to ensure services are provided 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 as outlined in the AdSS Medical Policy Manual, Policy 430, and abide by the Division's Appointment Standards specified in AdSS Operations Manual, Policy 417.

The Contractor shall adhere to ACOM Policy 449 regarding 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 Guidance Tool. 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 promote service delivery for children ages birth through five, including screening and high need identification.

The Contractor shall provide and promote expansion of services for children age 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 Substance Use Disorders (SUD) screening tools to identify youth with substance use disorders and refer to SUD specialty services as appropriate.

The Contractor shall ensure the use of the Child and Adolescent Level of Care Utilization System (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 health home. 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 provide High Needs Case Managements and 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 prior authorization.

The Contractor shall also monitor providers administering the CALOCUS to ensure that they have completed the training. The Contractor shall engage in performance improvement 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:

Standardized validated screening instruments by PCPs. The Contractor shall implement validated screening tools for PCPs to utilize for all children to assess for behavioral health needs, social determinants of health, and trauma.

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.

Case management (provider level) services based upon a member's acuity and service needs. The Contractor shall comply with the requirements specified in AMPM Policy 570 for high needs case managers at the provider level assigned to serve children with high service intensity needs. Case management at the provider level must work in collaboration with the Support Coordinator.

Community-based behavioral health services. The Contractor shall develop and maintain minimum network capacity standards for Specialist Support and Rehabilitation Services Providers.

a. The Contractor shall develop and maintain minimum network capacity standards for Specialist Support and Rehabilitation Services Providers,

b. The Contractor shall develop and maintain minimum network capacity standards for Generalist Support and Rehabilitation Services Providers, and

c. The Contractor shall develop and maintain minimum network capacity standards for Therapeutic Foster Care (TFC). The Contractor shall utilize TFC as an alternative to more restrictive levels of care when clinically indicated.

Centers of Excellence. The Contractor shall contract with Centers of Excellence which implement evidence-based practices and track outcomes for children with specialized healthcare needs.

Fidelity monitoring

a. Implement AHCCCS-approved methodology for in depth quality review, including necessary practice improvement activities as directed by the Division.

b. Implement protocols for Child and Family Team 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 CTDS numbers by the billing provider. The Contractor shall collaborate with schools and contracted providers to determine the extent of the services to be provided in individual schools. 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. Contractors 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 programing 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 its Website Certification deliverable as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Reference Document Websites

Additional reference documents in providing services to Children and Adolescents with I/DD can be found on the following web sites:

a. American Academy of Pediatrics at: https://www.aap.org.

b. American Academy of Child and Adolescent Psychiatry at: http://www.A.A.C.ap.org/.

c. Center for Disease Control at: https://www.cdc.gov/.

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 substance use disorder 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 substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder 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 substance use disorder 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 substance use disorder 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 substance use disorder 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 457, 42 CFR Part 438, and AdSS Operations Manual, Policy 110. The Contractor shall submit documentation which demonstrates compliance with mental health parity as promulgated under 42 CFR Part 438 and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Additionally, the Contractor shall submit a Parity Analysis Deficiency Report as specified in Section F, Exhibit 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. The Contractor may be required to participate with and respond to inquiries from the Division, AHCCCS

and/or an AHCCCS contracted consultant regarding Contractor policies and procedures requiring review to determine compliance with mental health parity regulations.

Further, 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 substance use disorder 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. 42 CFR 457.1201(e).

Additional Contractor Responsibilities

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

Access to Behavioral Health Services

The Contractor is responsible for collaborating with TRBHAs regarding referrals and follow-up activities, as necessary, for members identified by the Contractor as needing behavioral health evaluation and treatment. The Contractor is responsible for providing transportation to a member's first behavioral health evaluation appointment if a member is unable to provide their own transportation.

AzSH Discharges

Members who are residing in the AzSH and who require physical health services that are not provided by the AzSH during their stay, will receive services at Valleywise Center. The Contractor shall provide reimbursement for medically necessary physical health services for populations served under this Contract under one (1) 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. MIHS will be assigned to provide primary care services for all members residing in the AzSH.

2. In the absence of a contractual agreement, the enrolled entity shall be responsible for coordination of care, prior authorization 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 AzSH residents will be provided by Valleywise Medical Center and shall be reimbursed by the Contractor regardless of prior authorization or notification. Physical health related pharmacy services for AzSH residents will be provided by the AzSH in consultation with the Contractor. The Contractor responsible for the physical health services is responsible for such payment.

The Contractor shall monitor and coordinate care for enrolled members who are admitted to the AzSH, awaiting admission, and monitor those who have been discharged or determined discharged ready from AzSH as outlined in the AdSS Medical Policy Manual, Policy 1020. The Contractor shall ensure member discharge is complete. The Contractor Care Manager shall immediately begin discharge coordination and facilitation upon AzSH 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, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, AzSH Monitoring Report.

Conditional Release Plan

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 the AdSS Medical Policy Manual, Policy 1020, provide high touch care management for members on Conditional Release from the AzSH consistent with the CRP

issued by the assigned county Superior Court. This includes, but is not limited to, coordination with AzSH for discharge planning; participating in the development of CRPs; member outreach and engagement to ensure compliance with the approved CRP; attendance in outpatient settings 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, Exhibit 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 outlined in the AdSS Medical Policy Manual, Policy 1020 who is responsible for collaboration with AzSH and remediation of identified concerns. The Contractor may not delegate the Care 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:

a. Involuntary evaluation/petitioning;

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

c. Execution of court order; and

d. Judicial review.

Community Service Agencies

The Contractor may contract with community service agencies for the delivery of covered behavioral health services. Refer to the AHCCCS Medical Policy Manual, Policy 965, for more information and limitations.

Coordination of Care

The Contractor shall ensure that procedures are in place for ensuring that a member's behavioral health services are appropriately provided, are documented in the member's record are tracked by the case manager and included within the member's Service and Treatment Plans. The Contractor shall also have procedures in place for ensuring communication occurs between the case manager, the PCP and behavioral health providers and other agencies and involved parties. See the Division's AdSS Medical Medicaid Policy Manual, 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 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 behavioral health professional to assess, develop a care plan and preserve the current placement, if possible, when a member presents new or existing challenging behaviors in a non-behavioral health setting. When attempting to place a member in a Nursing Facility or Alternative HCBS Setting, the Contractor shall disclose all information that pertains to the behaviors demonstrated by members. Refer to AdSS Policy 310-R. The Contractor shall ensure a behavioral health professional provides consultation to a member's assigned Support Coordinator upon request or as needed to ensure coordination of care.

Evidence Based Practice Programs and Practices (EBPP)
The Contractor shall develop, manage, and monitor provider use of Evidence Based Programs and Practices 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 Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, Asexual, Pansexual, and Allies (LGBTQIA+) community;
        ii. Individuals who are involved with the Criminal Justice system; and
        iii. Adolescents; and
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; and
11. Gender based treatment.

EBPP shall be used by all providers for the treatment of SUD, including MAT, 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 and DDD, to utilize the ASAM Criteria (Third Edition, 2013) for assessment, service planning, and level of care placement for members who have SUD or co-occurring mental health and SUD.

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.

Monitoring, Training, and Education

The Contractor is responsible for training the Behavioral Health Coordinator, 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:

a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems,
b. The Arizona Vision-12 Principles for Children Behavioral Health Service Delivery,
c. The 10 Principles of Wraparound,
d. Covered behavioral health services and referrals,
e. How to access services,
f. Petitioning and court-ordered evaluation processes provided for in A.R.S. Title 36 (Ch. 5, Article 4), and
g. How to involve the member and their family in decision making and service planning.

Training for Behavioral Health Coordinator, 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.

Non-Title XIX/XXI Behavioral Health Services
Service provision for Non-Title XIX/XXI services for Contractor enrolled members is provided by the ACC-RBHA. Non-title XIX/XXI services include room and board, mental health services (formerly known as traditional healing), auricular acupuncture, childcare, and supportive housing rent/utility subsidies and relocation services. The Contractor shall have established processes in place to refer members to the ACC-RBHA for Non-Title XIX/XXI services. The Contractor shall assist members with how to access these services and shall coordinate care for the member as appropriate.

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

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 permanent housing placement. The Contractor shall be responsible for complying with all

AHCCCS or Division 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 quarterly Division and AHCCCS Housing Meeting and submit Housing deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall submit 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 with housing needs who have been identified as homeless or imminently homeless by the Contractor's network of providers. 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 Administrator 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. The Support Housing Report shall include the following:

a. Date of Referral,
b. Member Name,
c. AHCCCS ID,
d. HMIS ID Number, if available,

e. Member included on Contractor High-Cost High Needs Roster,
f. SMI Indicator,
g. Needs assessment score from VI-SPDAT, LOCUS, or other approved screening tool, if assessed,
h. If the member has designated housing navigation or supportive services,
i. Member's current housing situation including homelessness,
j. Referral or Intervention Provided and Outcomes (up to two),
k. Date of housing placement or resolution,
l. CoC meeting attendance and representative in attendance,
m. Include criteria used to determine members in need of PSH, total number of members in need statewide, and number of Housing Specialists at the provider level to meet the need, and
n. The criteria used to determine the number of Housing Specialists working for the health plan to meet the needs of the member and the total number of Housing Specialist staff working for the plan.

PCP 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, prior authorization 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 MAT 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

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

Referrals

The Contractor shall develop, monitor and continually evaluate its processes for timely referral, assessment, service and treatment planning for behavioral health services. The Contractor shall have identified staff members to assist the member in coordinating necessary services and to ensure that requests for behavioral health services made by the member, family, 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. See Paragraph 35, Appointment standards and AdSS Operations Manual, Policy 417. A direct referral for a behavioral health assessment may be made by the member or any health care professional. See the AdSS Medical Policy Manual, Policy 320-O for provisions regarding behavioral health assessment and treatment/service planning.

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 Division appointment standards with appropriate interventions to prevent a member from experiencing a lapse in medically necessary psychotropic medications.

Respite in BHRF and Outpatient Clinics

The Contractor shall ensure that behavioral health residential facilities (BHRF) or outpatient clinics (clinics) provides respite care to a child without a medical history and physical examination and exempts the BHRF or clinic from specified licensure requirements if a child is only receiving respite services, pursuant to State Bill 1388.

The provisions shall include:

a. BHRF shall provide respite care to a child for increments of less than five (5) consecutive days and not more than 12 days in a 90-day period without a medical history and physical examination.

b. Permits a clinic to provide respite care to a child for up to 10 continuous hours per day between 6:00 A.M. and 10:00 P.M. without a medical history and physical examination.

c. A child is receiving only respite services, a BHRF or clinic is exempt from all of the following licensure requirements in relation to the child's respite stay:

    1) providing counseling services;
    2) providing a discharge order and summary;

3) providing medication information to a child for whom medication assistance is required;
4) requirements for a review of the child's medication regime by a medical practitioner;
5) preparing and posting a food menu more than 24 hours in advance of food service; and
6) tuberculosis screening of the child.

d. Stipulates that a parent, guardian or custodian must be provided documentation of any incidence of illness, physical injury, use of emergency safety response or unacceptable behavior that occurs during the child's respite stay.

e. Requires a respite care provider to be given a list of the child's medications and allergies and emergency contact information on the child's arrival.

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 (including DDD Subcontracted Health Plan and the DES/DDD Tribal Health Program) 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 the AdSS Medical Policy Manual, Policy 520.

The Contractor shall establish policies and procedures for the transition of American Indian members who transition to another DDD Health Plan, the DES/DDD Tribal Health Program, or TRBHA for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members.

The policies and procedures shall address, at a minimum, the following:

a. Guidelines for when a transition of the member for ongoing treatment is indicated;

b. Protocols for notifying all entities of the member’s transfer, including reason for transfer, diagnostic information and medication history;

c. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to all entity's requests for additional medical record information;

d. Protocols for transition of prescription services, including but not limited to notification to all entities of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination shall ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with a prescriber and that all relevant member medical information, including the reason for transfer, is forwarded to prescriber prior to the member's first scheduled appointment with prescriber; and

e. Contractor monitoring activities to ensure that members are appropriately transitioned to another DDD Health Plan, the DES/DDD Tribal Health Program, or TRBHA for care.

Quality Management

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

Sharing of Data

On a recurring basis (no less than quarterly based on adjudication date), the Division shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services, during the member's enrollment period, from another contractor or through the Division's FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

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/DCAIR, OHR. The Contractor shall ensure consistency with the requirements as specified in AdSS Medical Policy 320-R. Additionally, the Contractor shall cooperate with the Independent Oversight Committee (IOC) in meeting its obligations as specified in AdSS Medical Policy 320-R and submit the deliverables related to Special Assistance Services reporting as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

SUD Services
The Contractor must utilize the American Society of Addiction Medicine (ASAM) Criteria (Third Edition, 2013) in SUD assessments, service planning, and level of care placement. See the AdSS Medical Policy Manual, Policy 320-O.

Coordination with the DCS
The Contractor is responsible for coordination of an urgent behavioral health response for child members involved with DCS as required in the AdSS Medical Policy Manual, Policies 540 and 541.

Specific Requirements for Behavioral Health Services for Members in Legal Custody of DCS
Upon notification by DCS that a child member has been taken into custody, the Contractor shall ensure that each member and family is referred for ongoing behavioral health services for a period of at least six (6) months, unless services are refused by the guardian or the member is no longer in DCS custody. A minimum of one (1) monthly documented service is required. Services shall be provided to:

a. Mitigate and address the child's trauma,

b. Support the child's temporary caretakers,

c. Promote stability and well-being, and

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

The Contractor is responsible for coordination of a Rapid Response for child members involved with DCS. Refer to AdSS Medical Policy Manual, Policy 541.

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 in DCS custody who have not received a Rapid Response, the Contractor shall ensure that a Rapid Response is delivered. The Contractor shall report reconciliation activities to the Division on the Rapid Response Reconciliation Reporting as specified in AdSS Operations Manual Policy 449 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall monitor monthly reconciliation reports for trends and address any identified systemic issues that prevent members in DCS custody from receiving Rapid Response within 72 hours.

The Contractor shall submit a narrative and data summary (Behavioral Health Utilization and Timeframes for Members in the custody of DCS), as specified in ACOM Policy 449 and Section F, Attachment F3, Contractor Chart of Deliverables, that specifically addresses successes and barriers associated with behavioral health service delivery. Data elements should include utilization data as well as any identified trends related to members in DCS custody, including but not limited to QOC, access, timeliness, and availability

The Contractor shall submit deliverables regarding member's access to behavioral health services and provider requests to terminate (DCS and Adopted Children Services Reporting: Access to Service) as specified in AdSS Operations Manual Policy 449 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall submit a deliverable to report the number of calls and emails received by the Children's Services Liaison and the afterhours line related to children in the custody of DCS (DCS and Adopted Children Services Reporting: Calls and Emails) as specified in ACOM Policy 449 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor is required to perform a recurring review of identified DCS members in shelter care or other out of home placement to determine appropriateness of current placement and supports, with the goal of achieving increased stability/permanency. Services and supports shall be provided as needed to either stabilize current placement or support transition to a more appropriate setting/level of care.

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.

12. OUT-OF-STATE SERVICES

Members who are temporarily absent from Arizona without authorization from the Contractor are eligible for long term services and support in accordance with 42 CFR 431.52. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Contractor shall report all absences of more than 30 days from the State to the Division for the Division to coordinate with the ALTCS eligibility office for a determination of continued eligibility as specified in AMPM Policy 1620.

The Contractor shall notify the Division before placing a member in an out-of-state placement and the Division will submit a written request to AHCCCS/DHCM as specified in AMPM Policy 1600 to facilitate a coordinated review with the Division of Member Services for any potential eligibility impact.

13. MEMBER AND FAMILY INVOLVEMENT AND PARTICIPATION

The Contractor is required to have member (peer) and/or family member representation 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. Each Committee shall include at least two (2) peer and/or family members that may not be employed by the Contractor. The Contractor shall submit a Roster of Peer and Family Committee Members as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Peer and Family Support Specialists

The Contractor shall comply with all terms, conditions and requirements in this Contract while embedding the following principles in the design and implementation of an integrated health care service delivery system:

a. Behavioral and physical service providers and peer support providers must share the same mission to place the member's whole-health needs above all else as the focal point of care;

b. Utilize peer and family delivered support services/specialists and embed peer and family voice at all levels of the system. The Contractor shall submit information noting Peer Support/Recovery Support Specialist involvement in service delivery as specified in Section F, Exhibit F3, Contractor Chart of Deliverables; and

c. Maximize the use of existing peer and family support infrastructure, including Peer and Family Run Organizations.

The Contractor shall ensure that provider sites where services are delivered shall have regular and ongoing member and/or family participation in decision making, development and enhancement of customer service.

Governance Committee

The Contractor shall have a formal Governance Committee with a purpose of directing the strategic planning, process improvement, decision making for the health care delivery system. The Governance

Committee shall meet at least twice a year and interact with Contractor leadership. The Governance Committee membership shall include at least two (2) peers and family members who are or have been participants in the Contractor's health care delivery system. Contractor staff shall not serve as peer or family member representatives on the Governance Committee.

ALTCS Advisory Council

The Contractor shall assist in recruiting an ALTCS DD member to serve on the AHCCCS ALTCS Advisory Council as requested by the Division. Upon Division request, the Contractor shall provide council members with orientation and ongoing training that includes sufficient information and ensures understanding of Council member responsibilities.

Councils and Organizations

The Contractor shall participate in and support existing councils and organizations as directed by the Division to promote a member-focused, collaborative effort to enhance the service delivery system in local communities.

Existing councils and organizations include, but are not limited to, the following:

a. Developmental Disabilities Advisory Council established pursuant to A.R.S. § 36-553;

b. Independent Oversight Committees established pursuant to A.R.S. § 41-3801 and § 41-3804;

c. Interagency Coordinating Council for Infants and Toddlers established pursuant to the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. Chapter 33, Part C; and

d. Developmental Disabilities Planning Council established pursuant to Executive Order 2009-08.

The Contractor shall develop, participate in and/or support other community-based councils or groups, such as a Member Advocacy Council, to engage members, family members and professionals, representative of the population and community served, to provide feedback on issues and opportunities to improve the Contractor's services and delivery system.

The Contractor shall provide members and their families with information regarding councils and organizations, orientation and training to facilitate their participation, and additional resources to inform them how they can impact and influence service delivery systems in their local communities (e.g., participation in National Core Indicator [NCI] survey).

For all councils and organizations the Contractor develops, participates in and/or supports, including those that operate independently of the Contractor, the Contractor shall request and provide all agendas, meeting minutes and lists of attendees for inclusion into an annual report of activities to the Division.

The Contractor shall submit an Annual Report of Member Council Activities related to the Contractor's development, participation in and support of such councils and organizations as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

For Contract Year Ending 2021 and thereafter, the Contractor's annual report shall include:

a. Activities completed by the Contractor,

b. Activities completed for each Council/Organization by district or county,

c. Schedule of activities,

d. Participants in activities,

e. Membership for Councils,

f. Information related to orientation and training provided by the Contractor or Council/Organization,

g. Contractor goals and objectives for the upcoming contract year,

h. Goals and objectives as stated by the Council/Organization,

i. An evaluation of the prior year's plan, goals and objectives as stated by the Contractor for each Council/Organization,

j. How the Contractor used input from the Councils/Organizations to influence and inform change, and

k. Actions the Contractor took to increase member participation on councils,

14. COLLABORATION WITH SYSTEM STAKEHOLDERS

The Contractor must create an ongoing stakeholder dialogue to learn, grow and improve the integrated approach and enhance the coordination and integrated delivery of physical and behavioral

health services with Division-provided LTSS. This collaboration is the means to routinely receive feedback on: the impact of the programs; developing relationships with the community; policy and procedure changes to improve inter-agency coordination and programs; and development of innovative solutions to problems. The Contractor shall develop policies and procedures that outline the collaborative processes on how the Contractor will engage and develop action plans with community agencies and communicate the plans to the Division to improve the quality of services for members. Examples of community agencies to collaborate with include, but are not limited to, the following:

a. ADOC and Adult Probation;

b. ADJC and Juvenile Probation;

c. Arizona Department of Education, Schools, or Other Local Educational Authorities (as necessary);

d. Tribal Social Services;

e. Pilot Parents; and

f. Raising Special Kids.

The Contractor shall work in partnership with all Contractors and TRBHAs statewide to meet, agree upon and reduce to 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 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, and
    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. 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. PCP Name and Phone Number

12. Diagnoses (Medical and Behavioral Health).

13. Medications.

Collaboration with Behavioral Health Crisis System
In addition, the Contractor shall collaborate with ACC-RBHAs, ACC-RBHA-selected Regional Crisis Provider(s) and local law enforcement and first responders to develop crisis response protocols which shall, at a minimum, address:

a. Availability of Contractor's ACC-RBHA-selected Regional Crisis Provider(s) for the Contractor's members;

b. Training and education to the ACC-RBHA-selected Regional Crisis Provider(s) and local law enforcement/first responders about the special needs of this population; and

c. Development of jail diversion efforts, to include education on the availability of treatment options.

Participation on Division and AHCCCS Workgroup and Stakeholder Meetings
The Contractor shall participate on Division and AHCCCS workgroup and stakeholder meetings as requested by the Division and AHCCCS.

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, Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans.

The Contractor shall include a summary of its collaboration with system stakeholder activities into the Annual Report of Member Council Activities, referenced in Section D, Paragraph 13, Member and Family Involvement and Participation above, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

15. SPECIAL HEALTHCARE NEEDS

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health services of a type or amount beyond that required by members generally. All members covered under this Contract are

individuals with special health care needs. The following populations meet this definition including, but not limited to:

a. Members with qualifying Children's Rehabilitative Services (CRS) conditions,

b. Members diagnosed with HIV/AIDS,

c. Members diagnosed with opioid use disorder, separately tracking pregnant members and members with co-occurring pain and opioid use disorder,

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

e. Members enrolled in the Arizona Long Term Care System:

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

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

g. Members who are enrolled in the CHP,

h. Members who transition out of the CHP up to one (1) year post transition,

i. Members with an SMI designation,

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

k. Members with a Seriously Emotionally Disturbed (SED) diagnosis flag in the system or an SED designation,

l. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS),

m. Members diagnosed with Severe Combined Immunodeficiency (SCID), and

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

Some members, including children with CRS-qualifying medical conditions, may require additional care coordination to manage complex care needs. For these members, health care service delivery involves multiple clinicians, covering the entire continuum of care. In addition to a PCP, these members 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 for members with CRS-qualifying medical conditions, for example, often 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 members, it is imperative that there be integrated health information and care coordination for the member. Services shall be provided using an integrated member/family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes the following elements:

a. 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;

b. 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; and

c. Collaboration with individuals, groups, providers, organizations and agencies charged with the administration, support or delivery of services for individuals with special health care needs.

The Contractor shall provide services using an integrated person- and family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes a process for the Support Coordinator, Contractor, Division and other service providers to exchange clinical, medical and

administrative information necessary to develop and implement the Service Plan, consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care.

The Contractor shall implement mechanisms to comprehensively assess each member to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate health care professionals with the appropriate expertise [42 CFR 457.1230(c), 42 CFR 438.240(c)(2) 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 457.1230(c), 42 CFR 438.208(b)(4) and (c)(3)].

The Contractor, in collaboration with the Support Coordinator, shall ensure that members determined through assessment to need a course of treatment or regular care monitoring have an individualized physical and behavioral treatment plan or service plan. In addition, the Contractor shall conduct multi-disciplinary staffing for members with challenging behaviors or health care needs [42 CFR 457.1230(c), 42 CFR 438.208(c)(3)].

For members 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 457.1230(c), 42 CFR 438.208(c)(4)]. For members transitioning, see Section D, Paragraph 8, Member Transition Activities.

The Contractor shall have a methodology to identify providers willing to provide a patient centered medical home for members 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:

a. Accessible,
b. Continuous,
c. Coordinated,
d. Family-centered,
e. Comprehensive,
f. Compassionate, and
g. Culturally effective.

For members determined in need of a Care Manager, the Contractor will participate with the Support-Coordinator led, multi-disciplinary team meetings to design, develop and periodically update a comprehensive assessment of a member's developmental and health status, strengths and needs. The Contractor Care Management staff will actively assist and monitor to ensure that care authorized through the Contractor is completed as recommended in the Service Plan.

The Contractor shall identify and implement industry-leading tools, technology, and strategies that improve clinical and administrative outcomes and reduce unnecessary costs for members with special health care needs. The Contractor's commitment to the rights of members, family involvement and continuous quality improvement shall be evident in its policies, practices and decision-making.

16. GUIDELINES, POLICIES AND MANUALS

All Division and AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this Contract. Guidelines, policies and manuals are available on the Division and AHCCCS websites. The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to the Division's and AHCCCS' guidelines, policies and manuals. The Contractor is responsible for complying with all requirements set forth in these sources as well as with any updates to any or all of these documents. In addition, linkages to Division and AHCCCS rules, statutes and other resources are available through the Division's and AHCCCS' websites. Upon adoption, updates will be available on the websites. In the event the applicable AdSS policy is not available or current the Contractor shall follow applicable ACOM/AMPM guidance.

17. MEDICAID SCHOOL BASED CLAIMING

Pursuant to an 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 Individualized Education Program as medically necessary for the child to obtain a public school education. Refer to AMPM, Chapter 7100.

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 (occupational therapy, physical therapy and speech/language therapy); 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 a Medicaid-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. The intent of services or member-specific goals for the services should not be duplicative. Contractor Care Managers and the Support Coordinators working with children who have special needs must 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.

18. PEDIATRIC IMMUNIZATIONS AND THE VACCINES FOR CHILDREN PROGRAM

Through the Vaccines For Children (VFC) program, the Federal and State governments purchase and make available to providers at no cost, vaccines for Medicaid children under age nineteen (19) years. The Contractor shall not utilize Medicaid funding to purchase vaccines for members under the age of nineteen (19) years. If vaccines are not available through the VFC program, the Contractor shall contact the Division for guidance. Any provider licensed by the State to administer immunizations, may register 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 the 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 PCP for members under the age of nineteen (19) years.

Whenever possible, members shall be assigned to VFC registered providers within the same or a nearby community within respective GSA. When that is not possible, the Contractor must develop

processes to ensure vaccinations are available through a VFC enrolled provider or through the appropriate County Health Department. In all instances, the vaccines are to be provided through the VFC program. The Contractor must develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

Arizona State law requires the reporting of all immunizations given to children under the age of nineteen (19) years. Immunizations shall be reported at least monthly to the ADHS Immunization Registry. Reported immunizations are held in a central database known as 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 must educate its provider network about these reporting requirements and the use of this resource. Refer to AMPM 430.

19. STAFF REQUIREMENTS

The Contractor shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all Contract requirements. For the purposes of this Contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 457.1285, 42 CFR 438.610 (a)- (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The Contractor is obligated to screen employees and subcontractors to determine whether they have been excluded from participation in Federal health care programs as specified in Section D, Paragraph 66, 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 Division 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 the Division as specified in Section G1, Special Terms and Conditions, Section 44, Sanctions.

The Contractor shall have staff available twenty-four hours a day, seven days a week (24/7) to work with the Division, AHCCCS and/or other State agencies such as ADHS/Bureau of Medical Facilities on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardy, 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 ability 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. Division Compliance Coordinator shall be notified and provided 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 must notify the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, prior to moving functions outside the State of Arizona. The notification must include an implementation plan for the transition. The Contractor shall be responsible for any additional costs associated with onsite audits or other oversight activities which result when required systems are located outside of the State of Arizona.

A Contractor's individual staff member is limited to occupying a maximum of two (2) Key Staff positions, meaning a staff member occupying two (2) positions within this single line of business, unless prior written approval is obtained from the Division. The following Key Staff positions are exempt from this limitation:

1. Chief Financial Officer,
2. Communications 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. Encounter Manager,

9. Information Systems Administrator,
10. Justice System Liaison,
11. Member Services Manager,
12. MSA Administrator,
13. Network Administrator,
14. Provider Claims Educator,
15. Provider Services Manager,
16. Transplant Coordinator, and
17. Workforce Development Administrator.

The Contractor may propose shared positions across lines of business (including non-Medicaid lines of business); however, the Division retains the final authority to approve or reject such a proposal. When submitting its functional organizational chart, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, the Contractor shall document, for each Key Staff position, the portion of time allocated to each Medicaid contract as well as all other lines of business.

The Contractor shall inform the Division in writing as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, when an employee leaves one (1) of the Key Staff positions listed below. The name of the interim contact person and qualifications shall be included with the notification. Unless otherwise approved by the Division, an individual staff member is limited to occupying an interim position for no longer than six (6) months from the date of notification submitted to the Division. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place with a revised Organization Chart complete with Key Staff.

The Contractor shall inform the Division in writing as specified in Section F, Exhibit 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, telephone number, email address, or the location.

The Division 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. The Division will not permit any Contractor staff to hold positions which may present a conflict of interest. Further, the Division may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of this Contract and/or Division and relevant AHCCCS policies.

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/Chief Operating Officer (COO)/Chief Executive Officer (CEO). The local CEO shall have the authority and ability to prioritize and direct work performed by Contractor staff and work performed under this Contract through a management service agreement or through a delegated agreement.

At a minimum, the following staff is required:

Key Staff Positions

Administrator/COO/CEO who is located in Arizona and directly oversees 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/COO/CEO is accountable to the Division for compliance with the requirements and obligations under this Contract. The Administrator/COO/CEO is limited to holding one (1) position, which is either the Administrator/COO/CEO for the line of business related to this Contract, or the Administrator/COO/CEO for the line of business related to this Contract and the affiliated Medicare D-SNP. Otherwise, the Administrator/COO/CEO is prohibited from holding any other position in any other line of business.

Medical Director/Chief Medical Officer (CMO) who is an employee of the Contractor, located in Arizona and who is an Arizona-licensed physician in good standing. The CMO shall provide oversight and management of the Clinical, Quality Management and MM components of the Contractor. This includes oversight of the Adult and Children's Healthcare Administrators, as well as oversight of physical health services and behavioral health services under this Contract. The CMO shall collaborate with the Adult and Children's Healthcare Administrators when designing the appropriate infrastructure and staffing resources in order to ensure that expertise for all services under this Contract are available and integrated within the organization.

Adult Healthcare Administrator who is located in Arizona and is an Arizona-licensed health care professional or a social worker in good standing, or has a bachelor's degree in social work, psychology, special education, family studies or related degree, with expertise in the adult physical and behavioral healthcare or LTSS systems, and who has experience working with individuals with I/DD. The Adult Healthcare Administrator is responsible for design and oversight of the adult delivery system for members eighteen (18) years of age and older and reports directly to the CMO. The Adult Healthcare Administrator shall ensure coordination of needed crisis services, address barriers to delivery of health care services, and ensure coordination with system stakeholders.

Children's Healthcare Administrator who is located in Arizona and is an Arizona-licensed health care professional or a social worker in good standing, or has a bachelor's degree in social work, psychology, special education, family studies or related degree, with expertise in the children's physical and behavioral healthcare or LTSS systems, and who has experience working with individuals with I/DD. The Children's Healthcare Administrator is responsible for design and oversight of the children's delivery system for members from birth through twenty (20) years of age and reports directly to the CMO. The Children's Healthcare Administrator shall oversee the children's service delivery system, address barriers to delivery of health care services, and ensure coordination with system stakeholders.

Chief Financial Officer (CFO) who is located in Arizona and responsible for oversight of the budget, accounting systems and financial reporting requirements.

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.

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 quality of care issues as related to dental services. The Dental Director may be an employee or subcontractor of the Contractor but may not be from the Contractor's delegated dental subcontractor.

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. Refer to Section D, Paragraph 66, Corporate Compliance. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position.

Dispute and Appeal Manager who is located in Arizona and is responsible for managing Grievance and Appeal System processes, as specified in the Grievance and Appeal System and who is responsible for forwarding all requests for hearing with the required information to AHCCCS and the Division. Any staff reporting to this position and who manage and adjudicate disputes and appeals

must also be located in Arizona. This individual shall collaborate with AHCCCS and the Division 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 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. Refer to Section D, Paragraph 29, Grievance and Appeal System.

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 the AdSS Operations Manual, Policy 104.

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, coordinating the tracking and submission of all Contract deliverables, fielding and coordinating responses to Division inquiries, coordinating the preparation and execution of Contract requirements such as Operational Reviews (ORs), random and periodic audits and ad hoc visits.

Quality Management (QM) Manager who is located in Arizona and is an Arizona-licensed registered nurse, physician or physician's assistant in good standing or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ), and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. The QM Manager is limited to holding one (1) position for the line of business dedicated to this Contract and shall not hold any other position for any other line of business. The QM Manager shall have experience in quality management and clinical investigations. The QM Manager shall have a direct hierarchical 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 BHPs to meet the requirements of the QM program. QM staff shall report directly to the QM Manager. The primary functions of the QM Manager position are:

a. Ensure individual and systemic quality of care,

b. Conduct comprehensive quality-of-care investigations,

c. Conduct onsite quality management visits/reviews,

d. Conduct Care Needed Today/Immediate Jeopardy investigations,

e. Integrate quality throughout the organization,

f. Implement quality improvement as it pertains to QM related focus areas,

g. Resolve, track and trend quality of care grievances.

Performance/Quality Improvement Manager who is located in Arizona, has a direct reporting relationship to the Contractor's CMO/Medical Director and who is a CPHQ by the NAHQ or CHCQM by the American Board of Quality Assurance and Utilization Review Physicians, or comparable education and experience in health plan data and outcomes measurement.

The Performance/Quality Improvement (QI) Manager is responsible for quality improvement for direct hierarchical reporting relationship activities and for staff conducting the quality management work. Staff reporting to this position shall have knowledge of both physical and behavioral health service delivery, and be appropriately qualified (education/certification/professional experience) to meet the Division's quality improvement contractual and policy requirements and shall be located in Arizona. 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/Quality Improvement Manager are:

a. Focus organizational efforts on improving quality performance measures,

b. Develop and implement PIPs,

c. Utilize data to develop intervention strategies to improve quality outcomes and member satisfaction, and

d. Report quality improvement/performance outcomes.

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 the Division 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.

Behavioral Health Coordinator who is a behavioral health professional as described in Health Services Rule A.A.C. R9-10-101, and is located in Arizona. This position is not designed to supplant the role of the Support Coordinator or Care Manager in coordinating behavioral health services for assigned members. Rather, this position's responsibilities shall include, but are not limited to: being the Contractor's primary point of contact to provide *Plan-level* leadership in working with behavioral health providers and other member-serving agencies involved to address barriers to crisis and other behavioral health care raised by members, family members and adoptive parents; working collaboratively with network managers to reduce out-of-state placements; referral assistance; and is actively involved in managing out-of-state placements. This position shall also serve as the Liaison for children in DCS custody.

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 Division 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.

Maternal Child Health (MCH) 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 Health Care Quality (CPHQ) or Certified in Health Care Quality and Management (CHCQM) certification. Staff reporting to this position must be appropriate to meet the MCH contractual and policy requirements, and quality and performance measure goals, and must be located in Arizona. MCH staff must either report directly to the MCH Coordinator or the MCH Coordinator must have the ability to ensure that MCH requirements are met. The MCH Coordinator may also serve as the EPSDT Coordinator. The primary functions of the MCH 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.

Medical Management Manager who is located in Arizona and is a registered nurse, physician, or physician's assistant in good standing. This position manages all MM requirements under Division policies, State regulations and Contract including, but not limited to: application of appropriate medical necessity criteria; concurrent review; discharge planning; care coordination; disease management; prior authorization 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 prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards. This position shall

serve as the single point of contact for out-of-home and out-of- state placements. Sufficient local staff reporting to this position must be in place to meet MM requirements.

Care Management Manager who is located in Arizona and is an Arizona registered nurse with experience in providing care management and coordination to individuals with I/DD or other special healthcare needs. This position is responsible for all care management and coordination activities, including the coordination with assigned Support Coordinators for LTSS administered by the Division. This position also provides clinical and programmatic leadership to Care Management Staff of the Contractor to ensure that appropriate documentation, tracking and monitoring meets all care management and coordination requirements.

Transition Coordinator who is located in Arizona and 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 the AdSS Operations Manual, Policy 402.

Transplant Coordinator who is an Arizona licensed registered nurse in good standing and who is responsible for the timely review and authorization of transplant services in accordance with Division policy and State regulations. Refer to the AdSS Medical Policy Manual, Policy 310-DD.

Member Services Manager who is located in Arizona and leads a team of member service representatives to coordinate communications with members and appropriate areas within the organization or subcontractors to respond to/resolve member inquiries/problems in a timely, effective and courteous manner. This position is also responsible for meeting Telephone Performance Standards, required under the Contract.

Court Coordinator who is located in Arizona and who is the single point of contact for information specific to the court's disposition for eligible members (e.g., Drug Court, MH Court, Criminal Proceedings), coordination of COE and COT, and who communicates court related follow-up/requirements to Contractor staff.

Network Administrator who is located in Arizona and who manages and oversees network development, network sufficiency and network reporting functions. This position ensures network sufficiency and that appointment and access standards (including ADA accessibility standards) are

met, develops network resources in response to identified unmet needs, and ensures a member's choice of providers.

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 program. Sufficient local staffing under this position shall be in place to ensure providers receive assistance and appropriate and prompt responses. See Section D, Paragraph 32, Network Management.

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 State and Federal requirements,

b. Develop processes for cost avoidance,

c. Ensure minimization of claims recoupments, and

d. Ensure claims processing timelines are met.

Encounter Manager who shall ensure Division encounter reporting requirements are met. Sufficient staffing under this position must be in place to ensure timely and accurate processing and submission of encounter data and reports to the Division.

Provider Claims Educator who is located in Arizona and facilitates the exchange of information between the grievances, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator are:

a. Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and Electronic Funds Transfer (EFT);

b. Educate contracted and non-contracted providers on available Contractor resources such as provider manuals website, and fee schedules;

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.

Information Systems Administrator who is responsible for information system management including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all data and data exchange elements. Sufficient staffing reporting to this position shall be in place to ensure timely and accurate information systems management to meet system and data exchange requirements.

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, and 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 with intellectual and developmental disabilities.

Cultural Competency Coordinator who is responsible for implementation and oversight of the Contractor's Cultural Competency Program and the Cultural Competency Plan.

Communications Administrator who is responsible for media inquiries, public relations, policy development, implementation and oversight of all social networking and marketing activities.

MSA Administrator who is responsible for oversight of the MSA subcontractor and is the Contractor's Key Contact for Division coordination and who is not employed by the MSA. **This position is only**

required when the Contractor subcontracts with an entity for delegated Plan functions under a MSA.

Tribal Coordinator is located in Arizona and is the Contractor's liaison with tribal nations and tribal providers, promoting services and programs to improve the health of American Indian members as outlined in Section D, Paragraph 27, Medical Management. The Tribal Coordinator assists in the planning and provides support to statewide American Indian Forums concerning issues that are specific to tribal behavioral health and physical health services.

Office of Individual and Family Affairs Administrator/Member Liaison Coordinator who is located in Arizona and has lived experience receiving behavioral health services and/or lived experience as a family member navigating who is a primary caregiver or natural support and experienced in a public behavioral health system; and experienced in working with individuals including members, families, youth, advocates, and other community members. As an advocacy department, this individual shall work within the Contractor to promote a vision of recovery, resiliency, empowerment, and wellness. The OIFA Administrator shall take an overarching approach to incorporate the perspective of lived experience with behavioral health challenges in all programs, policies, and procedures. This individual shall oversee Contractor OIFA activities in support of the AHCCCS OIFA mission, and OIFA Alliance initiatives.. This individual shall ensure staff members directly reporting to this position are sufficient to fulfill the responsibilities of the role. This position shall regularly report directly to the Executive/Senior Leadership Teams on all OIFA activities. At a minimum, the following staff shall report directly to the OIFA Administrator/Member Liaison Coordinator: 1) Adult Behavioral Health Member Liaison; and 2) Child Behavioral Health Member Liaison.

In support of the OIFA mission, the OIFA Administrator/Member Liaison Coordinator, and sufficient staff under this position, shall:

1. Build partnerships with Direct and educate on the vision for the OIFA Department ensuring its mission is integrated into the programs, policies, and practices of the Contractor,
2. Cultivate new relationships and nurture existing relationships with individuals, families, youth, and community members key stakeholders to promote recovery, resiliency, and wellness,
3. Assemble and Facilitate a Member Advocacy Council and assist and participate in the Contractor's Governance Committee, and establish structures and mechanisms as necessary to increase the member and family voice in areas of leadership, service delivery and Contractor decision-making committees and boards,

4. Identify and create other opportunities for member and family member participation including boards, committees, workgroups, and meetings to ensure representation of the peer and family perspective in programs and services,
5. Advocate for service delivery and environments that are supportive, welcoming, person-centered, trauma-informed, and recovery-focused,
6. Communicate and collaborate with members and families to identify concerns and remove barriers affecting service delivery or member satisfaction, Advocate for service environments that are supportive, welcoming and recovery oriented by implementing TIC service delivery approaches and other initiatives,
7. Oversee the provision, and ensure the availability of, peer support services and family support services by having access to utilization reports and other necessary means to monitor, track, and trend these services, Communicate and collaborate with members and families to identify concerns and remove barriers that affect service delivery or member satisfaction,
8. Guide the development, implementation, and monitoring of PROs and FROs as defined in the the AHCCCS Policy Dictionary, oversee the provision, and ensure the availability of, Peer Support services and Family Support services by having access to utilization reports and other necessary means to monitor, track, and trend these services,
9. Create an OIFA strategic plan in alignment with the Division's OIFA strategic plan and submit as specified in Section F, Attachment F3, Contractor Chart of Deliverables, Oversee, monitor, and provide assistance in the support and development of PROs and FROs as defined in the AHCCCS Contract and Policy Dictionary. Create an OIFA Strategic Plan in alignment with the Division's OIFA Strategic Plan and submit as specified in Section F, Attachment F3, Contractor Chart of Deliverables,
10. Actively collaborate and participate with in projects, initiatives, and events with the Division's, Office of Individual and Family Affairs,
11. Work with other Contractor's OIFAs in recognition of the interconnected relationships that providers have with multiple health plans Collaborate with the AHCCCS Office of Human Rights (OHR) and the IOC, provide information to regional IOCs, and attend IOC meetings, and
12. Participate and collaborate as a member of the OIFA Alliance on all projects, initiatives and events with the Division's, OIFA, and w ork towards their common goals with other Contractors' OIFAs in recognition of the interconnected relationships that providers have with multiple health plans.

13. Oversee OIFA deliverables specified in Section F, Attachment F3, Contractor Chart of Deliverables.
14. Collaborate with the OHR and the IOC, provide information to regional IOCs, and attend IOC meetings.

Workforce Development Administrator who is located in Arizona and is responsible for developing and implementing contractually required training and workforce development programs for the Contractor and its subcontracted providers. The Workforce Development Administrator shall have a professional background, authorities, and ongoing training and development needed to lead the Workforce Development Operation (WFDO) as specified in the 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 Workforce Development Administrator shall have a Professional Development Plan containing workforce development related training and development objectives. All personnel directly reporting to the Workforce Development Administrator having WFD roles (e.g., training managers, coordinators, specialists) shall have a Professional Development Plan.

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

1. An organization chart complete with the Key Staff positions. The chart must include the person's name, title, location, and portion of time allocated to the Division, each AHCCCS Contract and other lines of non-Medicaid business.

2. A functional organization chart of the key program areas, responsibilities and reporting lines (including functions performed by subcontracted entities), responsibilities and reporting lines.

A listing of all Key Staff to include the following:

a. Individual's name;

b. Individual's title;
c. Individual's telephone number;

d. Individual's email address;

e. Individual's location(s);

f. Documentation confirming applicable Key Staff functions are filled by individuals who are in good standing (for example, a printout from the Arizona Medical Board webpage showing the CMO's active license); and

g. A list of all Key Staff functions and their locations; and a list of any allowable functions that have moved outside of the State of Arizona in the past Contract Year.

Additional Required Staff
Division Liaison(s). This position is the single point of contact for the Division to respond and resolve access to care and care coordination concerns. The Contractor shall maintain sufficient staffing to respond to concerns raised by the Division to the Contractor's Division Liaison within 2 (two) business days unless a shorter timeframe is indicated by the Division.

Employment Staff are designated as the subject matter experts on employment supports, services, and resources within the Contractor's service area.

Prior Authorization staff to authorize health care services. This staff shall include but is not limited to Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. The staff will work under the direction of an Arizona-licensed physician.

Concurrent Review staff who are located in Arizona and who conducts inpatient medical necessity reviews. This staff shall, include but is not limited to, Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. This staff will work under the direction of an Arizona-licensed physician.

Care Managers who are Arizona licensed registered nurses in good standing, social workers or individuals with a minimum of two (2) years' experience in providing care management services to Members determined in need of care management. Care Managers participate in integrated, person-centered care planning services and care coordination for members in collaboration with assigned Support Coordinators for members determined to be high cost/high risk, or as requested by the assigned Support Coordinator.

Housing Specialist is designated as the subject matter expert on the provision of housing and housing resources to Members within the Contractor's service area as specified in Section D, Paragraph 10, Support Coordination.

Member Services staff to enable members to receive prompt resolution of their inquiries/grievances.

Legal Counsel, including both in-house and outside (as applicable) Legal Counsel, who are responsible to provide 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 these individuals with the Key Staff deliverables, as outlined below, and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Meeting Attendance

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

Staff Training

The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill the requirements of the Contract. Staff training shall be designed to develop a qualified, knowledgeable, skilled, and culturally competent workforce. The Contractor shall maintain evidence of training activities, the Division reserves the right to request training logs and other evidence of training verification.

The Contractor shall provide initial and ongoing staff training that includes an overview of the Division, Division Policy and Procedure Manuals, this Contract and state and federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with

members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns. Contractors shall ensure that procedures are developed, which include scripts that guide staff through the process of addressing quality of care and/or service concerns. These procedures may include, but are not limited to:

a. Internal subject matter experts that can address member concerns,

b. Available resources (e.g., stakeholder resources, Contractor webpages, etc.) that can assist members to know what services are available, how to access available services and where they are available,

c. How to file complaints regarding quality or service concerns.

All transportation, authorization, care management, member services and other personnel involved directly with coordinating care for members must be trained in the geography of Arizona 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.

Contractor personnel who investigate alleged incidents in any of the following facilities, ICF/IIDs, SNFs, ALFs, and Group Homes 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 is in compliance with the requirements set forth by AHCCCS. The Division reserves the right to audit these processes at any time, including during Operational Review 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., the Contractor's Care Managers and Customer/Member Service Staff) to be trained in identification of suicide risk using nationally recognized training materials (e.g., SafeTalk).

20. WRITTEN POLICIES AND PROCEDURES

The Contractor shall develop and maintain written policies and procedures consistent with the requirements in this Contract for each functional area, and consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies and procedures. All policies and procedures shall be reviewed at least annually by the Contractor to ensure that the Contractor's written policies reflect current practices.

All medical and quality management policies shall be approved and signed by the Contractor's Medical Director/CMO. All other policies shall be dated and signed by the Contractor's Administrator/COO/CEO 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/COO/CEO, Medical Director/CMO or CFO.

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

21. 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 ACA, 45 CFR Part 92, 42 CFR Part 457, 42 CFR Part 438 and related state requirements including the AdSS Operations Manual, Policies 404, 406 and 433. All member information must be written or provided using person-first language. The Contractor shall ensure that it takes reasonable steps to provide meaningful access to each individual with 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 Language Access Plan as specified in Section D, Paragraph 23, Cultural Competency. 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 92.201(c)]. For significant communications and publications, the Contractor shall comply with the nondiscrimination notice provisions in 45 CFR 92.8. In addition to the general requirements set forth in Section D, Paragraph 21, Member Information, the Contractor shall implement all other activities necessary to comport 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 TTY/TDD 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/TDD which shall be available 24hr/7days a week. The Contractor is prohibited from having separate phone numbers for physical health and behavioral health services or issues.

All informational materials prepared by the Contractor shall be approved by the Division and submitted as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Refer to the AdSS Operations Manual, Policies 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, use of auxiliary aids such as TTY/TDD and American Sign Language [42 CFR 457.1207, 42 CFR 438.10(d)(4)].

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

a. That oral interpretation is available for any language;

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

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

d. How members may access the services above [42 CFR 457.1207, 42 CFR 438.10(d)(5)].

All written materials to members shall be written in easily understood language, use font size of at least twelve (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 457.1207, 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 457.1207, 42 CFR 438.3(d)(3)]. These written 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 the availability of written translation or oral interpretation services to understand the

information with 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:

a. Member Handbooks

b. Provider Directories

c. Consent forms

d. Appeal and Grievance Notices

e. Denial and Termination Notices

When there are program changes, notification shall be provided to members at least thirty (30) days before implementation [42 CFR 457.1207, 42 CFR 438.10(g)(4)].

For consistency in the information provided to members, the Contractor is required to utilize AHCCCS required definitions for managed care terminology [42 CFR 457.1207, 42 CFR 438.10].

Social Networking Activities
Should the Contractor engage in Social Networking Activities, the Contractor shall adhere to the requirements for Social Networking Activities as described in the AdSS Operations Manual, Policy 425 and submit deliverables as specified in Section F, Exhibit 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 the AdSS Operations Manual, Policies 404, 406, and 416, and submit deliverables as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

The Division provides a direct URL website hyperlink to the below information to members via the Division's website. The Contractor shall notify the Division in writing when there is a change in a URL for the following information as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

a. Contractor's main website page for the line of business covered under this Medicaid Contract,

b. Contractor's Member Handbook, and

c. Contractor's Formulary.

The Contractor shall publish, on its website, a listing of individual providers who are formally trained in or specialize in the diagnosis of Autism Spectrum Disorder (ASD) on its website. This website 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 Arizona Department of Economic Security (DES) /Division of Developmental Disabilities (DDD). At a minimum, the listing shall include the following fields: Group Practice Name, Address, Phone Number, Provider Name, 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 with this 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:

a. Group Practice Name (or Agency Name),
b. Address,
c. Phone Number,
d. Provider Name,
e. Treatment Type, and
f. 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 with the 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 these specialized services. The Division may, at its discretion, request evidence that the Contractor verify the accuracy of website provider information and services as listed.

Member and Provider Directory

The Contractor shall provide the following information, in hard copy or electronically, to each member/responsible person or household within ten (10) business days of receipt of notification of the enrollment date [42 CFR 457.1207, 42 CFR 438.10(g)(3)(i)–(iv)]:

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 AdSS Operations Manual 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 AdSS Operations Policy 406 [42 CFR 438.10(g)(1)-(2), 42 CFR 457.1207, 42 CFR 438.10(c)(4)(ii), 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 the Division for approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Upon the initial case management assessment, and annually thereafter, the DDD Support Coordinator 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 AdSS Operations Manual Policy 404 and AdSS Operations Manual Policy 406, and 42 CFR 438.10(e)(2).

A *Provider Directory*, which at a minimum, includes those items listed in the AdSS Operations Manual, Policy 406 [42 CFR 457.1207, 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 specific in the AdSS Operations Manual, Policy 406 [42 CFR 438.10(g)(3)(i)–(iv)]. The written notification shall be sent to members within ten (10) 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 457.1207, 42 CFR 438.10(f)(1)].

The Contractor shall have information available for potential members as specified in the AdSS Operations Manual, Policies 404 and 406 [42 CFR 438.10(f)(4)].

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.

***Community Resource Guide**:* The Contractor shall develop a Community Resource Guide that is updated quarterly and contains community resource information applicable to the population in the assigned GSA and is provided in paper format when requested. The Community Resource Guide shall be provided on the Contractor's website as specified in ACOM Policy 404. The Contractor shall utilize the AHCCCS-Approved Statewide Closed-Loop Referral System (CLRS) and actively promote provider network utilization of the CLRS to properly refer members to Community Based Organizations (CBOs) providing services to address member HRSN.

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 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) as specified in AdSS Medical Policy Manual, Chapter 400 and AMPM Exhibit 400-3.

Member Newsletter

The Contractor shall develop and distribute, at a minimum, two (2) member newsletters during the Contract year. Member Newsletters shall be developed in accordance with the AdSS Operations Manual, Policy 404.

Member Rights

The Contractor shall, on an annual basis, inform all members of their right to request the information below [42 CFR 457.1220, 42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(a)(1) and (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.

a. An updated Member Handbook at no cost to the member; and

b. The Provider Directory as specified in the AdSS Operations Manual, 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 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 his or her 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 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 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(c)].

22. SURVEYS

The Division may conduct surveys of a representative sample of the Contractor's membership and/or providers. The results of the Division's conducted surveys may become public information and available to all interested parties on the Division website. The Contractor may be responsible for reimbursing the Division for the cost of such surveys based on its share of DDD 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 Corrective Action Plan (CAP), the Contractor being required to participate in technical assistance or DDD-led workgroups to improve any areas of concern noted by the Division, and/or sanctions. Failure to effectively develop or

implement DDD-approved CAPs and drive improvement may result in additional regulatory action by the Division.

The Contractor may be required to perform surveys at the Division's request. The Division participates annually in the NCI Survey. The Contractor may be required to complete a series of surveys and enter the data into a web-based data entry system designed by the Human Services Research Institute (HSRI) in collaboration with the National Association of State Directors of DD Services. NCI survey tools are developed by HSRI and do not require Division approval for use. Surveys are changed with some regularity and the most current survey must be used.

Division Required Surveys:

The Division may provide other surveys for the Contractor to use or may require the Contractor to develop a survey tool(s). The Final Survey Tool and Results, including any related analysis, shall be submitted to the Division as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall utilize member survey findings, including findings from the NCI survey, to improve services and supports for members.

As specified in Section F, Exhibit F3, Contractor Chart of Deliverables, the Contractor is required to perform surveys of its membership, as specified in the AdSS Operations Manual, Policy 424, 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 457.1285, 42 CFR 438.608(a)(5)].

The Contractor shall participate in the delivery and/or the review of results of member surveys as requested by the Division. Surveys may include Healthcare Effectiveness Data and Information Set (HEDIS) Experience of Care (Consumer Assessment of Healthcare Providers and Systems–CAHPS) surveys, and/or any other tool that the Division determines will benefit quality improvement efforts.

Non-AHCCCS Required Surveys:

For non-AHCCCS required surveys, including surveys required by NCQA to meet NCQA Accreditation 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 of 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.

23. CULTURAL COMPETENCY

The Contractor shall participate in the Division's 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 the AdSS Operations Manual, Policy 405 [42 CFR 457.1201(d), 42 CFR 457.1230(a), 42 CFR 438.3(d)(4), 42 CFR 438.206(c)(2), 45 CFR Part 92].

The Contractor shall annually develop and implement a Cultural Competency Plan and a Language Access Plan, which meets the requirements of the AdSS Operations Manual, Policy 405. The Language Access Plan must indicate how the needs of members with LEP are met. An annual assessment must include the effectiveness of both Plans, along with any modifications that were made. Both Plans must be submitted as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

24. 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 as well, including, but not limited to, medical records kept by placement settings such as NFs, behavioral health residential facilities, and Therapeutic Foster Care (TFC) licensing agencies.

The Contractor shall ensure that each member is guaranteed the right to request and receive one copy of his or her medical record at no cost annually. The Contractor shall have written policies

guaranteeing each member's right to request and receive a copy of his or her medical records, and to request that the medical record be amended or corrected [45 CFR Part 160, 164, 42 CFR 457.1220, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi)].

The Contractor shall have written policies and procedures to 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. Information related to fraud and abuse may be released, however, HIV related information shall not be disclosed except as provided in A.R.S. § 36-664, and MH and SUD information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR Part 2; 45 CFR Parts 160 and 164 and A.R.S. § 36-509, § 36-568.01 and § 36-568.02.

The Contractor is responsible for ensuring that a medical record (paper format 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 the AdSS Medical Policy Manual, Policy 940. The Contractor shall ensure that providers maintain and share a member health record in accordance with professional standards [42 CFR 457.1230(c), 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 and Division Policy.

The Contractor shall have written policies and procedures to ensure that MSICs have 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 quality of care 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 AdSS Medical Policy Manual, Policy 940 and comply with record retention requirements as specified in Section D, Paragraph 67, 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, his or her medical records or copies of medical records shall be forwarded to the new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

The Contractor shall have written policies and procedures for the maintenance and retention of medical records to ensure those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Contractor shall comply with medical record review requirements as specified in the AdSS Medical Policy Manual, Policy 940. The Contractor shall comply with record retention requirements as specified in AdSS Operations Manual, Policy 470 and Section D, Paragraph 67, Record Retention.

Neither the Division nor the Contractor is required to obtain written approval from a member to obtain a copy of the member's medical record from the PCP or any other provider, provider organization or provider agency if the reason for such request is directly related to the administration of the ALTCS-DD program, unless the member or minor member's parent has restricted the release of his/her medical records pursuant to A.R.S. § 36-568.02(B). The Division shall be afforded access to all members' medical records whether electronic or paper format within twenty (20) business days of receipt of request or more quickly if necessary.

The Contractor must ensure health information is accessible and available to the Contractor, Division, assigned Support Coordinator and service providers consistent with Federal and State confidentiality laws to facilitate well-coordinated, interdisciplinary care. The information available must include but is not limited to the member's Person Centered Service Plan reflecting all behavioral health services

and physical health services, as well as the clinical, medical, and administrative information necessary to coordinate quality care delivered by multiple providers, in multiple locations, at varying times.

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.].

25. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing advance directives for adult members as specified in 42 CFR 438.3(j) and 42 CFR 422.128, and the AdSS Medical Policy Manual, Policies 640 and 930. Policies and procedures developed by the Contractor must reflect the understanding that while members may temporarily or permanently lack the capacity to make some or all health care decisions reflected in an advance directive, a lack of capacity must not be assumed, nor should it be considered global. The Contractor shall ensure that to the extent possible, members are engaged in the development of advance directives to specify their wishes regarding the use of life-sustaining treatments and the nature, implications, and reversibility of their decision. The Contractor shall report information on advance directives as required in Section F, Exhibit F3, Contractor Chart of Deliverables.

The Contractor shall accommodate member needs for reading, language, learning, and other assistance necessary for meaningful member participation in developing an advance directive. In addition:

a. Each contract or agreement with a hospital, NF, hospice, and providers of home health care services and personal care, shall comply with Federal and State law regarding advance directives for adult members [42 CFR 438.3(j)(1)]. Requirements include:

   i. Maintain 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.

   ii. Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives, including any conscientious objections [42 CFR 438.3(j)(3)].

   iii. 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.

   iv. Preventing discrimination against a member because of his or her decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive.

   v. 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.

b. The Contractor shall require PCPs, which have agreements with the entities specified above, to comply with the requirements of subparagraphs 1 (i) through (v) above.

c. 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.

d. 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]:

   i. A member's rights regarding advance directives under Arizona State law;

ii. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

iii. A description of the applicable state law and information regarding the implementation of these rights;

iv. The member's right to file complaints directly with the Division or AHCCCS; and

v. 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:

1. Clarify institution-wide conscientious objections and those of individual physicians;

2. Identify state legal authority permitting such objections; and

3. Describe the range of medical conditions or procedures affected by the conscience objection.

vi. Changes to State law as soon as possible, but no later than ninety (90) days after the effective date of the change [42 CFR 438.6(i)(4)].

Written information regarding advance directives shall be provided to members at the time of enrollment with the Member Handbook. Refer to the AdSS Operations Manual, Policy 404 for member information and Policy 406 for Member Handbook requirements.

The Contractor is not relieved of its obligation to provide the above information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures shall be in place to provide the information to the individual directly at the appropriate time.

26. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI)

The Contractor shall provide quality medical care and services to members. The Contractor shall promote improvement in the quality of care provided to enrolled members through established QM/PI processes. The Contractor shall implement processes to assess, plan, implement, and evaluate QM/PI activities as specified in the AdSS Medical Policy Manual, Chapters 400 and 900 [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)]. Refer to Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor's QM/PI programs, at a minimum, shall comply with the requirements outlined in the AdSS Medical Policy Manual, AdSS Operations Manual, State and Federal Requirements, and this Paragraph.

AHCCCS engages an External Quality Review Organization (EQRO) for purposes of conducting the independent reviews of health plans and related oversight. The Contractor shall provide information as needed to support external quality reviews conducted by AHCCCS' EQRO.

The Contractor shall maintain and execute policies/procedures related to the implementation of a comprehensive, coordinated delivery of integrated physical and behavioral health services, including the administrative and clinical integration system for healthcare service delivery. Integration strategies and activities shall focus on improving individual health outcomes and increasing member satisfaction.

AHCCCS' Targeted Investments program outlines requirements that providers agree to implement to support and enable their ability to offer improved integration of physical and behavioral health services for members. These requirements, identified as core components, are found at https://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.

Structure and Staffing of QM/PI Unit

The Contractor shall establish a QM/PI Unit within the organizational structure and ensure that it is separate and distinct from any other units or departments such as Medical Management or Care Management Program. The Contractor may have separate but coordinated QM and Performance Improvement Units under the QM/PI Program. The Contractor is expected to integrate quality management processes, such as tracking and trending of issues, throughout all areas of the organization. Ultimate responsibility for QM/PI activities resides within the QM/PI Unit.

The Contractor shall submit QM/PI Program deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The QM/PI Unit must assure all staff members having contact with members or providers, such as member and provider services staff and Care management staff, receive initial and ongoing training

with regard to the appropriate identification and timely referral of complaints and quality of care/service concerns to the QM/PI Unit.

QM/PI Unit positions performing work functions related to the Contract must have a direct reporting relationship to the local CMO and the local CEO. The local CMO and CEO shall have the ability to direct, implement and prioritize interventions resulting from QM/PI 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, that performs functions under this Contract related to QM and QI.

Should the Contractor experience QM staff inadequacy which prevents the Contractor from meeting contractual requirements, the Contractor shall notify the Division QM of the staffing concerns, including a description of the concern and a plan to remedy. The Contractor shall submit Staffing Concern Notification as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The QM/PI Unit shall establish a QM Committee, Peer Review Committee and other subcommittees as required in the AdSS Medical Policy Manual, Policy 910. The QM Committee, Peer Review Committee and subcommittees must meet at least quarterly and be chaired by the local Medical Director/CMO.

Quality Management/Performance Improvement (QM/PI) 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 457.1240(b), 42 CFR 438.330(a)(1), 42 CFR 438.330(a)(3)]. At a minimum, the Contractor's QM/PI programs shall comply with the requirements outlined in the AdSS Medical Policy Manual, Chapters 400 and 900. See also Section F, Exhibit F3, Contractor Chart of Deliverables.

The Contractor's quality management program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and non-clinical care which are expected to have a favorable effect on health outcomes and member satisfaction as specified in the AdSS Medical Policy Manual, Chapter 900 [42 CFR 328.330(a)(1), 42 CFR 438.330(b)(1-2)].

The Contractor's QM/PI program shall include, but is not limited to:

a. Implementation, monitoring, evaluation, and compliance with applicable requirements in the AdSS Operational Policy Manual and the AdSS Medical Policy Manual.

b. A written QM/PI Program Plan in accordance with requirements under 42 CFR 438.330 and the AdSS Medical Policy Manual, Policy 910. The written QM/PI Program Plan must be submitted annually as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The QM/PI plan is reviewed annually by the Division and must be revised as needed to meet new regulations/requirements. The QI/PI Program Plan must have metrics to measure member outcomes.

c. 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)].

d. Timely, accurate and complete submission of QM/PI deliverables that address strategies and performance for Program activities, as specified in this section, the AdSS Medical Policy Manual and Section F, Exhibit F3, Contractor Chart of Deliverables. Information included within the Contractor's deliverable submissions and utilized as part of AHCCCS' External Quality Review Reporting may become public information and available to all interested parties on the AHCCCS website.

e. 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.

f. 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 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.

g. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 457.1240(b), 42 CFR 438.330(b)(4), and 42 CFR 438.340].

h. Mechanisms to detect both underutilization and overutilization of services [42 CFR 438.330(b)(3)].

i. QM/PI program monitoring and evaluation activities including Peer Review and Quality Management/Performance Improvement 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, and other subcommittee(s) under the QM Committee as

required or needed. The Division and/or AHCCCS may attend requested Peer Review Committee Meetings as a silent observer.

j. Protection of medical records and any other personal health and enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements.

k. Written policies regarding member rights and responsibilities [42 CFR 438.100(b)(1)].

l. Submission of any cases involving Medicaid fraud, waste or abuse to the AHCCCS Office of the Inspector General. Refer to Section D, Paragraph 66, Corporate Compliance.

m. Submission of inter-rater reliability (IRR) metrics and evidence of IRR activities, as reflective of the previous quarter reporting specified in Section F, Exhibit F3, Contractor Chart of Deliverables to include, at a minimum: triage, case leveling and corrective actions.

n. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credentialing for all provider types that shall comply with the requirements outlined in the AdSS Medical Policy Manual, AdSS Operational Policy Manual, State and Federal requirements, and this section [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b).

o. The Contractor must comply with requirements as specified in the AdSS Medical Policy Manual, Policy 950 and refer to Section F, Exhibit F3, Contractor Chart of Deliverables, for reporting requirements. [42 CFR 438.214].

p. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality-of-care issues related to abuse, neglect, exploitation, suicide attempts, opioid-related concerns, alleged human rights violations and unexpected deaths. The Contractor must comply with requirements as specified in the AdSS Medical Policy Manual, Policy 960.

q. Opioid Drug Utilization Review management. Refer to AMPM Policy 1024.

r. Mechanisms to assess the quality and appropriateness of care furnished to members and comply with requirements as specified in this Contract and the AdSS Medical Policy Manual, Policy 920 [42 CFR 438.330(b)(4), 42 CFR438.340];

s. Requirement for any ADHS licensed provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. The Contractor shall

monitor contracted providers for compliance with quality management measures including supervisory visits conducted by a Registered Nurse when a home health aide is providing services;

t. 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)];

u. 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 (as applicable) justice population, opioid and substance use, suicide, veterans and Social Determinants of Health [SDOH] which includes, but is not limited to, homelessness, employment and community engagement);

v. Implementation and management of Performance Improvement Programs including performance AdSS Medical Policy Manual;

w. Ensure the protection and confidentiality of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements [42 CFR 438.224];

x. Employment of sufficient, knowledgeable, and qualified local staff and utilize 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 Division Policy requirements;

y. Local staff that are available 24 hours per day, seven days per week to work with the Division, AHCCCS and/or other State agencies, such as the ADHS/Bureau of Medical Facilities, on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardies, 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, the ability to initiate new placements/services, and have the ability to perform status checks at affected facilities and perform ongoing monitoring, if necessary. The Contractor shall supply the Division's QM Department with the contact information for these staff, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. The Division's QM Manager must be notified and provided back up contact information when the primary contact person will be unavailable;

z. Provision of quality care and services to eligible members, regardless of payer source or eligibility category;

aa. Establishment of a QM Committee, a Peer Review Committee, a Children's QM subcommittee and other subcommittees under QM Committee as required or as a need is identified;

aa. Implementing processes to assess, plan, implement, and evaluate quality management and performance improvement activities related to services provided to members in conformance with the AdSS Medical Policy Manual, Chapters 400 and 900 [42 CFR 438.330(a)(1), (b)(2);];

bb. Demonstrating improvement in the quality of care provided to members through established quality management and performance improvement processes;

cc. Regular, and as requested, dissemination of subcontractor and provider quality improvement information including performance metrics, dashboard indicators and member outcomes to the Division and key stakeholders, including members and family members;

dd. Developing and maintaining mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to monitor service quality and to develop strategies to improve member outcomes and quality improvement activities related to the quality of care and system performance;

ee. Protecting and maintaining the confidentiality of a member's medical record and any other personal health/enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements, the AdSS Medical Policy Manual and Section D, Paragraph 24, Medical Records;

ff. Complying with requirements to assure member rights and responsibilities in conformance with the Division's policies on Title XIX/XXI Notice and Appeal Requirements; Special Assistance for Persons Determined to have a Serious Mental Illness (SMI), Notice and Appeal Requirements (SMI and Non-SMI), Member Grievance Resolution Process, and the AdSS Medical Policy Manual [42 CFR 438.100(a)(2), 42 CFR 438-228(a), 42 CFR 438.400(a), 42 CFR 438.402(a)], and comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964, etc.) including other laws regarding privacy and confidentiality [42 CFR 457.1200, 42 CFR 438.100(d)]; and

gg. Requiring its QM Committee to proactively and regularly review member grievance, and appeal data to identify outlier members who have filed multiple complaints, grievances or appeals regarding services or against the Contractor or who contact governmental entities for assistance, including the Division for the purposes of assigning a care coordinator to assist the member in navigating the health care system.

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) and that meet 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)]:

a. Is identified in the Arizona State Plan;

b. 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;

c. Has a negative consequence for the beneficiary;

d. Is auditable; and

e. 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.

If an HCAC or OPPC is identified, the Contractor shall report the occurrence to the Division and conduct and submit to the Division a quality of care investigation as specified in the AdSS Medical Policy Manual, Chapter 900 [42 CFR 434.6(a)(12)(ii and iii) and 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 the protection and enforcement, at a minimum, 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 457.1220, 42 CFR 438.100(a)(1), 42 CFR 100(b)(2)(v)]. The Contractor shall follow local, State and Federal regulations and requirements related to seclusion and restraint. Reports regarding incidents of seclusion and restraint shall be submitted to the Division 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).

Service and Service Site Monitoring

The Contractor shall monitor services and service sites as outlined in the AdSS Medical Policy Manual, Policy 920. The Contractor shall submit a Contractor Monitoring Summary as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

When the provider is included in more than one Contractor network, a collaborative process with the Division and other contractors must be utilized. This collaboration will include selection of a lead monitoring contractor, use of a common tool, and data sharing including outcomes of monitoring plans, corrective action, and contract action.

The Contractor (or the lead monitoring Contractor if Contractor collaborative monitoring was completed) shall submit the Contractor Monitoring Summary to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Standards for Providers Managing Behaviors

The Contractor and all service providers under this Contract must comply, to the extent applicable, with A.A.C. R6-6-Article 9 requirements, including the use and restrictions of behavioral intervention techniques, behavior modifying medications, emergency measures, and training, as well as the development, monitoring and approval process for a behavior plan. Service and service site monitoring conducted by the Contractor must include reviewing for compliance with these requirements. The Division intends to amend A.A.C. R6-6-901 through R6-6-909 as outlined in Section D, Paragraph 80, Pending Issues. The Contractor must engage with DES/DDD in communication and training with the Contractor's providers, providing public comments to proposed rules, and continued participation with the Division as additional requirements are established. At such time as the new Article 9 rules are promulgated, Contractor and DES/DDD will enter into an amendment of the Contract addressing the requirements with Article 9 as amended. The Contractor must ensure its providers comply with Article 9 as amended.

National Committee for Quality Assurance Accreditation

The Contractor shall achieve National Committee for Quality Assurance (NCQA) Accreditation for its Medicaid Line of Business (Health Plan Accreditation) by October 1, 2025. Additionally, the Division shall require its DDD Subcontractors to 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 the Division 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 the Division 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 the Division 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 the Division 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 the Division, 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 the Division 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. The Division 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 and the Division retain the ability to resume an operational review requirement that is removed or modified as part of nonduplication efforts.

In addition to reviewing operational review standards to identify duplicative operational review requirements, AHCCCS has reviewed deliverables to identify which may be addressed through the Contractors’ accreditation requirements to further reduce administrative burden. AHCCCS and the Division 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 or the Division:

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. NCQAs 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 NCQAs review activities applicable to the standards for the EQR activities.

5. The Contractor shall ensure that all information is furnished to AHCCCS and/or the Division 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.

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, and other appropriate authorities, Incident, Accident, and Death (IAD) Reports in conformance with the requirements established by AHCCCS and as specified in AdSS Medical Manual Policy 961. IAD Reports shall be submitted as specified in 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 concerns not meeting QOC criteria (which includes incidents of: HCAC, OPPC, abuse, neglect, exploitation, injuries, high profile cases, suicide attempts, substance use disorders/opioid-related concerns, alleged human rights violations, and unexpected death). The Contractor shall develop a process to report incidents to the Division's Quality Management Team as specified in Attachment F3, Contractor Chart of Deliverables. The Contractor shall also report Adverse Actions to Provider as specified in 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 Quality Management 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 the Contract and AdSS Medical Manual/AMPM Policy 960.

Subcontractor Monitoring

The Contractor shall develop and submit a Subcontractor Performance Monitoring Plan as a component of its QM/PI Program, to include language that addresses, at a minimum, the timely handling, completion, and submission of (in accordance with Contract and Policy requirements) the following quality management functions:

a. IAD Report,

b. QOC Concerns and investigations,

c. Division required Performance Measure calculations and reporting,

d. Performance Improvement Projects,

e. Provisional, initial, organizational, and re-credentialing processes and requirements,

f. Medical Record Reviews, and

g. Peer Review processes.

The Contractor shall conduct an annual audit of subcontracted provider services and service sites and assess each provider's performance on satisfying established quality management and performance measures standards. The Division 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:

a. When performance falls below the minimum performance level;

b. 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 AdSS Medical Manual/ AMPM Policy 910. The Contractor shall conduct comprehensive quality audits of each location where members receive services. The Contractor shall provide oversight to its Subcontrator in the completion of functions related to the QOC investigation processes. Onsite QOC visits and annual audits and reviews. The Contractor shall ensure that its Subcontractors are able to meet all requirements as specified in Contract and Division policies.

The Contractor shall ensure:

a. Instances where concerns are identified, corrective actions are implemented in order to bring the provider into compliance.

b. Any identified potential Individual and/or Systemic QOC concerns, and immediate jeopardy (IJ) and/or Health and Safety concerns shall be immediately (within 24 hours) triaged by the referred to the Contractor's QM/PI Program QM QOC staff as specified in AdSS Medical Manual Policy 960 staff for review.

c. Utilization of standardized monitoring tools by provider type, as required by AHCCCS.

d. IRR of quality monitoring processes with documented testing and results of individuals completing provider quality monitoring activities.

Credentialing

The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's local Medical Director [42 CFR 457.1230(a), 42 CFR 438.206(b)(6)]. The Contractor should refer to the AdSS Medical Policy Manual, Chapter 900, and Section F, Exhibit F3, Contractor Chart of Deliverables, for reporting requirements.

In applying credentialing requirements, the Contractor: must document provisional credentialing, initial credentialing, re-credentialing and organizational credentialing of providers who have signed contracts or participation agreements with the Contractor [42 CFR 438.206(b)(1-2)]; shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and, shall not employ or contract with providers excluded from participation in Federal health care programs [42 CFR 457.1233(a), 42 CFR 438.214].

The Contractor shall comply with uniform temporary/provisional credentialing, initial credentialing, and re-credentialing practices for all provider types as follows [42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b)]:

Document temporary/provisional credentialing, initial credentialing and re-credentialing of individual and organizational providers who have signed contracts or participation agreements with the Contractor or have seen 25 or more of the Contractor's members [42 CFR 438.206(b)(1-2)].

The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's local Medical Director.

The Contractor must comply with requirements as specified in the AdSS Medical Policy Manual, Policy 950 and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Credential Verification Organization Contract

The Arizona Association of Health Plans (AzAHP) has established a contract with a Credential Verification Organization (CVO) that is responsible for performing credentialing activities:

- Receiving completed applications, attestations and primary source verification documents for certain providers.
- Conducting annual entity site visits to the credentialed entities to ensure compliance with Division requirements.

The Contractor shall utilize the contracted CVO as part of its credentialing and recredentialing process for those providers benefited by the CVO organization, regardless of membership in the AzAHP. This requirement eases the administrative burden for providers that contract with AHCCCS Contractors which often results in duplicative submission of information used for credentialing purposes. The Contractor shall follow the Division's re-credentialing timelines for providers that submit their credentialing data and forms to the AzAHP CVO. The Contractor is responsible for maintaining a credentialing committee to complete the credentialing process. The Contractor shall continue to include utilization, performance, complaint, and quality of care information, as specified in the AdSS Medical Policy Manual, Policy 950, to complete the credentialing or re-credentialing files that are brought to the Credentialing Committee for a decision. In addition, the Contractor must also meet the AdSS Medical Policy Manual, 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 calculate and report to the Division, and notify providers of credentialing decisions (approved or denied) as specified in the AdSS Medical Policy Manual, Policy 950.

The Contractor shall report the credentialing information with regard to all credentialing applications as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall ensure that they have in place a process to monitor, at a minimum, on an annual basis, occurrences which may have jeopardized the validity of the credentialing process.

Accreditation

The Contractor is required to inform the Division 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 the Division a copy of its most recent accreditation review documents received from the accreditation body, including the following [42 CFR 457.1240(c), 42 CFR 438.332(a) and 42 CFR 438.332(b)(1)-(3)]:

a. Accreditation status, survey type, and level (as applicable);

b. Accreditation results including summaries of findings, recommended/required actions or improvements, and Corrective Action Plans (CAPs); and as provided/made available through the accreditation entity.

c. 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 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 the Division written notification or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Quality Management and Performance Improvement Program

The Contractor's Quality Management and Performance Improvement Program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and non-clinical care which are expected to have a favorable effect on health outcomes and member satisfaction as specified in the AdSS Medical Policy Manual, Chapter 900 [42 CFR 438.330(a)(1); 42 CFR 438.330(b)(1-2).

The Contractor shall:

a. Measure and report to the Division its performance, using standard measures required by the Division or as required by AHCCCS or CMS [42 CFR 438.330(c)(1)(i), 42 CFR 438.330(c)(2)(i)].

b. Submit specified data to the Division that enables the Division to measure the Contractor's performance using standardized measures as specified by the State [42 CFR 438.330(c)(1)(i)(ii), 42 CFR 438.330(c)(2)(ii)].

c. Perform a combination of the above activities [42 CFR 438.330(c)(2)(iii)].

Performance Improvement Projects (PIPs)

The Contractor shall implement PIPs designed to achieve and sustain, through ongoing measurements and interventions, significant improvement in the areas of clinical and non-clinical

care, as specified in the AdSS Medical Policy Manual, and that involve the following [42 CFR 457.1240(b), 42 CFR 438.330(d) (i)-(iv)]:

a. Measurement of performance using objective quality indicators;

b. Implementation of system interventions to achieve improvement in access to and quality of care;

c. Evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and

d. Planning and initiation of PIP activities for increasing or sustaining improvement.

PIPs are mandated by the Division, however, the Contractor shall also self-select additional projects meaningful to the population served, 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. If the Contractor holds AHCCCS Contracts for more than one Line of Business, the Contractor shall submit separate reports for each Line of Business that contain rates and results specific to Line of Business for which the submission pertains. For AHCCCS-mandated PIPs, the Contractor shall report combined rates/percentages for Title XIX and Title XXI. The Contractor shall ensure the inclusion of subpopulation data and disparities analysis within its reporting, with the identification of targeted interventions to be implemented specific to findings.

Upon notification and direction from AHCCCS or the Division, the Contractor shall:

- Participate in mandatory technical assistance sessions. The Contractor may also request technical assistance, as needed.

- Participate in AHCCCS or Division workgroups sessions aimed to identify barriers and implement interventions, including any interventions mandated by AHCCCS, to address system performance.

- Propose and implement Contractor-specific CAPs for identified deficiencies.

The Contractor shall report the status and results of each project to the Division no less than once per year or as requested using AHCCCS' PIP Reporting Template included on the AHCCCS Quality Management/Performance Improvement (QM/PI) Reporting Templates & Checklist webpage, AMPM Policy 980 and as specified in AMPM Policy 980, the AHCCCS Quality Management/Performance

Improvement (QM/PI) Reporting Templates & Checklist webpage, and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Performance for each PIP shall be evaluated 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 457.1240(b), 42 CFR 438.330(d)(1), 42 CFR 438.330(d)(3)]. PIP report submissions by the Contractor shall be provided to the External Quality Review Organization (EQRO) for review, evaluation, and potential inclusion within EQR annual technical report findings. In addition, AHCCCS may elect to require EQRO validation of AHCCCS-Mandated and Contractor Self-Selected PIP reports.

Performance Measures

To meet 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 collected, monitored, and evaluated in accordance with AdSS Medical Policy Manual, Policy 970. AHCCCS or the Division may utilize administrative, hybrid, or other methodologies for collecting and reporting performance measure rates, as allowed by CMS for Core Set of Adult and/or Child Health Care Quality Measures for Medicaid CMS (Adult and Child) Core Sets, the measures, the NCQA for selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as defined by other entities for nationally recognized measure sets, or as determined by AHCCCS or the Division.

For Contract Year Ending 2023 (10/1/2022 through 9/30/2023), Performance Measures shall be reflective of the Calendar Year 2022 2023 (1/1/2023 through 12/31/2023) measurement period in alignment with the applicable CMS Adult and Child Core Set technical specification requirements.

AHCCCS Performance Measures (Statewide Aggregate Rates)

Statewide aggregate performance measure rate calculations are conducted by AHCCCS' EQRO utilizing the CMS (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 or the Division 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 rates described in the preceding paragraph; these rates are considered the official measurements for statewide reporting. In lieu of AHCCCS or Division calculated statewide hybrid aggregate rates, AHCCCS or the Division may elect to utilize Contractor calculated hybrid performance measure rates that have been aggregated for official statewide

reporting. Official statewide rates will be compared with the Centers for Medicare and Medicaid Services (CMS) Adult/Child Core Sets, Child and Adult Health Care Quality Measures, national Medicaid Median (CMS Medicaid Median), or NCQA HEDIS® Medicaid Mean for selected HEDIS®-Only Measures, that aligns with the Calendar year for which the data reflects

CMS-416

The Division utilizes the methodology established within the CMS Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report for reporting EPSDT Participation.

The aggregate rates for Title XIX and Title XXI are generated one time per year and reported to CMS within specified timeframes. The Division may, in lieu of generating the rates, opt to utilize CMS-generated rates for reporting purposes. The Division may require the Contractor to implement a corrective action plan or participate in mandatory workgroup activities when statistically significant declines in the Title XIX and Title XXI aggregate rates are identified.

Hybrid Performance Measures

The Division may conduct hybrid performance measure reviews/audits for any CMS Child or Adult Core Set measure, NCQA HEDIS®, or other standardized measure to monitor and evaluate performance for performance measures and/or PIPs. Division conducted hybrid performance measure reviews/audits shall be reflective of statewide performance; however, AHCCCS reserves the right to conduct hybrid performance measure reviews/audits to also monitor Contractor and/or line of business performance. Contractor reported rates may be reported publicly, and the Contractor may be required to implement a CAP when: deficiencies are identified within hybrid performance measure rates, when hybrid performance measure rates do not meet performance requirements, or for declines in hybrid performance measure rates.

Hybrid Data Collection Procedures

AHCCCS or the Division may require the Contractor to submit data for standardized performance measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting the data. AHCCCS may elect to utilize an EQRO for conducting hybrid performance measure review/audit activities.

Contractor Performance Measures (Contractor Specific)

The Contractor shall comply with the Division requirements to improve the care, coordination, and services provided to members as demonstrated through performance metrics and performance

measure reporting. The Contractor shall measure and report upon all measures (inclusive of all submeasure rates and required stratifications) included as part of the CMS Adult and Child Core Sets for the associated measurement period as well as select NCQA HEDIS® or other AHCCCS-required measures, as listed below:

	HEDIS® OR OTHER ADULT/CHILD MEASURES
Assigned to the Contractor	
	Inpatient Utilization (IPU)
	Diagnosed Mental Health (DMH) Disorders
	Use of Opioids at High Dosage (HDO)
Assigned to the Division	Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update *(CMS LTSS Measure Set)*
	Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update *(CMS LTSS Measure Set)*
	Long-Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner *(CMS LTSS Measure Set)*

As measure sets are updated, performance measures required by the Division may also be updated to reflect the changes. In addition, AHCCCS may require the Contractor to 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 ensure qualified staff and personnel are utilized in the data collection, calculation, monitoring, evaluation, and reporting process. The Contractor shall calculate, monitor, analyze, and report performance measure rates (including all sub-measure and stratified rate reporting required as part of the associated performance measure technical specifications). Reporting shall be specific to the population/Line of Business.

Calculate and report combined rates/percentages for Title XIX and Title XXI populations; however, the Contractor must have the ability to calculate and report numerators, denominators, and rate/percentage for Title XIX as well as Title XXI, which shall be provided in accordance with Division request or instructions. For hybrid measures in which rates/percentages are based on sample

populations, the Contractor shall ensure its sample populations are inclusive of a representative sample of Title XIX and Title XXI members.

The Contractor shall analyze and have the ability to report performance measure data specific to applicable subpopulations [i.e., members with special health care needs, including, but not limited to: EPSDT, maternal, behavioral health category, and Children's Rehabilitative Services (CRS) designated members] in accordance with Division instruction and request.

The Contractor shall analyze and report performance measure data by placement (e.g. HCBS vs. nursing facility), system of care delivery model, GSA or County, applicable member designations, and/or other applicable demographic and SDOH factors.

The Contractor shall conduct routine monitoring and implement population/subpopulation specific targeted interventions, meant to ameliorate or eliminate identified disparities, which are based evaluation and analysis of previous performance.

The Contractor is responsible for collecting valid and reliable data in accordance with associated measure specifications, as well as technical guidance and instructions provided by AHCCCS or the Division and/or an EQRO conducting validation activities.

Responsibility for validation and oversight of performance measure data collection and rate reporting in alignment with Division requirements remain 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 this Contract and AdSS Medical Policy Manual, Chapter 900. 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/DDD.

Hybrid Performance Measures

The Contractor shall participate in hybrid performance measure reviews/audits for all measures identified by the Division, at intervals specified by the Division. The number of records that each Contractor collects will be based on CMS Core measure specifications, NCQA HEDIS® specifications, EQRO, or other sampling guidelines in accordance with instructions provided by the Division. 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 the Division. If records are missing for more than five percent (5%) of the Contractor's final sample, the Contractor is subject to sanctions by the Division.

Hybrid Data Collection Procedures

When requested by the Division, the Contractor shall submit data for standardized performance measures and/or PIPs (when applicable) within specified timelines and according to Division procedures or instruction for collecting and reporting the data. The Contractor shall collect data from medical records, Electronic Health Records (EHRs), or through other Division approved mechanisms in accordance with the technical specifications and/or methodology identified by the Division. Data collected for performance measures and/or PIPs shall be completed in accordance with the instructions and timelines provided by the Division and/or AHCCCS' EQRO, when applicable. Division directed hybrid studies shall be reported utilizing a standardized format for each hybrid measure, with allowable supporting documentation submitted, in accordance with Division 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 AdSS Medical Policy Manual, Policy 970. 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 and reporting performance measure rates, utilizing a standardized or adopted methodology, as defined and determined by the Division, for each required performance measure. The Contractor shall evaluate performance, based on unique population/Line of Business and applicable subpopulations, utilizing a Calendar Year. The Contractor shall have a mechanism for its QM/PI Committee to report the Contractor's performance on an ongoing basis to its CEO, stakeholders, and other key staff.

The Contractor shall measure, evaluate, and report performance measure rates in accordance with Division instructions. Contractor calculated performance measure/submeasure rates that have been validated by the EQRO are the official rates utilized for determination of Contractor compliance with performance requirements. The Division 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. AHCCCS calculated rates that have been validated by the EQRO are the official rates utilized for statewide aggregate rates; however, AHCCCS

or the Division may elect to utilize Contractor calculated rates that have been validated and compiled by the EQRO as the official population/Line of Business 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 Line of Business/population, and/or as directed by the Division. Contractors shall adhere to continuous enrollment criteria as outlined in the associated measure specifications. The Contractor shall have the ability to report numerators, denominators, and rate/percentage for Title XIX as well as Title XXI, which shall be provided in accordance with AHCCCS request or instructions.

The Contractor shall analyze and report, in accordance with AHCCCS or Division instruction and request, performance measure data specific to:

a. Applicable subpopulations [i.e., members with special health care needs, including, but not limited to: EPSDT, maternal, behavioral health diagnosis, disability status, and Children's Rehabilitative Services (CRS) designated members],

b. Placement (e.g., HCBS vs. nursing facility),

c. System of care delivery model,

d. Geographic Service Areas (GSA) or County,

e. Applicable member designations,

f. Other applicable demographic and SDOH factors not 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 or the Division including paid, denied and pended for purposes of Performance Measure monitoring. Reporting shall be directed to the Division's Quality Improvement 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 and Performance Measure Monitoring in accordance with this section; Section F, Attachment F3, Contractor Chart of Deliverables; and as required by the Division.

Quality Improvement Performance Requirements

Contractor performance is evaluated annually using the official rates described 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 Line of Business aggregate rates, as applicable, and the NCQA HEDIS® Medicaid Mean or the CMS Medicaid Median (for selected CMS 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 a sanction, for each deficient measure/measure 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 [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 the associated Line of Business aggregate measure/submeasure rate based on CMS Core Set (Adult and Child) list inclusion and age stratifications, as applicable, and the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median. The Division 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. The Division may require the implementation of a CAP for performance measure/submeasure rates that show a statistically significant decline in its rate. This includes measures that show a statistically significant decline that meets or exceeds the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median, as well as meets or exceeds the AHCCCS or DD Line of Business 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 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.

The Division may impose sanctions on the Contractor, if it does not show statistically significant improvement in its official performance measure/submeasure rates rates. Sanctions may also be imposed:

- Statistically significant declines of official rates, even if they meet or exceed the associated Line of Business aggregate rate, as applicable, and/or the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median
- Any rate that does not meet the associated NCQA HEDIS® Medicaid Mean/CMS Medicaid Median
- A rate that has a significant impact to the Line of Business or statewide aggregate rate
- Any rate that falls from a higher to lower performing percentile/quartile in alignment with the associated NCQA HEDIS® Medicaid Median/CMS Medicaid Median benchmark data. The Division may require the Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area.

Upon notification and direction from AHCCCS or the Division, the Contractor shall:

a. Participate in mandatory technical assistance sessions. The Contractor may also request technical assistance as needed,

b. Participate in workgroup sessions aimed to identify barriers and develop action plans to address system performance,
c. Propose and implement Contractor-specific corrective action plans (CAPs) for official statewide aggregate rates that:

    i. Do not meet the published NCQA HEDIS® Medicaid mean/CMS Medicaid Median, or
    ii. Demonstrate a significant decline for the applicable measurement period.

d. 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, which are based on Division evaluation and analysis of performance measure performance for which statistically significant disparities are identified.

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), 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.

Quality Improvement (QI) Corrective Action Plans: An evidence-based CAP inclusive of elements specified in the AdSS Medical Policy Manual, Policy 920 shall be received by the Division within 30 days of the notification of deficiency(ies) from the Division. Proposed CAPs shall be approved by the Division prior to implementation and CAP updates shall be submitted at intervals specified by the Division. In addition, the Division 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 Division 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 consideration via email communication sent at least two (2) business days prior to the deliverable due date to the Division.

Member Satisfaction Surveys: The Contractor shall, as requested by the Division, participate in member satisfaction surveys in accordance with CMS' External Quality Review Protocol [42 CFR 438.340(a), 42 CFR 438.340(b)(4)]. The Division may provide the survey tool or require the Contractor to develop the survey tool which shall be approved in advance by the Division and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Member satisfaction survey findings or performance rates for survey questions may result in regulatory action. The results of the surveys may become public information and available to all interested parties on the Division 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 the Division, as part of designing its quality improvement or CAP activities.

Health Disparity Summary and 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 Calendar Year, a

detailed overview of the Contractor's identified health equity goals/objectives for the upcoming Calendar Year, and targeted strategies/interventions planned for the upcoming Calendar Year to achieve its goals**.** The Contractor shall submit the Health Disparity Summary and Evaluation Report as specified in AdSS Medical 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 calendar year 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. 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 AdSS Medical Policy Manual, Policy 920 and Section F, Exhibit F3, Contractor Chart of Deliverables.

Targeted Investments (TI): AHCCCS' Targeted Investments program, including the 2016 1115 Waiver program and the 2023 1115 Waiver program, outlines including the 2016 1115 Waiver program and the 2023 1115 Waiver program, requirements that participating providers agree to implement 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:

a. Group practice with 1-2 practitioners, 8 charts per practitioner;

b. Group practice with 3-6 practitioners, 4 charts per practitioner;

c. Group practice with 7-15 practitioners, 2 chart per practitioner;

d. Group with 16+ practitioners, a maximum of 30 charts shall be reviewed;

   i. If the score after review of the required number of charts identified above, is less than 85 percent, technical assistance shall be provided to the practitioner, and the practitioners shall be audited the following year,

   ii. If the score after eight charts is 85 percent or greater, yet areas of deficiency are found, technical assistance shall be given to the practitioner, and

   iii. 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:

      1. A random sample of 30 providers per Geographic Service Area (GSA) will be pulled for audit each year. Eight charts will be audited per provider;

      2. If the score after eight charts is less than 85 percent, technical assistance shall be given to the provider, and the provider shall also be re-audited the following year;

      3. If the score after eight charts is 85 percent or greater, yet areas of deficiency are found, technical assistance shall be given to the provider; and

      4. 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, Arizona Association of Health Plans (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, a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) with current Licensure under the Arizona State Board of Nursing 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, OHR and HRC 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; and

3. Submit deliverables related to Quality Management 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, and

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 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, service codes for the following:

- Behavioral Health Assessment (e.g., 96160, 96161, H0031, 90791, H0001, H0031)
- Case Management (e.g., T1016, T1016-U1 [modifier for conducting CFT])
- 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)

Services associated with the above codes shall have occurred within the most recent twelve 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 lines of business, 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 the Division. 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 the Division 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.

Monitoring of Behavior Analysis

The Contractor shall monitor and coordinate care for members receiving Behavior Analysis (ABA). The Contractor shall collaborate with all MCOs in partnership to ensure that the contracted network of providers of Behavior Analysis services is utilizing the ABA code set, and to streamline system-wide processes for prior authorization and 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.

The Contractor shall provide an ABA Supplemental Report on a quarterly basis containing the following information:

a. Number of Behavior Analysts per geographical service area,
b. Number of members requesting care management assistance to access ABA services,
c. Capacity of ABA providers/Network,
d. Number of providers who serve adolescents and adults.

The ABA Supplemental Report will be submitted, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

DDD-Specific Quality Outcome Indicators for Members: The Contractor shall comply with the Division's requirements to report on and improve quality outcomes for members. The Contractor shall collect and report data through Division-developed data collection and reporting specifications and methodologies. The Contractor must evaluate performance based on sub-categories of populations, geographical regions (e.g., by county) and/or other applicable demographic factors as required by the Division or upon Division request. Quality outcome indicators, data collection and reporting specifications and methodologies, and MPS are subject to change by the Division.

The Contractor must have a process in place for monitoring performance on quality outcome indicators. In addition to the reporting requirements to the Division under Section F, Exhibit F3, Contractor Chart of Deliverables for quality outcome indicators, the Contractor's QM/PI Program will report its performance on quality outcome indicators on an ongoing basis to Contractor leadership and stakeholders.

Reserve Status Quality Outcome Indicators for Members*:* The Division has developed quality outcome indicators that the Division will be monitoring and may use for reporting purposes, but they are not considered indicators or measures subject to regulatory oversight (sanctions, financial withholds/cost sharing adjustments, etc.) of the Contractor. The Contractor is to refer to the AdSS Medical Policy Manual for quality outcome indicators for members and associated standards. Contractor performance on quality outcome indicators is evaluated annually by the Division and may be considered for regulatory oversight at a future date.

27. 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 continuum of care (from preventive care to end of life 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, identify trends, make recommendations for action and improvement, monitor the effectiveness of actions and report these findings back to the MM Committee for review, actions and ongoing process improvement.

The Contractor shall assess, monitor and report medical decisions quarterly through the Contractor's MM Committee to assure compliance with timeliness, language, Notice of Adverse Benefit Determination intent, and that the decisions comply with all Contractor coverage criteria.

The Contractor shall maintain a written Medical Management Program Plan that addresses the monitoring of MM activities. Refer to AdSS Medical Policy Manual, 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. 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 Medical Management Program Plan. The MM Plan and MM Work Plan Evaluation shall be submitted for review as specified in Section F, Exhibit 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 the AdSS Medical Policy Manual, Chapter 1000 and Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall evaluate, interpret variances, and monitor required MM activities, as specified in the AdSS Medical Policy Manual, Chapter 1000, including [42 CFR Part 457 and 42 CFR Part 438]:

a. Utilization Data Analysis and Data Management,

b. Concurrent review,

c. Discharge Planning,

d. Prior authorization and Service Authorization,

e. Inter-rater Reliability,

f. Retrospective Review,

g. Clinical Practice Guidelines developed in consultation with network providers [42 CFR Part 438.236(b)(3)],

h. New Medical Technologies and New Uses of Existing Technologies,

i. Contractor Care Management and Coordination,

j. Disease/Chronic Care/Management, and

k. Drug Utilization Review.

The Contractor shall disseminate practice guidelines to all affected providers and to members and potential members upon request [42 CFR 457.1233(c), 42 CFR 438.236(c)].

Each member will have a Support Coordinator who 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 PCP (individual or entity) [42 CFR 457.1230(c), 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 special health care needs [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 his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member [42 CFR 438.208].

The Contractor is responsible for assessing, identifying and providing the services and supports subject to coverage under this Contract. The Contractor shall make a best effort to conduct an initial screening of each member's needs as specified in the AdSS Medical Policy Manual, Policy 910 [42 CFR 457.1230(c), 42 CFR 438.208(b)(3)]. The Contractor shall share with the Support Coordinator and other contracted entities serving the member, the results of any identification and assessment of the member's needs to assist in the coordination of care and prevent duplication of services and activities [42 CFR 457.1230(c), 42 CFR 438.208(b)(4)].

Care coordination begins with the assessment of a member's physical, behavioral, functional, and psychosocial needs to develop a Planning Document, and includes the efforts necessary to ensure the timely access to and delivery of identified services and supports. Care coordination responsibilities require continuous monitoring to ensure that:

a. The member is receiving the services and supports as specified in the Planning Document;

b. The services and supports continue to be effective; and

c. The Planning Document is updated as the member's condition or treatment and support needs change.

Care management and care coordination shall, by design, be a shared responsibility between the Contractor (primarily through its Care Management Program) and the Division (primarily through its Support Coordination Program). The Contractor's care management staff, in partnership with the Support Coordinators, shall coordinate care for members in a comprehensive, holistic, person-centered manner. Care management provided through the Contractor is an administrative function and must be funded using the Contractor's administrative funding. The Contractor shall have

processes in place consistent with the AdSS Medical Policy Manual, Chapter 500 to coordinate the services provided for members between settings of care including appropriate discharge planning for short- and long-term hospital and institutional stays.

Members present with a wide spectrum of health conditions, acuity levels, provider involvement and health care risks that impact the level of potential care management needed from the Contractor. For example, the level of care management and coordination necessary for members with no complicating physical or behavioral health conditions is very different from that required for members with CRS-qualifying medical conditions who require care coordination across multiple clinicians, subspecialists and other specialty providers.

Care Management Program

The Contractor shall ensure the provision of care management when necessary to assist members who may or may not have a complex, chronic condition but have physical or behavioral health needs or risks that need immediate attention. This care management shall assure members get the services they need to prevent or reduce adverse health outcomes. Care management includes a comprehensive assessment of the member and development and implementation of a care plan as specific in AdSS Medical Manual Policy 1021. Care management, with the exception of members identified as high need/high cost, should be short term and time limited in nature and may include working with the Support Coordinator in assisting the member in making and keeping needed physical health and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' 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 emergency department 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 special healthcare needs, 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 the AdSS Medical Policy Manual, 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 lay persons including family members, physicians, specialists and other health care professionals. Care Managers should have experience in the coordination of care for populations with special health care needs and complex medical conditions, such as individuals with intellectual and developmental disabilities.

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 and/or provider as specified in AdSS Medical Manual 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. Request 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 quality of care/service concerns.

The Contractor shall report information on member's placement and the use of respite, incontinence supplies and psychotropic medications as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

High Need/High Cost

The Contractor shall identify, implement and monitor interventions for providing appropriate and timely care to members with high needs and/or high costs who have physical and/or behavioral health needs as specified in AdSS Medical Policy 1020.

High Cost Behavioral Health Needs

The Contractor shall report information on High Need/High Cost members as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. 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 prior authorizations and NOAs 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.

The Contractor is required to develop and submit, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, a summary of the Contractor's Care Management Program for High Need/High Cost members designed to provide care management to members in accordance with the requirements in this Contract. The Contractor's Care Management Program for High Need/High Cost members is subject to the prior approval of the Division. Material changes to a Division-approved Care Management Program must be approved in advance by the Division.

The Contractor's Care Management Program for High Need/High Cost members may incorporate a stratification approach to differentiate levels of care management provided based upon factors such as the severity of condition(s), complexity of treatment coordination needs, presence of co-occurring substance use and/or MH conditions, health or safety risks, inpatient or emergency department utilization, poly-pharmacy, functional deficits and involvement with other member-serving systems. The Contractor's proposed stratification methodology must provide for the appropriate levels of care management necessary to ensure health, welfare and safety for members and should consider factors such as: caseload mix; member acuity and coordination needs; and Care Manager qualifications, experience, and responsibilities.

The Contractor shall develop and implement policies and procedures related to the Contractor's Care Management Program for High Need/High Cost members to ensure the active coordination of integrated physical and behavioral health services with LTSS, in collaboration with the Support Coordinator, for these members. Required activities, at a minimum, include Care Management responsibility for the following:

a. Participate in person or telephonically with the Support Coordinator-led, multi-disciplinary team meetings to collaboratively develop a comprehensive Planning Document and update the Planning Document as the member's health condition requires. The Planning Document serves as a working document and integrates the member's multiple treatment plans, including physical health, behavioral health and LTSS, into a single document. The Support Coordinator is the primary point of contact interfacing with the member and their representative(s) to develop the Planning Document, communicating any change(s) as necessary;

b. Actively secure the necessary authorizations for the services that are the responsibility of the Contractor, coordinating with involved providers and member-serving entities to ensure the timely access to the covered services under this Contract as described in the Planning Document;

c. Communicate with the Support Coordinator, the PCP and other providers involved in the care and treatment of the member to promote optimal outcomes and reduce risks, duplication of services or errors. These communications must include member progress and health status, test results, lab reports, medications, and other health care information necessary to effectively coordinate physical and behavioral health care with supportive services;

d. Monitor to ensure that care that is the responsibility of the Contractor is delivered and completed as recommended in the Planning Document;

e. Manage all transitions of care for members:

   i. Transitions from one level of care to another,

   ii. Transitions between providers,

   iii. Discharge planning from hospitals, jails or other institutions,

   iv. Transitions between Division Contractors, AHCCCS Contractors and care covered through AHCCCS FFS,

   v. Transitions from the child serving system to the adult serving system, and

   vi. Transition of care for members receiving EPSDT services that are not otherwise covered under the State Plan for members.

f. Assure there are no gaps in or duplication of services;

g. Monitor and evaluate a member's emergency department and behavioral health crisis service utilization to determine the reason for these visits. The Care Manager, in conjunction with the

Support Coordinator, shall take appropriate action to facilitate appropriate utilization of these services, (e.g., communicating with the member's providers, educating the member/responsible person, conducting a needs reassessment, updating the Planning Document to provide alternatives that better manage the member's physical health or behavioral health condition);

h. Identify gaps in services and report gaps to Contractor's network development department;

i. Coordinate medical care for members who are inpatient at the AzSH in accordance with the AdSS Medical Policy Manual, Policy 1020;

j. Provide intensive care management for members on Conditional Release from the AzSH that includes but is not limited to coordination with the Support Coordinator and AzSH for discharge planning; participating in the development of CRPs; care coordination with the member's treatment teams and providers of physical and behavioral health services. The Contractor Care Manager shall assist the Support Coordinator with the development of the required comprehensive status reporting to the PSRB and AzSH; and

k. Coordinate with providers furnishing services covered by Medicare or the member's private health insurance as appropriate to coordinate the care and benefits of members who have additional insurance coverage.

The Contractor shall provide initial training to newly hired Care Managers and to existing Care Managers who will be serving members under this Contract. The training curriculum shall at a minimum include the training topics identified in the Division Medical Policy Manual, Policy 1060.

Ongoing training shall be provided by the Contractor and include topics determined necessary by the Contractor or the Division based on monitoring of care management activities.

For members receiving care management services, to support care management activities and the shared care coordination responsibilities between the Contractor and the Division, the Contractor must ensure health information is available to the Contractor, Division, Support Coordinator and service providers consistent with Federal and State confidentiality laws to facilitate well-coordinated, inter/multi-disciplinary care. The information available must include, but is not limited to, the member's Planning Document (reflecting all behavioral health services, physical health services and LTSS), as well as the clinical, medical, and administrative information necessary to coordinate quality care delivered by multiple providers, in multiple locations, at varying times.

The Contractor's care management information processes and systems must be able to produce timely, meaningful, accurate content to facilitate effective team-based care coordination activities, including the ability for Care Managers and Support Coordinators to access all relevant data about the member (e.g., claims/encounters, prior authorization data, crisis interactions, emergency department utilization, hospital admission and discharges) in order to coordinate and communicate care needs across providers and delivery systems, as required by the AdSS Medical Policy Manual, Policy 940.

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. For members identified as victims of sex trafficking, the Contractor or its contracted provider(s) shall notify the member's Support Coordinator and outreach to the member/ responsible person to provide trauma-informed resources, including the 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 the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Outreach activity results shall include the Arizona Child Abuse Hotline within thirty (30) days of the referral, including the date of contact with the member/responsible person, and a description of services referred or delivered.

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 AdSS Medical Policy 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), Behavioral Health Residential Facilities (BHRFs), and Therapeutic Foster Care (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 AdSS Medical 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 Health Care-Acquired Condition (HCAC) or an Other Provider–Preventable Condition (OPPC) (refer to AdSS Medical Policy Chapter 1000). If an HCAC or OPPC is identified, the Contractor shall report the occurrence to AHCCCS and conduct a quality-of-care investigation as specified in AdSS Medical 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, Behavioral Health Inpatient Facilities (BHIFs), Behavioral Health Residential Facilities (BHRFs), and Therapeutic Foster Care (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 medical management 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), and

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 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 Drug Utilization Review 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.

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 Outreach, Engagement, and Re-engagement for behavioral health services.

Justice System Reach-in Care Coordination

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 substance use disorder and/or meet medical necessity criteria to receive Medications for Opioid Use Disorder (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. The Division 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 must notify the Division upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended. The Division adjusts eligibility dates based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division, and capitation is adjusted as specified in Section D, Paragraph 58, Capitation Adjustment. The Contractor shall report the Reach-In Plan and outcome summaries as specified in section F, Exhibit F3, Contractor Chart of Deliverables.

Collaboration with Tribal Nations and Providers

The Contractor shall consult with each Tribal Nation within the Contractor's service areas to ensure availability of appropriate and accessible services. The Contractor shall designate a Tribal Coordinator to interface with Tribal Nations and providers. See also Section D, Paragraph 19, Staff Requirements. The Contractor shall coordinate service delivery for members receiving services at

IHS or 638 Tribal Facilities. The Contractor shall collaborate with providers serving American Indian members in its GSA(s) to facilitate, at least semi-annually, meetings/forums with the IHS and 638 Tribal Facilities that serve American Indian members.

The Contractor's Tribal Coordinator shall:

a. Develop collaborative relationships with IHS, TRBHAs, Tribes, Tribal Organizations, Urban Indian Organizations (ITU) serving tribes in its assigned GSA(s), for the purposes of care coordination, which shall include meetings and member data sharing;

b. Facilitate coordination of care to include face-to-face meetings with children in residential facilities located off tribal lands, ensuring the child has communication with the tribal community;

c. Communicate and collaborate with the tribal, county and state service delivery and legal systems and with the IHS and 638 Tribal Facilities to coordinate the involuntary commitment process for American Indian members;

d. Collaborate with the Tribes located within its assigned GSA(s) to provide mobile behavioral health and physical health services;

e. Collaborate with IHS and 638 Tribal Facilities in order to improve communication through the utilization of HIE in order to improve coordination of care and health outcomes for American Indian members;

f. Attend and participate in all Tribal Consultation Meetings as requested by the Division and collaborate with the Division to implement changes resulting from the Tribal Consultation meetings;

g. On an as requested basis, the Contractor shall make education and training courses available to licensed and unlicensed physical and behavioral health personnel working on tribal lands;

h. Assist in developing and providing in-service trainings for ITU on utilization of services and behavioral health resources available to American Indian Communities located outside of Maricopa County; and

i. Assist with collaborating with tribes to build and/or utilize existing technological infrastructure, so that both telemedicine and tele-psychiatry can occur on tribal lands which may include partnership with University of Arizona, Northern Arizona University, Arizona State University or other educational entities with community investment dollars that provide telemedicine.

The Contractor shall submit a Tribal Coordinator Report, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, summarizing the activities, services, programs and coordination of care for American Indian Members. The report shall include identified trends related to American Indian Members including, but not limited to, quality of care, access, timeliness, and availability of services. The report shall outline the Contractor's efforts to develop, maintain and monitor activities for the American Indian population that includes, at a minimum, the following:

a. The number of American Indian Members enrolled with the Contractor and the number of American Indian Members who are actively receiving care/treatment services;

b. A description of how the Contractor is consulting and establishing care coordination activities with tribal leaders within its assigned GSA(s);

c. A description of how the Contractor is consulting with tribal leaders in a meaningful way;

d. Description of training provided for Contractor staff related to the American Indian delivery system, including but not limited to tribal sovereignty, unique issues surrounding COE and COT, assistance provided to tribes its assigned GSA(s), COE/COT processes;

e. An outline of the interaction process utilized by the Contractor to keep the Tribal Coordinator updated on Contractor issues/concerns;

f. An explanation of how the Contractor leadership supports the Tribal Coordinator;

g. Describe staff roles that support the Tribal Coordinator and their interaction with tribes;

h. Collaboration for the involuntary commitment process, and the COE/COT process for American Indian members;

i. Care Coordination activities and collaboration for physical and behavioral health including:

    i. Status of facilitation for coordination of care;

    ii. Address face-to-face meetings with children in facilities located off tribal lands, ensuring the child has communication with the tribal community;

    iii. Continuity of Care from tribal court to discharge;

    iv. Use of blind spot data for care coordination efforts; and

v. Active engagement of IHS/638 facilities for participation in care coordination efforts.

j. Discuss the support and function provided for IHS and 638 Tribal facilities. Identify facilities and what physical and behavioral health services are provided. Discuss how gaps are identified. Identify what gaps have been identified and how the Contractor will mitigate these gaps;

k. Training provided on best practices and general clinical requirements;

l. Provide a list of training engagements offered/provided to these facilities;

m. Collaboration with tribes on building technological infrastructure for telemedicine and tele-psychiatry; and

n. Successes and barriers associated with physical and behavioral health service delivery to the American Indian population.

Monitoring Controlled and Non-Controlled Medication Utilization

The Contractor shall engage in activities to monitor controlled and non-controlled medication use as outlined in the AdSS Medical Policy Manual Policy 310-FF to ensure members receive clinically appropriate prescriptions.

The Contractor shall perform pattern analyses that evaluate clinical appropriateness, over- and under-utilization, therapeutic duplications, contraindications, drug interactions, polypharmacy, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications. The Contractor shall provide education to prescribers on drug therapy best practices using utilization analysis with the aim of improving safety, prescribing practices and therapeutic outcomes.

The Contractor is required to report to the Division, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, a Pharmacy and/or Prescriber – Member Assignment report which includes 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 the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables when the Contractor makes changes interventions and parameters, as outlined in the AdSS Medical Policy Manual, Policy 310-FF.

Inappropriate Emergency Department Utilization

The Contractor must identify and track members who utilize ED services inappropriately four or more times within a six (6)-month period. Interventions must be implemented in collaboration with Support Coordinators to educate members and/or caregivers on the appropriate use of the ED and divert members to the right care in the appropriate place of service, see the Division's Medical Policy Manual, Policy 1020. The Contractor shall submit an Emergency Department Diversion Summary report as specified in the AdSS Medical Policy Manual, Policy 1020 and Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall also track and report members who utilize the Emergency Department more than three times per quarter. The Contractor shall submit a report as identified in Section F, Exhibit F3, Contractor Chart of Deliverables.

24 Hours Post Medical Clearance Emergency Department Report

The Contractor shall monitor the length of time members (by adult and child) wait to be discharged from the Emergency Department (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 Support Coordinator and 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 Emergency Department Report utilizing the standardized AHCCCS reporting template as required in Section F, Exhibit F3, Contractor Chart of Deliverables.

28. TELEPHONE PERFORMANCE STANDARDS

The Contractor must meet and maintain established telephone performance standards to ensure member and provider satisfaction as specified in the AdSS Operations Manual, Policy 435. The Contractor shall report on compliance with these standards as specified in Section F, Exhibit F3, Contractor Chart of Deliverables and the policy identified above. All reported data is subject to validation through periodic audits and/or operational reviews.

29. GRIEVANCE AND APPEALS

The Division delegates the Grievance and Appeal System process responsibilities to the Contractor for the services and supports that the Contractor is responsible for providing under the terms of this Contract. The Contractor shall promptly direct all Grievances and Appeals for services not delegated to the Contractor to the Division for resolution. 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.

The Contractor shall have in place a written Grievance and Appeal System process for subcontractors, members and non-contracted providers, which define their rights regarding disputed matters with the Contractor. The Contractor's Grievance and Appeal System and associated reporting must comply with the Division's Grievance and Appeal System Report Guide. The Contractor's Grievance and Appeal System for members includes a grievance process (the procedures for addressing member grievances), an appeals process and access to the State's fair hearing process as outlined in Section F, Exhibit F1, Member Grievance and Appeal System Standards. The Contractor shall not delegate the Grievance and Appeal System requirements to its subcontracted providers. The Division, at its sole discretion, may choose to revoke its delegation of any portion of the Grievance and Appeal System to the Contractor throughout the term of the Contract.

The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Section F, Exhibit F2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Section F, Exhibit F1, Member Grievance and Appeal System Standards, Exhibit F2, Provider Claim Dispute Standards, and 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 shall provide the Division with a monthly report that summarizes all Contractor provider claim disputes, claim dispute volume, an explanation of cases that have not been resolved within thirty (30) days, significant trending in either direction, and interventions or implementations that have resulted from identified issues.

In addition to the Grievance and Appeals procedures described herein, the Contractor shall also make available the Grievance and Appeals processes described in Arizona Administrative Code Title 9, Chapter 21, Article 4 for individuals determined under Arizona law to be SMI. Refer to the ACOM Policies 444 and 446.

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 Division 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 provides written information within required timeframes to both members and providers, which clearly explains the Grievance and Appeal System requirements. This information must include: 1) the right to a State fair hearing; 2) the method for obtaining a State fair hearing; 3) the rules that govern representation at the hearing; 4) the right to file grievances, appeals and claim disputes; 5) the requirements and timeframes for filing grievances, appeals and claim disputes; f) 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; and, 9) that a provider may file an appeal on behalf of a member with the member's written consent.

The Contractor shall give members any reasonable assistance in completing Grievance and Appeal forms and other procedural steps related to a Grievance or Appeal. This includes availability of member support staff, auxiliary aids and services, such as interpreter services and toll-free numbers with adequate TTY/TDD and interpreter capability. Information to members must meet cultural competency and LEP requirements as specified in Section D, Paragraph 21, Member Information, and Paragraph 23, Cultural Competency.

The future enrollment of the Contractor's member to another Division or AHCCCS Contractor 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 the Contractor. The Contractor shall not take the position during the grievance and appeals process that a former member's subsequent enrollment with another Division or AHCCCS Contractor or the member's subsequent loss of AHCCCS eligibility are valid reasons to deny or dismiss an appeal of the adverse benefit determination if the member submitted the service

authorization request to the Contractor during a period of enrollment with the Contractor. The Contractor receiving the service authorization request is required to substantiate that the denial or reduction of the request is based upon medical necessity, the exclusion of the service from the scope of AHCCCS covered services, or cost effectiveness. If the authorization decision of the Contractor is overturned on appeal, the Contractor is financially responsible for coverage of those services notwithstanding the member's subsequent enrollment with a different Division or AHCCCS Contractor or the member's subsequent loss of AHCCCS eligibility.

The Contractor shall fully cooperate with the Division in the event the Division decides to intervene in, participate in or review any grievance and appeals system process or proceeding. The Contractor shall comply with or implement any Division directive related to a grievance, appeal or claim dispute within the time specified, pending formal resolution of the issue.

The Contractor shall provide a monthly Grievance and Appeal System Report and a cover letter to the Division as required in the Division's Grievance and Appeal System Report Guide and Section F, Exhibit F3, Contractor Chart of Deliverables. The Division reserves the right to request additional data and information beyond what is listed in the Division's Grievance and Appeal System Report Guide.

The Contractor shall also provide the Division with a monthly report that summarizes, by month, the number of grievances and complaints filed by or on behalf of members with a CRS designation. The report must be categorized by access to care and provider satisfaction and shall be submitted as a Supplement to Grievance and Appeal System Report as specified in Section F, Exhibit 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 Seriously Mental Illness: 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 AHCCCS Contractor Operations Manual (ACOM), AHCCCS Medical Policy Manual (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 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:

a. Upon request from and within the time specified by AHCCCS, provide any SMI grievance and/or SMI appeal information, report or document;

b. 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;

c. Comply with and/or implement any AHCCCS directive within the time specified pending formal resolution of the issue; and
d. 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 Serious Mental Illness: 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, Exhibit F3, Contractor Chart of Deliverables.

The Contractor is responsible for responding to requests from the DDD Healthcare Services Unit involving member complaints, concerns, and issues brought to the Division attention by members, family members, providers, and other concerned parties. Upon request, the Contractor shall provide the DDD Healthcare Services 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 DDD Healthcare Services Unit as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

30. 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 provider network that supports an individual member's needs as well as the needs of members covered under this Contract as a whole. The Contractor's network shall be supported by written agreements and sufficient to provide all covered services to members, including those with LEP, physical or cognitive disabilities, for the covered services the Contractor is responsible for under this Contract [42 CFR 457.1230(a); 42 CFR 438.206(b)(1)].

Regardless of the service 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's statewide service delivery system must provide member access to a statewide network of multi-specialty providers. Care shall be provided in a variety of service settings including community-based provider offices and locations, alternative clinic settings, and MSICs. The Contractor shall provide timely delivery of well-coordinated, multi-specialty, interdisciplinary covered services by a network of qualified providers to members in all regions of the State. Network design shall preserve continuity of care, existing member-provider relationships and member/family choice when feasible.

The Contractor's network shall include:

a. 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 in accordance with network standards and which maximize member choice and ensure timely access to covered services [42 CFR 438.206(b)(7)],

b. Ensuring providers have completed training or received certification related to the specific needs of the population that they serve, and as indicated on the scope of services included within their contract or facility license,

c. Innovative integrated service delivery models and 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, and

d. Community-based, PRO and FRO providers in urban, suburban and rural areas of the State.

The Contractor shall ensure covered services are accessible in terms of location and hours of operation. The Contractor must provide a comprehensive provider network that ensures its membership has access at least equal to community standards [42 CFR 457.1230, 42 CFR 438.206(b)(1)]. There shall be sufficient providers for the provision of all covered services, including emergency medical care on a 24-hour-a-day, seven-days-a-week basis [42 CFR 438.206(c)(1)(iii)]. The Contractor is required to have available non-emergent after-hours physician or primary care services within its network.

The Contractor is expected to develop a provider network that supports the provision of covered behavioral health services. The Contractor may not subcontract for or delegate to another entity for the delivery of behavioral health services. 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, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification [42 CFR 457.1201(1), 42 CFR 438.910(d)(3) and (5)].

The Contractor is expected to design a network that provides a geographically convenient flow of members among network providers to maximize member choice. The Contractor shall allow each member to choose his or her network provider to the extent possible and appropriate [42 CFR 457.1201(j), 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 457.1230(d), 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 457.1230(a), 42 CFR 438.206(c)(3)]. The Contractor shall meet network standards as specified in the AdSS Operations Manual, Policy 436 and the Contractor shall maintain a sufficient network in accordance with the requirements specified in ACOM Policy 436, 42 CFR 457.1218, 42, 42 CFR 438.68, 42 CFR 438.206(c)(1), 42 CFR 438.207(a), 42 CFR 438.207(c) AdSS Operations Manual Policy 436. In the event a Contractor is not able to meet set network standards, AHCCCS may review requested exceptions as specified in ACOM Policy 436 [42 CFR 457.1218, 42 CFR 438.68].

The Contractor’s provider network shall be designed to reflect the needs and service requirements of the Division’s culturally and linguistically diverse member population. The Contractor shall design its provider networks 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:

a. The AzSH;

b. Locally established, Arizona-based, independent Peer-Run Organizations and Family-Run Organizations. The Contractor shall provide technical assistance and support to Peer-Run Organizations and Family-Run Organizations as necessary; and

c. Master's and doctoral level trained clinicians in the fields of social work, counseling, marriage and family therapy, psychology and substance abuse counseling, who are trained in and implement nationally best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma-related disorders, substance use disorders, sexual offenders, sexual abuse victims, dialectical behavior therapy, members who are pregnant or postpartum, and specialized populations or age groups such as transition age youth and members aged birth to five years old. The Contractor shall develop incentive plans to recruit and retain locally-based Behavioral Health Professionals.

The Contractor shall ensure that all behavioral health services provided are medically necessary as determined by a licensed behavioral health professional.

MSICs

For members, including but not limited to members with CRS conditions, who could benefit from a multi-disciplinary approach, 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 event the Contractor and an MSIC fail to negotiate a contract, the Contractor must continue to allow members to utilize the MSIC.

In the absence of a contract, the Contractor shall reimburse the MSIC at the AHCCCS MSIC fee schedule. The Contractor shall not make payments for procedure code T1015 unless the procedure code is billed by an MSIC and it is for a member with a current or former CRS designation. 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 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 FQHCs/RHCs remains unchanged.

If the Contractor fails to negotiate contracts with all currently established MSICs, 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 MSIC shall be available:

a. Physicians,

b. Nurse Practitioners,

c. Physician Assistants,

d. Licensed Behavioral Health Professionals, and

e. Rehabilitation providers.

The Contractor shall take appropriate steps to include the availability of the following specialty providers at the single location:

a. Cardiologist,

b. Dentist,

c. Social Worker,

d. Nutritionist,

e. Physiatrist,

f. Otolaryngologist,

g. Gastroenterologist,

h. Neurologist,

i. Ophthalmologist,

j. Surgeon,

k. Orthopedist,

l. Plastic surgeon,

m. Urologist, and

n. Audiologist.

In the event the Contractor and an MSIC cannot agree to contract terms, the Contractor shall submit a description outlining the alternative delivery model, including proposed multispecialty

interdisciplinary care providers, to the Division for review and approval as specified in the AdSS Operations Manual, Policy 436 and Section F, Exhibit 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. 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 that includes allowing members with a CRS designation turning age twenty-one (21) years the choice to continue being served by an MSIC that is able to provide services and coordinate care for adults with special healthcare needs.

AzEIP

The Contractor is responsible for physical and behavioral health services for ALTCS members enrolled in AzEIP. All child members from birth until the child reaches the age of three (3) years are also enrolled in AzEIP and receive supports and services from Division contracted providers for Team-Based Early Intervention Services (TBEIS). TBEIS provides supports and resources to assist family members and caregivers to build upon and enhance children's learning and development through everyday learning opportunities.

The Contractor shall comply with the requirements of AzEIP. 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 must 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. 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 a child member who is enrolled in AzEIP. Irrespective of services covered by AzEIP, the Contractor remains responsible for timely coverage of all medically necessary services as specified in this Contract.

Centers of Excellence

The Contractor shall contract with Centers of Excellence which implement evidence-based practices and track outcomes for members with special healthcare needs (see Section D, Paragraph 11,

Behavioral Health Service Delivery Requirements, and Section D, Paragraph 81, Value-Based Purchasing).

Network Development and Management Plan

The Contractor shall develop and maintain a 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 457.1230(b), 42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)]. The submission of the NDMP to the Division is an assurance of the sufficiency of the Contractor's provider network. The NDMP Plan shall be evaluated, updated annually and submitted to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Network NDMP must include the requirements outlined in the AdSS Operations Manual, Policy 415.

The Contractor shall continually assess network sufficiency using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement 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)(c), 42 CFR 438.206].

The Contractor shall maintain a sufficient network in accordance with the requirements specified in the AdSS Operations Manual, Policy 436 and [42 CFR 457.1218, 42 CFR 438.6842 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 set network standards, the Contractor may request an exception to network standards to the Division for approval as specified in AdSS Operations Policy 436. The Division may review requested exceptions based upon a number of factors, including but not limited to, availability of out of network providers and geographic limitations of the service area [42 CFR 457.1218, 42 CFR 438.68].

The Contractor shall not discriminate with respect to participation in the Medicaid program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 457.1208, 42 CFR 438.12(a)(1)(2)]. In addition, the Contractor must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider

participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor 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 457.1208, 42 CFR 438.12(b)(1)-(3)]. If a Contractor declines to include individuals or groups of providers in its network, it must give the affected providers timely written notice of the reason for its decision [42 CFR 457.1208, 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)].

The Division may impose administrative actions for material deficiencies in the Contractor's provider network.

DME Service Delivery

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. Members with significant physical disabilities with electric wheelchairs in need of repair will be provided a manual wheelchair prior to the loss of the electric wheelchair. Additionally, a manual wheelchair will be provided to members whose planning team determines both an electric and manual wheelchair is needed. The Contractor is required to provide necessary DME to members in a timely manner consistent with Division Policy. The Contractor shall track and report timeliness of DME service delivery as outlined in the AdSS Operations Manual, Policy 415 and submit deliverables as specified Section F, Exhibit F3, Contractor Chart of Deliverables.

Graduate Medical Education Residency Training Programs

The Division is committed to workforce development and support of the medical residency and dental student training programs in the State of Arizona. The Division expects the Contractor to support these efforts. The Division encourages the Contractor to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in Contractor MM and committee activities. In the event of a contract termination between the Contractor and a GME Residency Training Program or training site, the Contractor may not remove members from that program in such a manner so as to harm the stability of the program. The Division reserves the right to determine what constitutes risk

to the program. Further, the Contractor must attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas.

Telehealth

Telehealth is defined as healthcare services delivered via asynchronous (store and forward), remote patient monitoring, teledentistry, telemedicine (interactive audio and video), or telephonic (audio-only). An appointment available to be delivered through telehealth is considered an available appointment where clinically appropriate. 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 and use of telehealth/tele monitoring in compliance with State and federal laws and the requirements of this Contract and all incorporated references. Refer to AdSS Medical Policy Manual, Policy 320-I. 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.

Workforce Development (WFD)

In accordance with ACOM Policy 407, the Contractor shall establish and maintain a Workforce Development Operation (WFDO). The WFDO works together with the Contractor's Network and Quality Management functions to ensure the provider network has:

a. Sufficient workforce capacity - An appropriate number of qualified workers needed to provide service,

b. Required level of workforce capability – Workers who are interpersonally, clinically, culturally, and technically competent in the skills needed to provide services, and

c. 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:

a. A Workforce Development Administrator;

b. A WFDO that is organizationally aligned with the Contractor's Network Management and Quality Management 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;

c. A Professional Development Plan for the Workforce Development Administrator; and

d. 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:

a. 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;

b. Produces the Contractor's Network Workforce Development Plan and contributes to the WFD Alliance's Annual Collaborative Assessment and Forecast of WFD Priorities of system wide workforce development needs and solutions for addressing them;

c. Ensures that Providers are following all AHCCCS required workforce training and competency requirements and practices;

d. Ensures that providers have access to and are following all training programs and practices required by the Report of the Abuse & Neglect Prevention Task Force to Governor Douglas A. Ducey (November 1, 2019):

   i. Resources and training programs to assist professionals and family caregivers prevent and manage stress and burnout,

   ii. Training for all personnel in the prevention and detection of all forms of abuse and neglect, and
   iii. 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.

e. Ensure 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.

f. Ensure 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.

g. Ensure 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
Other specialized populations as identified by the Contractor.

h. Collects and analyzes workforce data needed to prepare required and ad hoc workforce assessment reports, forecasts, and plans;

i. 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; and

j. Participates in routine and ad hoc WFD meetings with the AHCCCS Administrator of Healthcare Workforce Development as well as with the AZAHP WFD Alliance and Division staff as needed.

The Contractor shall submit deliverables related to WFD as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

COE Providers

The Contractor is expected to seek contracts with providers offering COE services to ensure timely follow-up and care coordination for its members.

31. PROVIDER AFFILIATION TRANSMISSION

The Contractor shall collect and submit information to the Division regarding its entire contracted provider network in the format specified in the AHCCCS 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 to the Division of a completed Minimum Network Requirements Verification Template as specified in AHCCCS' ACOM Policy 436, Attachment A. The PAT and the Minimum Network Requirements Verification Template must be submitted as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

32. NETWORK MANAGEMENT

The Contractor shall have written policies on how the Contractor will [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.12(a)(2), 42 CFR 438.214(a)]:

a. Communicate with the network regarding contractual and/or program changes and requirements;

b. Monitor network compliance with policies and rules of the Division, AHCCCS and the Contractor, including compliance with all policies and procedures related to the Grievance and Appeal System and ensuring the member's care is not compromised during the grievance/appeal processes;

c. Evaluate the quality of services delivered by the network;

d. Provide or arrange for covered services should the network become temporarily insufficient within the contracted service area;

e. Monitor the sufficiency, accessibility, and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;

f. Process provisional credentials;

g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling;

h. Provide training for its providers and maintain records of such training;

i. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate; and

j. Ensure that provider calls are acknowledged within three business days of receipt, resolved and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from the Division and/or AHCCCS).

Contractor policies are subject to approval by the Division, and shall be monitored through readiness and operational reviews. The Contractor shall monitor providers to demonstrate compliance with all network requirements in this Contract.

Facility and Member Placement Report: The Contractor shall comply with ACOM Policy 415 and submit the Therapeutic Foster Care, Adult Behavioral Health Therapeutic Home, and Adult Foster Care Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

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

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

The Contractor shall hold a Provider Forum no less than semi-annually. The forum must 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. The forum shall be open to all providers. The Contractor shall invite the Division to attend. The Provider Forum shall not be the only venue for the Contractor to communicate and participate in the issues affecting the provider network. Provider Forum meeting agendas and minutes must be made available to the Division upon request. The Contractor shall report information discussed during these Forums to Executive Management within the Contractor organization.

In addition to the Provider Forum, the Contractor shall coordinate a 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. The Contractor shall invite the Division to attend. These meetings shall occur no less than quarterly in the first year of the Contract and semi-annually thereafter.

The Contractor shall attend and participate in the Division's LTSS provider meetings as requested by the Division, in order to understand system-wide issues and challenges.

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, geographic service areas, 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 the Division. The Contractor shall submit the required documentation as specified in the AdSS Operations Manual, Policy 439 and as specified in Section F, Exhibit 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 46, Material Change to Business Operations, regarding material changes by the Contractor that may impact business operations. Refer to Section D, Paragraph 58, Capitation Adjustments, regarding material changes by the Contractor that may impact capitation rates.

The Contractor shall give hospitals and provider groups ninety (90) days' 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 opioid use disorder 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. Subcontractors.

   Populations served:
   a. Gender, and
   b. Age.

2. Services provided:
   a. Residential,
   b. Methadone maintenance,
   c. Buprenorphine maintenance,
   d. Naltrexone maintenance,
   e. Peer support, and
   f. Psychosocial.

3. Capacity (as applicable to provider type):
   a. Available beds,
   b. Methadone maintenance,
   c. Buprenorphine maintenance, and
   d. Naltrexone maintenance.

33. 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 the Division's appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. The Contractor shall adjust the size of a PCP's panel, as needed, for the PCP to meet appointment and clinical performance standards. The Division using the Provider Affiliation Transmission (PAT) Report, shall inform the Contractor when a PCP has a panel of more than 1,800 Medicaid members, 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 PCP assignments to the Division in an electronic data exchange format as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall provide information to the member on how to contact the member's assigned PCP [[42 CFR 457.1230(c), 42 CFR 438.208(b)(1)].

The Contractor shall ensure that providers serving EPSDT-aged members utilize AHCCCS required EPSDT Clinical Sample Forms and standardized developmental screening tools and are trained in the use of the tools. EPSDT-aged members shall be assigned to providers who have demonstrated a commitment to diagnosing and treating these members and who are trained on and who use AHCCCS approved developmental screening tools. See the AdSS Medical Policy Manual, Policy 430.

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 multi-disciplinary 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), 42 CFR 438.52(d), 42 CFR 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 (UIHP) PCP participating as a Contractor's network provider is permitted to choose that UIHP as his or her PCP as long as that provider has the capacity to provide the services [American Reinvestment and Recovery Act (ARRA) Section 5006(d), 42 CFR 457.1209, 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 Division shall inform the member in writing of his/her enrollment and of his/her PCP assignment. The Contractor is responsible for PCP assignment within ten (10) calendar days of the Contractor's receipt of notification of assignment by the Division. The Contractor shall make PCP assignment rosters available to providers within 10 business days of a provider's request. Refer to the AdSS Operations Manual, Policies 404 and 406 for member information requirements.

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

a. 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);

b. Initiating referrals for medically necessary specialty care;

c. Maintaining continuity of care for each assigned member;

d. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health;

e. Utilizing the EPSDT Clinical Sample Template required by the Division or electronic equivalent.

f. Providing clinical information regarding member's health and medications to the treating provider, including behavioral health providers, within ten (10) business days of a request from the provider;

g. If serving children, enrolling as a VFC provider; and

h. Checking the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program when prescribing controlled medications in accordance with A.R.S. § 36-2606.

Refer to requirements outlined in the AdSS Medical Policy Manual, 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.

34. MATERNITY CARE PROVIDER REQUIREMENTS

The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AdSS Medical Policy Manual. 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,
   c. Certified Nurse Midwives,
   d. 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 primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may elect to receive some or all of her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

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.

35. 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:

a. 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, the Contractor, PCP, hospital, court, Tribe, IHS, Tribal 638 Facility, school, or other State or community agency.

b. Use of Contractor's referral process;

c. 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;

d. 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;

e. Requirements for referral in order to ensure member access to behavioral health services. Refer to the AdSS Medical Policy Manual, Policy 580;

f. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners [42 CFR 457.1230(a), 42 CFR 438.206(b)(2)]; and

g. For members determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

Disposition of Referrals: The Contractor shall require that providers, when appropriate, communicate the final disposition of each referral to the referral source 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 457.1230(a), 42 CFR 438.206(b)(3)].

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

a. Clinical laboratory services,

b. Physical therapy services,

c. Occupational therapy services,

d. Outpatient speech-language pathology services,

e. Radiology and certain other imaging services,

f. Radiation therapy services and supplies,

g. Medical Equipment, appliances and medical supplies,

h. Parenteral and enteral nutrients, equipment and supplies,

i. Prosthetics, orthotics and prosthetic devices, and supplies,

j. Home health services,

k. Outpatient prescription drugs, and

l. 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 prior authorization.

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.

36. APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING AND REPORTING

The Contractor shall actively monitor and track compliance with appointment availability, transportation timeliness, monitoring, and reporting standards as required in the AdSS Operations Manual, Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that providers offer a range of appointment availability, per appointment timeliness standards, for initial services, and ongoing services based upon the clinical need of the member. The Contractor's network is prohibited from exclusively using same-day only appointment scheduling and/or open access. The Contractor is required to conduct regular reviews of the availability of providers and report this 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.

Pursuant to A.R.S. §8-201.01, for children in the Department of Child Safety custody and adopted children, if an initial behavioral health appointment is not provided within 21 days of the initial assessment the member may access services directly from any AHCCCS registered provider regardless of whether the provider is contracted with the Contractor. If the provider is not contracted with the Contractor, the provider must submit the claim to the Contractor and the Contractor shall reimburse the provider at the lesser of 130 percent of the AHCCCS system's negotiated rate or the provider's standard rate. Refer to AdSS Operations Policy manual, Policies 417 and 449.

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 forty-five (45) minutes, except when the provider is unavailable due to an emergency.

If the Contractor's network is unable to provide services required under this 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 457.1230(a), 42 CFR 438.206(b)(4)(5)].

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 (1) hour before the appointment; does not have to wait more than one (1) hour after the conclusion of the appointment for transportation home; and is not picked up prior to the completion of the appointment. 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 make the results from quarterly performance auditing protocols available to the Division upon request.

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

The Contractor shall establish processes to monitor and reduce the appointment “no-show” rate by provider and service type. As best practices are identified, the Division 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 [42 CFR 457.1230(a), 42 CFR 438.206(c)(1)(iv)-(vi)]. Appointment standards shall be included in the Contractor’s Provider Manual. The Contractor is encouraged to include the standards in the provider subcontracts. The Contractor shall meet the standards as specified in the AdSS Operations Manual, Policy 417 and the AdSS Medical Policy Manual, Policy 510.

37. 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 U.S.C. 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, RHC or FQHC Look-Alike.

The Contractor shall pay the unique PPS rates to FQHCs/RHCs and FQHC Look-Alikes for PPS-eligible visits. Reimbursement of case management, behavioral health group therapy, and telehealth and telemedicine services provided by a FQHC or RHC shall be in accordance with AHCCCS requirements. 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 Division reserves the right to review a Contractor's rates with an FQHC/RHC and FQHC Look-Alikes for reasonableness and to require adjustments when rates are found to be substantially less than those being paid to other, non-FQHC/RHC/FQHC Look-Alikes providers for comparable services, or not equal to or substantially less than the PPS rates.

The Contractor shall be required to submit member information for Title XIX and Title XXI members for each FQHC/RHC/FQHC Look-Alikes as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Division will perform periodic audits of the member information submitted. The Contractor should refer to the Financial Reporting Guide for further guidance. The FQHCs/RHCs/FQHC Look Alikes registered with AHCCCS are listed on the AHCCCS website.

Refer to Section D, Scope of Services Paragraph 9, Prescription Medications for more information related to 340B Drug Pricing.

38. PROVIDER ENROLLMENT/CERTIFICATION

Provider Enrollment

The Contractor shall ensure that all of 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 457.1285, 42 CFR 438.608; 42 CFR 455.100-106; and 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, date of birth, Social Security number, national provider identifier, 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 National Provider Identifier (NPI), for all providers eligible for an NPI, is required on all claim submissions from providers and subsequent encounters from MCOs to the Division and AHCCCS. The Contractor shall work with providers to obtain the NPI. The Division 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. The Division 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 Fee-For-Service provisions referenced in the AHCCCS Provider Participation Agreement located on the AHCCCS website (e.g., billing requirements, coding standards, payment rates) are in force between the provider and Contractor. The Contractor shall ensure that all of its subcontractors register with AHCCCS as an approved service provider. For specific requirements on Provider Registration refer to the AHCCCS website.

AHCCCS will screen and enroll, and periodically revalidate all of the Contractor's subcontracted providers as Medicaid providers as specified by 42 CFR 457.1285 and 42 CFR 438.602(b)(1).

HCBS Certification

The Contractor shall ensure that all of its subcontracted providers providing Physical Therapy Services for the habilitative needs of members twenty-One (21) years of age and older are HCBS certified by DES/DDD as required in A.A.C. R6-6-1501 through R6-6-1533. The Contractor shall ensure this requirement is listed in its Provider Manual. For specific requirements on HCBS Certification, refer to the Division's Provider Manual Chapter 61.

39. SUBCONTRACTS

The Contractor shall be held fully liable for the performance of all Contract requirements and for the performance of its subcontractors. 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 person 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 457.1201(i), 42 CFR 457.1233(b), 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 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(1)(i) - (ii), 42 CFR 438.6(l)], and shall incorporate by reference the applicable terms and conditions of this Contract.

The Contractor shall maintain a fully executed original or electronic copy of all subcontracts, which shall be accessible to the Division within five business days of the request by the Division. 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 the Division as proprietary. Information designated as confidential will not be disclosed by the Division 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.

The Division 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.

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor, the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities, then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor's local CEO must retain the authority to direct and prioritize any delegated Contract requirements.

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

The Contractor shall 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 457.1233(a), 42 CFR 438.214(d)(1)].

The Contractor shall require subcontracted providers to adhere to the requirements of the 2018 Arizona Opioid Epidemic Act SB1001, Laws 2018. First Special Session.

Minimum Subcontract Provisions
The Contractor and its subcontractors shall reference and require compliance with the AHCCCS Minimum Subcontract Provisions. Refer to the Minimum Subcontract Provisions 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 Minimum Subcontract Provisions and Contract.

In addition, each subcontract shall contain the following:

a. Subcontractor activities and obligations, and related reporting responsibilities [42 CFR 457.1233(b), 42 CFR 438.230(c)(1)(i)-(iii), 42 CFR 438.3(k)];

b. A provision requiring subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with Contract obligations [42 CFR 457.1233(b), 42 CFR 438.230(c)(2), 42 CFR 438.230(c)(1)(ii), 42 CFR 438.3(k)];

c. A provision that requires the subcontractor to comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance and Contract provisions [42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(2), 42 CFR 438.3(k)];

d. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor;

e. Identification of the name and address of the subcontractor;

f. Identification of the population, to include patient capacity, to be covered by the subcontractor;

g. The amount, duration and scope of medical services to be provided, and for which compensation will be paid;

h. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation;

i. The specific duties of the subcontractor relating to coordination of benefits and determination of TPL;

j. 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;

k. A description of the subcontractor's patient, medical, dental and cost record keeping system;

l. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AdSS Medical Policy Manual;

m. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of the Division;

n. A provision that indicates that the Division is responsible for enrollment, reenrollment and disenrollment of the covered population;

o. A provision that the subcontractor shall be fully responsible for payment of all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations, including but not limited to sexual abuse and molestation (SAM) coverage, which arise under this subcontract, for itself and its employees, and that the Division shall have no responsibility or liability for any such taxes or insurance coverage;

p. A provision that the subcontractor shall obtain any necessary authorization from the Contractor for services provided to eligible and/or enrolled members;

q. A provision that the subcontractor shall comply with encounter reporting and claims submission requirements as specified in the subcontract;

r. 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;

s. A provision for revocation of the delegation of activities or obligations, or specifies other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily [42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(1)(iii), 42 CFR 438.3(k)];

t. 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;

u. 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 457.1230(d), 42 CFR 438.210(e)];

v. A provision that the State, CMS, the 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 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(3)(i)-(iv)];

w. 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)];

x. 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;

y. 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 457.1233(b), 42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(3)(iv)];

z. For subcontractors licensed as an inpatient facility, Behavioral Health Residential or Therapeutic Foster Care (TFC) facility, a requirement to comply with Contractor's quality management and medical management programs; and

aa. A provision that the right to audit under Paragraph (c)(3)(i) of 42 CFR 438.230 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later [42 CFR 457.1233(b), 42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230].

In the event of a modification to the Minimum Subcontract Provisions, the Contractor shall issue a notification of the change to its subcontractors within thirty (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 (6) calendar months of the update, whichever comes first. Refer to AdSS Operations Manual, Policy 416.

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 providers who might typically document or provide these types of data to provide the required data via the DUGless portal.

The requirements, definitions, and values for submission of the identified data elements are outlined in the AHCCCS DUGless Portal Guide (DPG). Required information is collected by AHCCCS health care provider subcontractors and submitted via the DUGless Portal on the Provider AHCCCS Online. Data and information are recorded and reported to Contractors to assist in monitoring and tracking of the following:

a. Access and utilization of services,

b. Community and stakeholder information,

c. Compliance with Federal, State, and grant requirements,

d. Health disparities and inequities,

e. Member summaries and outcomes,

f. Quality and Medical Management activities, and

g. Social Determinants of Health.

Opioid Treatment Program Requirements

Pursuant to A.R.S. §36-2907.14, in addition to all State or Federal licensing and registration requirements, any Opioid Treatment Program (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.

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, or require that the provider not provide, services for any other Division 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 outlined in AdSS Medical Policy Manual, Chapter 600.

The Contractor shall make reasonable efforts to enter into a written agreement with any provider without a written agreement providing services at the request of the Contractor more than twenty-five (25) times during the previous Contract year and/or are anticipated to continue providing services for the Contractor. The Contractor shall follow the AdSS Operations Manual, Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the sufficiency 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 457.1208, 42 CFR 457.1233(a), 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 A.R.S. § 36-2918, § 36-2932, and § 36-2957.*

If the Contractor has a contract for specialty services with a NF, the contract shall include a Work Statement that outlines the special services being purchased, including admission criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description and other non-clinical services such as increased activities. In the event that a contract is terminated with a NF, the Contractor shall adhere to the requirements outlined in the AdSS Operations Manual, Policy 421.

NF 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 42 CFR 483.75(g-2). The provision shall also require the subcontractor to ensure these registry personnel are fingerprinted as required by A.R.S. § 36-411.

Administrative Services Subcontracts

All Administrative Services Subcontracts entered into by the Contractor require prior review and written approval by the Division and shall incorporate by reference the applicable terms and conditions of this Contract. Proposed Administrative Services Subcontracts shall be submitted as specified in the AdSS Operations Manual, Policy 438 and Section F, Exhibit 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. The Division will not permit one organization to own or manage more than one contract within the ALTCS-DD program. The Contractor's Administrator/CEO shall retain the authority to direct and prioritize any delegated

Contract requirements. The Contractor shall provide oversight to the Subcontractors in the completion of functions related to the QOC investigations processes onsite QOC visits and annual audits and reviews.

Delegated agreements for operational functions which are determined by the Division to inhibit integrated service delivery for the Medicaid or Medicare D-SNP lines of business are prohibited.

The Contractor shall not delegate the quality-of-care investigations processes or onsite quality of care 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 the Division. 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 the Division upon completion as specified in the AdSS Operations Manual, Policy 438 and Section F, Exhibit 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 non-compliance, the Contractor shall notify the Division and comply with the AdSS Operations Manual, Policy 438 and Section F, Exhibit F3, Contractor Chart of Deliverables.

The Contractor shall submit an annual Administrative Services Subcontractor Evaluation Report as specified in the AdSS Operations Manual, Policy 438 and Section F, Exhibit 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 66, Corporate Compliance.

A change to a subcontract due to a Change in Organizational Structure of an Administrative Services Subcontractor requires prior approval of the Division, as specified in the AdSS Operations Manual, Policy 438.

Pharmacy Benefit Manager Subcontracts Pass-Through PBM Pricing Model and Discrete Administrative Fee

The Contractor shall amend the subcontract between the Contractor and PBM to reflect a pass-through pricing model, defined as a PCM subcontract in which:

a. The Contractor reimburses the PBM the exact amount of the actual payments made to pharmacies inclusive of the ingredient costs and the dispensing fees for prescription claims;

b. The Contractor shall submit encounters to the Division 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.

c. All revenues, including direct 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/credits 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;

d. The Contractor pays 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;

e. For all Contractors, including those contracting with a PBM that subcontracts with another PBM, the submitted encounter 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; and

f. For Contractors whose PBMs subcontract with a Pharmacy Services Administrative Organization (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.

g. 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.

Effective October 1, 2020, the Division added a Contract recommendation limiting Pharmacy Benefits Manager administrative expenses to no more than $2.00 per prescription. This expense shall be reported by the Contractor as an administrative expense to the Division and shall not be included in the encounter amount. The discrete administrative fee shall be reported to the Division in the quarterly financial reporting packages as directed in the AHCCCS Financial Reporting Guide. Refer to Section F, Exhibit F3, Contractor Chart of Deliverables. Contractor pharmacy encounters must be submitted in accordance with the requirements in Section D, Paragraph 69, Encounter Data Reporting. The Contractor shall submit the PBM subcontract to the Division in order to demonstrate that it is in compliance with the above provisions as stated in Section F, Exhibit F3, Contractor Chart of Deliverables.

PBM Reimbursement Provision

The Contractor shall include specific content below in 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 95 percent Brand Name Prescription claims at a minimum, to be the following:

a. *84-Day Supply or Less*: The lesser of Average Wholesale Price (AWP) less 18 percent, the Submitted Ingredient Cost, or the Usual & Customary price, and

b. *Greater than an 84-Day Supply*: The lesser of AWP less 19.50 percent, the Submitted Ingredient Cost, or the Usual & Customary 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 – March 31 and followed by the period April 1 - September 30 and specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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 the Division their findings 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 AWP less 84 percent 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 Usual & Customary pricing or the submitted ingredient cost. All generic drugs prescription claims shall be reimbursed to network pharmacies at the lesser of the Maximum Allowable Cost (MAC), AWP less 18 percent, the Submitted Ingredient Cost, or Usual & Customary 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 – March 31 and followed by the period April 1 – 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 the Division their findings every six months for the time periods of October 1 through March 31 and April 1 through September 30.

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 percent for all Specialty and Biosimilar Drugs. Ninety-five percent of Specialty and Biosimilar Prescription claims, in aggregate, shall be reimbursed to pharmacies at the lesser of AWP less 18.25 percent, MAC, the Submitted Ingredient Cost, or the Usual & Customary price plus a Dispensing Fee. 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 – March 31 and followed by the period April 1 - 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 results of one guarantee shall not be used to off-set another guarantee.

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.

Mail Order Prescriptions Services

The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate for all Mail Order Pharmacy Prescriptions Claims of AWP less 24 percent and the Mail Order Prescription Claims shall be reimbursed, at a minimum, the lesser of AWP less 24 percent, the Submitted Ingredient Cost, MAC, or the Usual & Customary price. This is applicable to Contractors providing mail order services when the pharmacy is owned or 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 – March 31 and followed by the period April 1 – 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 results of one guarantee shall not be used to off-set another guarantee.

Pharmacy Benefit Manager — Rebate Payment

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:

a. 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 percent of the collected rebates, whichever is greater for all prescription utilization.

b. The PBM subcontractor shall include language that requires the PBM to report rebates and administrative fees to the Contractor in the AHCCCS requested format.

c. The PBM subcontract shall include language that does not allow administrative costs to be collected and kept by the PBM for utilization that is rebated 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.

d. The Contractor shall not apply monies received for rebates or the administration of rebates against the administrative costs of the PBM contract.

e. The PBM subcontract should include language requiring the PBM to monitor generic drug pricing with specific timelines and report back to the Contractor on the monitoring to ensure that adjustments are made to the pricing when drug pricing increases or erodes. The language should include a specific response time for pricing resolution when inquiries are brought to the attention of the PBM by the Contractor or Network Pharmacy. The PBM subcontract should consider language with performance guarantees that address adherence to the AHCCCS Drug List Preferred Agents for the AHCCCS Supplemental Rebate Classes Preferred Agents.

Other- Miscellaneous

The PBM subcontract shall include:

a. A clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy,

b. Language requiring the Contractor's PBM to monitor and update the Maximum Allowable Cost (MAC) 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 MAC 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 MAC price and receive instructions from the PBM as to where to purchase the drug at the MAC 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,

c. Language with performance guarantees that address adherence to the AHCCCS Drug List Preferred Agents for the AHCCCS Supplemental Rebate Classes Preferred Agents,

d. Language that allows the Contractor to terminate the PBM subcontract without cause and without penalty, and

e. Language that upon termination of the PBM's contract the following, at a minimum, will be transferred to the PBM at no charge:

   i. Claims History File,
   ii. Prior Authorization File,
   iii. Mail Order Open Refills File,
   iv. Specialty Drug Open Refills File,
   v. Accumulators File (if the Contractor has a corresponding Medicare Advantage Plan for Dual Eligibles),
   vi. Adjustments, and
   vii. Other requests by AHCCCS.

40. PROVIDER MANUAL

Provider Manual Requirements

The Contractor shall develop, distribute and maintain a provider manual as specified in the AdSS Operations Manual, Policy 416. The Contractor shall ensure that each contracted provider is made aware of the provider manual available on the Contractor's website or, if requested, issued a hard copy of the provider manual. The Contractor is encouraged to distribute a provider manual to any individual or group that submits claims data.

The Contractor remains responsible for ensuring that all providers, whether contracted or not, meet the applicable Division requirements.

41. SPECIALTY CONTRACTS

AHCCCS may at any time negotiate or contract for specialized hospital and medical services. In doing so, AHCCCS will consider existing resources in the development and execution of specialty contracts. As a result of these contracting activities, the Division may require the Contractor to modify its delivery network to accommodate the provisions of specialty contracts.

Specialized Hospital and Medical Services

The Division, subject to AHCCCS approval, may consider waiving the 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 adjudication of claims related to such payments provided under specialty contracts. Payment of such claims shall remain the responsibility of the Contractor.

Current mandated specialty contracts include transplant services, but may be expanded by AHCCCS to include other types of services. The Division may provide at least forty (40) days advance written notice to the Contractor and the Division prior to the implementation of any specialty contract. The Division may provide technical assistance prior to the implementation of any specialty contracts.

Refer to Section D, Paragraph 59, Reinsurance.

42. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

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

If there is an ownership change in the management services subcontractor, the assignment of the management services agreement shall be approved by the Division prior to the assignment to the new subcontractor. Refer to the AdSS Operations Manual, Policy 317. The Division may impose enrollment caps in any or all GSA's as a result of a change in ownership. The Division may also offer open enrollment to the members assigned to the Contractor should a change in ownership occur. The Division will not permit two Contractors within the same Line of Business to utilize the same management service company in the same GSA.

The performance of management service subcontractors shall be evaluated and included in the Administrative Services Subcontractor Evaluation Report as specified in Section F, Exhibit F3, Contractor Chart of Deliverables and as specified in the AdSS Operations Manual, Policy 438.

43. 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, A.R.S § 36-2905.01, A.R.S. § 36-2905.03, and A.A.C. R9-22, Article 7, which includes without limitation: reimbursement of the majority of inpatient hospital services using the All Patient Refined-Diagnosis Related Groups (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 by non-contracted hospitals in Pima and Maricopa Counties at ninety-five percent (95%) of the amounts otherwise payable for inpatient services; and, reimbursement of inpatient behavioral health services provided by non-contracted behavioral health inpatient facilities (in any county) at ninety percent (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 44, Claims Payment/Health Information System.

For information on Differential Adjusted Payments see Section D, Paragraph 56, Compensation.

44. CLAIMS PAYMENT/ HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data [Section 6504(a) of the Affordable Care Act, Section 1903(r)(1)(F) of the Social Security Act, 42 CFR 457.1233(d), 42 CFR 438.242(a)(b)]. These processes and systems shall result in information on areas including, but not limited to, service utilization, claim disputes and member grievance and appeals, and disenrollment for reasons other than loss of Medicaid eligibility [42 CFR 457.1233(d), 42 CFR 438.242(a)].

General Claims Processing Requirements

Claims submission deadlines for institutional claims (UB-04 CMS 1450) 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. When billing a date span for all other claim types, claims submission deadlines shall be calculated by using the “from” date if service.

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)(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:

a. Medicaid National Correct Coding Initiative for Professional, ASC and Outpatient services,

b. Multiple Procedure/Surgical Reductions, and

c. Global Day Evaluation and Management (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:

a. Benefit Package Variations,

b. Timeliness Standards,

c. Data Accuracy,

d. Adherence to Division and AHCCCS Policy,

e. Provider Qualifications,

f. Member Eligibility and Enrollment, and

g. 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:

a. The reason(s) for denials and adjustments,

b. A detailed explanation/description of all denials, payments and adjustments,

c. The amount billed,

d. The amount paid,

e. Application of COB and copays, and

f. 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 advices 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 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 68, Systems and Data Exchange Requirement, for specific standards related to remittance advice and EFT payment.

At the Division's direction, the Contractor must attend and participate in AHCCCS workgroups including Technical Consortium meetings to review upcoming initiatives and other technical issues.

Per A.R.S. § 36-2904, unless a shorter time period is specified in Contract, the Contractor shall not pay a claim initially submitted more than six (6) months after the date of service or date of eligibility posting whichever is later, or pay a clean claim submitted more than twelve (12) months after date of service or date of eligibility posting, whichever is later; except as directed by the Division or otherwise noted in this Contract.

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

Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)(5) – (6); 42 CFR 447.46; sections 1932(f) and 1902(a)(37)(A) of the Social Security Act].

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), ninety-five percent (95%) of all clean claims are adjudicated within thirty (30) days of receipt of the clean claim and ninety-nine percent (99%) are adjudicated within sixty (60) days of receipt of the clean claim. In accordance with the Deficit Reduction Act (DRA), Section 6085, SMD letter 06-010, and Section 1932 (b)(2)(D) of the Social Security Act, the Contractor is required to reimburse non-contracted emergency services providers at the AHCCCS 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 ninety-five percent (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, prior authorization, 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 prior authorization and the member failed to initially disclose additional insurance coverage other than Medicaid coverage.

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

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

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

In the absence of a contract specifying other late payment terms, a claim for an authorized service submitted by a NF shall be adjudicated within thirty (30) calendar days after receipt by the Contractor. A Contractor is required to pay interest on payments made after thirty (30) days of receipt of the clean claim. Interest shall be paid at the rate of one percent (1%) per month (prorated on a daily basis) from the date the clean claim is received until the date of payment [A.R.S. § 36- 2943(D)].

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

When interest is paid, the Contractor must report the interest as directed in the Division Encounter Manual and the Claims Dashboard Reporting Guide. Standardized claims for services shall be submitted per A.A.C. R9-28-701.10(5).

Refer to the AdSS Operations Manual, Policy 203 for additional information regarding requirements for the adjudication and payment of claims.

Recoupments

The Contractor's claims processes, as well as its prior authorization and concurrent review process, 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 twelve (12) months after the date of the original payment shall be approved as specified in Section F, Exhibit F3, Contractor Chart of Deliverables and as further specified in the AdSS Operations Manual, 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 Division as specified in the Division's Claims Dashboard Reporting Guide and Section F, Exhibit 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. The Division 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 one hundred and twenty (120) days of the approval of the recoupment. Refer to the AdSS Operations Manual, Policy 412, and the Division's Encounter Manual for further guidance.

Appeals

If the decision of the Contractor, Division, or AHCCCS Director 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 AHCCCS Director's Decision and applicable statutes, rules, policies, and Contract terms. The provider shall have ninety (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 ninety (90) day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process as a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

Claims Processing Related Reporting

The Contractor shall submit a monthly Claims Dashboard as specified in the Claims Dashboard Reporting Guide, AdSS Operations Manual, Policy 203, and Section F, Exhibit F3, Contractor Chart of Deliverables.

The Division may require the Contractor to review claim requirements, including billing rules and documentation requirements, and submit a report to the Division that will include the rationale for specified requirements. The Division 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:

a. Verification that provider contracts are loaded correctly, and

b. 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 in every five (5) 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.

45. 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 457.1201(h), 42 CFR 457.1207, 42 CFR 438.10(f)(3), 42 CFR 438.3(i), 42 CFR 422.208 and 42 CFR 422.210. These regulations, in part, prohibit the Contractor from operating any physician incentive plans 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 the Division. For those proposed contractual arrangements which meet the definition of substantial financial risk, the following shall be submitted to the Division for review and approval at least thirty (30) days prior to the implementation of the contract as specified in Section F, Exhibit F3, Contractor Chart of Deliverables [Section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 457.1201(h), 42 CFR 422.208(c)(2), 42 CFR 438.3(i), 42 CFR 438.6(g)]:

a. The type of incentive arrangement,

b. A plan for a member satisfaction survey,

c. Details of the stop-loss protection provided,

d. A summary of the compensation arrangement that meets the substantial financial risk definition, and

e. Any other items as requested by the Division.

Upon request from CMS, AHCCCS or the Division, the Contractor shall 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 the Division prior to implementation as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

The Division shall review the VBP deliverables required under Section D, Paragraph 81, VBP.

46. MATERIAL CHANGE TO BUSINESS OPERATIONS

The Contractor is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's business operations [42 CFR 438.207 (c)]. All material changes to the business operations shall be approved in advance by the Division.

The Contractor may be required to conduct meetings with providers and/or members to address issues related changes to business operations, changes in policy, reimbursement matters, prior authorizations and other matters as identified or requested by AHCCCS.

Refer to Section D, Paragraph 30, Network Development, regarding material changes by the Contractor that may impact the provider network.

Refer to Section D, Paragraph 68, Systems and Data Exchange Requirements, for additional submission requirements regarding system changes and upgrades.

47. MINIMUM CAPITALIZATION

The Contractor is required to meet a minimum capitalization requirement within thirty (30) days after Contract award. Once the new Contract period commences, the minimum capitalization may be applied to the Contractor’s equity per member standard, which continues throughout the Contract period. See Section D, Paragraph 52, Financial Viability Standards.

48. PERFORMANCE BOND OR BOND SUBSTITUTE

In addition to the minimum capitalization requirements, the Contractor shall be required to establish and maintain a performance bond for as long as the Contractor has liabilities of $50,000 or more outstanding, or fifteen (15) months following the termination date of this Contract, whichever is later, to guarantee: 1) payment of the Contractor's obligations to providers, and 2) performance by the Contractor of its obligations under this Contract [42 CFR 438.604(a)(4), 42 CFR 438.606, 42 CFR 438.116]. The Performance Bond shall be in a form acceptable to the Division as described in the AdSS Operations Manual, Policy 305.

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

a. Paying any damages sustained by providers, non-contracting providers and non-providers and other subcontractors by reason of a breach of the Contractor's obligations under this Contract;

b. Reimbursing the Division for any payments made by the Division on behalf of the Contractor;

c. Reimbursing the Division for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this Contract, including, but not limited to, expenses incurred after termination of this Contract for reasons other than the convenience of the State by the Division; and

d. Making any payments or expenditures deemed necessary to the Division, in its sole discretion, incurred by the Division in the direct operation of the Contractor.

If it is necessary for the Division to obtain payment under the performance bond or substitute security but finds it is not sufficient to cover payments or expenditures incurred by the Division in the direct operation of the Contractor, the Contractor shall reimburse the Division for expenses exceeding the performance bond or substitute security amount.

In the event the Division agrees to accept substitute security in lieu of the security types outlined in the AdSS Operations Manual, Policy 305, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce the Division’s security interest in such substitute security including, but not limited to, security agreements and necessary Uniform Commercial Code (UCC) filings pursuant to the Arizona UCC. The Contractor must request approval from the Division before a substitute security in lieu of the security types outlined in the AdSS Operations Manual, Policy 305 is established. In the event such substitute security is agreed to and accepted by the Division, the Contractor acknowledges that it has granted the Division a security interest in such substitute security to secure performance of its obligations under this Contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. The Division may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide the Division with a form of security described in the AdSS Operations Manual, Policy 305.

The Contractor may not change the amount, duration or scope of the performance bond without prior written approval from the Division.

The Contractor shall not leverage the bond as collateral for another loan or debt or use the bond as security to creditors. The Contractor shall be in material breach of this Contract if it fails to maintain or renew the performance bond as required by this Contract and as outlined in Section F, Exhibit F3, Contractor Chart of Deliverables.

49. AMOUNT OF PERFORMANCE BOND

The initial amount of the Performance Bond shall be equal to 100% of the total capitation payment expected to be paid to the Contractor in the first month of the Contract Year, or as determined by the Division. The total capitation amount excludes premium tax. This requirement must be satisfied by the Contractor no later than thirty (30) days after notification by the Division of the amount required. Thereafter, the Division shall review the capitation amounts of the Contractor on a monthly basis to determine if the Performance Bond must be increased. If the amount of the Performance Bond falls below ninety percent (90%) of the monthly capitation amount excluding premium tax, the amount of the performance bond must be increased to at least one hundred percent (100%) of the monthly capitation amount excluding premium tax. The Contractor shall increase the amount of the Performance Bond no later than thirty (30) days following notification by the Division. The Performance Bond amount that must be maintained after the Contract term shall be sufficient to cover all outstanding liabilities and will be determined by the Division. The Contractor may not change the amount, duration or type of the performance bond without prior written approval from the Division. Refer to the AdSS Operations Manual, Policy 305 for more details.

50. ACCUMULATED FUND DEFICIT

The Contractor and its owners must review 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 the Division. The capital contributions must be for the period in which the deficit is reported and shall occur within thirty (30) days of the financial statement due to the Division. The Division at its sole discretion may impose a different timeframe other than the thirty (30) days required in this paragraph. The Division may, at its option, impose an enrollment cap as a result of an accumulated deficit, even if unaudited.

51. ADVANCES, EQUITY DISTRIBUTIONS, LOANS AND INVESTMENTS

The Contractor shall not, without the prior approval of the Division, 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 of business within its organization. The Contractor shall not, without prior approval of the Division, make loans or advances to providers in excess of $50,000. All requests for prior approval are to be submitted to the Division, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Refer to the AdSS Operations Manual, Policy 418 for further information.

52. FINANCIAL REPORTING AND VIABILITY STANDARDS

The Contractor must comply with the Division established financial viability standards or any revisions or modifications of the standards, in conformance with the AHCCCS Financial Reporting Guide. On a quarterly basis, the Division 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 and Contract Year to Date Total Administrative Cost Percentage [42 CFR 438.116 (a)-(b)]. These same standards will be reviewed for the financial statements applicable to the Contractor's Medicare line of business if the Contractor's Medicare line of business is certified by AHCCCS. The Contractor shall submit all required reporting to the Division for financial viability standards as specified in AHCCCS' Financial Reporting Guide and Section F, Exhibit F3, Contractor Chart of Deliverables.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. The Division 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 Medical Loss Ration (MLR) and Contract Year to Date Administrative ratio Cost Percentage results. However, if a critical combination of the Financial Viability Standards is not met, or if the Contractor's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

The Contractor shall cooperate with the Division reviews of the ratios and financial viability standards below. The ratios and financial viability standards are as follows:

FINANCIAL VIABILITY STANDARDS

Current Ratio	Current assets 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 percent). All components of the calculation should include annual audit adjustments. Standard: At least 1.00 If current assets include a receivable from a parent or related company, the parent or related company must have liquid assets that support the amount of the inter-company loan. Other assets deemed restricted by the Division are excluded from this ratio.
Equity per Member	Unrestricted equity, less on-balance sheet performance bond, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted, divided by the number of members enrolled at the end of the period. Contract Year Ending (CYE)2020: At least $450 per member CYE2021 and thereafter: At least $500 per member The Contractor must demonstrate compliance with the equity per member standard for CYE2020 and CYE2021 by the end of each Contract period. Once the equity per member standard is met, the Contractor must maintain compliance with the equity per member requirements for the remainder of the Contract term. Additional information regarding the Equity per Member requirement may be found in the Performance Bond and Equity per Member Requirements policy in the AdSS Operations Manual, Policy 305. [42 CFR 438.604(a)(4); 42 CFR 438.606; 42 CFR 438.116].
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. For additional information, refer to the AHCCCS Financial Reporting Guide. Standard: At least eighty-five percent (85%)

Administrative Cost Percentage	Total administrative expenses - administrative expenditures for activities that improve health care quality included in the Medical Loss Ratio above, divided by premium revenue ─ less Federal, State, and local taxes and licensing and regulatory fees. All components of the calculation should include annual audit adjustments. Refer to the AHCCCS Financial Reporting Guide. Standard: No greater than eight percent (8%)

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 457.1201(k), 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 Contract term 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.

Additional information regarding the Equity per Member requirement may be found in the AdSS Operations Manual, Policy 305.

Medical Loss Ratio (MLR) Annual Requirement

The Contractor shall submit an MLR report and Attestation in compliance with 42 CFR 457.1203 and 42 CFR 438.8 as specified in Section F, Exhibit 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 the Division, a new report incorporating the change will be required to be submitted within twenty (20) days of the capitation rate adjustment payment by the Division. For additional information see AHCCCS' Financial Reporting Guide.

53. FINANCIAL REPORTING

The Contractor shall submit annual audit adjustments with the draft and final audit packages and comply with all financial reporting requirements contained in Section F, Exhibit F3, Contractor Chart of Deliverables and the applicable AHCCCS Financial Reporting Guide, a copy of which may be found on the Division's website. The required reports are subject to change during the Contract term and are summarized in Section F, Exhibit F3, Contractor Chart of Deliverables [[42 CFR 457.1201(k), 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, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall utilize the AHCCCS prepared Excel template as specified in the AHCCCS Financial Reporting Guide.

54. SEPARATE OR AFFILIATED CORPORATION

Within 120 days of Contract award, a non-governmental Contractor shall have established a separate or affiliated corporation for the purposes of this Contract, whose sole activity is the performance of the requirements of this Contract or other contracts with the Division.

55. CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

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

members are not diminished and that major components of the organization and Division programs are not adversely affected by the change in organizational structure. The Division 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, the Division reserves the right to temporarily suspend a Contractor's new member enrollment including, but not limited to, auto-assignment pending the Division 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 the Division determines that a change in organizational structure is not in the best interest of the State, the Division may terminate this Contract pursuant to Section G2: Uniform Terms and Conditions. The Division may offer open enrollment to the members assigned to the Contractor should a change in organizational structure occur.

56. COMPENSATION

The method of compensation under this Contract will be PPC, prospective capitation and reinsurance, as specified and defined within this Contract and appropriate laws, regulations or policies [42 CFR 438.6(b)(1)]. Final capitation rates are identified and developed, and payment is made in accordance with 42 CFR 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 457.1201(c), 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/capitation.html Subject to the availability of funds, the Division shall make payments to the Contractor in accordance with the terms of this Contract provided that the Contractor's performance is in compliance with the terms and conditions of this Contract. Payment must comply with requirements of A.R.S. Title 36. The Division reserves the option to make payments to the Contractor by wire or National Automated Clearing House Association transfer and will provide the Contractor at least thirty (30) days' notice prior to the effective date of any such change.

Where payments are made by EFT, the Division shall not be liable for any error or delay in transfer or 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 Contract term may be kept by the Contractor.

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

Except for monies received from the collection of third-party liabilities, the only source of payment to the Contractor for the services provided hereunder is from funds under the control of the Division. An error discovered by the State, in the amount of fees paid to the Contractor, with or without an audit, will be subject to adjustment or repayment by the Division 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, the Division must be notified and reimbursed within thirty (30) days of identification [42 CFR 438.608(c)(3)].

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

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 457.1270; 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].

Capitation Rate Development

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

a. Utilization and unit cost data derived from fully adjudicated and approved encounters, as well as individual encounter level detail as needed;

b. Audited financial statements reported by the Contractor;

c. HCBS and Institutional inflation trends;

d. AHCCCS Fee-For-Service schedule pricing adjustments, if applicable;

e. Historical and projected enrollment by risk group.

f. Member specific statistics, e.g., member acuity, member choice.

g. Programmatic or Medicaid Covered Service changes that affect reimbursement;

h. Additional administrative requirements for the Contractor that affect reimbursement; and

i. Other changes to medical practices that affect reimbursement.

The Division adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The Division reserves the right in future periods to implement risk mitigation methodologies, including but not limited to risk adjustment and/or acuity adjustment, likely utilizing available encounter data. Therefore, the Contractor is strongly encouraged to ensure that encounters are submitted accurately and timely. The Division will provide the Contractor with appropriate notice should the decision be made to implement one or more risk mitigation strategies.

Additional elements that may be considered in capitation rate development include:

a. Reinsurance (as specified in Section D, Paragraph 59, Reinsurance),

b. Age/Gender,

c. Medicare enrollment, and

d. Supplemental information requested from Contractors.

Information is reviewed by the Division and AHCCCS each year to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan or the Section 1115 Demonstration Waiver Special Terms and Conditions approved by CMS; however, those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e), (Section 1903(i) and 1903(i)(17) of the Social Security Act]. Graduate Medical Education payments (GME) are not included in the capitation rates but are paid out separately consistent with the terms of Arizona's State Plan. Likewise, EHR payments are also excluded from the capitation

rates and are paid out separately by AHCCCS pursuant to Section 4201 of the HITECH Act, 42 USC 1396b(t), and 42 CFR 495.300 et seq.

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

Capitation rate development will not include costs for amounts expended for providers excluded by Medicare or Medicaid, except for emergency services.

Capitation

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 during the prospective and PPC period coverage.

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 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)].

Cost Settlement for COVID Vaccine

The Contractor is responsible for COVID vaccine administration and submitting those expenses as encounters. AHCCCS will make cost-settlement payments to the Contractor based upon adjudicated/approved encounter data.

Reconciliation of Prospective and Prior Period Coverage (PPC) Costs to Reimbursement

The Division will reconcile the Contractor's prospective and PPC service cost expenses to prospective and PPC net capitation paid to the Contractor for each Contract year. Refer to the AdSS Operations

Manual, Policy 311, CYE20 and Forward – Tiered Prospective and PPC Reconciliation, for further details. For CYE23, this reconciliation 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 PROFIT**
<= 2%	100%	0%	2%	2%
> 2%	0%	100%	0%	2%

The Division intends to review the administrative rate at the end of the Contract period to ensure the capitation rate included the correct administrative rate based on the actual member months for the Contract period. The Division will ensure the amounts are contractually compliant with the admin rate and the overall capitation rate is valid. This will result in additional funds to or recoupment from the Contractor.

SMI Costs for AIHP

The Division will compute the SMI Costs for AIHP BH services on a quarterly basis from the encounters submitted to the Division and will make the associated amounts of payments owed to the Contractor outside of the monthly capitation payments through a separate payment.

Practitioner/Dentist Rate Requirements

The Contractor shall be required to pass through an adjustment equal to the AHCCCS defined adjustment to base reimbursement rates for services reimbursed under the AHCCCS dental fee schedule and physician fee schedule effective October 1, 2020 for all contracted rates in place three

months prior to the effective date of the rate adjustment required by Laws 2020, Ch. 46, Sec 2. AHCCCS or the Division may verify that these pass-through requirements have been met.

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 Prospective Payment System (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. Refer to Section D, Paragraph 38, Federally Qualified Health Centers And Rural Health Clinics for additional information.

Special Provisions for Payments

In accordance with 42 CFR 438.6, the Contractor shall be eligible for an incentive payment, and shall participate in delivery system and provider payment initiatives, and shall direct payments to providers as specified by the Division. These provisions are specified below.

Incentive Arrangements

This Contract provides for the following incentive arrangement between the Division and the Contractor.

Alternative Payment Model–Performance Based Payments

The APM-PBM 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 improving access to care. In accordance with AdSS Operations Manual, Policy 307, for those APM arrangements which result in PBP to providers, the Division will make a lump-sum payment to the Contractor on an annual basis.

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 Division. 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 five percent (5%) of the approved capitation payments attributable to the members or services covered by the incentive arrangement.

These incentive arrangements:

a. 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.

b. Are not to be renewed automatically.

c. Are made available to both public and private contractors under the same terms of performance.

d. Do not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

e. 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)(3)].

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 prior 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, and

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 (APSI)

Access to Professional Services Initiative (APSI) is a program to preserve and promote access to medical services through 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 outlined in ACOM Policy 330.

Federal regulation mandates that APSI payments be approved by CMS before they shall be implemented. The Division will notify the Contractor when CMS approves the APSI preprint.

AHCCCS will compute the Qualified Practitioners rate increase and will make a fifth of the estimated annual payment amounts on a quarterly basis. Interim payments are calculated using projected experience for the Contract Year.

The Division may amend APSI components annually or during the contract year and will provide guidance to the Contractor as applicable.

Pediatric Services Initiative

The Division 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 the freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds as outlined in ACOM Policy 327. Federal regulation mandates that these payments be prior approved by CMS before they shall be implemented. The Division 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.

Effective with dates of service on and after October 1, 2019, the Division will pay qualifying providers in accordance with ACOM 327, to freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds as defined in ACOM Policy 327 for all claims for which AHCCCS is the primary payer. The funding source provided by this initiative is intended to supplement, not supplant, payments to the freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than one hundred (100) licensed pediatric beds, excluding nursery beds.

AHCCCS will compute the Qualified Practitioners interim rate increase on a quarterly basis and will make the associated amounts of payments owed. Interim payments are calculated using projected experience for the Contract Year.

The Division may amend the PSI components annually or during the contract period, and will provide guidance to the Contractor as applicable.

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 prior approved by CMS before they shall be implemented. The Division will notify the Contractor when CMS approves the Differential Adjusted Payments (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 on 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.*

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 Fee-For-Service Fee Schedules - Differential Adjusted Payments - “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 prior approved by CMS before they shall be implemented. AHCCCS will notify the Contractor when CMS approves the HEALTHII. Contractors shall 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 percent of the total on a quarterly basis. Lump sum payments made outside of monthly capitation will be sent by the Division with payment directions. No later than 24 months after the end of the contract period, AHCCCS intends to adjust final HEALTHII payment amounts by the Division and provider based on actual utilization incurred and will direct the Division to adjust payments at that time. AHCCCS may amend the HEALTHII components annually or during the contract period and will provide guidance to the Division, as applicable.

57. MEMBER TRUST FUND ACCOUNT MONITORING

The Contractor shall have a policy regarding on-site monitoring of trust fund accounts for members residing in NFs to ensure that expenditures from the 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 66, Corporate Compliance.

If the Contractor identifies that a patient trust account combined with other resources will exceed the allowable resource limit outlined in A.A.C. R9-28-407 or a balance nearing that limit, the Contractor shall notify the Division. The Division will ensure that the assigned support coordinator submits an electronic MCR.

58. CAPITATION ADJUSTMENTS

Rate Adjustments

Capitation rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR 457.10 [42 CFR 457.1203(a)]. Capitation rates may be modified during the term of the Contract when changes made to provisions in the Contract require adjustment to maintain actuarially sound rates. In addition, the Division, at its sole discretion, may adjust capitation rates to address fundamental changes in circumstances such as:

a. Program changes,

b. Legislative requirements,

c. Updated encounter experience,

d. Rate setting assumptions, and

e. 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; the Division will not unreasonably withhold such a review.

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

Contractor Default

In accordance with Section G1, Special Terms and Conditions, Paragraph 33.3, if the Contractor is in any manner in default in the performance of any obligation under this Contract, the Division 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 the Division and/or the Division may deduct from future monthly capitation for any portion of a month during which the Contractor was not at risk due to, for example:

a. Death of a member,

b. Inmate of a public institution,

c. IMD stays greater than fifteen (15) cumulative days during the calendar month for members aged twenty-one (21) – sixty-four (64) years,

d. Duplicate capitation to the same Contractor,

e. Adjustment based on change in member's contract type, or

f. Voluntary withdrawal.

The Division reserves the right to modify its approach to capitation recoupments at any time during the term of this Contract.

Inmate of a Public Institution Reporting

The AZ Department of Corrections Rehabilitation and Reentry (ADCRR) and several counties are submitting daily files of all inmates entering or being released from their custody. AHCCCS will match these files against the database of active members. 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. The Division will provide the Contractor with incarceration information for the member on the Contractor's 834 file. The file will indicate an "IE" code for ineligible

associated with the disenrollment. The file will also include a data element indicating the County of jurisdiction and "CTYPRI" as the new Contractor of enrollment due to incarceration. Upon release from jail, the member will be re-enrolled with his/her previous Contractor unless that Contractor 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 by the Contractor via email to the following email address: MCDUJustice @azahcccs.gov with a copy sent to the Division at DDDJusticeSystemLiaison@azdes.gov.

Notifications shall include:

a. AHCCCS ID,

b. Name,

c. Date of Birth (DOB),

d. When incarcerated, and

e. Where incarcerated.

59. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS through the Division to the Contractor for the partial reimbursement of covered medical services for the Contract year as specified in this paragraph. The reinsurance Contract Year is October 1 and ending on September 30. Reinsurance is paid for services incurred for a member beyond an annual deductible level. The reinsurance program is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which the Division 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 the Division during the term of this Contract. Any change would have a corresponding impact on capitation rates. Refer to the Division's Reinsurance Policy Manual.

The Division will reimburse the 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. PPC and prospective expenses are included under the reinsurance program.

The Division may perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits and the Contractor will be given appropriate advance notice.

The table below represents deductible and coinsurance levels. Refer to the specific case types below for coverage details.

REINSURANCE CASE TYPE	DEDUCTIBLE	COINSURANCE
Regular Reinsurance	$150,000	75%
Catastrophic Reinsurance	NA	85%
Transplant and Other Case Types	See specific paragraphs below	See specific paragraphs below

Annual deductible levels apply to all members eligible for reinsurance.

Regular Reinsurance

Regular reinsurance covers partial reimbursement of covered inpatient hospital services. Inpatient services are those services provided in an acute care hospital (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 residential treatment centers and subacute facilities. Reimbursement for these reinsurance benefits will be made to the Contractor each month. This coverage applies to prospective and PPC enrollment periods. In certain situations, as outlined in the Division's Reinsurance Policy Manual, per diem rates paid for NF services provided within thirty (30) days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to ninety (90) days in any Contract year shall be eligible for reinsurance coverage. The NF stay must be the first continuous NF stay post inpatient discharge. A second admission to the NF is not eligible for reinsurance unless there is an additional Inpatient stay

preceding the second admission. Same-day admit-and-discharge services do not qualify for reinsurance. Regular reinsurance covers the inpatient provider types listed above, but does not cover services provided by any other inpatient provider type, including but not limited to residential treatment centers and subacute facilities. See the Division's Reinsurance Policy Manual for additional details.

Encounter Submission and Payments for Reinsurance

Contractors are reimbursed for reinsurance claims by submitted encounters that associate to a reinsurance case. All reinsurance associated encounters, except as provided below for "Disputed Matters," shall reach an adjudicated/approved status within fifteen (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 limits the allowable reimbursement, the amount to be used in the computation of reinsurance will be the lesser of the contracted/mandated amount or the Contractor paid amount.

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. The Division 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, replacement encounters shall be submitted. For replacement encounters resulting in an increased claim value, the replacement encounter shall reach adjudicated/approved status within fifteen (15) months of end date of service to receive additional reinsurance benefits. The Contractor should refer to Section D, Paragraph 69, Encounter Data Reporting, for encounter reporting requirements.

Catastrophic Reinsurance

The Catastrophic Reinsurance program encompasses members receiving certain biologic/high-cost specialty drugs and those members diagnosed with Hemophilia, Von Willebrand's Disease or Gaucher's Disease, as follows:

a. *Biologic/High-Cost Specialty Drugs:* Catastrophic reinsurance is available to cover the cost of certain biologic/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 Division's Reinsurance Policy Manual for a complete list of the approved biologic/high-cost specialty drugs. When a generic equivalent of a biologic/high-cost specialty drug is available, the Division will reimburse at eighty-five percent (85%) of the lesser of the biologic/high cost specialty drug or its biosimilar equivalent for reinsurance purposes, unless the biosimilar equivalent is contra-indicated for a specific member. If the AHCCCS Pharmacy & Therapeutics Committee mandates the utilization of only the brand name biologic/high-cost specialty drug rather than biosimilar, the Division will reimburse at eighty-five percent (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, MM for each separate drug in order to receive Reinsurance.

b. *Hemophilia:* Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia. 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 prior authorization, 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 eighty-five percent (85%) of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower.

c. *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.

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

For additional detail and restrictions refer to the Division's Reinsurance Policy Manual.

There are no deductibles for catastrophic reinsurance cases. For member's receiving biologic/high-cost specialty drugs, the Division will reimburse at eighty-five percent (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 eighty-five percent (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 Willebrands, Gaucher's and all other disease states.

The Contractor must notify the Division and AHCCCS of cases identified for catastrophic reinsurance coverage, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Catastrophic reinsurance will be paid for a maximum thirty (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, Exhibit F3, Contractor Chart of Deliverables. All catastrophic claims are subject to medical review by the Division and AHCCCS.

Transplant Reinsurance

This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the AdSS Medical Policy Manual, Policy 310-DD and the Division's Reinsurance Policy Manual for covered services for organ and tissue transplants. The Contractor must notify the Division and 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 the Division. In order to qualify for reinsurance benefits, the Transplant Reinsurance Request shall be received by the Division as specified in Section F, Exhibit 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, Exhibit F3, Contractor Chart of Deliverables.

1. The Contractor shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant medications prior to denying services.

2. Any Contractor network provider who requests authorization for a service shall be notified of the option to request a peer-to-peer discussion with the Contractor's Medical Director when additional information is requested by the Division or when a PA request is denied.

3. 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 Division's Medical Director. An approved transplant performed at a non-contracted facility will be reimbursed at 85 percent 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, Division Finance/Reinsurance may consider, on a case-by-case basis, the Contractor's reinsurance coverage at eighty-five percent (85%) of the Contractor's paid amount for comparable case/component rates. If no prior approval is obtained, and the Contractor incurs costs at non-contracted facility or for a non-contracted transplant type, those costs will not be eligible for either transplant or regular reinsurance.

Payment of Transplant Reinsurance Cases

Reinsurance coverage for transplants received at an AHCCCS contracted facility is to be paid at the lesser of eighty-five percent (85%) of the AHCCCS Contract amount for the transplantation services rendered, or eighty-five percent (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 eighty-five percent (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 reimbursement is eighty-five percent (85%) of the AHCCCS transplant contract amount.

Reinsurance payments will be linked to transplant encounter submissions. The Contractor is required to submit all supporting service encounters for transplant services and additional documentation as identified in the Division's Reinsurance Policy Manual. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters shall equal the amounts on the required documentation submitted to the Division. 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 adjudicated no later than fifteen (15) months from the end date of service for each particular transplant stage. Refer to the Division's Reinsurance Policy Manual for appropriate billing of transplant services.

Other Catastrophic Reinsurance

For all reinsurance case types other than transplants, the Contractor will be reimbursed one hundred percent (100%) for all medically necessary covered expenses provided in a contract year, after the Contractor paid amount in the reinsurance case reaches $1,000,000. It is the responsibility of the Contractor to notify the Division, AHCCCS DHCM, Reinsurance Supervisor and Reinsurance Analyst, once a reinsurance case reaches $1,000,000. Failure to notify AHCCCS or failure to adjudicate encounters appropriately within fifteen (15) months from the end date or service will disqualify the related encounters for one hundred percent (100%) reimbursement consideration.

Payment of Regular and Catastrophic Reinsurance Cases:

The Division will reimburse the Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/Third Party Liability (TPL) payment, less any applicable quick pay discounts, slow payment penalties and interest. For reimbursement of reinsurance encounters in subcapitated arrangements, as identified in the Division's Reinsurance Policy Manual.

Disputed Matters

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

60. COMMUNITY REINVESTMENT

The Contractor shall demonstrate a commitment to the local communities in which it operates by contributing six percent (6%) of its annual profits to community reinvestment projects or proposals designed to support members in achieving or maintaining his/her highest level of self-sufficiency. The

Contractor shall submit a plan, detailing its anticipated community reinvestment activities, within 60 days of the start of the contract year for the expected profits as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor is required to submit an annual Community Reinvestment Report as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

61. MEMBER BILLING AND LIABILITY FOR PAYMENT

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

Except for calculated Member SOC, the Contractor and its subcontractors must ensure that members are not held liable for:

a. The Contractor's or subcontractor's debts in the event of the Contractor's or the subcontractor's insolvency [42 CFR 438.606, 42 CFR 438.116, Section 1932(b)(6) of the Social Security Act]; and

b. Covered services provided to the member except as permitted under A.A.C. R9-28-701.10(2) [42 CFR 457.1226, 42 CFR 457.1233(b), 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].

Payments to the Contractor or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or the 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].

62. MEMBER SHARE OF COST

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 SOC, have a SOC in the amount of $0.00. Generally, only institutionalized members have a SOC. For members receiving NF services, Collection of the member SOC shall remain the responsibility of the Division. The Contractor will receive capitation payments which do not incorporate an assumed deduction for the SOC members contribution to the cost of care with the expectation that NF provider

rates are not deducted by the SOC. Collection of the member SOC shall remain the responsibility of the Division.

63. COORDINATION OF BENEFITS AND THIRD-PARTY LIABILITY

Medicaid is the payor of last resort unless specifically prohibited by applicable State or Federal law, for instance, AzEIP. This means Medicaid funding 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 the AdSS Operations Manual, Policy 434. The Contractor's coordination of benefits must not result in the delay of the provision of services to members, nor result in the inappropriate use of Medicaid funding when services are payable by liable third parties.

If the Contractor verifies the probable existence of a liable third party that is not known to the Division or AHCCCS, or identifies any change in coverage, the Contractor shall report the information to the Division and AHCCCS, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the sanctions specified in Section G1, Special Terms and Conditions, Section 44 Sanctions.

The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. § 36-2903, and A.A.C. R9-28, Article 9, so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this Contract. The two methods used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as described in A.A.C. R9-28, Article 9, Federal and State law, and the AdSS Operations Manual, Policy 434. For Contractor cost sharing responsibilities for members covered by both Medicare and Medicaid see AdSS Operations Manual, Policy 201 [42 CFR 433 Subpart D, 42 CFR 447.20].

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

Division's TPL Unit shall provide the format and reporting schedule for this information to the Contractor.

Cost Avoidance

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

If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the Contractor is responsible for making these payments in accordance with the AdSS Operations Manual, 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 FFS Crossover Claims Payment Coordination

The Division delegates the coordination of benefits payment activities with legally liable third parties, including Medicare, to the Contractor. For dual eligible members, the Contractor shall coordinate Medicare FFS crossover claims payment activities with the Medicare BCRC in accordance with 42 CFR 438.3(t).

The Contractor shall be registered with the BCRC and AHCCCS as a trading partner to electronically process Medicare FFS crossover claims. An attachment to the existing AHCCCS Medicare FFS COBA shall be executed by the Contractors and AHCCCS to register with the BCRC as a trading partner. Upon completion of the registration process, the BCRC shall issue the Contractor a unique COB ID number

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 the Contractor regarding the Medicare FFS COBA process and BCRC requirements are available at:

Medicare BCRC webpage: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html

COBA Implementation User Guide: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Downloads/COBA-Implementation-Guide-January-2017.pdf

Electronic File Layouts: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/COBA-File-Formats-and-Connectivity/COBA-File-Formats-and-Connectivity-page.html

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

Members Covered by both Medicare and Medicaid (Duals)
Refer to Section D, Paragraph 65, 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 the AdSS Operations Manual, 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 Sources
For a period of two (2) 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. See the AdSS Operations Manual, 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 TPL 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 the Division:

a. Motor Vehicle Cases,

b. Other Casualty Cases,

c. Tortfeasors,

d. Restitution Recoveries, and/or

e. Worker's Compensation Cases.

Upon identification of a potentially liable third party for any of the above situations, the Contractor shall, within ten (10) business days, report the potentially liable third party to the Division and the AHCCCS' TPL Contractor on behalf of the Division for determination of a mass tort, total plan case, or joint case, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section G1, Special Terms & Conditions, Section 44, Sanctions.

A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tortfeasor(s) to recover damages arising from the same or similar set of circumstances (e.g., class action lawsuits) regardless of whether any reinsurance or 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 the Division's authorized representative in all collection efforts.

Total Plan Cases

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

a. Total collections received do not exceed the total amount of the Contractor's financial liability for the member;

b. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (e.g., lien filing); and

c. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify the 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 sanctions specified in Section G1, Special Terms and Conditions, Section 44 Sanctions.

The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Settlement Notification Form (see ACOM Policy 434), within 10 business days from the settlement date or in an AHCCCS-approved monthly file, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the sanctions specified in Section G1, Special Terms and Conditions, Section 44, Sanctions.

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 ten (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.

The Contractor shall cooperate with the Division, AHCCCS and AHCCCS' authorized TPL Contractor in all collection efforts.

Cost Avoidance/Savings/Recoveries Report

The Contractor shall submit reports regarding cost avoidance/saving/recovery activities, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

Contract Termination

Upon termination of this Contract, the Contractor will complete the existing TPL cases or make any necessary arrangements to transfer the cases to the Division and AHCCCS' authorized TPL representative.

64. COPAYMENTS

The Contractor is required to comply with the requirements articulated in the AdSS Operations Manual, Policy 431; the MH parity requirements under Section D, Paragraph 9, Scope of Services, of this Contract; and Division directives regarding the application of copayments.

Populations exempt from copayments or subject to non-mandatory (also known as nominal or optional) copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108]. Members under this Contract are currently exempt from mandatory and optional copayments.

65. 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 (Fee-for-Service), a Medicare Advantage Plan, or a State-contracted Medicare Advantage Dual Eligible Special Needs Plan 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 costs. 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 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 outlined in the AdSS Operations Manual, Policy 201. Refer to Section D, Paragraph 9, Scope of Services, Prescription Medications, regarding coverage of Medicare Part D medications.

In Original Medicare, a dual eligible member may access Medicare services from any provider enrolled (authorized to participate) in Medicare. Dual eligible members who choose to obtain Medicare-covered services from a "non-participating" (not authorized to participate) Medicare provider may be required to pay for the entire charge at the time of service, which may be greater than the Medicare-approved amount. Dual eligible members are to be encouraged to obtain Medicare covered services from participating Medicare providers that accept "assignment" (accept the Medicare-approved amount as payment in full for Medicare covered services).

For a dual eligible member enrolled in a State-contracted Medicare Advantage D-SNP for Medicare covered services, the dual eligible member must follow the D-SNP's rules as approved by CMS, including but not limited to those governing use of the plan's provider network in obtaining covered services.

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 the Division pursuant to the AdSS Operations Manual, Policy 201 and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

66. CORPORATE COMPLIANCE

Corporate Compliance Program

The Contractor shall be in compliance with 42 CFR 457.1285 and 42 CFR 438.608 and all applicable Division and AHCCCS policies, manuals and regulations. The Contractor shall have a Corporate Compliance Program that is designed to guard against fraud, waste and abuse (FWA) 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 19, Staff Requirements. The Contractor's written Corporate Compliance Plan shall adhere to the Contract requirements, including the AdSS Operations Manual, Policy 103, and shall be submitted annually to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

The Corporate Compliance Program shall be designed to prevent, detect, and report FWA. The Corporate Compliance Program shall include:

a. 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.

b. The Corporate Compliance Officer shall be a local management or virtual official who reports directly to the Contractor's Administrator/CEO or 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.

c. Effective lines of communication between the Corporate Compliance Officer and the Contractor's employees.

d. Enforcement of standards through well-publicized disciplinary guidelines.

e. Establishment and implementation of procedures that include provision for the prompt referral of any potential fraud, waste, or abuse to the Division and AHCCCS-OIG.

f. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, fact finding 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.

g. Submission of an External Audit Plan/Schedule, and Audit Report of all individual provider audits submitted to the Division and AHCCCS-OIG, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

h. 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.

Pursuant to the DRA of 2005, the Contractor, as a condition for receiving payments, shall establish written policies for any employees and of any contractor or agent detailing [Section 1902(a)(68) of the Social Security Act, 42 CFR 457.1285, 42 CFR 438.608(a)(6)]:

a. Federal False Claims Act provisions,

b. The administrative remedies for false claims and statements,

c. Any State laws relating to civil or criminal penalties for false claims and statements, and

d. The whistleblower protections under such laws.

The Contractor must require, through documented policies and subsequent Contract amendments, that subcontractors and providers train their staff on the following aspects of the Federal False Claims Act provisions:

a. The administrative remedies for false claims and statements,

b. Any State laws relating to civil or criminal penalties for false claims and statements, and

c. The whistleblower protections under such laws.

The Contractor must establish a system for training and education for the Corporate Compliance Officer, the Contractor's senior management, all staff and new hires on the Federal and State standards and requirements under the Contract. All training must be conducted in such a manner that can be verified by the Division.

The Contractor must notify the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

The Contractor shall report a 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 [Section 1903(m)(4)(B) of the Act] as specified in Section F, Exhibit F3, Contractor Chart of Deliverables:

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 DHHS Secretary may require that information reported with respect to 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.

Reporting Alleged FWA

In accordance with A.R.S. § 36-2918.01, § 36-2932, § 36-2905.04 and the AdSS Operations Manual, Policy 103, the Contractor, its subcontractors and providers are required to notify the AHCCCS OIG, copying the Division, of all allegations of FWA involving the Medicaid Program immediately, but no later than ten (10) business days. The Contractor shall promptly notify AHCCCS and the Division, 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 457.1285, 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 Medicaid Program. Notification to AHCCCS-OIG and the Division shall be in accordance with the AdSS Operations Manual, Policy 103 and as specified

in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall also report to AHCCCS and the Division, as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, any credentialing denials including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.17, 42 CFR 455.1(a)(1)].

The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS-OIG and/or the Division 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 and/or the Division. The Contractor agrees to provide documents, including original documents, to the AHCCCS-OIG and/or the Division upon request and at no cost. The AHCCCS-OIG and/or the Division shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed twenty (20) business days from the date of the request.

Once the Contractor has referred a case of alleged FWA 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 FWA, including any and all monetary recoveries in connection with, related to or otherwise arising out of the overpayment(s).

In the event that the Contractor has recovered an overpayment, the Contractor shall notify AHCCCS/OIG, copying the Division, as specified in Section F, Exhibit 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 Division and AHCCCS policy manuals for disposition.

In addition, the Contractor must furnish to the Division, AHCCCS or CMS within thirty-five (35) days of receiving a request, full and complete information, pertaining to business transactions [42 CFR 455.105]:

a. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the twelve (12)-month period ending on the date of request; and

b. Any significant business transactions between the Contractor, any subcontractor, and wholly owned supplier, or between the Contractor and any subcontractor during the five (5) year period ending on the date of the request.

Disclosure Information

The Contractor shall submit all disclosure Information requested in AdSS Operations Manual, 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, AdSS Operations Manual, Policy 103, and in Section F, Exhibit F3, Contractor Chart of Deliverables; and creditors [42 CFR 455, Subpart B, 42 CFR 455.436, 42 CFR 457.1285, 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 AdSS Operations Manual, Policy 103, as directed by regulation, and upon request from the Division, AHCCCS or CMS [42 CFR 455, Subpart B].

The Contractor shall provide the above-listed disclosure information to the Division at any of the following times [Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act, 42 CFR 457.1285, 42 CFR 438.608(c)(2), 42 CFR 455.100 – 103, and 42 CFR 455.104(c)(3)]:

a. Upon the Contractor submitting the Proposal in accordance with the State's procurement process;

b. Upon the Contractor executing the Contract with the State;

c. Upon renewal or extension of the Contract;

d. Forty-five (45) days prior to the effective date of commencement of operations for a change in Contractor Organizational Structure (see Section D, Paragraph 55, Change of Contractor Organizational Structure);

e. Within thirty-five (35) days after any change in ownership of the Contractor; and

f. Upon request by the Division or AHCCCS.

The Contractor must immediately notify AHCCCS-OIG, copying the Division, of any person who has been excluded through these checks in accordance as specified in Section F, Exhibit 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:

a. The Contractor is controlled by a sanctioned individual [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].

b. 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 CFR 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].

c. 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 457.1285, 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].

d. 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), SMDL6/12/08, SMDL 1/16/09].

e. 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:

   i. Any individual or entity is or was excluded from participation in 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]; or

   ii. Any entity that would provide those services through an excluded individual or entity (Section 1903(i)(2) of the Social Security Act, 42 CFR 431.55(h), 42 CFR 438.808, 42 CFR 1002.3(b)(3), SMD letter 6/12/08, and SMD letter 1/16/09).

Should the Division 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, the Division 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 457.1285, 42 CFR 438.610].

The Contractor shall require Fiscal Agents, Administrative Services Subcontractors and their contracted providers to adhere to the requirements outlined above regarding disclosure Information requested in the AdSS Operations Manual, 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 and the Division the identity of any excluded person [42 CFR 438.604(a)(6), 42 CFR

438.606, 42 CFR 455.104(b)(1)(i)-(iii), 42 CFR 455.104(b)(2)-(4), 42 CFR 438.230, 42 CFR 438.608(c)(2)].

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).

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.

67. RECORD RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to the Division and documentation used in the preparation of reports to the Division. The Contractor

shall comply with all specifications for record keeping established by the Division. All records shall be maintained to the extent and in such detail as required by the Division rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by the Division.

The Contractor agrees to make available, at all reasonable times during the term of this Contract, any of its records for inspection, audit or reproduction by any authorized representative of the Division, AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

The Contractor is required to retain records for the longest period of time under applicable state and federal requirements including but not limited to A.R.S. §35-214, §12-2297, 42 CFR 431.17, and 42 CFR 438.3(u). At a minimum record must be retained for five years after completion of the subcontract.

Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Subcontract, or costs and expenses of the Subcontract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law (42 CFR 431.17, A.R.S. §41-2548).

68. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

The Division supports new and evolving technologies that create efficiencies, improve quality of care 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 electronic health records (EHRs), e-prescribing, Health Information Organization (HIO), and a Health Information Exchange (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:

a. Access to care,

b. Care coordination,
c. Prescribing practices, for example, polypharmacy,
d. Evidence based care,
e. Medical management programs,
f. EPSDT services,
g. Coordination with community services,
h. Referral management,
i. Discharge planning,
j. Performance measures,
k. Performance improvement projects,
l. Medical record review,
m. Quality of care review processes,
n. Quality improvement,
o. Claims processing,
p. Claims review, and
q. Prior authorization.

The Contractor is required to exchange data with the Division relating to the information requirements of this Contract and as required to support the data elements to be provided to the Division. All data exchanged shall be in the formats prescribed by the Division, which include those required/covered by HIPAA. Details for the formats may be found in the Claims Dashboard Reporting Guide, Grievance and Appeal Report Guide, Financial Reporting Guide, HIPAA Transaction Companion Guides, Encounter Manual, Technical Interface Guidelines, 834, and Capitation Guide available on AHCCCS' website and in the Division User Guides and Addendums for Claims Submissions.

The information exchanged with the Division 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 the Division.

Electronic Transactions

The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or prior authorization

requests; or the receipt of electronic remittance. The Contractor shall be able to make claims payments via EFT and have the capability to accept electronic claims attachments.

Contractor Data Exchange

Before a Contractor may exchange data with the Division, certain agreements, authorizations, and control documents are required in order to exchange data with the Division.

With the completion of required documents as specified in the AHCCCS Encounter Manual, each Contractor is assigned a 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 imposed on the Division by AHCCCS applied due to any error, omission, deletion, or incorrect data submitted by the Contractor. Any data that does not meet the standards required by the Division shall not be accepted by the Division.

The Contractor is required to provide an 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 [42 CFR 438.606] as outlined in the HIPAA Transaction Companion Guides and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables [42 CFR 457.1201(o), 42 CFR 457.1201(n)(2), 42 CFR 438.606].

Neither the State of Arizona nor DES/DDD 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 claims.

The Contractor is also responsible for identifying any inconsistencies immediately upon receipt of data from the Division. If any unreported inconsistencies are subsequently discovered, the Contractor shall be responsible for the necessary adjustments to correct its records at its own expense.

Member Data

The Contractor shall accept from the Division original evidence of eligibility and enrollment in the Division prescribed electronic data exchange formats. Upon request, the Contractor shall provide to the Division PCP and Dental Home assignments in a Division-prescribed electronic data exchange format.

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, § 36-2904 and A.A.C. R9-28-701.10. The system shall be adaptable to updates in order to support future Division 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:

a. Receive eighty-five percent (85%) of total claims (e.g., professional, institutional and dental), with a minimum of sixty percent (60%) requirement by form type, based on volume of actual claims excluding claims processed by PBMs electronically;

b. Produce and distribute seventy-five percent (75%) of remittances electronically; and

c. Provide eighty-five percent (85%) of claims payments via EFT.

The Division intends to increase the percentage requirements over the term of the Contract.

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. The DES will work with the Contractor as they evaluate Electronic Data Interchange options. A DES MIS systems contact will be assigned after the Contract award.

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to the Division for review and comment as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

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. The contractor shall report HIPAA incidents to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Data Security

The Contractor is required to have a security audit performed by an independent third party on an annual basis. See the AdSS Operations Manual, Policy 108. The annual audit report must be submitted to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. If the Contractor is an Affiliated Organization of another contracted AHCCCS Plan, a single, joint annual audit report may be submitted to AHCCCS and the Division in satisfaction of this annual deliverable.

The audit must include, at a minimum, a review of Contractor compliance with all security requirements as specified in the Security Rule Compliance Summary Checklist, as specified in the AdSS Operations Manual, Policy 108. In addition, the audit must include a review of Contractor policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Contractor's business practices, and the production processing systems.

The audit must result in a findings report and as necessary a CAP, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The CAP must also include timelines for corrective actions related to all issues or discrepancies identified. The annual report must include the findings and CAP for review and approval. The Division will verify that the required audit has been completed and the approved remediation plans are in place and being followed.

Contractor Warrants

The Contractor warrants that it will establish and maintain procedures and controls acceptable to ADES and the Division for ensuring that all information obtained, and records prepared in the course of providing any services to members under the Contract is protected from unauthorized access, is not mishandled, misused, or inappropriately released or disclosed. To comply with the foregoing warranty, the Contractor:

a. *Shall*: (1) notify the Division immediately of any unauthorized access or inappropriate disclosures, whether stemming from an external security breach, internal security breach, system failure, or procedural lapse; (2) cooperate with the Division to identify the source or cause of and respond to

each unauthorized access or inappropriate disclosure; and (3) notify the Division promptly of any security threat that could result in unauthorized access or inappropriate disclosures; and

b. *Shall not*: release information or allow it to be released or divulge any such information to anyone other than its employees or officers or authorized sub-contractors as needed for each person's individual performance of his or her duties under the Contract, unless the Division has agreed otherwise in advance and in writing.

The Contractor warrants that the Contractor:

a. Is familiar with and will comply with the applicable aspects of the following collective regulatory requirements regarding patient information privacy protection: (1) the "Privacy Rule" under HIPAA; (2) Arizona laws, rules, and regulations applicable to PHI/ePHI that are not preempted by 45 CFR 160(B) as amended; and (3) the Division's current and published privacy and security policies and procedures;

b. Will cooperate with the Division in the course of performing under the Contract so that both the Division and Contractor stay in compliance with the requirements in (a) above; and

c. Will sign any documents that are reasonably necessary to keep both DES/DDD and Contractor in compliance with the requirements in (a) above, in particular "Business Associate Agreements" in accordance with the Privacy Rule.

Health Information Exchange (HIE)

The Contractor is required to contract with the State designated Health Information Exchange (HIE) organization, Contexture, a non-profit organization which provides a secure network for the exchange of clinical health information. The Contractor shall sign a participation agreement, with Contexture, to ensure each Contractor has access to the HIE for any permitted uses, as described in the Contexture Participation Agreement. To further the integration of technology-based solutions and the promotion of interoperability of Electronic Health Records (EHR) within the system of care, AHCCCS and the Division will increase opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption and use of health information technology may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor is expected

to actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' and the Division's expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the DDD program. The Division also anticipates establishing minimum standards, goals, and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. The Division 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 Contexture'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, and
5. Identifying value-based purchasing opportunities that link with a provider's adoption and use of Health Information Technology (HIT).

The Contractor shall encourage providers that are participating in the Medicaid 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 the Division and Contexture 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 continuum of care facilities,
2. Identifying partnerships for integrated care among other health care delivery participants,
3. Identifying and implementing strategies that improves care coordination and health outcomes for high need/high-cost members,
4. Coordinating care for members who are enrolled in the DDD Tribal Health Program,
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 Contexture 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 quality improvement activities and reporting as identified by the Contractor or the Division, and
11. Other activities as identified by the Division and that are allowed under the Permitted Use Policy of the HIE organization, Contexture.

To support outreach to the providers in each Contractor's network, each Contractor is recommended to develop, with Contexture, a recruitment plan that can achieve a ten percent (10%) increase in the number of providers that join the HIE.

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 the Division's effective dates.

69. ENCOUNTER DATA REPORTING

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 (ONCs) "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.

Complete, accurate and timely reporting of encounter data is crucial to the management of the Division and Medicaid program. Encounter data is used 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 the Division for all services for which the Contractor incurred a 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 457.1233(d), 42 CFR 457.1285, 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)].

A new Contractor must successfully exchange encounter data for all applicable form types with the Division no later than 120 days after the start of the Contract or be subject to possible corrective actions up to and including sanctions and enrollment caps.

Encounter Submissions

Encounters shall be submitted in the format prescribed by the Division. Encounter data shall be provided to the Division as specified in the Division's Encounter Manual and HIPAA Transaction

Companion Guides, 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 the Division no later than 210 days after the date of service 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 Division's Encounter Submission Guide.

Covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act; the State shall collect such rebates from manufacturers (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMD letter 10-006). To ensure compliance with this requirement, pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing shall be provided to the Division 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 U.S.C. § 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 SMD letter 10-006).

The Contractor's 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.

The Contractor shall prepare, review, verify, certify, and submit encounters for consideration to the Division. Upon submission, the Contractor shall provide attestation that the services listed were actually rendered.

The Contractor shall be subject to sanctions for noncompliance with encounter submission completeness, accuracy and timeliness requirements.

Encounter Reporting

The Contractor 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 the Division as required per the Division's Encounter Manual or as directed by the Division and as further specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

On a monthly basis, the Division will produce encounter reconciliation files containing the prior eighteen (18) months of approved, voided, plan-denied, pended and AHCCCS-denied encounters received and processed by the Division. 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 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 should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the Encounter Submission Guide for further information regarding the content and layouts of these files.

Encounter Corrections

The Contractor is required to monitor and resolve pended encounters and encounters denied by the Division or AHCCCS.

The Contractor is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission as specified below. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by the Division, 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 Division's Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards

The Division has established encounter performance standards as detailed in the Division's 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 Validation Studies

Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. The Contractor must provide medical records and supporting documentation upon request by the Division or AHCCCS as required under Section F, Exhibit F3, Contractor Chart of Deliverables. These studies may result in sanctions of the Contractor and/or require a CAP 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' 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.

70. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

Enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data is produced daily. 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.

A Monthly Enrollment Transaction is also produced, 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 Monthly Enrollment Transaction in addition to the daily enrollment transaction update to update its member records.

71. PERIODIC REPORTING REQUIREMENTS

Under the terms and conditions of the Division's contract with AHCCCS, and as an agency of the State, the Division 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 sanction as specified in Section G1, Special Terms and Conditions, Section 44 Sanctions.

Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242(b)(2)]:

Timeliness
Reports or other required data shall be received on or before scheduled due dates.

Accuracy
Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or Division-defined standards.

Completeness
All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

Exclusive: All reports including, but not limited to Work Plans and Annual Program Plans, shall include a comprehensive analysis and reporting of Contractor activities exclusive to the Division of Developmental Disabilities line of business. The Contractor shall submit timely, accurate, and complete initiatives that address strategies and performance activities for the provision of integrated services for members enrolled in the ALTCS-DD Program.

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 457.1285, 42 CFR 438.604(b), 42 CFR 438.606]. Division 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 the Division including those pertaining to subcontractor reporting requirements. The Contractor shall be responsible for continued reporting beyond the term of the Contract.

72. REQUESTS FOR INFORMATION

The Division 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 the Division as proprietary. Information designated as confidential will not be disclosed by the Division without the written consent of the Contractor except as required by law. Upon receipt of such requests for information from the Division, the Contractor shall provide complete information as requested no later than ten (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 legal analysis to the Division, within the timeframe designated by the Division, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that the Division 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.

73. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by the Division, AHCCCS or the Federal government, to its members and subcontractors. All costs shall be the responsibility of the Contractor.

74. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including the AdSS Operations Manual, Policy 101 [42 CFR 457.1224, 42 CFR 438.104]. The Contractor shall submit all proposed marketing materials for approval as specified in Section F, Exhibit F3, Contractor Chart of Deliverables and as specified in the AdSS Operations Manual, Policy 101. All marketing materials that have been approved by the Division may be distributed by the Contractor for a period of two (2) years from the date of approval and shall be re-approved after that time.

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 was in compliance with ACOM Policy 101. If AHCCCS determines a violation occurred, the Contractor may be subject to administrative action.

75. READINESS REVIEW

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 the Division 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 Division requirements on all Readiness Review elements in order to continue operating under this Contract [42 CFR 438.66(d)(3)].

Following the award of the Contract, the Division will conduct a comprehensive Readiness Review to evaluate the Contractor's ability to implement the terms of this Contract. Readiness Review activities will begin immediately upon the award of the Contract and continue until the Contractor has satisfied all Readiness Review elements to commence operations and receive member assignments for enrollment. The Readiness Review activities will assess the Contractor's ability to provide covered services to members at the start of the program and service implementation date. The Contractor may be subject to onsite reviews as part of the readiness activities to determine the adequacy of the Contractor's infrastructure to support the provision of services to the ALTCS-DD population on a statewide basis. Readiness includes, but is not limited to, the Contractor having a comprehensive network that complies with all network sufficiency standards as outlined in Section D, Paragraph 30, Network Development and AdSS Operations Manual, Policy 436 no later than August 1, 2019. The Contractor must satisfy the Division's requirements on all Readiness Review elements in order to commence and continue operating under this Contract [42 CFR 438.66(d)(3)]. The Division reserves the right to not assign membership to the Contractor in the event the Division determines that readiness requirements are not met.

76. MONITORING AND OPERATIONAL REVIEWS

The Contractor shall comply with all reporting requirements contained in this Contract and Division policy. In accordance with CMS and AHCCCS requirements, the Division has in effect procedures for monitoring the Contractor's operations to ensure program compliance and identify best practices,

including, but not limited to, evaluation of submitted deliverables, ad hoc reporting, and periodic focused and operational reviews.

These monitoring procedures shall include, but are not limited to, operations related to the following [42 CFR 438.66(c)(1)(12)]:

a. Member enrollment and disenrollment;

b. Member Services;

c. Member grievances and appeals;

d. Provider Claim Disputes and Appeals;

e. Findings from the State's External Quality Review process;

f. Member satisfaction surveys conducted by the Contractor;

g. Performance on required quality measures;

h. MM committee reports and minutes;

i. Annual quality improvement plan;

j. Audited financial and encounter data;

k. Medical loss ratio summary reports;

l. Customer service performance data;

m. Any other data related to the provision of services under this Contract;

n. Violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438;

o. Violations of the conditions for receiving federal financial participation, as set forth in Subpart J of 42 CFR 438; and

p. All other provisions of the Contract, as appropriate.

Operational Reviews

The Division, or an independent agent, will at least on an annual basis conduct reviews of the Contractor to ensure program compliance and identify best practices.

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, duration and frequency of the review(s) will be solely at the discretion of the Division.

Except in cases where advance notice is not possible or advance notice may render the review less useful, the Division will give the Contractor at least three weeks' advance notice of the date of the scheduled Operational Review. The Division reserves the right to conduct reviews without notice to monitor contractual requirements and performance as needed.

The Division may request, at the expense of the Contractor, to conduct onsite 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 the Division by forwarding in advance, in the format prescribed by the Division, 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. The Contractor shall provide an appropriate private workspace and internet access.

The Contractor will be furnished a copy of the draft Operational Review report and given the opportunity to comment on any review findings prior to the Division issuing the final report. The Division 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 report. The CAPs and modifications to the correction action plan shall be approved by the Division. Unannounced follow-up reviews may be conducted at any time after the initial Operational Review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the Operational Review Tool, draft Operational Review report, or final report to any other Division Contractor(s).

77. TECHNICAL ASSISTANCE

For Technical Assistance, the Contractor shall note the following Technical Assistance Provisions:

a. Recognize the Division's 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;

b. Recognize that the Contractor's acceptance of the Division's 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;

c. Recognize that the Division 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; and

d. Recognize that a Contractor's subcontractor participation in a technical assistance matter, in full or in part, does not relieve the Contractor of its contractual duties nor modify the Contractor's contractual obligations.

78. CONTINUITY OF OPERATIONS AND RECOVERY PLAN

The Contractor shall develop a Continuity of Operations and Recovery Plan, as specified in the AdSS Operations Manual, 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 familiar with, the Plan. The Contractor shall ensure its Subcontracted Health Plans prepare adequate business continuity and recovery plans and that the subcontractors review their plans annually, updating them as needed. The subcontractor plans shall, at a minimum, address the areas listed above as they apply to the subcontractors. The Continuity of Operations and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

79. MEDICARE REQUIREMENTS

Medicaid members who are also enrolled in Medicare are referred to as dual eligible members. To improve care coordination for dual eligible members, the Division requires the Contractor, or its corporate affiliate, to be a Medicare Advantage D-SNP, capable of serving its statewide membership. To match the population served, the D-SNP Type shall be a D-SNP subset that matches this Contract.

The Contractor shall provide care coordination as well as information and data reporting as required by the Division, and as detailed in its *Medicare Advantage D-SNP Health Plan Agreement* with AHCCCS which outlines requirements which aim to improve care coordination and timely information sharing for dual eligible members enrolled in State-contracted Medicare Advantage D-SNPs consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the Affordable Care Act. State-contracted D-SNP MIPPA agreements and terms are available on the AHCCCS website. Further information regarding execution of a D-SNP MIPPA Agreement with AHCCCS is available in ACOM Policy 107.

Medicare Structure

The Contractor shall ensure the integration of Medicare and Medicaid services. As required by A.R.S. § 36-2906.01, a Contractor shall establish an affiliated corporation whose only authorized business is to provide services under this Contract to members enrolled with the Contractor. This affiliated corporation shall be established within 120 days of Contract award. In addition, the Contractor shall operate a CMS approved, State-contracted D-SNP serving beneficiaries eligible for both Medicare and Medicaid. The Contractor shall have, and assure the Division it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this Contract and the companion Medicare D-SNP organization to the extent necessary to ensure integration of Medicare and Medicaid services for members enrolled with the Contractor for both programs. The State-contracted D-SNP shall be an affiliated organization or a part of the same legal entity of the Contractor as defined at 42 CFR 422.2(4)(ii) for a highly integrated dual eligible special needs plan (HIDE) serving DDD enrolled dual eligible members.

Medicaid Eligibility

D-SNPs are responsible for coordinating care for full benefit dual eligible members. These dual eligible members receive full Medicaid benefits, and are defined as:

a. Qualified Medicaid Beneficiary with Medicaid Benefits (QMB+),

b. Specified Low Income Beneficiary with Medicaid Benefits (SLMB+), and

c. Other Full Benefit Dual Eligible Beneficiary (FBDE).

Medicare Branding

The Contractor shall establish and implement appropriate CMS-approved branding for the Medicare D-SNP product that ensures it is easily identifiable to members and providers as an integrated health plan for both Medicare and Medicaid 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 the Contractor for Medicare purposes. The Contractor is able to apply for certification through AHCCCS or apply and receive licensure through the Arizona Department of Insurance (DOI).

If a Contractor serves more than dually eligible Medicare and Medicaid members under its Medicare Plan, the Contractor is required to obtain certification by DOI and not AHCCCS. Also, if the Contractor is applying to become a stand-alone Prescription Drug Plan (PDP), the Contractor shall apply for certification with the DOI.

Due to the timing of this procurement with CMS' annual Medicare Advantage application process, AHCCCS may provide a conditional certification that will allow an Offeror to start the process of becoming a Medicare Advantage plan proposing to offer a D-SNP during the procurement process for the new contracting cycle. The conditional certification is contingent upon an Offeror being awarded a Division Contract. Conditional certification will be revoked if an Offeror is not awarded a Contract. Likewise, conditional certification will be made final if an Offeror is awarded a Contract.

The certification process is detailed in the AdSS Operations Manual, Policy 313.

State Contracting with Dual Eligible Special Needs Plans

The State shall not contract with any Dual Special Needs Plan (D-SNP) to serve the Contractor's dual eligible population outside of awarded contracts. Contractors who fail to maintain a D-SNP will be subject to administrative action. Detailed D-SNP responsibilities will be reflected in the Contractor's *Medicare Advantage D-SNP Health Plan Agreement* as executed with AHCCCS.

Default Enrollment Activities to Enhance Alignment

State-contracted D-SNPs not previously approved by CMS for Default Enrollment activities shall submit to CMS an 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 (seamless conversion) 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.

Member Transition

The Contractor is required to participate in all activities as directed by the Division in partnership with AHCCCS which pertain to member transitions as a result of a termination of a D-SNP contract with CMS, a Contract termination resulting from this procurement, or such contract termination initiated by the D-SNP. Within five calendar days of identification, the Contractor is required to notify the Division and 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 MIPPA-contracted Medicare Advantage Organization, terminations, deficiencies, notices of intent to deny, and novation agreements.

The Contractor must submit to the Division and AHCCCS DHCM any D-SNP related CMS warning letters or CAPs within ten (10) business days of receipt as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Other Activities to Enhance Alignment

The Division, in collaboration with AHCCCS, will continue to establish requirements to improve alignment and enhance care coordination for dual eligible members. State-contracted D-SNPs shall

collaborate with the Division and AHCCCS in developing and implementing additional strategies to enhance alignment of dual-eligibles enrolled D-SNPs and companion Medicaid Plans.

80. PENDING ISSUES

The following constitute pending items that may be resolved after the issuance of this Contract or any Contract amendment. Any program changes due to the resolution of the issues will be reflected in future amendments to the Contract. Capitation rates may also be adjusted to reflect the financial impact of program changes. The 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.

Standards for Providers Managing Behaviors

As noted in Section D, Paragraph 26, Quality Management and Performance Improvement, Standards for Providers Managing Behaviors, the Division is in the process of amending A.A.C. Title 6, Chapter 6, Article 9, R6-6-901 through R6-6-909 under Executive Order-01: 2c. The revisions are intended to clarify current requirements to reflect the most current evidence-based practices and to align standards with the requirements in A.A.C. R9-21-204.

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 the Division 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, 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 Centers for Medicare and Medicaid Services (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 AHCCCS Medical Policy Manual (AMPM), the AHCCCS Contractor Operation Manual (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

Section 1115 Demonstration Waiver
As part of AHCCCS' 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, if necessary. October 14, 2022, CMS approved AHCCCS' request for a five-year extension of its Section 1115 Demonstration 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. Pending Waiver proposals and amendments can be found on the AHCCCS website.

Health Equity: The Division remains committed to identifying and addressing health disparities among its members and reviewing opportunities to promote equitable care for its members. The Division is considering the following strategies to advance health equity for its members:

1. Using the CLRS, through the Division 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.

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.

81. VALUE-BASED PURCHASING (VBP)

VBP is fundamental to Arizona's strategy to bend the upward trajectory of health care costs. AHCCCS is leading the implementation of 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 quality improvement and learning. The Contractor shall participate in payment VBP efforts.

Due to the dynamic nature of VBP strategies and changes necessary to keep current with the marketplace and national trends, the VBP policy decisions regarding the areas of focus described below are subject to modification after Contract award and prior to Contract implementation.

Alternative Payment Model (APM) Initiative

The purpose of APM initiative is to encourage Contractor activity in quality improvement by aligning the incentives of the Contractor and provider through APM strategies in the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model Framework with a focus on Categories 2, 3, and 4. Requirements are further specified in the AdSS Operations Manual, Policy 307 and as specified in Section F, Exhibit F3, Contractor Chart of Deliverables.

Value-Based Providers

The Contractor shall develop strategies that ensure that members are directed to providers who participate in VBP initiatives and who offer value as determined by measurable outcomes. The Contractor shall submit annually to the Division a Value-Based Providers/Centers of Excellence Report as required under the AdSS Operations Manual, Policy 415 and submitted as specified in Section F, Exhibit F3, Contractor Chart of Deliverables, describing its strategies to direct members to valued providers.

Centers of Excellence

Identification of a Center of Excellence must 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.

To encourage Contractor activity which incentivizes utilization of the best value providers for select, evidenced-based, high volume procedures or conditions, the Contractor shall submit a Value Based Providers/Centers of Excellence Attachment to its Provider Network Development and Management Plan as required under the AdSS Operations Manual, Policy 415, and submitted to the Division as specified in Section F, Exhibit F3, Contractor Chart of Deliverables. The Contractor shall identify the Centers of Excellence under contract for the Contract Year being reported and shall include a description as to how these Centers were selected.

Adult's Integrated System of Care

The Contractor shall contract with providers which adhere to nationally recognized criteria as a Center 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 healthcare needs:

a. Members with chronic pain with or without co-occurring substance use disorders that address behavioral and physical healthcare needs.

b. Dementia and related disorders.

Children's Integrated System of Care

The Contractor shall contract with providers which adhere to nationally recognized criteria as a Center of Excellence, and demonstrate in annual reporting how these providers implement evidence-based practices in adherence with nationally recognized criteria and shall track present outcome data for the following groups of children with specialized healthcare needs:

a. Children aged birth to five with behavioral health needs: Staffed with specialists who are endorsed by the Infant Toddler Mental Health Coalition of Arizona (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®).

b. Children at risk of/with ASD.

c. Adolescents with substance use disorders: e.g. A-CRA, Assertive Community Care, and GAIN.

d. Transition Aged Youth: First episode psychosis programs and TIP Model.

E-Prescribing

E-Prescribing is an effective tool to improve members' health outcomes and reduce costs as specified in the AdSS Operations Manual, 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 the AdSS Operations Manual, 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 Division's NCPDP Post Adjudicated History Transaction Companion Guide in order for the Division to measure the Contractor's success.

82. THE AMERICAN RESCUE PLAN ACT

Section 9187 of the American Rescue Plan Act (ARPA) 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 percent FMAP on qualifying home and community-based and behavioral health services to March 31, 2025. 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; individuals SMI; and children with behavioral health needs.

The Contractor shall collaborate with the Division and AHCCCS on select initiatives specified in the State's HCBS Spending Plan. Several initiatives improve and expand services provided to AHCCCS members. 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 the Division, and as agreed upon by the Contractor. Additional HCBS Spending Plan initiatives 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 ARPA website: https://www.azahcccs.gov/AHCCCS/Initiatives/ARPA/index.html.

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 the Division on the status of these initiatives, upon the Division's request. AHCCCS recognizes that activities under the HCBS Spending Plan are evolving and dependent on State and Federal programmatic and expenditure authority. If revisions or modifications to the HCBS Spending Plan are required, AHCCCS will document and communicate any impact to the Division 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 State Medicaid Director Letter MD # 21-003 (SMD) .

Refer to Section D, Paragraph 51, Compensation for ARPA-related Directed Payments.

[END OF SECTION D: PROGRAM REQUIREMENTS]

SECTION E: RESERVED

Per Amendment One (1), Section E has been removed in its entirety

SECTION F: EXHIBITS

EXHIBIT 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 twelve (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 thirty (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 in Arizona and in large print (font size of at least eighteen [18] point) explaining the availability of written translation or oral interpretation services to understand the information and include the Contractor's toll free and TTY/TDD telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials. Refer to the AdSS Operations Manual, Policies 404 and 406 for additional information and requirements [42 CFR 438.408(d)(1), 42 CFR 438.10].

The Contractor shall also 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 deaf or hard of hearing or are blind or have low vision.

For additional information regarding the member Notice of Adverse Benefit Determination process, refer to the AdSS Operations Manual, Policy 414 and 42 CFR Part 438 [42 CFR 457.1207, 42 CFR 438.10(c)(4)(ii)]. For additional information regarding member information requirements, the

EXHIBIT F1: Member Grievance and Appeal System Standards	
Contract No:	**CTR047021**
Description:	**DDD Health Plans**

Contractor should refer to the AdSS Operations Manual, Policies 404 and 406. Failure to comply with any of these provisions may result in an administrative action.

At a minimum, the Contractor shall comply with the following Member 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 457.1260, 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,
    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 a mechanism for tracking receipt, acknowledgement, investigation and resolution of grievances and appeals, and for tracking requests for hearing within the required timeframes.
3. The Contractor shall 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 and in accordance with the Division's Grievance and Appeal System Report Guide.

5. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include [42 CFR 457.1260, 42 CFR 438.414, 42 CFR 438.10(g)(2)(xi)(A)-(C)]:

    a. A description of the circumstances when there is a right to a hearing;

    b. The method for obtaining a hearing;

    c. The requirements which govern representation at the hearing;

    d. The right to file grievances and appeals and the requirements; and

    e. Timeframes for filing a grievance or appeal and requests for hearings.

5. The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps related to the grievance and appeal process. This includes 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 457.1260, 42 CFR 438.406(a), 42 CFR 438.228(a)].

6. The availability of toll-free numbers that a member can use to file a grievance or appeal by phone if requested by the member.

7. Oral inquiries appealing an Adverse Benefit Determination are treated as standard appeals and are confirmed in writing unless the member or the provider requests expedited resolution [42 CFR 457.1260, 42 CFR 438.406(b)(3)].

8. The Contractor shall permit both oral and written appeals and grievances [42 CFR 457.1260, 42 CFR 438.402(c(i), 42 CFR 438.402(c)(3)(ii)].

9. 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 (5) business days of receipt of the request. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five (5) business days of receipt and within one (1) day of receipt of expedited appeals [42 CFR 457.1260, 42 CFR 438.406(b)(1), 42 CFR 438.228(a)].

10. 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 that have the appropriate clinical expertise in treating the member's condition or disease [42 CFR 457.1260, 42 CFR 438.406(b)(2)(ii)(A)-(C), 42 CFR 438.228(a)].Decisions makers on grievance and appeals of Adverse Benefit Determinations take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination [42 CFR 457.1260, 42 CFR 438.406(b)(2)(iii), 42 CFR 438.228(a)]. The Division does not offer or arrange for an external medical review as specified in 42 CFR 457.1260 and42 CFR 438.402(c)(1)(i)(B).

11. The Contractor shall not delegate the Grievance and Appeal System requirements to its providers.

12. 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.

13. A member shall file a grievance with the Contractor and the member is not permitted to file a grievance directly with the Division or AHCCCS [42 CFR 457.1260, 42 CFR 438.402(c)(3)(i)].

14. The Contractor shall address identified issues as expeditiously as the member's condition requires and shall resolve each grievance within ten (10) business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed ninety (90) days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(1)].

15. The Contractor responds to a grievance in writing, if a member requests a written explanation of the resolution, and the response shall be mailed within ten (10) business days of resolution of the grievance.

16. 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 can file a request for hearing [42 CFR 457.1260, 42 CFR 438.408, 42 CFR 438.402(c)(1)(i)(A)].

17. 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 457.1260, 42 CFR 438.408(b)(1)-(3), 42 CFR 438.408(c)(1)(i)-(iii)].

18. If the Contractor extends the timeframe for a grievance 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 (2) 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 457.1260, 42 CFR 438.408(c)(2)(i)-(ii), 42 CFR 438.408(b)(1)-(3)].

19. 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 Prior Authorization (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.

20. 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 457.1260, 42 CFR 457.1230(d), 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.

21. 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 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(2)(i)-(ii), 42 CFR 438.404(c)(6).

22. 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 prior authorization 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)].

23. 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.

24. Define an Adverse Benefit Determination as set forth below [42 CFR 438.400(b)] and permit a member, or their designated representative, to file an appeal of an Adverse Benefit Determination taken by the Contractor. Adverse Benefit Determinations are any of the following:

    a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

    b. Reduction, suspension, or termination of a previously authorized service;

    c. A denial, in whole or in part, of a payment for a service. However, 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 457.1260 and 42 CFR 438.408(b)(1)(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.

25. 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 457.1260, 42 CFR 438.408(b)(1)(3), 42 CFR 438.408(c)(1)(i)(iii)].

26. The Notice of Adverse Benefit Determination for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire, and the decision constitutes 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.

27. 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 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(1)(ii), 42 CFR 438.404(c)(4)(i)]and (ii)].

28. The Contractor shall notify the requesting provider, in writing, of the decision to deny or reduce a service authorization request. Electronic notification is acceptable.

29. The Contractor shall mail a Notice of Adverse Benefit Determination: 1) at least ten (10) days before the date of a termination, suspension or reduction of previously authorized Medicaid services, except as provided in (a)-(e) below; 2) at least five(5) 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 fourteen (14) calendar days from receipt of a standard service authorization request and within seventy-two (72) hours from receipt of an expedited service authorization request, unless an extension is in effect.

    For service authorization decisions, the Contractor shall also ensure that the Notice of Adverse Benefit Determination provides the member with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service [42 CFR 438.404(c)(1), 42 CFR 431.211, 42 CFR 438.404(c)(1), 42 CFR 431.214, 42 CFR 438.404(c)(2)].

    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), 42 CFR 483.12(a)(5)(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 he/she is ineligible for further services;

d. The member's address is unknown and mail directed to the member has no forwarding address; and

e. The member has been accepted for Medicaid in another local jurisdiction.

30. 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 bases 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 NOA 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; and

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 AdSS Operations Policy 414 [42 CFR 457.1260, 42 CFR 438.404(b)(1)-(b)(6) 42 CFR 438.402(b)-(c)].

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.

31. Define an appeal as the request for review of an Adverse Benefit Determination, as defined above [42 CFR 438.400(b)].

32. The Contractor shall resolve standard appeals as expeditiously as the member's health condition requires but no later than thirty (30) calendar days from the date of receipt of the appeal unless an extension is in effect [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(2)]. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing [42 CFR 457.1260, 42 CFR 438.402(b), 42 CFR 438.228(a)].

33. 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 seventy-two (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 457.1260, 42 CFR 438.408(d)(2)(ii)]. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing [42 CFR 438.402(b), 42 CFR 438.228(a)].

34. A member shall be given sixty (60) calendar days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal [42 CFR 457.1260, 42 CFR 438.402(c)(2)(ii)].

35. 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 457.1260, 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 sixty (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 457.1260, 42 CFR 438.402(c)(1)(ii), 42 CFR 438.402(c)(2)(ii) , 42 CFR 438.402(c)(3)(ii)].

36. 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 457.1260, 42 CFR 438.406(b)(6)].

37. That 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 457.1260, 42 CFR 438.410(b)].

38. The resolution timeframes for standard appeals and expedited appeals may be extended up to fourteen (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 457.1260, 42 CFR 438.408(c), 42 CFR 438.408(b)].

39. 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 (2) calendar days with a written notice of the reason for the decision to extend the timeframe and the member's grievance rights [42 CFR 457.1260, 42 CFR 438.408(c)(2)(i)-(iii), 42 CFR 438.408(b)(2)(3)].

40. 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 457.1260, 42 CFR 438.210(d)(2)(i), 42 CFR 438.404(c)(6), 42 CFR 438.410(a)].

41. If the Contractor denies a request for expedited resolution, it shall transfer the appeal to the thirty (30)-calendar day timeframe for a standard appeal [42 CFR 457.1260, 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 (2) calendar days with a written notice of the denial of expedited resolution and the member's grievance rights.

42. 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.

43. 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)].

44. For appeals, the Contractor provides the member and his/her representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal. This information shall be provided at no charge to the member and sufficiently in advance of the resolution timeframe [42 CFR 457.1260, 42 CFR 438.406(b)(5)].

45. For Appeals, the Contractor must send copies of all appeals to the Division.

46. The Contractor shall provide written Notice of Appeal Resolution to the member and the member's representative or the representative of the deceased member's estate which 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 Notice of Appeal Resolution 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 Adverse Benefits Determination 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:

        i. Specific reasons for the Contractor denial,
        ii. Specific criteria used in making the decision and that the criteria used to make the decision is available upon request,

iii. 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.

1) 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, and

2) The applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.

iv. 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) shall have no less than 90 calendar days and no more than 120 calendar days from the date of the Contractor's notice of resolution to request a State fair hearing. [42 CFR 438.408(f)(2)],

v. The right to receive continued benefits pending the hearing when the member has requested a hearing within 10 calendar days from the date the notice of resolution was sent and how to request continuation of benefits, and

vi. 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 (NOA).

47. Benefits shall continue until a hearing decision is rendered if: 1) the member files an appeal before the later of a) ten (10) calendar days from the mailing of the Notice of Adverse Benefit Determination or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment that has not yet expired or b) the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service, 3) the services were ordered by an authorized provider and 4) the member requests a continuation of benefits.

48. Benefits shall be continued if all of the following occur: [42 CFR 438.420(a), 42 CFR 438.420(b)(1)-(5), 42 CFR 438.402(c)(2)(ii)].

a. The member files the request for an appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination notice;

b. The appeal involves the termination, suspension, or reduction of a previously authorized service or the appeal involves 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 ten (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.

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 ten (10) calendar days from the date the Contractor sends the notice of an adverse appeal resolution; or

c. A state fair hearing decision adverse to the member is issued.

The Contractor may, consistent with the Division's 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)].

42 CFR 438.420 provides that benefits shall be continued as specified in #42 f. through h. above, regardless of the period of the initial prior authorization, if all of the requirements in #42 a. through e above are met.

49. The Contractor must continue to extend benefits originally provided to the member until any of the following occurs: 1) the member withdraws the appeal or request for State fair hearing, 2) the member has not specifically requested continued benefits pending a hearing decision within ten (10) calendar days of the Contractor mailing of the appeal resolution notice, or 3) AHCCCS issues a state fair hearing decision adverse to the member.

50. If the member files a written request for State Fair Hearing the Contractor shall ensure that the hearing request and supporting documentation is submitted to the Division's Office of Administrative Review as specified by the AdSS Operations Manual, Policy 445. State Fair Hearing notices will be issued by the AHCCCS Administration and are not delegated to the Contractor [42 CFR 438.228(b)].

51. 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 seventy-two (72) hours from the date it receives the notice reversing the determination [42 CFR 457.1260, 42 CFR 438.424(a)]. Services shall be authorized within the above timeframe irrespective of whether the Contractor contests the decision.

52. 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 457.1260, 42 CFR 438.424(b)].

53. 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 ninety (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 un-timeliness if they are submitted within the ninety (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: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

54. 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.

55. 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.

56. 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 EXHIBIT F1]

EXHIBIT F2: PROVIDER CLAIM DISPUTE STANDARDS

The Contractor shall have in place a written claim 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 Claim 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 Claim Dispute Policy within forty-five (45) days of receipt of a claim. The policy may be mailed with a remittance advice, provided the remittance is sent within forty-five (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 twelve (12) months from the date of service, twelve (12) months after the date of eligibility posting or within sixty (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. Specific individuals shall be appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.

6. The Contractor shall develop and maintain a tracking log for all claim disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claim dispute, resolution of the claim dispute and the date of resolution.

7. Claim disputes are acknowledged in writing within five (5) business days of receipt.

8. Claim 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. Claim disputes are filed in a secure, designated area and are retained for five (5) years following the Contractor's decision, the AHCCCS decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.

11. The Provider Claim Dispute Policy must specify that a Contractor's Notice of Decision "Decision" shall be mailed to all parties no later than thirty (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 name, pertinent dates of service, dates and specific reasons for 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 thirty (30) days after the date the provider receives the 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 fifteen (15) business days of the date of the Decision.

12. If the provider files a written request for State Fair Hearing, the Contractor shall ensure that the hearing request and supporting documentation is submitted to the Division's Office of Administrative Review as specified in the Hearing Request File Submission Timeframes identified in the AdSS Operations Manual, Policy 445. The file sent by the Contractor shall contain a cover letter that includes the following information:

    a. The provider's name;

    b. The provider's address;

    c. The member's name and AHCCCS Identification Number;

    d. The provider's phone number (if applicable);

e. The date that the claim dispute was received by the Contractor; and

f. A summary of the actions undertaken by the Contractor to resolve the claim dispute and basis for the determination.

The following materials shall be included in the file sent by the Contractor:

a. The written request for hearing filed by the Provider;

b. Copies of the entire file including pertinent records; and the Contractor's Decision; and

c. Other information relevant to the Decision.

13. If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor 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 fifteen (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 seventy-two (72) hours from the date it receives the notice reversing the determination irrespective of whether the Contractor contests the decision.

[END OF EXHIBIT F2]

EXHIBIT F3: CONTRACTOR CHART OF DELIVERABLES	
Contract No.: **CTR047021**	
Description: **DDD Health Plans**	

EXHIBIT F3: CONTRACTOR CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the Contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Deliverables must be timely, accurate, and complete.
The Contractor shall review the content of reports listed herein, self-identifying performance that falls below Contract standards. The Contractor, in the submission of reports, shall include a cover letter to the Division's Compliance Officer that identifies the area(s) of deficiency, and the steps taken by the Contractor to bring performance to a level that complies with Contract standards.

Unless otherwise specified in the Contractor Chart of Deliverables, the deliverables are due by 5:00 p.m. on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 p.m. on the next business day. The submission of late, inaccurate, or incomplete data shall be subject to the penalty provisions described in Section D, Paragraph 76, Administrative Actions.

Geographic Regions for Reporting Purposes: Although this is a statewide contract, the Contractor shall use the following geographic regions and associated counties as required for purposes of reporting, deliverables and network standards as required by the Division:

GEOGRAPHIC REGION	ASSOCIATED COUNTIES
North	Mohave/Coconino/Apache/Navajo/Yavapai
Central	Maricopa/Gila/Pinal (excluding zip codes 85542, 85192, and 85550)
South	Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma (including zip codes 85542, 85192, and 85550)

EXHIBIT F3: CONTRACTOR CHART OF DELIVERABLES	
Contract No.:	**CTR047021**
Description:	**DDD Health Plans**

Refer to the spreadsheet entitled: EXHIBIT F3: CONTRACTOR CHART OF DELIVERABLES.

SECTION G1: SPECIAL TERMS AND CONDITIONS

1. Definition of Terms. In addition to the terms and conditions defined in Section 1 of the Uniform Terms and Conditions, the following shall apply:

1.1. "*Department*" means the Arizona Department of Economic Security (ADES), unless otherwise indicated.

1.2. "*Division*" means the Arizona Department of Economic Security's DDD.

1.3. "*Equipment*" means all vehicles, furniture, machinery, electronic data processing (EDP) equipment, software and all other equipment costing $1,000.00 or more, including all normal and necessary expenses incurred to make the equipment ready for its intended use (e.g., taxes, freight, installation, assembly and testing charges, etc.), and with a useful life of greater than one year. Equipment as used herein does not include real property (e.g., land, buildings, structures, or facilities' improvements).

1.4. "*May*" indicates something that is not mandatory but permissible.

1.5. "*Shall, Must*" indicates a mandatory requirement. Failure to meet these mandatory requirements may result in the rejection of a proposal as non-responsive.

1.6. "*Should*" indicates something that is recommended but not mandatory. If the Contractor fails to provide recommended information, the State may, at its sole option, ask the Contractor to provide the information.

1.7. "*Vulnerable adult*" means an individual who is eighteen (18) years of age or older who is unable to protect himself from abuse, neglect or exploitation by others because of a physical or mental impairment.

2. Abuse, Neglect, and Exploitation Prevention. Medicaid covered institutional, residential, employment, and/or day program providers that provide direct services to Children or Vulnerable Adults, as defined by A.R.S. §46-451(A)(9), shall develop policies, signage, and training aimed at preventing abuse, neglect, and exploitation, as well as reporting and stabilizing incidents. Providers shall implement, disclose, and monitor policies and practices

aimed at preventing abuse, neglect, and exploitation, reporting incidents, conducting investigations, and ensuring incident stabilization and recovery. Providers shall post signage on how to anonymously report abuse, neglect, and exploitation and post signage explaining whistleblower protections. All signage shall be appropriate for the setting, culturally appropriate, easy to read, and as accessible as possible for all members, and interpretation shall be available. Posted signage shall be in compliance with any additional AHCCCS issued guidance. In addition to these policies and signage, information regarding abuse, neglect, and exploitation reporting shall be conveyed by providers to served members, families/guardians, and staff through ongoing training and communication mechanisms. Providers shall offer training on the prevention of abuse, neglect, and exploitation. Training shall address retaliation (e.g. harassment or loss of employment) and penalization (e.g. changes to the nature and/or location of services and supports). Providers shall conduct routine testing of staff responses to simulated acts of exploitive, abusive, and neglectful behavior in a manner similar to routine fire and other emergency drills.

The executive officers, managers, and board (if any) of any provider under this section, whether governed by a board or otherwise, shall:

2.1. Commit to oversight of abuse and neglect prevention, recognition, and reporting,

2.2. Approve and oversee policies and procedures related to reporting and investigating reports of abuse and neglect, including protections for whistleblowers, and

2.3. Complete an annual training on abuse and neglect prevention, recognition, and reporting.

(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).

3. **Adult Protective Services (APS) Registry Check.** Providers are required to conduct a search of the Adult Protective Services (APS) Registry for all personnel (including subcontracted personnel and volunteers) who provide direct services to members in Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IIDs), Skilled Nursing Facilities (SNFs), Assisted Living Facilities (ALFs), and Group Homes as well as all subcontracted personnel, including paid family members, who provide direct service to

members in their homes and other community based settings. The personnel shall be prohibited from providing services to members if the search of the APS Registry contains any substantiated report of abuse, neglect, or exploitation of vulnerable adults. Providers may choose to allow exceptions to the background requirements for DCWs providing services to family members only as specified in AMPM Policy 1240-A. The search of the APS Registry shall be conducted at the time of hire/initial contract and annually thereafter. (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).

4. Advertising, Publishing and Promotion of Contract. In addition to the terms and conditions in Section 3.6 of the Uniform Terms and Conditions, the following shall apply:

4.1. The Contractor shall provide to the Department for review and approval all reports or publications (written, visual or sound) that are funded or partially funded under this Contract, a minimum of fifteen (15) calendar days prior to public release. All reports and publications whether written, visual or verbal shall contain the following statement:

4.1.1. *This program was funded through a contract with the Arizona Department of Economic Security. Points of view are those of the author and do not necessarily represent the official position or policies of the Department.*

4.2. The Contractor shall submit all proposed marketing and outreach materials and events that will involve the general public to the Division's Health Care Services for prior approval in accordance with [42 CFR 438.104]. The Contractor shall have signed contracts with PCPs, specialists, dentists, and pharmacies in order for them to be included in marketing materials. Marketing materials that have received prior approval shall be resubmitted to the Division's Health Care Services every two (2) years for re-approval.

4.3. The brochures used for the Open Enrollment Period shall contain information on the moral objection position of the Contractor and what services, if any, will not be provided by the Contractor.

4.4. The Contractor shall not advertise or publish information for commercial benefit concerning this Contract without the prior written approval of the Department.

5. Assignment. In addition to the terms and conditions in Section 5.3 of the Uniform Terms and Conditions, the following shall apply:

5.1. **Merger, Reorganization or Change of Ownership**

5.2. A proposed merger, reorganization or change in ownership of the Contractor shall require prior approval of the Department and may require an assignment of the Contract documented by a Contract amendment. The Department may terminate this Contract pursuant to the Termination clauses of the Contract, if the Contractor does not obtain prior approval or the Department determines that the change in ownership is not in the best interest of the State. In addition, the Department reserves the right to temporarily suspend a Contractor's new member enrollment including, but not limited to, auto-assignment pending Department review and final determination regarding a Contractor's Change in Organizational Structure. The Department may offer open enrollment to the members assigned to the Contractor should a change in ownership occur.

This Contract is voidable and subject to immediate cancellation by the Department upon the Contractor becoming insolvent, or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning right or obligations under this Contract without the prior written consent of the Department

5.3. The Contractor shall submit a detailed merger, reorganization and/or transition of ownership plan to the Department, for review at least sixty (60) days prior to the effective date of the proposed change. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to support the provider network, ensure that services to members are not diminished and that major components of the organization and the ALTCS programs are not adversely affected by such merger, reorganization or change in ownership.

6. Audit. In addition to the terms and conditions in Section 3.3 of the Uniform Terms and Conditions, the following shall apply:

6.1. The Contractor must prepare financial reports in accordance with Generally Accepted Auditing Principles (GAAP). Annual financial audit reports must be conducted in

accordance with Generally Accepted Auditing Standards (GAAS) audited by an independent Certified Public Accountant. The auditors audit opinion and the memorandum on internal control must be submitted to the Department in accordance with the Scope of Work.

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

7. Availability of Funds. In addition to the terms and conditions in Section 4.4 and 4.5 of the Uniform Terms and Conditions, the Department may reduce payments or terminate this Contract without further recourse, obligation or penalty in the event that insufficient funds are appropriated or allocated. The Director of the Department shall have the sole and unfettered discretion in determining the availability of funds. The Department and the Contractor may mutually agree to reduce reimbursement to the Contractor when the payment type is Fixed Price with Price Adjustment by executing a contract amendment.

8. Certification of Cost or Pricing Data. By submittal of the offer, the Contractor is certifying that, to the best of the Contractor's knowledge and belief, any cost or pricing data submitted is accurate, complete and current as of the date submitted or other mutually agreed upon date. Furthermore, the price to the State shall be adjusted to exclude any significant amounts by which the State finds the price was increased because the Contractor-furnished cost or pricing data was inaccurate, incomplete or not current as of the date of certification. Such adjustment by the State may include overhead, profit or fees. The certifying of cost or pricing data does not apply when contract rates are set by law or regulation.

9. Certification Regarding Lobbying. The Contractor agrees by submittal of the Certification Regarding Lobbying form, compliance with 49 CFR Part 20.

10. Code of Conduct. The Contractor shall avoid any action that might create or result in the appearance of having:

10.1. Inappropriate use or divulging of information gathered or discovered pursuant to the performance of its duties under the Contract;

10.2. Acted on behalf of the State without appropriate authorization;

10.3. Provided favorable or unfavorable treatment to anyone;

10.4. Made a decision on behalf of the State that exceeded its authority, could result in partiality, or have a political consequence for the State; or

10.5. Misrepresent or otherwise impeded the efficiency, authority, actions, policies, or adversely affect the confidence of the public or integrity of the State.

11. Collection of Actual Damages. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by the Division, up to and including "Collection of Actual Damages" assessed to the Department. Also see Special Terms and Conditions, Section 44 Sanctions.

12. Competitive Bidding. The Contractor is authorized to purchase the supplies and equipment itemized in the Contract for utilization in the delivery of Contract services. Contractor shall procure all such supplies and equipment at the lowest practicable cost and shall purchase all non-expendable items having a useful life of more than one year and an acquisition cost of $1,000 or more, through generally accepted and reasonable competitive bidding processes. Any procurement in violation of this provision shall be considered a financial audit exception.

13. Compliance with Applicable Laws. In addition to the terms and conditions in Section 7.5 of the Uniform Terms and Conditions, the following shall apply:

13.1. In accordance with A.R.S. § 36-551.01 as may be amended (Purchase of community developmental disabilities services; application; contracts; limitation), as applicable, all recipients of Contract services shall have all of the same specified rights as they would have if enrolled in a service program operated directly by the State.

13.2. The Contractor shall comply with the requirements related to reporting to a peace officer or child protective services incidents of crimes against children as specified in A.R.S. § 13-3620 as may be amended.

13.3. The Contractor shall comply with P.L. 101-121, Section 319 (31 U.S.C. section 1352) as may be amended and 29 CFR Part 93 as may be amended which prohibit the use of federal funds for lobbying and which state, in part: Except with the express authorization of Congress, the Contractor, its employees or agents, shall not utilize

any federal funds under the terms of this Contract to solicit or influence, or to attempt to solicit or influence, directly or indirectly, any member of Congress regarding pending or prospective legislation. Indian Tribes, tribal organizations and any other Indian organizations are exempt from these lobbying restrictions with respect to expenditures that are specifically permitted by other federal law.

13.4. The Contractor shall comply with all applicable state and federal statutes and regulations. This shall include A.R.S. § 23-722.01 as may be amended relating to new hire reporting, A.R.S. § 23-722.02 as may be amended relating to wage assignment orders to provide child support, and A.R.S. § 25-535 as may be amended relating to administrative or court-ordered health insurance coverage for children.

13.5. The Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

14. Confidentiality. The Contractor shall observe and abide by all applicable State and Federal statutes, rules and regulations regarding the use or disclosure of information including, but not limited to, information concerning applicants for and recipients of Contract services. To the extent permitted by law, the Contractor shall release information to the Department and to the Attorney General's Office as required by the terms of this Contract, by law or upon their request.

15. Contract Term and Option to Extend. The term of the resultant Contract shall commence upon date of award and shall remain in effect through September 30, 2022 or otherwise specified date, unless terminated, cancelled, or extended as otherwise provided herein. The Transition Period of the Contract will be from the date of award until September 30, 2019. There are no payments to the Contractor for during the Transition Period. The initial Contract term shall be October 1, 2019 through September 30, 2022 (three [3] years) and the additional seven (7) year period shall be at a minimum of one (1) year period or any combination of the remaining eight-four (84) months to extend for a total Contract term not to exceed ten (10) years. Amendments may include adjustment to capitation rates and/or changes to the Scope of Work.

15.1. The State has no obligation to extend or renew this Contract. However, this Contract may be extended or renewed for multiple periods or may be established as a multi-year Contract in its entirety or in part at the sole option of the State.

15.2. The State shall have the unilateral right to extend the Contract period following the initial Contract term for any combination of eighty-four (84) months for a total Contract term not to exceed ten (10) years, in whole or in part. The terms and conditions of any such Contract extension shall remain the same as the original Contract.

15.3. Any extension or renewal must be made prior to the end of the Contract period specified in this Contract.

15.4. The Contractor shall not provide services prior to Contract term commencing or after the end date of the Contract. (No billable activity outside of the effective dates).

16. Cooperation. The Department may undertake or award other contracts for additional work related to the work performed by the Contractor, and the Contractor shall fully cooperate with such other Contractors and State employees, and carefully fit its own work to such other Contractors' work. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by State employees. The Contractor shall cooperate as the State deems necessary, with the transfer of work, services, case records and files performed or prepared by the Contractor to other Contractor(s).

17. Corporate Compliance. In accordance with A.R.S. Section 36-2918.01, and AdSS Operations Manual, Policy 103, the Contractor and its subcontractors and providers are required to immediately notify the AHCCCS-OIG and the Division's Corporate Compliance Unit, regarding any suspected fraud and report the information within ten (10) business days of discovery by completing the confidential referral to AHCCCS via https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx for any and all suspected fraud or abuse [42 CFR 455.1(a)(1)] This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS members or funds.

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

17.2. The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS-OIG and/or the Department 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 Administration and/or the Department. The Contractor agrees to provide documents, including original documents, to representatives of the Office of Program Integrity and/or the Department upon request. The AHCCCS-OIG/ADES shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed twenty (20) business days from the date of the AHCCCS-OIG/ADES request.

18. Corporate Governance for Providers. Corporate Governance applies to providers of services to Children and/or Vulnerable Adults (as defined by A.R.S. §46-451(A)(10)). Providers shall comply with the following standards of good governance:

18.1. If the provider has a board, then the board shall:

18.1.1. Keep minutes for every meeting of the board. Meeting minutes shall comply with all privacy and confidentiality laws and regulations.

18.1.2. Stagger terms for board members. Prior to the appointment or re-appointment of a board member, the board shall consider the diversity of knowledge and experience of its members.

18.1.3. Implement and enforce a conflict-of-interest policy that requires board members to disclose any conflict of interest to the board prior to appointment to the board or as soon as a conflict arises. The policy shall provide for appropriate action by the board in response to an identified conflict of interest that includes requiring the board member to recuse themselves from participation in board discussions or actions and/or removal from the board.

18.2. The executive officers, managers, and board (if any) of any provider, whether governed by a board or otherwise, shall: Review the Provider's financial statements annually and implement measures to ensure the Provider's financial statements are complete, accurate, prepared in accordance with generally accepted accounting

principles, and include all necessary disclosures.

18.3. Providers shall maintain records, such as policies and procedures, demonstrating compliance with each requirement, to be available for inspection by AHCCCS, for five years. (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).

19. Data Exchange Requirements. In addition to the requirements in Section D, Scope of Work, Paragraph 38, Provider Registration/Certification, the Contractor is authorized to exchange data with the Department relating to the information requirements of this Contract and as required to support the data elements to be provided to the Department in the formats prescribed by Department and AHCCCS, which include formats prescribed by the HIPAA.

19.1. The information so recorded and submitted to the Department and AHCCCS shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this Contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following appropriate notification by AHCCCS or the Department.

19.2. The Contractor shall be provided with a Contractor-specific security code for use in all data transmissions made in accordance with Contract requirements. Each data transmission by the Contractor shall include the Contractor's security code. The Contractor agrees that by use of its security code, it certifies that any data transmitted is accurate and truthful, to the best of the Contractor's CEO, CFO, or designee's knowledge [42 CFR 438.606]. The Contractor further agrees to indemnify and hold harmless the State of Arizona, AHCCCS and the Department from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the Contractor in the submitted input data. Neither the State of Arizona, nor AHCCCS nor the Department shall be responsible for any incorrect or delayed payment to the Contractor's service providers resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of claims or encounters.

20. Data Sharing Agreement. When determined by the Department that sharing of confidential data will occur with the Contractor, the Contractor shall complete the ADES Data Sharing Request Agreement and submit the completed Agreement to the Department Program Designated Staff prior to any work commencing or data shared. A separate Data Sharing Request Agreement shall be required between the Contractor and each Department Program sharing confidential data.

21. Dugless Data Reporting Requirements

For those demographic elements with no identified alternative data source or Social Determinate identifier, AHCCCS created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members.

A Subcontracted provider organization that provides data for the DUG as well as all providers who might document or provide these types of data are required to provide the required data via the DUGless portal.

The requirements, definitions, and values for submission of the identified data elements are outlined in the AHCCCS DUGless Portal Guide (DPG). Subcontracted providers must collect the required information and submit the information via the DUGless Portal on the Provider AHCCCS Online. Data and information are recorded and reported to MCOs to assist in monitoring and tracking of the following:

21.1. Access and utilization of services,

21.2. Community and stakeholder information,

21.3. Compliance of Federal, State, and grant requirements,

21.4. Health disparities and inequities,

21.5. Member summaries and outcomes,

21.6. Quality and Medical Management activities, and

21.7. Social Determinants of Health.

22. Equipment. If the Contractor is authorized to purchase Equipment, Equipment shall be

itemized in the Contract for utilization in the delivery of Contract services. If Equipment is purchased as authorized by this Contract, the Contractor shall maintain complete and up-to-date inventory records for all Equipment purchased hereunder. Equipment specifically designated within this Contract, to be purchased in whole or part with the Department funds, shall be reported in accordance with Department inventory policies and procedures. The Contractor shall report Equipment purchased with Contract funds to the Department within thirty (30) days of purchase, perform an annual inventory of all Equipment purchased with Department funds and submit the Equipment inventory form to the Department person designated to receive notices.

22.1. The Department shall retain an equitable interest equal to the purchase price paid, or a fair estimate or appraisal of current market value, whichever is greater, in all Equipment purchased under this Contract. The Department shall be included as a co-insured on any insurance policy which covers Equipment purchased under this Contract.

22.2. The Contractor shall not dispose of any Equipment purchased under this Contract without the prior written consent of the Department during and after the Contract term. Such consent, if given, may include direction as to the means of disposition and the utilization of proceeds, including any necessary adjustments to the Contract.

22.3. Upon termination of this Contract, any Equipment purchased under this Contract shall be disposed of as directed by the Department and, if sold, the Department shall be compensated in the amount of its equitable interest.

22.4. Under a fixed price Contract, Section 18 does not apply unless specifically required by Federal or State law.

23. Evaluation. The Department may evaluate, and the Contractor shall cooperate in the evaluation of, Contract services. Evaluation may assess the quality and impact of Contract services, either in isolation or in comparison with other similar services, and assess the Contractor's progress and/or success in achieving the goals, objectives and deliverables set forth in this Contract.

23.1. As requested by the Department, the Contractor shall participate in third party

evaluations relative to Contract impact in support of Department goals.

23.2. Following the award of the Contract, the Division will conduct a comprehensive Readiness Review to evaluate the Contractor's ability to implement the terms of this Contract. Readiness Review activities will begin immediately upon the award of the Contract and continue until the Contractor has satisfied all Readiness Review elements to commence operations and receive member assignments for enrollment. The Readiness Review activities will assess the Contractor's ability to provide covered services to members at the start of the program and service implementation date. The Contractor may be subject to on-site reviews as part of the readiness activities to determine the adequacy of the Contractor's infrastructure to support the provision of services to the ALTCS-DD population on a statewide basis. Readiness includes, but is not limited to, the Contractor having a comprehensive network that complies with all network sufficiency standards as outlined in Section D, Scope of Work, Paragraph 30, Network Development and AdSS Operations Manual, Policy 436 no later than August 1, 2019. The Contractor must satisfy the Division's requirements on all Readiness Review elements in order to commence and continue operating under this Contract [42 CFR 438.66(d)(3)]. The Division reserves the right to not assign membership to the Contractor in the event the Division determines that readiness requirements are not met.

24. E-Verify. 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 as may be amended. (That subsection reads: "After December 31, 2007, every employer, after hiring an employee, shall verify the employment eligibility of the employee through the E-Verify program.")

24.1. A breach of the warranty regarding compliance with immigration laws and regulations shall be deemed a material breach of the Contract and the Contractor may be subject to sanctions up to and including termination of the Contract.

24.2. Failure to comply with a State audit process to randomly verify the employment records of the Contractor and its subcontractors shall be deemed a material breach of the Contract and the Contractor may be subject to penalties up to and including termination of the Contract.

24.3. The Department retains the legal right to inspect the papers of any employee who works on the Contract to ensure that the Contractor or subcontractor is complying with the warranty under Section D, Scope of Work, Paragraph 20, Written Policies and Procedures.

25. 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 subcontract. Further, the Contractor shall flow down this requirement to all its subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and Contractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any of its 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.

26. Fees and Program Income. Unless specifically authorized in the Contract, the Contractor shall impose no fees or charges of any kind upon recipients for Contract services.

27. Inclusive Contractor. Contractor is encouraged to make every effort to utilize subcontractors that are small, women-owned and/or minority owned business enterprises. This could include subcontractors for a percentage of the administrative or direct service being proposed. Contractor who is committing a portion of its work to such subcontractors shall do so by identifying the type of service and work to be performed by providing detail concerning the Contractor's utilization of small, women-owned and/or minority business enterprises. Emphasis should be placed on specific areas that are subcontracted and percentage of contract utilization and how this effort will be administered and managed, including reporting requirements.

28. Indemnification and Insurance.

28.1. **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 the 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 sub-contractor(s) is/are an agency, board, commission or university of the State of Arizona.

28.2. **Insurance Requirements:**

28.2.1. Contractor and subcontractors shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Contract, are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, employees or subcontractors.

28.2.2. 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 Contractor is free to

purchase additional insurance.

28.3. **Minimum Scope and Limits of Insurance:** Contractor shall provide coverage with limits of liability not less than those stated below.

28.3.1. **Commercial General Liability – Occurrence Form**

Policy shall include bodily injury, property damage, personal injury and broad form contractual liability.

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 include coverage for Sexual Abuse and Molestation (SAM). This coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit or provided by separate endorsement with its own limits. If the Contractor is unable to obtain SAM coverage under the Contractor's General Liability because the insurance market will not support it, the Contractor must include coverage within the Professional Liability limit. The following statement must be provided on the Contractor's Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

b. The policy shall be endorsed as required by this Contract 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.

c. The policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

28.3.2. **Business Automobile Liability**

Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of this Contract or Subcontracts. If no automobiles are used in the performance of this Contract or Subcontracts, then this is not applicable).

Combined Single Limit (CSL)	$1,000,000

a. The policy shall be endorsed with endorsement page, as required by this Contract, 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. The policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Contractor.

28.3.3. **Worker's 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. The policy shall contain a waiver of subrogation against the State of Arizona, its departments, agencies, boards, commissions, universities and its 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).

28.3.4. **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, the Contractor must provide the following statement on their Certificate(s) of Insurance: “Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.” This coverage may be sub-limited to no less than $500,000.

b. In the event that the professional liability insurance required by this Contract is written on a claims-made basis, Contractor warrants that any retroactive date under the policy shall precede the effective date of this Contract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under this Contract is completed.

c. The policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of this contract.

28.3.5. **Medical Directors Professional Liability**

Each Claim	$2,000,000
Annual Aggregate	$3,000,000

a. 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.

b. The policy shall cover the administrative duties as well as patient care, if necessary, to any member as outlined in the Scope of Work.

c. The policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of this Contract.

28.4. **Additional Insurance Requirements:** The policies shall include, or be endorsed to include, as required by this Contract, the following provisions:

28.4.1. 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).

28.4.2. Insurance provided by the Contractor shall not limit the Contractor’s liability assumed under the indemnification provisions of this Contract.

28.5. **Notice of Cancellation:** Applicable to all insurance policies required within the Insurance Requirements of this Contract, the Contractor’s insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without thirty (30) days prior written notice to the State of Arizona. Within two (2) business days of receipt, the Contractor must provide notice to the State of Arizona

if they receive notice of a policy that has been or will be suspended, cancelled, materially changed for any reason, has expired, or will be expiring. Such notice shall be sent directly to the Arizona Department of Economic Security Office of Procurement and shall be mailed, emailed, hand delivered or sent by facsimile transmission to (**Arizona Department of Economic Security, 1789 West Jefferson Street, Mail Drop 1222, Phoenix, AZ 85007**).

28.6. **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 DOI 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.

28.7. **Verification of Coverage:** Contractor shall furnish the State of Arizona with certificates of insurance (valid ACORD form or equivalent approved by the State of Arizona) evidencing that Contractor has the insurance as required by this Contract. An authorized representative of the insurer shall sign the certificates. All certificates and endorsements are to be received and approved by the State of Arizona before work commences. Each insurance policy required by this Contract must be in effect at or prior to commencement of work under this Contract and remain in effect for the duration of the project. Failure to maintain the insurance policies as required by this Contract, or to provide evidence of renewal, is a material breach of Contract. All certificates required by this Contract shall be sent directly to the Arizona **Department of Economic Security, Office of Procurement, 1789 West Jefferson Street, Mail Drop 1222, Phoenix, AZ 85007.** The State of Arizona Contract number and Contract description shall be noted or referenced on the certificate of insurance. The State of Arizona reserves the right to require complete, certified copies of all insurance policies required by this Contract at any time**.**

28.8. **Subcontractors:** The 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 minimum Insurance Requirements identified

above. The Department 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.

28.9. **Approval and Modification:** The Department, in consultation with the Department of Administration, Risk Management Section, 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.

28.10. **Exceptions:** In the event the Contractor or subcontractor(s) is/are a public entity, the Insurance Requirements above 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.

29. IT 508 Compliance. Unless specifically authorized in the Contract, any electronic or information technology offered to the State of Arizona under this Contract shall comply with A.R.S. § 18-131 and § 18-132 as may be amended and Section 508 of the Rehabilitation Act of 1973, which requires that employees and members of the public shall have access to and use of information technology that is comparable to the access and use by employees and members of the public who are not individuals with disabilities.

30. Levels of Service. If the Contractor determines service recipient eligibility, the Contractor shall maintain and regulate the units or services set forth in this Contract to ensure continuity and availability of services to eligible persons during the term of this Contract and during any transition to a subsequent Contractor.

30.1. The Department makes no guarantee to purchase specific quantities of goods or services, or to refer eligible persons as may be identified or specified herein. Further, it is understood and agreed that this Contract is for the sole convenience of the Department and that the Department reserves the right to obtain goods or services from other sources when such need is determined necessary by the Department.

30.2. Any administration within the Department may obtain services under this Contract. Any Department administration utilizing services will follow the contract pricing and rates

established through the contract when available. If rates are offered through a capitation method, the Administration will negotiate fair and reasonable pricing or rate for services.

30.3. The Department makes no guarantee to purchase all of the service units authorized or to provide any number of referrals. If quantities of units are specified, they are estimates only and the Department may decrease and/or increase them by providing written notice to the Contractor.

30.4. When the method of compensation for the service is Fixed Price with Price Adjustment, the Contract may be amended, by mutual agreement, to purchase additional services by increasing the Contract service budget and/or budget summary.

31. Monitoring. The Department may monitor the Contractor and/or subcontractor and they shall cooperate in the monitoring of services delivered, facilities and records maintained and fiscal practices.

32. Non-Discrimination. In addition to the terms and conditions in Section 3.2 of the Uniform Terms and Conditions, the following shall apply:

32.1. Unless exempt under Federal law the Contractor shall comply with Title VII of the Civil Rights Act of 1964 as amended. Contractor shall comply with the Age Discrimination in Employment Act. The Contractor shall comply with the Rehabilitation Act of 1973, as amended, which prohibits discrimination in the employment or advancement in employment of qualified persons because of physical or mental handicap. The Contractor shall comply with the requirements of the Fair Labor Standards Act of 1938, as amended.

32.2. If Contractor is an Indian Tribal Government, Contractor shall comply with the Indian Civil Rights Act of 1968. It shall be permissible for an Indian Tribal Contractor to engage in Indian preference in hiring.

32.3. The Contractor shall comply with Title VI of the Civil Rights Act of 1964, which prohibits the denial of benefits of or participation in Contract services on the basis of race, color, or national origin. The Contractor shall comply with the requirements of Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis

of handicap, in delivering Contract services; and with Title II of the ADA and the Arizona Disability Act, which prohibit discrimination on the basis of physical or mental disabilities in the provision of Contract programs, services and activities.

32.4. The following shall be included in all publications, forms, flyers, etc. that are distributed to recipients of Contract services:

"Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI and VII) and the ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, insert Contractor name here) prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. The (insert Contractor name here) must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, the (insert Contractor name here) must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the (insert Contractor name here) will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: (insert Contractor contact person and phone number here)."

32.5. **Non-Discrimination of Division ALTCS Members**

32.5.1. The Division adheres to the principles of individual dignity, respect and self-direction for all persons with developmental disabilities. The role of the Division and its Contractors is to assist persons to grow, develop and achieve their unique potential. The Division and its Contractors recognize that the family is often the primary caregiver for the person with developmental disabilities and shall be consulted and involved in all care and service decisions as appropriate. The collective mission of the Division and its Contractors is to support the choices of individuals with disabilities and their families by

promoting and providing, within communities, flexible, quality, consumer-driven services and supports. It is the role of the Division and its contractors to assist persons with developmental disabilities and their families in exercising their rights by adopting and implementing these principles and philosophy in the delivery of services. The Division requires Contractors to take affirmative action to ensure that members are provided covered services without regard to race, color, creed, gender, religion, age, national origin (to include those with LEP), ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated.

32.5.2. The Contractor shall take into account a member's literacy and culture when addressing members and their concerns, and shall take reasonable steps to request subcontractors to do the same. The Contractor shall make interpreters, including assistance for the vision- or hearing- impaired, available free of charge for all members to ensure appropriate delivery of covered services. The Contractor shall provide members with information instructing them how to access these services.

32.5.3. Prohibited practices include, but are not limited to, the following, in accordance with Title VI of the US Civil Rights Act of 1964, 42 U.S.C., Section 2001, Executive Order 13166, and rules and regulation promulgated according to, or as otherwise provided by law:

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

32.5.3.2. Providing to a member any 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.

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

32.5.3.4. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS or ALTCS membership, or physical or mental handicap of the participants to be served.

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

32.5.5. If the Contractor identifies a problem involving discrimination by one of its providers, it shall promptly intervene and implement a CAP. Failure to take prompt corrective measures may place the Contractor in default of this Contract.

33. Notices. In addition to the terms and conditions in Section 3.5 of the Uniform Terms and Conditions, the following shall apply:

33.1. All notices shall reference the Contract number.

33.2. The Contractor shall give written notice to the Department of changes to the following, and a written amendment to the Contract shall not be necessary:

33.2.1. Change of telephone number;

33.2.2. Changes in the name and/or address of the person to whom notices are to be sent;

33.2.3. Changes in Contract-related personnel positions of the Contractor which do not affect staffing ratios, staff qualifications or specific individuals required under this Contract; or

33.2.4. In a fixed price with price adjustment Contract, whenever there is less than a ten percent (10%) increase in any budget category; any such increase must be offset by an equal value decrease in another budget category or categories.

34. Offshore Performance of Work Prohibited. Due to security and identity protection concerns, direct services under this Contract shall be performed within the defined territories of the United States. Any services that are specified in the specifications or Scope of Work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the Contract. No claims paid by the Contractor to a 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]. This provision applies to work performed by subcontractors at all tiers.

35. Order of Precedence. In addition to the terms and conditions in Section 2.3 of the Uniform Terms and Conditions, Contract Order of Precedence of the Uniform Terms and Conditions, the following shall apply:

In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

35.1. ADES Special Terms and Conditions;

35.2. Uniform Terms and Conditions;

35.3. Scope of Work or Specification, including documents reference or included within the Solicitation;

35.4. Attachments; and

35.5. Exhibits.

36. Pandemic Contractual Performance. The State shall require a written plan that illustrates how the Contractor shall perform up to Contractual standards in the event of a pandemic. The state may require a copy of the plan at any time prior or post award of a Contract. At a minimum, the pandemic performance plan shall include:

36.1. Key succession and performance planning if there is a sudden significant decrease in Contractor's workforce.

36.2. Alternative methods to ensure there are services or products in the supply chain.

36.3. An up to date list of company contacts and organizational charts.

In the event of a pandemic, as declared by the Governor of Arizona, U.S. Government or the World Health Organization, which makes performance of any term under this Contract impossible or impracticable, the State shall have the following rights:

36.4. After the official declaration of a pandemic, the State may temporarily void the Contract(s) in whole or specific sections if the Contractor cannot perform to the standards agreed upon in the initial terms.

36.5. The State shall not incur any liability if a pandemic is declared and emergency procurements are authorized by the Director of the Arizona Department of Administration per A.R.S. § 41-2537 as may be amended of the Arizona Procurement Code.

36.6. Once the pandemic is officially declared over and/or the Contractor can demonstrate the ability to perform, the State, at its sole discretion may reinstate the temporarily voided Contract(s).

37. Payments. In addition to the terms and conditions in Section 4.1 of the Uniform Terms and Conditions, the following shall apply:

37.1. Payments shall be made according to the type of payment defined in Section D, Scope of Work, Paragraph 56, Compensation.

37.2. The Contractor shall report to the Department in the manner prescribed by the "Reporting Requirements" section of these terms and conditions. Upon receipt of applicable, accurate and complete reports, the Department will authorize payment or reimbursement in accordance with the type of payment indicated by this Contract.

37.3. If the Contractor is in any manner in default in the performance of any obligation under

this Contract, or if audit exceptions are identified, the Department may, at its option and in addition to other available remedies, either adjust the amount of payment or withhold payment until satisfactory resolution of the default or exception.

37.4. Under no circumstances shall the Department make payment to the Contractor that exceeds the:

37.4.1. The payment authorized as stated in Section 33.1; or

37.4.2. The authorized payment maximum as stated in Section 33.1; Under no circumstances shall the Department make payment to the Contractor for services performed prior to or after the term of the Contract without timely extension or renewal of the Contract.

37.5. The Contractor may offer a price reduction adjustment at any time during the term of the Contract. Any price reduction shall be executed by a Contract amendment.

38. Payment Recoupment. The Contractor shall reimburse the Department upon demand or the Department may deduct from future payments the following:

38.1. Any amounts received by the Contractor from the Department for Contract services which have been inaccurately reported or are found to be unsubstantiated;

38.2. Any amounts paid by the Contractor to a subcontractor not authorized in writing by the Department;

38.3. Any amount or benefit paid directly or indirectly to an individual or organization not in accordance with the “Substantial Interest” section of these terms and conditions;

38.4. Any amounts paid by the Department for services which duplicate services covered or reimbursed by other specific grants, Contracts, or payments;

38.5. Any amounts expended for items or purposes determined unallowable by the Department when this Contract provides for the reimbursement of costs, see the “Unallowable Costs” section of these terms and conditions;

38.6. Any amounts paid by the Department for which the Contractor's books, records, and other documents are not sufficient to clearly substantiate that those amounts were used by the Contractor to perform Contract services;

38.7. Any amounts received by the Contractor from the Department which are identified as a financial audit exception;

38.8. Any amounts paid or reimbursed in excess of the Contract or service reimbursement ceiling;

38.9. Any amounts paid to the Contractor which are subsequently determined to be defective pursuant to the "Certification of Cost or Pricing Data" section of these terms and conditions; and

38.10. Any payments made for services rendered before the Contract begin date or after the Contract termination date.

39. Amount of Performance Bond. The initial amount of the Performance Bond shall be equal to 100% of the total capitation payment expected to be paid to the Contractor in the first month of the contract year, or as determined by the Department. The total capitation amount (including delivery supplement) excludes premium tax. This requirement must be satisfied by the Contractor no later than thirty (30) days after notification by the Department of the amount required. Thereafter, the Department shall review the adequacy of the Performance Bond on a monthly basis to determine if the Performance Bond must be increased. The Contractor shall have thirty (30) days following notification by the Department to increase the amount of the Performance Bond. The Performance Bond amount that must be maintained after the contract term shall be sufficient to cover all outstanding liabilities and will be determined by the Department. The Contractor may not decrease the amount of the performance bond without prior written approval from the Department. Refer to the AdSS Operations Manual, Policy 305 for more details.

40. Personnel. The Contractor's personnel shall satisfy all qualifications, carry out all duties, and work the hours as set forth in this Contract.

41. Predecessor and Successor Contracts. The execution or termination of this Contract shall not be considered a waiver by the Department of any rights it may have for damages suffered

through a breach of this or a prior contract with the Contractor.

42. Prior Authorization and Utilization Management

The Contractor shall obtain Prior Authorization as required by the Contract and AHCCCS Rules and Policies. In addition, the Contractor must cooperate with Utilization Management processes established by the Contract and AHCCCS' Rules and Policies.

43. Professional Standards. The Contractor shall deliver Contract services in a humane and respectful manner and in accordance with any and all applicable professional accreditation standards. Levels of staff qualifications, professionalism, numbers of staff and individuals identified by name must be maintained as presented in the Contract.

44. Payment Adjustments. The Contractor may submit a request for a rate increase in accordance with the requirements in Section D, Scope of Work, Paragraph 58 for Capitation Adjustments. Any other request for payment adjustments must be submitted a minimum of forty-five (45) days prior to the Contract extension date. The request shall be in writing and include supportive justification for the proposed increase. The rate increase shall only be considered at time of Contract extension. The State will review the request and shall determine if the increase shall be granted or if an alternative option is in the best interests of the State. The rate increase adjustment, if approved, will be effective and executed via a contract amendment.

44.1. The Contractor shall submit the request for a rate increase to:

Procurement Manager
ADES Office of Procurement
1789 West Jefferson, Mail Drop 1222
Phoenix, Arizona, 85007

45. Records. In addition to the terms and conditions in Section 3.1 of the Uniform Terms and Conditions, the following shall apply:

45.1. Contract service records will be maintained in accordance with this Contract. Records shall, as applicable, meet the following standards consistent with the requirements in Section D, Scope of Work, and:

45.1.1. Adequately identify the service provided and each service recipient's application for Contract and subcontract activities;

45.1.2. Include personnel records which contain applications for employment, job titles and descriptions, hire and termination dates, a copy of the fingerprint clearance card, wage rates, and effective dates of personnel actions affecting any of these items;

45.1.3. Include time and attendance records for individual employees to support all salaries and wages paid;

45.1.4. Include records of the source of all receipts and the deposit of all funds received by the Contractor;

45.1.5. Include original copies of invoices, statements, sales tickets, billings for services, deposit slips, etc., and a cash disbursement journal and cancelled checks to reflect all disbursements applicable to the Contract;

45.1.6. Include a complete general ledger with accounts for the collection of all costs and/or fees applicable to the Contract; and,

45.1.7. Include copies of lease/rental agreements, mortgages and/or any other agreements which in any way may affect Contract expenditures.

45.2. Any such records not maintained shall mandate an audit exception in the amount of the inadequately documented expenditures.

45.3. Contractor shall preserve and make available all records for a period of ten (10) years from the date of final payment under this Contract except as provided in Section 42.0 of the DES Special Terms and Conditions or if subject to 42 CFR 438.3(n) and the Health Insurance Portability & Accountability Act:

45.3.1. If this Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of ten (10) years from the date of any such termination.

45.3.2. Records which related to disputes, litigation or the settlement of claims arising out of the performance of this Contract, or costs and expenses of this Contract to which exception has been taken by the state, shall be retained by the Contractor until such disputes, litigations, claims or exceptions have been disposed of.

45.4. The Contractor shall maintain records relating to covered services and expenditures including reports to the Department and documentation used in the preparation of reports to the Department. The Contractor shall comply with all specifications for record keeping established by the Department. All records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

45.5. The Contractor agrees to make available, at all reasonable times during the term of this Contract, any of its records for inspection, audit or reproduction by any authorized representative of Department, AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

45.6. HIPAA related documents shall be retained as required by 45 CFR 164.530(j)(2).

45.7. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this Contract, or costs and expenses of this Contract to which exception has been taken, shall be retained by the Contractor for a period of ten (10) years after the date of final disposition or resolution thereof or five years after the last Contract payment, whichever is longer.

46. Relationship of Parties. In addition to the terms and conditions in Section 2.4 of the Uniform Terms and Conditions, the following shall apply:

46.1. In the event that the Contractor or its personnel is sued or prosecuted for conduct arising from this Contract, the Contractor or their personnel will not be represented by the Department or Department of Law/Attorney General's Office.

46.2. Taxes or Social Security payments will not be withheld from a State payment issued

hereunder and the Contractor shall make arrangements to directly pay such expenses, if any.

47. Reporting Requirements. Unless otherwise provided in this Contract, reporting shall adhere to the following schedule: with the exception of the last month of the Contract term, the Contractor shall submit programmatic and financial reports to the Department in the form set forth in the Contract no later than the fifteenth (15th) day following the end of each month during the Contract term. Failure to submit accurate and complete reports by the fifteenth (15th) day following the end of each month may result, at the option of the Department, in retention of payment. Failure to provide such a report within forty-five (45) days following the end of a month may result, at the option of the Department, in a forfeiture of such payment.

47.1. Following the end of each Contract term, the Contractor shall submit programmatic and financial reports to the Department in the form set forth in the Contract no later than the forty-fifth (45th) day following the end of each Contract term. The final fiscal report for the Contract term shall include all adjustment to prior financial reports submitted for the Contract term.

47.2. No later than the forty-fifth (45th) day following the termination of this Contract, Contractor shall submit to the Department a final program and fiscal report. Failure to submit the final program and fiscal report within the above time period may result, at the option of the Department, in forfeiture of final payment.

47.3. All reports shall reference the Contract number and be submitted to the person designated by the Department.

48. Responsibility for Payments Indemnification. The Contractor shall be responsible for issuing payment for services performed by the Contractor's employees, subcontractors, suppliers, or any other third party incurred in the furtherance of the performance or the arising out of the Contract and will indemnify and save the Department harmless for all claims whatsoever out of the lawful demands of such parties. The Contractor shall, at the Department's request, furnish satisfactory evidence that all obligations of the nature hereinabove designated have been paid, discharged or waived.

49. Sanctions.

49.1. In addition to the State's contractual remedies in Section G2, Uniform Terms and Conditions, the Contractor shall be subject to sanction for failure to comply with any of the requirements in this Contract.

49.2. **Collection of Damages – AHCCCS Imposed Sanction**

49.2.1. Penalties imposed against the Department by AHCCCS as a result of the Contractor's acts or omissions related to the Contractor's performance under the terms of this Contract will be assessed dollar for dollar to the Contractor as actual damages.

49.3. **Reservation of Monetary Penalties**

49.3.1. The Division currently does not have legal authority to impose civil monetary penalties. The Division intends to seek legal authority to impose such penalties, which for covered services under the Contract, would be subject to the limits authorized by the Social Security Act 42 U.S.C.A. § 1396U-2, A.R.S. § 36-2903 and A.A.C. R9-22-606. The Division reserves the right to impose monetary penalties, in addition to any other of the sanctions available to the Division under the Contract, if legal authority is obtained in the future.

49.4. **Administrative Actions**

49.4.1. In accordance with applicable Federal and State regulations, AdSS Operations Manual, Policy 408 and the terms of this Contract, the Division may impose administrative actions for failure to comply with any provision of this Contract, including but not limited to: suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension, refusal to renew, termination of the Contract or any related subcontracts [42 CFR 457.1201(m), 42 CFR 457.1212, 42 CFR 422.208, 42 CFR 438.56(c)(2)(iv), 42 CFR 438.700, 702, 704, 406, 722, 45 CFR 92.36(i)(1), 42 CFR 438.726(b), 42 CFR 438.730(e)(1)(i)-(ii), 45 CFR 74.48. 42 CFR Part 455, 42 CFR Part 457, 42 CFR Part 438, Sections 1903 and 1932 of the Social Security Act]; or, subject to the approval of legal authority as referred to in

Section G1, Special Terms and Conditions, Paragraph 44.3.1 above, monetary penalties.

49.4.2. Written notice will be provided to the Contractor specifying the administrative action to be imposed, the grounds for such action and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose an administrative action in accordance with the process set forth in the Arizona Procurement Code (A.R.S. §§ 41-2611, 41-2612, 41-2614, and 41-2615).

49.5. **Notice to Cure**

49.5.1. The Division may provide a written Notice to Cure to the Contractor outlining the details of the non-compliance and timeframe to remedy the Contractor's performance. If, at the end of the specified time period, the Contractor has complied with the Notice to Cure requirements, the Division may choose not to impose a sanction.

49.5.2. The Notice to Cure does not limit the Department from imposing sanctions or taking any other actions available to the DES/DDD under the Contract without providing a Notice to Cure.

49.6. Refer to AdSS Operations Manual, Policy 408 for additional information and requirements.

50. Liquidated Damages

50.1. The parties to this Contract acknowledge and agree that the Department's members have high and often very complex needs and that the services as defined in Section D, Scope of Work, must be extremely reliable. Failure of the Contractor to meet these performance requirements in a timely and accurate manner could impede the Department in meeting its obligation to AHCCCS, its members, its other network contractors, and increase the cost of meeting those obligations.

50.2. The parties agree that the calculation of damage as of the date of the Contract will be extremely impracticable and difficult to ascertain, and the goods and services under

this contract are not readily available on the open market. Accordingly, the parties agree to use established-liquidated damages formula (see paragraph 45.7 below) and that the liquidated damages established in this section are fair and reasonable. All requirements described in the Contract are subject to monitoring by the Department or its designee.

50.3. At the sole discretion of the DES Chief Procurement Officer, the Department may elect to assess liquidated damages.

50.4. Payment of liquidated damages - Liquidated damages that are assessed will be:

50.4.1. Invoiced to Contractor for payment; or

50.4.2. Deducted from any monies owed the Contractor by the Department, and in the event the amount due the Contractor is not sufficient to satisfy the amount of the liquidated damages, the Contractor shall pay the balance to the Department within thirty (30) calendar days of written notification.

50.5. The Department reserves the right, at its sole discretion:

50.5.1. To determine the existence of any factors relevant to the assessment of liquidated damages (such as the fact or length of noncompliance or degraded performance);

50.5.2. To waive any liquidated damages as determined by the Department, but the waiver of any liquidated damages due the Department shall constitute a waiver only as to such liquidated damages and not a waiver of any future liquidated damages;

50.5.3. To assess liquidated damages under each section applicable to any given incident, and to calculate any liquidated damages assessment based on the cumulative effect of two (2) or more damages categories;

50.6. If the Department elects to not exercise a damage clause in a particular instance, this decision shall not be construed as a waiver of its right to pursue associated damages for failure to meet that performance requirement in the future.

50.7. **Assessment of Liquidated Damages Amounts and Formula**

50.7.1. The Department may assess liquidated damages in the following damage categories, according to the following formula.

50.7.1.1. **Deliverables**. If the Contractor does not provide a Deliverable in conformance with the criteria set forth in Section F, Exhibit F3, Contractor Chart of Deliverables, the Department may assess liquidated damages if it is determined that late, inaccurate or incomplete data is submitted. The Department shall assess liquidated damages in the amount of $300.00 dollars per Deliverable for each day that the Deliverable is late and does not meet the criteria in Section F, Exhibit F3, Contractor Chart of Deliverables. The date for delivery of a Deliverable that meets all requirements in Section F, Exhibit F3, Contractor Chart of Deliverables, may be extended as agreed to in writing by the DES/DDD in which event, liquidated damages would not apply unless the Deliverable was not delivered by the new date.

50.7.1.2. **Corrective Action Plan.** For each accepted CAP, if the CAP is not successfully implemented or its execution does not correct the identified defect to be remedied by the CAP or correct the defect within the time specified in the CAP, the Contractor shall be assessed liquidated damages in the amount of $300 dollars for each day determined by DES/DDD that an acceptable CAP remains uncorrected.

50.7.1.3. **Corrective Action Plan Related to AHCCCS Administrative Action.** For each accepted CAP that is required by DES/DDD to respond to an Administrative Action or Notice to Cure issued by AHCCCS to DES/DDD, if the CAP is not successfully executed or its execution does not correct the identified Defect to be remedied by the CAP or correct the defect within the time specified in the CAP, the Contractor shall be assessed liquidated damages in the amount of $1,000.00 dollars, or a portion thereof, for each day determined by

DES/DDD, where the CAP defect remains uncorrected.

50.8. The Contractor shall not be required to pay liquidated damages for delays or damage due to matters enumerated in the section entitled “Force Majeure”, for delay or damages due to DES/DDD for delays or damages due to changes that are requested in writing by DES/DDD, or for time delays specifically approved in writing by DES/DDD, through its contractually authorized individual.

50.9. If it is determined that the Contractor would have been able to meet the Contract requirements listed in 45.7.1.1, 45.7.1.2, and 45.7.1.3 but for the DES/DDD failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly from DES/DDD’s failure to perform as provided in this Contract.

50.10. Additional Information:

50.10.1. For the purposes of this Section, “day” or “calendar day” shall be defined as a twenty-four (24)-hour period, commencing at 12:00 a.m. and ending at 11:59 p.m.

50.10.2. Notification of Liquidated Damages – Upon determination that liquidated damages are to be assessed, the Department shall notify the Contractor of the assessment in writing.

50.10.3. Severability of Liquidated Damages Clauses – If any clause of this provision is determined to be unenforceable, the remainder of the provision will remain in effect.

50.10.4. Assessment of liquidated damages shall not be exclusive of, or in any way limit, remedies available to the Department at law or equity for Contractor breach.

51. Subcontracts. In addition to the terms and conditions in Section 5.2 of the Uniform Terms and Conditions, the following shall apply:

51.1. The Contractor shall provide copies of each contract with a subcontractor relating to the provision of Contract services to the Department upon five (5) calendar days of the

request.

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

51.3. 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)].

51.3.1. The following types of Administrative Services subcontracts shall be submitted to the Department, for prior approval at least thirty (30) days prior to the beginning date of the subcontract. All Administrative Services subcontracts entered into by the Contractor are subject to prior review and written approval by the Department and shall incorporate by reference the terms and conditions of this Contract.

51.3.2. Administrative Services Subcontracts:

51.3.2.1. Delegated agreements that subcontract;

- Any function related to the management of the Contract with the Department. Examples include member services, provider relations, quality management, MM (e.g., prior authorization, concurrent review, medical claims review),
- Claims processing, including pharmacy claims,
- Credentialing including those for only primary source verification.

51.3.2.2. All Management Service Agreements;

51.3.2.3. All Service Level Agreements with any division or Subsidiary of a corporate parent owner.

51.3.3. The ADES 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.

51.3.4. The Contractor shall maintain a fully executed original or electronic copy of all subcontracts, which shall be accessible to the Department within two (2) business days of request by the Department.

51.3.5. All requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from the Department as proprietary. Information designated as confidential may not be disclosed by the Department without the prior written consent of the Contractor except as required by law, including Public Record Request laws.

51.3.6. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

51.3.7. Before entering into a subcontract which delegates the Contractor duties or responsibilities to a subcontractor, the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities such as utilization management or claims processing to a subcontractor, then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

51.3.8. The Contractor shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions

of this Contract [42 CFR 434.6(c)]. The monitoring schedule for review shall be submitted to the Division, Health Care Services, for prior approval. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a CAP. The results of the performance review and the correction plan shall be communicated to the Department, Health Care Services and the ADES Office of Procurement, upon completion [42 CFR 438.230(b)].

51.3.9. A merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require prior written approval by the Department.

51.3.10. The Contractor shall submit the Annual Subcontractor Assignment and Evaluation Report (within ninety (90) days from the start of the Contract year) detailing any Contractor and duties or responsibilities that have been subcontracted as described under administrative subcontracts previously in this section. If the Contractor does not assign any duties under the subcontract types listed in the paragraph above, a statement to this effect must be submitted in lieu of the Annual Subcontractor Assignment and Evaluation Report. The Annual Subcontractor Assignment and Evaluation Report will include the following:

- Subcontractor's name;
- Delegated duties and responsibilities;
- Most recent review date of the duties, responsibilities and financial position of the subcontractor;
- A comprehensive evaluation of the performance (operational and financial) of the subcontractor;
- Identified areas of deficiency;
- CAPs as necessary;
- Next scheduled review date.

51.3.11. The Contractor shall promptly inform the Department in writing if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract. The Contractor shall submit a CAP and an Assurance that the Contractor will meet the Contract requirements to the ADES Office of Procurement, with a copy to the ADES/DDD Health Care Services Unit.

51.3.12. The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Specifically, the Contractor shall not contract with a provider and require that the provider not provide services for any other ALTCS Contractor. In addition, except for cost sharing requirements, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

51.3.13. The Contractor shall enter into a written agreement with any provider (including out-of-state providers) the Contractor reasonably anticipates will be providing services at the request of the Contractor more than twenty-five (25) times during the Contract year [42 CFR 438.206(b)(1)]. Exceptions to this requirement include the following:

- If a provider who provides services more than twenty-five (25) times during the Contract year refuses to enter into a written agreement with the Contractor, the Contractor shall submit documentation of such refusal to the Division, Health Care Services within seven days of its final attempt to gain such agreement.
- If a provider performs emergency services such as an emergency room physician or an ambulance company, a written agreement is not required.
- Individual providers as detailed in the AMPM.
- Hospitals, as discussed in Section D, Paragraph 43, Hospital Subcontracting and Reimbursement.
- If a provider primarily performs services in an inpatient setting.

- If upon the Medical Director's review, it is determined that the Contractor or members would not benefit by adding the provider to the contracted network.

- Any other exceptions to this requirement must be approved by the ADES Office of Procurement. The Contractor may request an expedited review and approval.

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

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

51.3.15. In addition to the above, each subcontract must contain the following:

52. Substantial Interest Disclosure. Contractor shall not make any payments, either directly or indirectly, to any person, partnership, corporation, trust, or any other organization which has a substantial interest in Contractor's organization or with which Contractor (or one of its directors, officers, owners, trust certificate holders or a relative thereof) has a substantial interest, unless Contractor has made a full written disclosure of the proposed payments, including amounts, to the Department.

52.1. Leases or rental agreements or purchase of real property which would be covered by Section 44.1 shall be in writing and accompanied by an independent commercial appraisal of fair market rental, lease, or purchase value, as appropriate.

52.2. For the purpose of this Section, "relative" shall have the same meaning as in A.R.S. § 38-502 as may be amended.

53. Supporting Documents and Information. In addition to any documents, reports or information required by any other section of this Contract, Contractor shall furnish the Department with any further documents and information deemed necessary by the Department. Upon receipt of a request for information from the Department, the Contractor shall provide complete and accurate information no later than fifteen (15) days after the receipt of the request.

54. Suspension or Debarment. In addition to the terms and conditions in Section 9.3 of the Uniform Terms and Conditions, the Contractor shall submit the Certification Regarding Debarment, Suspension and Voluntary Exclusion Lower Tier Covered Transactions form.

54.1. **Suspensions and Modifications**

54.1.1. Suspensions ─ Suspensions will be defined as a complete temporary release from the deliverable requirement as presented in Contract for the term shown in Part 2 of 2, Section J, Attachment 5, Certification Regarding Debarment, Suspension and Voluntary Exclusion Lower Tier Covered Transactions.

54.1.2. Modifications ─ Modifications will be defined as a reduction in the frequency or content of a deliverable requirement that will remain in place throughout the temporary term shown in Part 2 of 2, Section J, Attachment 5, Certification Regarding Debarment, Suspension and Voluntary Exclusion Lower Tier Covered Transactions.

55. Technical Assistance. In addition to the provisions under Section D, Scope of Work, Paragraph 78, Continuity of Operations and Recovery Plan, the Department may, but shall not be obligated to, provide technical assistance to the Contractor in the administration of Contract services, or relating to the terms and conditions, policies and procedures governing this Contract. Notwithstanding the foregoing, the Contractor shall not be relieved of full responsibility and accountability for the provision of Contract services in accordance with the terms and conditions set forth herein.

56. Termination for Any Reason. In the event the Contract is terminated, with or without cause, or expires, the Contractor, whenever determined appropriate by the Department, shall assist the Department in the transition of services or eligible persons to other Contractors. Such

assistance and coordination shall include, but not be limited to, the forwarding of program and other records as may be necessary to assure the smoothest possible transition and continuity of services. The cost of reproducing and forwarding such records and other materials shall be borne by the Contractor. The Contractor must make provisions for continuing all management/administrative services until the transition of services or eligible persons is complete and all other requirements of this Contract are satisfied.

56.1. In the event of termination or suspension of the Contract by the Department, such termination or suspension shall not affect the obligation of the Contractor to indemnify the Department and the State for any claim by any other party against the State or Department arising from the Contractor's performance of this Contract and for which the Contractor would otherwise be liable under this Contract. To the extent such indemnification is excluded by A.R.S. § 41-621, et seq., as may be amended or an obligation is unauthorized under A.R.S. § 35- 154as may be amended the provisions of this paragraph shall not apply.

56.2. In the event of early termination for any reason, any funds advanced to the Contractor shall be returned to the Department within ten (10) days after the date of termination or upon receipt of notice of termination of the Contract, whichever is earlier.

56.3. The Department 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 Contractor 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), 1932 of the Social Security Act]

57. Termination for Default. In addition to the terms and conditions in Section 9.5 of the Uniform Terms and Conditions, the following shall apply:

57.1. The Department may immediately terminate this Contract if the Department determines that the health or welfare or safety of service recipients is endangered.

58. Transfer of Knowledge. The Contractor shall, whenever feasible, share strategies and

techniques with Department staff to transfer the skills and knowledge acquired in the delivery of the contracted service.

59. Transition of Activities. In the event that a contract is awarded to a new contractor for services similar to those being performed by Contractor under this Contract, there shall be a transition of services period. During this period, the Contractor under this Contract shall work closely with the new contractor's personnel and/or Department staff to ensure a smooth and complete transfer of duties and responsibilities. The Department's authorized representative will coordinate all transition activities. A transition plan will be developed in conjunction with the existing contractor to assist the new contractor and/or Department staff to implement the transfer of duties. The Department reserves the right to determine which projects/service delivery nearing completion will remain with the current Contractor of record.

59.1. In the event that the Contract or any portion thereof is terminated for any reason, or expires, the Contractor shall assist the Department in the transition of its members to other Contractors, and shall abide by standards and protocols set forth in Section D, Scope of Work, Paragraph 8, Member Transition Activities. In addition, the Department reserves the right to extend the term of the Contract on a month-to-month basis to assist in any transition of members. The Contractor shall make provision for continuing all management and administrative services until the transition of all members is completed and all other requirements of this Contract are satisfied. The Contractor shall be responsible for providing all reports set forth in this Contract and necessary for the transition process, and shall be responsible for the following:

59.1.1. Notification of subcontractors and members.

59.1.2. Payment of all outstanding obligations for medical care rendered to members. Until the Department is satisfied that the Contractor has paid all such obligations, the Contractor shall provide the following reports to the Division on a monthly basis (due the 15th day of the month, for the preceding month):

59.1.2.1. A monthly claims aging report by provider/creditor including IBNR amounts;

59.1.2.2. A monthly summary of cash disbursements and provider/creditor settlements;

59.1.2.3. A monthly accounting of Member Grievances and Provider Claim Disputes and their disposition;

59.1.2.4. Additional reporting as requested in the termination letter issued by the Department.

59.1.3. Quarterly and Audited Financial Statements up to the date of Contract termination. The financial statement requirement will not be absolved without an official release from the Department.

59.1.4. Encounter reporting until all services rendered prior to Contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from the Department.

59.1.5. Cooperation with reinsurance audit activities on prior Contract years until release has been granted by the Department.

59.1.6. Cooperation with any open reconciliation activities including, but not limited to PPC or SSDI-TMC until release has been granted by the Department.

59.1.7. Quarterly Quality Management and MM reports will be submitted as required by Scope of Work as appropriate to provide the Department with information on services rendered up to the date of Contract termination. This will include quality of care (QOC) concern reporting based on the date of service, as opposed to the date of reporting, for a period of three (3) months after Contract termination.

59.1.8. Performance Bond will be required until remaining Department liabilities are less than $50,000.

59.1.9. In the event of termination or suspension of the Contract by the Department, such termination or suspension shall not affect the obligation of the

Contractor to indemnify the Department for any claim by any third party against the State or the Department arising from the Contractor's performance of this Contract and for which the Contractor would otherwise be liable under this Contract.

59.1.10. Any dispute by the Contractor, with respect to termination or suspension of this Contract by the Department, shall be exclusively governed by the provisions of the Arizona State Procurement Code.

59.1.11. Any capitation paid to the Contractor for coverage of members for periods after the date of termination shall be pro-rated and returned to the Department within thirty (30) days of termination of the Contract.

59.1.12. Record retention requirements, as described in Scope of Work, will apply.

59.2. All transition activities must be in compliance with Division policies and procedures. Refer to the AdSS Medical Policy Manual for details.

60. Unallowable Costs. The cost principles set forth in the Code of Federal Regulations, 48 CFR, Chapter 1, Subchapter e, Part 31, (October 1, 1991), including later amendments and editions, on file with the Arizona Secretary of State and incorporated by this reference, shall be used to determine the allow ability of incurred costs for the purpose of reimbursing costs under Contract provisions that provide for the reimbursement of costs. Those costs which are specifically defined as unallowable therein will not be submitted for reimbursement by the Contractor and may not be reimbursed with Department funds.

60.1. In addition, the Contractor shall comply with any applicable federal Uniform Guidance that provides an authoritative set of rules and requirements for federal awards. This guidance can be referenced through the Code of Federal Regulations (CFR) or previously noted in the Office of Management and Budget (OMB).

61. Visitation, Inspection and Copying. Contractor's and/or subcontractor's facilities, services and individuals served, books and records pertaining to the Contract shall be available for visitation, inspection and copying by the Department and any other appropriate agent of the State or Federal Government. At the discretion of the Department, visitation, inspection and copying may be at any time during regular business hours, announced or unannounced. If the

Department deems it to be an emergency situation, it may at any time visit and inspect the Contractor's or subcontractor's facilities, services and individuals served, as well as inspect and copy their Contract-related books and records.

62. **Warranty of Services.** The Contractor warrants that all services provided under this Contract shall conform to the requirements stated herein and any amendments hereto. The Department's acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, the Department Procurement Officer 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 G1]

SECTION G2: UNIFORM TERMS AND CONDITIONS

1. **Definition of Terms**

As used in this Solicitation and any resulting Contract, the terms listed below are defined as follows:

1.1. *"Attachment"* means any item the Solicitation requires the Offeror to submit as part of the Offer.

1.2. *"Contract"* means the combination of the Solicitation, including the Uniform and Special Instructions to Offerors, the Uniform and Special Terms and Conditions, and the Specifications and Statement or Scope of Work; the Offer and any Best and Final Offers (BAFO); and any Solicitation Amendments or Contract Amendments.

1.3. "*Contract Amendment"* means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.

1.4. *"Contractor"* means any person who has a Contract with the State.

1.5. *"Days"* means calendar days unless otherwise specified.

1.6. *"Exhibit"* means any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.

1.7. *"Gratuity"* means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

1.8. "*Materials"* means all property, including equipment, supplies, printing, insurance and leases of property but does not include land, a permanent interest in land or real property or leasing space.

1.9. *"Procurement Officer"* means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

1.10. *"Services"* means the furnishing of labor, time or effort by a contractor or subcontractor which does not involve the delivery of a specific end product other than required reports and performance, but does not include employment agreements or collective bargaining agreements.

1.11. *"Subcontract"* means any Contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.

1.12. *"State"* means the State of Arizona and the Department or Agency of the State that executes the Contract.

1.13. "*State Fiscal Year*" means the period beginning with July 1 and ending June 30.

2. **Contract Interpretation**

2.1. Arizona Law. The Arizona law applies to this Contract including, where applicable, the UCC as adopted by the State of Arizona and the Arizona Procurement Code, Arizona Revised Statutes (A.R.S.) Title 41, Chapter 23, and it s implementing rules, Arizona Administrative Code (A.A.C.) Title 2, Chapter 7.

2.2. 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.

a.3. Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

2.3.1. Special Terms and Conditions;

2.3.2. Uniform Terms and Conditions;

2.3.3. Statement or Scope of Work;

2.3.4. Specifications;

2.3.5. Attachments;

2.3.6. Exhibits;

2.3.7. Documents referenced or included in the Solicitation.

a.4. 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.

a.5. 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.

a.6. 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 terms used in this document and no other understanding either oral or in writing shall be binding.

a.7. 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 nonconforming performance knows of the nature of the performance and fails to object to it.

3. Contract Administration and Operation

3.1. Records. Under A.R.S. § 35-214 and § 35-215, the Contractor shall retain and shall contractually require each subcontractor to retain all data and other "records" relating to the acquisition and performance of the Contract for a period of ten (10) after the completion of the Contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records.

3.2. Non-Discrimination. The Contractor shall comply with State Executive Order No. 2009-09 and all other applicable Federal and State laws, rules and regulations, including the ADA.

3.3. Audit. Pursuant to ARS § 35-214, at any time during the term of this Contract and ten (10) years thereafter, the Contractor's or any subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract.

3.4. Facilities Inspection and Materials Testing. The Contractor agrees to permit access to its

facilities, subcontractor facilities and the Contractor's processes or services, at reasonable times for inspection of the facilities or materials covered under this Contract. The State shall also have the right to test, at its own cost, the materials to be supplied under this Contract. Neither inspection of the Contractor's facilities nor materials testing shall constitute final acceptance of the materials or services. If the State determines non-compliance of the materials, the Contractor shall be responsible for the payment of all costs incurred by the State for testing and inspection.

3.5. Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the Offer and Acceptance form submitted by the Contractor unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to the Solicitation Contact Person indicated on the Solicitation cover sheet, unless otherwise stated in the Contract. An authorized Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice to the other and an amendment to the Contract shall not be necessary.

3.6. Advertising, Publishing and Promotion of Contract. The Contractor shall not use, advertise or promote information for commercial benefit concerning this Contract without the prior written approval of the Procurement Officer.

3.7. Property of the State. Any materials, including reports, computer programs and other deliverables, created under this Contract are the sole property of the State. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of the State.

3.8. Ownership of Intellectual Property. Any and all intellectual property, including but not limited to copyright, invention, trademark, trade name, service mark, and/or trade secrets created or conceived pursuant to or as a result of this Contract and any related subcontract ("Intellectual Property"), shall be work made for hire and the State shall be considered the creator of such Intellectual Property. The agency, department, division, board or commission of the State of Arizona requesting the issuance of this Contract shall own (for and on behalf of the State) the entire right, title and interest to the Intellectual Property throughout the

world. Contractor shall notify the State, within thirty (30) days, of the creation of any Intellectual Property by it or its subcontractor(s). Contractor, on behalf of itself and any subcontractor(s), agrees to execute any and all document(s) necessary to assure ownership of the Intellectual Property vests in the State and shall take no affirmative actions that might have the effect of vesting all or part of the Intellectual Property in any entity other than the State. The Intellectual Property shall not be disclosed by Contractor or its subcontractor(s) to any entity not the State without the express written authorization of the agency, department, division, board or commission of the State of Arizona requesting the issuance of this Contract.

3.9. 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.

3.10 E-Verify Requirements. In accordance with A.R.S. § 41-4401, 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.

3.11 Offshore 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.

4. Costs and Payments

4.1. Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days.

4.2. Delivery. Unless stated otherwise in the Contract, all prices shall be F.O.B. Destination and shall include all freight delivery and unloading at the destination.

4.3. Applicable Taxes.

4.3.1. Payment of Taxes. The Contractor shall be responsible for paying all applicable taxes.

4.3.2. State and Local Transaction Privilege Taxes. The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure to collect such taxes from the buyer does not relieve the seller from its obligation to remit taxes.

4.3.3. Tax Indemnification. Contractor and all subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall, and require all subcontractors to hold the State harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation.

4.3.4. IRS W9 Form. In order to receive payment, the Contractor shall have a current I.R.S. W9 Form on file with the State of Arizona, unless not required by law.

4.4. Availability of Funds for the Next State fiscal year. Funds may not presently be available for performance under this Contract beyond the current state fiscal year. No legal liability on the part of the State for any payment may arise under this Contract beyond the current state fiscal year until funds are made available for performance of this Contract.

4.5. Availability of Funds for the current State fiscal year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these goods or services are not funded, the State may take any of the following actions:

4.5.1. Accept a decrease in price offered by the Contractor;

4.5.2. Cancel the Contract; or

4.5.3. Cancel the Contract and re-solicit the requirements.

5. Contract Changes

5.1. Amendments. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment within the scope of the 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 a person who is not specifically authorized by the procurement officer in writing 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.

5.2. Subcontracts. Except as provided in Sections D and E, the Contractor shall not enter into any Subcontract under this Contract for the performance of this Contract without the advance written approval of the Procurement Officer. The Contractor shall clearly list any proposed subcontractors and the subcontractor's proposed responsibilities. The Subcontract shall incorporate by reference the terms and conditions of this Contract.

5.3. Assignment and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

6. Risk and Liability

6.1. Risk of Loss: The Contractor shall bear all loss of conforming material covered under this

Contract until received by authorized personnel at the location designated in the purchase order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming materials shall remain with the Contractor regardless of receipt.

6.2. Indemnification

6.2.1. 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. However, the parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence. Each party to this Contract is responsible for its own negligence.

6.2.2. Public Agency Language Only. Each party (as 'indemnitor') agrees to indemnify, defend, and hold harmless the other party (as 'indemnitee') from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers."

6.3. Indemnification - Patent and Copyright. The Contractor shall 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. If the Contractor is insured pursuant to A.R.S. § 41-621 and § 35-154, this section shall not apply.

6.4. Force Majeure.

6.4.1. Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force majeure. The term *"force majeure"*

means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; war; riots; strikes; mobilization; labor disputes; civil disorders; fire; flood; lockouts; injunctions-intervention-acts; or failures or refusals to act by government authority; and other similar occurrences beyond the control of the party declaring force majeure which such party is unable to prevent by exercising reasonable diligence.

6.4.2. Force Majeure shall not include the following occurrences:

6.4.2.1. Late delivery of equipment or materials caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market;

6.4.2.2. Late performance by a subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition; or

6.4.2.3. Inability of either the Contractor or any subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

6.4.3. If either party is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day, of the commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified-return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that results or effects of such delay prevent the delayed party from performing in accordance with this Contract.

6.4.4. Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such delay or failure is caused by force majeure.

6.5. 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.

7. Warranties

7.1. Liens. The Contractor warrants that the materials supplied under this Contract are free of liens and shall remain free of liens.

7.2. Quality. Unless otherwise modified elsewhere in these terms and conditions, the Contractor warrants that, for one year after acceptance by the State of the materials, they shall be:

7.2.1. Of a quality to pass without objection in the trade under the Contract description;

7.2.2. Fit for the intended purposes for which the materials are used;

7.2.3. Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units;

7.2.4. Adequately contained, packaged and marked as the Contract may require; and

7.2.5 Conform to the written promises or affirmations of fact made by the Contractor.

7.3. Fitness. The Contractor warrants that any material supplied to the State shall fully conform to all requirements of the Contract and all representations of the Contractor, and shall be fit for all purposes and uses required by the Contract.

7.4. Inspection/Testing. The warranties set forth in subparagraphs 7.1 through 7.3 of this paragraph are not affected by inspection or testing of or payment for the materials by the State.

7.5. Compliance with Applicable Laws. The materials and services supplied under this Contract shall comply with all applicable Federal, state and local laws, and the Contractor shall maintain all applicable license and permit requirements.

7.6. Survival of Rights and Obligations after Contract Expiration or Termination.

7.6.1. Contractor's Representations and Warranties. All representations and warranties made by the Contractor under this Contract shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12-510, except as provided in A.R.S. § 12-529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S., Title 12, Chapter 5.

7.6.2. Purchase Orders. The Contractor shall, in accordance with all terms and conditions of the Contract, fully perform and shall be obligated to comply with all purchase orders received by the Contractor prior to the expiration or termination hereof, unless otherwise directed in writing by the Procurement Officer, including, without limitation, all purchase orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

8. State's Contractual Remedies

8.1. Right to Assurance. If the State in good faith has reason to believe that the Contractor does not intend to, or is unable to perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. 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 under the Uniform Terms and Conditions or other rights and remedies available by law or provided by the Contract.

8.2. Stop Work Order.

8.2.1. The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part, of the work called for by this Contract for period(s) of days indicated by the State after the order is delivered to the Contractor. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage.

8.2.2. If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

8.3. Non-exclusive Remedies. The rights and the remedies of the State under this Contract are not exclusive.

8.4. Nonconforming Tender. Materials or services supplied under this Contract shall fully comply with the Contract. The delivery of materials or services or a portion of the materials or services that do not fully comply constitutes a breach of Contract. On delivery of nonconforming materials or services, the State may terminate the Contract for default under applicable termination clauses in the Contract, exercise any of its rights and remedies under the UCC, or pursue any other right or remedy available to it.

8.5. Right of Offset. The State shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by the State, or damages assessed by the State concerning the Contractor's non-conforming performance or failure to perform the Contract, including expenses, costs and damages described in the Uniform Terms and Conditions.

9. Contract Termination

9.1. Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is or becomes at any time while the Contract or an 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 in A.R.S. § 38-511.

9.2. Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State 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. The State, 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.

9.3. Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that the Contractor is not currently suspended or debarred. If the Contractor becomes suspended or debarred, the Contractor shall immediately notify the State.

9.4. Termination for Convenience. The State reserves the right to terminate the Contract, in whole or in part at any time when in the best interest of the State, without penalty or recourse. Upon receipt of the 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 the State 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. The cost principles and procedures provided in A.A.C. R2-7-701 shall apply.

9.5. Termination for Default.

9.5.1. In addition to the rights reserved in the Contract, the State may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

9.5.2. Upon termination under this paragraph, all goods, materials, documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State on demand.

9.5.3. The State 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 to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Contractor.

1.6. 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, as directed in the termination notice.

10. Contract Claims

All contract claims or controversies under this Contract shall be resolved according to A.R.S. Title 41, Chapter 23, Article 9, and rules adopted thereunder.

11. 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).

12. Comments Welcome

The State Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: State Procurement Administrator, State Procurement Office, 100 North 15th Avenue, Suite 201, Phoenix, Arizona, 85007.

[END OF SECTION G2]