	Notice of Request for Proposal		**AHCCCS** Arizona Health Care Cost Containment System
	SOLICITATION NO.: **YH14-0001**	PAGE 1	701 East Jefferson, MD 5700
		OF 337	Phoenix, Arizona 85034

Solicitation Contact Person

Meggan Harley
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Phoenix, AZ 85034

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Issue Date: November 1, 2012

LOCATION: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)**
Contracts and Purchasing Section (First Floor)
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

DESCRIPTION: **ACUTE CARE / CHILDREN'S REHABILITATIVE SERVICES (CRS)**

PROPOSAL DUE DATE: **January 28, 2013** **AT 3:00 P.M. Arizona Time**

Pre-Proposal Conference: A Pre-Proposal Offer's Conference has been scheduled for **Friday, November 9, 2012** starting at **9:00 A.M. Arizona time**. The Conference will be held in the following location:

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

QUESTIONS CONCERNING THIS SOLICITATION SHALL BE SUBMITTED TO THE SOLICITATION CONTACT PERSON NAMED ABOVE, IN WRITING VIA E-MAIL AS SPECIFED IN SECTION H, INSTRUCTIONS TO OFFERORS. QUESTIONS MUST BE SUBMITTED ON THE ACUTE CARE AND CRS PROGRAM RFP YH14-0001 QUESTIONS AND RESPONSES TEMPLATE LOCATED IN THE BIDDERS' LIBRARY.

The Solicitation Process shall be in accordance with the "RFP and Contract Process" Rules set forth in Title 9 Chapter 22 Article 6 and effective November 11, 2012. These rules are posted on the AHCCCS website at:

http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf

The RFP and Contract Process Rules were also published on October 5, 2012 in the Arizona Administrative Register at:

http://www.azsos.gov/public_services/Register/contents.htm

Competitive sealed proposals will be received at the above specified location, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each Offeror will be publicly read. Proposals must be in the actual possession of AHCCCS on or prior to the time and date and at the location indicated above.

Late proposals shall not be considered.

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

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the appropriate Procurement Agency. Requests should be made as early as possible to allow time to arrange the accommodation. A person requiring special accommodations may contact the solicitation contact person responsible for this procurement as identified above.

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

OFFER

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, and amendments.

Arizona Transaction (Sales) Privilege Tax License No.: _____

Federal Employer Identification No.: _____

E-Mail Address: _____

_____
Company Name

_____
Address

_____
City State Zip

For Clarification of this offer, contact:

Name: _____

Phone: _____

Fax: _____

_____
Signature of Person Authorized to Sign Offer

_____
Printed Name

_____
Title

CERTIFICATION

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

The submission of the offer did not involve collusion or other anti-competitive practices.

The bidder shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 99-4 or A.R.S. §41-1461 through 1465.

The bidder has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the offer. Signing the offer with a false statement shall void the offer, any resulting contract and may be subject to legal remedies provided by law.

In accordance with A.R.S. §35-393, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Iran.

In accordance with A.R.S. §35-391, the Offeror hereby certifies that the Offeror does not have scrutinized business operations in Sudan.

The bidder certifies that the above referenced organization ____is / ____is not a small business with less than 100 employees or has gross revenues of $4 million or less.

ACCEPTANCE OF OFFER (to be completed by AHCCCS)

Your offer, including all exhibits and amendments contained herein, is accepted. The Contractor is now bound to provide all services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by AHCCCS.

This contract shall henceforth be referred to as Contract No. YH14-0001 Awarded this ___ day of _____, 2013

_____
Michael Veit, as AHCCCS Contracting Officer and not personally

SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS

The Contractor shall provide services as described in this contract. This section will be amended to include capitation rates awarded to the successful Offeror.

SECTION C: PART 1, DEFINITIONS PERTAINING TO ALL AHCCCS CONTRACTS

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

638 TRIBAL FACILITY	A facility that is operated by an Indian Tribe and that is authorized to provide services pursuant to Public Law (P.L.) 93-638, as amended.
ABUSE (OF MEMBER)	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. §46-451 and A.R.S. §13-3623.
ABUSE (BY PROVIDER)	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
ACUTE CARE SERVICES	Medically necessary services as specified in Paragraph 10, Scope of Services.
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.
ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.
AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.
AHCCCS MEMBER	See "MEMBER."
AHCCCS RULES	See "ARIZONA ADMINISTRATIVE CODE."
AMERICAN INDIAN HEALTH PROGRAM (AIHP)	An acute care fee-for-service program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider. AIHP was formerly known as AHCCCS IHS.

AMERICANS with DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as "Rules." AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.
ARIZONA DEPARTMENT OF ECONOMIC SECURITY /DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for licensure/certification of facilities that specifically serve individuals with a developmental/intellectual disability, contracting with providers that serve individuals with developmental disabilities, and provide services for eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with ADES to serve eligible individuals with a developmental/intellectual disability.
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The state agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	A State agency, as described in A.R.S. Title 36, Chapter 29, which is responsible for the provision of hospitalization and medical care to members through contracts with Contractors. AHCCCS is Arizona's Medicaid program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
AUTHORIZED REPRESENTATIVE	Authorized representative means a person who is authorized to apply for medical assistance or act on behalf of another person (R9-22-101).
BALANCED BUDGET ACT (BBA)	See "MEDICAID MANAGED CARE REGULATIONS."

BEHAVIORAL HEALTH PROFESSIONAL	An Arizona licensed psychologist, a registered nurse with at least one year of full time behavioral health work experience, or a behavioral health medical practitioner, or an Arizona licensed social worker, counselor, marriage and family therapist or substance abuse counselor licensed according to A.R.S. Title 32, Chapter 33, or an out of State individual who is licensed or certified to practice social work, counseling or marriage and family therapy by a government entity in another sate if the individual has documentation of submission of an application for Arizona licensure per A.R.S. Title 32, Chapter 33 and is licensed within one year after submitting the application.
BEHAVIORAL HEALTH RECIPIENT	A Title XIX or Title XXI acute care member who is receiving behavioral health services through ADHS and the subcontractors.
BEHAVIORAL HEALTH SERVICES	Behavioral Health Services means the assessment, diagnosis, or treatment of an individual's behavioral health issue and include services for both mental health and substance abuse conditions. See also "COVERED SERVICES."
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
BORDER COMMUNITIES	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
CHILDREN with SPECIAL HEALTH CARE NEEDS (CSHCN)	Children under age 19 who are: Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI). Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett); in foster care or other out-of-home placement; receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS).

CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
CONTRACT SERVICES	See "COVERED SERVICES."
CONTRACT YEAR (CY)	Corresponds to the contract year as specified in Section A of the contract.
CONTRACT YEAR ENDING (CYE)	Corresponds to the contract ending year as specified in Section A of the contract.
CONTRACTOR	An organization or entity that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. §36-2904 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
CONVICTED	A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.
COVERED SERVICES	The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements.
DAY	A day means a calendar day unless otherwise specified.

DAY – BUSINESS/WORKING	A business means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.
DISCLOSING ENTITY	An AHCCCS provider or a fiscal agent.
DISENROLLMENT	The discontinuance of a member's ability to receive covered services through a Contractor.
DIVISION OF HEALTH CARE MANAGEMENT (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, rate setting, encounters, and financial/operational oversight.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
DURABLE MEDICAL EQUIPMENT (DME)	An item or appliance that is not an orthotic or prosthetic and that is: designed for a medical purpose, is generally not useful to a person in the absence of an illness or injury, can withstand repeated use, and is generally reusable by others.
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)	EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].
ENCOUNTER	A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.10(a)].
ENROLLMENT	The process by which an eligible person becomes a member of a Contractor's plan.
EXHIBITS	All items attached as part of the solicitation.
FEDERAL FINANCIAL PARTICIPATION (FFP)	FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FEE-FOR-SERVICE MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.
FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.

GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996 addresses issues regarding the privacy and security of member confidential information.
HEALTH PLAN	See "CONTRACTOR."
INCURRED BUT NOT REPORTED LIABILITY (IBNR)	Incurred but not reported liability for services rendered for which claims have not been received.
INDIAN HEALTH SERVICES (IHS)	A Federal agency pursuant to 25 U.S.C. 1661.
INFORMATION SYSTEMS	The component of the Offeror's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
INTERGOVERNMENTAL AGREEMENT (IGA)	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).

LIABLE PARTY	A individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in R9-22-1001.
LIEN	A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MAJOR UPGRADE	Any systems upgrade or changes that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.
MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive 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.
MATERIAL CHANGE	An alteration or development within a provider network that may reasonably be foreseen to affect the quality or delivery of services provided under this contract.
MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

MEDICAID MANAGED CARE REGULATIONS	The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
MEDICALLY NECESSARY	As defined in 9 A.A.C. 22 Article 1. Medically necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.
MEMBER NFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.
NATIONAL PROVIDER IDENTIFIED (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.

NOTICE OF APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
OFFEROR	An organization or other entity that submits a proposal to AHCCCS in response to a Request For Proposal as defined in 9 A.A.C. 22, Article 1.
PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.
PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
PERFORMANCE STANDARDS	A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.
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)].
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
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.
PRIOR PERIOD	See "PRIOR PERIOD COVERAGE."

PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1.
PROVIDER	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.
PROVIDER GROUP	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).
PRUDENT LAYPERSON (for purposes of determining whether an emergency medical condition exists)	A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)	A person determined eligible under Title 9 Chapter 29 Article 2 of A.A.C. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in 9 A.A.C. 22 or ALTCS services provided for in 9 A.A.C. 28. A QMB dual person received both Medicare and Medicaid services and cost sharing assistance.
REFERRAL	A verbal, written, telephonic, electronic or in-person request for health services.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	An organization under contract with the ADHS to administer covered behavioral health services in a geographically specific area of the state. Refer to A.R.S. §36-3401 and A.R.S. Title 9, Chapter 22, Article 12.
REINSURANCE	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.

RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
REQUEST FOR PROPOSAL (RFP)	A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a proposal under 9 A.A.C. 22 Article 6.
ROOM AND BOARD (or ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Level 2) or an apartment like setting that may provide meals.
SCOPE OF SERVICES	See "COVERED SERVICES."
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract.
SERVICE PLAN	A document that is developed consistent with applicable Evidence Based Practice Guidelines, which combines the various elements of treatment plans with needed family support services and care coordination activities to provide a map of the steps to be taken for each member in achieving treatment and quality of life goals.
SPECIAL HEALTH CARE NEEDS	Serious or chronic physical, developmental and/or behavioral health conditions. Members with special health care needs require medically necessary services of a type or amount beyond that generally required by members.
SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
STATE	The State of Arizona.

STATEWIDE	Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE PLAN	The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22 Article 1.
SUBCONTRACTOR	1. A provider of health care who agrees to furnish covered services to members. 2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities. 3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY (TPL)	See "LIABLE PARTY."
TITLE XIX	Means Medicaid as defined in 42 U.S.C. 1396 et seq.
TITLE XIX MEMBER	Title XIX members include those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.

TREATMENT	The range of health care received by a member that is consistent with the therapeutic goals.
TRIBAL/REGIONAL BEHAVIORAL HEALTH AUTHORITY (T/RBHA)	An organization under contract with ADHS/DBHS that administers covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members.
YEAR	See "CONTRACT YEAR."

[END OF PART 1 DEFINITIONS]

SECTION C: PART 2, DEFINITIONS PERTAINING TO ONE OR MORE AHCCCS CONTRACTS

1931 (also referred to as TANF related)	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL). See also "TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)."
ADMINISTRATIVE OFFICE OF THE COURTS (AOC)	The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS BENEFITS	See "Section D, Scope of Services".
AHCCCS CARE	Eligible individuals and childless adults whose income is less than or equal to 100% of the FPL, and who are not categorically linked to another Title XIX program. Also known as Childless Adults (Formerly Non-MED). See also "Title XIX WAIVER GROUP MEMEBR."
AID FOR FAMILIES WITH DEPENDENT CHILDREN (AFDC)	See "TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)."
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners physician assistants and other health care providers.
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a person to change Contractors every 12 months; effective on their anniversary date.

ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	Arizona Department of Juvenile Correction.
BED HOLD	A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility. Refer to the Arizona Medicaid State Plan, 42 C.F.R. §§447.40 and 483.12, and 9 A.A.C. 28 for more information on the bed hold service.
BEHAVIORAL HEALTH MEDICAL PRACTITIONER	A medical practitioner, i.e., a physician, physician assistant, nurse practitioner, with one year of full-time behavioral health experience as specified in A.A.C. Title 9, Chapter 22, Article 12.
BEHAVIORAL HEALTH PARAPROFESSIONAL	A staff member of a licensed behavioral health service agency as specified in A.A.C. Title 9, Chapter 20.
BEHAVIORAL HEALTH TECHNICIAN	A staff member of a licensed behavioral health service agency as specified in A.A.C. Title 9, Chapter 20.
BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.
CASH MANAGEMENT IMPROVEMENT ACT (CMIA)	Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.
CHILD PROTECTIVE SERVICES (CPS)	Child Protective Services (CPS) is a program mandated under ARS §8-802 for the protection of children alleged to be abused and neglected. This program provides specialized welfare services that seek to prevent dependency, abuse and neglect of children. The Child Protective Services program receives, screens and investigates allegations of child abuse and neglect, performs assessments of child safety, assesses the imminent risk of harm to the children and evaluates conditions that support or refute the alleged abuse or neglect and need for emergency intervention. This program also provides services designed to stabilize a family in crisis and to preserve the family unit by reducing safety and risk factors.

CHILDREN'S REHABILITATIVE SERVICES (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 22.
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from DES/DDD.
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.
COMPETITIVE BID PROCESS	A state procurement system used to select Contractors to provide covered services on a geographic basis.
COUNTY OF FISCAL RESPONSIBILITY	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
CRS-ELIGIBLE	An individual AHCCCS member who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS-related services as specified in 9 A.A.C. 22.
CRS RECIPIENT	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS related covered Services.
DEPARTMENT OF ECONOMIC SECURITY (DES)	Department of Economic Security.
DEVELOPMENTALLY/INTELLECTUALLY DISABLED MEMBER (DD)	A member who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.
DIVISION OF CHILDREN, YOUTH, and FAMILIES (DCYF)	The Division of Children, Youth and Families within DES.

FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member.
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may also include siblings, grandparents, aunts and uncles.
FEDERAL EMERGENCY SERVICES (FES)	A program delineated in R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(1)(B) of the Social Security Act and received funds under Section 330 of the Public Health Service Act.
FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of "health center" under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.
FIELD CLINIC	A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a: health care institution defined in A.R.S. §36-401; residential care institution defined in A.R.S. §36-401; community residential facility defined in A.R.S. §36-551; or behavioral health service facility defined in 9 A.A.C. 20 Article 1.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.

INTEGRATED MEDICAL RECORD	A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.
INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF)	A placement setting for persons with intellectual disabilities.
JUVENILE PROBATION OFFICE (JPO)	Juvenile Probation Office.
KIDSCARE	Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare I program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income at or below 200% Federal Poverty Level (FPL). The KidsCare II program has the same benefits and premium requirements as KidsCare I, however household income limits cannot be greater than 175% FPL.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
NON-MEDICAL EXPENSE DEDUCTION (FORMERLY NON-MED) MEMBER	See "AHCCCS CARE."
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.

RATE CODE	Eligibility classification for capitation payment purposes.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.
RURAL HEALTH CLINIC (RHC)	A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.
SERIOUSLY MENTALLY ILL (SMI)	A person 18 years of age or older who is seriously mentally ill as defined in A.R.S. §36-550.
SIXTH OMNIBUS BUDGET AND RECONCILATION ACT (SOBRA)	Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.
SOBRA FAMILY PLANNING EXTENSION PROGRAM	A program that provides family planning services only, for a maximum of two consecutive 12-month periods to a SOBRA woman whose pregnancy has ended and who is not otherwise eligible for full Title XIX services (Also referred to as Family Planning Services Extension Program).
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.
SUBSTANCE ABUSE	The chronic, habitual, or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse.

TELEMEDICINE	The practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation. Refer to A.R.S. §36-3601.
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).
TITLE XIX WAIVER GROUP MEMBER	Eligible individuals and couples whose income is at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. Formerly known as Non-MED members. See also "AHCCCS CARE."
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "Children's Health Insurance Program" (CHIP). The Arizona version of CHIP is referred to as "KidsCare."
TRANSITION PLAN	A plan developed for each member in accordance with AHCCCS Policy, which includes developmentally-appropriate strategies to transition from a pediatric to an Adult system of health care and a plan that addresses changing work, education, recreation and social needs.
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.
VIRTUAL CLINICS	Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

[END OF PART 2 DEFINITIONS]

TABLE OF CONTENTS

SECTION D1: ACUTE CARE PROGRAM REQUIREMENTS

All references to Section D correspond to Section D1 - Acute Care Program Requirements.

1. PURPOSE, APPLICABILITY, AND INTRODUCTION

PURPOSE AND APPLICABILITY

The purpose of the contract between AHCCCS and the Contractor is to implement and operate the Arizona Acute Care Program pursuant to A.R.S. §36-2901 et seq.

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

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

INTRODUCTION

AHCCCS Mission and Vision

AHCCCS' mission and vision are to reach across Arizona to provide comprehensive quality healthcare to those in need while shaping tomorrow's managed health care from today's experience, quality and innovation. AHCCCS is dedicated to continuously improving the efficiency and effectiveness of the Acute Care Program while supporting member choice in the delivery of the highest quality care to its customers.

AHCCCS expects the Contractor to implement program innovation and best practices on an ongoing basis. Furthermore, it is important for the Contractor to continuously develop mechanisms to reduce administrative cost and improve program efficiency. Over the term of the contract, AHCCCS will work collaboratively with the Contractor to evaluate ways to reduce program complexity, improve care coordination and chronic disease management, reduce administrative burdens, leverage joint purchasing power, and reduce unnecessary administrative and medical costs.

AHCCCS has remained a leader in Medicaid Managed Care through the diligent pursuit of excellence and cost effective managed care by its collaboration with Contractors.

The Contractor must continue to add value to the program. A Contractor adds value when it:

- Recognizes that Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrates special effort throughout its operations to assure members receive necessary services.
- Recognizes that Medicaid members with special health care needs or chronic health conditions require care coordination, and provides that coordination.
- Recognizes that health care providers are an essential partner in the delivery of health care services, and operates the Health Plan in a manner that is efficient and effective for health care providers as well as the Contractor.
- Recognizes that performance improvement is both clinical and operational in nature and self-monitors and self-corrects as necessary to improve contract compliance or operational excellence.
- Recognizes that the program is publicly funded, is subject to public scrutiny, and operates in a manner consistent with the public trust.

The Acute Care Program

In 1982 Arizona introduced its innovative Medicaid program by establishing the Arizona Health Care Cost Containment System (AHCCCS), a demonstration program based on principles of managed care. In doing so, AHCCCS became the first statewide Medicaid managed care system in the nation. As of October 1, 2012, AHCCCS, through its Managed Care Organizations (MCOs) serves 1,062,361 members under the Acute Care Program.

AHCCCS contracts for acute care services in seven geographic service areas that include the 15 Arizona counties. Contractors are responsible for coordinating, managing and providing acute care services to members and coordinating carved out behavioral health services delivered by the Regional Behavioral Health Authorities through the Arizona Department of Health Services.

Additional information may be obtained by visiting the AHCCCS website: www.azahcccs.gov.

2. ELIGIBILITY CATEGORIES

AHCCCS is Arizona's Title XIX Medicaid program operating under an 1115 Waiver and Title XXI program operating under Title XXI State Plan authority. Arizona has the authority to require mandatory enrollment in managed care. All Acute Care Program members eligible for AHCCCS benefits, with exceptions as identified below, are enrolled with acute care Contractors that are paid on a capitated basis. AHCCCS pays for health care expenses on a fee-for-service (FFS) basis for Title XIX- and Title XXI- eligible members who receive services through the American Indian Health Program; for Title XIX eligible members who are entitled to emergency services under the Federal Emergency Services (FES) program; and for Medicare cost sharing beneficiaries under the QMB-Only program.

The following describes the eligibility groups enrolled in the managed care program and covered under this contract:

Title XIX

1931 (Also referred to as TANF-related): Eligible individuals and families under the 1931 provision of the Social Security Act, with income at or below 100% of the FPL.

SSI Cash: Eligible individuals receiving Supplemental Security Income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have income at or below 100% of the Federal Benefit Rate (FBR).

SSI Medical Assistance Only (SSI MAO) and Related Groups: Eligible individuals who are aged, blind or disabled and have household income levels at or below 100% of the FPL.

***Freedom to Work (Ticket to Work)*:** Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.

SOBRA: Under the Sixth Omnibus Budget Reconciliation Act of 1986, eligible pregnant women, with income at or below 150% of the FPL, and children with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.

SOBRA Family Planning: Family Planning Extension Program that covers the costs for family planning services only, for a maximum of two consecutive 12-month periods following the loss of SOBRA eligibility.

Breast and Cervical Cancer Treatment Program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.

Title IV-E Foster Care and Adoption Subsidy: Children who are in State foster care or are receiving Federally funded adoption subsidy payments.

Young Adult Transitional Insurance (YATI): Individuals age 18 through age 20 who were in foster care under jurisdiction of Department of Economic Security (DES) Division of Children Youth and Families (DCYF) in Arizona on their 18th birthday or are in the DCYF Young Adults Program.

Title XIX Waiver Group

AHCCCS Care (also known as Childless Adults): Eligible individuals and couples whose income is at or below 100% of the FPL, and who are not categorically linked to another Title XIX program. Formerly known as Non-MED members.

Title XXI

KidsCare: Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare I program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income at or below 200% Federal Poverty Level (FPL). The KidsCare II program has the same benefits and premium requirements as KidsCare I, however household income limits cannot be greater than 175% FPL.

State-Only

State-Only Transplants: Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:

1. The individual has been determined ineligible for Title XIX due to excess income;
2. The individual had been placed on a donor waiting list before eligibility expired; and
3. The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

The following options for extended eligibility are available to these members:

Option 1: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.

Option 2: The member loses AHCCCS eligibility but maintains transplant candidacy status as long as medical eligibility for a transplant is maintained. At the time that the transplant is scheduled to be performed the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor

to receive all covered transplant services. Option 2-eligible individuals are not eligible for any non-transplant related health care services from AHCCCS.

Eligibility for the various AHCCCS coverage groups is determined by one of the following agencies:

Social Security Administration (SSA)	SSA determines eligibility for the Supplemental Security Income (SSI) cash program. SSI cash recipients are automatically eligible for AHCCCS coverage.
Department of Economic Security (DES)	DES determines eligibility for families with children under section 1931 of the Social Security Act, pregnant women and children under SOBRA, the Adoption Subsidy Program, Title IV-E foster care children, Young Adult Transitional Insurance Program, and Title XIX Waiver Members (AHCCCS Care).
AHCCCS	AHCCCS determines eligibility for the SSI-Medical Assistance Only (SSI-MAO) groups, the Arizona Long Term Care System (ALTCS), the Children's Rehabilitative Services (CRS), the Medicare Savings Programs, BCCTP, the Freedom to Work program, the Title XXI KidsCare program, and the State-Only Transplant program.

3. ENROLLMENT AND DISENROLLMENT

AHCCCS Acute Care members are enrolled with the Contractor in accordance with the rules set forth in 9 A.A.C. 22 Article 17, and 9 A.A.C. 31 Articles 3 and 17. AHCCCS has the exclusive authority to enroll and disenroll members. The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS. The Contractor may request AHCCCS to change the member's enrollment in accordance with the ACOM Policy 401. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, nor because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. An AHCCCS member may request disenrollment from the Contractor for cause at any time. Please refer to ACOM Policy 401.

AHCCCS will disenroll the member from the Contractor when:

- The member becomes ineligible for the AHCCCS program;
- In limited situations when the member moves out of the Contractor's service areas;
- The member changes Contractors during the member's open enrollment/annual enrollment choice period;
- 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 AHCCCS in accordance with the requirements in Section D, Paragraph 10, Scope of Services;
- The member is approved for a Contractor change through the ACOM Policy 401 [42 CFR 438.56]; or
- The member is eligible to transition to another AHCCCS program.

Members may submit plan change requests to the Contractor or AHCCCS. A denial of any plan change request must include a description of the member's right to appeal the denial.

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

a. Previously enrolled members who have been disenrolled for less than 90 days will be automatically enrolled with the same Contractor, if still available.
b. Women who become eligible for the SOBRA Family Planning Extension Program will remain assigned to their current Contractor.
c. Members residing in a Geographic Service Area where only one Contractor is available will be automatically enrolled with that Contractor and will be given a choice of PCPs.

AHCCCS members eligible under this contract who become eligible for another AHCCCS program will be enrolled as follows:

a. Members eligible for Children's Rehabilitative Services will be enrolled in the statewide integrated Contractor, unless they choose to use private insurance for the CRS covered condition.
b. Adult members in Maricopa County with Serious Mental Illness will be enrolled in the Maricopa RHBA.
c. Children in State custody will be enrolled in CMDP.

Members who do not choose a Contractor prior to AHCCCS being notified of their eligibility are automatically assigned to a Contractor based on re-enrollment rules, family continuity, or the auto-assignment algorithm. If a member is auto-assigned, AHCCCS sends a Choice Notice to the member and allows the member 30 days to choose a different Contractor. See Section D, Paragraph 6, Auto-Assignment Algorithm, for further explanation.

The effective date of enrollment for a new Title XIX member with the Contractor is the day AHCCCS takes the enrollment action. The Contractor is responsible for payment of medically necessary covered services retroactive to the member's beginning date of eligibility, as reflected in PMMIS.

The effective date of enrollment for a Title XXI member will be the first day of the month following notification to the Contractor. In the event that eligibility is determined on or after the 25th day of the month, eligibility will begin on the first day of the second month following the determination.

***Prior Period Coverage*:** AHCCCS provides prior period coverage for the period of time prior to the Title XIX member's enrollment during which the member is eligible for covered services. Prior Period Coverage refers to the time frame from the effective date of eligibility to the day the member is enrolled with the Contractor. The Contractor receives notification from AHCCCS of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services, excluding most behavioral health services, provided to members during prior period coverage. This may include services provided prior to the contract year.

Newborns: Newborns born to AHCCCS eligible mothers enrolled at the time of the child's birth will be enrolled with the mother's Contractor (except as noted in the following paragraph), when newborn notification is received by AHCCCS. The Contractor is responsible for notifying AHCCCS of a child's birth to an enrolled member. Capitation for the newborn will be retroactive to the date of birth if notification is received no later than one day from the date of birth. In all other circumstances, capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility for the newborn will be the newborn's date of birth, and the Contractor is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is available to receive notification 24 hours a day, seven days a week via the AHCCCS website. Each eligible mother of a newborn is sent a Choice notice advising her of her right to choose a different Contractor for her child; the date of the change will be the date of processing the request from the mother. If the mother does not request a change within 30 days, the child will remain with the mother's Contractor.

Babies born to mothers enrolled in the Federal Emergency Services program (FES), the Maricopa RBHA, CRS, or CMDP are auto-assigned to a Contractor. Mothers of these newborns are sent a Choice Notice advising them of their right to choose a different Contractor for their children, and allows them 30 days to make a choice. In the event the mother chooses a different Contractor, AHCCCS will recoup all capitation paid to the originally assigned Contractor and the baby will be enrolled retroactive to the date of birth with the second Contractor. The second Contractor will receive prior period capitation from the date of birth to the day before assignment and prospective capitation from the date of assignment forward. The second Contractor will be responsible for all covered services to the newborn from date of birth.

Enrollment Guarantees: Upon initial capitated enrollment as a Title XIX-eligible member, the member is guaranteed a minimum of five full months of continuous enrollment. Upon initial capitated enrollment as a Title XXI-eligible member, the member is guaranteed a minimum of 12 full months of continuous enrollment. The enrollment guarantee is a one-time benefit. If a member changes from one Contractor to another within the enrollment guarantee period, the remainder of the guarantee period applies to the new Contractor. AHCCCS rules at 9 A.A.C 22 Article 17, and 9 A.A.C. 31 Article 3, describe other reasons for which the enrollment guarantee may not apply.

American Indians: American Indians, on- or off-reservation, may choose to receive services from Indian Health Service (IHS), a 638 tribal facility or any available Contractor. If a choice is not made prior to AHCCCS being notified of their eligibility, American Indian Title XIX members living on-reservation will be assigned to the AHCCCS American Indian Health Program (AIHP) as FFS members. American Indian Title XIX members living off-reservation who do not make a Contractor choice will be assigned to an available Contractor using the AHCCCS protocol for family continuity and the auto-assignment algorithm. The designation of a zip code as a 'reservation zip code', not the physical location of the residence, is the factor that determines whether a member is considered on or off-reservation for these purposes. Further, if the member resides in a zip code that contains land on both sides of a reservation boundary and the zip code is assigned as off-reservation, the physical location of the residence does not change the off-reservation designation for the member. American Indian Title XXI members may change from AHCCCS AIHP FFS to a Contractor or from a Contractor to AHCCCS AIHP FFS at any time.

4. ANNUAL AND OPEN ENROLLMENT CHOICE

AHCCCS conducts an Annual Enrollment Choice (AEC) for members on their annual anniversary date [42 CFR 438.56(c)(2)(ii)]. During AEC, members may change Contractors subject to the availability of other Contractors within their GSA. AHCCCS provides enrollment and other information required by Medicaid Managed Care Regulations 60 days prior to the member's AEC date. The member may choose a new Contractor by contacting AHCCCS to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made (except for approved changes under the ACOM Policy 401) during the new anniversary year. This holds true if a Contractor's contract is renewed and the member continues to live in a Contractor's service area. The Contractor shall comply with the ACOM Policy 402, and the AMPM.

AHCCCS may hold an open enrollment in any GSA or combination of GSAs as deemed necessary.

5. RESERVED

6. AUTO-ASSIGNMENT ALGORITHM

Members who do not exercise their right to choose and do not have family continuity are assigned to a Contractor through an auto-assignment algorithm.

Assignment by the algorithm applies to the following members who do not exercise their right to choose a Contractor within the prescribed time limits:

1. New members and members re-enrolling outside the 90-day re-enrollment window.
2. Members enrolled with a Contractor that is not available after the member moves to a new geographic service area (GSA).
3. Infants born to a mother who is enrolled with the Maricopa County RBHA and diagnosed as Seriously Mentally Ill (SMI) and who has no family continuity with an AHCCCS Acute Care Contractor in Maricopa County.
4. Members who were enrolled with the Maricopa County RBHA and diagnosed as SMI but who have been determined to no longer qualify as SMI and who do not have family continuity with an AHCCCS Acute Care Contractor in Maricopa County.
5. Members who are disenrolled from the CRS Contractor and who do not have family continuity with an AHCCCS Acute Care Contractor.

Once auto-assigned, AHCCCS sends a Choice notice to the member, allowing the member 30 days to choose a different Contractor from the auto-assigned Contractor.

The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. AHCCCS may change the algorithm at any time during the term of the contract in response to Contractor-specific issues (e.g. imposition of an enrollment cap) or in the best interest of the AHCCCS Program and/or the State.

Maximum Enrollment: A Contractor in Maricopa or Pima County will no longer be eligible for auto assignment of members once the Contractor's membership reaches 45% of the County's total enrollment. Member choices will not be impacted by the auto assignment algorithm freeze.

For further details on the AHCCCS Auto-Assignment Algorithm, refer to ACOM Draft Policy, Auto-Assignment Algorithm.

7. AHCCCS MEMBER IDENTIFICATION CARDS

The Contractor is responsible for the production, distribution and costs of AHCCCS member identification cards in accordance with ACOM Draft Policy 433.

8. MAINSTREAMING OF AHCCCS MEMBERS

To ensure mainstreaming of AHCCCS members, the Contractor shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information, or physical or mental illnesses. The Contractor must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors to do the same. The Contractor must also make interpreters, including assistance for the visual- or hearing-impaired, available to members at no cost to ensure appropriate delivery of covered services.

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

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

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 its contract.

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

9. TRANSITION ACTIVITIES

Member Transition: The Contractor shall comply with the AMPM and the ACOM standards for member transitions between Contractors or Geographical Service Areas (GSAs), Children's Rehabilitative Services (CRS), the Comprehensive Medical and Dental Program (CMDP), or to the Arizona Long Term Care System (ALTCS) Contractor, and upon termination or expiration of a contract. The Contractor shall develop and implement policies and procedures which include but are not limited to:

a. Members with significant medical conditions such as, a high-risk pregnancy or pregnancy within the last trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.;
b. Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;
c. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth;
d. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;
e. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, or nursing home admission;
f. Continuing prescriptions, Durable Medical Equipment (DME) and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor; and
g. 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).

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the AHCCCS transition staff and staff from other Contractors to ensure a safe, timely, and orderly transition.

A new Contractor who receives members from another Contractor as a result of a contract award shall ensure a smooth transition for members by continuing previously approved prior authorizations for 30 days after the member transition unless mutually agreed to by the member or member's representative.

When relinquishing members, the Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special needs of transitioning members. When receiving a transitioning member with special needs, the Contractor is responsible for coordinating care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with Contractor and service information, emergency numbers and instructions about how to obtain services. See ACOM Policy 402 and AMPM Chapter 500.

Contract Termination: In the event that the contract or any portion thereof is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members to other Contractors. In addition, AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. AHCCCS may discontinue enrollment of new members with the Contractor three months prior to the contract termination date. The Contractor shall make provisions for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. The Contractor shall submit a detailed plan to AHCCCS for approval regarding the transition of members in the event of contract expiration or termination. The name and title of the Contractor's transition coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process, and shall be responsible for the following:

a. Notifying subcontractors and members;
b. Paying all outstanding obligations for medical care rendered to members until AHCCCS is satisfied that the Contractor has paid all such obligations. The Contractor shall provide a monthly claims aging report including IBNR amounts (due the 15th day of the month, for the prior month);
c. Providing Quarterly and Audited Financial Statements up to the date of contract termination. The financial statement requirement will not be absolved without an official release from AHCCCS;
d. Continuing encounter reporting until all services rendered prior to contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from AHCCCS;
e. Cooperating with reinsurance audit activities on prior contract years until release has been granted by AHCCCS;
f. Cooperating with AHCCCS to complete and finalize any open reconciliations, until release has been granted by AHCCCS. AHCCCS will work to complete any pending reconciliations as timely as can be completed, allowing for appropriate lag time for claims run-out and/or changes to be entered into the system;
g. Supplying quarterly Quality Management and Medical Management reports will be submitted as required by Section D, Paragraphs 23, Quality Management, and 24, Medical Management, as appropriate to provide AHCCCS with information on services rendered up to the date of contract termination. This will include quality of care (QOC) concern reporting based on the date of service;
h. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by AHCCCS;
i. Maintaining a Performance Bond in accordance with Section D, Paragraph 46, Performance Bond or Bond Substitute. A formal request to release the performance bond, as well as a balance sheet, must be submitted when appropriate;
j. Indemnifying AHCCCS for any claim by any third party against the State or AHCCCS arising from the Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract;
k. Returning to AHCCCS, any funds advanced to the Contractor for coverage of members for periods after the date of termination. Funds must be returned to AHCCCS within 30 days of termination of the contract;
l. Providing a monthly accounting of Member Grievances and Claim Disputes and their disposition; and
m. Preserving and making available all records for a period of five years from the date of final payment under contract. Records covered under HIPAA must be preserved and made available for six years per 45 CFR 164.530(j)(2).

The above list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met. Any dispute by the Contractor, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E1, Contract Terms and Conditions, Paragraph 19, Disputes.

10. SCOPE OF SERVICES

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal and State laws, regulations and policies, including those listed by reference in attachments and this contract. The services are described in detail in AHCCCS rules R9-22 Article 2, the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM), all of which are incorporated herein by reference, and may be found on the AHCCCS website [42 CFR 438.210(a)(1)]. To be covered, services must be medically necessary and cost effective. The covered services are briefly described below.

The Contractor must ensure the coordination of services it provides with services the member receives from other entities, including behavioral health services the member receives through an ADHS/RBHA provider. 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)(4) and 438.224].

Services must 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. 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. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)(3)].

Moral or Religious Objections

The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution to allow members' access to the services. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. If AHCCCS does not approve the Contractor's proposed solution, AHCCCS will disenroll members who are seeking these services from the Contractor and assign them to another Contractor [42 CFR 438.56]. That proposal must:

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

If AHCCCS approves the Contractor's proposed solution for its members to access the services, the Contractor must notify members how to access these services when directed by AHCCCS. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to newly assigned members within 12 days of enrollment, and must be provided to all current members at least 30 days prior to the effective date of the approved policy [42 CFR 438.102(a)(2) and (b)(1)].

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

Notice of Action
The Contractor shall notify the requesting provider and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested [42 CFR 438.400(b)]. The notice shall meet the requirements of 42 CFR 438.404, AHCCCS rules and ACOM Policy 414. The notice to the provider must also be in writing as specified in Attachment A1, Enrollee Grievance System Standards of this contract [42 CFR 438.210(c)]. The Contractor must comply with all decision timelines outlined in ACOM Policy 414.

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

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

Covered Services
Please refer to the AHCCCS Medical Policy Manual (AMPM) for a comprehensive list of Covered Services.

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

American Indian Health Program (AIHP): The AHCCCS, Division of Fee For Service Management (DFSM) will reimburse claims for acute care services that are medically necessary, and are provided to Title XIX members enrolled with the Contractor by an IHS or a tribal 638 facility, eligible for 100% Federal reimbursement, when the member is eligible to receive services through an IHS or a tribally operated 638 program. Encounters for Title XIX services billed by an IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

The Contractor is responsible for reimbursement to IHS or tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. The Contractor may choose to subcontract with an IHS or 638 tribal facility as part of its provider network for the delivery of Title XXI covered services. Expenses incurred by the Contractor for Title XXI services billed by an IHS or a 638 tribal facility shall be encountered and considered in capitation rate development.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and Von Willebrand's disease. See Section D, Paragraph 57, Reinsurance.

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

Behavioral Health: The Contractor shall provide behavioral health services as described in Section D, Paragraph 12, Behavioral Health Services.

Children's Rehabilitative Services (CRS): The CRS program is administered by AHCCCS utilizing a CRS Contractor for children with special health care needs who meet CRS eligibility criteria. The CRS Contractor provides various combinations of acute, behavioral health and specialty CRS services for these children. The Contractor shall refer children to AHCCCS Division of Member Services (DMS) who are potentially eligible for services related to CRS-covered conditions, as specified in R9-22 Article 13, and A.R.S. Title 36. In addition, the Contractor shall notify the member when a referral to CRS has been made. The Contractor is responsible for care of members until those members are determined eligible by the CRS Contractor. In addition, the Contractor is responsible for covered services for CRS-eligible members unless and until the Contractor has received confirmation from AHCCCS that the member has transitioned to the CRS Contractor. For more detailed information regarding eligibility criteria, referral practices, and Contractor-CRS coordination issues, refer to the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor's Operation Manual (ACOM) located on the AHCCCS website.

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

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

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

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

The Contractor shall ensure the initiation and coordination of a referral as indicated on the EPSDT forms received, to the T/RBHA system for members in need of behavioral health services. The Contractor shall have processes in place to follow up with the T/RBHA to monitor whether members have received these EPSDT

services. The Contractor will ensure the coordination of referrals and follow-up collaboration, as necessary, for members identified by the T/RBHA as needing acute care services.

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 21 years of age and older. These services include, but are not limited to, screening and treatment for hypertension; elevated cholesterol; colon cancer; sexually transmitted diseases; tuberculosis; HIV/AIDS; breast cancer, cervical cancer; and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in R9-22-205. AHCCCS does not cover well exams (i.e., physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination) for adult members.

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

a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by R9-22 Article 1. Emergency medical services are covered without prior authorization. The Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. The Contractor shall monitor emergency 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.
b. All medical services necessary to rule out an emergency condition; and
c. Emergency transportation.

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

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

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

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

Additionally, the Contractor may not:

a. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
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 10 calendar days of presentation for emergency services. Claims submission by the hospital within 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.

c. Require notification of Emergency Department treat and release visits as a condition of payment unless the plan has prior approval from AHCCCS.

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

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

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

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

The Contractor shall provide services to members enrolled in the SOBRA Family Planning Extension Program, a program that provides family planning services only, for a maximum of two consecutive 12-month periods, to women whose SOBRA eligibility has terminated. The Contractor is responsible for notifying AHCCCS when a SOBRA woman is sterile in order to ensure that the member is not enrolled in the SOBRA Family Planning Extension Program R9-22-1431. Notification should be made at the time the newborn is reported or after the sterilization procedure is completed.

Foot and Ankle Services:

Children: The Contractor shall provide foot and ankle services for members under the age of 21 to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a non-professional person.

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

Home and Community Based Services (HCBS): Assisted living facility, alternative residential setting, or home and community based services (HCBS) as defined in R9-22 Article 2, and R9-28 Article 2 that meet the provider standards described in R9-28 Article 5, and subject to the limitations set forth in the AMPM. These services are covered in lieu of a nursing facility.

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.

Hospice: These services are covered for members who are certified by a physician as being terminally ill and having six months or less to live. See the AMPM for details on covered hospice services.

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

Immunizations: The Contractor shall provide medically necessary immunizations for adults 21 years of age and older. Human Papilloma virus (HPV) is covered only for EPSDT aged male and female members (through age 20). (Refer to the AMPM for current immunization requirements). The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 23, Quality Management and Performance Improvement.

Incontinence Briefs: In general, incontinence briefs (diapers) are not covered unless medically necessary to treat a medical condition. For AHCCCS members over three years of age and under age 21 years of age incontinence briefs, including pull-ups, are covered to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances. See R9-22-212 and AMPM Chapter 400.

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

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 AHCCCS.

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

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

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal testing and the availability of medical counseling if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter, to encourage pregnant women to be tested and instructions about where to be tested. Semi-annually, the Contractor shall report to AHCCCS, Division of Health Care Management (DHCM) the number of pregnant women who have been identified as HIV/AIDS-positive for each quarter during the contract year. This report is due as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

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

Medical Supplies, Durable Medical Equipment (DME), and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the AMPM. Prosthetic devices must be medically necessary and meet criteria as described in the AMPM. For persons age 21 or older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs. Medical equipment may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

Nursing Facility: The Contractor shall provide services in nursing facilities, including religious non-medical health care institutions, for members who require short-term convalescent care not to exceed 90 days per contract year. In lieu of a nursing facility, the member may be placed in an assisted living facility, an alternative residential setting, or receive home and community based services (HCBS) as defined in R9-22 Article 2 and R9-28 Article 2 that meet the provider standards described in R9-28 Article 5, and subject to the limitations set forth in the AMPM.

Nursing facility services must be provided in a dually-certified Medicare/Medicaid nursing facility, which includes in the per-diem rate: nursing services; basic patient care 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. See Section D, Paragraph 41, Responsibility for Nursing Facility Reimbursement, for further details.

The Contractor shall notify the Assistant Director of the Division of Member Services, by Email, when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage, if the stay goes beyond the 90 day per contract year maximum. The notice should be sent via e-mail to HealthPlan45DayNotice@azahcccs.gov.

Notifications must include:

a. Member Name
b. AHCCCS ID
c. Date of Birth
d. Name of Facility
e. Admission Date to the Facility
f. Date the member will reach the 90 days
g. Name of Contractor of enrollment

Nutrition: Nutritional assessments are conducted as a part of the EPSDT screenings for members under age 21, and to assist members 21 years of age and older whose health status may improve with over- and under-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. AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary, according to the criteria specified in the AMPM, to provide either complete daily dietary requirements or to supplement a member's daily nutritional and caloric intake.

Oral Health: The Contractor shall provide all members under the age of 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 AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 23, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

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

Orthotics: These services are covered for members under the age of 21 when prescribed by the member's PCP, attending physician, practitioner, or by a dentist as described in the AMPM. Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item.

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

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

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

The Contractor must 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:

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

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

a. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
b. A Contractor physician assumes responsibility for the member's care through transfer;
c. A Contractor representative and the treating physician reach an agreement concerning the member's care; or
d. The member is discharged.

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

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

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

Medicare Part D: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS. This applies to members who are enrolled in Medicare Part D or are eligible for Medicare Part D.

Primary Care Provider (PCP): PCP services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services [42 CFR 438.208(b)]. The PCP is responsible for maintaining the member's primary medical record, which contains documentation of all health

risk assessments and health care services of which they are aware whether or not they were provided by the PCP.

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

Rehabilitation Therapy: The Contractor shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation.

Occupational and Speech therapy is covered for all members receiving inpatient hospital (or nursing facility services). Occupational Therapy and Speech therapy services provided on an outpatient basis are only covered for members under the age of 21. Physical Therapy is covered for all members in both inpatient and outpatient settings. Outpatient physical therapy for members 21 years of age or older are subject to a 15 visit limit per contract year as described in the AMPM.

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

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation; donor search; organ/tissue harvesting or procurement; preparation and transplantation services; and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided, within limitations, after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 57, Reinsurance.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

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

Vision Services/Ophthalmology/Optometry: The Contractor shall provide all medically necessary emergency eye care, vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition. Vision examinations and the provision of prescriptive lenses are covered for adults when medically necessary following cataract removal. Medically necessary vision examinations and prescriptive lenses and frames are covered if required following cataract removal. Refer to AMPM Chapter 300.

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.

11. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its Quality Strategy certain populations with special health care needs including members enrolled in DDD, CRS and those receiving behavioral health services.

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

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)]. For members transitioning, see Section D, Paragraph 9, Transition Activities.

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

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

- Accessible
- Continuous
- Coordinated
- Family-centered
- Comprehensive
- Compassionate
- Culturally effective

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. See Section D, Paragraph 33, Appointment Standards.

12. BEHAVIORAL HEALTH SERVICES

With the exception of certain behavioral health conditions referenced below, AHCCCS members receive the behavioral health benefit through the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) or for American Indians, through the Tribal/Regional Behavioral Health Authority (T/RBHA) system. These benefits include but are not limited to screening, treatment and assistance in coordinating care between the Acute and behavioral health providers. SOBRA Family Planning Extension Program members are not eligible for behavioral health services. For more detailed information about Contractor responsibility for payment of behavioral health services refer to ACOM Policy 432.

***Member Education*:** The Contractor shall be responsible for including information in the Member Handbook and other materials to inform members how to access covered behavioral health services. Materials shall include information about behavioral health conditions that may be treated by the member's primary care physician (PCP) which includes anxiety, depression and ADHD. Refer to the AMPM for covered behavioral health services.

Access to Behavioral Health Services: Members may self–refer to the T/RBHA system for screening, evaluation or treatment or be referred by schools, State agencies, providers, or other parties. The Contractor is responsible for providing transportation to a member's first T/RBHA evaluation appointment if the member is unable to provide his/her own transportation.

EPSDT: As specified in Section D, Paragraph 10, Scope of Services, EPSDT, the Contractor must provide behavioral health screenings for members under 21 years of age in compliance with the AHCCCS EPSDT Periodicity Schedule. The Contractor shall initiate and coordinate behavioral health referrals to the T/RBHA when determined necessary through the screening process.

Emergency Services: When members present in an emergency room setting, the Contractor is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. The Contractor is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member. Refer to ACOM Policy 432. ADHS is responsible for medically necessary professional psychiatric consultations in either emergency room or inpatient settings. ADHS is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member who requires behavioral services after medical stabilization.

***Coordination of Care*:** The Contractor shall meet with the Regional Behavioral Health Authorities to improve and address coordination of care issues.

Medical Records: The Contractor is responsible for ensuring that a medical record is established by the PCP when behavioral health information is received from the T/RBHA or the behavioral health provider about a member assigned to the PCP even if the PCP has not yet seen the assigned member. In lieu of establishing a medical record, the information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

***Sharing of Data*:** On a recurring basis, AHCCCS shall provide the Contractor behavioral health claims data for members enrolled with the Contractor that have received services through the T/RBHAs for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

Sharing of Records: The Contractor shall within 10 business days of receiving the request, require the PCP to coordinate care and respond to T/RBHA and/or behavioral health provider information requests pertaining to members receiving services through the behavioral health system. The response should include, but is not limited to, current diagnoses, medications, laboratory results, most recent PCP visit, and information about recent hospital and emergency room visits. The Contractor will ensure coordination of referrals and follow-up collaboration, as necessary, for members identified by the behavioral health provider as needing acute care services. For guidance in addressing the needs of members with multi system involvement and complex behavioral health and co-occurring conditions, refer to AMPM Policy 570, Community Collaborative Care Teams.

Arizona State Hospital Discharges: The Contractor must ensure that members diagnosed with diabetes who are being discharged from the Arizona State Hospital (AzSH) are issued the same brand and model of both glucometer and supplies that the member was trained to use while in the AzSH. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

For enrolled members who are inpatient at the Arizona State Hospital, the Contractor is required to follow ACOM Policy 422 regarding medical care coordination for these members.

Home Health Services: In the event that a member's mental health status renders them incapable or unwilling to manage their medical condition and the member has a skilled medical need, the Contractor must arrange ongoing medically necessary nursing services. The Contractor shall also have a mechanism in place for tracking members for whom ongoing medically necessary services are required.

Medication Management Services: The Contractor shall allow PCPs to treat members diagnosed with anxiety, depression and attention deficit hyperactivity disorder (ADHD). PCPs who choose to treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. The Contractor shall make available, on the Contractor's formulary, medications for the treatment of these disorders. The Contractor is responsible for these services both in the prospective and prior period coverage timeframes.

Tool Kits: Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AMPM. These tool kits are a resource only and may not apply to all patients and all clinical situations. The tool kits are not intended to replace clinical judgment. The Contractor shall ensure that PCPs who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized, clinical tools/evidence-based guidelines. The Contractor shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

Step Therapy: The Contractor may implement step therapy for behavioral health medications used for treating anxiety, depression and ADHD disorders. The Contractor shall provide education and training for providers regarding the concept of step therapy. If the T/RBHA/behavioral health provider provides documentation to the Contractor that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the Contractor shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression or ADHD. The Contractor shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

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 T/RBHA prescriber 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 members to the T/RBHA for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members. The policies and procedures must address, at a minimum, the following:

1. Guidelines for when a transition of the member to the T/RBHA for ongoing treatment is indicated;
2. Protocols for notifying the T/RBHA of the member's transfer, including reason for transfer, diagnostic information, and medication history;
3. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to T/RBHA requests for additional medical record information;
4. Protocols for transition of prescription services, including but not limited to notification to the T/RBHA of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination must ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with a T/RBHA prescriber and that all relevant member medical information including the reason for transfer is forwarded to the receiving T/RBHA prescriber prior to the member's first scheduled appointment with the T/RBHA prescriber; and

5. Contractor monitoring activities to ensure that members are appropriately transitioned to the T/RBHA for care.

Integrated Services: The Contractor is encouraged to develop specific strategies to promote care integration activities. These strategies may include but are not limited to contracting with T/RBHAs or behavioral health providers as well as establishing integrated settings which serve members' primary care and behavioral health needs. The Contractor should consider the behavioral health needs, in addition to the primary health care needs, of members during network development to improve member access to care, care coordination and to reduce duplication of services.

Court Ordered Treatment: Reimbursement for court ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S. §36-545. For additional information regarding behavioral health services refer to Title 9 Chapter 22 Articles 2 and 12.

Monitoring, Training and Education: The Contractor shall ensure that information and training is available to PCPs regarding behavioral health coordination of care processes. The Contractor shall establish policies and processes for coordination of care and shall describe them in its provider manual. Policies for referral must include, at a minimum, criteria, processes, responsible parties and minimum requirements no less stringent than those specified in this contract for the forwarding of member medical information.

The Contractor shall ensure that its quality management program incorporates monitoring of the PCP's management of behavioral health disorders, coordination of care with, and transfer of care to T/RBHA providers as required under this contract.

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals, including but not limited to, ACOM, AMPM, Reporting Guides, and Manuals are hereby incorporated by reference into this contract. Guidelines, policies and manuals are available on the AHCCCS website. The Contractor is responsible for complying with all requirements set forth in these sources as well as with any updates. In addition, linkages to AHCCCS rules, statutes and other resources are available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available on the AHCCCS website.

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSB)

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

MSB services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSB approved alternative setting. Currently, services include audiology, therapies (OT, PT and speech/language); behavioral health evaluation and counseling; nursing and attendant care (health aid services provided in the classroom); and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSB service.

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

The Contractor and its providers should coordinate with schools and school districts that provide MSB services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with special needs children, should coordinate with the appropriate school staff working with these members. Transfer of member medical information and progress toward treatment goals between the Contractor and the member's school or school district is required as appropriate and should be used to enhance the services provided to members.

15. 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 AHCCCS children under age 19. The Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC program, the Contractor shall contact the AHCCCS Division of Health Care Management, Clinical Quality Management Unit for guidance. Any provider licensed by the State to administer immunizations, may register with Arizona Department of Health Services (ADHS) as a VFC provider to receive these free vaccines. 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 physicians are registered as VFC providers when acting as primary care physicians (PCP) for members under the age of 19 years.

Due to low numbers of children in their panels providers in certain geographic service areas (GSAs) may choose not to provide vaccinations. Whenever possible, members should be assigned to VFC registered providers within the same or a nearby community. 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 19. Immunizations must be reported at least monthly to the ADHS Immunization Registry. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor must educate its provider network about these reporting requirements and the use of this resource.

16. STAFF REQUIREMENTS AND SUPPORT SERVICES

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 [42 CFR 438.610 (a) & (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The Contractor is obligated to screen all employees and Contractors to determine whether any of them have been excluded from participation in Federal health care programs. The HHS-OIG website can be searched by the names of any individuals. The database can be accessed at www.oig.hhs.gov.

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

AHCCCS. This action may include, but is not limited to, requiring the Contractor to hire additional staff and actions specified in Section D, Paragraph 72, Sanctions.

The Contractor shall have local staff available 24 hours per day, seven days per week to work with AHCCCS and/or other State agencies, such as Arizona Department of Health Services (ADHS)/Office of Licensure, on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardies (IJ), fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, 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 AHCCCS, Clinical Quality Management (CQM) with the contact information for these staff. At a minimum the contact information shall include a current 24/7 telephone number. CQM must be notified and provided back up contact information when the primary contact person will be unavailable.

For functions not required to be in State, the Contractor must notify AHCCCS as specified in Attachment B1, Acute Care Program Contractors' 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 costs associated with on-site audits or other oversight activities which result when functions are located outside of the State of Arizona.

An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below, including the same key position across multiple lines of business, unless prior approval is obtained by AHCCCS, Division of Health Care Management (DHCM). The Contractor shall inform the AHCCCS DHCM in writing as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, when an employee leaves one of the **Key Staff** positions listed below. The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff.

At a minimum, the following staff is required**:**

Key Staff Positions

a. ***Administrator/CEO/COO*** who is located in Arizona, oversees the entire operation of the Contractor, and have the authority to direct and prioritize work, regardless of where performed.
b. ***Medical Director/CMO*** who is located in Arizona and who is an Arizona-licensed physician in good standing. The Medical Director shall be actively involved in all major clinical programs and Quality Management and Medical Management components of the Contractor. The Medical Director shall ensure timely medical decisions, including after-hours consultation as needed (see Section D, Paragraph 27, Network Development).
c. ***Chief Financial Officer/CFO*** who is available to fulfill the responsibilities of the position and to oversee the budget, accounting systems, and financial reporting implemented by the Contractor.
d. ***Pharmacy Director/Coordinator*** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Plan.
e. ***Dental Director/Coordinator*** who is responsible for coordinating dental activities of the Contractor and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or Contractor of the plan and must be a licensed dentist in Arizona if they are required to review or deny dental services.
f. ***Corporate Compliance Officer*** who is located in Arizona and who will implement and oversee 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 the AHCCCS Office of the Inspector General. See Section D, Paragraph 62, Corporate Compliance.

g. ***Dispute and Appeal Manager*** who is located in Arizona and who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes.
h. ***Business Continuity Planning Coordinator*** as noted in the ACOM Policy 104.
i. ***Contract Compliance Officer*** who is located in Arizona and who will serve as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all contract deliverables, fielding and coordinating responses to AHCCCS inquiries, and coordinating the preparation and execution of contract requirements such as Operational and Financial Reviews (OFRs), random and periodic audits and ad hoc visits.
j. ***Quality Management Coordinator*** who is an Arizona-licensed registered nurse, physician or physician's assistant or 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 Coordinator must be located in Arizona and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet quality management requirements. The primary functions of the Quality Management Coordinator position are:
    - Ensure individual and systemic quality of care
    - Integrate quality throughout the organization
    - Implement process improvement
    - Resolve, track and trend quality of care grievances
    - Ensure a credentialed provider network
k. ***Performance/Quality Improvement Coordinator*** who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in health plan data and outcomes measurement. The primary functions of the Performance/Quality Improvement Coordinator are:
    - Focus organizational efforts on improving clinical quality performance measures
    - Develop and implement performance improvement projects
    - Utilize data to develop intervention strategies to improve outcomes
    - Report quality improvement/performance outcomes
l. ***Maternal Child Health/EPSDT Coordinator*** who is an Arizona licensed nurse, physician or physician's assistant; or has a Master's degree in health services, public health, health care administration or other related field, and/or a CPHQ or CHCQM certification and is located in Arizona. Sufficient local staffing under this position must be in place to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator are:
    - Ensure receipt of EPSDT services
    - Ensure receipt of maternal and postpartum care
    - Promote family planning services
    - Promote preventive health strategies
    - Identify and coordination assistance for identified member needs
    - Interface with community partners
m. ***Medical Management Coordinator*** who is an Arizona licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations. This position is located in Arizona and manages all required medical management requirements under AHCCCS policies, rules, and contract. Sufficient local staffing under this position must be in place to meet medical management requirements. The primary functions of the Medical Management Coordinator are:
    - Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
    - Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted

- Develop, implement and monitor the provision of care coordination, disease management and case management functions
- Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
- Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards

n. ***Behavioral Health Coordinator*** who is a behavioral health professional as described in Health Services R9-20, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are implemented. The primary functions of the Behavioral Health Coordinator are:
- Coordinate member behavioral care needs with the RBHA system
- Develop processes to coordinate behavioral health care between PCPs and RBHAs
- Participate in the identification of best practices for behavioral health in a primary care setting
- Coordinate behavioral care with medically necessary services

o. ***Member Services Manager*** who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times.

p. ***Provider Services Manager*** who coordinates communications between the Contractor and its subcontractors and providers. This position is located in Arizona and ensures that providers receive prompt resolution to their problems or inquiries, appropriate education about participation in the AHCCCS program and maintain a sufficient provider network. Sufficient local staffing under this position must be in place to ensure appropriate provider responsiveness.

q. ***Claims Administrator*** who shall ensure prompt and accurate provider claims processing. The primary functions of the Claims Administrator are:
- Develop and implement claims processing systems capable of paying claims in accordance with State and Federal requirements
- Develop processes for cost avoidance
- Ensure minimization of claims recoupments
- Meet claims processing timelines
- Meet AHCCCS encounter reporting requirements

r. ***Provider Claims Educator*** who is located in Arizona and facilitates the exchange of information between the grievance, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator are:
- Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc.
- Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
- Identify trends and guides the development and implementation of strategies to improve provider satisfaction. Frequently communicate (i.e.: telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices

Additional Required Staff:

s. **Prior Authorization staff** to authorize health care 24 hours per day, seven days per week. This staff shall include but is not limited to Arizona-licensed nurses, physicians and/or physician's assistants.

t. **Concurrent Review staff** who is located in Arizona and who conduct inpatient concurrent review. This staff shall consist of Arizona-licensed nurses, physicians, and/or physician's assistants.

u. **Member Services staff** to enable members to receive prompt resolution of their inquiries/problems.

v. **Provider Services staff** who is located in Arizona and who enable providers to receive prompt responses and assistance. See Section D, Paragraph 29, Network Management.

w. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
x. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.
y. **Case Management staff** who is located in Arizona and who provide care coordination for members with special health care needs.

The Contractor must submit the following items as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, and when there is a change in staffing or organizational functions:

1. The name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as a, b and c. AHCCCS will compare this information against Federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42 CFR 455.104].
2. An organization chart complete with the **Key Staff** positions. The chart must include the person's name, title, location and portion of time allocated to each Medicaid contract and other lines of business.
3. A functional organization chart of the key program areas, responsibilities and reporting lines.
4. A listing of key staff positions including the person's name, title, telephone number, and email address.
5. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

The Contractor is responsible for maintaining a significant local presence within the State of Arizona. Positions performing functions related to this contract must have a direct reporting relationship to the local Administrator/Chief Executive Officer (CEO). The local CEO shall have the authority to direct, implement and prioritize work to ensure compliance with contract requirements. 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. This significant presence includes staff listed below.

In State Positions:

- Administrator/CEO/COO
- Behavioral Health Coordinator
- Case Managers
- Concurrent Review Staff
- Contract Compliance Officer
- Corporate Compliance Officer
- Dispute and Appeal Manager
- Maternal Child Health/EPSDT Coordinator
- Medical Director/CMO
- Medical Management Coordinator
- Provider Claims Educator
- Provider Services Manager
- Provider Services Staff
- Quality Management Coordinator

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

The Contractor must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals, and contract requirements and State and Federal requirements

specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

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

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. AHCCCS may require attendance by subcontracted entities, as defined in Section D, Paragraph 37, Subcontracts, when deemed necessary. All meetings shall be considered mandatory unless otherwise indicated.

17. WRITTEN POLICIES AND PROCEDURES

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

If AHCCCS deems a Contractor policy or process to be inefficient and/or place an unnecessary burden on the members or providers, the Contractor must work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS. In addition, if AHCCCS deems a Contractor lacks a policy or process necessary to fulfill the terms of this contract, the Contractor must work with AHCCCS to adopt a policy or procedure within a time period specified by AHCCCS.

18. MEMBER INFORMATION

The Contractor shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by the Contractor, shall be approved by AHCCCS prior to distribution to members. The reading level and name of the evaluation methodology used shall be included. The Contractor should refer to the ACOM Draft Policy 404 for further information and requirements. See also Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10%, whichever is less, of the Contractor's members, who also have Limited English Proficiency (LEP).

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

All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5%, whichever is less, of the Contractor's members speak that language and have LEP [42 CFR 438.10(c)(3)].

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

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

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

The Contractor has the option of providing each new member/representative or household the Member Handbook and Network Description/Provider Directory with the new member packet in hardcopy format, or providing written notification that the information is available on the Contractor's website, by electronic mail or by postal mailing. The information shall be available within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]. Should the Contractor elect not to provide the hard copy, the contents of the written notification must be approved per the requirements listed in ACOM Draft Policy 404.

The Member Handbook, at a minimum, shall include the items listed in the ACOM Draft Policy 404. The Contractor shall review and update the Member Handbook at least once a year. The Handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to being made available to members.

In addition, the Member Handbook shall provide a description of the Contractor's provider network, which at a minimum, includes those items listed in the ACOM Draft Policy 404.

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

The Contractor must develop and distribute, at a minimum, semi-annual newsletters during the contract year. The following types of information are to be contained in the newsletter:

1. Educational information on chronic illnesses and ways to self-manage care
2. Reminders of flu shots and other prevention measures at appropriate times
3. Medicare Part D issues
4. Cultural Competency, other than translation services
5. Contractor specific issues (in each newsletter)
6. Tobacco cessation information
7. HIV/AIDS testing for pregnant women
8. Other information as required by AHCCCS

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

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

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

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

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

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

19. SURVEYS

The Contractor may be required to perform surveys at AHCCCS' request. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. The final survey tool shall be approved in advance by AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The results and the analysis of the results shall be submitted to the Division of Health Care Management as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

For non-AHCCCS required surveys, the Contractor shall provide notification as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and analysis of the results of any Contractor initiated surveys shall be submitted to the Division of Health Care Management as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

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

As specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, the Contractor is required to survey a sample of its membership that have received services to verify that services the Contractor paid for were delivered as outlined in ACOM Policy 424 [42 CFR 455.20 and 433.116].

20. CULTURAL COMPETENCY

The Contractor shall ensure compliance with a Cultural Competency Plan which meets the requirements of the ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the DHCM Operations Unit, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. This plan shall address cultural considerations and limited English proficiency for all services and settings [42 CFR 438.206(c)(2)].

21. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers. Each member is entitled to one copy of his or her medical record at no cost annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

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

The Contractor shall have written policies and procedures for the maintenance of medical records to ensure those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment.

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

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

AHCCCS is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. The Contractor may obtain a copy of a member's medical records without written approval of the member if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request or more quickly if necessary.

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 substance abuse information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

22. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing advanced directives for adult members as specified in 42 CFR 422.128:

1. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care, must comply with Federal and State law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:

    a. 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 must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. §36-3205.C.1;
    b. Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives, including any conscientious objections [42 CFR 438.6(i)(3)];
    c. Documenting in the member's medical record whether or not the adult member has been provided the information, and whether an advance directive has been executed;
    d. Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care; and
    e. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, if any advanced directives are executed by members to whom they are assigned to provide services.

2. The Contractor shall require PCPs, which have agreements with the entities described above, to comply with the requirements of subparagraphs 1 (a) through (e) above. The Contractor shall also encourage

health care providers specified in subparagraph a. to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

3. The Contractor shall provide written information to adult members that describe the following:

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

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

The Contractor shall provide quality medical care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement (QM/PI) processes. The Contractor shall execute processes to assess, plan, implement, and evaluate QM/PI activities [42 CFR 438.240]. At a minimum, the Contractor's QM/PI programs shall comply with the requirements outlined in the AMPM Chapters 400 and 900. See also Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

The Contractor must ensure that the QM/PI Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Case Management. The Contractor is expected to integrate quality management processes, such as tracking and trending of issues, throughout all areas of the organization. Ultimate responsibility for QM/PI activities resides within the QM/PI Unit.

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

Federal regulation 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider –Preventable Condition (OPPC) (refer to AMPM Chapter 900 requirements). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.

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

1. A written QM/PI plan and an evaluation of the previous year's QM/PI program;
2. Quality management quarterly reports that address strategies for QM/PI activities;
3. QM/PI program monitoring and evaluation activities which include Peer Review and Quality Management Committees which are chaired by the Contractor's local Chief Medical Officer;
4. Protection of medical records and any other personal health and enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements;
5. Member rights and responsibilities;
6. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational assessment verification [42 CFR 438.206(b)(6)]. 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 438.214]. The Contractor should refer to the AMPM and Attachment B1, Acute Care Program Contractors' Chart of Deliverables for reporting requirements. The process:

a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credentialing verification of providers who have signed contracts or participation agreements with the Contractor;
b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
c. Shall not employ or contract with providers excluded from participation in Federal health care programs.

7. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation and unexpected deaths. The resolution process must include:
   a. Acknowledgement letter to the originator of the concern;
   b. Documentation of all steps utilized during the investigation and resolution process;
   c. Follow-up with the member to assist in ensuring immediate health care needs are met;
   d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;
   e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern; and
   f. Analysis of the effectiveness of the interventions taken.
8. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs;
9. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO); and
10. Performance improvement programs including performance measures and performance improvement projects.

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

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall calculate and report to AHCCCS a completion percentage. This percentage is calculated by dividing the number of complete applications processed (approved/denied) during the time period by the number of complete applications that were received during the time period.

The standards for processing are listed by category below:

Type of Credentialing	14 days	90 days	120 days	180 days
Provisional	100%			
Initial		90%	95%	100%

The Contractor must report the credentialing information with regard to all credentialing applications as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

***Quality Improvement*:** The Contractor's quality management program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care which are expected to have a favorable effect on health outcomes and member satisfaction. The Contractor must [42 CFR 438.240(b)(2) and (c)]:

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

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

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

Performance Measures:
The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures can be found in the most recently published reports of acute care Performance Measures located on the AHCCCS website. The EPSDT Participation performance measure description utilizes the methodology established in CMS "Form 416" which can also be found on the AHCCCS website at:

http://www.azahcccs.gov/reporting/quality/performancemeasures.aspx.

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

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

The Contractor must have a process in place for monitoring performance measure rates. The Contractor shall utilize a standard methodology established or adopted by AHCCCS for measurement of each required performance measure. The Contractor's QM/PI Program will report its measured performance on an ongoing

basis to its Administration. The Contractor performance measure monitoring results shall also be reported to AHCCCS in conjunction with its Quarterly EPSDT Improvement and Adult Quarterly Monitoring Report.

The Contractor must meet AHCCCS stated Minimum Performance Standards (MPS) for each population/eligibility category for which AHCCCS reports results. It is equally important that, in addition to meeting the contractual MPS, the Contractor continually improve performance measure outcomes from year to year. The Contractor shall strive to meet the goal established by AHCCCS.

Minimum Performance Standard – MPS is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to a sanction of up to $100,000 dollars for each deficient measure.

Goal – If the Contractor has already met or exceeded the AHCCCS MPS for any measure, the Contractor must strive to meet the established goal for the measure(s).

A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically significant improvement in a measure rate. AHCCCS may require the Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan and may sanction any Contractor that shows a statistically significant decrease in its rate even if it meets or exceeds the MPS.

An evidence-based corrective action plan must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up desktop or on-site reviews to verify compliance with a corrective action plan.

All Performance Measures apply to all member populations [42 CFR 438.240(a)(2), (b)(2) and (c)]. AHCCCS may analyze and report results by line of business, Geographical Service Area (GSA), or County, as well as applicable demographic factors.

AHCCCS has established standards for the measures listed below.

The following table identifies the MPS and Goals for each measure:

Acute Care Performance Measures:

Performance Measure	Minimum Performance Standard (MPS)	Goal
ADULT MEASURES		
Inpatient Utilization (days/1,000)	<480	<430
ED Utilization (visits/1,000)	<725	<600
Readmissions within 30 days of discharge	<11.5%	<9%
Adult asthma Admission Rate*	TBD	TBD
Use of Appropriate Medications for People with Asthma	86%	93%
Follow-up After Hospitalization (all cause) within 7 Days	50%	80%

Follow-up After Hospitalization (all cause) within 30 Days	70%	90%
Comprehensive Diabetes Management		
HbA1c Testing	77%	89%
LDL-C Screening	70%	91%
Eye Exam	49%	68%
Flu Shots for Adults		
Ages 50-64	75%	90%
Ages 65+	75%	90%
Diabetes Admissions, short-term complications*	TBD	TBD
Chronic obstructive pulmonary disease admissions*	TBD	TBD
Congestive heart failure admissions*	TBD	TBD
HIV/AIDS: Medical visit*	TBD	90%
Annual monitoring for patients on persistent medications: Combo Rate	75%	80%
Timeliness of prenatal care — prenatal care visit in the first trimester or within 42 days of enrollment	80%	90%
Prenatal and Postpartum Care: Postpartum Care Rate (second component to CHIPRA core measure "Timeliness of Prenatal Care)*	TBD	90%
CAHPS Health Plan Survey v 4.0 - Adult Questionnaire*	TBD	TBD
NCQA Supplemental items for CAHPS® 4.0 Adult Questionnaire (CAHPS 4.0H)*	TBD	TBD
CHILDRENS MEASURES		
Children's Access to PCPs, by age: ***12-24 mo.***	93%	97%
Children's Access to PCPs, by age: ***25 mo.- 6 yrs.***	84%	90%
Children's Access to PCPs, by age: ***7 - 11 yrs.***	83%	90%
Children's Access to PCPs, by age: ***12 - 19 yrs.***	82%	90%
Well-Child Visits: ***15 mo.***	65%	90%
Well-Child Visits: ***3 - 6 yrs.***	66%	80%
Adolescent Well-Child Visits: ***12–21 yrs.***	41%	50%
Children's Dental Visits (**ages 2-21**)	60%	75%

EPSDT Participation	68%	80%
EPSDT Dental Participation	46%	54%
Annual number of asthma patients (≥ 1 year old) with ≥ 1 asthma related ER visit*	TBD	TBD
Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)*	TBD	89%
Emergency Department (ED) Utilization (visits/1,000)	<700	<560
Inpatient Utilization (days/1,000)	TBD	TBD
Hospital Readmission Rate	<11.5%	<9%
CAHPS Health Plan Survey 4.0, Child Version including Medicaid and Children with Chronic Conditions supplemental items*	TBD	TBD
Childhood Immunization Status		
DTaP	85%	90%
IPV (1)	91%	95%
MMR (1)	91%	95%
Hib (1)	90%	95%
HBV (1)	90%	95%
VZV (1)	88%	95%
PCV (1)	82%	95%
4:3:1:3:3:1 Series	74%	80%
4:3:1:3:3:1:4 Series	68%	80%
Hepatitis A (HAV)	40%	60%
Rotovirus	60%	80%
Influenza	45%	80%
Immunizations for Adolescents		
Adolescent Meningococcal	75%	90%
Adolescent Tdap	75%	90%
Adolescent Combo	75%	90%

Notes:

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

(1) AHCCCS will continue to measure and report results of these individual antigens; however, a Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.

Rates by Contractor for each measure will be compared with the MPS specified in the contract in effect during the measurement period; Performance Standards in the CYE 14 contract apply to results calculated by AHCCCS for the CYE 14 measurement period.

Contractor performance is evaluated annually on the AHCCCS-reported rate for each measure. Rates for measures that include only members less than 21 years of age are reported and evaluated separately for Title XIX and Title XXI eligibility groups.

The Contractor shall participate in immunization audits, at intervals specified by AHCCCS, based on random sampling to verify the immunization status of members at 24 months of age and by 13 years of age. If records are missing for more than 5 percent of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS. An EQRO may conduct a study to validate the Contractor's reported rates.

AHCCCS will measure and report the Contractor's EPSDT Participation Rate, utilizing the CMS 416 methodology. The Contractor must take affirmative steps to increase EPSDT Participation rates, including the EPSDT Dental Participation Rate. The Contractor is required to improve dental participation rates, as specified in the Performance Measure table, by 10 percentage points by 2015 (compared to 2011 rates).

The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. The Contractor must implement processes to reduce non-medically necessary elective or induced deliveries prior to 39 weeks gestation.

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

***Data Collection Procedures*:** When requested by AHCCCS, the Contractor must submit data for standardized Performance Measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data and using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or PIPs must be returned by the Contractor in a format specified by AHCCCS, and by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date and is subject to approval by AHCCCS. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

24. MEDICAL MANAGEMENT (MM)

The Contractor shall implement processes to assess, plan, implement, evaluate, and as mandated, report Medical Management (MM) monitoring activities as specified in the AMPM Chapter 1000. This shall include the Quarterly Inpatient Hospital Showings report, HIV Specialty Provider List, Transplant Report and Prior Authorization Requirements report as specified in the AMPM and Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The Contractor shall evaluate MM activities, as specified in the AMPM Chapter 1000*,* including:

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer.
2. Prior authorization and Referral Management; for the processing of requests for initial and continuing authorizations of services the Contractor shall:
    a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
    b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
    c. Monitor and ensure that all enrollees with special health care needs have direct access to care;

d. Review all prior authorization requirements for services, items or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for those changes must be included in the annual MM/UM Plan and Evaluation submission; and
e. Comply with all decision timelines as outlined in the ACOM and the AMPM.

3. Development and/or Adoption of Practice Guidelines [42 CFR 438.236(b)] that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
   b. Consider the needs of the Contractor's members;
   c. Are adopted in consultation with contracting health care professionals;
   d. Are reviewed and updated periodically as appropriate;
   e. Are disseminated by the Contractor to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
   f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].

4. Concurrent review:
   a. Consistent application of review criteria; provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply;
   b. Contractors must have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into acute care 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; and
   c. In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider–Preventable Condition (OPPC) (refer to AMPM Chapter 1000). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.

5. Continuity and coordination of care:
   a. Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
   b. Establish a process for timely and confidential communication of clinical information among providers;
   c. Must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management; and
   d. Meet with the Regional Behavioral Health Authorities to improve and address coordination of care issues. Meetings shall occur at least quarterly or more frequently if needed.

6. Monitor and evaluate over and/or underutilization of services [42 CFR 438-240(b)(3)];

7. Evaluate new medical technologies, and new uses of existing technologies; and

8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee.

AHCCCS will provide a new Contractor (including an Incumbent Contractor new to a GSA) with three years of historical Acute Care Program encounter data for members enrolled with the Contractor as of December 1, 2013. Contractors should use this data to assist with identifying members in need of medical management. On a recurring basis AHCCCS shall provide the Contractor a claims data file of behavioral health encounters for all General Mental Health, Children's and non-integrated members with serious mental illness enrolled with the Contractor, for purposes of care coordination. The Contractor shall develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs (see Section D, Paragraph 64, Systems and Data Exchange Requirements). 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 must be reported in the annual MM/UM Plan and Evaluation submitted to AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM Committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the Committee. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438.240(b)(4)].

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

The Contractor shall maintain a written MM plan and work plan that addresses the monitoring of MM activities (AMPM Chapter 1000). The plan and work plan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

25. TELEPHONE PERFORMANCE STANDARDS

The Contractor must meet and maintain established telephone performance standards to ensure member and provider satisfaction as specified in ACOM Draft Policy, Telephone Performance Standards Measurement and Reporting. The Contractor shall report on compliance with these standards as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables and the policy identified above. All reported data is subject to validation through periodic audits and/or operational reviews.

26. GRIEVANCE SYSTEM

The Contractor shall have in place a written grievance system process for subcontractors, enrollees and non-contracted providers, which define their rights regarding disputed matters with the Contractor. The Contractor's grievance system for enrollees includes a grievance process (the procedures for addressing enrollee grievances), an appeals process and access to the State's fair hearing process as outlined in Attachment A1, Enrollee Grievance System Standards. The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Attachment A2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Attachments A1, Enrollee Grievance System Standards, A2, Provider Claim Dispute Standards, and 42 CFR Part 438 Subpart F.

Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 18, Member Information and Paragraph 20, Cultural Competency.

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

The Contractor may delegate the grievance system process to subcontractors, however, the Contractor must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information

to both enrollees and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a State fair hearing, the method for obtaining a State fair hearing, the rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or State fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent.

The Contractor must provide reports on the Grievance System as required in the AHCCCS Grievance System Reporting Guide available on the AHCCCS website. See also Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

27. NETWORK DEVELOPMENT

The Contractor shall develop and maintain a provider network that is supported by written agreements which is sufficient to provide all covered services to AHCCCS members. The Contractor shall ensure covered services are reasonably 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 norms. Services shall be as accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those services are available to non-AHCCCS persons within the same service area [42 CFR 438.210(a)(2)]. The Contractor is encouraged to have available non-emergent after-hours physician or primary care services within its network. If the Contractor's network is unable to provide medically necessary services required under contract, the Contractor must adequately and timely cover these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. The Contractor shall design its provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems.

There shall be sufficient personnel for the provision of 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 shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The requirements for the Network Development and Management Plan are found in ACOM Draft Policy 415. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

In accordance with the requirements specified in the ACOM Draft Policy, Acute Network Standards the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing Pima and Maricopa counties do not have to travel more than 15

minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Draft Policy, Acute Network Standards.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [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 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs and quality consistent with its responsibilities under this contract nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. 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 438.12(a)(1)]. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

MSICs are established facilities providing interdisciplinary services for members with qualifying CRS conditions and are under contract with the CRS Contractor. Contractors are encouraged to contract with MSICs for specialty care. Pediatric specialists that work in the MSIC are in limited quantity in Arizona. Contracting with the MSICs provides Contractors an opportunity to increase access to these pediatric specialists.

The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services.

The Contractor is also encouraged to develop non-financial incentive programs to increase participation in its provider network.

AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the State of Arizona. AHCCCS expects the Contractor to support these efforts. AHCCCS encourages plans to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in Contractor medical management and committee activities. In the event of a contract termination between the Contractor and a 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. AHCCCS reserves the right to determine what constitutes risk to the program. Further, the Contractor must attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas.

Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services. Contracts must stipulate that:

1. Only those members who request a homeless clinic as a PCP may be assigned to them; and
2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization, and resolving claims issues.

28. PROVIDER AFFILIATION TRANSMISSION

Quarterly, the Contractor must submit information regarding its provider network. This information must be submitted in the format described in the Provider Affiliation Transmission (PAT) User Manual as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The PAT User Manual may be found on the AHCCCS website. The provider affiliation transmission must be timely, accurate, and complete or the Contractor may be required to submit a corrective action plan.

29. NETWORK MANAGEMENT

The Contractor shall have policies on how the Contractor will [AMPM, 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 AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
c. Evaluate the quality of services delivered by the network;
d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
f. 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 30 business days of receipt (this includes referrals from AHCCCS).

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

The Contractor shall hold a Provider Forum no less than quarterly. 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 including dental providers. 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 AHCCCS upon request. The Contractor shall report information discussed during these Forums to Executive Management within the organization.

Material Change to Provider Network
All material changes in the Contractor's provider network that are initiated by the Contractor must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. The Contractor must submit the request for approval of a material change in their provider network, including draft notification to affected members, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. AHCCCS will respond to the Contractor within 30 days. A material change in the Contractor's provider network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

The Contractor shall notify AHCCCS, Division of Health Care Management, of any unexpected changes that would impair its provider network, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables [42 CFR 438.207 (c)]. This notification shall include (1) information about how the provider network change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

See Section D, Paragraph 55, Capitation Adjustments regarding material changes by the Contractor that may impact capitation rates.

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

Provider Termination Report: The Contractor must submit a Quarterly Provider Terminations Due to Rates Report as described in ACOM Draft Policy 415 and Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

30. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)].

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

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCPs with assigned members diagnosed with AIDS or as HIV positive, shall meet criteria and standards set forth in the AMPM.

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

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m) and 438.52(d) and this contract. The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. See ACOM Draft Policy 404.

At a minimum, the Contractor shall hold the PCP responsible for the following activities [42 CFR 438.208(b)(1)]:

a. Supervising, coordinating and providing care to each assigned member (except for 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 AHCCCS approved EPSDT Tracking form;
f. Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider; and
g. If serving children, for enrolling as a Vaccines for Children (VFC) provider.

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.

31. MATERNITY CARE PROVIDER STANDARDS

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

a. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services
b. Physician Assistants
c. Nurse Practitioners
d. Certified Nurse Midwives
e. Licensed Midwives

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide 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 OB hospital privileges. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice.

32. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

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

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

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

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

33. APPOINTMENT STANDARDS

The Contractor shall monitor appointment availability utilizing the methodology found in the ACOM Draft Policy 417. For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. The Contractor shall have procedures in place that ensure the following standards are met.

For ***Primary Care Appointments***, the Contractor shall be able to provide:

a. Emergency appointments the same day or within 24 hours of the member's phone call or other notification
b. Urgent care appointments within 2 days of request
c. Routine care appointments within 21 days of request

For ***Specialty Referrals***, the Contractor shall be able to provide:

a. Emergency appointments within 24 hours of referral
b. Urgent care appointments within 3 days of referral
c. Routine care appointments within 45 days of referral

For ***Dental Appointments***, the Contractor shall be able to provide:

a. Emergency appointments within 24 hours of request
b. Urgent care appointments within 3 days of request
c. Routine care appointments within 45 days of request

For ***Maternity Care***, the Contractor shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:

a. First trimester - within 14 days of request
b. Second trimester - within 7 days of request
c. Third trimester - within 3 days of request
d. High risk pregnancies - within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

The Contractor shall actively monitor provider compliance with appointment standards as required in ACOM Draft Policy 417.

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

For medically necessary non-emergent transportation**,** the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. Also see Section D, Paragraph 11, Special Health Care Needs. The Contractor must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

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

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

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

34. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs)

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

For FQHC and FQHC Look-Alike pharmacies, all drugs identified in the 340B Drug Pricing Program are required to be billed at the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price. These drugs shall be reimbursed at the lesser of the two amounts above plus a dispensing fee. See AHCCCS rule R9-22-710 (C) for further details.

The Contractor is required to submit member information for Title XIX and Title XXI members for each FQHC/RHC/FQHC Look-Alikes as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. AHCCCS will perform periodic audits of the member information submitted. The Contractor should refer to the AHCCCS Financial Reporting Guide for Acute Care Contractors with the Arizona Health Care Cost Containment System for further guidance. The FQHCs/RHCs/FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website.

35. PROVIDER MANUAL

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

36. PROVIDER REGISTRATION

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 at:

http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx.

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

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

37. SUBCONTRACTS

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

All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

Administrative Services Subcontracts:

1. Delegated agreements that subcontract;
    a. Any function related to the management of the contract with AHCCCS,
    b. Claims processing, including pharmacy claims,
    c. Credentialing including those for only primary source verification (CVO).
2. All Management Service Agreements;
3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner.

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

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

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. In order to determine adequate performance, the Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

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

The Contractor must submit the Administrative Services Annual Subcontractor Assignment and Evaluation Report as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, detailing any Contractor duties or responsibilities that have been subcontracted as described under Administrative Services Subcontracts previously in this section. The Administrative Services Annual Subcontractor Assignment and Evaluation Report will include the following:

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

If the subcontractor is in significant non-compliance with the subcontract, the Contractor shall notify AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The Contractor will submit this in writing and provide the corrective action plan and any measures taken by the Contractor to bring the subcontractor into compliance.

Provider Agreements: 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 AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

The Contractor must make reasonable efforts to enter into a written agreement with any provider providing services at the request of the Contractor more than 25 times during the previous contract year and/or are anticipated to continue providing services for the Contractor. The Contractor must follow ACOM Draft Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the adequacy of its network.

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

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

All subcontracts must reference and require compliance with the Minimum Subcontract Provisions. See Section I, Exhibit B, Minimum Subcontract Provisions. In addition, each subcontract must contain the following:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor;
2. Identification of the name and address of the subcontractor;
3. Identification of the population, to include patient capacity, to be covered by the subcontractor;
4. The amount, duration and scope of medical services to be provided, and for which compensation will be paid;
5. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation;
6. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability;
7. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to the Contractor;
8. A description of the subcontractor's patient, medical, dental and cost record keeping system;
9. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM;
10. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS;
11. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population;
12. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage;
13. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members;
14. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract;
15. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation;

16. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor; and
17. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

38. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes that ensure the correct collection and processing of claims, analyzes, integrates, and reports data. The processes shall result in information on areas including, but not limited to, service utilization, claim disputes and appeals [42 CFR 438.242(a)].

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

a. Medicaid Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services
b. Multiple Procedure/Surgical Reductions
c. Global Day E & M Bundling standards

The Contractor claims payment system must 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 AHCCCS Policy
e. Provider Qualifications
f. Member Eligibility and Enrollment
g. Over-Utilization Standards

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

a. The reasons for denials and adjustments
b. An adequate description of all denials and adjustments
c. The amount billed
d. The amount paid
e. Application of COB and copays
f. Provider rights for claim disputes

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. See Section D, Paragraph 64, Systems and Data Exchange Requirements, for specific standards related to remittance advice and EFT payment.

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

Per A.R.S. §36-2904, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than six months after the end date of service, inpatient claim date of discharge or date of eligibility posting whichever is later, or pay a clean claim submitted more than 12 months after date of service; except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim

mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. §36-2904.

Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

In accordance with the Deficit Reduction Act of 2005, Section 6085, the Contractor is required to reimburse non-contracted emergency services providers at the AHCCCS Fee-For-Service rate. This applies to in State as well as out of State providers.

In accordance with A.R.S. §36-2903 and §36-2904, in the absence of a written negotiated rate and when directed out of network by the Contractor, the Contractor is required to reimburse non-contracted non-emergent in State providers at the AHCCCS fee schedule and methodology, or pursuant to A.R.S. §36-2905.01, at 95% of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

Effective 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 late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of 10% per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a Contractor shall apply quick pay discounts and slow payment penalties, when appropriate, in accordance with A.R.S. §2903.01. When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Manual.

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

Any individual recoupment in excess of $50,000 per provider, or Tax Identification Number within a contract year or greater than 12 months after the date of the original payment must be approved as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables and, as further described in ACOM Draft Policy 412. Upon submission of a request for approval, AHCCCS will respond within 30 days of the recoupment request.

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

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

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

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

Claims Processing Related Reporting: The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide and Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

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

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

a. Verification that provider contracts are loaded correctly
b. Accuracy of payments against provider contract terms

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

In addition, in the event of a system change or upgrade, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, the Contractor may also be required to initiate an independent audit of the Claim Payment/Health Information System. The Division of Health Care Management will approve the scope of this audit, and may include areas such as a verification of eligibility and enrollment information loading, contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

Recovery Audit Contractor (RAC) Audits: A Recovery Audit Contractor (RAC) is a private entity that is contracted to identify underpayments and overpayments, and to recoup overpayments made to providers. The Affordable Care Act of 2010 required States to establish Medicaid RAC programs. CMS promulgated rules regarding the implementation of the Medicaid RAC requirements (42 CFR 455.500 et seq.), including the provision that Medicaid RACs are only required to review fee-for-service claims until a permanent Medicare managed care RAC program is fully operational or a viable State managed care model is identified and CMS undertakes rules regarding managed care RAC efforts.

AHCCCS is exploring what opportunities may exist in the marketplace regarding a methodology for conducting a recovery audit of its services delivered through its managed care contracts (excluding reinsurance). The Contractor shall participate in any RAC activities mandated by AHCCCS, via contract amendment or policy, upon determination of the method of approach.

39. SPECIALTY CONTRACTS

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

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty Contractors to enhance the cost effectiveness of service delivery, medical management, and adjudication of claims related to payments provided under specialty contracts shall remain the responsibility of the Contractor. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

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

40. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

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

All Counties <u>EXCEPT</u> Maricopa and Pima: The Contractor shall reimburse hospitals for member care in accordance with AHCCCS rule R9-22 Article 7. The Contractor is encouraged to obtain subcontracts with hospitals in all GSAs. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

For Out-of-State Hospitals: The Contractor shall reimburse out of State hospitals in accordance with R9-22 Article 7. A Contractor serving border communities (excluding Mexico) is strongly encouraged to establish contractual agreements with those out of State hospitals that are identified by GSA in ACOM Draft Policy, Acute Network Standards.

Outpatient Hospital Services: In the absence of a contract, the default payment rate for outpatient hospital services billed on a UB-04 will be based on the AHCCCS outpatient hospital fee schedule pursuant to A.R.S. §36-2904.

Hospital Recoupments: The Contractor may conduct prepayment and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Contractor fails to identify lack of medical necessity through concurrent review and/or prepayment medical review, lack of medical necessity identified during post-payment medical review shall not constitute a basis for recoupment by the Contractor. See also Section D, Paragraph 38, Claims Payment/Health Information System. For a more complete description of the guidelines for hospital reimbursement, please consult the applicable statutes and rules.

41. RESPONSIBILITY FOR NURSING FACILITY REIMBURSEMENT

The Contractor shall provide medically necessary nursing facility services as outlined in Section D, Paragraph 10, Scope of Services. The Contractor shall also provide medically necessary nursing facility services for any enrolled member who has a pending ALTCS application who is currently residing in a nursing facility and is eligible for services provided under this contract. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days per contract year of nursing facility coverage, the Contractor is only responsible for nursing facility reimbursement during the time the member is enrolled with the Contractor as shown in the PMMIS. Nursing facility services covered by another liable party (including Medicare) while the member is enrolled with the Contractor, shall be applied to the 90 day per contract year limitation.

The Contractor shall not deny nursing facility services when the member's eligibility, including prior period coverage, had not been posted at the time of admission. In such situations the Contractor shall impose reasonable authorization requirements. There is no ALTCS enrollment, including prior period coverage that occurs concurrently with AHCCCS acute enrollment.

The Contractor shall notify the Assistant Director of the Division of Member Services when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days as specified in Section D, Paragraph 10, Scope of Services, under the heading *Nursing Facility.* This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage if the stay goes beyond the 90 day per contract year maximum.

42. INCENTIVES/PAY FOR PERFORMANCE

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

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

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

1. A complete copy of the contract;
2. A plan for the member satisfaction survey;
3. Details of the stop-loss protection provided; and
4. A summary of the compensation arrangement that meets the substantial financial risk definition.

The Contractor shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

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

Any Contractor-selected and/or developed pay for performance initiative that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management prior to implementation.

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made.

If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two Acute Care Contractors to utilize the same management service company in the same GSA.

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 37, Subcontracts and as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

44. MATERIAL CHANGE TO OPERATIONS

A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol, such as prior authorization or retrospective review) which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this contract. It also includes any change that would impact more than 5% of total membership and/or provider network in a specific GSA.

The Contractor must submit the request for approval of a material change to operations, including draft notification to affected members and providers, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. The request should contain, at a minimum, information regarding the nature of the operational change; the reason for the change; methods of communication to be used; and the anticipated effective date. AHCCCS will respond to the Contractor within 30 days. A material change in Contractor operations requires 30 days advance written notice to affected providers and members. The requirements regarding material changes to operations do not extend to contract negotiations between the Contractor and a provider.

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

45. MINIMUM CAPITALIZATION

The Contractor is required to meet a minimum capitalization requirement within 30 days after contract award. Details regarding this requirement are included in AHCCCS' solicitation, released prior to the expiration of the

current contract period. 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 50, Financial Viability Standards.

46. 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 AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to providers, and (2) performance by the Contractor of its obligations under this contract [42 CFR 438.116]. The Performance Bond shall be in a form acceptable to AHCCCS. See ACOM Draft Policy 306.

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

a. Paying any damages sustained by providers, non-contracting providers and non-providers by reason of a breach of the Contractor's obligations under this contract;
b. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and
c. Reimbursing AHCCCS for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the State by AHCCCS.

In the event AHCCCS agrees to accept substitute security in lieu of the security types outlined in ACOM Draft Policy 306, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce AHCCCS' security interest in such substitute security including, but not limited to, security agreements and necessary UCC filings pursuant to the Arizona Uniform Commercial Code. The Contractor must request approval from AHCCCS before a substitute security in lieu of the security types outlined in the ACOM Draft Policy 306 is established. In the event such substitute security is agreed to and accepted by AHCCCS, the Contractor acknowledges that it has granted AHCCCS a security interest in such substitute security to secure performance of its obligations under this contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. AHCCCS may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide AHCCCS with a form of security described in ACOM Draft Policy 306.

The Contractor may not change the amount, duration or scope of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. The Contractor shall not leverage the bond for another loan or create other creditors using the bond as security.

47. 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 AHCCCS. The total capitation amount (including delivery supplement) excludes premium tax. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall review the capitation amounts of the Contractor on a monthly basis to determine if the Performance Bond must be increased. The Contractor shall have 30 days following notification by AHCCCS 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 AHCCCS. The Contractor may not change the amount of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. Refer to ACOM Draft Policy 305 for more details.

48. 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 AHCCCS. The capital contributions must be for the period in which the deficit is reported and shall occur within 30 days of the financial statement due to AHCCCS. AHCCCS at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. AHCCCS may, at its option, impose enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

49. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line of business within its organization. The Contractor shall not, without prior approval of AHCCCS, make loans or advances to providers in excess of $50,000. All requests for prior approval are to be submitted to the AHCCCS, Division of Health Care Management, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Refer to the ACOM Policy 418 for further information.

50. FINANCIAL VIABILITY STANDARDS

The Contractor must comply with the AHCCCS-established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: current ratio; equity per member; medical expense ratio; and the administrative cost percentage. These same standards will be reviewed for the financial statements applicable to the Contractor's Medicare line of business if the Contractor is certified by AHCCCS.

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

FINANCIAL VIABILITY STANDARDS – Acute Care

Current Ratio	Current assets divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%). *Standard: At least 1.00* If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.

Equity per Member Unrestricted equity, less on-balance sheet performance bond, divided by the number of non-SOBRA Family Planning Extension members enrolled at the end of the period.

Standard: At least *$170 for Contractors with enrollment < 100,000*
$115 for Contractors with enrollment of 100,000+

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

Medical Expense Ratio Total medical expenses less TPL divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + Reinsurance less premium tax

Standard: At least 85%

Administrative Cost Percentage Total administrative expenses divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + Reinsurance less premium tax

Standard: No greater than 10%

FINANCIAL VIABILITY STANDARD – Medicare Advantage Plan Certified by AHCCCS

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

Standard: At least $350

The Contractor shall comply with all financial reporting requirements contained in Attachment B1, Acute Care Program Contractors' Chart of Deliverables for the Acute Care line of business. The Contractor shall also comply with all financial reporting requirements contained in the AHCCCS Financial Reporting Guide for Acute Care Contractors, a copy of which may be found on the AHCCCS website. This reporting is required for both the Acute Care and Medicare lines of business, regardless of the licensing or certifying entity for the Medicare Advantage Plan. If the Contractor is a Medicare Advantage Plan licensed through the Department of Insurance, quarterly reporting to AHCCCS is required for informational purposes only. The required reports are subject to change during the contract term and are summarized in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. See ACOM Draft Policy 305 for more detail.

51. SEPARATE INCORPORATION

Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract.

52. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP

A proposed merger, reorganization or change in ownership of the Contractor shall require prior approval of AHCCCS, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, and may require a contract amendment. AHCCCS may terminate this contract pursuant to Section E1, Contract Terms and Conditions, Paragraph 44, Temporary Management/Operation of a Contractor and Termination. If the Contractor does not obtain prior approval or AHCCCS determines that a merger, reorganization or change in ownership is

not in the best interest of the State, AHCCCS may offer open enrollment to the members assigned to the Contractor should a merger, reorganization or change in ownership occur. AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA.

The Contractor must submit notification to AHCCCS, Division of Health Care Management, of a merger, reorganization or change of ownership at least 180 days prior to the effective date. The Contractor must also submit a detailed merger, reorganization and/or transition plan to AHCCCS, Division of Health Care Management, for review at least 90 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 maintain and support the contract requirements, and to ensure that services to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by such merger, reorganization or change in ownership.

53. COMPENSATION

The method of compensation under this contract will be Prior Period Coverage (PPC) capitation, prospective capitation, delivery supplement, and reinsurance, as described and defined within this contract and appropriate laws, regulations or policies.

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

a. Utilization and unit cost data derived from adjudicated encounters
b. Both audited and unaudited financial statements reported by the Contractor
c. Market basket inflation trends
d. AHCCCS fee-for-service schedule pricing adjustments
e. Programmatic or Medicaid covered service changes that affect reimbursement
f. Other changes to medical practices or administrative requirements that affect reimbursement

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. AHCCCS utilizes a national episodic/diagnostic risk adjustment model that will be applied to all prospective capitation rates for all risk groups (excluding supplemental payments and SOBRA Family Planning). Additional risk factors that may be considered in capitation rate development include:

a. Reinsurance (as described in Section D, Paragraph 57, Reinsurance)
b. Age/Gender
c. Medicare enrollment
d. Delivery supplemental payment
e. Geographic Service Area adjustments
f. Risk sharing arrangements for specific populations
g. Member specific statistics, e.g. member acuity, member choice, member diagnosis, etc.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan; however those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)].

In instances in which 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.

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

Prior Period Coverage (PPC) Capitation: Except for SOBRA Family Planning services, and KidsCare, the Contractor will be paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during prior period coverage. The PPC capitation rates will be set by AHCCCS and will be paid to the Contractor along with the prospective capitation described above. The Contractor will not receive PPC capitation for newborns of members who are enrolled at the time of delivery.

Reconciliation of Prospective Costs to Reimbursement: AHCCCS will reconcile the Contractor's prospective medical cost expenses to prospective net capitation paid to the Contractor. Refer to the ACOM Draft Policy 311 for further details. This reconciliation will limit the Contractor's profits and losses as follows:

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 3%	100%	0%	3%	3%
> 3% and <= 6 %	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

Loss	MCO Share	State Share	Max MCO Loss	Cumulative MCO Loss
<= 3%	100%	0%	3%	3%
> 3%	0%	100%	0%	3%

Reconciliation of PPC Costs to Reimbursement: AHCCCS will reconcile the Contractor's PPC medical cost expenses to PPC capitation paid to the Contractor during the year. This reconciliation will limit the Contractor's profits and losses to 2%. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. Refer to the ACOM Policy Draft 302-I for further details.

Delivery Supplement: When the Contractor has an enrolled woman who delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to women who deliver in a prior period coverage time period, or State Only Transplant members. AHCCCS reserves the right at any time during the term of this contract to adjust the amount of this payment for women who deliver at home.

Payment Reform – Shared Savings: Providers and payers in the health care industry are exploring new innovations that further drive improvements in cost control and quality improvement. Effective October 1, 2013, AHCCCS shall require all Contractors to participate in payment reform efforts as delineated by AHCCCS in order to further these initiatives without penalizing Contractors and providers for their innovative efforts.

AHCCCS anticipates that capitation rates will be reduced by a withhold of no less than 1% in CYE 14, 100% of which will be paid to one or more Contractors according to relative Contractor performance. Measurement will be coordinated with and built on other AHCCCS performance measures. AHCCCS will provide details regarding the shared savings methodology no later than six months prior to the start of the contract.

State Only Transplants Option 1 and Option 2: The Contractor will only be paid capitation for an administrative component for those member months the member is enrolled with the Contractor. For Option 1 members the Contractor will be paid the administrative component up to a 12-month continuous period of extended eligibility. For Option 2 members the administrative component will be paid for the period of time the transplant is scheduled or performed. All medically necessary covered services will be reimbursed 100% with no deductible through Reinsurance payments based on adjudicated encounters. Delivery supplemental payments

will not apply to women who deliver during the 12 month continuous period of extended eligibility specified as Option 1.

54. PAYMENTS TO CONTRACTORS

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

Where payments are made by electronic funds transfer, AHCCCS shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor. 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 AHCCCS. 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 AHCCCS via a recoupment from future payment(s) to the Contractor, or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS must be notified and reimbursed within 30 days of identification.

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

55. CAPITATION ADJUSTMENTS

Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation during the contract period. AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions

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

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

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

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

a. Death of a member
b. Inmate of a public institution
c. Duplicate capitation to the same Contractor
d. Adjustment based on change in member's contract type
e. Voluntary withdrawal

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

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

Notifications must include:

- AHCCCS ID
- Name
- Date of Birth (DOB)
- When incarcerated
- Where incarcerated

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

Several counties are submitting daily files of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration. The Contractor will see the "IE" code for ineligible associated with the disenrollment. Upon release from jail, the member will be re-enrolled with their previous Contractor. A member is eligible for covered services until the effective date of the member's "no-pay" status.

If a member is enrolled twice with the same Contractor, recoupment will be made as soon as the double capitation is identified. AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this contract.

56. MEMBER BILLING AND LIABILITY FOR PAYMENT

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

The Contractor must ensure that members are not held liable for:

a. The Contractor's or any subcontractor's debts in the event of Contractor's or the subcontractor's insolvency;
b. Covered services provided to the member except as permitted under R9-22-702; or,
c. Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly.

57. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services incurred for a member beyond an annual deductible level. AHCCCS is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates. Refer to the AHCCCS Reinsurance Processing Manual for further details on the Reinsurance Program.

The table below represents deductible and coinsurance levels. See specific case types below for coverage details.

Reinsurance Case Type	*Deductible*	*Coinsurance*
Regular Reinsurance	*$25,000*	*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 except for State Only Transplant and SOBRA Family Planning Extension Program members. Beginning October 1, 2014 and annually thereafter, the regular reinsurance deductible levels above may increase by $5,000.

PPC expenses are not covered for any members under the reinsurance program unless they qualify under catastrophic or transplant reinsurance.

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

Regular Reinsurance: Regular reinsurance covers partial reimbursement of covered inpatient facility medical services. This coverage applies to prospective enrollment periods. In certain situations as outlined in the AHCCCS Reinsurance Processing Manual, per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage. Same-day admit-and-discharge services do not qualify for reinsurance.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs and those members diagnosed with hemophilia, non-DDAVP responding Von Willebrand's Disease or Gaucher's Disease, as follows:

> *Biotech Drugs:* Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. The biotech drugs covered under reinsurance may be reviewed by AHCCCS at the start of each contract year. Refer to the AHCCCS Reinsurance Processing Manual for a complete

list of the approved biotech drugs. When a generic equivalent of a biotech drug is available, AHCCCS will reimburse at the lesser of the biotech drug or its generic equivalent for reinsurance purposes, unless the generic equivalent is contra-indicated for a specific member.

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

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

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

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

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

The Contractor must notify AHCCCS, DHCM, Medical Management Unit, of cases identified for catastrophic reinsurance coverage, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS.

All catastrophic claims are subject to medical review by AHCCCS.

Transplant Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the AMPM and the AHCCCS Reinsurance Processing Manual for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered or 85% of the Contractor's paid amount. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. The Contractor must notify AHCCCS, DHCM, Medical Management Unit when a member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS Medical Management Unit within 30 days of referral to the transplant facility for evaluation.

If a Contractor intends to use an out of State transplant facility for a covered transplant and AHCCCS already holds an in State contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. If no prior approval is obtained, and the Contractor incurs costs at the out of State facility, those costs will not be eligible for either transplant or regular reinsurance.

***Option 1 and Option 2 Transplant Services**:* Reinsurance coverage for State Only Option 1 and Option 2 members (as described in Section D, Paragraph 2, Eligibility Categories) for transplants received at an AHCCCS contracted facility is paid at the lesser of 100% of the AHCCCS contract amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. All Option 1 and Option 2 transplants are subject to the terms regarding out of State transplants set forth above and in the AHCCCS Reinsurance Processing Manual. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCS, DHCM, Medical Management Unit as specified in the AMPM Chapter 300.

Option 1 Non-transplant Reinsurance: All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters.

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

Encounter Submission and Payments for Reinsurance

Encounter Submission: All reinsurance associated encounters, except as provided below for "Disputed Matters," must reach a clean claim status within 15 months from the end date of service, or date of eligibility posting, whichever is later.

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

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

The Contractor must void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. See the AHCCCS Reinsurance Processing Manual for further details. The Contractor should refer to Section D, Paragraph 65, Encounter Data Reporting, for additional encounter reporting requirements.

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

arrangements, AHCCCS shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest.

When a member with an annual enrollment choice changes Contractors within a contract year, for reinsurance purposes, costs incurred for that member do not follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level. For further details regarding this policy and other reinsurance policies refer to the AHCCCS Reinsurance Processing Manual.

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

Reinsurance Audits
AHCCCS may, at a later date, perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits providing the Contractor with appropriate advance notice.

58. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Pursuant to Federal and State law, AHCCCS is the payor of last resort, except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and R9-22-1001 et seq., so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. 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 in the coordination of benefits are cost avoidance and post-payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq. and Federal and State law. See also Section D, Paragraph 60, Medicare Services and Cost Sharing.

Cost Avoidance: The Contractor shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost-avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions.

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.

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. See ACOM Draft Policy, Coordination of Benefits/Third Party Liability.

Members with CRS condition: A member with private insurance or Medicare coverage is not required to be enrolled with or utilize the CRS Contractor. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. When the member elects to be enrolled with the Acute Care Contractor and when the private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to CRS-covered conditions, the Contractor shall refer the member to AHCCCS for determination of CRS eligibility. The Contractor is not responsible to provide CRS services in instances when a member with a CRS covered condition refuses to participate in the CRS application process, or refuses to receive CRS covered services through the CRS program. The member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

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

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

Other Recoveries: The Contractor shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6) external causes of injury codes E000 through E999, and other procedures. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

- Uninsured/underinsured motorist insurance
- First-and third-party liability insurance
- Tort feasors, including casualty
- Special Treatment Trust Recovery
- Restitution Recovery
- Worker's Compensation
- Estate Recovery

Upon identification of any of the above situations, the Contractor shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or fee-for-service payments are involved. By contrast, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Contractor shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Case Requirements

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

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 (i.e., lien filing , etc.); and,
c. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that there is no reinsurance or fee-for-service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Total Plan Cases: The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Notification of Settlement form, within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Joint Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Contractor. In joint cases, AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. 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.

Retroactive Recoveries: The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service, to determine if there are other payor sources that were not known at the time of payment. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way.

After two years from the service date, AHCCCS will direct recovery efforts for retroactive recovery of claims not previously identified by the Contractor as having a reasonable expectation of recovery. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the Contractor. The total recovery period for the Contractor and AHCCCS combined is limited to three years after the date of service as defined in A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

See ACOM Draft Policy, Coordination of Benefits/Third Party Liability for details regarding encounter adjustments as a result of retroactive recoveries. Additionally, AHCCCS will develop an automated process allowing the Contractor to "tag" claims that have a reasonable expectation of recovery. This process, and any other requirements for Contractors, will be added to ACOM Draft Policy, Coordination of Benefits/Third Party Liability prior to October 1, 2013.

Other Reporting Requirements

If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, or any change in coverage, the Contractor must report the information to the AHCCCS contracted vendor as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Notification by the Contractor must occur electronically through the Third Party Leads submission process. Refer to:

http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/TPLleads.aspx.

Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

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

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

Cost Avoidance/Recovery Report: The Contractor shall report, as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables, a summary of their cost avoidance/recovery activity. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

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

59. COPAYMENTS

The Contractor is required to comply with R9-22-711, the ACOM Policy 431 and other directives by AHCCCS. Most AHCCCS members remain exempt from copayments while others may be subject to optional or mandatory copayments for certain services.

Those populations exempt or subject to optional copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108]. However, for those populations subject to mandatory copayments services may be denied for the inability to pay the copayment.

60. MEDICARE SERVICES AND COST SHARING

The Contractor must pay most Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost-sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor must limit their cost sharing responsibility according to ACOM Policies 201 and 202. The Contractor shall have no cost sharing obligation if the Medicare payment exceeds what the Contractor would have paid for the same service of a non-Medicare member. Please refer to Section D, Paragraph 10, Scope of Services, for information regarding prescription medication for Medicare Part D.

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

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to CMS, the Contractor must notify the AHCCCS, Member Database Management Administration (MDMA), pursuant to ACOM Policy 431, Attachment A, as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

a. Members who have Medicare part "B" only;

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

For purposes of the medical institution notification, medical institutions are defined as acute hospitals, psychiatric hospital – Non IMD, psychiatric hospital – IMD, residential treatment center – Non IMD, residential treatment center – IMD, skilled nursing facilities, and Intermediate Care Facilities for the Intellectually Disabled.

61. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including the ACOM Policy 101 [42 CFR 438.104]. The Contractor shall submit all proposed marketing, outreach and retention activities and participation in events that will involve the general public to the AHCCCS Marketing Committee as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables and as outlined in the ACOM Policy 101. All marketing materials that have been approved by the Marketing Committee must be resubmitted every two years for re-approval.

62. CORPORATE COMPLIANCE

In accordance with A.R.S. §36-2918.01 and ACOM Policy 103, the Contractor and its subcontractors and providers is required to immediately notify the AHCCCS Office of Inspector General (OIG) regarding any suspected fraud or abuse [42 CFR 455.17]. The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)] by completing the confidential AHCCCS Referral for Preliminary Investigation form. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, Contractors, or subcontractors.

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.

The Contractor agrees to permit and cooperate with any onsite review. A review by the OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the OIG upon request and at no cost. The OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the OIG request.

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

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

1. Written policies, procedures, and standards of conduct that articulates the organization's commitment to and processes for complying with all applicable Federal and State standards.
2. The written designation of a compliance committee who are accountable to the Contractor's top management.

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

Once the Contractor has referred a suspected case of fraud or abuse to AHCCCS, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments until AHCCCS provides written notice to the Contractor that the fraud or abuse case has been closed or otherwise dispositioned. At that time, and after conducting a cost benefit analysis to determine if such action is warranted, the Contractor should attempt to recover any overpayments identified. The OIG shall be advised of the final disposition of the research and advised of actions, if any, taken by the Contractor.

In addition, the Contractor must furnish to AHCCCS or CMS within 35 days of receiving the request, full and complete information, pertaining to business transactions [42 CFR 455.105]:

- The ownership of any subcontractor with whom the Contractor has had business transaction totaling more than $25,000 during the two month period ending on the date of request; and
- Any significant business transactions between the Contractor and wholly owned supplier, or between the Contractor and any subcontractor ending on the date of the request.

In the event that OIG, either through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. Furthermore, the Contractor is fully subrogated to AHCCCS for all civil recoveries.

Disclosure of Ownership and Control [42 CFR 455.104)(SMDL09-001]

A. The Contractor must provide the following information to AHCCCS:

1.(a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

(b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the Contractor;

(c) The Tax Identification Number of any corporation with an ownership or control interest in the Contractor;

2. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;

3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest;

4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the Contractor as defined in 42 CFR 455.101.

The Contractor shall provide the above-listed information to AHCCCS at any of the following times:

1. Upon the Contractor submitting the proposal in accordance with the State's procurement process;
2. Upon the Contractor executing the contract with the State;
3. Upon renewal or extension of the contract;
4. Within 35 days after any change in ownership of the Contractor.

B. The Contractor shall also, with regard to its subcontracted providers and fiscal agents, obtain the following information regarding ownership and control:

1.(a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the subcontracted Provider or Fiscal Agent. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;

(b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the subcontracted provider or fiscal agent;

(c) The Tax Identification Number of any corporation with an ownership or control interest in the subcontracted provider or fiscal agent;

2. Whether the person (individual or corporation) with an ownership or control interest in the subcontracted provider or fiscal agent is related to another person with ownership or control interest in the subcontracted provider or fiscal agent as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the subcontracted provider or fiscal agent has a 5% or more interest is related to another person with ownership or control interest in the subcontracted provider or fiscal agent as a spouse, parent, child, or sibling;

3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the subcontracted provider or fiscal agent has an ownership or control interest;

4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the subcontracted provider or fiscal agent as defined in 42 CFR 455.101.

Disclosure of Information on Persons Convicted of Crimes [42 CFR 455.101; 106; 436] [SMDL09-001]
The Contractor must identify all persons associated with the Contractor and its subcontracted providers and fiscal agents with an ownership or control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. The Contractor shall, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

a. Social Security Administration DEATH MASTER FILE
b. The National Plan and Provider Enumeration System (NPPES)
c. The List of Excluded Individuals (LEIE)
d. The Excluded Parties List (EPLS)
e. Any other databases directed by AHCCCS or CMS

The Contractor must immediately notify AHCCCS of any person who has been excluded through these checks.

The results of the ***Disclosure of Ownership and Control*** and the ***Disclosure of Information on Persons Convicted of Crimes*** shall be held by the Contractor. The Contractor shall submit an annual attestation that the above-listed information has been requested and obtained from its contracted providers and fiscal agents. Refer to Attachment B1, Acute Care Program Contractors' Chart of Deliverables for further information. Upon request, the Contractor shall provide AHCCCS with the above-listed information.

63. RECORDS RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor agrees to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

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

All records must be maintained until three years after the member has exceeded the age of 18 years or for at least six years after the last date the child received medical or health care services from the provider, whichever date occurs later, as specified in A.R.S. §12-2297.

HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j)(2).

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

64. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

The Contractor is required to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided to AHCCCS. All data exchanged must be in the formats prescribed by AHCCCS, which include those required/covered by the Health Insurance Portability

and Accountability Act (HIPAA). Details for the formats may be found in the HIPAA Transaction Companion Guides, Trading Partner Agreements, the AHCCCS Encounter Manual and in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website.

The information exchanged with AHCCCS shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following notification by AHCCCS.

Electronic Transactions: The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or prior authorization requests; or the receipt of electronic remittance. The Contractor must be able to make claims payments via electronic funds transfer and have the capability to accept electronic claims attachments.

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations and control documents are required. The Contractor must have completed and submitted the EDI Trading Partner Agreement in order to exchange data with AHCCCS.

Each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

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

The Contractor is required to provide an attestation that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606] as outlined by AHCCCS.

The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCS 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 shall be responsible for any incorrect or delayed payment to the Contractor's providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

Member Data: The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in the AHCCCS prescribed electronic data exchange formats. Upon request, the Contractor shall provide to AHCCCS PCP assignments in an AHCCCS prescribed electronic data exchange format.

Claims Data: This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2903 and 2904 and AHCCCS rules R9-22 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

On a monthly basis AHCCCS will make available a claims data file of behavioral health claims and encounters for all General Mental Health, Children and non-integrated members with serious mental illness enrolled with the Contractor, for purposes of care coordination.

In addition, the Contractor shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

1. Receive and process 60% of each claim type (professional, institutional and dental) based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically.
2. Produce and distribute 60% of remittances electronically.
3. Provide 60% of claims payments via EFT.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned after contract award. AHCCCS will work with the Contractor as they evaluate Electronic Data Interchange options.

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to AHCCCS for review and comment as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

Health Insurance Portability and Accountability Act (HIPAA): 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.

HIPAA Privacy and Security: The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements. The annual audit report must be submitted to AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

The audit must include a review of Contractor policies and procedures to verify that appropriate security and privacy requirements have been adequately incorporated into the Contractor's business practices, and the use of automated and/or manual scans of the production processing systems to validate compliance.

The audit must result in a findings report and as necessary a remediation plan, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The remediation plan must also include timelines for corrective actions related to all issues or discrepancies identified. The findings report and remediation plan must be submitted to AHCCCS for review and approval. AHCCCS will verify that the required audit has been completed and the appropriate approved remediation plans are in place and being followed as part of Operational Reviews.

Health Information Exchange: The Contractor is required to contract with Health Information Network of Arizona (HINAz) or its successor, as a data user.

65. ENCOUNTER DATA REPORTING

Complete, accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance

with performance standards. The Contractor shall submit encounter data to AHCCCS 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 prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)][42 CFR 455.1 (a)(2)].

The Contractor must successfully exchange encounter data for all form types with AHCCCS no later than 120 days after the start of the contract or be subject to possible corrective actions up to and including sanctions and enrollment caps.

Encounter Submissions*:* Encounters must be submitted in the format prescribed by AHCCCS. Encounter data must be provided to AHCCCS as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements and the AHCCCS Encounter Manual.

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed.

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor must provide attestation that the services listed were actually rendered.

The Contractor may be assessed sanctions for noncompliance with encounter submission completeness, accuracy and timeliness requirements.

Encounter Reporting: The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions and revisions of encounters. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual or as directed by AHCCCS and as further specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 18 months of approved, voided, plan-denied, pended and AHCCCS-denied encounters received and processed by AHCCCS. These files must be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

Encounter Supporting Data Files: AHCCCS provides the Contractor with periodic (no less than twice monthly) full replacement files containing provider and medical coding information as stored in PMMIS. These files should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information regarding the content and layouts of these files.

Encounter Corrections: The Contractor is required to monitor and resolve pended encounters and encounters denied by AHCCCS.

The Contractor is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters including approved, pended, denied and voided encounters, impact completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days for example), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

Encounter Validation Studies: Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. These studies may result in sanctions of the Contractor and/or require a corrective action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness and omission of encounters. Refer to the AHCCCS 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.

66. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

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

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two

days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

67. PERIODIC REPORT REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 72, Sanctions and Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242(b)(2)]:

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

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specified by AHCCCS. The Contractor shall be responsible for continued reporting beyond the term of the contract.

68. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information to AHCCCS as requested no later than 20 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 AHCCCS, within the timeframe designated by AHCCCS, 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 AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

69. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS or the Federal government to its members and all costs shall be the responsibility of the Contractor. All advertisements, publications and printed materials that are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCS.

70. OPERATIONAL AND FINANCIAL READINESS REVIEWS

AHCCCS will conduct an Operational and Financial Readiness Review of the Contractor and will, subject to the availability of resources, provide technical assistance as appropriate. The Readiness Review will be conducted prior to the start of business. The purpose of a Readiness Review is to assess the Contractor's operational

readiness and its ability to provide covered services to members at the start of the contract year. The Contractor will be permitted to commence operations only if the Readiness Review factors are met to AHCCCS' satisfaction.

71. OPERATIONAL REVIEWS

In accordance with CMS requirements and Arizona Administrative Code [Title 9, A.A.C. Chapter 22 Article 5], AHCCCS, or an independent agent, will conduct periodic Operational Reviews to ensure program compliance and identify best practices [42 CFR 438.204]. The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. The type and duration of the review will be solely at the discretion of AHCCCS.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled Operational Review. AHCCCS reserves the right to conduct reviews without notice to monitor contractual requirements and performance as needed.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out of State locations and will coordinate travel arrangements and accommodations with the Contractor.

In preparation for the reviews, the Contractor shall cooperate with AHCCCS by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. 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 an opportunity to comment on any review findings prior to AHCCCS issuing the final report. The Contractor must develop corrective action plans based on these recommendations. The corrective action plans and modifications to the corrective action plans must be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational Review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the Operational Review Tool, draft Operational Review Report or final report to other Contractors.

72. SANCTIONS

In accordance with applicable Federal and State regulations, R9-22-606, ACOM Policy 408 and the terms of this contract, AHCCCS may impose sanctions for failure to comply with any provision of this contract. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in R9-34-401 et seq.

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

AHCCCS may impose sanctions including but not limited to:

a. Civil monetary penalties.

b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M).
c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll [42 CFR 438.702(a)(3)].
d. Suspension of all new enrollments, including auto assignments after the effective date of the sanction.
e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Refer to the ACOM Policy 408 for details.

Automatic Sanctions: AHCCCS will assess the sanctions listed in Attachment B1, Acute Care Program Contractors' Chart of Deliverables on deliverables listed under DHCM Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

73. BUSINESS CONTINUITY AND RECOVERY PLAN

The Contractor shall develop a Business Continuity and Recovery Plan as detailed in the ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. All staff shall be trained on, and familiar with, the Plan. This Plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at the Contractor's main place of business
- Complete loss of use of the main site and satellite offices out of State
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCS in the event of a business disruption
- Periodic Testing (at least annually)

The Business Continuity and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to AHCCCS as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables.

74. RESERVED

75. PENDING LEGISLATION / OTHER ISSUES

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

Federal and State Legislation: AHCCCS and its Contractors are subject to legislative mandates that may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

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

To further the integration of technology based solutions and the meaningful use of electronic health records within provider offices, AHCCCS anticipates increasing opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates expanding utilization of health information technology as it relates to health care management and Contractor deliverables in the following, but not limited to, areas:

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

KidsCare: On November 6, Arizona voters will have the opportunity to vote on Proposition 204, also known as The Quality Education and Jobs Act. This initiative would extend the one cent sales tax currently in place and would dedicate a small portion of the funds collected to reopen the KidsCare program effective July 1, 2013. If approved, the KidsCare program would enroll new children in households between 133 percent FPL and 200 percent FPL. If the initiative is not approved, enrollment in the KidsCare program will remain frozen and children currently enrolled in KidsCare II will be transitioned to either Medicaid or the Exchange.

Payment Methodology For Hospital Inpatient Claims: AHCCCS currently uses a tiered per diem methodology for the payment of acute care hospital inpatient claims. This payment structure is the default methodology, as required by Arizona State law that must be used by AHCCCS' Managed Care Organizations

(MCOs) when no contract exists between an MCO and a hospital. Laws 2012, Second Regular Session, Chapter 122 ends the tiered per diem methodology effective September 30, 2013. AHCCCS is required to obtain legislative approval of an alternative reimbursement methodology for inpatient dates of service on and after October 1, 2013. AHCCCS is exploring the benefits of the APR-DRG payment methodology and will be establishing workgroups to seek stakeholder input on such a methodology. AHCCCS will be unable to implement a new methodology by October 1, 2013, and will seek a one-year extension of the tiered per diem methodology through September 30, 2014, with an effective date of October 1, 2014 for the new inpatient reimbursement system (pursuant to Chapter 122). MCOs will be required to utilize the AHCCCS inpatient payment methodology for all non-contracted inpatient hospital stays.

***ICD-10 Readiness*:** In 2009 the Federal government published the final regulation that adopted the ICD-10 code sets as HIPAA standards (45 CFR 162.1002). As HIPAA covered entities, State Medicaid programs must comply with use of the ICD-10 code sets by the deadline established by CMS. The compliance date published in the final rule is October 1, 2013. However, in October 2012, the ICD-10 compliance date was amended through a correction of final rule (originally published in September 2012), delaying the effective date to October 1, 2014; this indicates the dates of service for which these codes must be used. The Contractor shall comply with the use of ICD-10 code sets for all claims with dates of services on and after October 1, 2014. The Contractor shall meet all AHCCCS deadlines for communication, testing, and implementation planning with AHCCCS and providers. Failure to meet deadlines may result in regulatory action.

[END OF SECTION D1]

TABLE OF CONTENTS

SECTION D2: CRS PROGRAM REQUIREMENTS

All references to Section D correspond to Section D2 - CRS Program Requirements.

1. PURPOSE, APPLICABILITY, AND INTRODUCTION

PURPOSE AND APPLICABILITY

The purpose of the contract between AHCCCS and the Contractor is to implement and operate the Children's Rehabilitative Services Program (CRS) pursuant to A.R.S. §36-260 et seq. and §36-2901 et seq. The Contractor shall be responsible for providing integrated care addressing all physical and behavioral health needs for the majority of AHCCCS children with CRS-qualifying conditions.

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

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

INTRODUCTION

AHCCCS Mission and Vision

AHCCCS' mission and vision are to reach across Arizona to provide comprehensive quality healthcare to those in need while shaping tomorrow's managed health care from today's experience, quality and innovation. AHCCCS is dedicated to continuously improving the efficiency and effectiveness of the CRS program and ensuring the delivery of the highest quality care to its customers.

AHCCCS expects the Contractor to implement program innovation and best practices to improve outcomes on an ongoing basis. Furthermore, it is important for the Contractor to continuously develop mechanisms to reduce administrative cost and improve program efficiency. Over the term of the contract, AHCCCS will work collaboratively with the Contractor to evaluate ways to reduce program complexity, improve care coordination and chronic disease management, reduce administrative burdens, leverage joint purchasing power, and reduce administrative and medical costs.

AHCCCS has remained a leader in Medicaid managed care through the diligent pursuit of excellence and cost effective managed care by its collaboration with Contractors.

The Contractor must continue to add value to the program. A Contractor adds value when it:

- Recognizes that Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrates special effort throughout its operations to assure members receive necessary services;
- Recognizes that Medicaid members with special health care needs or chronic health conditions require care coordination, and provides that coordination;
- Recognizes that health care providers are an essential partner in the delivery of health care services, and operates the health plan in a manner that is efficient and effective for health care providers as well as the Contractor;
- Recognizes that performance improvement is both clinical and operational in nature and self-monitors and self-corrects as necessary to improve contract compliance or operational excellence; and
- Recognizes that the program is publicly funded, is subject to public scrutiny, and operates in a manner consistent with the public trust.

The CRS Program

CRS is a unique health care program that provides services to children with specified chronic and/or disabling or potentially disabling health conditions. Children with CRS-qualifying medical conditions typically require complex care and are medically fragile. For these children, health care service delivery involves multiple clinicians, covering the entire continuum of care. Within the CRS program, in addition to a primary care physician, children may receive services from subspecialists who manage care related to the CRS condition(s) and coordinate with other specialty services including but not limited to behavioral health, pharmacy, durable medical equipment, therapies, diagnostic services, and telemedicine visits. CRS care includes a multi-disciplinary team made up of subspecialists and caregivers such as pulmonologists, cardiologists, nutritionists, psychologists, and therapists. Because of the complexity of the needs of these children requiring multiple surgeries, hospitalization, and clinical care it is imperative that there be integrated health information for the member.

The CRS Contractor shall be a statewide Managed Care Organization (MCO) that will serve as the single Contractor for the majority of AHCCCS members with CRS-qualifying conditions per R9-22-1303. For the month of August 2012, CRS served 24,627 members under this Program. The Contractor shall be responsible for improving care coordination and health outcomes for the majority of AHCCCS children with these special health care needs by integrating care for CRS related conditions as well as all other physical and behavioral health care needs. The CRS Contractor shall operate a model that ensures optimal access to specialty care and offers effective coordination of all services. Members and their families shall be efficiently served by a network of providers that includes Multi-Specialty Interdisciplinary Clinics (MSICs) that are designed to address more of a member's whole health needs.

The Contractor will be responsible for delivering various combinations of acute, behavioral health and CRS services for the AHCCCS enrolled populations depending upon the primary program in which the member is enrolled for acute care services and choices made by American Indian (AI) members regarding where to receive their acute care and behavioral health services. See Section D, Paragraph 3, Enrollment and Disenrollment for a description of the AHCCCS populations under this contract and the responsibilities for service provision.

CRS services shall be provided using an integrated 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 CRS Contractor and services 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 CRS Contractor and service providers that is consistent with Federal and State privacy laws that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation;
c. Development of Transition Plans to facilitate transition into adulthood for those transitioning to another Contractor; and
d. Collaboration with individuals, groups, providers, organizations and agencies charged with the administration, support or delivery of services for persons with special health care needs.

2. ELIGIBILITY CATEGORIES

AHCCCS is Arizona's Title XIX Medicaid program operating under an 1115 Waiver and Title XXI program operating under Title XXI State Plan authority. Arizona has the authority to require mandatory enrollment in managed care. All CRS members eligible for AHCCCS benefits, with exceptions as identified below, are enrolled with the CRS Contractor that is paid on a capitated basis. AHCCCS pays for health care expenses on a fee-for-service (FFS) basis for Title XIX- and Title XXI- eligible members who receive services through the

American Indian Health Program or through ALTCS EPD Tribal program; for Title XIX eligible members who are entitled to emergency services under the Federal Emergency Services (FES) program; and for Medicare cost sharing beneficiaries under the QMB-Only program.

Children's Rehabilitative Services (CRS) Program: Beginning October 1, 2013 AHCCCS shall determine and re-determine medical eligibility for the CRS program. An AHCCCS eligible individual who needs active treatment for one or more of the CRS qualifying medical conditions shall be enrolled with the CRS Contractor, unless enrolled with an ALTCS EPD Contractor. The CRS Contractor shall provide covered services necessary to treat the CRS qualifying condition and other services described within this contract. The effective date of enrollment in CRS is the date the CRS medical eligibility is approved. The CRS Contractor is responsible for notifying the AHCCCS Division of Member Services (DMS) of the date when a CRS member is no longer in active treatment for the CRS qualifying condition(s) [R9-22-1303] as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables and ACOM Draft Policy 426.

The following describes the eligibility groups enrolled in the CRS program and covered under this contract:

Title XIX

1931 (Also referred to as TANF-related): Eligible individuals and families under the 1931 provision of the Social Security Act, with income at or below 100% of the FPL.

SSI Cash: Eligible individuals receiving Supplemental Security Income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have income at or below 100% of the Federal Benefit Rate (FBR).

SSI Medical Assistance Only (SSI MAO) and Related Groups: Eligible individuals who are aged, blind or disabled and have household income levels at or below 100% of the FPL.

***Freedom to Work (Ticket to Work)*:** Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.

SOBRA: Under the Sixth Omnibus Budget Reconciliation Act of 1986, eligible pregnant women, with income at or below 150% of the FPL, and children with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.

Breast and Cervical Cancer Treatment Program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.

Title IV-E Foster Care and Adoption Subsidy: Children who are in State foster care or are receiving Federally funded adoption subsidy payments.

Young Adult Transitional Insurance (YATI): Individuals age 18 through age 20 who were in foster care under jurisdiction of Department of Economic Security (DES) Division of Children Youth and Families (DCYF) in Arizona on their 18th birthday or are in the DCYF Young Adults Program.

Title XIX Waiver Group

AHCCCS Care (also known as Childless Adults): Eligible individuals and couples whose income is at or below 100% of the FPL, and who are not categorically linked to another Title XIX program. Formerly known as Non-MED members.

Title XXI

KidsCare: Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare I program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income at or below 200% Federal Poverty Level (FPL). The KidsCare II program has the same benefits and premium requirements as KidsCare I, however household income limits cannot be greater than 175% FPL.

State-Only

State-Only Transplants: Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:

1. The individual has been determined ineligible for Title XIX due to excess income;
2. The individual had been placed on a donor waiting list before eligibility expired;
3. The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

The following options for extended eligibility are available to these members:

Option 1: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.

Option 2: As long as medical eligibility for a transplant (status on a transplant waiting list) is maintained, at the time that the transplant is scheduled to be performed the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor to receive all covered transplant services. Option 2-eligible individuals are not eligible for any non-transplant related health care services from AHCCCS.

Eligibility for the various AHCCCS coverage groups is determined by one of the following agencies:

Social Security Administration (SSA)	SSA determines eligibility for the Supplemental Security Income (SSI) cash program. SSI cash recipients are automatically eligible for AHCCCS coverage.
Department of Economic Security (DES)	DES determines eligibility for families with children under section 1931 of the Social Security Act, pregnant women and children under SOBRA, the Adoption Subsidy Program, Title IV-E foster care children, Young Adult Transitional Insurance Program, and Title XIX Waiver Members. (AHCCCS Care)

AHCCCS AHCCCS determines eligibility for the SSI-Medical Assistance Only (SSI-MAO) groups, the Arizona Long Term Care System (ALTCS), the Children's Rehabilitative Services (CRS), the Medicare Savings Programs, BCCTP, the Freedom to Work program, the Title XXI KidsCare program, and the State Only Transplant program.

3. ENROLLMENT AND DISENROLLMENT

Members eligible for CRS will be enrolled with the CRS Contractor, unless they choose to use private insurance for the CRS-covered condition and enroll in another AHCCCS program. CRS Services will be available from a single CRS Contractor; therefore CRS eligible members will be automatically enrolled with that Contractor for various combinations of CRS, acute and/or behavioral health services as outlined under the CRS coverage types. AHCCCS members are eligible and enrolled with the Contractor in accordance with the rules set forth in R9-22 Article 13.

CRS Coverage Types: CRS eligible members will be enrolled under one of the following four CRS coverage types depending upon the primary program in which the member is enrolled for acute care services and choices made by American Indian (AI) members regarding where to receive their acute care and behavioral health services:

	Contractor Service Responsibility			
Coverage Type	CRS	Acute	BH	Notes
1. CRS Fully Integrated	X	X	X	Members receiving all services from the CRS Contractor including acute health, behavioral health and CRS-related services
2. CRS Partially-Integrated - Acute	X	X		AI members receiving all acute health and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal RBHA.
3. CRS Partially-Integrated – Behavioral Health (BH)	X		X	CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute health services from the primary program of enrollment.
4. CRS Only	X			Members receiving all CRS-related services from the CRS Contractor, receiving acute health services from the primary program of enrollment, and receiving behavioral health services as follows: • CMDP and DDD AI members from a Tribal RBHA • AIHP members from a T/RBHA CRS Only also includes ALTCS/EPD AI Fee For Service members.

American Indian members' enrollment choices may be exercised at any time; these enrollment choices may affect their CRS coverage type.

AHCCCS has the exclusive authority to enroll and disenroll members. The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, nor because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

AHCCCS will disenroll the member from the Contractor when:

- The member becomes ineligible for the AHCCCS program;
- The member becomes ineligible for CRS services, either through a determination of medical need or through an age out of the member (unless the member elects an opt in choice);
- The Contractor does not, because of moral or religious objections, cover the service the member seeks; or
- The member transitions to ALTCS/EPD. The member becomes eligible for the SOBRA Family Planning Extension Program.

Effective Date of Enrollment: The effective date of enrollment for a new Title XIX or Title XXI member with the Contractor is the day AHCCCS takes the enrollment action. The Contractor is responsible for payment of medically necessary covered services retroactive to the member's enrollment date with the Contractor, as reflected in PMMIS.

Prior Period Coverage: AHCCCS may provide prior period coverage for Title XIX members. Prior Period Coverage refers to the time frame from the effective date of eligibility to the day the member is enrolled with the Contractor. During the prior period coverage the Contractor is responsible for payment of all claims for medically necessary covered services, provided to members during prior period coverage. This may include services provided prior to the contract year. Prior Period Coverage for CRS will only occur when a Title XIX CRS enrolled member loses eligibility and then regains eligibility within 12 months, resulting in re-enrollment with the CRS Contractor.

Newborns: Newborns born to a CRS member in category types CRS Fully Integrated and CRS Partially-Integrated – Acute will be auto-assigned to a Contractor in another AHCCCS program.

The CRS Contractor is responsible for notifying AHCCCS of a child's birth to an enrolled member; notification must be received no later than one day from the date of birth. AHCCCS is available to receive notification 24 hours a day, seven days a week via the AHCCCS website. Failure of the CRS Contractor to notify AHCCCS within the one day timeframe may result in sanctions being assessed to the CRS Contractor by AHCCCS.

Enrollment Guarantees: Upon initial capitated enrollment as a Title XIX-eligible member, the member is guaranteed a minimum of five full months of continuous enrollment. Upon initial capitated enrollment as a Title XXI-eligible member, the member is guaranteed a minimum of 12 full months of continuous enrollment. The enrollment guarantee is a one-time benefit. If a member changes from one Contractor to another within the enrollment guarantee period, the remainder of the guarantee period applies to the new Contractor. AHCCCS rules at 9 A.A.C. 22 Article 17, and 9 A.A.C. 31 Article 3, describe other reasons for which the enrollment guarantee may not apply.

Age Out – Opt In: Upon reaching their 21st birthday, members will be transitioned out of the CRS program, unless they opt to remain with the CRS Contractor.

4. RESERVED

5. RESERVED

6. COVERAGE RESPONSIBILITY FOR PARTIALLY-INTEGRATED MEMBERS

In general, for CMDP and DDD children (also known as coverage type CRS Partially-Integrated – Behavioral Health) CRS provides specialty services related to the member's CRS condition and all behavioral health services, but does not cover other routine, preventive or acute non-specialized medical services. For members enrolled in DDD or CMDP, DDD and CMDP remain ultimately responsible for the provision of all AHCCCS-covered services to its members including a service denied by the CRS Contractor for the reason that it is not a service related to a CRS condition. Coordination with CMDP and DDD regarding issues of coverage and reimbursement is necessary to avoid administrative barriers with the potential to negatively impact timely service delivery or adverse outcomes.

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

7. AHCCCS MEMBER IDENTIFICATION CARDS

The Contractor is responsible for the production, distribution and costs of AHCCCS member identification cards in accordance with ACOM Draft Policy 433.

8. MAINSTREAMING OF AHCCCS MEMBERS

To ensure mainstreaming of AHCCCS members, the Contractor shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information, or physical or mental illnesses. The Contractor must take into account a member's literacy and culture when addressing members and their concerns, and must take reasonable steps to ensure subcontractors to do the same. The Contractor must also make interpreters, including assistance for the visual- or hearing-impaired, available to members at no cost to ensure appropriate delivery of covered services.

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

a. Denying or not providing a member any covered service or access to an available facility;
b. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary;

c. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
d. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental illnesses of the participants to be served.

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 its contract.

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

9. TRANSITION ACTIVITIES

Member Transition: The Contractor shall comply with the AMPM and the ACOM standards for member transitions between AHCCCS programs and upon termination or expiration of a contract. The Contractor shall develop and implement policies and procedures which include but are not limited to:

a. Members with significant medical conditions such as, a high-risk pregnancy or pregnancy within the last trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.;
b. Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;
c. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth;
d. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;
e. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, or nursing home admission;
f. Continuing prescriptions, Durable Medical Equipment (DME) and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor; and
g. 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).

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the AHCCCS transition staff and staff from other Contractors to ensure a safe, timely, and orderly transition.

A new Contractor who receives members from the relinquishing Contractor as a result of a contract award shall ensure a smooth transition for members by maintaining their current providers and service authorizations at the time of enrollment for a period of up to 90 days unless mutually agreed to by the member or member's representative. The Contractor must reimburse a non-emergent, non-contracted provider in accordance with Section D, Paragraph 38, Claim Payment/Health Information System.

When relinquishing members, the Contractor is responsible for timely notification to the new Contractor regarding pertinent information related to any special needs of transitioning members. When receiving a transitioning member with special needs, the Contractor is responsible for coordinating care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with Contractor and service information, emergency numbers and instructions about how to obtain services. See ACOM Policy 402 and AMPM Chapter 500.

Contract Termination

In the event that the contract or any portion thereof is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members. In addition, AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. The Contractor shall make provisions for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. The Contractor shall submit a detailed plan to AHCCCS for approval regarding the transition of members in the event of contract expiration or termination. The name and title of the Contractor's transition coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process, and shall be responsible for the following:

a. Notifying subcontractors and members;
b. Paying all outstanding obligations for medical care rendered to members until AHCCCS is satisfied that the Contractor has paid all such obligations. The Contractor shall provide a monthly claims aging report including IBNR amounts (due the 15th day of the month, for the prior month);
c. Providing Quarterly and Audited Financial Statements up to the date of contract termination. The financial statement requirement will not be absolved without an official release from AHCCCS;
d. Continuing encounter reporting until all services rendered prior to contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from AHCCCS;
e. Cooperating with reinsurance audit activities on prior contract years until release has been granted by AHCCCS;
f. Cooperating with AHCCCS to complete and finalize any open reconciliations, until release has been granted by AHCCCS. AHCCCS will work to complete any pending reconciliations as timely as can be completed, allowing for appropriate lag time for claims run-out and/or changes to be entered into the system;
g. Supplying quarterly Quality Management and Medical Management reports will be submitted as required by Section D, Paragraphs 23, Quality Management and Performance Improvement, and 24, Medical Management, as appropriate to provide AHCCCS with information on services rendered up to the date of contract termination. This will include quality of care (QOC) concern reporting based on the date of service;
h. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by AHCCCS;
i. Maintaining a Performance Bond in accordance with Section D, Paragraph 46, Performance Bond or Bond Substitute. A formal request to release the performance bond, as well as a balance sheet, must be submitted when appropriate;
j. Indemnifying AHCCCS for any claim by any third party against the State or AHCCCS arising from the Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract;
k. Returning to AHCCCS, any funds advanced to the Contractor for coverage of members for periods after the date of termination. Funds must be returned to AHCCCS within 30 days of termination of the contract;
l. Providing a monthly accounting of member grievances and claim disputes and their disposition; and
m. Preserving and making available all records for a period of five years from the date of final payment under contract. Records covered under HIPAA must be preserved and made available for six years per 45 CFR 164.530(j)(2).

The above list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met. Any dispute by the Contractor, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E2, Contract Terms and Conditions, Paragraph 19, Disputes.

The CRS Contractor shall establish an electronic process for the identification of CRS members who have completed treatment or are no longer in active care. The CRS Contractor's process shall identify members, on a monthly basis that have completed treatment for a CRS condition and do not have any other CRS eligible conditions. The Contractor shall request relevant medical records for these members and provide to AHCCCS Division of Member Services for redetermination of the member's continued CRS eligibility. The CRS Contractor shall also identify members who have not received any care or services related to a CRS qualifying condition and provide medical records to the AHCCCS Division of Members Services for a redetermination of the member's CRS eligibility. Members who are determined to no longer be in active care or who have completed care for their qualifying CRS condition may be provided an opportunity to remain with the CRS Contractor.

Pediatric to Adult Transition: The Contractor shall develop a Pediatric to Adult Transition Plan for each Member by age twenty (20) years. The Transition Plan shall be developed with Members, families, and their providers. The Transition Plan shall include strategies to address barriers to transitioning from a pediatric- to an adult-oriented system of care. The Transition Plan should be age-appropriate and periodically updated to address the Member's current needs and identify an adult-care PCP, if the Member elects to transition to another health plan prior to transition out of the CRS program. In addition to health care, developmentally-appropriate discussions related to work, 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. The CRS Contractor shall adhere to policies in the AMPM, Chapter 520, regarding Pediatric to Adult Transition Plans. Utilizing the Enrollment Transition Information (ETI) form, the CRS Contractor shall notify the Member's receiving AHCCCS Contractor once the CRS Member turns 21 years of age and chooses to leave the CRS program or the member is no longer eligible for the CRS program. CRS Members often require care over extended periods of time. Therefore, transitions from the children's to the adult system of care; from the CRS Contractor to another AHCCCS Contractor or a private health plan; between levels of inpatient and outpatient care; from physician to physician; from one carve out service program, such as behavioral health, to another; often are needed. Accordingly, the CRS Contractor shall implement specific policies and procedures to preserve the continuity of care during such transitions. The CRS Contractor must facilitate the development and implementation of a transition plan for members who are no longer eligible for CRS or choose to transition to another AHCCCS Contractor or private health plan after they turn 21 years of age. The transition plan must be consistent with applicable evidence based practice guidelines, which combines the various elements of treatment plans with needed family support services and care coordination activities to provide a roadmap of the steps to be taken for each Member in achieving treatment and quality of life goals. The plan developed for each member must be completed in accordance with AHCCCS Policy, which includes developmentally-appropriate strategies to transition from a pediatric to an adult system of health care and a plan that addresses changing work, education, recreation and social needs.

The CRS Contractor shall assist in the transition of care and discharge planning for members who are changing from an AHCCCS Contractor to the CRS Contractor or from the CRS Contractor to another AHCCCS Contractor or for an AHCCCS carve-out service program, or changing PCPs to ensure that all parties are aware of the full spectrum of care that a member is receiving in the AHCCCS program. In addition, the CRS Contractor shall ensure continuity of care upon discharge from hospitals, clinics, or from the CRS program. The Contractor shall coordinate continued care with a member's Primary Care Physician, as appropriate, upon a member's discharge from a hospital; advising the PCP of all services provided during the stay, the date of completion for any short term service, and any follow up care indicated.

Service Completion: Upon the completion or closure of a course of treatment related to a CRS condition, members may no longer require the multi-specialty, interdisciplinary care, provided in the CRS program. The CRS Contractor must notify DMS upon identification of such cases and supply supporting medical record information as specified in ACOM Draft Policy 426.

10. SCOPE OF SERVICES

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal and State laws, regulations and policies, including those listed by reference in attachments and this contract. The services are described in detail in AHCCCS rules R9-22 Articles 2, 12, and 13, AMPM and the ACOM, all of which are incorporated herein by reference, and may be found on the AHCCCS website [42 CFR 438.210(a)(1)]. To be covered, services must be medically necessary and cost effective. The covered services are briefly described below.

The Contractor must ensure the coordination of services it provides with services the member receives from other entities, including behavioral health providers. 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)(4) and 438.224].

Services must 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. 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. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)(3)].

Moral or Religious Objections: The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution to allow members' access to the services. If AHCCCS does not approve the Contractor's proposed solution, AHCCCS will determine how the services will be provided. That proposal must:

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

If AHCCCS approves the Contractor's proposed solution for its members to access the services, the Contractor must notify members how to access these services when directed by AHCCCS. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to newly assigned members within 12 days of enrollment, and must be provided to all current members at least 30 days prior to the effective date of the approved policy [42 CFR 438.102(a)(2) and (b)(1)].

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

Notice of Action
The Contractor shall notify the requesting provider and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested [42 CFR 438.400(b)]. The notice shall meet the requirements of 42 CFR 438.404, AHCCCS rules and ACOM Policy 414. The notice to the provider must also be in writing as specified in Attachment A1, Enrollee Grievance System Standards of this contract [42 CFR 438.210 (c)]. The Contractor must comply with all decision timelines outlined in ACOM Policy 414.

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

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

Covered Services
Please refer to the AHCCCS Medical Policy Manual (AMPM) Chapter 300 and 400 for a comprehensive list of CRS Covered Services. For CMDP and DDD members, the services below are generally covered when related to the CRS condition.

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 Health Program (AIHP): The AHCCCS, Division of Fee For Service Management (DFSM) will reimburse claims for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided to Title XIX members enrolled with the Contractor by an IHS or a 638 tribal facility and when the member is eligible to receive services at the IHS or a tribally operated 638 program. Encounters for Title XIX services billed by an IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

The Contractor is responsible for reimbursement to IHS or tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. The Contractor may choose to subcontract with an IHS or 638 tribal facility as part of its provider network for the delivery of Title XXI covered services. Expenses incurred by the Contractor for Title XXI services billed by an IHS or a 638 tribal facility shall be encountered and considered in capitation rate development.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and Von Willebrand's disease. See Section D, Paragraph 57, Reinsurance.

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

Behavioral Health: The Contractor shall provide behavioral health services as described in Section D, Paragraph 12, Behavioral Health Services.

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

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

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

Emergency Services for coverage types, CRS Fully Integrated and CRS Partially-Integrated – Acute: The Contractor shall provide emergency services per the following:

a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by R9-22 Article 1. Emergency medical services are covered without prior authorization. The Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. The Contractor shall monitor emergency 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;
b. All medical services necessary to rule out an emergency condition; and
c. Emergency transportation.

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

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

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

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

Additionally, the Contractor may not:

a. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.

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 10 calendar days of presentation for emergency services. Claims submission by the hospital within 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.
c. Require notification of Emergency Department treat and release visits as a condition of payment unless the plan has prior approval from AHCCCS.

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

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

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

Emergency Services for coverage types, CRS Partially-Integrated – BH and CRS Only: The Contractor shall not cover outpatient emergency services.

Family Planning: The Contractor shall provide family planning services in accordance with the AMPM, and consistent with the terms of the demonstration, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, are also included.

Foot and Ankle Services:

Children: The Contractor shall provide foot and ankle services for members under the age of 21 to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a non-professional person.

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

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.

Hospice: These services are covered for members who are certified by a physician as being terminally ill and having six months or less to live. See the AMPM for details on covered hospice services.

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

Immunizations: The Contractor shall provide medically necessary immunizations for adults 21 years of age and older. Human Papilloma virus (HPV) is covered only for EPSDT aged male and female members (through age 20). (Refer to the AMPM for current immunization requirements). The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 23, Quality Management and Performance Improvement.

Incontinence Briefs: In general, incontinence briefs (diapers) are not covered unless medically necessary to treat a medical condition. For AHCCCS members over three years of age and under age 21 years of age incontinence briefs, including pull-ups, are covered to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances. See R9-22-212 and AMPM Chapter 400.

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

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 AHCCCS.

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

The Contractor shall allow women to receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother prior to the minimum length of stay. However, for payment purposes, inpatient limits will apply to the extent consistent with EPSDT.

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal testing and the availability of medical counseling if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter, to encourage pregnant women to be tested and

instructions about where to be tested. Semi-annually, the Contractor shall report to AHCCCS, Division of Health Care Management (DHCM) the number of pregnant women who have been identified as HIV/AIDS-positive for each quarter during the contract year. This report is due as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

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

Medical Supplies, Durable Medical Equipment (DME), and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the AMPM. Prosthetic devices must be medically necessary and meet criteria as described in the AMPM. For persons age 21 or older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs. Medical equipment may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

Nursing Facility: The Contractor shall provide services in nursing facilities, including religious non-medical health care institutions, for members who require short-term convalescent care not to exceed 90 days per contract year. In lieu of a nursing facility, the member may be placed in an assisted living facility, an alternative residential setting, or receive home and community based services (HCBS) as defined in R9-22 Article 2 and R9-28 Article 2 that meet the provider standards described in R9-28 Article 5, and subject to the limitations set forth in the AMPM.

Nursing facility services must be provided in a dually-certified Medicare/Medicaid nursing facility, which includes in the per-diem rate: nursing services; basic patient care 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. See Section D, Paragraph 41, Responsibility for Nursing Facility Reimbursement, for further details.

The Contractor shall notify the Assistant Director of the Division of Member Services, by Email, when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage, if the stay goes beyond the 90 day per contract year maximum. The notice should be sent via e-mail to HealthPlan45DayNotice@azahcccs.gov.

Notifications must include:

a. Member Name
b. AHCCCS ID
c. Date of Birth
d. Name of Facility
e. Admission Date to the Facility
f. Date the member will reach the 90 days
g. Name of Contractor of enrollment

Nutrition: Nutritional assessments are conducted as a part of the EPSDT screenings for members under age 21, and to assist members 21 years of age and older whose health status may improve with over- and under-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. AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary, according to the criteria specified in the AMPM, to provide either complete daily dietary requirements or to supplement a member's daily nutritional and caloric intake.

Oral Health: The Contractor shall provide all members under the age of 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 AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 23, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

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

Orthotics: These services are covered for members under the age of 21 when prescribed by the member's PCP, attending physician, practitioner, or by a dentist as described in the AMPM. Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item.

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

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

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

The Contractor must 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:

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

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

a. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
b. A Contractor physician assumes responsibility for the member's care through transfer;
c. A Contractor representative and the treating physician reach an agreement concerning the member's care; or
d. The member is discharged.

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

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

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

> *Medicare Part D*: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS. This applies to members who are enrolled in Medicare Part D or are eligible for Medicare Part D.

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

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

Rehabilitation Therapy: The Contractor shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation.

Occupational and Speech therapy is covered for all members receiving inpatient hospital (or nursing facility services). Occupational Therapy and Speech therapy services provided on an outpatient basis are only covered for members under the age of 21. Physical Therapy is covered for all members in both inpatient and outpatient settings. Outpatient physical therapy for members 21 years of age or older are subject to a 15 visit limit per contract year as described in the AMPM.

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

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation; donor search; organ/tissue harvesting or procurement; preparation and transplantation services; and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided, within limitations, after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 57, Reinsurance.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

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

Vision Services/Ophthalmology/Optometry: The Contractor shall provide all medically necessary emergency eye care, vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition, Vision examinations and the provision of prescriptive lenses are covered for adults when medically necessary following cataract removal. Medically necessary vision examinations and prescriptive lenses and frames are covered if required following cataract removal. Refer to AMPM Chapter 300.

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.

11. SPECIAL HEALTH CARE NEEDS

The Contractor shall have in place a mechanism to identify all members with special health care needs [42 CFR 438.240(b)(4)]. The Contractor shall implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment, regular care monitoring, or transition to another AHCCCS program. The assessment mechanisms shall use appropriate health care professionals [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to the member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3), A.R.S. §36-260 et seq., and R9-22 Article 13].

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)]. For members transitioning, see Section D, Paragraph 9, Transition Activities.

The CRS program specializes in services for individuals with chronic and/or disabling or potentially disabling health conditions. The CRS Contractor shall provide timely delivery of 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 shall implement proven strategies that ensure members access to effective, person- and family-centered, culturally and linguistically appropriate care, delivered in a manner consistent with Evidence Based Guidelines.

The Contractor shall administer a single, statewide service delivery system. The system will provide member access, incorporating technology such as telemedicine, to a statewide network of multi-specialty providers. Care shall be provided in a variety of service settings including Multi Specialty Interdisciplinary Clinics (MSIC's), alternative clinic settings, and community-based provider offices and locations.

The CRS 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 member rights, family involvement and continuous quality improvement shall be evident in its policies, practices and decision-making.

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

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

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

- Accessible
- Continuous
- Coordinated
- Family-centered
- Comprehensive
- Compassionate
- Culturally effective

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. See Section D, Paragraph 33, Appointment Standards.

The CRS Contractor must develop a written Service Plan that includes services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-disciplinary team including health care professionals that may provide care and services in the community setting. The CRS Contractor must provide active follow-up and

assistance in scheduling appointments for CRS members to ensure that they are aware of and complete care recommended in the Service Plan.

12. BEHAVIORAL HEALTH SERVICES

Members receive behavioral health services through the CRS Contractor depending on their CRS coverage type as defined in Section D, Paragraph 3, Enrollment and Disenrollment. Refer to the AMPM for covered behavioral health services and the AHCCCS Behavioral Health Covered Services Guide for more information.

Member Education: The Contractor shall be responsible for including information in the Member Handbook and other materials to inform members how to access covered services.

Access to Behavioral Health Services: Members may self–refer to a behavioral health provider, or be referred by CMDP, DDD, schools, State agencies, providers, or other parties. The Contractor shall be responsible for meeting the appointment standards found in Section D, Paragraph 33, Appointment Standards.

The Contractor's network shall include Master's level and doctoral trained clinicians in the fields of social work and psychology that are trained in implementation of best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma related disorders, substance abuse, sexual disorders, and special age groups such as transition age youth and members aged birth to five years old.

EPSDT: As specified in Section D, Paragraph 10, Scope of Services, EPSDT, the Contractor must provide behavioral health screenings for members under 21 years of age in compliance with the AHCCCS EPSDT Periodicity Schedule.

Specific Requirements for Services to American Indians: The Contractor shall ensure that all covered behavioral health services are available to American Indian members, whether they live on or off reservation. The Contractor is not responsible for payment of behavioral health services provided to American Indian members by an IHS or 638 providers, even if the member is enrolled with the Contractor.

Arizona State Hospital Discharges: The Contractor must ensure that members diagnosed with diabetes who are being discharged from the Arizona State Hospital (AzSH) are issued the same brand and model of both glucometer and supplies that the member was trained to use while in the AzSH. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

For enrolled members who are inpatient at the Arizona State Hospital, the Contractor is required to follow ACOM Policy 422 regarding medical care coordination for these members.

Medication Management Services: The Contractor shall allow PCPs to treat members diagnosed with anxiety, depression and attention deficit hyperactivity disorder (ADHD). PCPs who choose to treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. The Contractor shall make available, on the Contractor's formulary, medications for the treatment of these disorders.

Tool Kits: Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AMPM. These tool kits are a resource only and may not apply to all patients and all clinical situations. The tool kits are not intended to replace clinical judgment. The Contractor shall ensure that PCPs who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized, clinical tools/evidence-based guidelines. The Contractor shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

Step Therapy: The Contractor may implement step therapy for behavioral health medications used for treating anxiety, depression and ADHD disorders. The Contractor shall provide education and training for providers regarding the concept of step therapy. If the behavioral health provider provides documentation to the Contractor that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the Contractor shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression or ADHD. The Contractor shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

Court Ordered Treatment: Reimbursement for court ordered screening and evaluation services are the responsibility of the County pursuant to A.R.S. §36-545. For additional information regarding behavioral health services refer to Title 9 Chapter 22 Articles 2 and 12.

Community Service Agencies: The Contractor may contract with Community Service Agencies that are TXIX certified by ADHS/DBHS for the delivery of covered behavioral health services. Refer to the AHCCCS Behavioral Health Covered Services Guide for more information and limitations.

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals, including but not limited to, ACOM, AMPM, Reporting Guides, and Manuals are hereby incorporated by reference into this contract. Guidelines, policies and manuals are available on the AHCCCS website. The Contractor is responsible for complying with all requirements set forth in these sources as well as with any updates. In addition, linkages to AHCCCS rules, statutes and other resources are available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available on the AHCCCS website.

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSB)

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

MSB services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSB approved alternative setting. Currently, services include audiology, therapies (OT, PT and speech/language); behavioral health evaluation and counseling; nursing and attendant care (health aid services provided in the classroom); and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSB service.

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

The Contractor and its providers should coordinate with schools and school districts that provide MSB services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with special needs children, should coordinate with the appropriate school staff working with these members. Transfer of member medical information and progress toward treatment goals between the Contractor and the

member's school or school district is required as appropriate and should be used to enhance the services provided to members.

15. 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 AHCCCS children under age 19. The Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC program, the Contractor shall contact the AHCCCS Division of Health Care Management, Clinical Quality Management Unit for guidance. Any provider licensed by the State to administer immunizations, may register with Arizona Department of Health Services (ADHS) as a VFC provider to receive these free vaccines. 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 physicians are registered as VFC providers when acting as primary care physicians (PCP) for members under the age of 19 years.

Due to low numbers of children in their panels providers in certain geographic service areas (GSAs) may choose not to provide vaccinations. Whenever possible, members should be assigned to VFC registered providers within the same or a nearby community. 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 19. Immunizations must be reported at least monthly to the ADHS Immunization Registry. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor must educate its provider network about these reporting requirements and the use of this resource.

16. STAFF REQUIREMENTS AND SUPPORT SERVICES

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 [42 CFR 438.610 (a) & (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The Contractor is obligated to screen all employees and Contractors to determine whether any of them have been excluded from participation in Federal health care programs. The HHS-OIG website can be searched by the names of any individuals. The database can be accessed at www.oig.hhs.gov.

The Contractor must employ sufficient staff and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS. This action may include, but is not limited to, requiring the Contractor to hire additional staff and actions specified in Section D, Paragraph 72, Sanctions.

The Contractor shall have local staff available 24 hours per day, seven days per week to work with AHCCCS and/or other State agencies, such as Arizona Department of Health Services (ADHS)/Office of Licensure, on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardies (IJ), fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, 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 AHCCCS, Clinical Quality Management (CQM) with the contact information for these staff. At a minimum, the contact information shall include a current 24/7 telephone number. CQM must be notified and provided back up contact information when the primary contact person will be unavailable.

For functions not required to be in State, the Contractor must notify AHCCCS as specified in Attachment B2, CRS Program Contractor's 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 costs associated with on-site audits or other oversight activities which result when functions are located outside of the State of Arizona.

An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below, including the same key position across multiple lines of business, unless prior approval is obtained by AHCCCS, Division of Health Care Management (DHCM). The Contractor shall inform the AHCCCS DHCM in writing as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, when an employee leaves one of the **Key Staff** positions listed below. The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff.

At a minimum, the following staff is required**:**

Key Staff Positions

a. ***Administrator/CEO/COO*** who is located in Arizona, oversees the entire operation of the Contractor, and has the authority to direct and prioritize work, regardless of where performed.
b. ***Medical Director/CMO*** who is located in Arizona and who is an Arizona-licensed physician in good standing. The Medical Director shall be actively involved in all major clinical programs and Quality Management and Medical Management components of the Contractor and will utilize specialty consultants as necessary, including psychiatry. The Medical Director shall ensure timely medical decisions, including after-hours consultation as needed (see Section D, Paragraph 27, Network Development).
c. ***Chief Financial Officer/CFO*** who is available to fulfill the responsibilities of the position and to oversee the budget, accounting systems, and financial reporting implemented by the Contractor.
d. ***Pharmacy Director/Coordinator*** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Plan.
e. ***Dental Director/Coordinator*** who is responsible for coordinating dental activities of the Contractor and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or Contractor of the plan and must be a licensed dentist in Arizona if they are required to review or deny dental services.
f. ***Corporate Compliance Officer*** who is located in Arizona and who will implement and oversee 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 the AHCCCS Office of the Inspector General. See Section D, Paragraph 62, Corporate Compliance.
g. ***Dispute and Appeal Manager*** who is located in Arizona and who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes.

h. ***Business Continuity Planning Coordinator*** as noted in the ACOM Policy 104.

i. ***Contract Compliance Officer*** who is located in Arizona and who will serve as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all contract deliverables, fielding and coordinating responses to AHCCCS inquiries, and coordinating the preparation and execution of contract requirements such as Operational and Financial Reviews (OFRs), random and periodic audits and ad hoc visits.

j. ***Quality Management Coordinator*** who is an Arizona-licensed registered nurse, physician or physician's assistant or 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 Coordinator must be located in Arizona and have experience in quality management and quality improvement. Sufficient local staffing under this position must be in place to meet quality management requirements. The primary functions of the Quality Management Coordinator position are:
    - Ensure individual and systemic quality of care
    - Integrate quality throughout the organization
    - Implement process improvement
    - Resolve, track and trend quality of care grievances
    - Ensure a credentialed provider network

k. ***Performance/Quality Improvement Coordinator*** who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in health plan data and outcomes measurement. The primary functions of the Performance/Quality Improvement Coordinator are:
    - Focus organizational efforts on improving clinical quality performance measures
    - Develop and implement performance improvement projects
    - Utilize data to develop intervention strategies to improve outcomes
    - Report quality improvement/performance outcomes

l. ***Maternal Child Health/EPSDT Coordinator*** who is an Arizona licensed nurse, physician or physician's assistant; or has a Master's degree in health services, public health, health care administration or other related field, and/or a CPHQ or CHCQM certification and is located in Arizona. Sufficient local staffing under this position must be in place to meet quality and performance measure goals. The primary functions of the MCH/EPSDT Coordinator are:
    - Ensure receipt of EPSDT services
    - Ensure receipt of maternal and postpartum care
    - Promote family planning services
    - Promote preventive health strategies
    - Identify and coordination assistance for identified member needs
    - Interface with community partners

m. ***Ombudsman/Client Advocate*** who is located in Arizona and is experienced in working with parents, advocates and governmental entities with responsibility for children with special health care needs. The position is responsible for overseeing the organization's member/parent advocacy program. This includes serving as an advocate within the organization and in the community on behalf of CRS members and family members. This position works closely with other member support areas, including but not limited to the Behavioral Health, Member Services, and Provider Services. This position disseminates information that could assist or impact CRS members and their families.

n. ***Medical Management Coordinator*** who is an Arizona licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations. This position is located in Arizona and manages all required medical management requirements under AHCCCS policies, rules, and contract. Sufficient local staffing under this position must be in place to meet medical management requirements. The primary functions of the Medical Management Coordinator are:

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

o. ***Behavioral Health Coordinator*** who is a behavioral health professional as described in Health Services R9-20, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are implemented. The primary functions of the Behavioral Health Coordinator are:

- Coordinate member behavioral care needs
- Develop processes to coordinate behavioral health care and physical health care between all providers
- Participate in the identification of best practices for behavioral health services
- Coordinate and liaise for American Indians who exercise choice options regarding behavioral health

p. ***Member Services Manager*** who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times.

q. ***Provider Services Manager*** who coordinates communications between the Contractor and its subcontractors and providers. This position is located in Arizona and ensures that providers receive prompt resolution to their problems or inquiries, appropriate education about participation in the AHCCCS program and maintain a sufficient provider network. Sufficient local staffing under this position must be in place to ensure appropriate provider responsiveness.

r. ***Claims Administrator*** who shall ensure prompt and accurate provider claims processing. The primary functions of the Claims Administrator are:

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

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

- Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc.
- Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
- Identify trends and guides the development and implementation of strategies to improve provider satisfaction. Frequently communicate (i.e.: telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices

Additional Required Staff:

t. **Prior Authorization staff** to authorize health care 24 hours per day, seven days per week. This staff shall include but is not limited to Arizona-licensed nurses, physicians and/or physician's assistants.
u. **Concurrent Review staff** who is located in Arizona and who to conduct inpatient concurrent review. This staff shall consist of Arizona-licensed nurses, physicians, and/or physician's assistants.
v. **Member Services staff** to enable members to receive prompt resolution of their inquiries/problems.
w. **Provider Services staff** who is located in Arizona and who enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management).
x. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
y. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.
m. **Case Management staff** who is located in Arizona and who provide care coordination for members with special health care needs.

The Contractor must submit the following items as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, and when there is a change in staffing or organizational functions:

1. The name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as a, b and c. AHCCCS will compare this information against Federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42 CFR 455.104].
2. An organization chart complete with the **Key Staff** positions. The chart must include the person's name, title, location and portion of time allocated to each Medicaid contract and other lines of business.
3. A functional organization chart of the key program areas, responsibilities and reporting lines.
4. A listing of key staff positions including the person's name, title, telephone number, and email address.
5. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

The Contractor is responsible for maintaining a significant local presence within the State of Arizona. Positions performing functions related to this contract must have a direct reporting relationship to the local Administrator/Chief Executive Officer (CEO). The local CEO shall have the authority to direct, implement and prioritize work to ensure compliance with contract requirements. 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. This significant presence includes staff listed below.

In State Positions:

- Administrator/CEO/COO
- Behavioral Health Coordinator
- Case Managers
- Concurrent Review Staff
- Contract Compliance Officer
- Corporate Compliance Officer
- Dispute and Appeal Manager
- Maternal Child Health/EPSDT Coordinator
- Medical Director/CMO
- Medical Management Coordinator
- Ombudsman/Client Advocate Manager
- Provider Claims Educator
- Provider Services Manager
- Provider Services Staff
- Quality Management Coordinator

Contractor staff shall be responsible for designing, implementing, and adjusting the CRS program health delivery system operations to meet the cultural needs of members and their families. The Contractor is responsible for ensuring staff has an appropriate level of experience and expertise in the identification of health service delivery components and processes that value and promote health and improved quality of life in diverse cultures.

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

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

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

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. AHCCCS may require attendance by subcontracted entities, as defined in Section D, Paragraph 37, Subcontracts, when deemed necessary. All meetings shall be considered mandatory unless otherwise indicated.

17. WRITTEN POLICIES AND PROCEDURES

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

If AHCCCS deems a Contractor policy or process to be inefficient and/or place an unnecessary burden on the members or providers, the Contractor must work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS. In addition, if AHCCCS deems a Contractor lacks a policy or process necessary to fulfill the terms of this contract, the Contractor must work with AHCCCS to adopt a policy or procedure within a time period specified by AHCCCS.

18. MEMBER INFORMATION

The Contractor shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by the Contractor, shall be approved by AHCCCS prior to distribution to members. The reading level and name of the evaluation methodology used shall be included. The Contractor should refer to the ACOM Draft Policy

404 for further information and requirements. See also Attachment B2, CRS Program Contractor's Chart of Deliverables.

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10%, whichever is less, of the Contractor's members, who also have Limited English Proficiency (LEP).

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

All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5%, whichever is less, of the Contractor's members speak that language and have LEP [42 CFR 438.10(c)(3)].

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

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

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

The Contractor has the option of providing each new member/representative or household the Member Handbook and Network Description/Provider Directory with the new member packet in hardcopy format, or providing written notification that the information is available on the Contractor's website, by electronic mail or by postal mailing. The information shall be available within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]. Should the Contractor elect not to provide the hard copy, the contents of the written notification must be approved per the requirements listed in ACOM Draft Policy 404.

The Member Handbook, at a minimum, shall include the items listed in the ACOM Draft Policy 404. The Contractor shall review and update the Member Handbook at least once a year. The Handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to being made available to members.

In addition, the Member Handbook shall provide a description of the Contractor's provider network, which at a minimum, includes those items listed in the ACOM Draft Policy 404.

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

The Contractor must develop and distribute, at a minimum, semi-annual newsletters during the contract year. The following types of information are to be contained in the newsletter:

1. Educational information on chronic illnesses and ways to self-manage care
2. Reminders of flu shots and other prevention measures at appropriate times

3. Medicare Part D issues
4. Cultural Competency, other than translation services
5. Contractor specific issues (in each newsletter)
6. Tobacco cessation information
7. HIV/AIDS testing for pregnant women
8. Other information as required by AHCCCS

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

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

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

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

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

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

19. SURVEYS

The Contractor is required to perform an annual survey. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. If the survey tool is developed by the Contractor, this survey shall include questions related to access to care including appointment waiting time. The final survey tool shall be approved in advance by AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The results and the analysis of the results shall be submitted to the Division of Health Care Management as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. Survey results should be reported separately by Title XIX and Title XXI categories and in aggregate. The Contractor shall utilize member survey findings to improve care for Title XIX and Title XXI members.

For non-AHCCCS required surveys, the Contractor shall provide notification as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, sampling methodology, distribution methodology, project timeline and a copy of the survey. Survey results should be reported separately by Title XIX and Title XXI categories and in aggregate. 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 shall be submitted to the Division of Health Care Management as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

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

As specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, the Contractor is required to survey a sample of its membership that have received services to verify that services the Contractor paid for were delivered as outlined in ACOM Policy 424 [42 CFR 455.20 and 433.116].

20. CULTURAL COMPETENCY

The Contractor shall ensure compliance with a Cultural Competency Plan which meets the requirements of the ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the DHCM Operations Unit, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. This plan shall address cultural considerations and limited English proficiency for all services and settings [42 CFR 438.206(c)(2)].

21. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers. Each member is entitled to one copy of his or her medical record at no cost annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

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

The Contractor shall have written policies and procedures for the maintenance of medical records to ensure those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment. For care coordination purposes, medical records must be shared with other care providers, such as the multi-specialty interdisciplinary team.

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

The Contractor shall have written policies and procedures to ensure that the MSIC has an integrated electronic medical record for each member that is maintained and available for the multi-specialty treatment team and community providers. An integrated electronic medical record shall contain all information necessary to facilitate the coordination and quality of care delivered by multiple providers in multiple locations at varying times.

The CRS Contractor shall retain medical records in compliance with A.R.S. §12-2291 and 2297, which requires, among other things, that children's medical records be retained for at least three (3) years after the child's eighteenth (18th) birthday or for at least six (6) years after the last date the child received medical or health care services from the Provider, whichever date occurs later.

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

AHCCCS is not required to obtain written approval from a member before requesting the member's medical record from the PCP or any other organization or agency. The Contractor may obtain a copy of a member's

medical records without written approval of the member if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request or more quickly if necessary.

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 substance abuse information shall only be disclosed consistent with federal and State law, including but not limited to 42 CFR 2.1 et seq.

22. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing advanced directives for adult members as specified in 42 CFR 422.128:

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

2. The Contractor shall require PCPs, which have agreements with the entities described above, to comply with the requirements of subparagraphs 1 (a) through (e) above. The Contractor shall also encourage health care providers specified in subparagraph a. to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

3. The Contractor shall provide written information to adult members that describe the following:
    a. A member's rights under State law, including a description of the applicable State law;
    b. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
    c. The member's right to file complaints directly with AHCCCS; and
    d. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)].

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

The Contractor shall provide quality medical care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement (QM/PI) processes. The Contractor shall execute processes to assess, plan, implement, and evaluate QM/PI activities [42 CFR

438.240]. At a minimum, the Contractor's QM/PI programs shall comply with the requirements outlined in the AMPM Chapters 400 and 900. See also Attachment B2, CRS Program Contractor's Chart of Deliverables.

The Contractor must ensure that the QM/PI Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Case Management. The Contractor is expected to integrate quality management processes, such as tracking and trending of issues, throughout all areas of the organization. Ultimate responsibility for QM/PI activities resides within the QM/PI Unit.

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

Federal regulation 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider–Preventable Condition (OPPC) (refer to AMPM Chapter 900 requirements). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.

Quality Management Program

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

1. A written QM/PI plan and an evaluation of the previous year's QM/PI program;
2. Quality management quarterly reports that address strategies for QM/PI activities;
3. QM/PI program monitoring and evaluation activities which include Peer Review and Quality Management Committees which are chaired by the Contractor's local Chief Medical Officer;
4. Protection of medical records and any other personal health and enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements;
5. Member rights and responsibilities;
6. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational assessment verification [42 CFR 438.206(b)(6)]. 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 438.214]. The Contractor should refer to the AMPM and Attachment B2, CRS Program Contractor's Chart of Deliverables for reporting requirements. The process:
    a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credentialing verification of providers who have signed contracts or participation agreements with the Contractor;
    b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
    c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
7. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation and unexpected deaths. The resolution process must include:
    a. Acknowledgement letter to the originator of the concern;
    b. Documentation of all steps utilized during the investigation and resolution process;
    c. Follow-up with the member to assist in ensuring immediate health care needs are met;
    d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all

covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;

e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern; and
f. Analysis of the effectiveness of the interventions taken.

8. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs;
9. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO); and
10. Performance improvement programs including performance measures and performance improvement projects.

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

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall calculate and report to AHCCCS a completion percentage. This percentage is calculated by dividing the number of complete applications processed (approved/denied) during the time period by the number of complete applications that were received during the time period.

The standards for processing are listed by category below:

Type of Credentialing	14 days	90 days	120 days	180 days
Provisional	100%			
Initial		90%	95%	100%

The Contractor must report the credentialing information with regard to all credentialing applications as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

***Quality Improvement*:** The Contractor's quality management program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care which are expected to have a favorable effect on health outcomes and member satisfaction. The Contractor must [42 CFR 438.240(b)(2) and (c)]:

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

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

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

Performance Measures

The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures can be found in the most recently published reports of acute care Performance Measures located on the AHCCCS website. The EPSDT Participation performance measure description utilizes the methodology established in CMS "Form 416" which can also be found on the AHCCCS website at:

http://www.azahcccs.gov/reporting/quality/performancemeasures.aspx.

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

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

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

The Contractor must meet AHCCCS stated Minimum Performance Standards (MPS) for each population/eligibility category for which AHCCCS reports results. It is equally important that, in addition to meeting the contractual MPS, the Contractor continually improve performance measure outcomes from year to year. The Contractor shall strive to meet the goal established by AHCCCS.

Minimum Performance Standard – MPS is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to a sanction of up to $100,000 dollars for each deficient measure.

Goal – If the Contractor has already met or exceeded the AHCCCS MPS for any measure, the Contractor must strive to meet the established goal for the measure(s).

A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically significant

improvement in a measure rate. AHCCCS may require the Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan and may sanction any Contractor that shows a statistically significant decrease in its rate even if it meets or exceeds the MPS.

An evidence-based corrective action plan must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up desktop or on-site reviews to verify compliance with a corrective action plan.

All Performance Measures apply to all member populations [42 CFR 438.240(a)(2), (b)(2) and (c)]. AHCCCS may analyze and report results by line of business, Geographical Service Area (GSA), or County, as well as applicable demographic factors.

AHCCCS has established standards for the measures listed below.

The following table identifies the MPS and Goals for each measure:

CRS Performance Measures:

Performance Measure	**Minimum Performance Standard (MPS)**	**Goal**
Timeliness of Initial Service Plan Development	95%	100%
Initiation of Services (within 30 days)	75%	90%
Access to Behavioral Health Provider (encounter for a visit) within **7** days of being designated as "active care" for an initial visit	75%	85%
Access to Behavioral Health Provider (encounter for a visit) within **23** days of being designated as "active care" for an initial visit	90%	95%
Children's Access to PCPs, by age: ***12-24 mo.***	93%	97%
Children's Access to PCPs, by age: ***25 mo.- 6 yrs.***	84%	90%
Children's Access to PCPs, by age: ***7 - 11 yrs.***	83%	90%
Children's Access to PCPs, by age: ***12 - 19 yrs.***	82%	90%
Well-Child Visits: ***15 mo.***	65%	90%
Well-Child Visits: ***3 - 6 yrs.***	66%	80%
Adolescent Well-Child Visits: ***12–21 yrs.***	41%	50%
Children's Dental Visits (ages **2-21**)	65%	75%
EPSDT Participation	68%	80%

EPSDT Dental Participation	46%	54%
Emergency Department (ED) Utilization* (visits/1,000)	TBD	TBD
Inpatient Utilization* (days/1,000)	TBD	TBD
Hospital (All Cause) Readmission Rate	<13%	<11%
CAHPS Health Plan Survey 4.0, Child Version including Medicaid and Children with Chronic Conditions supplemental items*	TBD	TBD
Childhood Immunization Status		
DTaP	85%	90%
IPV (1)	91%	95%
MMR (1)	91%	95%
Hib (1)	90%	95%
HBV (1)	90%	95%
VZV (1)	88%	95%
PCV (1)	82%	95%
4:3:1:3:3:1 Series	74%	80%
4:3:1:3:3:1:4 Series	68%	80%
Hepatitis A (HAV)	40%	60%
Rotovirus	60%	80%
Influenza	45%	80%
Immunizations for Adolescents		
Adolescent Meningococcal	75%	90%
Adolescent Tdap	75%	90%
Adolescent Combo	75%	90%

***Notes*:**

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

(1) AHCCCS will continue to measure and report results of these individual antigens; however, a Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.

Rates by Contractor for each measure will be compared with the MPS specified in the contract in effect during the measurement period; Performance Standards in the CYE 14 contract apply to results calculated by AHCCCS for the CYE 14 measurement period.

Contractor performance is evaluated annually on the AHCCCS-reported rate for each measure. Rates for measures that include only members less than 21 years of age are reported and evaluated separately for Title XIX and Title XXI eligibility groups.

The Contractor shall participate in immunization audits, at intervals specified by AHCCCS, based on random sampling to verify the immunization status of members at 24 months of age and by 13 years of age. If records are missing for more than 5 percent of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS. An EQRO may conduct a study to validate the Contractor's reported rates.

AHCCCS will measure and report the Contractor's EPSDT Participation Rate, utilizing the CMS 416 methodology. The Contractor must take affirmative steps to increase EPSDT Participation rates, including the EPSDT Dental Participation Rate. The Contractor is required to improve dental participation rates, as specified in the Performance Measure table, by 10 percentage points by 2015 (compared to 2011 rates).

The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. The Contractor must implement processes to reduce non-medically necessary elective or induced deliveries prior to 39 weeks gestation.

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

***Data Collection Procedures*:** When requested by AHCCCS, the Contractor must submit data for standardized Performance Measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data and using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or PIPs must be returned by the Contractor in a format specified by AHCCCS, and by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date and is subject to approval by AHCCCS. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

24. MEDICAL MANAGEMENT (MM)

The Contractor shall implement processes to assess, plan, implement, evaluate, and as mandated, report Medical Management (MM) monitoring activities as specified in the AMPM Chapter 1000. This shall include the Quarterly Inpatient Hospital Showings report, HIV Specialty Provider List, Transplant Report and Prior Authorization Requirements report as specified in the AMPM and Attachment B2, CRS Program Contractor's Chart of Deliverables. The Contractor shall evaluate Medical Management (MM) activities, as specified in the AMPM Chapter 1000, including:

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer.
2. Prior authorization and Referral Management; for the processing of requests for initial and continuing authorizations of services the Contractor shall:
    a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions
    b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)]
    c. Monitor and ensure that all enrollees with special health care needs have direct access to care
    d. Review all prior authorization requirements for services, items or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for those changes must be included in the annual MM/UM Plan and Evaluation submission and
    e. Comply with all decision timelines as outlined in the ACOM and the AMPM.

3. Development and/or Adoption of Practice Guidelines [42 CFR 438.236(b)] that:
    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field

b. Consider the needs of the Contractor's members
c. Are adopted in consultation with contracting health care professionals
d. Are reviewed and updated periodically as appropriate
e. Are disseminated by the Contractor to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)] and
f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].

4. Concurrent review:
   a. Consistent application of review criteria; provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply;
   b. Contractors must have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into acute care 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; and
   c. In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider–Preventable Condition (OPPC) (refer to AMPM Chapter 1000). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.
5. Continuity and coordination of care:
   a. Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
   b. Establish a process for timely and confidential communication of clinical information among providers;
   c. Must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management;
   d. Meet regularly with the CMDP and DES/DDD Contractors to improve and address coordination of care issues. Meetings shall occur at least quarterly or more frequently if needed; and
6. Monitor and evaluate over and/or underutilization of services [42 CFR 438-240(b)(3)];
7. Evaluate new medical technologies, and new uses of existing technologies; and
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee.

AHCCCS will provide the Contractor with three years of historical encounter data during CYE 14 for all members enrolled with the Contractor, for all CRS coverage types, for medical management purposes.

On a recurring basis, AHCCCS shall provide the Contractor a claims data file of encounter data for members enrolled with the Contractor that have received services through CMDP and DES/DDD for the purposes of member care coordination. The Contractor shall develop a plan outlining short- and long-term strategies for improving care coordination using the CMDP data and/or DES/DDD data provided (see Section D, Paragraph 64, Systems and Data Exchange Requirements). 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 must be reported in the annual MM/UM Plan and Evaluation submitted to AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM Committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the Committee. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438.240(b)(4)].

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

The Contractor shall maintain a written MM plan and work plan that addresses the monitoring of MM activities (AMPM Chapter 1000). The plan and work plan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

25. TELEPHONE PERFORMANCE STANDARDS

The Contractor must meet and maintain established telephone performance standards to ensure member and provider satisfaction as specified in ACOM Draft Policy, Telephone Performance Standards Measurement and Reporting. The Contractor shall report on compliance with these standards as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables and the policy identified above. All reported data is subject to validation through periodic audits and/or operational reviews.

26. GRIEVANCE SYSTEM

The Contractor shall have in place a written grievance system process for subcontractors, enrollees and non-contracted providers, which define their rights regarding disputed matters with the Contractor. The Contractor's grievance system for enrollees includes a grievance process (the procedures for addressing enrollee grievances), an appeals process and access to the State's fair hearing process as outlined in Attachment A1, Enrollee Grievance System Standards. The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Attachment A2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Attachments A1, Enrollee Grievance System Standards A2, Provider Claim Dispute Standards, and 42 CFR Part 438 Subpart F.

Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 18, Member Information and Paragraph 20, Cultural Competency.

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

The Contractor may delegate the grievance system process to subcontractors, however, the Contractor must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a State fair hearing, the method for obtaining a State fair hearing, the rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or State fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished

during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent.

The Contractor must provide reports on the Grievance System as required in the AHCCCS Grievance System Reporting Guide available on the AHCCCS website. See also Attachment B2, CRS Program Contractor's Chart of Deliverables.

27. NETWORK DEVELOPMENT

The Contractor shall develop and maintain a provider network that is supported by written agreements which is sufficient to provide all covered services to AHCCCS members. The Contractor shall ensure covered services are reasonably 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 norms. Services shall be as accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those services are available to non-AHCCCS persons within the same service area [42 CFR 438.210(a)(2)]. The Contractor is encouraged to have available non-emergent after-hours physician or primary care services within its network. If the Contractor's network is unable to provide medically necessary services required under contract, the Contractor must adequately and timely cover these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. 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 Arizona Administrative Code R9-7-202, to ensure a reduction in the 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.

Covered services shall be delivered through a combination of established Multi-Specialty Interdisciplinary Clinics (MSICs), Field Clinics, Virtual Clinics, and in community settings. Field Clinics are provided by specialty providers who travel to locations closer to the homes of members who are not conveniently located near MSICs. Virtual Clinics may also be implemented where treatment team members in community settings collaborate and conduct treatment planning through the use of Telemedicine using an Integrated Medical Record. The CRS Contractor shall also include primary care, dental and other specialty providers throughout the State. Regardless of the setting, the CRS Contractor shall develop and implement organizational structures and procedures that promote collaboration and consultation among multi-specialty treatment team members and community providers.

The Contractor shall also contract with at least one (1) MSIC site in Maricopa County, at least one (1) MSIC site in Pima County, at least one (1) MSIC site in the Prescott/Sedona/Flagstaff area, and at least one (1) MSIC site in the Yuma area.

The Contractor's network shall also include:

- Physicians (including adult and child psychiatrists), laboratory, x-ray and therapy services available onsite at the MSIC or through a network of community-based providers closer to members' homes.
- Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State.
- Community-based, family support providers in urban, suburban and rural areas of the State.

There shall be sufficient personnel for the provision of covered services, including emergency medical care and psychiatric care on a 24-hour-a-day, seven-days-a-week basis [42 CFR 438.206(c)(1)(iii)].

The Contractor shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The requirements for the Network Development and Management Plan are found in ACOM Draft Policy 415. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

In accordance with the requirements specified in the ACOM Draft Policy, Acute Network Standards the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing within Pima and Maricopa counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through the Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Draft Policy Acute Network Standards.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [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 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs and quality consistent with its responsibilities under this contract nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. 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 438.12(a)(1)]. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services.

The Contractor is also encouraged to develop non-financial incentive programs to increase participation in its provider network.

AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the State of Arizona. AHCCCS expects the Contractor to support these efforts. AHCCCS encourages plans to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in Contractor medical management and committee activities. In the event of a contract termination between the Contractor and a 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. AHCCCS reserves the right to determine what constitutes risk to the program. Further, the Contractor must attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas.

Telemedicine/Virtual Clinics: The Contractor shall be responsible for the oversight, administration and implementation of telemedicine/virtual clinic services and use of telemedicine equipment in compliance with State and federal laws and the requirements of this Contract and all incorporated references. The Contractor shall ensure that telemedicine 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 telemedicine services, when indicated and appropriate. Telemedicine should include the delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.

Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services. Contracts must stipulate that:

1. Only those members who request a homeless clinic as a PCP may be assigned to them; and
2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization, and resolving claims issues.

28. PROVIDER AFFILIATION TRANSMISSION

Quarterly, the Contractor must submit information regarding its provider network. This information must be submitted in the format described in the Provider Affiliation Transmission (PAT) User Manual as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The PAT User Manual may be found on the AHCCCS website. The provider affiliation transmission must be timely, accurate, and complete or the Contractor may be required to submit a corrective action plan.

29. NETWORK MANAGEMENT

The Contractor shall have policies on how the Contractor will [AMPM, 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 AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
c. Evaluate the quality of services delivered by the network;
d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
f. 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 30 business days of receipt (this includes referrals from AHCCCS).

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

The Contractor shall hold a Provider Forum no less than quarterly. 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 including dental providers. 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 AHCCCS upon request. The Contractor shall report information discussed during these Forums to Executive Management within the organization.

Material Change to Provider Network

All material changes in the Contractor's provider network that are initiated by the Contractor must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. The Contractor must submit the request for approval of a material change in their provider network, including draft notification to affected members, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. AHCCCS will respond to the Contractor within 30 days. A material change in the Contractor's provider network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

The Contractor shall notify AHCCCS, Division of Health Care Management, of any unexpected changes that would impair its provider network, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables [42 CFR 438.207 (c)]. This notification shall include (1) information about how the provider network change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

See Section D, Paragraph 55, capitation adjustments regarding material changes by the Contractor that may impact capitation rates.

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

Provider Termination Report: The Contractor must submit a Quarterly Provider Terminations Due to Rates Report as described in ACOM Draft Policy 415 and Attachment B2, CRS Program Contractor's Chart of Deliverables.

30. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)].

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

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCPs with assigned members diagnosed with AIDS or as HIV positive, shall meet criteria and standards set forth in the AMPM.

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

The Contractor shall ensure that primary care services are available and accessible statewide in the communities in which CRS 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 setting in addition to those specialty and multi-disciplinary services that are available through the MSIC.

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m) and 438.52(d) and this contract. The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. See ACOM Draft Policy 404.

At a minimum, the Contractor shall hold the PCP responsible for the following activities [42 CFR 438.208(b)(1)]:

a. Supervising, coordinating and providing care to each assigned member (except for 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 AHCCCS approved EPSDT Tracking form;
f. Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider; and
g. If serving children, for enrolling as a Vaccines for Children (VFC) provider.

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.

31. MATERNITY CARE PROVIDER STANDARDS

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

a. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers who provide maternity care services
b. Physician Assistants
c. Nurse Practitioners
d. Certified Nurse Midwives

e. Licensed Midwives

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide 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 OB hospital privileges. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may be provided in the member's home by physicians, nurse practitioners, and certified nurse midwives who include such services within their practice.

32. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

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

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

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

a. Clinical laboratory services
b. Physical therapy services
c. Occupational therapy services
d. Radiology services
e. Radiation therapy services and supplies
f. Durable medical equipment and supplies
g. Parenteral and enteral nutrients, equipment and supplies

h. Prosthetics, orthotics and prosthetic devices and supplies
i. Home health services
j. Outpatient prescription drugs
k. Inpatient and outpatient hospital services

33. APPOINTMENT STANDARDS

The Contractor shall monitor appointment availability utilizing the methodology found in the ACOM Draft Policy 417. For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. The Contractor shall have procedures in place that ensure the following standards are met.

For ***Primary Care Appointments***, the Contractor shall be able to provide:

a. Emergency appointments the same day or within 24 hours of the member's phone call or other notification
b. Urgent care appointments within 2 days of request
c. Routine care appointments within 21 days of request

For ***Specialty Referrals***, the Contractor shall be able to provide:

a. Emergency appointments within 24 hours of referral
b. Urgent care appointments within 3 days of referral
c. Routine care appointments within 45 days of referral

For ***Dental Appointments***, the Contractor shall be able to provide:

a. Emergency appointments within 24 hours of request
b. Urgent care appointments within 3 days of request
c. Routine care appointments within 45 days of request

For ***Maternity Care***, the Contractor shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:

a. First trimester - within 14 days of request
b. Second trimester - within 7 days of request
c. Third trimester - within 3 days of request
d. High risk pregnancies - within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

For ***Behavioral Health***, the Contractor shall be able to provide:

a. Emergency appointments the same day or within 24 hours of the referral or request
b. Urgent care appointments for CMDP enrolled members no later than 72 hours after notification by DES/CPS that a child has been or will be removed from their home
c. Appointment for initial services within 7 days of referral
d. Appointment for ongoing services within 23 days of initial appointment
e. The monitoring results as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

The Contractor shall actively monitor provider compliance with appointment standards as required in ACOM Draft Policy 417.

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

For medically necessary non-emergent transportation**,** the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. Also see Section D, Paragraph 11, Special Health Care Needs. The Contractor must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

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

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

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

34. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs)

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

For FQHC and FQHC Look-Alike pharmacies, all drugs identified in the 340B Drug Pricing Program are required to be billed at the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price. These drugs shall be reimbursed at the lesser of the two amounts above plus a dispensing fee. See AHCCCS rule R9-22-710 (C) for further details.

The Contractor is required to submit member information for Title XIX and Title XXI members for each FQHC/RHC/FQHC Look-Alikes as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. AHCCCS will perform periodic audits of the member information submitted. The Contractor should refer to the AHCCCS Financial Reporting Guide for the CRS Contractor with the Arizona Health Care Cost Containment System for further guidance. The FQHCs/RHCs/FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website.

35. PROVIDER MANUAL

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

36. PROVIDER REGISTRATION

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 at:

http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx.

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

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

37. SUBCONTRACTS

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

All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

Administrative Services Subcontracts:

1. Delegated agreements that subcontract;
    a. Any function related to the management of the contract with AHCCCS,
    b. Claims processing, including pharmacy claims,
    c. Credentialing including those for only primary source verification (CVO).
2. All Management Service Agreements;
3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner.

The Contractor must ensure the integration of acute, behavioral, and specialty services within the following key functional areas of the organization or when utilizing administrative services subcontracts:

- Network Management/Provider Relations;
- Member Services;
- Quality Management;
- Medical Management;
- Finance;
- Claims/Encounters;
- Information Services; and
- Grievance System.

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

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

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. In order to determine adequate performance, the Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

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

The Contractor must submit the Administrative Services Annual Subcontractor Assignment and Evaluation Report as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, detailing any Contractor duties or responsibilities that have been subcontracted as described under Administrative Services Subcontracts previously in this section. The Administrative Services Annual Subcontractor Assignment and Evaluation Report will include the following:

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

If the subcontractor is in significant non-compliance with the subcontract, the Contractor shall notify AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The Contractor will submit this in writing and provide the corrective action plan and any measures taken by the Contractor to bring the subcontractor into compliance.

Provider Agreements: 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 AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

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

anticipated to continue providing services for the Contractor. The Contractor must follow ACOM Draft Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the adequacy of its network.

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

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

All subcontracts must reference and require compliance with the Minimum Subcontract Provisions. See Section I, Exhibit B, Minimum Subcontract Provisions. In addition, each subcontract must contain the following:

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

38. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes that ensure the correct collection and processing of claims, analyzes, integrates, and reports data. The processes shall result in information on areas including, but not limited to, service utilization, claim disputes and appeals [42 CFR 438.242(a)].

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

a. Medicaid Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services;
b. Multiple Procedure/Surgical Reductions;
c. Global Day E & M Bundling standards.

The Contractor claims payment system must 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 AHCCCS Policy;
e. Provider Qualifications;
f. Member Eligibility and Enrollment;
g. Over-Utilization Standards.

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

a. The reasons for denials and adjustments;
b. An adequate description of all denials and adjustments;
c. The amount billed;
d. The amount paid;
e. Application of COB and copays;
f. Provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. See Section D, Paragraph 64, Systems and Data Exchange Requirements, for specific standards related to remittance advice and EFT payment.

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

Per A.R.S. §36-2904, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than six months after the end date of service, inpatient claim date of discharge or date of eligibility posting whichever is later, or pay a clean claim submitted more than 12 months after date of service; except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. §36-2904.

Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

In accordance with the Deficit Reduction Act of 2005, Section 6085, the Contractor is required to reimburse non-contracted emergency services providers at the AHCCCS Fee-For-Service rate. This applies to in State as well as out of State providers.

In accordance with A.R.S. §36-2903 and §36-2904, in the absence of a written negotiated rate and when directed out of network by the Contractor, the Contractor is required to reimburse non-contracted non-emergent in State providers at the AHCCCS fee schedule and methodology, or pursuant to A.R.S. §36-2905.01, at 95% of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

Effective 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 late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of 10% per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a Contractor shall apply quick pay discounts and slow payment penalties, when appropriate, in accordance with A.R.S. §2903.01. When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Manual.

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

Any individual recoupment in excess of $50,000 per provider, or Tax Identification Number within a contract year or greater than 12 months after the date of the original payment must be approved as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables and, as further described in the ACOM Draft Policy 412. Upon submission of a request for approval, AHCCCS will respond within 30 days of the recoupment request.

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

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

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

Appeals: If the Contractor or a Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's

Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

Claims Processing Related Reporting: The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide and Attachment B2, CRS Program Contractor's Chart of Deliverables.

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

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

a. Verification that provider contracts are loaded correctly
b. Accuracy of payments against provider contract terms

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

In addition, in the event of a system change or upgrade, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, the Contractor may also be required to initiate an independent audit of the Claim Payment/Health Information System. The Division of Health Care Management will approve the scope of this audit, and may include areas such as a verification of eligibility and enrollment information loading, contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

Recovery Audit Contractor (RAC) Audits: A Recovery Audit Contractor (RAC) is a private entity that is contracted to identify underpayments and overpayments, and to recoup overpayments made to providers. The Affordable Care Act of 2010 required States to establish Medicaid RAC programs. CMS promulgated rules regarding the implementation of the Medicaid RAC requirements (42 CFR 455.500 et seq.), including the provision that Medicaid RACs are only required to review fee-for-service claims until a permanent Medicare managed care RAC program is fully operational or a viable State managed care model is identified and CMS undertakes rules regarding managed care RAC efforts.

AHCCCS is exploring what opportunities may exist in the marketplace regarding a methodology for conducting a recovery audit of its services delivered through its managed care contracts (excluding reinsurance). The Contractor shall participate in any RAC activities mandated by AHCCCS, via contract amendment or policy, upon determination of the method of approach.

39. SPECIALTY CONTRACTS

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

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty Contractors to enhance the cost effectiveness of service delivery, medical management, and adjudication of claims related to payments provided under specialty contracts shall remain the responsibility of the Contractor. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

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

40. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

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

All Counties <u>EXCEPT</u> Maricopa and Pima: The Contractor shall reimburse hospitals for member care in accordance with AHCCCS rule R9-22 Article 7. The Contractor is encouraged to obtain subcontracts with hospitals in all GSAs. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

For Out-of-State Hospitals: The Contractor shall reimburse out of State hospitals in accordance with R9-22 Article 7. A Contractor serving border communities (excluding Mexico) is strongly encouraged to establish contractual agreements with those out of State hospitals that are identified by GSA in ACOM Draft Policy, Acute Network Standards.

Outpatient Hospital Services: In the absence of a contract, the default payment rate for outpatient hospital services billed on a UB-04 will be based on the AHCCCS outpatient hospital fee schedule pursuant to A.R.S. §36-2904.

Hospital Recoupments: The Contractor may conduct prepayment and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Contractor fails to identify lack of medical necessity through concurrent review and/or prepayment medical review, lack of medical necessity identified during post-payment medical review shall not constitute a basis for recoupment by the Contractor. See also Section D, Paragraph 38, Claims Payment/Health Information System. For a more complete description of the guidelines for hospital reimbursement, please consult the applicable statutes and rules.

41. RESPONSIBILITY FOR NURSING FACILITY REIMBURSEMENT

The Contractor shall provide medically necessary nursing facility services as outlined in Section D, Paragraph 10, Scope of Services. The Contractor shall also provide medically necessary nursing facility services for any enrolled member who has a pending ALTCS application who is currently residing in a nursing facility and is eligible for services provided under this contract. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days per contract year of nursing facility coverage, the Contractor is only responsible for nursing facility reimbursement during the time the member is enrolled with the Contractor as shown in the PMMIS. Nursing facility services covered by another liable party (including Medicare) while the member is enrolled with the Contractor, shall be applied to the 90 day per contract year limitation.

The Contractor shall not deny nursing facility services when the member's eligibility, including prior period coverage, had not been posted at the time of admission. In such situations the Contractor shall impose reasonable authorization requirements. There is no ALTCS enrollment, including prior period coverage, that occurs concurrently with AHCCCS acute enrollment.

The Contractor shall notify the Assistant Director of the Division of Member Services when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days as specified in Section D, Paragraph 10, Scope of Services, under the heading *Nursing Facility.* This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential fee-for-service coverage if the stay goes beyond the 90 day per contract year maximum.

42. INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives

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

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

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

1. A complete copy of the contract;
2. A plan for the member satisfaction survey;
3. Details of the stop-loss protection provided; and
4. A summary of the compensation arrangement that meets the substantial financial risk definition.

The Contractor shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

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

Any Contractor-selected and/or developed pay for performance initiative that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management prior to implementation.

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made.

If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 37, Subcontracts and as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

44. MATERIAL CHANGE TO OPERATIONS

A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol, such as prior authorization or retrospective review) which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this contract. It also includes any change that would impact more than 5% of total membership and/or provider network in a specific GSA.

The Contractor must submit the request for approval of a material change to operations, including draft notification to affected members and providers, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. The request should contain, at a minimum, information regarding the nature of the operational change; the reason for the change; methods of communication to be used; and the anticipated effective date. AHCCCS will respond to the Contractor within 30 days. A material change in Contractor operations requires 30 days advance written notice to affected providers and members. The requirements regarding material changes to operations do not extend to contract negotiations between the Contractor and a provider.

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

45. MINIMUM CAPITALIZATION

The Contractor is required to meet a minimum capitalization requirement within 30 days after contract award. Details regarding this requirement are included in AHCCCS' solicitation, released prior to the expiration of the current contract period. 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 50, Financial Viability Standards.

46. 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 AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Contractor's obligations to providers, and (2) performance by the Contractor of its obligations under this contract [42 CFR 438.116]. The Performance Bond shall be in a form acceptable to AHCCCS. See ACOM Draft Policy 306.

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

a. Paying any damages sustained by providers, non-contracting providers and non-providers by reason of a breach of the Contractor's obligations under this contract;
b. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and
c. Reimbursing AHCCCS for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the State by AHCCCS.

In the event AHCCCS agrees to accept substitute security in lieu of the security types outlined in ACOM Draft Policy 306, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce AHCCCS' security interest in such substitute security including, but not limited to, security agreements and necessary UCC filings pursuant to the Arizona Uniform Commercial Code. The Contractor must request approval from AHCCCS before a substitute security in lieu of the security types outlined in the ACOM Draft Policy 306 is established. In the event such substitute security is agreed to and accepted by AHCCCS, the Contractor acknowledges that it has granted AHCCCS a security interest in such substitute security to secure performance of its obligations under this contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. AHCCCS may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide AHCCCS with a form of security described in ACOM Draft Policy 306.

The Contractor may not change the amount, duration or scope of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. The Contractor shall not leverage the bond for another loan or create other creditors using the bond as security.

47. 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 AHCCCS. The total capitation amount excludes premium tax. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall review the capitation amounts of the Contractor on a monthly basis to determine if the Performance Bond must be increased. The Contractor shall have 30 days following notification by AHCCCS 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 AHCCCS. The Contractor may not change the amount of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. Refer to ACOM Draft Policy 305 for more details.

48. 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 AHCCCS. The capital contributions must be for the period in which the deficit is reported and shall occur within 30 days of the financial statement due to AHCCCS. AHCCCS at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. AHCCCS may, at its option, impose enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

49. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line of business within its organization. The Contractor shall not, without prior approval of AHCCCS, make loans or advances to providers in excess of $50,000. All requests for prior approval are to be submitted to the AHCCCS, Division of Health Care Management, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. Refer to the ACOM Policy 418 for further information.

50. FINANCIAL VIABILITY STANDARDS

The Contractor must comply with the AHCCCS-established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: current ratio; equity per member; medical expense ratio; and the administrative cost percentage.

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

FINANCIAL VIABILITY STANDARDS

Current Ratio

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

Standard: At least 1.00

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

Equity per Member

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

Standard: At least $260 per member for CYE 2014
At least $320 per member for CYE 2015
At least $370 per member for CYE 2016 and thereafter

Additional information regarding the Equity per Member requirement may be found in the Performance Bond and Equity per Member Requirements policy in the ACOM Draft Policy 305.

Medical Expense Ratio	Total medical expenses less TPL divided by the sum of total capitation + reconciliation settlements + Reinsurance less premium tax *Standard: At least 85%*
Administrative Cost Percentage	Total administrative expenses divided by the sum of total capitation + reconciliation settlements + Reinsurance less premium tax *Standard: No greater than 13%*

The Contractor shall comply with all financial reporting requirements contained in Attachment B2, Contractor's Chart of Deliverables and the AHCCCS Financial Reporting Guide for the CRS Contractor with the Arizona Health Care Cost Containment System, a copy of which may be found on the AHCCCS website. The required reports are subject to change during the contract term and are summarized in Attachment B2, Contractor's Chart of Deliverables.

51. SEPARATE INCORPORATION

Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract.

52. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP

A proposed merger, reorganization or change in ownership of the Contractor shall require prior approval of AHCCCS, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, and may require a contract amendment. AHCCCS may terminate this contract pursuant to Section E2, Contract Terms and Conditions, Paragraph 44, Temporary Management/Operation of a Contractor and Termination.

The Contractor must submit notification to AHCCCS, Division of Health Care Management, of a merger, reorganization or change of ownership at least 180 days prior to the effective date. The Contractor must also submit a detailed merger, reorganization and/or transition plan to AHCCCS, Division of Health Care Management, for review at least 90 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 maintain and support the contract requirements, and to ensure that services to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by such merger, reorganization or change in ownership.

53. COMPENSATION

The method of compensation under this contract will be Prior Period Coverage (PPC) capitation, prospective capitation, and reinsurance, as described and defined within this contract and appropriate laws, regulations or policies.

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

a. Utilization and unit cost data derived from adjudicated encounters
b. Both audited and unaudited financial statements reported by the Contractor
c. Market basket inflation trends
d. AHCCCS fee-for-service schedule pricing adjustments
e. Programmatic or Medicaid covered service changes that affect reimbursement
f. Other changes to medical practices or administrative requirements that affect reimbursement

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. Risk factors that may be considered in capitation rate development include:

a. Reinsurance (as described in Section D, Paragraph 57, Reinsurance)
b. Age/Gender
c. Medicare enrollment
d. Geographic Service Area adjustments
e. Risk sharing arrangements for specific populations
f. Member specific statistics, e.g. member acuity, member diagnosis, etc.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan; however those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)].

In instances in which 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.

Prospective Capitation: The Contractor will be paid capitation to cover the costs of providing medically necessary covered services to members during the prospective period coverage, as follows:

- Coverage types CRS Fully Integrated and CRS Partially-Integrated – Acute: Capitation will be paid for all prospective member months, including partial member months. The Contractor will be paid monthly and weekly capitation.
- Coverage types CRS Partially-Integrated – BH and CRS Only: Capitation will be paid for all prospective member months, including partial member months. The Contractor will be paid monthly capitation, which will include a reconciliation of the prior month's member months.

Prior Period Coverage (PPC) Capitation: Prior period coverage for CRS will only occur when a Title XIX CRS enrolled member loses eligibility and then regains eligibility within 12 months, resulting in re-enrollment with the CRS Contractor. The Contractor will be reimbursed for PPC expenses incurred for providing medically necessary covered services to members during prior period coverage. The reimbursement will be included in the prospective capitation described above.

Reconciliation of Costs to Reimbursement: AHCCCS will reconcile the Contractor's medical cost expenses to net capitation paid to the Contractor. Refer to the ACOM Draft Policy 312. This reconciliation will limit the Contractor's profits and losses as follows:

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 3%	100%	0%	3%	3%
> 3% and <= 6 %	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

Loss	MCO Share	State Share	Max MCO Loss	Cumulative MCO Loss
<= 3%	100%	0%	3%	3%
> 3%	0%	100%	0%	3%

Payment Reform – Shared Savings: Providers and payers in the health care industry are exploring new innovations that further drive improvements in cost control and quality improvement. AHCCCS anticipates that the Contractor will be required to participate in payment reform efforts during the term of this contract as delineated by AHCCCS in order to further these initiatives without penalizing the Contractor and providers for their innovative efforts. AHCCCS will provide details regarding the shared savings methodology no later than six months prior to the effective date of implementation.

State Only Transplants Option 1 and Option 2: The Contractor will only be paid capitation for an administrative component for those member months the member is enrolled with the Contractor. For Option 1 members the Contractor will be paid the administrative component up to a 12-month continuous period of extended eligibility. For Option 2 members the administrative component will be paid for the period of time the transplant is scheduled or performed. All medically necessary covered services will be reimbursed 100% with no deductible through Reinsurance payments based on adjudicated encounters.

54. PAYMENTS TO CONTRACTORS

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

Where payments are made by electronic funds transfer, AHCCCS shall not be liable for any error or delay in transfer or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor. 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 AHCCCS. 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 AHCCCS via a recoupment from future payment(s) to the Contractor, or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS must be notified and reimbursed within 30 days of identification.

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

55. CAPITATION ADJUSTMENTS

Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation during the contract period. AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions

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

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

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

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

a. Death of a member
b. Inmate of a public institution
c. Duplicate capitation to the same Contractor
d. Adjustment based on change in member's contract type
e. Voluntary withdrawal

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

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

Notifications must include:

- AHCCCS ID
- Name
- Date of Birth (DOB)
- When incarcerated
- Where incarcerated

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

Several counties are submitting daily files of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration. The Contractor will see the "IE" code for ineligible associated with the disenrollment. Upon

release from jail, the member will be re-enrolled with their previous Contractor. A member is eligible for covered services until the effective date of the member's "no-pay" status.

If a member is enrolled twice with the same Contractor, recoupment will be made as soon as the double capitation is identified. AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this contract.

56. MEMBER BILLING AND LIABILITY FOR PAYMENT

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

The Contractor must ensure that members are not held liable for:

a. The Contractor's or any subcontractor's debts in the event of Contractor's or the subcontractor's insolvency;
b. Covered services provided to the member except as permitted under R9-22-702; or,
c. Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly.

57. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services incurred for a member beyond an annual deductible level. AHCCCS is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates. Refer to the AHCCCS Reinsurance Processing Manual for further details on the Reinsurance Program.

The table below displays deductible and coinsurance levels. See specific case types below for coverage details.

Reinsurance Case Type	*Deductible*	*Coinsurance*	*Coverage Type*
Regular Reinsurance	$75,000	75%	CRS Fully Integrated CRS Partially-Integrated – Acute CRS Partially-Integrated – BH CRS Only
Catastrophic Reinsurance	NA	85%	CRS Fully Integrated CRS Partially-Integrated – Acute CRS Partially-Integrated – BH (limited applicability – see below) CRS Only (limited applicability – see below)
Transplant Reinsurance	See specific paragraphs below	See specific paragraphs below	CRS Fully Integrated CRS Partially-Integrated – Acute

Other Reinsurance	See specific paragraphs below	See specific paragraphs below	CRS Fully Integrated CRS Partially-Integrated – Acute CRS Partially-Integrated – BH CRS Only

Annual deductible levels apply to all members except for State Only Transplant members. Beginning October 1, 2014 and annually thereafter, the regular reinsurance deductible level displayed above may increase by $5,000.

PPC expenses are not covered for any members under the reinsurance program unless they qualify under catastrophic or transplant reinsurance.

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

Regular Reinsurance: Regular reinsurance covers partial reimbursement of covered inpatient facility medical services. Inpatient services are those services provided in an acute care hospital (provider type 02) and accredited psychiatric hospitals (provider type 71). This coverage applies to prospective enrollment periods. In certain situations as outlined in the AHCCCS Reinsurance Processing Manual, per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage. Same-day admit-and-discharge services do not qualify for reinsurance.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs, and those members diagnosed with hemophilia, non-DDAVP responding Von Willebrand's Disease, or Gaucher's Disease, as follows:

Biotech Drugs: Catastrophic reinsurance is available for all CRS coverage types to cover the cost of certain biotech drugs when medically necessary. The biotech drugs covered under reinsurance may be reviewed by AHCCCS at the start of each contract year. Refer to the Reinsurance Processing Manual for a complete list of the approved biotech drugs. When a generic equivalent of a biotech drug is available, AHCCCS will reimburse at the lesser of the biotech drug or its generic equivalent for reinsurance purposes, unless the generic equivalent is contra-indicated for a specific member.

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

- CRS Fully Integrated
- CRS Partially Integrated – Acute

Catastrophic reinsurance for members with hemophilia is not available for coverage types:

- CRS Partially integrated – BH
- CRS Only

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

- CRS Fully Integrated
- CRS Partially Integrated – Acute

Catastrophic reinsurance for members with von Willebrand's Disease is not available for coverage types:

- CRS Partially integrated – BH
- CRS Only

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

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

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

The Contractor must notify AHCCCS, DHCM, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually within 30 days of the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS.

All catastrophic claims are subject to medical review by AHCCCS.

Transplant Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the AMPM and the AHCCCS Reinsurance Processing Manual for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered or 85% of the Contractor's paid amount. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. The Contractor must notify AHCCCS, DHCM, Medical Management Unit when a member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS Medical Management Unit within 30 days of referral to the transplant facility for evaluation.

If a Contractor intends to use an out of State transplant facility for a covered transplant and AHCCCS already holds an in State contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. If no prior approval is obtained, and the Contractor incurs costs at the out of State facility, those costs will not be eligible for either transplant or regular reinsurance.

Option 1 and Option 2 Transplant Services: Reinsurance coverage for State Only Option 1 and Option 2 members (as described in Section D, Paragraph 2, Eligibility Categories) for transplants received at an AHCCCS contracted facility is paid at the lesser of 100% of the AHCCCS contract amount for the

transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplantation services rendered, or the Contractor paid amount, less the transplant share of cost. All Option 1 and Option 2 transplants are subject to the terms regarding out of State transplants set forth above and in the AHCCCS Reinsurance Processing Manual. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCS, DHCM, Medical Management Unit as specified in the AMPM Chapter 300.

> *Option 1 Non-transplant Reinsurance:* All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters.

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

Encounter Submission and Payments for Reinsurance

Encounter Submission: All reinsurance associated encounters, except as provided below for "Disputed Matters," must reach a clean claim status within 15 months from the end date of service, or date of eligibility posting, whichever is later.

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

> Failure to submit encounters in clean claim status within the applicable timeframes specified above will result in the denial of reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.
>
> The Contractor must void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. See the AHCCCS Reinsurance Processing Manual for further details.
>
> The Contractor should refer to Section D, Paragraph 65, Encounter Data Reporting, for additional encounter reporting requirements.

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

When a member remains eligible for CRS but changes CRS coverage types within a contract year, for reinsurance purposes, costs incurred for that member will follow the member to the new coverage type, in accordance with limitations on reinsurance coverage for catastrophic and transplant cases as noted above. For further details regarding this policy and other reinsurance policies refer to the AHCCCS Reinsurance Processing Manual.

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

Reinsurance Audits
AHCCCS may, at a later date, perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits providing the Contractor with advance notice.

58. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Pursuant to Federal and State law, AHCCCS is the payor of last resort, except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and R9-22-1001 et seq., so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. 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 in the coordination of benefits are cost avoidance and post-payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq. and Federal and State law. See also Section D, Paragraph 60, Medicare Services and Cost Sharing.

Cost Avoidance: The Contractor shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost-avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions.

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.

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. See ACOM Draft Policy, Coordination of Benefits/Third Party Liability.

Members with CRS condition: A member with private insurance or Medicare coverage is not required to be enrolled with or utilize the CRS Contractor. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. When the member elects to be enrolled with the CRS Contractor, , the CRS Contractor is responsible for all applicable deductibles and copayments if the member uses the private insurance network or Medicare for a CRS-covered condition. When the private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to CRS-covered conditions, the Contractor will be responsible for all services covered under this contract. The Contractor is not responsible to provide CRS services in instances when a member with a CRS covered condition refuses to participate in the CRS application process, or when an AHCCCS member refuses to receive CRS covered services through the CRS program. The member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

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

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

Other Recoveries: The Contractor shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6) external causes of injury codes E000 through E999, and other procedures. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

- Uninsured/underinsured motorist insurance
- First-and third-party liability insurance
- Tort feasors, including casualty
- Special Treatment Trust Recovery
- Restitution Recovery
- Worker's Compensation
- Estate Recovery

Upon identification of any of the above situations, the Contractor shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or fee-for-service payments are involved. By contrast, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Contractor shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Case Requirements

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

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 (i.e., lien filing , etc.); and,
c. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that there is no reinsurance or fee-for-service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Total Plan Cases: The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Notification of Settlement form, within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Joint Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Contractor. In joint cases, AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. 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.

Retroactive Recoveries: The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service, to determine if there are other payor sources that were not known at the time of payment. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way.

After two years from the service date, AHCCCS will direct recovery efforts for retroactive recovery of claims not previously identified by the Contractor as having a reasonable expectation of recovery. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the Contractor. The total recovery period for the Contractor and AHCCCS combined is limited to three years after the date of service as defined in A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

See ACOM Draft Policy, Coordination of Benefits/Third Party Liability for details regarding encounter adjustments as a result of retroactive recoveries. Additionally, AHCCCS will develop an automated process allowing the Contractor to "tag" claims that have a reasonable expectation of recovery. This process, and any other requirements for Contractors, will be added to ACOM Draft Policy, Coordination of Benefits/Third Party Liability prior to October 1, 2013.

Other Reporting Requirements

If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, or any change in coverage, the Contractor must report the information to the AHCCCS contracted vendor as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables. Notification by the Contractor must occur electronically through the Third Party Leads submission process. Refer to:

http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/TPLleads.aspx.

Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Upon AHCCCS' request, the Contractor shall provide an electronic extract of the casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name;

AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to the Contractor. AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the Technical Interface Guidelines.

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

Cost Avoidance/Recovery Report: The Contractor shall report, as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables, a summary of their cost avoidance/recovery activity. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

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

59. COPAYMENTS

The Contractor is required to comply with R9-22-711, the ACOM Policy 431 and other directives by AHCCCS. CRS eligible members are exempt from mandatory and optional copayments.

Those populations exempt or subject to optional copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108].

60. MEDICARE SERVICES AND COST SHARING

The Contractor must pay most Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost-sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor must limit their cost sharing responsibility according to ACOM Policies 201 and 202. The Contractor shall have no cost sharing obligation if the Medicare payment exceeds what the Contractor would have paid for the same service of a non-Medicare member. Please refer to Section D, Paragraph 10, Scope of Services, for information regarding prescription medication for Medicare Part D.

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

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to CMS, the Contractor must notify the AHCCCS, Member Database Management Administration (MDMA), pursuant to ACOM Policy 431, Attachment A, as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

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

For purposes of the medical institution notification, medical institutions are defined as acute hospitals, psychiatric hospital – Non IMD, psychiatric hospital – IMD, residential treatment center – Non IMD, residential treatment center – IMD, skilled nursing facilities, and Intermediate Care for the Intellectually Disabled.

61. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including the ACOM Policy 101 [42 CFR 438.104]. The Contractor shall submit all proposed marketing, outreach and retention activities and participation in events that will involve the general public to the AHCCCS Marketing Committee as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables and as outlined in the ACOM Policy 101. All marketing materials that have been approved by the Marketing Committee must be resubmitted every two years for re-approval.

62. CORPORATE COMPLIANCE

In accordance with A.R.S. §36-2918.01 and ACOM Policy 103, the Contractor and its subcontractors and providers is required to immediately notify the AHCCCS Office of Inspector General (OIG) regarding any suspected fraud or abuse [42 CFR 455.17]. The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)] by completing the confidential AHCCCS Referral for Preliminary Investigation form. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, Contractors, or subcontractors.

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.

The Contractor agrees to permit and cooperate with any onsite review. A review by the OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the OIG upon request and at no cost. The OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the OIG request.

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

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

1. Written policies, procedures, and standards of conduct that articulates the organization's commitment to and processes for complying with all applicable Federal and State standards.
2. The written designation of a compliance committee who are accountable to the Contractor's top management.
3. The Compliance Officer must be an onsite management official who reports directly to the Contractor's top management. Any exceptions must be approved by AHCCCS.
4. Effective training and education.
5. Effective lines of communication between the compliance officer and the organization's employees.

6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Provision for internal monitoring and auditing.
8. Provision for prompt response to problems detected.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), Contractors, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The Federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any State laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. The Contractor must establish a process for training existing staff and new hires on the compliance program and on the items in 10 above. All training must be conducted in such a manner that can be verified by AHCCCS.
12. The Contractor must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions:
    a. The administrative remedies for false claims and statements;
    b. Any State laws relating to civil or criminal penalties for false claims and statements;
    c. The whistleblower protections under such laws.
13. The Contractor must notify AHCCCS of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

Once the Contractor has referred a suspected case of fraud or abuse to AHCCCS, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments until AHCCCS provides written notice to the Contractor that the fraud or abuse case has been closed or otherwise dispositioned. At that time, and after conducting a cost benefit analysis to determine if such action is warranted, the Contractor should attempt to recover any overpayments identified. The OIG shall be advised of the final disposition of the research and advised of actions, if any, taken by the Contractor.

In addition, the Contractor must furnish to AHCCCS or CMS within 35 days of receiving the request, full and complete information, pertaining to business transactions [42 CFR 455.105]:

- The ownership of any subcontractor with whom the Contractor has had business transaction totaling more than $25,000 during the two month period ending on the date of request; and
- Any significant business transactions between the Contractor and wholly owned supplier, or between the Contractor and any subcontractor ending on the date of the request.

In the event that OIG, either through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. Furthermore, the Contractor is fully subrogated to AHCCCS for all civil recoveries.

Disclosure of Ownership and Control [42 CFR 455.104)(SMDL09-001]

A. The Contractor must provide the following information to AHCCCS:

1. (a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
   (b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the Contractor;
   (c) The Tax Identification Number of any corporation with an ownership or control interest in the Contractor;

2. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;

3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest;

4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the Contractor as defined in 42 CFR 455.101.

The Contractor shall provide the above-listed information to AHCCCS at any of the following times:

1. Upon the Contractor submitting the proposal in accordance with the State's procurement process;
2. Upon the Contractor executing the contract with the State;
3. Upon renewal or extension of the contract;
4. Within 35 days after any change in ownership of the Contractor.

B. The Contractor shall also, with regard to its subcontracted providers and fiscal agents, obtain the following information regarding ownership and control:

1.(a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the subcontracted Provider or Fiscal Agent. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
(b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the subcontracted provider or fiscal agent;
(c) The Tax Identification Number of any corporation with an ownership or control interest in the subcontracted provider or fiscal agent;

2. Whether the person (individual or corporation) with an ownership or control interest in the subcontracted provider or fiscal agent is related to another person with ownership or control interest in the subcontracted provider or fiscal agent as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the subcontracted provider or fiscal agent has a 5% or more interest is related to another person with ownership or control interest in the subcontracted provider or fiscal agent as a spouse, parent, child, or sibling;

3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the subcontracted provider or fiscal agent has an ownership or control interest;

4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the subcontracted provider or fiscal agent as defined in 42 CFR 455.101.

Disclosure of Information on Persons Convicted of Crimes [42 CFR 455.101; 106; 436] [SMDL09-001]
The Contractor must identify all persons associated with the Contractor and its subcontracted providers and fiscal agents with an ownership or control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program. The Contractor shall, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

a. Social Security Administration DEATH MASTER FILE
b. The National Plan and Provider Enumeration System (NPPES)
c. The List of Excluded Individuals (LEIE)

d. The Excluded Parties List (EPLS)
e. Any other databases directed by AHCCCS or CMS

The Contractor must immediately notify AHCCCS of any person who has been excluded through these checks.

The results of the ***Disclosure of Ownership and Control*** and the ***Disclosure of Information on Persons Convicted of Crimes*** shall be held by the Contractor. The Contractor shall submit an annual attestation that the above-listed information has been requested and obtained from its contracted providers and fiscal agents. Refer to Attachment B2, CRS Program Contractor's Chart of Deliverables for further information. Upon request, the Contractor shall provide AHCCCS with the above-listed information.

63. RECORDS RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor agrees to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

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

All records must be maintained until three years after the member has exceeded the age of 18 years or for at least six years after the last date the child received medical or health care services from the provider, whichever date occurs later, as specified in A.R.S. §12-2297.

HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j)(2).

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

64. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

The Contractor is required to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided to AHCCCS. All data exchanged must be in the formats prescribed by AHCCCS, which include those required/covered by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the HIPAA Transaction Companion Guides, Trading Partner Agreements, the AHCCCS Encounter Manual and in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website.

The information exchanged with AHCCCS shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following notification by AHCCCS.

Electronic Transactions: The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or prior authorization requests; or the receipt of electronic remittance. The Contractor must be able to make claims payments via electronic funds transfer and have the capability to accept electronic claims attachments.

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations and control documents are required. The Contractor must have completed and submitted the EDI Trading Partner Agreement in order to exchange data with AHCCCS.

Each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

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

The Contractor is required to provide attestation that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606] as outlined by AHCCCS.

The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCS 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 shall be responsible for any incorrect or delayed payment to the Contractor's providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

Member Data: The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in the AHCCCS prescribed electronic data exchange formats. Upon request, the Contractor shall provide to AHCCCS PCP assignments in an AHCCCS prescribed electronic data exchange format.

Claims Data: This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2903 and 2904 and AHCCCS rules R9-22 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

On a monthly basis AHCCCS will make available a claims data file of claims and encounters for all members enrolled with the Contractor, for all CRS coverage types except CRS Fully Integrated, for purposes of care coordination as follows:

1. CRS Partially-Integrated – Acute: Tribal RBHA claims
2. CRS Partially-Integrated – Behavioral Health (BH): CMDP and DDD encounters
3. CRS Only: Tribal RBHA, Fee For Service and Tribal Program Contractor claims; RBHA, CMDP and DDD encounters

In addition, the Contractor shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

1. Receive and process 60% of each claim type (professional, institutional and dental) based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically.
2. Produce and distribute 60% of remittances electronically.
3. Provide 60% of claims payments via EFT.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned after contract award. AHCCCS will work with the Contractor as they evaluate Electronic Data Interchange options.

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to AHCCCS for review and comment as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

Health Insurance Portability and Accountability Act (HIPAA): 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.

HIPAA Privacy and Security: The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements. The annual audit report must be submitted to AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

The audit must include a review of Contractor policies and procedures to verify that appropriate security and privacy requirements have been adequately incorporated into the Contractor's business practices, and the use of automated and/or manual scans of the production processing systems to validate compliance.

The audit must result in a findings report and as necessary a remediation plan, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The remediation plan must also include timelines for corrective actions related to all issues or discrepancies identified. The findings report and remediation plan must be submitted to AHCCCS for review and approval. AHCCCS will verify that the required audit has been completed and the appropriate approved remediation plans are in place and being followed as part of Operational Reviews.

Health Information Exchange: The Contractor is required to contract with Health Information Network of Arizona (HINAz) or its successor, as a data user.

65. ENCOUNTER DATA REPORTING

Complete, accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. The Contractor shall submit encounter data to AHCCCS 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 prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)][42 CFR 455.1 (a)(2)].

The Contractor must successfully exchange encounter data for all form types with AHCCCS no later than 120 days after the start of the contract or be subject to possible corrective actions up to and including sanctions.

Encounter Submissions: Encounters must be submitted in the format prescribed by AHCCCS. Encounter data must be provided to AHCCCS as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements and the AHCCCS Encounter Manual.

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed.

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor must provide attestation that the services listed were actually rendered.

The Contractor may be assessed sanctions for noncompliance with encounter submission completeness, accuracy and timeliness requirements.

Encounter Reporting: The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions and revisions of encounters. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual or as directed by AHCCCS and as further specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 18 months of approved, voided, plan-denied, pended and AHCCCS-denied encounters received and processed by AHCCCS. These files must be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

Encounter Supporting Data Files: AHCCCS provides the Contractor with periodic (no less than twice monthly) full replacement files containing provider and medical coding information as stored in PMMIS. These files should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information regarding the content and layouts of these files.

Encounter Corrections: The Contractor is required to monitor and resolve pended encounters and encounters denied by AHCCCS.

The Contractor is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters including, approved, pended, denied and voided encounters, impact completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters

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

Encounter Validation **Studies**: Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. These studies may result in sanctions of the Contractor and/or require a corrective action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness and omission of encounters. Refer to the AHCCCS 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.

66. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data as outlined in the HIPAA Transaction Companion Guides Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines, available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

For category types CRS Fully Integrated and CRS Partially-Integrated – Acute, AHCCCS also produces a daily Manual Payment Transaction as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction as outlined in the HIPAA Transaction Companion Guides, and Trading Partner Agreements, will be produced for category types CRS Fully Integrated and CRS Partially-Integrated – Acute to provide the Contractor with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

A monthly capitation transaction will be produced for category types CRS Partially-Integrated Behavioral Health (BH) and CRS Only to provide the Contractor with member-level capitation payment information.

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the

monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two days of the month. For category types CRS Fully Integrated and CRS Partially-Integrated – Acute, the last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

The Contractor will receive separate enrollment and capitation transactions for each of the CRS coverage types under unique AHCCCS Contractor ID Numbers.

67. PERIODIC REPORT REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 72, Sanctions and Attachment B2, CRS Program Contractor's Chart of Deliverables.

Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242(b)(2)]:

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

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specified by AHCCCS. The Contractor shall be responsible for continued reporting beyond the term of the contract.

68. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information to AHCCCS as requested no later than 20 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 AHCCCS, within the timeframe designated by AHCCCS, 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 AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

69. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS or the Federal government to its members and all costs of such dissemination shall be the responsibility of the Contractor. All advertisements, publications and printed materials that are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCS.

70. OPERATIONAL AND FINANCIAL READINESS REVIEWS

AHCCCS will conduct an Operational and Financial Readiness Review of the Contractor and will, subject to the availability of resources, provide technical assistance as appropriate. The Readiness Review will be conducted prior to the start of business. The purpose of a Readiness Review is to assess the Contractor's operational readiness and its ability to provide covered services to members at the start of the contract year. The Contractor will be permitted to commence operations only if the Readiness Review factors are met to AHCCCS' satisfaction.

71. OPERATIONAL REVIEWS

In accordance with CMS requirements and Arizona Administrative Code [Title 9, A.A.C. Chapter 22 Article 5], AHCCCS, or an independent agent, will conduct periodic Operational Reviews to ensure program compliance and identify best practices [42 CFR 438.204]. The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements, and provide the Contractor with technical assistance when necessary. The type and duration of the review will be solely at the discretion of AHCCCS.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled Operational Review. AHCCCS reserves the right to conduct reviews without notice to monitor contractual requirements and performance as needed.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out of State locations and will coordinate travel arrangements and accommodations with the Contractor.

In preparation for the reviews, the Contractor shall cooperate with AHCCCS by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. 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 an opportunity to comment on any review findings prior to AHCCCS issuing the final report. The Contractor must develop corrective action plans based on these recommendations. The corrective action plans and modifications to the corrective action plans must be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational Review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the Operational Review Tool, draft Operational Review Report or final report to other Contractors.

72. SANCTIONS

In accordance with applicable Federal and State regulations, R9-22-606, ACOM Policy 408 and the terms of this contract, AHCCCS may impose sanctions for failure to comply with any provision of this contract. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in R9-34-401 et seq.

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

AHCCCS may impose sanctions including but not limited to:

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

Refer to the ACOM Policy 408 for details.

Automatic Sanctions: AHCCCS will assess the sanctions listed in Attachment B2, CRS Program Contractor's Chart of Deliverables on deliverables listed under DHCM Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

73. BUSINESS CONTINUITY AND RECOVERY PLAN

The Contractor shall develop a Business Continuity and Recovery Plan as detailed in the ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. All staff shall be trained on, and familiar with, the Plan. This Plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at the Contractor's main place of business
- Complete loss of use of the main site and satellite offices out of State
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCS in the event of a business disruption
- Periodic Testing (at least annually)

The Business Continuity and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to AHCCCS as specified in Attachment B2, CRS Program Contractor's Chart of Deliverables.

74. PARENT ACTION COUNCIL

The Contractor must facilitate a Parent Action Council (PAC) consisting of members, parents of a child who is or has been a CRS member, adults who are or were CRS members, and the Contractor. The PAC may also

include professionals and advocacy groups. PAC meeting minutes must be made available to AHCCCS upon request.

Discussion of issues and opportunities resulting from the PAC meetings should be included on the agenda and addressed by the Contractor's Executive Management Committee. Meeting minutes should reflect the results of the discussion and any direction of interventions or activities assigned by the Committee to Contractor operational units.

75. PENDING LEGISLATION / OTHER ISSUES

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

Federal and State Legislation: AHCCCS and its Contractors are subject to legislative mandates that may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

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

To further the integration of technology based solutions and the meaningful use of electronic health records within provider offices, AHCCCS anticipates increasing opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates expanding utilization of health information technology as it relates to health care management and Contractor deliverables in the following, but not limited to, areas:

- Access to care
- Care coordination
- Pharmacy, including but not limited to polypharmacy

- Evidence based care
- Disease management
- EPSDT services
- Coordination with community services
- Referral management
- Discharge planning
- Performance measures
- Performance improvement projects
- Medical record review
- Quality of care review processes
- Quality improvement
- Claims review
- Prior authorization
- Claims

KidsCare: On November 6, Arizona voters will have the opportunity to vote on Proposition 204, also known as The Quality Education and Jobs Act. This initiative would extend the one cent sales tax currently in place and would dedicate a small portion of the funds collected to reopen the KidsCare program effective July 1, 2013. If approved, the KidsCare program would enroll new children in households between 133 percent FPL and 200 percent FPL. If the initiative is not approved, enrollment in the KidsCare program will remain frozen and children currently enrolled in KidsCare II will be transitioned to either Medicaid or the Exchange.

The Affordable Care Act (ACA): The Contractor shall comply with the applicable sections of the ACA upheld by the United States Supreme Court.

The Contractor shall provide services to Medicaid eligible individuals who may be covered by the Medicaid Expansion starting January 1, 2014. Governor Brewer and State lawmakers have yet to determine the course for the Medicaid program as it relates to options under the ACA. While growth in AHCCCS enrollment is anticipated due to the individual mandate and woodwork effect related to the ACA, the level of growth will be impacted by policy decisions regarding restoration of Childless Adult (also known as AHCCCS Care) coverage (between 0%-100% FPL) and expansion for adults (between 100%-133% FPL). For instance, enrollment is expected to increase by about 180,000 in the first three years for growth related to woodwork and mandated increases for children ages 6-18. If the current enrollment freeze for Childless Adults between 0-100% FPL is lifted, that growth would add approximately 187,000 new lives in the first three years. Expanding Medicaid for the non-mandated populations under the ACA would add an additional 60,000 lives in the first three years.

In addition to the outstanding policy decision regarding Childless Adults, Waiver authority for this population expires December 31, 2013. Waiver authority for the KidsCare II population also expires December 31, 2013. However, these eligibility categories, as well as the SOBRA Family Planning Extension Program, are all subject to change based on State and CMS decisions related to the impacts of the Supreme Court Ruling on Medicaid Expansion and the Health Insurance Exchange (Exchange).

The ACA establishes the creation of an Exchange offering subsidized coverage for individuals and small businesses from 133% to 400% of the federal poverty limit starting January 1, 2014. Historically, the AHCCCS program has experienced some significant churn with approximately 70,000 members losing coverage and an equal number coming onto the program every month. In order to further improve care coordination to Medicaid members, Contractors will be required to participate in data sharing for care coordination in a manner stipulated by AHCCCS. Data will be shared between the Contractors and the Qualified Health Plans on the Exchange for those members who transition between coverage on Medicaid and coverage on the Exchange.

Contractors may also be required to supply network and other information in a prescribed electronic format for member plan selection purposes when making a choice of Medicaid plans through an automated process. This automated process and requirement may be implemented concurrently with the Exchange.

The Contractor shall meet other requirements as stipulated, including but not limited to a Health Insurer Fee effective January 1, 2014.

Payment Methodology For Hospital Inpatient Claims:: AHCCCS currently uses a tiered per diem methodology for the payment of acute care hospital inpatient claims. This payment structure is the default methodology, as required by Arizona State law that must be used by AHCCCS' Managed Care Organizations (MCOs) when no contract exists between an MCO and a hospital. Laws 2012, Second Regular Session, Chapter 122 ends the tiered per diem methodology effective September 30, 2013. AHCCCS is required to obtain legislative approval of an alternative reimbursement methodology for inpatient dates of service on and after October 1, 2013. AHCCCS is exploring the benefits of the APR-DRG payment methodology and will be establishing workgroups to seek stakeholder input on such a methodology. AHCCCS will be unable to implement a new methodology by October 1, 2013, and will seek a one-year extension of the tiered per diem methodology through September 30, 2014, with an effective date of October 1, 2014 for the new inpatient reimbursement system (pursuant to Chapter 122). MCOs will be required to utilize the AHCCCS inpatient payment methodology for all non-contracted inpatient hospital stays.

***ICD-10 Readiness*:** In 2009 the Federal government published the final regulation that adopted the ICD-10 code sets as HIPAA standards (45 CFR 162.1002). As HIPAA covered entities, State Medicaid programs must comply with use of the ICD-10 code sets by the deadline established by CMS. The compliance date published in the final rule is October 1, 2013. However, in October 2012, the ICD-10 compliance date was amended through a correction of final rule (originally published in September 2012), delaying the effective date to October 1, 2014; this indicates the dates of service for which these codes must be used. The Contractor shall comply with the use of ICD-10 code sets for all claims with dates of services on and after October 1, 2014. The Contractor shall meet all AHCCCS deadlines for communication, testing, and implementation planning with AHCCCS and providers. Failure to meet deadlines may result in regulatory action.

[END OF SECTION D2]

E1 ACUTE CARE PROGRAM CONTRACT TERMS AND CONDITIONS

1. ADVERTISING AND PROMOTION OF CONTRACT

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

2. APPLICABLE LAW

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

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

3. ARBITRATION

The parties to this contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. §12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this contract. Delegation of less than all of the duties of this contract must conform to the requirements of Section D, Subcontracts.

5. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCS.

6. AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable A.R.S. §35-214 and §35-215 and AHCCCS rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

7. AUTHORITY

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

8. CHANGES

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

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

9. CHOICE OF FORUM

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

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

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

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

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

12. CONFLICT OF INTEREST

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

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

14. CONTRACT

The contract between AHCCCS and the Contractor shall consist of (1) the Request for Proposal (RFP) including AHCCCS policies and procedures incorporated by reference as part of the RFP and (2) the proposal submitted by the Contractor in response to the RFP including any Best and Final Offers. In the event of a conflict in language between the proposal (including any Best and Final Offers) and the RFP (including AHCCCS policies and procedures incorporated by reference), the provisions and requirements set forth and/or referenced in the RFP(including AHCCCS policies and procedures incorporated by reference) shall govern.

The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the contract until funds have been encumbered.

15. CONTRACT INTERPRETATION AND AMENDMENT

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

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

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

16. COOPERATION WITH OTHER CONTRACTORS

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

17. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who reports directly to the CEO or CFO [42 CFR 438.604 et seq.].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by 9 A.A.C. Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and A.R.S. §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S §41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

21. EFFECTIVE DATE

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

22. 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.

23. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

24. INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

25. INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency):
The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

Contractor/Vendor Indemnification (Public Agency):
Each party ("as indemnitor") agrees to indemnify, defend, and hold harmless the other party ("as indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

26. INDEMNIFICATION - PATENT AND COPYRIGHT

To the extent permitted by applicable law the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

27. INSURANCE

The Contractor is required to maintain insurance, at a minimum, as specified in Attachment E1 Standard Professional Service Contracts and E2 Standard Professional Service Contracts – Under $50,000. For policies for insurance for professional service contracts working with children or vulnerable adults the policy shall be endorsed to include coverage for sexual abuse and molestation.

28. IRS W9 FORM

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

29. LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

30. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

31. NON-DISCRIMINATION

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

32. NON-EXCLUSIVE REMEDIES

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

33. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this paragraph does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

34. ORDER OF PRECEDENCE

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

35. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this contract, as otherwise allowed under this contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74.

36. RESERVED

37. RELATIONSHIP OF PARTIES

The Contractor under this contract is an independent Contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

38. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any sums due the Contractor any expenses or costs incurred by AHCCCS or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract, including but not limited to expenses, costs and damages.

39. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or is unable to continue to perform this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

41. SCRUTINIZED BUSINESSES

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

42. 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.

43. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610(a)(b)] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

44. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR 438.700 et seq. and State Law A.R.S. §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law A.R.S. §36-2903 authorizes AHCCCS to operate a Contractor as specified in this contract. In addition to the bases specified in 42 CFR 438.700 et seq., AHCCCS may directly operate the Contractor if, in the judgment of AHCCCS, the Contractor's performance is in material breach of the contract or the Contractor is insolvent. Under these circumstances, AHCCCS may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other Contractors. Prior to operation of the Contractor by AHCCCS pursuant to state statute, the Contractor shall have the opportunity for a hearing. If AHCCCS determines that emergency action is required, operation of the Contractor may take place prior to hearing. Operation by AHCCCS shall occur only as long as it is necessary to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other Contractors, or until the Contractor reorganizes or otherwise corrects contract performance failure.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

Termination: AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the

termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS on demand.

AHCCCS may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

45. TERM OF CONTRACT AND OPTION TO RENEW

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

If the Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCS may renew the Contractor's contract in one GSA, but not in another. In the event AHCCCS determines there are issues of noncompliance by the Contractor in one GSA, AHCCCS may request an enrollment cap for the Contractor's contracts in all other GSAs. Further, AHCCCS may require the Contractor to renew all currently awarded GSAs, or may terminate the contract if the Contractor does not agree to renew all currently awarded GSAs.

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 30 days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. Failure of an existing Contractor to accept an amendment (or renew) may result in immediate suspension/ termination of member assignment. If the Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor. The Contractor is required to provide 180 days advance written notice to the Contracts and Purchasing Administrator of its intent not to renew the contract. If the Contractor provides the Contracts and Purchasing Administrator written notice of its intent not to renew this contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

46. TERMINATION - AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

47. TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any

time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R.S. §38-511.

48. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

49. THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

50. TYPE OF CONTRACT

Firm Fixed-Price stated as capitated per member per month except as otherwise provided.

51. WARRANTY OF SERVICES

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

ATTACHMENT E-1

STANDARD PROFESSIONAL SERVICE CONTRACT

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or subcontractors.

The *insurance requirements* herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$2,000,000
• Products – Completed Operations Aggregate	$1,000,000
• Personal and Advertising Injury	$1,000,000
• Blanket Contractual Liability – Written and Oral	$1,000,000
• Fire Legal Liability	$ 50,000
• Each Occurrence	$1,000,000

   a. If applicable, the policy shall be endorsed to include coverage for sexual abuse and molestation.

b. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

c. 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.

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.

Combined Single Limit (CSL)	$1,000,000

a. The policy shall be endorsed to include the following additional insured language: **"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".**

b. 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.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$ 500,000
Disease – Each Employee	$ 500,000
Disease – Policy Limit	$1,000,000

a. 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: Separately, EACH Contractor or subcontractor exempt under A.R.S. §23-901, AND when such Contractor or subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:**

The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this Contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this Contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require written notice to the State of Arizona as specified in Attachment F, Contractors Chart of Deliverables. Such notice shall be sent directly to Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034, and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this Contract and as specified in Attachment F, Contractors Chart of Deliverables. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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**. DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this Contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal Contract amendment, but may be made by administrative action.

H. **EXCEPTIONS:** In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

ATTACHMENT E-2

STANDARD PROFESSIONAL SERVICE CONTRACT – UNDER $50,000

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or subcontractors.

The *insurance requirements* herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$1,000,000
• Products – Completed Operations Aggregate	$ 500,000
• Personal and Advertising Injury	$ 500,000
• Blanket Contractual Liability – Written and Oral	$ 500,000
• Fire Legal Liability	$ 25,000
• Each Occurrence	$ 500,000

   a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees***

shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".

b. Policy shall contain a waiver of subrogation 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.

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.

Combined Single Limit (CSL)	$500,000

a. The policy shall be endorsed to include the following additional insured language: **"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".**

b. 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.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$100,000

a. 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: Separately, EACH Contractor or subcontractor exempt under A.R.S. §23-901, AND when such Contractor or subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$ 500,000
Annual Aggregate	$1,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require written notice to the State of Arizona as specified in Attachment F, Contractors Chart of Deliverables. Such notice shall be sent directly to Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this contract and as specified in Attachment F, Contractors Chart of Deliverables. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION**.

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal contract amendment, but may be made by administrative action.

H. **EXCEPTIONS:** In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

E2 CHILDREN'S REHABILITATIVE SERVICES PROGRAM CONTRACT TERMS AND CONDITIONS

1. ADVERTISING AND PROMOTION OF CONTRACT

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

2. APPLICABLE LAW

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

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

3. ARBITRATION

The parties to this contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. §12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this contract. Delegation of less than all of the duties of this contract must conform to the requirements of Section D, Subcontracts.

5. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCS.

6. AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable A.R.S. §35-214 and §35-215 and AHCCCS rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

7. AUTHORITY

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

8. CHANGES

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

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

9. CHOICE OF FORUM

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

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

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

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

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

12. CONFLICT OF INTEREST

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

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

14. CONTRACT

The contract between AHCCCS and the Contractor shall consist of (1) the Request for Proposal (RFP) including AHCCCS policies and procedures incorporated by reference as part of the RFP and (2) the proposal submitted by the Contractor in response to the RFP including any Best and Final Offers. In the event of a conflict in language between the proposal (including any Best and Final Offers) and the RFP (including AHCCCS policies and procedures incorporated by reference), the provisions and requirements set forth and/or referenced in the RFP(including AHCCCS policies and procedures incorporated by reference) shall govern.

The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the contract until funds have been encumbered.

15. CONTRACT INTERPRETATION AND AMENDMENT

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

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

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

16. COOPERATION WITH OTHER CONTRACTORS

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

17. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who reports directly to the CEO or CFO [42 CFR 438.604 et seq.].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by 9 A.A.C. Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and A.R.S. §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S §41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

21. EFFECTIVE DATE

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

22. 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.

23. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

24. INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

25. INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency):
The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

Contractor/Vendor Indemnification (Public Agency):
Each party ("as indemnitor") agrees to indemnify, defend, and hold harmless the other party ("as indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

26. INDEMNIFICATION - PATENT AND COPYRIGHT

To the extent permitted by applicable law the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

27. INSURANCE

The Contractor is required to maintain insurance, at a minimum, as specified in Attachment E1 Standard Professional Service Contracts and E2 Standard Professional Service Contracts – Under $50,000. For policies for insurance for professional service contracts working with children or vulnerable adults the policy shall be endorsed to include coverage for sexual abuse and molestation.

28. IRS W9 FORM

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

29. LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

30. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

31. NON-DISCRIMINATION

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

32. NON-EXCLUSIVE REMEDIES

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

33. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this paragraph does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

34. ORDER OF PRECEDENCE

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

35. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this contract, as otherwise allowed under this contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall not be used by the Contractor for any independent project of the

Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74.

36. RESERVED

37. RELATIONSHIP OF PARTIES

The Contractor under this contract is an independent Contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

38. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any sums due the Contractor any expenses or costs incurred by AHCCCS or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract, including but not limited to expenses, costs and damages.

39. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or is unable to continue to perform this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

41. SCRUTINIZED BUSINESSES

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

42. 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.

43. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610(a)(b)] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

44. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR 438.700 et seq. and State Law A.R.S. §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law A.R.S. §36-2903 authorizes AHCCCS to operate a Contractor as specified in this contract. In addition to the bases specified in 42 CFR 438.700 et seq., AHCCCS may directly operate the Contractor if, in the judgment of AHCCCS, the Contractor's performance is in material breach of the contract or the Contractor is insolvent. Under these circumstances, AHCCCS may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other Contractors. Prior to operation of the Contractor by AHCCCS pursuant to state statute, the Contractor shall have the opportunity for a hearing. If AHCCCS determines that emergency action is required, operation of the Contractor may take place prior to hearing. Operation by AHCCCS shall occur only as long as it is necessary to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other Contractors, or until the Contractor reorganizes or otherwise corrects contract performance failure.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

Termination: AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS on demand.

AHCCCS may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

45. TERM OF CONTRACT AND OPTION TO RENEW

The term of this contract shall be for two (2) initial years unless terminated or extended. The Contract may be extended for supplemental periods of up to a maximum of twenty-four (24) months, for a time period not to exceed four (4) years. AHCCCS is seeking amendment to the CRS statutes to change the term of the contract to 5 years. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment, and shall be at the sole option of AHCCCS.

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 30 days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. Failure of an existing Contractor to accept an amendment (or renew) may result in immediate suspension/ termination of member assignment. If the Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor. The Contractor is required to provide 180 days advance written notice to the Contracts and Purchasing Administrator of its intent not to renew the contract. If the Contractor provides the Contracts and Purchasing Administrator written notice of its intent not to renew this

contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

46. TERMINATION - AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

47. TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R.S. §38-511.

48. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

49. THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

50. TYPE OF CONTRACT

Firm Fixed-Price stated as capitated per member per month except as otherwise provided.

51. WARRANTY OF SERVICES

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

ATTACHMENT E-1

STANDARD PROFESSIONAL SERVICE CONTRACT

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or subcontractors.

The *insurance requirements* herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.
   • General Aggregate $2,000,000
   • Products – Completed Operations Aggregate $1,000,000
   • Personal and Advertising Injury $1,000,000
   • Blanket Contractual Liability – Written and Oral $1,000,000
   • Fire Legal Liability $ 50,000
   • Each Occurrence $1,000,000

   a. If applicable, the policy shall be endorsed to include coverage for sexual abuse and molestation.

b. The policy shall be endorsed to include the following additional insured language:

"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".

c. 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.

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.

Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed to include the following additional insured language: **"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".**

b. 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.

3. **Worker's Compensation and Employers' Liability**
Workers' Compensation Statutory
Employers' Liability
Each Accident $ 500,000
Disease – Each Employee $ 500,000
Disease – Policy Limit $1,000,000

a. 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: Separately, EACH Contractor or subcontractor exempt under A.R.S. §23-901, AND when such Contractor or subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**
Each Claim $1,000,000
Annual Aggregate $2,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:**

The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this Contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this Contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require written notice to the State of Arizona as specified in Attachment F, Contractors Chart of Deliverables. Such notice shall be sent directly to Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this Contract and as specified in Attachment F, Contractors Chart of Deliverables. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION**.

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this Contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal Contract amendment, but may be made by administrative action.

H. **EXCEPTIONS:** In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

ATTACHMENT E-2

STANDARD PROFESSIONAL SERVICE CONTRACT – UNDER $50,000

INDEMNIFICATION CLAUSE:

Contractor shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or subcontractors.

The *insurance requirements* herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$1,000,000
• Products – Completed Operations Aggregate	$ 500,000
• Personal and Advertising Injury	$ 500,000
• Blanket Contractual Liability – Written and Oral	$ 500,000
• Fire Legal Liability	$ 25,000
• Each Occurrence	$ 500,000

a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

b. Policy shall contain a waiver of subrogation 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.

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.

Combined Single Limit (CSL)	$500,000

a. The policy shall be endorsed to include the following additional insured language: **"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".**

b. 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.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation	Statutory
Employers' Liability	
Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$100,000

a. 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: Separately, EACH Contractor or subcontractor exempt under A.R.S. §23-901, AND when such Contractor or subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$ 500,000
Annual Aggregate	$1,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require written notice to the State of Arizona as specified in Attachment F, Contractors Chart of Deliverables. Such notice shall be sent directly to (Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this contract and as specified in Attachment F, Contractors Chart of Deliverables. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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**. DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor. All coverages for subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal contract amendment, but may be made by administrative action.

H. **EXCEPTIONS:** In the event the Contractor or subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

ATTACHMENT A1 ENROLLEE GRIEVANCE SYSTEM STANDARDS

The Contractor shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall furnish Grievance System information to enrollees no later than 12 days after the Contractor receives notice of the enrollment and annually thereafter. The Contractor shall also provide this information to all providers and subcontractors at the time of contract. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to enrollees describing the Grievance System including the grievance process, the appeals process, enrollee rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the Contractor's service area and in an easily understood language and format. Written documents, including but not limited to, the Notice of Action, the Notice of Extension of Notice of Action, the Notice of Appeal Resolution and Notice of Extension for Resolution, shall be translated in the enrollee's language if information is received by the Contractor, orally or in writing, indicating that the enrollee has a limited English proficiency. Otherwise, these documents shall be translated in the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the enrollee that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how enrollees may obtain this information. The Contractor shall also inform enrollees that oral interpretation services are available in any language. This information must be in large, bold print appearing in a prominent location on the first page of the document,

For additional information regarding the enrollee Notice of Action process, the Contractor should refer to the ACOM Policy 414 and 42 CFR Part 438. **Failure to comply with any of these provisions may result in an imposition of sanctions.**

At a minimum, the Contractor's Grievance System Standards and Policy shall specify:

1. That the Contractor shall maintain records of all grievances, appeals and requests for hearing.

2. That the Contractor has a mechanism for tracking receipt, acknowledgement, investigation and resolution of grievances, appeals and requests for hearing within the required timeframes.

3. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to a hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievance and appeals and the requirements and timeframes for filing a grievance, appeal, or request for hearing.

4. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone.

5. That the Contractor shall acknowledge receipt of each grievance and appeal. For grievances, the Contractor is not required to acknowledge receipt of the Grievance in writing, however, if the enrollee requests written acknowledgement, the acknowledgement must be made within five business days of receipt of the request. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.

6. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

7. The definition of action [42 CFR 438.400(b)] and that an enrollee, or their designated representative, may file an appeal of an action taken by the Contractor. Actions include:

    a. Denial or limited authorization of a requested service, including the type or level of service;
    b. Reduction, suspension, or termination of a previously authorized service;
    c. Denial, in whole or in part, of payment for a service;
    d. Failure to provide services in a timely manner, as defined by the State;
    e. Failure to act within the timeframes provided in 42 CFR 438.408(b) required for standard and expedited resolution of appeals and standard disposition of grievances; or
    f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

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

9. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions. They are no time limits for filing an enrollee grievance.

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

11. That the Contractor must resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on enrollee grievances cannot be appealed.

12. That the Contractor responds in writing, if an enrollee requests a written explanation of the resolution, and the response must be mailed within 10 business days of resolution of the grievance.

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

14. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.

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

16. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.

17. That the Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

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

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

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

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

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

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

24. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider must be written.

25. That the Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least five days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the

26. Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:

    a. The Contractor receives notification of the death of an enrollee
    b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information)
    c. The enrollee is admitted to an institution where he is ineligible for further services
    d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address
    e. The enrollee has been accepted for Medicaid in another local jurisdiction

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

28. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

29. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals no later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

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

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

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

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

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

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

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

36. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:

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

37. The following material shall be included in the file sent by the Contractor:

    a. The Enrollee's written request for hearing
    b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records
    c. The Contractor's Notice of Appeal Resolution
    d. Other information relevant to the resolution of the appeal

38. That 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 promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

39. That 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.

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

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

ATTACHMENT A2 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 an imposition of sanctions.**

The claim dispute policy shall include the following provisions:

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

2. That the Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

3. That specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.

4. That 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.

5. That claim disputes are acknowledged in writing and within five business days of receipt.

6. Claim disputes are thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.

7. All documentation received by the Contractor during the claim dispute process is dated upon receipt.

8. Claim disputes are filed in a secure, designated area and are retained for five 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.

9. A copy of the Contractor's Notice of Decision "Decision" shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:

    a. The nature of the claim dispute.
    b. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member name, pertinent dates of service, dates and specific reasons for Contractor denial / payment of the claim, and whether or not the provider is a contracted provider.
    c. The reasons supporting the Contractor Decision, including an explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, contractual

provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.

d. The Provider's right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Decision.
e. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.

10. If the provider files a written request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS), no later than five business days from the date the Contractor receives the provider's written hearing request. The file sent by the Contractor must contain a cover letter that includes:

    a. The provider's name
    b. The provider's address
    c. The member's name and AHCCCS Identification Number
    d. The provider's phone number (if applicable)
    e. The date that the claim dispute was received by the Contractor
    f. A summary of the actions undertaken by the Contractor to resolve the claim dispute and basis for the determination

If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor must review the matter to determine why the request for hearing was filed and resolve the matter when appropriate.

11. The following material 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 which includes pertinent records; and the Decision
    c. Other information relevant to the Decision

12. If the Contractor's Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision along with any applicable interest within 15 business days of the date of the Decision.

If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

ATTACHMENT B1 ACUTE CARE PROGRAM CONTRACTORS' CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

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

AHCCCS will assess the following sanctions on the deliverables listed below, under DHCM, Acute Care Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

Late Deliverables

1st time "late" sanction/ 1-10 days:	$5,000
1st time "late" sanction/ 11-20 days:	$10,000
1st time "late" sanction/ over 21 days:	$15,000
2nd time "late" sanction/ 1-10 days:	$10,000
2nd time "late" sanction/ 11-20 days:	$20,000
2nd time "late" sanction/over 21 days:	$30,000
3rd time "late" sanction/ 1-10 days:	$20,000
3rd time "late" sanction/ 11-20 days:	$40,000
3rd time "late" sanction/over 21 days:	$60,000

The sanctions outlined above are deliverable specific. For example, if the Contractor submits its claims dashboard five days late in January, a $5,000 sanction will be assessed. The next month, if the Contractor submits its administrative measures five days late, it will be assessed a 1st time late sanction of $5,000. However if the Contractor submits the claims dashboard five days late again in March AHCCCS will asses a 2nd time late sanction of $10,000.

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DBF CONTRACTS & PURCHASING	Ad Hoc	Certifications of Insurance	Within 10 days of notification of contract award and prior to commencement of any services under this contract.	Section E	Paragraph 27	N/A	DBF Contracts Manager	FTP server with email notification
DBF CONTRACTS & PURCHASING	Ad Hoc	Insurance Material Change	Within 30 days of event	Section E	Paragraph 27	N/A	DBF Contracts Manager	FTP server with email notification
DBF CONTRACTS & PURCHASING	Ad Hoc	Third Party Liability Reporting	Within 10 days of discovery	Section D	Paragraph 58	AHCCCS Technical Interface Guidelines	AHCCCS TPL Administrator	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Advise of Significant Incidents/Accidents Including Abuse, Neglect and Unexpected Death	Within 1 day of awareness	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	Secure email to CQM Administrator
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Pediatric Immunization Audit	As requested by AHCCCS	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Performance Improvement Project Final	Refer to AMPM	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Stillbirth Supplement Request	Immediately following procedure	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	Secure email to CQM Administrator
DHCM CLINICAL QUALITY MANAGEMENT	Annually	EPSDT Annual Plan	December 15th	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Maternity Care Plan	December 15th	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Baseline	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Re-Measurement	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Quality Assessment/Performance Improvement Plan and Evaluation	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Monthly Pregnancy Termination	The last day of the month following the pregnancy termination	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	Secure email to CQM Administrator
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Credentialing Quarterly Report	30 days after the end of each quarter	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	EPSDT Improvement and Adult Quarterly Monitoring	15 days after the end of each quarter	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	QM Quarterly	45 days after the end of each quarter	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Semi-Annually	Semi-Annual Report of Number of Pregnant Women who are HIV/AIDS Positive	30 days after the reporting periods of: [10/1 through 3/31] & [4/1 through 9/30]	Section D	Paragraph 10	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Medical Records or Supporting Documentation	As specified in the requesting letter	Section D	Paragraph 65	AHCCCS Data Validation User Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Monthly	Corrected Pended Encounter Data	Monthly, according to established schedule	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Monthly	New Day Encounter	Monthly, according to established schedule	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Encounter Submission and Tracking	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Overrides	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Voids	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter mail	FTP server with email notification
DHCM FINANCE	Ad Hoc	Advances/Loans/Equity Distributions	Submit for approval prior to effective date	Section D	Paragraph 49	ACOM Policy 418	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Corporate Cost Allocation Plans and Adjustment in Management Fees	Prior approval required	Section D	Paragraph 43	N/A	DHCM Finance Manager	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Ad Hoc	Performance Bond or Bond Substitute	30 days after notification from AHCCCS of the amount required	Section D	Paragraph 46; Paragraph 47	ACOM Policy 305; ACOM Policy 306	DHCM Program Compliance Auditor	Secure email
DHCM FINANCE	Annually	Annual Disclosure Statement	120 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Draft Audit	90 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Final Audit	120 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Draft Annual Financial Reporting Package	90 days after the end of each fiscal year	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Annual Financial Reporting Package	120 days after the end of each fiscal year	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Management Letter	120 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Cost Avoidance/Recovery	Due 45 days after the reporting quarter: (Oct - Dec: Due Feb 14) (Jan – March: Due May 15) (Apr – June: Due August 14) (July – Sept: Due Nov 14)	Section D	Paragraph 58	AHCCCS Program Integrity Reporting Guide	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	FQHC Member Information	60 days after the end of each quarter	Section D	Paragraph 34	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Premium Tax Reporting	March 15th, June 15th, September 15th, December 15th	Section D	Paragraph 50	ACOM Policy 304	DHCM Finance Program Monitor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Quarterly Financial Reporting Package	60 days after the end of each quarter	Section D	Paragraph 50	AHCCCS Financial Reporting Guide For Acute Care Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Verification of Receipt of Paid Services	15th day after the end of the quarter that follows the reporting quarter (Oct – Dec: Due April 15) (Jan – March: Due July 15) (April – June: Due Oct 15) (July – Sept: Due Jan 15)	Section D	Paragraph 19	ACOM Policy 424	DHCM Program Compliance Auditor	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	HIV Specialty Provider List	December 15th	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	MM/UM Plan and Evaluation	December 15th	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM MEDICAL MANAGEMENT	Annually	Non-Transplant and Catastrophic Reinsurance	Within 30 days of the beginning of the contract year and when newly enrolled in the plan or newly diagnosed.	Section D	Paragraph 57	AMPM Chapter 1000; AHCCCS Reinsurance Processing Manual	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Quarterly Inpatient Hospital Showings	15 days after the end of each quarter	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Transplant Report	15 days after the end of each quarter	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontracts	60 days prior to the beginning date of the subcontract	Section D	Paragraph 37	ACOM Policy 106	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	AHCCCS Required Survey Results	45 days after the completion	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	All Physician Incentive Agreements Upon Contract Renewal	Prior to initiation of new contract or upon request form AHCCCS or CMS	Section D	Paragraph 42	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Claim Recoupments >$50,000	Upon identification by Contractor	Section D	Paragraph 38	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Final Survey Tool	90 days prior to the intended start	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Independent Audits of Claims Payment/Health Information Systems	Upon request by AHCCCS	Section D	Paragraph 38	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Position Change	Within 7 days of learning of resignation	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Marketing and Outreach Materials	30 days prior to dissemination	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Non-AHCCCS Required Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Notification of Moving Functions Out of State	60 days prior to proposed change	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Reorganization or Ownership Change	Prior approval required	Section D	Paragraph 52	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Provider Advances	10 days prior to disbursement of funds	Section D	Paragraph 49	ACOM Policy 418	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Material Change to Provider Network	60 days prior to expected implementation of the change	Section D	Paragraph 29	ACOM Policy 416	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Material Change to Operations	60 days prior to expected implementation of the change	Section D	Paragraph 44	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Unexpected Change to Provider Network	Within one business day	Section D	Paragraph 29	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Report of Subcontractor Non-Compliance	Within 30 days of discovery	Section D	Paragraph 37	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	System Change Plan	Six months prior to expected implementation	Section D	Paragraph 64	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual HIPAA Security and Privacy Audit Review	Within 90 days of the start of the contract year	Section D	Paragraph 64	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Annual Subcontractor Assignment and Evaluation	Within 90 days of the start of the contract year	Section D	Paragraph 37	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual Website Certification	45 days after the start of the contract year	Section D	Paragraph 18	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Attestation of Disclosure Information: Ownership & Control and Persons Convicted of a Crime	15 days after the start of the contract year	Section D	Paragraph 62	ACOM Policy 103	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Business Continuity and Recovery Plan Summary	15 days after the start of the contract year	Section D	Paragraph 73	ACOM Policy 104	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Cultural Competency Plan Assessment	45 days after the start of the contract year	Section D	Paragraph 20	ACOM Policy 405	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Functional Organization Chart with Key Program Areas	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Listing of All Key Staff Functions and Locations Including Those Outside of Arizona	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Marketing Attestation Statement	45 days after the start of the contract year	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Member Handbook	Within 4 weeks of receiving annual amendment and upon any changes prior to distribution	Section D	Paragraph 18	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Organization Chart with Key Staff Positions	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Provider Network Development and Management Plan	45 days after the start of the contract year	Section D	Paragraph 27	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	*Administrative Measures	15th day the quarter following the reporting period	Section D	Paragraph 25	ACOM Policy Telephone Performance Standards Measurement and Reporting	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	*Claims Dashboard	15th day of the month following the reporting period	Section D	Paragraph 38	AHCCCS Claims Dashboard Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Grievance System Report	First day of the 2nd Month following the month Being Reported	Section D	Paragraph 26	AHCCCS Grievance System Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Monthly	Marketing Report	10th of the month for the previous months activities	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider Affiliation Transmission	15 days after the end of each quarter	Section D	Paragraph 28	AHCCCS Provider Affiliation Transmission Manual	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider Terminations Due To Rates	15 days after the end of each quarter	Section D	Paragraph 29	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Eligible Person Fraud/Abuse	Within 10 business days of discovery	Section D	Paragraph 62	ACOM Policy 103	Office of Inspector General Manager	Secure email or web portal
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Provider Fraud/Abuse	Within 10 business days of discovery	Section D	Paragraph 62	ACOM Policy 103	Office of Inspector General Manager	Secure email or web portal

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
OFFICE OF INSPECTOR GENERAL	Annually	Key Staff Name, Social Security Number, Date of Birth	15 days after the start of the contract year	Section D	Paragraph 16	N/A	OIG/Provider Relations Program Manager	Secure email

[END OF ACUTE CARE PROGRAM DELIVERABLES]

ATTACHMENT B2 CRS PROGRAM CONTRACTOR'S CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

If a Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the 7 is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

AHCCCS will assess the following sanctions on the deliverables listed below, under DHCM, Acute Care Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

Late Deliverables

1st time "late" sanction/ 1-10 days:	$5,000
1st time "late" sanction/ 11-20 days:	$10,000
1st time "late" sanction/ over 21 days:	$15,000
2nd time "late" sanction/ 1-10 days:	$10,000
2nd time "late" sanction/ 11-20 days:	$20,000
2nd time "late" sanction/over 21 days:	$30,000
3rd time "late" sanction/ 1-10 days:	$20,000
3rd time "late" sanction/ 11-20 days:	$40,000
3rd time "late" sanction/over 21 days:	$60,000

The sanctions outlined above are deliverable specific. For example, if the Contractor submits its claims dashboard five days late in January, a $5,000 sanction will be assessed. The next month, if the Contractor submits its administrative measures five days late, it will be assessed a 1st time late sanction of $5,000. However if the Contractor submits the claims dashboard five days late again in March AHCCCS will asses a 2nd time late sanction of $10,000.

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DBF CONTRACTS & PURCHASING	Ad Hoc	Certifications of Insurance	Within 10 days of notification of contract award and prior to commencement of any services under this contract.	Section E	Paragraph 27	N/A	DBF Contracts Manager	FTP server with email notification
DBF CONTRACTS & PURCHASING	Ad Hoc	Insurance Material Change	Within 30 days of event	Section E	Paragraph 27	N/A	DBF Contracts Manager	FTP server with email notification
DBF CONTRACTS & PURCHASING	Ad Hoc	Third Party Liability Reporting	Within 10 days of discovery	Section D	Paragraph 58	AHCCCS Technical Interface Guidelines	AHCCCS TPL Administrator	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Advise of Significant Incidents/Accidents Including Abuse, Neglect and Unexpected Death	Within 1 day of awareness	Section D	Paragraph 23	AMPM Chapter 900	Secure email to CQM Administrator	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Pediatric Immunization Audit	As requested by AHCCCS	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Performance Improvement Project Final	Refer to AMPM	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Stillbirth Supplement Request	Immediately following procedure	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	Secure email to CQM Administrator
DHCM CLINICAL QUALITY MANAGEMENT	Annually	EPSDT Annual Plan	December 15th	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Maternity Care Plan	December 15th	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Baseline	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Re-Measurement	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Quality Assessment/Performance Improvement Plan and Evaluation	December 15th	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Monthly Pregnancy Termination	The last day of the month following the pregnancy termination	Section D	Paragraph 23	AMPM Chapter 400	DHCM Clinical Quality Management Unit	Secure email to CQM Administrator
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Behavioral Health Utilization & Timeframes for CMDP & DDD Members	45 days after the end of each quarter	Section D	Paragraph 33	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Credentialing Quarterly Report	30 days after the end of each quarter	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	EPSDT Improvement and Adult Quarterly Monitoring Report	15 days after the end of each quarter	Section D	Paragraph 10	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	QM Quarterly Report	45 days after the end of each quarter	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification
DHCM CLINICAL QUALITY MANAGEMENT	Semi-Annually	Semi-Annual Report of Number of Pregnant Women who are HIV/AIDS Positive	30 days after the reporting periods of: [10/1 through 3/31] & [4/1 through 9/30]	Section D	Paragraph 10	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Medical Records or Supporting Documentation	As specified in the requesting letter	Section D	Paragraph 65	AHCCCS Data Validation User Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Monthly	Corrected Pended Encounter Data	Monthly, according to established schedule	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Monthly	New Day Encounter	Monthly, according to established schedule	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Encounter Submission and Tracking	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Overrides	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Voids	15 days after the end of each quarter	Section D	Paragraph 65	AHCCCS Encounter Manual	DHCM Encounter Administrator and AHCCCS Encounter Email	FTP server with email notification
DHCM FINANCE	Ad Hoc	Advances/Loans/Equity Distributions	Submit for approval prior to effective date	Section D	Paragraph 49	ACOM Policy 418	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Corporate Cost Allocation Plans and Adjustment in Management Fees	Prior approval required	Section D	Paragraph 43	N/A	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Performance Bond or Bond Substitute	30 days after notification from AHCCCS of the amount required	Section D	Paragraph 46; Paragraph 47	ACOM Policy 305; ACOM Policy 306	DHCM Program Compliance Auditor	Secure email
DHCM FINANCE	Annually	Annual Disclosure Statement	120 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Annual Reconciliation to Draft Audit	90 days after year end	Section D	Paragraph 50	N/A	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Final Audit	120 days after year end	Section D	Paragraph 50	N/A	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Draft Annual Financial Reporting Package	90 days after the end of each fiscal year	Section D	Paragraph 50	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Annual Financial Reporting Package	120 days after the end of each fiscal year	Section D	Paragraph 50	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Management Letter	120 days after year end	Section D	Paragraph 50	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Cost Avoidance/Recovery Report	Due 45 days after the reporting quarter: (Oct - Dec: Due Feb 14) (Jan – March: Due May 15) (Apr – June: Due August 14) (July – Sept: Due Nov 14)	Section D	Paragraph 58	AHCCCS Program Integrity Reporting Guide	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	FQHC Member Information	60 days after the end of each quarter	Section D	Paragraph 34	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Premium Tax Reporting	March 15th, June 15th, September 15th, December 15th	Section D	Paragraph 50	ACOM Policy 304	DHCM Finance Program Monitor	FTP server with email notification
DHCM FINANCE	Quarterly	Quarterly Financial Reporting Package	60 days after the end of each quarter	Section D	Paragraph 50	AHCCCS Financial Reporting Guide for the CRS Contractor	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Verification of Receipt of Paid Services	15th day after the end of the quarter that follows the reporting quarter (Oct – Dec: Due April 15) (Jan – March: Due July 15) (April – June: Due Oct 15) (July – Sept: Due Jan 15)	Section D	Paragraph 19	ACOM Policy 424	DHCM Program Compliance Auditor	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	HIV Specialty Provider List	December 15th	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	MM/UM Plan and Evaluation	December 15th	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	Non-Transplant and Catastrophic Reinsurance	Within 30 days of the beginning of the contract year and when newly enrolled in the plan or newly diagnosed.	Section D	Paragraph 57	AMPM Chapter 1000; AHCCCS Reinsurance Processing Manual	DHCM Medical Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM MEDICAL MANAGEMENT	Quarterly	Quarterly Inpatient Hospital Showings	15 days after the end of each quarter	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Transplant Report	15 days after the end of each quarter	Section D	Paragraph 24	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontracts	60 days prior to the beginning date of the subcontract	Section D	Paragraph 37	ACOM Policy 106	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	All Physician Incentive Agreements Upon Contract Renewal	Prior to initiation of new contract or upon request form AHCCCS or CMS	Section D	Paragraph 42	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Claim Recoupments >$50,000	Upon identification by Contractor	Section D	Paragraph 38	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Final Survey Tool	90 days prior to the intended start	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Independent Audits of Claims Payment/Health Information Systems	Upon request by AHCCCS	Section D	Paragraph 38	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Position Change	Within 7 days of learning of resignation	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Marketing and Outreach Materials	30 days prior to dissemination	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Non-AHCCCS Required Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Notification of Moving Functions Out of State	60 days prior to proposed change	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Reorganization or Ownership Change	Prior approval required	Section D	Paragraph 52	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Provider Advances	10 days prior to disbursement of Funds	Section D	Paragraph 49	ACOM Policy 418	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Material Change to Provider Network	60 days prior to expected implementation of the change	Section D	Paragraph 29; Paragraph 55	ACOM Policy 416	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Material Change to Operations	60 days prior to expected implementation of the change	Section D	Paragraph 44	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Unexpected Change to Provider Network	Within one business day	Section D	Paragraph 29	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Report of Subcontractor Non-Compliance	Within 30 days of discovery	Section D	Paragraph 37	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	System Change Plan	Six months prior to expected implementation	Section D	Paragraph 64	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Annual HIPAA Security and Privacy Audit Review	Within 90 days of the start of the contract year	Section D	Paragraph 64	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual Subcontractor Assignment and Evaluation	Within 90 days of the start of the contract year	Section D	Paragraph 37	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual Website Certification	45 days after the start of the contract year	Section D	Paragraph 18	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Attestation of Disclosure Information: Ownership & Control and Persons Convicted of a Crime	15 days after the start of the contract year	Section D	Paragraph 62	ACOM Policy 103	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Business Continuity and Recovery Plan Summary	15 days after the start of the contract year	Section D	Paragraph 73	ACOM Policy 104	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Cultural Competency Plan Assessment	45 days after the start of the contract year	Section D	Paragraph 20	ACOM Policy 405	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Functional Organization Chart with Key Program Areas	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Listing of All Key Staff Functions and Locations Including Those Outside of Arizona	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Marketing Attestation Statement	45 days after the start of the contract year	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Member Handbook	Within 4 weeks of receiving annual amendment and upon any changes prior to distribution	Section D	Paragraph 18	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Member Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Organization Chart with Key Staff Positions	15 days after the start of the contract year	Section D	Paragraph 16	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Provider Network Development and Management Plan	45 days after the start of the contract year	Section D	Paragraph 27	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	*Administrative Measures	15th day the quarter following the reporting period	Section D	Paragraph 25	ACOM Policy Telephone Performance Standards Measurement and Reporting	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	*Claims Dashboard	15th day of the month following the reporting period	Section D	Paragraph 38	AHCCCS Claims Dashboard Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Grievance System Report	First day of the 2nd Month following the month Being Reported	Section D	Paragraph 26	AHCCCS Grievance System Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Marketing Report	10th of the month for the previous months activities	Section D	Paragraph 61	ACOM Policy 101	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Quarterly	Provider Affiliation Transmission	15 days after the end of each quarter	Section D	Paragraph 28	AHCCCS Provider Affiliation Transmission Manual	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider Terminations Due To Rates	15 days after the end of each quarter	Section D	Paragraph 29	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DMS	Monthly	Members With Completed Treatment or Inactive Treatment	15 days after the start of the month (reporting for the prior month)	Section D	Paragraph 2	ACOM Policy 426	DMS CRS Manager	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Eligible Person Fraud/Abuse	Within 10 business days of discovery	Section D	Paragraph 62	ACOM Policy 103	Office of Inspector General Manager	Secure email or web portal
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Provider Fraud/Abuse	Within 10 business days of discovery	Section D	Paragraph 62	ACOM Policy 103	Office of Inspector General Manager	Secure email or web portal
OFFICE OF INSPECTOR GENERAL	Annually	Key Staff Name, Social Security Number, Date of Birth	15 days after the start of the contract year	Section D	Paragraph 16	N/A	OIG/Provider Relations Health Program Manage	Secure email

[END OF CRS PROGRAM DELIVERABLES]

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

2. CERTIFICATION OF NON-COERCION

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING

By signing this offer the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the "Stark I" and "Stark II" laws governing related-entity and compensation there-from. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services [See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361].

4. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed?

b. License/Certification: Attach a list of all licenses and certification (e.g. Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates.

Have any licenses been denied, revoked or suspended within the past 10 years? **Yes** ☐ **No** ☐

If yes, please explain:

c. Accessibility Assurance: Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities?

(Note: Check local zoning ordinances for accessibility requirements) **Yes** ☐ **No** ☐

If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.

d. Prior Convictions: List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.

e. Provide the name(s) and address(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and/or reviewing published capitation rate information.

f. Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? **Yes** ☐ **No** ☐

If yes, what is the name and address of this firm or organization?

g. Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? **Yes** ☐ **No** ☐

If yes, is the Management Information System being obtained from a vendor? **Yes** ☐ **No** ☐

If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.

5. FINANCIAL DISCLOSURE STATEMENT

Information to be furnished in 5.a. through 5.h. and 6.a. below should be inserted in the Excel spreadsheet Section G-2, Disclosure Templates, tabs 5.a. through 5.h. and 6.a. The Disclosure Templates is in the Bidders' Library.

NOTE: Information regarding Social Security Numbers and Dates of Birth will be maintained in a secure location and will only be used for the purposes as required by 42 CFR Part 455.

42 CFR 455.101 and 455.102 Definitions refer to G1 Definitions or click on the link below:

http://www.law.cornell.edu/cfr/text/42/455.101

The Offeror must provide the following information as required by 42 CFR Part 455. This Financial Disclosure Statement shall be prepared as of September 30, 2012.

a. Ownership: List the Name, Address, Date of Birth, and Social Security Number of each person with an ownership or control interest, as defined by 42 CFR 455.101, in the entity submitting this offer. List the Name, TIN and Address of any organization, corporation or entity with an ownership or control interest as defined by 42 CFR 455.101, in the entity submitting this offer.

b. Subcontractor Ownership: List the Name, Address, Date of Birth and Social Security Number of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. List the Name, TIN and Address of any organization, corporation or entity with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

List the Names of above persons who are related to one another as spouse, parent, child or sibling.

c. Managing Employees: List the Name, Address, Date of Birth and Social Security Number of any managing employee as defined in 42 CFR 455.101 of the entity submitting this offer.

d. Ownership in Other Entities: List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest.

e. Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end.

f. Criminal Offenses: List the Name, Title, Social Security Number (SSN), Date of Birth (DOB) and Address of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

g. Suspension/Exclusion or Debarment: List the Name, Title, SSN, DOB and Address of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been suspended or debarred from participating in Medicare, Medicaid or the Title XX services program since the inception of those programs.

h. Creditors: List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror's company.

i. Outstanding Legal Actions:

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization? If yes, provide details including the dollar amount. **Yes** ☐ **No** ☐

2. Has your organization ever gone through bankruptcy? **Yes** ☐ **No** ☐

If yes, provide the year:

6. RELATED PARTY TRANSACTIONS

a. Board of Directors: List the Names, SSN, DOB, and Addresses of the Board of Directors of the Offeror:

b. Related Party Transactions: Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the Office of the Director:

Justification:

G-1 42 CFR 455 - DEFINITIONS

§ 455.101 Definitions.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means 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.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.

Primary care case manager (PCCM) has the meaning specified in § 438.2.

§ 455.101 Definitions continued

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

§ 455.102 Determining Ownership or Control Percentages

(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

G-2- DISCLOSURE OF INFORMATION TEMPLATE

The Template is located in the Bidders' Library.

END OF SECTION

SECTION H: INSTRUCTIONS TO OFFERORS

This Request for Proposal solicits participation by Offerors to provide covered health care services to members enrolled in the Acute Care and CRS Programs. The services are to be provided in a managed care environment with reimbursement to Offerors awarded contracts on a capitated rate basis. Offerors are advised that services shall commence on October 1, 2013.

All Acute Care Offerors, if awarded a contract, are required to be organizations that contract with the Centers for Medicare and Medicaid Services to provide and manage Medicare benefits for dual eligible members in all (Geographic Service Area) GSAs in which they are awarded a contract. See Section I: Exhibit D, Medicare Requirements for additional details regarding this requirement.

The Solicitation Process shall be in accordance with the "RFP and Contract Process" rules set forth in Title 9 Chapter 22 Article 6 and effective November 11, 2012. These rules are posted on the AHCCCS internet website at:

http://www.azahcccs.gov/reporting/Downloads/UnpublishedRules/NOFR22_6.pdf

The RFP and Contract Process rules were also published on October 5, 2012 in the Arizona Administrative Register at:

http://www.azsos.gov/public_services/Register/contents.htm

Please read this RFP in its entirety as many provisions have changed from previous RFPs.

Please note that *days* as referenced in Instructions to Offerors means *calendar days*, unless otherwise specified. If a due date falls on a Saturday, Sunday or legal holiday, then the due date is considered the next *business day*. A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

Computation of time begins the day after the event that triggers the period and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

RFP Sections, Attachments, & Exhibits

The RFP document consists of Sections A through I. Separate section numbers have been created, specific to the CRS Program, when necessary.

Offerors bidding on the **Acute Care Program (Acute)**, should reference RFP **Sections A, B, C, D1, E1, F-A1, F-A2, G, H, and I** for documents pertaining to the Acute Care Program information and requirements.

Offerors bidding on the **CRS Program (CRS)** should reference RFP **Sections A, B, C, D2, E2, F-A1, F-A2, G, H, and I** for documents pertaining to the CRS Program information and requirements.

Once the RFP is awarded the Acute and CRS RFP documents will be separated to develop two unique contracts.

RFP sections will be posted to the Bidders' Library as follows:

Sections A, B, & C

Section A: Solicitation Page
Section B: Capitation Rates
Section C: Definitions

Section D: Program Requirements
Section D1: Acute Care Program Requirements
Section D2: CRS Program Requirements

Section E: Contract Terms and Conditions
Section E1: Acute Care Program Contract Terms and Conditions
Section E2: CRS Program Contract Terms and Conditions

Section F: Attachments
Attachment A1 – Enrollee Grievance System
Attachment A2 – Provider Claims Disputes
Attachment B1 – Acute Care Program Contractors' Chart of Deliverables
Attachment B2 – CRS Program Contractor's Chart of Deliverables

Section G: Representations and Certifications of Offeror

Section H: Instructions to Offerors

Section I: Exhibits
Exhibit A – Offeror's Checklist
Exhibit B – Minimum Subcontract Provisions
Exhibit C – Attestation Form
Exhibit D – Medicare Requirements

All references to Section D throughout Section H, Instructions to Offerors, correspond to Section D1 for the Acute Care Program and D2 for the CRS Program, as applicable.

1. PROSPECTIVE OFFERORS' INQUIRIES

Any questions related to this solicitation must be directed to the Solicitation Contact Person listed in Section A, Solicitation Page. Questions shall be e-mailed to the Solicitation Contact Person on the Acute Care and CRS Program RFP YH14-0001 Questions and Responses Template document available in the Bidders' Library. Any correspondence pertaining to this RFP must refer to the appropriate page, section and paragraph number. AHCCCS will respond, in writing, to all questions submitted through this process via a posting in the Bidders' Library or a formal amendment to the RFP in accordance with the schedule of milestone dates found in Paragraph 12, RFP Milestone Dates, of this section. Offerors shall not contact or ask questions of AHCCCS staff related to the RFP unless authorized by the Contracting Solicitation Contact Person.

2. PROSPECTIVE OFFERORS' CONFERENCE AND TECHNICAL INTERFACE MEETING

An Offerors' Conference will be held on November 9, 2012, beginning at 9:00 a.m. Arizona time, at AHCCCS, 701 E. Jefferson, in the Gold Room on the 3rd Floor. The purpose of this conference will be to: 1) orient new Offerors to AHCCCS, 2) clarify the contents of this solicitation, and 3) clarify AHCCCS PMMIS System and interface requirements. Questions posed during the Prospective Offerors' Conference must be submitted as specified in Paragraph 1, Prospective Offerors' Inquiries, of this section. Verbal responses provided during the Conference are not binding.

3. PROPOSAL OPENING

Proposals will be opened publicly immediately following the proposal due date and time. The name of each Offeror will be read publicly and recorded but no other information contained in the proposals will be disclosed. Proposals will not be available for public inspection until after contract award.

4. LATE PROPOSALS

Late proposals will not be considered.

5. WITHDRAWAL OF PROPOSAL

At any time prior to the proposal due date and time, the Offeror (or designated representative) may withdraw any previously submitted proposal. Withdrawals must be provided in writing and submitted to the Solicitation Contact person listed in Section A, Solicitation Page.

6. AMENDMENTS TO RFP

Amendments may be issued subsequent to the issue date of this solicitation. Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person listed in Section A, Solicitation Page.

7. EVALUATION FACTORS AND SELECTION PROCESS

The items which are designated for scoring in this RFP shall be evaluated and scored using only the information submitted to AHCCCS by the Offeror, including verbal responses provided as part of the Oral Presentation. It is the responsibility of the Offeror to clearly and comprehensively respond to each requested item and to ensure that there are no omissions or ambiguities. Failure of the Offeror to provide a clear, thorough, and detailed response may affect the award of points for a scored item.

Through an attestation process, the Offeror is required to specifically acknowledge the importance of several contractual provisions and their critical value to the AHCCCS program. This information will not be scored, however it will be verified through the readiness review process. If during the readiness review, AHCCCS determines that the successful Offeror (Contractor) fails to satisfy any of the requirements of the attestation and/or is unprepared to receive membership, AHCCCS may limit or prohibit the assignment of members for any GSAs in which the Contractor was awarded a contract. Under these circumstances, AHCCCS will authorize assignment when it is satisfied that the requirements have been met.

The final decision regarding both the number of Contractors in a particular GSA and which Offerors are awarded contracts will be made by AHCCCS. The decision will be guided, but not bound, by the scores awarded by the evaluators. However, AHCCCS will ultimately make its decision based on a determination of which proposals are deemed to be most advantageous to the State.

Although AHCCCS does not anticipate this situation will occur, if there is no responsive and responsible bid for a particular rural GSA, AHCCCS may assign that rural GSA to the successful bidder in another GSA. Should this occur, the capitation rate awarded would equal the top of the actuarially sound capitation rate range published by AHCCCS (which is the midpoint), with an 8% administrative component.

If AHCCCS deems that there is a negligible difference in scores between two or more competing proposals for a particular GSA, in the best interest of the State AHCCCS may consider additional factors in awarding the contract including, but not limited to:

1. An Offeror's past Medicare performance; and/or
2. An Offeror who is an incumbent health plan and has performed in an adequate manner (in the interest of continuity of care); and/or
3. An Offeror who participates satisfactorily in other lines of AHCCCS business; and/or
4. An Offeror's past performance with AHCCCS; and/or
5. The nature, frequency and significance of any compliance actions; and/or
6. Any convictions or civil judgments entered against the Offeror's organization; and/or

7. Potential disruption to members; and/or
8. Administrative burden to the Agency; and/or
9. Amount of choice and competition.

The Offeror should note that, if successful, it must meet all AHCCCS requirements, irrespective of what is requested and evaluated through this solicitation. The proposal provided by the Offeror will become part of the contract with AHCCCS.

All of the components listed in Paragraph 15, Contents of Offeror's Proposal, of this section, will be evaluated against relevant statutes, rules, policies, the requirements specified in this RFP, and other referenced sources.

Contracts will be awarded to Offerors whose proposals are deemed to be most advantageous to the State in accordance with Paragraph 09, Award of Contract, of this section.

Acute Scoring

AHCCCS has established a scoring methodology to evaluate an Offeror's ability to provide cost-effective, high-quality contract services in a managed care setting in accordance with the AHCCCS mission and goals. The following four components will be evaluated and weighted in the order listed:

Capitation and Program (Program includes Oral presentations)
Access to Care/Network and Organization

The Capitation section will be scored by GSA. The remaining submission areas will be scored on a statewide basis, not specific to any GSA. The scores received for each of the four required components will be weighted separately and then combined to derive a final score for the Offeror, by GSA.

CRS Scoring

In order to be considered for the CRS contract, Offerors are required to bid for and be awarded an Acute Care contract for at least one GSA. AHCCCS will combine the raw scores from an Offeror's Acute Care submission, excluding capitation, with the raw scores from the additional required submissions for the CRS proposal including CRS capitation, and apply CRS-specific weighting, to determine the final scoring and awards for the CRS Program contract.

The following four components will be evaluated and weighted in the order listed:

Program (including Oral presentations) and Access to Care/Network
Organization
Capitation

8. ON-SITE REVIEW

Prior to contract award, all Offerors may be subject to on-site review(s) to determine that an infrastructure is in place that will support the provision of services within the GSAs bid. AHCCCS reserves the right to not assign membership to Contractors that are determined to not meet minimum readiness requirements.

9. AWARD OF CONTRACT

Notwithstanding any other provision of this solicitation, AHCCCS expressly reserves the right to:

a. Waive any immaterial mistake or informality;
b. Reject any or all proposals, or portions thereof; and/or
c. Reissue a Request for Proposal

A response to this Request for Proposal is an offer to contract with AHCCCS based upon the terms, conditions, scope of work and specifications of the RFP. All of the terms and conditions of the contract are contained in this solicitation, solicitation amendments and subsequent contract amendments, if any, signed by the AHCCCS Contracting Officer. Proposals do not become contracts unless and until they are accepted by the Contracting

Officer. The proposal provided by the Offeror will become part of the contract with AHCCCS. A contract is formed when the AHCCCS Contracting Officer signs the award page and provides written notice of the award(s) to the successful Offeror(s), and the Offeror accepts any special provisions to the contract and the final rates awarded. All Offerors will be promptly notified of award. If a successful Offeror wishes to decline an awarded contract, they must do so in writing within 16 calendar days of the date of the award letter.

Acute Care Program

"***Incumbent Contractor***" means an entity that is a party to State Contract Number YH09-0000 as of the date the Proposals are due under this RFP.

"***Successful Incumbent Contractor***" means an Incumbent Contractor that is awarded a contract under this RFP in the GSA in which they serve under YH09-0000.

"***Unsuccessful Incumbent Contractor***" means an Incumbent Contractor that is not awarded a contract under this RFP in the GSA in which they serve under YH09-0000.

"***New Contractor***" means an entity that is awarded a contract under this RFP that is not an Incumbent Contractor or an Incumbent Contractor that is new to a GSA.

Although AHCCCS encourages Offerors to bid on multiple GSAs, AHCCCS may limit the number of GSAs awarded to any one Offeror, if deemed in the best interest of the State.

AHCCCS will not make an award in a GSA to an organization that also has a management service agreement with another Contractor in the same GSA. AHCCCS will not make an award to two or more Contractors that utilize the same management service company in that GSA. In either of those events, AHCCCS will make an award to the higher scoring Offeror.

If an Offeror had a contract in a GSA that was terminated by AHCCCS, and that same GSA is in the Offeror's proposal, AHCCCS may reject the proposal with respect to that GSA. If, as of the date proposals are due, an Offeror is materially out of compliance with a managed care contract with any governmental entity, including Arizona, AHCCCS may reject a proposal from the Offeror unless AHCCCS has obtained satisfactory assurances that the non-compliance will be resolved prior to October 1, 2013 and that the non-compliance will not recur.

AHCCCS reserves the right to modify the number of Acute contracts to be awarded in any GSA; however, AHCCCS anticipates awarding Acute contracts as follows:

GSA #:	*County or Counties*	*Number of Awards:*
2	Yuma, La Paz	Maximum of 2
4	Apache, Coconino, Mohave, and Navajo	Maximum of 2
6	Yavapai	Maximum of 2
8	Gila, Pinal	Maximum of 2
10	Pima, Santa Cruz*	Maximum of 5
12	Maricopa	Maximum of 7
14	Graham, Greenlee, Cochise	Maximum of 2

*Note: *AHCCCS anticipates awarding up to five contracts in the Pima County portion of the Pima/Santa Cruz GSA. Contracts in Santa Cruz County will be awarded to two of the five Pima contract awardees.*

At any time during the term of this contract (including extensions thereof), AHCCCS may make additional awards to Offerors based on the evaluations of the proposals received in response to this RFP.

Capped Contract Awards
An Unsuccessful Incumbent Acute Care Contractor in Maricopa or Pima County may request, in writing, to have its enrollment capped and to continue providing services under the terms and condition of this RFP. The deadline for such a request is two days from the date of the award letter. Only one capped contract in Maricopa and Pima Counties may be granted. Capped contracts will not be allowed in any other counties/GSAs. If more than one Unsuccessful Incumbent Contractor requests a capped contract, AHCCCS shall consider the request of the Offeror with the highest overall score or, in the case of differences deemed to be negligible by AHCCCS between the scores of the Unsuccessful Incumbent Contractors, consider the request that is in the best interest of the State after applying the evaluation factors. AHCCCS may, at its sole discretion, grant or deny a capped contract request. If a capped contract is granted in Maricopa or Pima Counties, AHCCCS will notify the requesting Offeror(s) and all Offerors that were awarded a contract in Maricopa or Pima Counties within nine days of the award letter.

If a capped contract is granted, the Contractor would continue to serve its existing members but would not receive any new members. AHCCCS intends to hold an open enrollment for all members assigned to the capped Contractor during the first year of the contract to allow members a choice of all available Contractors.

The capped Contractor will be awarded capitation rates factoring in the following:

a. The bottom of the actuarial rate range for the medical component (as adjusted by Section D, Paragraph 53, Compensation and Section D, Paragraph 55, Capitation Adjustments); and
b. The lesser of the lowest awarded administration rate or the Offeror's administration bid.

At no time during the course of a capped contract will any Contractor in that GSA be entitled to any reconciliations other than reconciliations already provided for in this RFP.

The enrollment cap will not be lifted at any time during the total contracting period specified in Section E, Contract Terms and Conditions unless one of the following conditions exists, in which case AHCCCS may lift the cap:

a. Another Contractor is terminated and increased member capacity is needed, or
b. Legislative action creates an unforeseen increase in the overall AHCCCS population, or
c. Extraordinary and unforeseen circumstances make such an action necessary and in the best interest of the State.

CRS Program
AHCCCS will award one statewide CRS contract. No capped contract will be permitted for CRS.

10. ACUTE CARE PROGRAM ENROLLMENT AFTER CONTRACT AWARD

Member Assignment
Beginning October 1, 2013, AHCCCS will favor new and small Contractors in each GSA as applicable. Small Contractors will be determined based on enrollment as of May 1, 2013. A small Contractor is defined by GSA and has a membership level as delineated in the following table:

County/GSA	GSA-specific Enrollment Threshold
Maricopa – GSA 12	<65,000
Pima County Only	<35,000
Rural GSAs (including Santa Cruz County)	less than or equal to 45% of enrollment in the entire GSA

Conversion Group Assignment

Members who are enrolled as of June 30, 2013 with an Unsuccessful Incumbent Contractor which was not granted a capped contract (Conversion Group) will be assigned to new and small Contractors within their GSA, effective October 1, 2013. These members will be allowed to remain with the Contractor to which they were assigned or choose a different Contractor by August 31, 2013 from any of the incumbent or new Contractors in the GSA that are effective October 1, 2013.

If the number of members in the Conversion Group in a GSA is enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, the members will be assigned at random until all of the new and small Contractors reach the thresholds. The remaining members of the Conversion Group will then be auto-assigned to all Contractors in the GSA according to the CYE 14 algorithm methodology as described in ACOM Draft Policy, Auto-Assignment Algorithm.

If the number of Conversion Group members in a GSA is not enough to bring all new and small Contractors within the GSA above the thresholds listed in the table above, a random assignment will be utilized to bring all new and small Contractors as close to equal as possible, without reducing any Contractor size.

In a rural GSA, if both Contractors are new to AHCCCS, the Conversion Group members will be assigned approximately equally between the two Contractors.

In the Maricopa GSA, if there are no Unsuccessful Incumbent Contractors and/or if in the Maricopa and Pima GSAs, there is one Unsuccessful Incumbent Contractor and a capped contract is awarded, there will be no Conversion Group members to assign to the new Contractor(s).

During the Conversion Group assignment process, members may intentionally be assigned to Contractors they are currently enrolled with for Medicare services in order to maximize alignment and care coordination opportunities.

For members being auto-assigned in July 2013, the algorithm will be based on the CYE 13 contract. For members auto-assigned during August and September 2013, the algorithm will be based on the CYE 13 contract with Unsuccessful Incumbent Contractors in each GSA excluded, except in family continuity, newborn enrollment, and 90-day re-enrollment situations. For GSAs in which all Contractors are unsuccessful, the CYE 13 algorithm will remain in effect through September 30, 2013. Details on member choice of Contractors for the months proceeding October 1, 2013 and impacts on Unsuccessful Incumbent Contractors will be released at a later date.

If during the readiness review, AHCCCS determines the Contractor fails to satisfy any of the requirements of the attestation and/or is unprepared to receive membership:

- The Contractor may not be included in the assignment of Conversion Group members for any GSAs in which the Contractor was awarded a contract; and
- For members being auto-assigned, AHCCCS may not permit members to be auto-assigned until such time that AHCCCS is satisfied that the requirements have been met.

Enhanced Auto-Assignment Post-Conversion

At the conclusion of the Conversion Group auto-assignment, New Contractors and Successful Incumbent Contractors still below the thresholds on September 1, 2013 will receive members under an enhanced auto-assign algorithm beginning October 1, 2013. The enhanced algorithm will be based on the factors used in the CYE 14 algorithm and will continue to favor those Contractors below the threshold through December 2013. **In this situation, as described in ACOM Draft Policy, Auto-Assignment Algorithm, Contractors not qualifying for the enhanced auto-assignment algorithm will not receive any members via auto-assignment for the time period.**

AHCCCS may evaluate the enrollment by Contractor throughout the remaining months of CYE 14 to determine whether to continue and/or reinstate the enhanced algorithm for some additional period. AHCCCS does not anticipate continuing the enhanced auto-assign algorithm past September 2014.

All efforts will be made to auto-assign members based on the methodology in ACOM Draft Policy, Auto-Assignment Algorithm and the thresholds above, however amounts may not be exact due to issues such as family continuity, newborns, 90-day re-enrollment etc.

See ACOM Draft Policy, Auto-Assignment Algorithm for more information.

11. FEDERAL DEADLINE FOR SIGNING CONTRACT

The Centers for Medicare and Medicaid Services (CMS) has imposed strict deadlines for finalization of contracts in order to qualify for Federal financial participation. This contract, and all subsequent amendments, must be completed and signed by both parties, and must be available for submission to CMS prior to the beginning date for the contract term (October 1, 2013). All public entity Offerors must ensure that the approval of this contract is placed on appropriate agendas sufficiently in advance of the deadline to ensure compliance with this requirement. In the event CMS denies or withholds Federal financial participation due to the Offeror's failure to comply with this requirement, payments to the Contractor will be reduced by the amount of the Federal financial participation denied or withheld. Additionally, all member choice and assignment may be frozen if the Contractor fails to submit the signed amendment by the effective date of an amendment. This freeze will last until CMS approves the tardy submission.

12. RFP MILESTONE DATES

The following is the schedule of events regarding the solicitation process:

Activity	Date
RFP Issued	November 1, 2012
Prospective Offerors' Conference and Technical Interface Meeting	November 9, 2012
First Set of Technical Assistance and RFP Questions Due	November 14, 2012
RFP Amendment Including Responses to RFP Questions Issued On or Before	November 27, 2012
Second Set of Technical Assistance and RFP Questions Due	December 10, 2012
Second RFP Amendment Including Responses to RFP Questions Issued On or Before	December 19, 2012
Proposals Due by 3:00 p.m.	**January 28, 2013**
Contracts Awarded On or Before	March 22, 2013
Readiness Reviews Begin On or After	April 1, 2013
New Contracts Effective	October 1, 2013

Note: *Dates are subject to change.*

13. BIDDERS' LIBRARY

The Bidders' Library contains critical reference material including but not limited to AHCCCS policies, Offeror's Checklist, utilization and cost data, member data, and performance requirements to assist the Offeror in preparing a thorough and realistic response to this solicitation. References are made throughout this solicitation to material in the Bidders' Library and Offerors are responsible for reviewing the contents of the Bidders' Library material as if they were printed in full herein. AHCCCS may continue to update the Bidders' Library after this solicitation is released; the Offeror is responsible for monitoring updates to the Bidders' Library. The Bidders' Library is located on the AHCCCS website at http://azahcccs.gov/commercial/purchasing/bidderslibrary/YH14-0001.aspx.

14. MINIMUM CAPITALIZATION

If the Offeror cannot meet the minimum capitalization requirements or the performance bond requirements, described herein for the Acute Care Program and/or the CRS Program, AHCCCS requests that the Offeror not submit a proposal.

Minimum Capitalization Requirements – Acute Care Program:
The Offeror must meet a minimum capitalization requirement for each GSA bid in the Acute Care Program. The capitalization requirement must be met within 30 days after contract award**.**

Minimum capitalization requirements by GSA are as follows:

Geographic Service Area (GSA)	**Capitalization Requirement**
Mohave/Coconino/Apache/Navajo	$4,400,000
La Paz/Yuma	$3,000,000
Maricopa	$5,000,000
Pima/Santa Cruz	$4,500,000
Cochise/Graham/ Greenlee	$2,150,000
Pinal/Gila	$2,400,000
Yavapai	$1,600,000

New Offerors (any Offeror that is not currently an Acute Care Contractor with AHCCCS): To be considered for a contract award in a given GSA or group of GSAs, a new Offeror must meet the minimum capitalization requirements listed above. The capitalization requirement is subject to a $10,000,000 ceiling regardless of the number of GSAs awarded. This requirement is in addition to the Performance Bond requirements defined in Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirement may be applied toward meeting the equity per member requirement (see Section D, Paragraph 50, Financial Viability Standards) and is intended for use in operations of the Contractor.

Incumbent Contractors: Incumbent Contractors that are bidding a county or GSA in which they currently have a contract must meet the current equity per member standard for their current membership (see CYE 13 contract Section D, Paragraph 50, Financial Viability Standards). Successful Incumbent Contractors that do not meet the current equity standard must fund, through capital contribution, the necessary amount to meet the equity per member requirement within 30 days after contract award. Incumbent Contractors that are bidding a new GSA must provide the minimum capitalization requirement listed above for each new GSA they are bidding. The capitalization requirement for new GSAs is subject to a $10,000,000 ceiling regardless of the number of new GSAs awarded. Incumbent Contractors will not be required to provide additional capitalization for new GSAs if

their excess equity within 30 days of contract award is at least $10,000,000 above all current equity per member requirements.

Minimum Capitalization Requirement – CRS Program: The Offeror must meet a minimum capitalization requirement for the CRS Program bid. The capitalization requirement must be met within 30 days after contract award. The minimum capitalization requirement is $5,500,000.

New Offerors (any Offeror that is not currently the CRS Contractor with AHCCCS): To be considered for a contract award, a new Contractor must meet the minimum capitalization requirement listed above. This requirement is in addition to the Performance Bond requirement defined in Section D, Paragraphs 46, Performance Bond or Bond Substitute, and 47, Amount of Performance Bond, and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirement may be applied toward meeting the equity per member requirement (see Section D, Paragraph 50, Financial Viability Standards) and is intended for use in operations of the Contractor.

Incumbent Contractor: The Incumbent Contractor must meet the current equity per member standard for its current membership (see CYE 13 contract, Attachment J, Paragraph 50, Financial Viability Standards). If the Successful Incumbent Contractor does not have excess equity in an amount sufficient to meet the minimum capitalization requirement, it must fund, through capital contribution, the necessary amount to meet the minimum capital requirement of $5,500,000 within 30 days after contract award.

15. CONTENTS OF OFFEROR'S PROPOSAL

All proposals (original and six copies) shall be organized with strict adherence to Exhibit A, Offeror's Checklist, as described below in this section and submitted using the forms and specifications provided in this RFP. A PDF version of the Offeror's proposal must also be submitted to AHCCCS by 3:00 p.m. Arizona time on January 28, 2013 via the EFT/SFTP server. Instructions for access to the EFT/SFTP server are included in the General Section of the Bidders' Library. The Offeror will upload the proposal to a secured location on the EFT/SFTP server as follows:

- Folder: AcuteCare-CRS-RFP14
  - Sub-Folder: CapitationandProposalSubmission
    - Sub-Folder: <Offeror's Name>

In the event that hard copy submissions differ from electronic submissions, the hard copy submissions will prevail.

NOTE: AHCCCS will post all proposals including capitation rate bids to the website once the contract awards have been made. No pages will be withheld with the exception of Section G: Representations and Certifications of Offeror. The Offeror shall not designate any information to be proprietary in nature with the exception of Section G: Representations and Certifications of Offeror.

All pages of the Offeror's proposal must be numbered sequentially with documents placed in sturdy 3-inch, 3-ring binders. All responses shall be in Times New Roman 11 point font or larger with borders no less than ½". Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages. Erasures, interlineations, or other modifications in the proposal must be initialed in original ink by the authorized person signing the offer. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's bid. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the bid when reviewing a specific response to an individual submission requirement.

Except in the case of a negligible difference, in scores between two or more competing proposals for a particular GSA, as referenced in Paragraph 7, Evaluation Factors and Selection Process, only information expressly provided by the Offeror will be considered. No inferences or assumptions will be made by the evaluation team when scoring in order to evaluate information submitted by the Offeror which is not clear, explicit, or thoroughly presented. Use of contingent language such as 'exploring' or 'taking under consideration' will not be given any weight during the scoring evaluation process. A policy, brochure, or reference to a policy or manual does not constitute an adequate response and will not be given any weight during the scoring evaluation process.

It is the responsibility of the Offeror to examine the entire RFP, timely seek clarification of any requirement that may not be clear, and review all responses for accuracy before submitting its proposal. The proposal becomes a part of the contract. Therefore, whatever information is stated in the proposal may be evaluated either during the proposal evaluation process or subsequently during other reviews. Proposals may not be withdrawn after the published due date and time.

All proposals will become the property of AHCCCS. AHCCCS will not reimburse the Offeror for the cost of proposal preparation.

During the readiness review process AHCCCS will verify that the Offeror has made sufficient progress related to commitments in the Offeror's RFP proposal.

All proposals shall be organized according to the following major categories:

A. General Matters
   A1. Offeror's Bid Choice Form
B. Attestation
C. Capitation
D. Executive Summary and Disclosure
E. Narrative Submissions
   Acute Care
   - Access to Care/Network
   - Program
   - Organization

   CRS
   - Access to Care/Network
   - Program
   - Organization

Each section shall be separated by a divider and contain all information requested in this solicitation. Numbering of pages should continue in sequence through each separate section. For example, "Attestation" would begin with the page number following the last page number in "General Matters." Each section shall begin with a table of contents.

Proposals that are not submitted in conformance with the requirements described herein may not be considered. References to certain sections of the RFP document in Section H are intended only to provide general assistance to Offerors and are not necessarily intended to represent all requirements. Other possible resources may be found in the Bidders' Library. It is the obligation of the Offeror to identify all relevant information.

16. SUBMISSION REQUIREMENTS

A. General Matters

See Section I: Exhibit A, Offeror's Checklist for information to be submitted under this section.

B. Attestation

In addition to complying with all contractual requirements, the Offeror must specifically acknowledge the importance of the following provisions and their critical value to the AHCCCS program. The statements in the attestation are not intended to alter or amend the contractual obligations set forth elsewhere in the RFP. In the event of any inconsistency or ambiguity regarding the meaning of an attestation, the provisions of the RFP are controlling.

The Offeror can find the following information on the Attestation Form in Section I, Exhibit C, Attestation Form. The Offeror should complete the Attestation Form and submit as required per Section I: Exhibit A, Offeror's Checklist.

ATTESTATION	
Corporate Compliance	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. ☐	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in the ACOM Policy 103 and the contract, by the contract start date *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. ☐	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☐	Limit Key Staff to occupying a maximum of two of the Key Staff positions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☐	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☐	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 *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
6. ☐	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ☐	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ☐	Have sufficient staffing levels to operate in compliance with the terms of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*

9. ☐	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. ☐	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ☐	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. ☐	Have structures in place to ensure and support current and future IT Federal mandates *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. ☐	Accept and process both paper and electronic submissions *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ☐	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
15. ☐	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
Quality Management	
The Offeror attests that, by the start date of the contract, it will have:	
16. ☐	A process to include the health risks assessment tool in the new member welcome packet. The Offeror has/will have a process for coordination of care across the continuum based on early identification of health risk factors or special care needs, including those members identified who would benefit from disease management and care coordination. [42 C.F.R. 438.208] *AMPM Chapter 900*

17. ☐	A process that requires the reporting of all incidents of abuse, neglect, exploitation, unexpected deaths, healthcare acquired and provider preventable conditions to the AHCCCS Clinical Quality Management Unit *AMPM Chapters 900 and 1000*
18. ☐	Processes in place to receive data and forms from a provider's certified electronic medical records including Early, Periodic, Screening, Diagnostic and Treatment forms, performance measure and audit information, and information to facilitate assistance with care coordination activities *AMPM Chapter 400*
19. ☐	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source *RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)*
20. ☐	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation *RFP, Section D, Paragraph 11, Special Health Care Needs*
MCH/EPSDT	
The Offeror attests that it will have:	
21. ☐	A process and a plan that includes outreach and care coordination processes for children with special health care needs and other hard to reach populations, and coordination with community and government programs *AMPM Chapter 400*
Medical Management	
The Offeror attests that it will have:	
22. ☐	A process in place for proactive discharge planning when members have been admitted to an inpatient facility *RFP, Section D, Paragraph 24, Medical Management (MM)*
23. ☐	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ☐	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. ☐	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ☐	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ☐	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*

Access to Care ***(Only Offerors submitting a proposal for the CRS Program must attest to #29)***	
The Offeror attests that it will have:	
28. ☐	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***CRS Only***	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
30. ☐	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ☐	A process for monitoring and addressing provider performance issues up to and including contract termination *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
Finance	
The Offeror attests that it will:	
32. ☐	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental *New Contractor*. *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ☐	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a *Successful Incumbent Contractor.* *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ☐	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

C. Capitation

Capitation is a fixed (per-member) monthly payment to a Contractor for the provision of covered services to members. It is an actuarially sound amount computed to cover expected utilization and costs:

- By individual risk groups, by GSA, in a risk-sharing, managed care environment for Acute Care Contractors; and
- Across all coverage types, statewide, in a risk-sharing, managed care environment for the CRS Contractor.

Acute Care Program Capitation Rates
Prior Period Coverage (PPC), SOBRA Family Planning Extension Program and State Only Transplant rates will be set by the AHCCCS actuaries and not bid by the Offeror. All other risk groups and the Delivery Supplement (hereafter referred to as risk groups) will be subject to competitive bidding, including:

- TANF all risk groups
- SSI with and without Medicare
- AHCCCS Care
- Delivery Supplement

Offerors are encouraged to submit their most competitive bids as AHCCCS anticipates that there will be no best and final offers. Offerors should note that AHCCCS will not increase a Contractor's capitation rates throughout the term of this contract if a Contractor later determines that the rates bid (with or without subsequent adjustment and update by AHCCCS) are insufficient.

Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)
All GSAs for which an Offeror bids will require a capitation rate bid submission for each risk group. Each bid will encompass two components; a gross medical component and an administrative component. Each component will be scored separately. The lowest bid within each GSA and risk group will receive the maximum allowable points. Conversely, the highest bid will receive the least number of points.

Bid component requirements:

1. Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid. Prior to October 1, 2013 AHCCCS will develop projections for reinsurance offsets and will adjust awarded capitation rates accordingly.
    - Capitation bids submitted with a medical component outside of the published ranges (described below) will earn a medical component score of zero points.
2. Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration / Gross Medical Component.
    - Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points.

AHCCCS reserves the right to request supporting documentation for any component of the capitation rate bids submitted.

It is recommended that Offerors bid rates reflecting the average monthly cost of a member utilizing the Data Book provided in the Bidders' Library (and used by AHCCCS' actuaries). Rates will be adjusted after award as indicated below.

If any moral or religious objections are submitted as specified in Paragraph 16, Submission Requirements, of this section the Offeror must not exclude direct and related costs from the capitation bid(s). If awarded a contract, capitation will be reduced for these costs via a subsequent contract amendment.

Acute Care Program Capitation Resources
To facilitate the preparation of its capitation proposals, AHCCCS will provide Offerors with a Data Supplement located in the Bidders' Library. This data source should not be used as the sole source of information in making decisions concerning the capitation proposal. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its capitation proposal.

On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from the minimum to the midpoint. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

A template for the capitation rate bid submission is included in the Data Supplement. The template must be completed for each GSA in which the Offeror submits a bid. The template(s) must be submitted in Microsoft Excel to AHCCCS via the EFT/SFTP server by 3 p.m. Arizona time on the Proposal Due Date in Section A, Solicitation Page. Instructions for access to the EFT/SFTP are included in the General Section of the Bidders' Library. In addition to the electronic submission of the template(s), hard copies of the completed template(s) for each GSA in which the Offeror submits a bid must be included in the RFP submission. In the case of differences between the hard copies and the electronic template submissions, the hard copies will prevail and will be the official bids that are scored. The Offeror must have an actuary who is a member of the American Academy of Actuaries certify that the bid submission is actuarially sound by including a signed hard copy of an actuarial certification of all rates submitted with the RFP submission. The Offeror may submit a separate certification for each GSA or a single certification that covers all GSAs bid.

Acute Care Program Capitation Adjustments After Award

AHCCCS will adjust the awarded medical components of the capitation rates for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates
- Payment reform withhold

Prior to October 1, 2013, AHCCCS will provide fully loaded capitation rates including the following components by risk group by GSA:

- The awarded medical component, adjusted as noted above
- The awarded administrative component
- The reinsurance offset determined by AHCCCS' actuaries
- Risk contingency and premium tax

The CYE 14 fully loaded capitation rates will be amended retroactively to October 1, 2013 to account for risk adjustment based on the Contractor's membership. For more detail on risk adjustment and the proposed methodologies effective on and after October 1, 2013, see Section I of the Data Supplement in the Bidders' Library.

CRS Program Capitation Rates

The medical components of the CRS capitation rates will be set by the AHCCCS actuaries and not bid by the Offeror. AHCCCS will set three unique medical component rates for the following service types:

- Acute services
- Behavioral health services
- CRS services

The medical component rates will be combined to compute a total medical component for each coverage type, as follows:

- CRS Fully Integrated: acute services + behavioral health services + CRS services = total medical
- CRS Partially-Integrated – Acute: acute services + CRS services = total medical
- CRS Partially-Integrated – BH: behavioral health services + CRS services = total medical
- CRS Only: CRS services = total medical

CRS Program Capitation Bid Submission* *(Submission Requirement No. 2)
The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. Conversely, the highest bid will receive the least number of points.

Bid component requirements:

1. Offerors will submit a single administrative component bid that will be added to the total medical component by coverage type. The administrative component will not vary by coverage type.
2. The administrative component bid will be stated as a per member per month (PMPM) figure.
    - Capitation bids submitted with an administrative component PMPM value exceeding $60 PMPM will earn an administrative component score of zero points.

Offerors are encouraged to submit their most competitive administrative component bid as there will be no best and final offers. Offerors should note that AHCCCS will not increase a Contractor's administrative rate throughout the term of this contract if a Contractor later determines that the rate bid (with or without subsequent adjustment and update by AHCCCS) is insufficient.

CRS Program Capitation Resources
To facilitate the preparation of its administrative component bid and review of total medical component rates, AHCCCS will provide Offerors with a Data Supplement located in the Bidders' Library. This data source should not be used as the sole source of information in making decisions concerning the administrative bid. Information referenced below is located in this Data Supplement. Each Offeror is solely responsible for research, preparation and documentation of its administrative capitation proposal.

A template for the administrative bid submission is included in the Data Supplement. The template must be submitted in Microsoft Excel to AHCCCS via the EFT/SFTP server by 3 p.m. Arizona time on the Proposal Due Date in Section A, Solicitation Page. Instructions for access to the EFT/SFTP are included in the General Section of the Bidders' Library. In addition to the electronic submission of the template, a hard copy of the completed template must be included in the RFP submission. In the case of differences between the hard copy and the electronic template submission, the hard copy will prevail and will be the official bid that is scored.

On or about December 14, 2012, AHCCCS intends to publish actuarially-sound total medical component rates by coverage type.

The Offeror must have an actuary who is a member of the American Academy of Actuaries provide an attestation that the total medical component rates set by AHCCCS, and the administrative component bid submitted with the RFP submission, are reasonable in relation to medical services and administrative costs expected to be incurred for the period of October 1, 2013 through September 30, 2014. The Offeror's proposal must include this attestation and must include the Offeror's agreement to accept the published total medical component rates. A signed hard copy of this attestation must be included with the RFP submission.

CRS Program Capitation Adjustments After Award
AHCCCS will adjust the total medical component rates for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions that were not previously included in the published capitation rate ranges or the awarded capitation rates

Prior to October 1, 2013, AHCCCS will provide fully loaded capitation rates including the following components by coverage type:

- The total medical component, adjusted as noted above
- The awarded administrative component
- The reinsurance offset determined by AHCCCS' actuaries
- Risk contingency and premium tax

D. Executive Summary and Disclosure

1. ***Executive Summary***: The Offeror must provide an Executive Summary that includes an overview of the organization and its relevant experience, a high-level description of its proposed approach to meeting contract requirements and a discussion of how it will bring added value to the program. In the final portion of the Executive Summary, the Offeror must describe how it will meet the requirements specified in Section I, Exhibit D, Medicare Requirements, Section 2. The Executive Summary will not be scored, but may be used in whole or part by AHCCCS in public communications, following contract awards. (4 page limit)

2. ***Moral or Religious Objections***: The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. The Contractor may propose a solution not already contemplated by this Contract to allow members to access the services. The Contractor must identify solutions pertinent to the Acute Care Program and the CRS Program if submitting proposals for both. AHCCCS does not intend to offer the services on a fee-for-service basis to the Contractor's enrollees. The proposal must be submitted to AHCCCS in writing as part of this submission. This submission will not be scored.

E. Narrative Submissions

ACUTE CARE – NARRATIVE SUBMISSIONS	
Access to Care/Network	
1.	AHCCCS anticipates that its membership will grow as a result of implementation of the Affordable Care Act (ACA). It is estimated that an additional 180,000 to 430,000 new members will be eligible and enrolled with AHCCCS in the first year of implementation. These growth figures are dependent on decisions made by Governor Brewer and Arizona lawmakers regarding the many options under the ACA. In addition to the increased AHCCCS enrollment, the implementation of the Health Insurance Exchange will increase demand for provider accessibility. What steps will the Offeror take to ensure access to care to support the influx of members?

	In addition to network management, how will the Offeror ensure its operational and administrative structure is sufficient to efficiently implement all program operations to accommodate the membership growth?
2.	Describe how the Offeror evaluates and measures its network in order to ensure timely access to care to underserved populations, identify deficiencies in the network, manage the network, make improvements to the network and sustain an adequate network.
Program	
3.	AHCCCS supports efforts to reward desired care outcomes attained through care coordination and the provision of the best and most appropriate evidence-based care that results in lower costs. How will the Offeror use data and evidence based decision support tools, both within its organization and in working with providers and stakeholders, to maximize care coordination for members, improve outcomes, and create cost efficiencies? How will these tools and data be used to implement outcome- and value-oriented payment models? Describe the Offeror's experience and specific results.
4.	Mr. Andrews is a member in your plan. He is extremely overweight, and spends long periods in bed due to ill health and complete exhaustion. He has no family. He can not walk 100 feet without resting. His medical diagnosis is COPD and he has a chronic cardiac condition following two heart attacks and stent insertions. When he becomes short of breath, he becomes very anxious and calls 911 to take him to the ER. He has been to the ER 12 times in the last six months. His PCP has referred him to the health plan for disease management. Please describe how the Offeror would address the needs of Mr. Andrews. Describe what systemic processes the Offeror will use to improve health care outcomes for members with one or more chronic illnesses.

5.	George Robertson, a 29 year old AHCCCS member, was involved in a motor vehicle accident on March 1, 2012. After immediate stabilization at the scene, George was rushed to the Arizona General Hospital and treated in the emergency room as a trauma patient. George sustained multiple injuries including a fractured femur, internal bleeding, and trauma to the sternum. After surgery to resolve the internal bleeding, and internal fixation of the fractured femur, George was transferred to the hospital floor. George has been an AHCCCS member for five years. George has a history of substance abuse which may have been a contributing factor in the accident. George is in active substance abuse treatment with a Regional Behavioral Health Authority provider but is not consistent in participating in treatment. After 21 days in the hospital, George is discharged home. George lives alone in a run-down apartment complex in Phoenix. George must navigate two flights of stairs to reach his apartment. Four weeks after discharge, George was found by a maintenance worker at the bottom of the stairs. Paramedics were called and George was rushed to the emergency room. George was diagnosed with a head injury, later determined to be a traumatic brain injury, and broken ribs that were sustained from the fall down a flight of stairs. George was found to be in possession of illegal substances by the paramedics, resulting in police involvement at the hospital. After an additional four day inpatient stay, George is transitioned by the hospital Social Worker to a skilled nursing facility that specializes in TBI patients. The skilled nursing facility is not a contracted provider. Describe what processes would be used to coordinate care for George as he moves through the continuum of care related to these documented health issues. What does the Offeror see as the greatest setback risks/challenges for George and how will the Offeror proactively address these concerns?
6.	Describe the Offeror's experience in Medicare Advantage and/or Medicare Special Needs Plans. Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror. What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment
Organization	
7.	The health care system in the United States is currently on an unsustainable path. The projected growth of Medicare and Medicaid based on demographics and historical trends result in public programs that consume an excessive portion of the U.S. Gross Domestic Product. There have been numerous studies that document that while having some of the highest costs in the world, the U.S. health care system based on some measures does not have the best outcomes. Recently the Institute of Medicine (IOM) released a report titled *Best Care at Lower Cost* that estimated $750 billion nationally is "wasted". This includes $210 billion in unnecessary services, $130 billion in inefficient care - $190 billion in excess administration - $105 billion in inflated prices - $55 billion in prevention failures and $75 billion in fraud. The same IOM study also identified various strategies that should be pursued to improve care and lower costs. As one of the single largest payers in the state of Arizona, AHCCCS has an important role

	to play in helping to move the health care system to a more sustainable model that improves outcomes. As a participant in the AHCCCS program, provide specific initiatives and efforts your organization will pursue to deal with "waste" that exists within the existing system and improve outcomes. Provide specific information describing the initiatives that would be pursued to improve quality and enhance cost containment including but not limited to the stakeholders involved, the timelines for implementation and the desired outcomes.
8.	The Offeror is required to develop a compliance program designed to guard against fraud and abuse. Beyond the requirements outlined in the RFP and AHCCCS policies, describe additional activities your compliance program will take to limit, identify, and address fraud and abuse. Describe the Offeror's experience using these methods and include examples of successful application.
9.	Describe in detail the ongoing processes and strategies the Offeror will implement to minimize the need for providers to utilize the claims dispute process to obtain proper reimbursement. In addition, describe the interventions and strategies the Offeror will employ to resolve claims disputes without resorting to the hearing process.
10.	**Information Technology (IT) Systems Demonstration** Demonstrate, by participating in mock Information Systems scenarios over a 10-day period, that the Offeror will understand how to, and have the capability to, accurately and timely: • Process data exchanged with AHCCCS • Administer actions based on the data processed Supplemental materials to assist in preparation for this demonstration are available in the Bidders' Library under the heading "Information Technology (IT) Systems Demonstration," and include: • Guidelines • 10-day Calendar • User Guides and Manuals These mock scenarios will begin on Tuesday, January 29, 2013. For this Submission Requirement, the Offeror shall provide written acknowledgement as follows: • <Offeror> acknowledges that its participation in the IT Systems Demonstration beginning on January 29, 2013, constitutes fulfillment of Submission Requirement No.10 • <Offeror> acknowledges that it will comply with the stated guidelines and calendar for this process. • <Offeror> acknowledges that the IT Systems Demonstration will be scored as part of the Offeror's Proposal

[End of Acute Care Program Submissions]

CRS – NARRATIVE SUBMISSIONS	
Access to Care/Network	
11.	Describe the steps that the Offeror will take to ensure that individuals with a qualifying CRS condition under R9-22-1301 et seq. are able to access the care needed, including specialty care, to serve their qualifying medical condition(s) as well as their other medical and behavioral health needs. Also describe how the Offeror will leverage and balance the use of providers in the multi-specialty interdisciplinary clinics (MSICs) versus those in the broader community.
Program	
12.	A 13-year old foster child diagnosed with Spina Bifida, Intermittent Explosive Disorder, history of poly-substance abuse, and PTSD resulting from sexual abuse, is enrolled in CRS. Describe the comprehensive treatment plan developed for all diagnoses to address the complex care needs of the child.
13.	Describe the Offeror's approach to integrating and coordinating behavioral health services for CRS members.
14.	Describe the mechanisms that the Offeror will use to ensure that all providers, including those within the MSIC setting and those outside of the MSIC setting, have access to the data needed to appropriately coordinate care for the member.
Organization	
15.	Describe the role that stakeholder input will play in all facets of the CRS Program. Provide a written narrative outlining your organization's expectations, goals and responsibilities for the Ombudsman/Client Advocate as well as the client advocacy program.

[End of CRS Program Submissions]

E. Oral Presentations

All Offerors shall participate in a scheduled oral presentation to last up to two hours. All presentations will be scheduled to occur during the weeks of February 18 and March 6, 2013. Presentations will be audio-taped by AHCCCS solely for the Agency's use in the evaluation process. AHCCCS shall notify each Offeror of their scheduled presentation no later than 5:00 pm Arizona time on January 31, 2013.

The purpose of the oral presentation is for the Offeror to demonstrate its expertise by presenting solutions to health care situations and operational challenges and responding to oral questions posed by AHCCCS. A previously prepared presentation about the Offeror will not be allowed. Offerors will be allotted time to privately discuss each question and to prepare a timed oral presentation.

The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate. Among these six individuals, the Offeror shall include persons with expertise in:

- Quality Management;

- Medical Management; and
- Comprehensive knowledge of the Offeror's Operations

The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. Arizona time on February 13, 2013.

AHCCCS will provide a white board or flip charts and markers for Offeror use in preparing for the Oral Presentation.

The Offeror will not be permitted to bring laptops, tablets or any prepared handouts into the room. Outside communication will be prohibited including but not limited to use of cell phones, telephones or text messaging. Offerors will be able to utilize any hard copy material brought with them including copies of policies and procedures as they prepare for the presentation.

EXHIBIT A: OFFEROR'S CHECKLIST

The Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder. Offerors must submit all items below, unless otherwise noted.

The Offeror must complete the Offeror's Bid Choice Form, Section A1 identifying the program(s) for which the Offeror is submitting a proposal. In addition, when bidding on the Acute Care Program, the Offeror must indicate the Geographical Service Area(s) (GSAs) for which the Offeror is submitting a proposal.

In the column titled "Offeror's Page No.," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Team may find the Offeror's response to the specified requirement.

A. GENERAL MATTERS

Subject:	***Page Number Reference***	***Offeror's Page No.***
Offeror's Checklist *(This Exhibit)*	Exhibit A	1 - 3
Offeror's Bid Choice Form *(Form provided below in this Exhibit and submitted with the checklist)*	See A1 below	N/A
Offeror's Signature Page	1 and 2	4 - 5
Signed Cover Sheets of Solicitation Amendments, if any	289	
Completion of all items in Section G: Representations and Certifications of Offeror	Section G	6 - #

A1: OFFEROR'S BID CHOICE FORM

ACUTE CARE PROGRAM

☐ Checking this box indicates the Offeror is bidding on the ***Acute Care Program***.

_____ **is bidding on the ACUTE Care Program**
Offeror's Name **in the GSAs checked below:**

- ☐ **GSA 2 Yuma, La Paz**
- ☐ **GSA 4 Apache, Coconino, Mohave, and Navajo**
- ☐ **GSA 6 Yavapai**
- ☐ **GSA 8 Gila, Pinal**
- ☐ **GSA 10 Pima, Santa Cruz**
- ☐ **GSA 12 Maricopa**
- ☐ **GSA 14 Graham, Greenlee, Cochise**

_____ _____
Authorized Signature Date

_____ _____
Print Name Title

CHILDREN'S REHABILITATIVE PROGRAM
☐ Checking this box indicates the Offeror is bidding on the ***Children's Rehabilitative Program***.

Authorized Signature _____ Date _____

Print Name _____ Title _____

NOTE: The "Requirement No." shown in Parts B, C, D, E, and F below refers to the **Submission Requirements** outlined in *Section H: Instructions to Offerors* of this RFP.

B. *ATTESTATION*

Attestation	***Requirement No.***	***Offeror's Page No.***
	1-34	

C. *CAPITATION SUBMISSION*

Capitation	***Requirement No.***	***Offeror's Page No.***
Acute Care Program Capitation Bid Submission Including Actuarial Certification	1	
CRS Program Capitation Bid Submission Including Actuarial Attestation	2	

D. EXECUTIVE SUMMARY AND DISCLOSURE

Executive Summary and Disclosure	***Requirement No.***	***Offeror's Page No.***
	1	
	2	

E. *ACUTE CARE NARRATIVE SUBMISSIONS*

Access to Care/Network	***Requirement No.***	***Offeror's Page No.***
	1	
	2	

Program	***Requirement No.***	***Offeror's Page No.***
	3	
	4	
	5	
	6	

Organization	***Requirement No.***	***Offeror's Page No.***
	7	
	8	
	9	
	10	

F. CRS NARRATIVE SUBMISSIONS

Access to Care/Network - CRS	***Requirement No.***	***Offeror's Page No.***
	11	

Program - CRS	***Requirement No.***	***Offeror's Page No.***
	12	
	13	
	14	

Organization - CRS	***Requirement No.***	***Offeror's Page No.***
	15	

EXHIBIT B: MINIMUM SUBCONTRACT PROVISIONS

For the sole purpose of this Attachment, the following definitions apply:

"*Subcontract*" means any contract between the Contractor and another party for the performance of any or all services or requirements specified under the Contractor's contract with AHCCCS.

"*Subcontractor*" means any party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS.

Subcontractors who provide services under the AHCCCS ALTCS and/or the Acute Care Program including but not limited to Division of Developmental Disabilities (DDD), DES/Comprehensive Medical and Dental Program (CMDP), ADHS/Behavioral Health Services (BHS), and Children's Rehabilitative Services (CRS), must comply with the following applicable rules and statutes:

- ALTCS - Arizona Administrative Code (A.A.C.) Title 9, Chapter 28. AHCCCS statutes for long term care are generally found in Arizona Revised Statue (A.R.S.) Title 36, Chapter 29, Article 2.

- Acute Care Program - A.A.C. Title 9, Chapter 22. AHCCCS statutes for the Acute Care Program are generally found in A.R.S. Title 36, Chapter 29, Article 1. Rules for the KidsCare Program are found in A.A.C. Title 9, Chapter 31 and the statutes for KidsCare Program may be found in A.R.S. 36, Chapter 29, Article 4.

- Medicare Cost Sharing - A.A.C. Title 9, Chapter 29 (for Acute) and A.A.C. Title 9, Chapter 29 (for ALTCS).

- DES/DDD - A.A.C. Title 9, Chapter 22, 28, and 33. AHCCCS statutes for DDD are generally found in A.R.S. Title 36, Chapter 5.1 and § 36-2932.

- DES/CMDP - A.A.C. Title 6, Chapter 5, Article 60. AHCCCS statutes for CMDP are generally found in A.R.S. Title 8, Chapter 5, Article 1.

- ADHS/BHS - A.A.C. Title 9, Chapter 20, 21, and Chapter 22, Articles 2 and 12, and A.A.C. Title 9, Chapter 31, Article 12. AHCCCS statutes for BHS are generally found in A.R.S. Title 36, Chapter 34.

- CRS - A.A.C. Title 9, Chapter 22, A.A.C. Title 9, Chapter 7. AHCCCS statutes for CRS are generally found in A.R.S. Title 36, Chapter 2, A.R.S. §36-797.43 and 44.

All statutes, rules and regulations cited in this attachment are listed for reference purposes only and are not intended to be all inclusive.

[*The following provisions must be referenced and compliance required in every contract.*]

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor.

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other Contractors, Subcontractors or state employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor, Subcontractor or state employee.

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING

By signing this subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements. (CLIA of 1988; 42 CFR 493, Subpart A)

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS. (A.R.S. §41-2548; 45 CFR 74.48 (d))

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Subcontractor shall comply with all Federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract. [42 CFR 434.70] [42 CFR 438.6(l)]

8. CONFIDENTIALITY REQUIREMENT

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

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S. Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules, A.R.S. §36-2901 et seq. (for Acute) and A.R.S. §36-2931 et seq. (for ALTCS).

11. ENCOUNTER DATA REQUIREMENT

If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. E-VERIFY REQUIREMENTS

In accordance with A.R.S. §41-4401, the Contractor and Subcontractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

14. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor 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.

15. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of the Inspector General (OIG). All incidents of potential fraud shall be reported to the OIG.

16. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

17. INSURANCE

The Contractor and Subcontractor are required to maintain insurance, at a minimum, as specified in Attachment E-1, Standard Professional Service Contracts and E-2, Standard Professional Service Contracts – Under $50,000. For policies for insurance for professional service contracts working with children or vulnerable adults the policy shall be endorsed to include coverage for sexual abuse and molestation.

18. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in Federal and State law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

19. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

20. NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability. (Federal regulations, State Executive order # 99-4)

21. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by Subcontractors at all tiers.

22. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Management that is consistent with AHCCCS Rules and the Contractor's policies.

23. RECORDS RETENTION

The Subcontractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available, at no cost, all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available, at no cost, for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by 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. [45 CFR 74.53; 42 CFR 431.17; A.R.S. §41-2548]

24. SCRUTINIZED BUSINESS

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

25. SEVERABILITY

If any provision of these subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

26. SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of covered services.

27. TERMINATION OF SUBCONTRACT

AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. [A.A.C. R2-5-501; A.R.S. §41-2616 C.; 42 CFR 434.6, a. (6)]

28. VOIDABILITY OF SUBCONTRACT

This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS' prior written approval.

29. WARRANTY OF SERVICES

The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

ATTACHMENT E-1

STANDARD PROFESSIONAL SERVICE CONTRACT

INDEMNIFICATION CLAUSE:

Contractor and Subcontractors shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.

This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or Subcontractors.

The *insurance requirements* herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$2,000,000
• Products – Completed Operations Aggregate	$1,000,000
• Personal and Advertising Injury	$1,000,000
• Blanket Contractual Liability – Written and Oral	$1,000,000
• Fire Legal Liability	$ 50,000
• Each Occurrence	$1,000,000

   a. If applicable, the policy shall be endorsed to include coverage for sexual abuse and molestation.

b. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

c. 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.

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.

Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".***

b. 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.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation Statutory

Employers' Liability

Each Accident	$ 500,000
Disease – Each Employee	$ 500,000
Disease – Policy Limit	$1,000,000

a. 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: Separately, EACH Contractor or Subcontractor exempt under A.R.S. §23-901, AND when such Contractor or Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:**
The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require (30) days written notice to the State of Arizona. Such notice shall be sent directly to Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor and Subcontractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all Subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each Subcontractor. All coverages for Subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal contract amendment, but may be made by administrative action.

H. **EXCEPTIONS**: In the event the Contractor or Subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or Subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

ATTACHMENT E-2

STANDARD PROFESSIONAL SERVICE CONTRACT – UNDER $50,000

INDEMNIFICATION CLAUSE:

Contractor and Subcontractors shall indemnify, defend, save and hold harmless the State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of Contractor or any of its owners, officers, directors, agents, employees or Subcontractors. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such Contractor to conform to any Federal, State or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by Contractor from and against any and all claims. It is agreed that Contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable. In consideration of the award of this contract, the Contractor agrees to waive all rights of subrogation against the State of Arizona, its officers, officials, agents and employees for losses arising from the work performed by the Contractor for the State of Arizona.
This indemnity shall not apply if the Contractor or Subcontractor(s) is/are an agency, board, commission or university of the State of Arizona.

INSURANCE REQUIREMENTS:

Contractor 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, his agents, representatives, employees or Subcontractors.

The *insurance requirements* herein are minimum requirements for this contract and in no way limit the indemnity covenants contained in this contract. The State of Arizona in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that might 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.

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Contractor shall provide coverage with limits of liability not less than those stated below.

1. **Commercial General Liability – Occurrence Form**
   Policy shall include bodily injury, property damage, personal injury and broad form contractual liability coverage.

• General Aggregate	$1,000,000
• Products – Completed Operations Aggregate	$ 500,000
• Personal and Advertising Injury	$ 500,000
• Blanket Contractual Liability – Written and Oral	$ 500,000
• Fire Legal Liability	$ 25,000
• Each Occurrence	$ 500,000

a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor".***

b. Policy shall contain a waiver of subrogation 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.

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.

Combined Single Limit (CSL)	$500,000

a. The policy shall be endorsed to include the following additional insured language: ***"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor".***

b. 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.

3. **Worker's Compensation and Employers' Liability**

Workers' Compensation Statutory

Employers' Liability

Each Accident	$100,000
Disease – Each Employee	$100,000
Disease – Policy Limit	$100,000

a. 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: Separately, EACH Contractor or Subcontractor exempt under A.R.S. §23-901, AND when such Contractor or Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$ 500,000
Annual Aggregate	$1,000,000

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 professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work of this contract.

B. **ADDITIONAL INSURANCE REQUIREMENTS:** The policies shall include, or be endorsed to include, the following provisions:

1. The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees wherever additional insured status is required. Such additional insured shall be covered to the full limits of liability purchased by the Contractor, even if those limits of liability are in excess of those required by this contract.
2. The Contractor's insurance coverage shall be primary insurance with respect to all other available sources.
3. Coverage provided by the Contractor shall not be limited to the liability assumed under the indemnification provisions of this contract.

C. **NOTICE OF CANCELLATION:** With the exception of (10) day notice of cancellation for non-payment of premium, any changes material to compliance with this contract in the insurance policies above shall require (30) days written notice to the State of Arizona. Such notice shall be sent directly to Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034 and shall be sent by certified mail, return receipt requested.

D. **ACCEPTABILITY OF INSURERS:** Insurance is to be placed with duly licensed or approved non-admitted insurers in the state of Arizona with an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor from potential insurer insolvency.

E. **VERIFICATION OF COVERAGE:** Contractor shall furnish the State of Arizona with certificates of insurance (ACORD form or equivalent approved by the State of Arizona) as required by this contract. The certificates for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf.

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 Michael Veit, Contracts Administrator, AHCCCS, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. The State of Arizona project/contract number and project description shall be noted 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. **DO NOT SEND CERTIFICATES OF INSURANCE TO THE STATE OF ARIZONA'S RISK MANAGEMENT DIVISION.**

F. **SUBCONTRACTORS:** Contractors' certificate(s) shall include all Subcontractors as insureds under its policies **or** Contractor shall furnish to the State of Arizona separate certificates and endorsements for each Subcontractor. All coverages for Subcontractors shall be subject to the minimum requirements identified above.

G. **APPROVAL:** Any modification or variation from the *insurance requirements* in this contract shall be made by the contracting agency in consultation with the Department of Administration, Risk Management Division. Such action will not require a formal contract amendment, but may be made by administrative action.

H. **EXCEPTIONS:** In the event the Contractor or Subcontractor(s) is/are a public entity, then the Insurance Requirements shall not apply. Such public entity shall provide a Certificate of Self-Insurance. If the Contractor or Subcontractor(s) is/are a State of Arizona agency, board, commission, or university, none of the above shall apply.

EXHIBIT C: ATTESTATION FORM

In order to be considered a responsive offer, the Offeror must attest to each element below by indicating with a check mark in the box next to each requirement. Failure to check any box will result in automatic disqualification of the offer.

If the Offeror is submitting a proposal for both the Acute Care and CRS Programs, the attestation of each element shall apply to both Programs. If the Offeror is submitting a proposal for the Acute Care Program only, the attestation of each element shall apply to that Program only.

In addition to complying with all contractual requirements, the Offeror specifically acknowledges the importance of the following provisions and their critical value to the Arizona Health Care Cost Containment System program. The statements in the attestations are not intended to alter or amend the contractual obligations set forth elsewhere in the Request for Proposal. In the event of any inconsistency or ambiguity regarding the meaning of an attestation, the provisions of the Request for Proposal are controlling.

AHCCCS has identified the general references for each element as a convenience for the Offeror; however, all references may not have been identified. It is the responsibility of the Offeror to identify all relevant sources for each element.

Corporate Compliance	
AHCCCS is committed to protecting the public from fraud, waste and abuse. As part of this commitment, AHCCCS Contractors must comply with all applicable Federal and State program integrity requirements. The Offeror attests that it will:	
1. ☐	Have a corporate compliance program and plan consistent with 42 CFR 438.608, and practices which comply with program integrity requirements specified in 42 CFR 455, and the AHCCCS requirements described in ACOM Policy 103 and the contract, by the contract start date *RFP Section D, Paragraph 62, Corporate Compliance*
Staffing	
The Offeror will demonstrate by the start date of the contract that all staff shall be fully qualified to perform the requirements of the contract. The Offeror attests that it will:	
2. ☐	Maintain a local presence within the State of Arizona as outlined in Section D, Paragraph 16, Staffing Requirements and Support Services, of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
3. ☐	Limit Key Staff to occupying a maximum of two of the Key Staff positions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
4. ☐	Have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies on urgent issue resolutions *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
5. ☐	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 *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*

Staffing - *continued*	
6. ☐	Screen all employees and subcontractors to determine whether any of them have been excluded from participation in Federal health care programs *RFP, Section D, Paragraphs 16, Staff Requirements and Support Services and 62 Corporate Compliance*
7. ☐	Require all staff members to have appropriate training, education, experience and orientation to fulfill the requirements of the position *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
8. ☐	Have sufficient staffing levels to operate in compliance with the terms of the contract *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
9. ☐	Have an Administrator/Chief Executive Officer (CEO) who shall have the authority and ability to direct Arizona priorities. *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
Information Systems	
The Offeror will demonstrate by the start date of the contract that its information system has clearly defined change control processes. The Offeror attests that it will:	
10. ☐	Maintain a change control process which includes the Offeror's ability to participate in setting and modifying the priorities for all information systems including those of the Parent Company, subcontractors and vendors *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
11. ☐	Maintain system upgrade and conversion processes which include appropriate planning and implementation standards *RFP, Section D, Paragraph 16, Staff Requirements and Support Services*
12. ☐	Have structures in place to ensure and support current and future IT Federal mandates *RFP, Section D, Paragraph 64, Systems and Data Exchange Requirements*
Claims/Encounters Processing	
The Offeror will demonstrate by September 1, 2013 that its systems and related processes can support the following key components of the AHCCCS Medicaid claims processing lifecycle. The Offeror attests that the entity and its IT system will:	
13. ☐	Accept and process both paper and electronic submissions *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
14. ☐	Allow for the proper load of provider contract terms, support processing of claims within timeliness standards, incorporate coordination of benefit activities, and generate claims payments and HIPAA compliant remittance advices *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*

Claims/Encounters Processing- *continued*	
15. ☐	Have the ability to generate encounter submissions and have the appropriate remediation processes in place when standards are not met *RFP, Section D, Paragraphs 38, Claims Payment/Health Information System; 64, Systems and Data Exchange Requirements; 65, Encounter Data Reporting*
Quality Management	
The Offeror attests that, by the start date of the contract, it will have:	
16. ☐	A process to include the health risks assessment tool in the new member welcome packet. The Offeror has/will have a process for coordination of care across the continuum based on early identification of health risk factors or special care needs, including those members identified who would benefit from disease management and care coordination. [42 C.F.R. 438.208] *AMPM Chapter 900*
17. ☐	A process that requires the reporting of all incidents of abuse, neglect, exploitation, unexpected deaths, healthcare acquired and provider preventable conditions to the AHCCCS Clinical Quality Management Unit *AMPM Chapters 900 and 1000*
18. ☐	Processes in place to receive data and forms from a provider's certified electronic medical records including Early, Periodic, Screening, Diagnostic and Treatment forms, performance measure and audit information, and information to facilitate assistance with care coordination activities *AMPM Chapter 400*
19. ☐	A process that meets AHCCCS requirements for identifying, reviewing, evaluating and resolving quality of care or service issues raised by any source *RFP, Section D, Paragraph 23, Quality Management and Performance Improvement (QM/PI)*
20. ☐	A process to provide recurring scheduled transportation for members with on-going medical needs, including, but not limited to dialysis, chemotherapy, and radiation *RFP, Section D, Paragraph 11, Special Health Care Needs*
MCH/EPSDT	
The Offeror attests that it will have:	
21. ☐	A process and a plan that includes outreach and care coordination processes for children with special health care needs and other hard to reach populations, and coordination with community and government programs *AMPM Chapter 400*
Medical Management	
The Offeror attests that it will have:	
22. ☐	A process in place for proactive discharge planning when members have been admitted to an inpatient facility *RFP, Section D, Paragraph 24, Medical Management (MM)*

***Medical Management** - continued*	
23. ☐	A process that ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field and disseminated to providers *RFP, Section D, Paragraph 24, Medical Management (MM)*
24. ☐	A process in place to provide emergency services without prior authorization regardless of contract status of the provider *AMPM Chapter 310F*
25. ☐	A process to analyze utilization data and use the results to implement medical management changes to improve outcomes and experience *RFP, Section D, Paragraph 24, Medical Management (MM)*
26. ☐	Disease and chronic care management programs that are designed to coordinate evidence based care focused on improving outcomes for members with one or more chronic illnesses which may include behavioral health conditions *RFP, Section D, Paragraph 24, Medical Management (MM)*
Behavioral Health	
The Offeror attests that it will have:	
27. ☐	A process for identifying members with behavioral health care needs and assisting members in accessing services in the Regional Behavioral Health Authority system *RFP, Section D, Paragraph 12, Behavioral Health Services; AMPM Chapters 400 and 1000*
Access to Care ***(Only Offerors submitting a proposal for the CRS Program must attest to #29)***	
The Offeror attests that it will have:	
28. ☐	A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
29. ☐ ***CRS Only***	A comprehensive network that complies with all CRS network sufficiency standards as outlined in RFP YH14-0001 (see Section D, Paragraphs 10, Scope of Services and 27, Network Development), no later than August 1, 2013 *RFP, Section D, Paragraph 27, Network Development*
30. ☐	A process for researching, resolving, tracking and trending provider inquiries/complaints and requests for information that includes contacting providers within three days and resolving issues within 30 days *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*
31. ☐	A process for monitoring and addressing provider performance issues up to and including contract termination *RFP, Section D, Paragraphs 27, Network Development and 29, Network Management*

Finance	
The Offeror attests that it will:	
32. ☐	Have a separate entity established for purposes of this contract within 120 days of the contract award if the Offeror is a non-governmental *New Contractor*. *RFP, Section D, Paragraph 51, Separate Incorporation*
33. ☐	Meet the minimum capitalization requirements within 30 days of the contract award if the Offeror is a *New Contractor;* or, fund through a capital contribution the necessary amount to meet the equity per member requirement within 30 days of the contract award if the Offeror is a *Successful Incumbent Contractor.* *RFP, Section D, Paragraph 45, Minimum Capitalization; Section H, Instructions to Offerors-Paragraph 14, Minimum Capitalization*
34. ☐	Secure a performance bond as defined in amount and type in Section D, Paragraphs 46, Performance Bond or Bond Substitute and 47, Amount of Performance Bond, and ACOM policies 305 and 306 no later than 30 days after notification by AHCCCS of the amount required. *RFP, Section D, Paragraphs 46, Performance Bond or Bond Substitute; 47, Amount of Performance Bond*

ATTESTATION SIGNATURE

In order for the proposal to be considered for AHCCCS review purposes, all boxes must be checked. The attestation must be signed and dated by the Offeror. A proposal containing check boxes left blank or lacking a signature and date below will not be considered further.

Offeror's Name:_____ certifies the elements attested to in this document are true and it is understood that AHCCCS will rely on this attestation in determination of the award.

Authorized Signature **Date**

Individual's Printed Name **Title**

EXHIBIT D: MEDICARE REQUIREMENTS TO COORDINATE CARE FOR DUAL ELIGIBLE ACUTE INDIVIDUALS

Section 1: Background Information

Medicaid members who are also enrolled in Medicare are referred to as dual eligible members. In an effort to improve care coordination for AHCCCS dual eligible members, the State will require all Acute Care Contractors to be organizations that manage and provide Medicare benefits to dual eligible members in all GSAs in which they hold a contract.

The State is currently working with CMS to implement a three-year Demonstration beginning January 1, 2014 which will integrate Medicare and Medicaid for dual eligible AHCCCS members. The State submitted a Demonstration proposal to CMS on May 31, 2012 which is available at http://www.azahcccs.gov/reporting/legislation/Integration/Duals.aspx. This Demonstration presents a novel and unique opportunity for Contractors to improve quality and reduce costs for dual eligible members in Arizona. Under the CMS Capitated Financial Alignment Demonstration "Demonstration," CMS, AHCCCS, and an AHCCCS Contractor enter into a Contract/Memorandum of Understanding (MOU) in which the Contractor receives payments from both AHCCCS and CMS to provide comprehensive, coordinated care for the integrated Medicare and Medicaid benefits. This Contract/MOU may modify some or all aspects of the clinical and non-clinical performance measures, the performance improvement projects and the quality management requirements that are specified in this RFP as well as other requirements or provisions in this RFP. The State is proposing the automatic enrollment of all dual eligible members into their AHCCCS plan for Medicare benefits on January 1, 2014. Under the Demonstration, individuals will have the ongoing option to opt-out so that they may receive their Medicare benefits on a fee-for-service basis through Original Medicare or through a Medicare Advantage plan, as negotiated with CMS.

It is important for Offerors to note that this Demonstration is not final and is currently undergoing Federal review. The State will continue to work with CMS, and AHCCCS intends to have a finalized Contract/MOU with CMS in early 2013. AHCCCS anticipates that the Contract/MOU will outline State-specific details associated with the terms and conditions of the Demonstration including, but not limited to: Program Authority, Contracting Process, Readiness Review, Enrollment, Beneficiary Protections, Administration and Reporting, Quality Management, Financing and Payment, Evaluation, and Oversight Responsibilities. Additional information and MOU templates can be found in the July 8 State Medicaid Director Letter *Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*. The Demonstration approach is subject to change until the Contract/MOU is finalized and approved by CMS.

July 8 State Medicaid Director Letter: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
AHCCCS Dual Demonstration Website: http://www.azahcccs.gov/reporting/legislation/Integration/Duals.aspx

Section 2: Medicare Structure

As required by A.R.S. §36-2906.01, the awarded Contractor must establish a separate corporation whose only authorized business is to provide services under this contract to AHCCCS eligible persons enrolled with the Contractor. This separate corporation must be established within 120 days of contract award. In addition, the Contractor must by January 1, 2014 operate either a Medicare Demonstration plan or a D-SNP serving beneficiaries eligible for both Medicare and Medicaid. The Contractor must have, and assure AHCCCS it has, the legal and actual authority to direct, manage, and control the operations of both the corporation established under this contract and the Medicare product to the extent necessary to ensure integration of AHCCCS and Medicare services for persons enrolled with the Contractor for both programs. The Contractor must ensure the integration of Medicare and Medicaid services within the following key functional areas of the organization or when utilizing administrative services subcontracts:

- Network Management/Provider Relations;
- Member Services;
- Quality Management;
- Medical Management;
- Corporate Compliance; and
- Grievance System.

In addition, the Contractor must establish or assure AHCCCS that it intends to establish branding for the Medicare product that ensures it is easily identifiable to members and providers as an integrated plan for both Medicare and Medicaid.

Section 3: Medicare State Certification
Medicare Advantage plans are required to be licensed under State law. As outlined in A.R.S 36-2903(B)(2) AHCCCS has the authority to certify its Contractors for Medicare purposes. Contractors are able to apply for certification through AHCCCS or apply and receive licensure through the Arizona Department of Insurance. The AHCCCS certification process is detailed in ACOM Policy 313.

Section 4: Participation in the Demonstration
In addition to all requirements of this RFP, the Contractor must meet all Medicare Demonstration participation requirements as dictated by CMS and the State. This may include, but is not limited to, approval of a Medicare Demonstration specific application, approval of a formulary consistent with Part D requirements, approval of a medication therapy management program (MTMP), and approval of a unified model of care. Additional information can be found in the March 29 CMS Memo found here: http://www.azahcccs.gov/reporting/Downloads/Integration/Duals_CMSMemo_MarchGuidanceDocumentforFinancialAlignmentDemonstrationPlans032912.pdf

With regard to the Demonstration's emphasis on coordination of Medicare and Medicaid benefits for dual eligible members, Medicare-Medicaid Demonstration Plans will be rigorously evaluated by CMS and the State as to their ability to improve quality and reduce costs for dual eligible individuals. After evaluation and selection by CMS and the State of the Acute plans to become Medicare-Medicaid Demonstration plans, a contract will be signed between CMS, the State, and the Offerors awarded the Acute Care contracts. To comply with the statute outlined in Section 2, this contract will be signed with the Medicare entity, not the AHCCCS entity. This contract will outline the health plan responsibilities for dual eligible members enrolled in the Demonstration plan. Additional details will be made available as determined by CMS and AHCCCS.

Finally, Contractors must pass a rigorous Readiness Review completed prior to enrollment of any beneficiary for Medicare benefits. Plans will be subject to a Readiness Review by CMS and the State across all areas, including but not limited to, network adequacy, stakeholder involvement, and consumer protections.

AHCCCS requires that Offerors submit a Notice of Intent to Apply (NOIA) with CMS as a Medicare-Medicaid Demonstration Plan (MMP) by November 14, 2012. Information can be found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf. To comply with ARS 36-2906.01, the NOIA must be submitted under the Medicare entity name. Separate NOIAs must be submitted for all AHCCCS lines of business in which the Offeror wishes to participate (Acute, ALTCS-EPD, and the Maricopa RBHA). The NOIA must be submitted specifically for the State of Arizona. The specific service area will be defined during the application process. This is a non-binding submission, but is required for Offerors to participate as a Demonstration plan. In addition, all Offerors must submit Demonstration specific applications to CMS by February 21, 2013 unless AHCCCS has notified Offerors otherwise. If the State does not move forward with the Demonstration or if an Offeror is not awarded a contract in a specific GSA, there is no penalty for an Offeror to withdraw an Application.

Section 5: Demonstration Requirements
While past Medicare performance is not required for the Offeror to be awarded a contract or for participation as a Medicare Demonstration plan, CMS and the State will consider this performance, if applicable. Organizations that are either an outlier in CMS' past performance analysis for CY 2014 or have a "consistently low performing" icon on the Medicare Plan Finder website may qualify to offer a Demonstration plan, after meeting other requirements, but will not be eligible to receive any new passive enrollments.

If the Contractor does not meet all CMS Demonstration requirements and is not approved by CMS and the State to participate as a Demonstration plan or is not eligible to receive new passive enrollments, the State reserves the right to take whatever action it deems is in the best interest of the State and may re-evaluate the Medicaid contract.

Section 6: Rates under the Medicare-Medicaid Demonstration
If the State and CMS successfully reach an agreement to implement the Demonstration, capitation rates shall be adjusted for dual members participating in the Demonstration. The awarded Acute Care capitation rates will be replaced with capitation rates computed by AHCCCS and CMS for the Medicaid and Medicare expenses, respectively, of the dual members projected under the Demonstration. AHCCCS intends to work with CMS to develop actuarially sound rates ensuring sufficient reimbursement for the Demonstration. AHCCCS proposes to use its current rate-setting methods for the Medicaid component of the Demonstration, including the potential for reconciliation of excess profits or losses.

Section 7: Participation as a Medicare Advantage Special Needs Plan
If the State and CMS are unable to reach an agreement to implement the Demonstration, all Acute Care Contractors will be required to provide Medicare benefits to dual eligible members as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in all awarded GSAs. Contractors will be required to implement Medicare business on January 1, 2014 and thus all Offerors are required to submit a non-binding Notice of Intent to Apply (NOIA) as D-SNPs to CMS no later than November 14, 2012 if applicable. Additional information found here: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NOIA_Memo.pdf. Offerors should note that this submission is **in addition** to the submission of the Notice of Intent to Apply as a Medicare-Medicaid Demonstration plan (see Section 3). To comply with the statute outlined in Section 2, the NOIA must be submitted under the Medicare entity name. D-SNPs must have a contract with AHCCCS to enroll Acute full benefit dual eligible members and must have a D-SNP subset that matches this contract. All respondents must also submit D-SNP applications to CMS by February 21, 2013. Additional information on D-SNPs can be found at: http://www.cms.gov/SpecialNeedsPlans/.

Section 8: State Contracting with D-SNPs
AHCCCS will not contract with any D-SNP to serve the Acute Care Medicaid population outside of awarded Acute Care contracts. If the State and CMS successfully reach an agreement to implement the Demonstration, Medicare-Medicaid Plans under the Demonstration will replace D-SNPs as a method for aligning Medicare and AHCCCS enrollment for dual eligible members.

Section 9: D-SNP Responsibilities
This section outlines requirements which are designed to improve care coordination and timely information sharing for dual eligible members enrolled in Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) consistent with 42 CFR 422.107, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Affordable Care Act.

9.1 ***Care Coordination***: If the dual eligible member is eligible for AHCCCS acute care benefits, then the D-SNP is responsible for coordination of both Medicare and Medicaid services regardless of whether the individual is enrolled with the D-SNP for Medicaid.

A. If the dual eligible member is enrolled with a D-SNP for both Medicare and Medicaid services, the D-SNP is responsible for coordinating all benefits covered by both the D-SNP and AHCCCS.

B. If the dual eligible member is not enrolled with the D-SNP for Medicaid, the D-SNP is responsible for coordinating AHCCCS only benefits with the member's AHCCCS Contractor. Coordination of Medicaid benefits is not the beneficiary's responsibility.

C. AHCCCS will ensure that the D-SNP has access to the dual eligible member's AHCCCS enrollment through AHCCCS Online.

D. The D-SNP will establish a contact within each AHCCCS Contractor that will be responsible to share, at minimum, timely inpatient hospital, emergency room, and chronic illness information to assist the AHCCCS Contractor with coordinating care when benefit coverage switches from Medicare to Medicaid.

E. The D-SNP will provide AHCCCS with the name of the contact person at the D-SNP who will be responsible for the coordination of care for dual eligible members.

F. The D-SNP will participate in any AHCCCS meetings (telephonic or in person) relating to care for dual eligible members and timely provide any necessary information and data.

9.2 ***Medicaid Eligibility***: D-SNPs are responsible for coordinating care for full benefit dual eligible AHCCCS Acute Care members. These members are eligible for receiving full AHCCCS benefits and do not meet criteria for long term care services through the Arizona Long Term Care System. These members are defined as:

- Qualified Medicaid Beneficiary with AHCCCS Benefits (QMB+)
- Specified Low Income Beneficiary with AHCCCS Benefits (SLMB+)
- Other Full Benefit Dual Eligible Beneficiary (FBDE)

9.3 ***Benefits Covered by D-SNP***: The D-SNP is not responsible for the provision or reimbursement of any Medicaid benefits. The D-SNP is responsible to maintain current knowledge and familiarity with AHCCCS acute covered services through ongoing review of AHCCCS laws, rules, policies, contracts, and guidance, as well as through information posted on AHCCCS' website. The D-SNP shall timely coordinate provision of AHCCCS covered services for persons enrolled in the D-SNP who are also enrolled with an Acute Care Contractor.

9.4 ***Medicaid cost-sharing protections covered under the D-SNP***: The D-SNP providers shall not impose Medicare cost sharing on dual eligible members for services covered by both Medicare and Medicaid. The D-SNP providers agree to accept the D-SNP payment as payment in full for services covered by both Medicare and Medicaid, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid. Dual eligible members shall be responsible for any applicable AHCCCS copayment.

Section 1902(n)(3)(B) of the Social Security Act prohibits Medicare providers from balance billing QMB members for Medicare cost-sharing, including deductibles, coinsurance, and copayments. QMB members have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. The D-SNP shall include a provision in all provider agreements specifying that the provider agrees to accept the D-SNP payment as payment in full, or bill the appropriate AHCCCS Contractor for additional payments that may be reimbursed under Medicaid.

9.5 ***Identification and Sharing of Information on Medicaid Providers***: The D-SNP shall develop a network of providers which includes an overlap of providers in the D-SNP network who are also contracted with AHCCCS Acute Care Contractors. AHCCCS Contractor networks can be accessed online through individual websites from https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx.

9.6 ***Verification of Eligibility for both Medicare and Medicaid***: The D-SNP is responsible for accurately verifying both Medicare and Medicaid eligibility of potential and enrolled members.

The D-SNP will have access to AHCCCS Online to verify member real-time Medicaid eligibility. Members who have Medicare eligibility can be clearly identified.

9.7 ***D-SNP Service Area***: The D-SNP service area shall match the Acute Care Medicaid contract service area.

Section 10: Medicare Data
For purposes of care coordination and future analysis, AHCCCS will be reviewing mechanisms for receiving all data on dual eligible members. AHCCCS may require D-SNPs to submit Medicare encounters to AHCCCS in addition to CMS.

Section 11: Transition of Dual Eligible Members
If AHCCCS does not move forward with the Demonstration, where possible and in the best interest of members, in instances where dual eligible members are enrolled with an Unsuccessful Incumbent Contractor, AHCCCS may assign the dual eligible members to Contractors they are currently enrolled with for Medicare services in order to align members and maximize care coordination opportunities.

Section 12: Other Options for Improving Alignment
If AHCCCS does not move forward with the Demonstration, AHCCCS will explore and identify other methods for improving care for dual eligible members with D-SNPs. AHCCCS may implement ways to encourage alignment of Medicare and Medicaid plan including, but not limited to:

- On an ongoing basis, aligning Medicaid enrollment with Medicare;
- Working with community stakeholders for outreach and education;
- Conducting state sponsored outreach and education;
- Requiring plan outreach and education; and
- Data and information submission from D-SNPs.

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. **1 (One)** Solicitation Due Date: **January 28, 2013** **3:00 PM (Arizona Time)**	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 27th **day of November, 2012,** in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** **SIGNED COPY ON FILE**
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 1 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.				When will the Letter of Intent format be released?	Watch the AHCCCS website for major RFP decisions.
2.				Where can I find information on Duals?	Information can be found on the AHCCCS website; AHCCCS Duals Page: http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx
3.				What is the projected enrollment for next year? Do you anticipate the number to continue to decline?	AHCCCS measures Historical Enrollment numbers. Projection of future enrollment is not posted. Information may be posted to the Bidders' Library.
4.				For entities that have a traditional CMS Institutional Special Needs Plan (I-SNP), could they maintain their patient population that has both Medicare and Medicaid coverage? Or, is the intent of the AHCCCS to move the long-term care residents (SNFs/ALFs) with Medicare-Medicaid status into a current ALTCS-contracted entity?	Under the AHCCCS proposal for the Dual Demonstration, all individuals who have AHCCCS and Medicare whether they are enrolled in a Medicare Advantage plan or Medicare FFS would be passively enrolled into their current ALTCS plan for Medicare in addition to Medicaid. Members will have a choice to opt-out of the Demonstration for Medicare and AHCCCS has proposed that members can opt out to Medicare FFS only. All details of the Demonstration are subject to change and negotiation with CMS until there is a signed Memorandum or Understanding with AHCCCS and CMS. You can find all the details of the AHCCCS proposal here http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx

Question #	Section	Paragraph #	Page #	Question	Response
5.				Is the Request for the Acute Care program of AHCCCS or is this a new program specific to CRS and Acute Services related to the CRS recipients? If it is a separate program, do you know when information for the Acute Care Program RFP will be posted? Based on the following, LOIs will not be required as part of the Acute Care RFP Process; has this been the case in the past?	Combined RFP to streamline services for our members and avoid members having to navigate multiple separate systems for care. RFP due out November 1, 2013. No LOI will be required as they have been in the past.
6.				Do plans have to be separately incorporated? Can plans be certified by AHCCCS to be a Medicare Special Needs Plan (SNP)? Is it a requirement to go through AHCCCS for certification?	Statute requires that a plan be separately incorporated for purposes of their Medicaid business with AHCCCS. Separately, statute allows AHCCCS plans to be certified through AHCCCS for their Medicare Advantage SNP business instead of licensed through DOI if they choose. This is not a requirement. AHCCCS plan SNPs are also able to receive licensure through DOI for their Medicare business instead of through AHCCCS if they choose. Although the Medicare SNP and Medicaid plans are separately incorporated, plans which offer companion AHCCCS and D-SNP plans that coordinate Medicare and Medicaid for dual eligible members meet AHCCCS requirements. The goal is for dual eligible members to be enrolled with an organization for both Medicare and Medicaid where coverage is coordinated and seamless to the member.

Question #	Section	Paragraph #	Page #	Question	Response
7.				When is the procurement for the Duals Demonstration?	There will be no separate procurement for the Duals Demonstration. For the ALTCS population, Arizona will use its current ALTCS Contractors. For the Acute population, plan selection will be determined through the upcoming Acute RFP. There will be no separate plans who serve the dual eligible population only, thus to participate in the Duals Demonstration, bidders must bid on the entire Acute Medicaid population in Geographic Service Areas they choose. Additional information can be found on the Acute RFP page: http://www.azahcccs.gov/commercial/Purchasing/RFPInfo.aspx under Presentation/Meeting Materials AHCCCS Duals Page: http://www.azahcccs.gov/reporting/legislation/integration/Duals.aspx
8.				If AHCCCS pursues the alternative model and requires that health plans also be D-SNPs, then does that mean health plans will not need to submit documentation to CMS as specified by the CMS Duals Demonstration timeline (e.g., health plans are only required to go through the D-SNP application process)? Are timelines for the Acute Care/CRS RFP still firm despite the delayed MOU sign off from CMS? Under our umbrella of companies we have a business unit that specializes in Medicaid and a Medicare division that has been successful with Medicare Advantage, including the development of D-SNPs. Would it be acceptable for our Medicaid division to own the Medicaid contract with AHCCCS while using the expertise of our affiliated Medicare organization to	If a decision is made that AHCCCS will not be pursuing the Duals Demonstration then yes, plans would not be required to submit Demonstration required information. At this time, AHCCCS is still pursuing the Demonstration so Offerors are required to submit required information for both the Demonstration and D-SNP. See the RFP, Exhibit D, Medicare Requirements, for additional information. The delayed MOU timeframe does not impact the Acute Care/CRS RFP timeline. Yes, this is the situation with most of our current

Question #	Section	Paragraph #	Page #	Question	Response
				meet the requirements of the Duals Demonstration? If there is a delay in securing approval from CMS of the AHCCCS Duals Demonstration Proposal, should health plans continue to move forward with the CMS 2014 Duals Demonstration data submission requirements? These include the submission of the Notice of Intent to Apply (NOIA) in November 2012 and the Duals Demonstration Application in February 2013. Please provide clarification regarding network requirements if AHCCCS moves forward with its alternative model for the Duals and requires that health plans be a D-SNP. Specifically, if a health plan's D-SNP operates with a narrow network, will the State require the health plan to enlarge the network to meet AHCCCS network requirements as well? Or, can a health plan meet AHCCCS network requirements as part of its Medicaid operations and meet Medicare/Duals requirements under its D-SNP?	health plans. However, we are aware that changes may need to be made in the future if we pursue the Demonstration. We have no further details at this time. Yes, plans should move forward with all Demonstration and D-SNP requirements until AHCCCS notifies otherwise. Health plans will be required to meet AHCCCS network requirements outlined in the RFP. In addition, health plans will be required to meet CMS Medicare network requirements outlined in the Demonstration and/or D-SNP applications.

Question #	Section	Paragraph #	Page #	Question	Response
9.				I was hoping that we might be able to get some clarification/detail regarding the estimate that AHCCCS receives roughly a few hundred out-of-state claims per year. Specifically, my questions are: Are those few hundred out-of-state claims per year a reflection of only claims that AHCCCS pays direct? Or does it include contractors' out-of-state payments as well (based on encounter types that payors must provide AHCCCS)?	AHCCCS and our Contractors pay for out of state services when the services are emergent and when the medically necessary service was not available in-state. In addition, our contractors have out of state providers in their offered networks to provide services to members that live close to the border when it is closer for them to see a provider out of state than one in-state. We do not have the exact numbers, but would expect that there are far more than a few hundred out of state claims per year when both AHCCCS and the contractors are included.
10.				As we discussed, I would appreciate clarification regarding the "Plan B" option relative to an Acute Bidder being required to submit a Medicare-Medicaid Plan application to CMS for the Demonstration and/or a D-SNP Application to CMS in February 2013. As you are aware, The University of Arizona Health Plans (UAHP) provides management services to Maricopa Health Plan (MHP), which is owned by Maricopa Integrated Health Systems (MIHS). While MIHS is a current AHCCCS contractor, MIHS is no longer a D-SNP contractor with Medicare. Rather, their D-SNP partnership with The University of Arizona Health Plans ended in 2011. At that time, UAHP extended its D-SNP—University Care Advantage--into Maricopa County. Our question then relative to the upcoming AHCCCS RFP/dual demonstration is whether any of the following would fulfill either/both of the above SNP alignment requirements? • MHP to Partner/Align with UCA to supply the D-SNP component in Maricopa County;	Per our Oct 9th Major Decisions document we specify that: All Contractors will be required to serve dual members and to participate with Medicare as either a Dual Eligible Special Needs Plan or CMS Capitated Financial Alignment Demonstration Plan as required by AHCCCS in all GSAs awarded. Additional information about the Medicare requirement will be found in the RFP issued next week.

Question #	Section	Paragraph #	Page #	Question	Response
				• Enter into a joint venture relationship with an exiting D-SNP, such as UCA; or • Contract directly with CMS as a D-SNP	
11.				I am hoping for your guidance on the following points on behalf of a client that is planning to participate in the RFP. (Apologies if you covered this in last week's presentation—it was hard to hear some of the discussion for phone participants.) 1. Can Medicaid MCOs propose to sub-contract with an MA SNP to satisfy the D-SNP requirement? 2. Are there any limitations on the use of sub-contracting for care coordination?	It is the intention of AHCCCS for the Medicaid MCO to also have a Medicare product – through the CMS Capitated Financial Demonstration or as a D-SNP. See the RFP or other documents for additional details.
12.	General Inquiry			Does AHCCCS intend to adjust hospital rates and/or capitation rates based on readmission scores and/or performance outcomes in 2013 or 2014?	It is possible that hospital rates (using a DRG-methodology effective on or after October 1, 2014) could be adjusted for readmission scores or performance outcomes. It is also possible that capitation rates under this contract could be impacted by a Contractor's performance outcomes – see the discussion regarding Payment Reform – Shared Savings in Section D1, Paragraph 53, Compensation.
13.	Policy 433			What vendor does AHCCCS currently use to produce and distribute member ID cards?	The current AHCCCS Member ID Card Vendor is Custom Card Solutions.
14.	IT Demo			Will AHCCCS be sending any HIPAA transactions (820, 834, 837)? If so, which ones can the bidder expect?	Yes, as outlined in the Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* and *Calendar*, it is AHCCCS' intent to develop and make available mock 834, 820 and 837 claims files.

Question #	Section	Paragraph #	Page #	Question	Response
15.	IT Demo			Will a separate SFTP site be created for the IT demonstration files? If so, how will the bidder gain access to the site?	It is AHCCCS' intent to place and retrieve these files to and from specific secured folders. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Introduction* is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders' Library, General, *Instructions to Electronic File Transfer - Secured File Transfer Protocol*.
16.	IT Demo			Will the bidder be required to demonstrate electronic claim attachment functionality?	No, it is not AHCCCS' intent to include electronic attachment based scenarios as a component of this process.
17.	IT Demo			Will the claims being sent be only for the members within the membership files provided by AHCCCS?	Yes, it is AHCCCS' intent to send claims only for those members within the membership files provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent
18.	IT Demo			Will the claim be all form types (dental, professional, institutional)?	Yes, the three form types listed are included; however, the pharmacy form type is not included. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.
19.	IT Demo			Should the bidder expect to receive pharmacy claims?	No, it is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.

Question #	Section	Paragraph #	Page #	Question	Response
20.	IT Demo			For what pharmacies will any pharmacy claims be sent?	It is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.
21.	IT Demo	Provision Document		When can the bidder expect the formats and content for "processing summaries" to be provided by AHCCCS?	Processing summary layouts and required content will be provided as outlined in the IT Systems Demonstration Calendar with each related date provided by AHCCCS. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Calendar* are amended to clearly reflect this intent.
22.	H	Section H: Enrollment Information		When will reports H1, H2 and H3 be available? Will these be posted to the website or the ShareInfo folder? If the latter, can you provide the sub folder these documents will be stored in?	Reports H1, H2, H3 and H4 from the Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section H, *Enrollment Information*, have been available since November 1, 2012. These reports are found on the EFT server, as indicated in the Bidders' Library. See Bidders' Library, Data Supplement for Offerors'-Acute Care/CRS, Section A, *Data Supplement Instructions and Overview* for instructions on where to find data and reports that are posted to the EFT server: The data and reports will be located in a secured folder named Acute Care-CRS-RFP14. Under that folder is a secured folder named Data Supplement Files in which the Offerors will be able to download the data.
23.	IT Demo IT Calendar			The third claims scenario group is to be available to the bidders on 2/6 and the summary is due to AHCCCS on 2/8. The second encounter submission is due to AHCCCS on 2/7. Is the expectation that the second encounter submission include the third claims scenario group?	No, the second encounter submission should not include the third claims scenario group. There is not an encounter submission associated with the third set of claims scenarios.

Question #	Section	Paragraph #	Page #	Question	Response
24.	N/A	N/A		Does AHCCCS intend to prepare and provide Offerors with template provider agreements?	No, AHCCCS will not be providing templates of provider agreements.
25.				When does AHCCCS intend to publish the Capitation Bid Templates?	The Capitation bid templates were published, along with instructions, on November 19, 2012. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section F, Bid Submission Information.
26.				AHCCCS has stated that the bidding entity must have actual and legal authority [over the Medicare plan]. Assume holding Company A (wholly owned by two Arizona corporations) owns two entities: Company B, a legal entity which will be an Offeror and Company C; another separate legal entity that is a licensed health care services organization under Title 20. Companies B and C are sister corporations, each of which is a separate legal entity owned by Company C. Does this organizational structure satisfy the cited requirement?	The question is unclear. The first clause states that Company A owns both Company B and Company C; the last clause of the last sentence states that Company C owns Companies B and C. Second, the question does not clearly state that either Company B or Company C are separate corporations. Third, the question does not identify which business entity holds a Medicare Advantage contract. Based on information provided, we cannot determine whether business organizations comply with A.R.S. §36-2906.01 or whether the hypothetical Offeror has actual and legal authority over the Medicare Advantage plan.
27.	Pending Data Book			If not already included in the pending data book release, please quantify TPL recovery amounts. Also, please include an estimate for copay collection rates (where applicable).	The question is unclear. Does the Offeror mean TPL recovery amounts that are included in adjudicated encounters, or TPL recovery amounts that are self-reported by Contractors? Assuming the Offeror means TPL recovery amounts that are included in adjudicated encounters, such data was not extracted and will not be provided. Copay data is available on 5010 transactions, thus this data only became available beginning with dates of service July 1, 2012. No copay collection rates are available at this time.

Question #	Section	Paragraph #	Page #	Question	Response
28.	A through B	N/A	100-101	Are bidders required to disclose ownership and managing employee information for subcontractors?	For purposes of the RFP, an Offeror will be considered to be in compliance with Section D1, 62, (A through B) if Offeror submits a completed and accurate Section G, Representations and Certifications of Offerors. Section D1, Paragraph 62, Corporate Compliance Bullet A, pertains to the Disclosure of Ownership and Control of the Contractor. Bullet B, requires the Contractor to obtain the information in 1 through 4 from its subcontracted providers and fiscal agents. Once an Offeror is awarded a contract they must meet these requirements.
29.	D1 and D2	62	101 & 86	The health plans have been having discussions with AHCCCS on the Corporate Compliance Requirements as specified in Paragraph 62. Will there be changes to this paragraph based on the outcome of these discussions?	At this time, the section should be considered amended by removing the requirement to routinely check the a. Social Security Administration DEATH MASTER FILE and b. The National Plan and Provider Enumeration System (NPPES) in the section regarding Disclosure of Information on Persons Convicted of Crimes. Future amendments may be included at a later date.
30.	D1	75	108-109	"AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved." Please provide adjustments applied to the rate ranges (if any) to account for anticipated technology efficiencies.	AHCCCS will not adjust the rate ranges to account for anticipated technological efficiencies.

Question #	Section	Paragraph #	Page #	Question	Response
31.	D1	75	109	Proposition 204 was not passed. Please provide an estimate of the impact of KidsCare II enrollees transitioning to Medicaid.	AHCCCS' member month projections assumed that Proposition 204 would not pass, thus no revisions to the member month projections are necessary. See the Bidders' Library, Data Supplement for Offerors'- Acute Care/CRS, Section H, Enrollment Information, *Introduction* and *H-3 Enrollment by Month (Historical and Projected)* for more information.
32.	D-2-CRS	3	117	To ensure continuity of care, can existing ALTCS EPD/CRS members be grandfathered into the CRS Fully Integrated Coverage Type on 10/1/13 should they choose to?	No. ALTCS EPD members that have CRS eligible conditions will be fully integrated into their ALTCS EPD Contractor. ALTCS EPD Contractors are encouraged to contract with or authorize services with providers that have been providing services to the member for their CRS covered condition.
33.	D-2-CRS	Covered Services	124	Currently, there are services that have not been covered through CRS such as: ventilator services; chronic or acute infections related to a CRS condition; cancers related to a CRS condition; diapers/toileting items and dialysis. These services are not clearly written as out of scope in the RFP Section D2 or in the AMPM draft for a partially integrated CRS member. Can you confirm that these services will continue to be covered by the member's primary coverage, or will they be carved-in to the CRS capitation?	All covered services <u>related to the member's CRS condition</u> are the responsibility of the CRS Contractor currently and under the RFP.

Question #	Section	Paragraph #	Page #	Question	Response
34.	D-2-CRS	Performance Measures	148	Currently, the AHCCCS performance measure for Initiation of First CRS Service is within the date specified on the member's ISP or within 90 days of positive CRS eligibility (Att J, CYE13, pg. 22). In the RFP, the Performance Measure is stated as "Initiation of Services (within 30 days)". We interpret this to mean that the initiation of services should be within 30 days of development of the ISP. Please confirm.	No, services for a CRS member will be measured based on an appointment completed within 30 days from the date of enrollment with the CRS Contractor.
35.	Sections E1 and E2 Contract Terms and Conditions	Paragraph #8	199 & 217	Under the Changes paragraph an amendment is deemed accepted 60 days after the date of the mailing by AHCCCS even if the amendment has not been signed by the Contractor. Paragraph 45 Term of Contract and Option to Renew states that an amendment will be deemed accepted 30 days after the mailing date. Which is correct?	Section E1 and Section E2, Paragraph 8, Changes, is amended to state "When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 30 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment." This change will appear in a future version of the contract.
36.	Sections E1 &E2	Paragraph 50	207 & 225	Is the "Type of Contract" language correct on page 207?	No, the language has been amended to "Fixed-Price, stated as capitated per member per month, except as otherwise provided." This change will appear in a future version of the contract

Question #	Section	Paragraph #	Page #	Question	Response
37.	Sections E1 & E2, & Section I, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2, Paragraph F, and Attachment E-1, Item F. - Subcontractors and Attachment E-2 Item F.- Subcontractors	210, 214, 228, 232 322, 326	Should the Offeror furnish to the State of Arizona separate certificates and endorsements of each subcontractor?	No, Item F. *Subcontractors*, is amended to read, "Contractors' certificate(s) shall include all subcontractors as insureds under its policies **or** upon request, the Contractor shall furnish to the State of Arizona separate certificates and endorsements for each subcontractor upon request." This change will appear in a future version of the contract and the Minimum Subcontract Provisions.
38.	Sections E1 & E2 and Section I, Exhibits, Exhibit B, Minimum Subcontract Provisions	Attachments E-1 & E-2	210, 214, 228, 232, 322, 326	Where should the insurance verifications, for both Offerors and providers, be submitted?	Section E1 & E2 and Minimum Subcontract Provisions are amended to clarify that insurance verifications of the Contractor shall be sent to AHCCCS Contracts Unit, Mail Drop 5700, Division of Business and Finance, 701 E. Jefferson St., Phoenix, AZ 85034. Additionally, all subcontractors are required to maintain appropriate insurance per the RFP and Minimum Subcontract requirements and to provide verification upon request. These changes will appear in a future version of the contract and the Minimum Subcontract Provisions.
39.	Section G	4,5 & 6	278-282	When completing SECTION G, can responses requiring narrative (for example 4.c - Accessibility Assurance) be attached as a separate document if it is longer than the space provided on the form?	The form boxes expand to include the narrative response as it is typed. No additional pages are necessary.
40.	G	Item 5.b.	280	Please define "subcontractor" as it applies to this question? Does "subcontractor" by definition include a bidding entity's network providers? Please clarify	The definition of a subcontractor is defined in G-1, 42 CFR 455.101 Definitions, pages283-284. Section G, Item 5.b. pertains to the Offeror's ownership or control

Question #	Section	Paragraph #	Page #	Question	Response
				whether AHCCCS wants the Offeror to submit this information, including social security numbers for all subcontractors (including providers) with submission of the bid.	interest in any subcontractor in which they have direct or indirect ownership of more than 5%. If the Offeror has ownership or controlling interest of 5% or more in a subcontractor then it must submit all the required information including social security numbers.
41.	G	Item 6.b.	281	Please define "disclosing entity" and "Offeror" as both terms apply to this question?	Disclosing entity means any Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent. "Disclosing entity" and "Offeror" are synonymous as they pertain to this question. Refer to Section G, G-1, 42 CFR 455.101 Definitions, pages 283-284.

Question #	Section	Paragraph #	Page #	Question	Response
42.	H	N/A	287	This section states that all acute care Offerors, if awarded a contract, are required to be organizations that contract with CMS to provide and manage Medicare benefits for dual eligible member. However, this appears to conflict with the Arizona requirements that the AHCCCS Contractor be a separately organized entity whose only business is the AHCCCS contract. Please clarify the required legal relationship between the AHCCCS Contractor and the CMS-contracted entity for dual eligibles.	There is no conflict. A.R.S. 36-2906.01(A) provides that "Entities, including insurers as defined in section 20-104, hospital, medical, dental and optometric service corporations defined in title 20, chapter 4, article 3 and health care services organizations as defined in section 20-1051, are prohibited from contracting with the administration as a system contractor unless the entity establishes an affiliated corporation whose only authorized business is to provide services or coverage pursuant to a contract with the administration to persons defined as eligible in section 36-2901, paragraph 6, subdivisions (a), (f) and (g)." Thus, the legal entity that is an Offeror in response to this RFP can be an entity that contracts with CMS as a Medicare Advantage Special Needs plan and can also establish an affiliated corporation whose only authorized business is to provide Title XIX services pursuant to Title 36, Chapter 29, Article 1 of the Arizona Revised Statutes.
43.	Section H	7	289	How will the scoring be weighted for: • The narrative submissions • The IT demonstration • The Oral Presentations • Capitation Distribution	AHCCCS is not providing the actual weighting of the four components.

Question #	Section	Paragraph #	Page #	Question	Response
44.	H.7 Acute Scoring	All	290	The proposal states, "The following four components will be evaluated and weighted in the order listed: - Capitation and Program (Program includes Oral presentations) - Access to Care/Network and Organization What is the actual weighting of each of these four components?	AHCCCS is not providing the actual weighting of the four components.
45.	Section H, Number 7. EVALUATION FACTORS AND SELECTION PROCESS	Paragraph 1 "Acute Scoring"	290	Will AHCCCS please describe in more detail how will weights be assigned to the four RFP response sections? For example, if the four sections are weighted in decreasing order: 1) Capitation; 2) Program and oral presentations; 3) Access to Care/Network; 4) Organization, what are the weights assigned to each section, i.e. 30% for Capitation, 25% for Program, etc. Is each question within the four sections weighted equally, if not, how is each question weighted with respect to the section? What weight will the oral presentation receive in comparison to the written responses within the Program section?	AHCCCS is not providing the actual weighting of the four components.
46.	H	7	290	There are four components that will be evaluated and weighted for the Acute care bid. Can AHCCCS describe the scoring methodology and relative weights of the four components?	AHCCCS is not providing the actual weighting of the four components.
47.	H, Acute Scoring	4-5	290	Regarding the Acute Scoring process, please provide the percentages regarding how each of the four scoring components will be weighted. Will they be equally weighted at 25% each or differentially weighted? Or will each of the ten Acute Care questions be weighted 10%?	AHCCCS is not providing the actual weighting of the four components.

Question #	Section	Paragraph #	Page #	Question	Response
48.	H	9	292	Will a capped Contractor be required to be a Medicare Special Needs Plans (SNP) or participate in the Duals Demonstration? If a capped Contractor wants to participate in the Duals Demonstration, can they?	No, a capped Contractor will not be required to be a Medicare Special Needs Plans (SNP) or participate in the CMS Capitated Financial Alignment Demonstration. Dual eligible members will be disenrolled from the Contractor. Section H, Instructions to Offerors, Paragraph 9, Award of Contract, *Capped Contract Awards* is amended to disenroll dual eligible members from the capped Contractor.
49.	Section H	10	293	At the 11/19 meeting, it was stated that AHCCCS would not assign members to a plan that was unprepared to receive membership yet section H uses a more liberal phrasing of "may not." Please confirm whether the decision to assign to an unprepared contractor is at the discretion of AHCCCS.	The RFP document prevails. Responses given during the Offerors' Conference are not binding. The decision to assign members is at AHCCCS' discretion based on Readiness Reviews.
50.	H	12	294	The current RFP schedule includes only one round of questions after the data book is released and this 2nd and final round is prior to the rate ranges being released. Will AHCCCS consider having another round of questions for any follow up data or rate range questions?	Due to the release of the capitation rates/rate ranges currently anticipated for December 14, 2012, AHCCCS will permit a third set of Technical Assistance and RFP Questions which will be limited to the published capitation rates/rate ranges. AHCCCS will not respond to any other questions. Questions will be due by 3:00 p.m. Arizona time Friday December 21st, 2012. AHCCCS will issue the third RFP amendment on or around January 4th, 2013.
51.	Section H	15	296	Does the offeror need to identify Section G as proprietary or will AHCCCS automatically deem it proprietary?	AHCCCS has automatically deemed Section G, Representations and Certifications of Offeror, as proprietary.
52.	Section H	15	296	Can offeror logos be included on the page outside of the ½" margin?	Yes, the Offeror's logo can be included in the margins.

Question #	Section	Paragraph #	Page #	Question	Response
53.	Section H	Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission	296	This section provides that responses to each submission requirement must be limited to five pages and permitted attachments. Can AHCCCS confirm that no attachments are permitted to the Narrative submissions outlined in Section H, Number 16. SUBMISSION REQUIREMENTS, E. Narrative Submission?	No attachments are permissible unless specifically noted. There are no Narrative Submission Requirements outlined in Section H, Instructions to Offerors, which allow attachments.
54.	H	15	296	AHCCCS will only consider the information provided within the allotted page limit and permitted attachments. What are the permitted attachments?	No attachments are permissible unless specifically noted.
55.	H-15	3	296	The instruction states: "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 81/2" x 11" one sided, single spaced, type written pages". Narrative Submissions in section E are not identified as separate submission requirements. Is each "narrative submission" subject to a 5 page minimum (for a total of 45 page minimum for the 9 questions) or is the combined submission subject to the 5 page minimum?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.
56.	H.	15. Contents of Proposal, 16. Submission Requirements, and E. Narrative Submissions	296 and 305	Please provide clarification regarding page limits for each response section. This RFP section states, "Unless otherwise specified, responses to each submission requirement must be limited to five (5) 8½" x 11" one sided, single spaced, type written pages." In Section E. Narrative Submission, AHCCCS asks for responses to several sub-questions in each section. Does the five page limit apply to each sub-question, i.e. Access to Care/Network number 1-five page maximum, number 2, five page maximum, etc. or does the five page limit apply to the overall major section?	Each individual submission requirement is preceded by a number (e.g. 1.) and each number is limited to five pages, unless otherwise noted. There are 10 narrative submissions for Acute Care plus 5 additional for CRS.

Question #	Section	Paragraph #	Page #	Question	Response
57.	Section H	15	296	Is the Offeror required to include the question from the RFP in the response, or is it acceptable to reference the question number from the RFP without repeating the question in the proposal?	The Offeror is not required to include the question from the RFP in the response; however, the response must clearly identify which question is being answered.
58.	Section H	15	297	Can the page numbering fall within the ½" margin?	Yes, the page numbering can be included in the margins.
59.	H	5	297	Use of contingent language such as "exploring" or "taking under consideration" will not be given any weight during the scoring evaluation process. Narrative submission # 7 asks the bidder to describe any initiatives it will pursue to deal with waste and would pursue to improve quality. How should the bidder present future driven initiatives that will be favorably scored?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
60.	H-15 and I-A	15 A	297 and 311	In Section H-15 it states that "each section shall begin with a table of contents" In Section I-A: Offeror's Checklist, opening paragraph it states the "Offeror's Checklist must be submitted with the proposal and shall be the first pages in the binder". Given that the table of contents is required to begin each section, is the table of contents to not be included in the sequential page numbering?	Yes, the Table of Contents for each section must be included in the sequential page numbering. The Offeror's Checklist (Exhibit A) must be submitted as the first pages in the binder and only appears at the start of the binder. The Table of Contents, however, accompanies each section and shall be sequentially numbered

Question #	Section	Paragraph #	Page #	Question	Response
61.	B	All	3	Should the bid amount include the cost of paying PCPs 100% of Medicare allowable in 2013/2014?	No, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates. The Bidders' Library, Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
62.	H.	16. Submission Requirements, B. Attestation, Access to Care, number 28.	301	This section states, " A comprehensive network that complies with all Acute Care network sufficiency standards as outlined in RFP YH14-0001 and ACOM Draft Policy, Acute Network Standards, no later than August 1, 2013 RFP, Section D, Paragraph 27, Network Development." In addition to this attestation and the narrative description described in Section E.1 and 2, does AHCCCS expect the bidder to submit additional documentation relative to its network build out with the bid submittal? i.e. Do bidders have to submit a list of actual contracts and/or LOIs by network area as outlined in the RFP?	No additional documentation related to the Offeror's network build out, including LOIs, is required with the proposal.
63.	H	16	302	Can you please list what is included in the administrative fee limit of 8%? For example, is care management, health insurer fees, etc. included in this amount?	Funding for all administrative functions is included in the administrative fee limit. This includes non-encountered functions like care management. The Health Insurer Fee should **not** be included in the administrative component. This Fee will be handled outside the administrative component, similar to the

Question #	Section	Paragraph #	Page #	Question	Response
					Premium Tax.
64.	Section H	16-C	302/303	AHCCCS indicates that bids submitted with a medical component outside of the published range will receive zero points (page 302). AHCCCS indicates it will publish an actuarially sound rate range equivalent to the bottom half of the rate ranges from the minimum to the midpoint (page 303). Does this mean that a bid that is above the dollar value of the stated/published midpoint but yet still within the rate range will receive a score of 0?	Yes, a capitation bid outside (above or below) the **published** rate range will receive a score of 0.
65.	H	16	303	When the rate ranges are released, please indicate if any adjustments were made to account for generic launches. If so, please provide the adjustments applied.	AHCCCS did not make any adjustments for generic launches.
66.	Section H	E. Narrative Submissions	305	When responding to Section E or other sections requesting Offeror experience, is it acceptable for an Offeror to include information related to the experience its Management Services Subcontractor and its affiliate companies have owning and administering health plans, provided that the State prior approves the Management Services Subcontractor in advance?	Yes, this would be acceptable if the Offeror clearly identifies which organization's experience they are presenting.
67.	H	16	305	The additional 180,000 to 430,000 new members eligible for Medicaid will likely have pent-up demand. Does AHCCCS anticipate adjusting the rate ranges for this pent-up demand? If so, please provide the adjustments applied.	AHCCCS will not adjust the rate ranges for assumptions like pent-up demand.
68.	H	16	305	This may be addressed in the yet unreleased risk adjustment information but given the overall Medicaid population is expected to increase significantly (additional 180,000 to 430,000 new members eligible), how does AHCCCS anticipate risk adjusting for these	Information on risk adjustment is now available in the Bidders' Library, Data Supplement for Offerors'- Acute Care/CRS, Section I, Risk Adjustment Information.

Question #	Section	Paragraph #	Page #	Question	Response
				members? Will their risk scores be based on demographics only?	
69.	H	16E	305-309	AHCCCS does not appear to be differentiating bidders based on their approaches to meeting contract requirements, but is using "value-adds" to distinguish among bidders. What types of "value-adds" are of most importance or how will AHCCCS consider them?	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
70.	H-16-E	6	307	Narrative Submission 6 states in part "….Describe processes that will be utilized to enhance and maximize care coordination and improve member experience for members being served for both Medicare and Medicaid services by the Offeror and for members who will only be served for Medicaid by the Offeror…." Does the last section of this sentence (underlined) refer to dual members who are in the Offeror's Medicaid plan and another entities Medicare plan or utilizing Medicare FFS?	Yes, the underlined section refers to a Contractor's members that are dual (Medicare and Medicaid) that are enrolled with the Contractor for Medicaid but another entity for their Medicare benefits.
71.	H-16-E	5	307	Narrative submission #5. In the response to this case scenario, is it acceptable to add information to fill in the gaps of why and how certain circumstances came about and then use that information as the basis for parts of the response.	AHCCCS will not provide suggestions on how to write a proposal that will be favorably scored.
72.	H	Question 6	307	Assume Arizona Corp A and Arizona Corp B own (50/50 interest each) in Corp C, which is a holding company that owns the Offeror (Arizona Entity D). Is the Offeror in this question inclusive of the experiences of C as well as of A and B and any subcontractor that provides operational support to the Offeror; such as utilization management?	The Offeror may provide experience for Corp A, Corp B Corp C and entity D. The Offeror must specify which entity's experience they are describing when providing the narrative response.

Question #	Section	Paragraph #	Page #	Question	Response
73.	H	E – Narrative Submissions	307	Submission 6 states, "What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment" Can we assume that the question mark was left off and that this is the end of this submission requirement.	Submission requirement number six is complete and has been amended to include a question mark at the end of the sentence. The amended sentence reads as follows: "What strategies will be used to increase and maintain aligned Medicaid and Medicare enrollment?"
74.	H	16	307-308	Each Offeror must "provide specific initiatives and efforts… [they] will pursue to deal with 'waste' that exists within the existing system and improves outcomes." Is AHCCCS planning on adjusting the rate ranges to account for such initiatives? If so, please provide the assumptions/adjustments used.	AHCCCS will not adjust the rate ranges for initiatives the Offeror will describe in its Proposal.
75.	H	E	307-308	Since the RFP states that there will be no points awarded for future strategies, how will your Narrative questions that are specifically soliciting future strategies be addressed/scored?	The RFP does not state that there will be no points awarded for future strategies. Future strategies will indeed be scored; however, use of contingent language such as 'exploring' or 'taking under consideration' will not be given any weight during the scoring evaluation process. Furthermore, the Offeror will be held to initiatives and strategies presented in their proposal.
76.	H	E. Narrative Submissions (Question 10)	308	Where are the user guides and manuals located, mentioned on page 308?	User Guides and Manuals are located in the Bidders' Library, under the heading *Current Reporting Guides and Manuals*.
77.	H	E. Narrative Submissions (Question 10)	308	For existing SFTP access- Will the mock files/data for the scenarios be housed in the State's current SFTP site or will there be a different access point or requirement?	It is AHCCCS' intent to place and retrieve these files to and from specific secured folders. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Introduction* is amended to add information on these folders. Instructions to gain access to the site are found in the Data Supplement in the Bidders' Library, General, *Instructions to Electronic File Transfer - Secured File Transfer Protocol*.

Question #	Section	Paragraph #	Page #	Question	Response
78.	Section H	16-E	309	At the 11/19 meeting, it was stated that an offeror's subcontractor could participate in the oral presentations. Will AHCCCS require any specific documentation supporting that the individual is employed by a subcontractor as opposed to being a consultant?	No specific documentation will be required beyond the resumes of the staff participating in the oral presentation. AHCCCS reserves the right to request additional documentation.
79.	H.	15. Contents of Proposal and E. Oral Presentations	309	AHCCCS states the following relative to the Oral Presentation: "The Offeror shall bring no more than six individuals to the meeting. All participants must be employees of the Offeror; no consultants may participate." If the Offeror plans to subcontract several of these functions, is it permissible to bring personnel who will be administering these operations who are not employees of the offeror to the Oral Presentation?	Yes, staff as you have described would be allowed to participate in the Oral Presentation. However, refer to D1 and D2, ¶16, Staff Requirements and Support Services and ¶37, Subcontracts for specific staffing/subcontract Contract Requirements.
80.	Section H	Number 16. SUBMISSIO N REQUIREME NTS, E. Oral Presentations Paragraph 3	310	This section provides that the offeror may not be permitted to bring laptops, tablets or any prepared handouts to the Oral presentations, but will be able to utilize hard copy material "including copies of policies and procedures as they prepare for the presentation." Can AHCCCS confirm that bidders may bring prepared background material for their own use, in addition to copies of policies and procedures?	The Offeror may bring prepared background material, policies and procedures to assist in preparing for the oral presentation. These materials will not be provided to or utilized by AHCCCS in the scoring process.
81.	H	Instructions to Offerors	312	The Instructions require the Bid Response to be in Times New Roman, 11 point font. Should the Capitation Bid Template also be in Times New Roman, 11 point font? How do we address page numbers as required by the Checklist?	No. The Capitation Bid Template is already formatted. Page numbers for the template and the Certification will have to be added manually.

Question #	Section	Paragraph #	Page #	Question	Response
82.	Section I	Exhibit B – Minimum Subcontract Provisions – Attachment E-1	320	A reference to a new attachment E-1 was added to the insurance section within the minimum subcontract provisions (#17). Please explain the general purpose of this new attachment specifically, the requirement on page 321 for policies to be endorsed to include the additional language of: *"The State of Arizona, its departments, agencies, boards, commissions, universities and its officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor*". What actions, if any, does AHCCCS anticipate to be required by the provider and/or contractor to meet the requirement? Please address both existing contracts and newly contracted providers.	This requirement applies to all awarded contracts under this RFP. It is the responsibility of the Contractor (MCO) to ensure that each of its subcontractors (providers) are in compliance with the applicable insurance requirements as described in the contract, in addition to holding the State and its officers harmless. Each subcontractor shall have appropriate liability insurance and workman's compensation coverage as evidenced by an insurance certificate which should be sent to the Contractor and compliance shall be monitored by the Contractor.
83.	I	Exhibit C, Item #10	329	"Change Control" can have many different meanings. In the context of this attestation, how does AHCCCS define "change control" as well any parameters regarding "change control"?	Change control is defined as a systematic approach to managing all changes made to a system, the purpose of which is to ensure that no unnecessary changes are made, that all changes are documented, that services are not unnecessarily disrupted and that resources are used efficiently.

Question #	Section	Paragraph #	Page #	Question	Response
84.	Section I, Exhibit D	General	333	The Offeror is required to pursue its Medicare bid through a dual process: the normal bid process and the Demo bid process. What role will AHCCCS play in the CMS bid approval process, and how will AHCCCS validate or verify the Offeror's CMS application?	Under the Medicare Advantage SNP application process, AHCCCS will work with CMS when possible, but ultimate authority of approval is done by CMS. AHCCCS will work with CMS to verify submissions. Under the CMS Capitated Financial Alignment Demonstration, there is no bid process as there is in the Medicare Advantage process. Offerors are required to submit an Application to CMS in February as well as additional CMS required documents. AHCCCS will work with CMS to verify and review these documents.
85.	Section I, Exhibit D	General	333	Since the Offeror will be submitting its Network through the HSD table process with CMS, what is the timeline and process that AHCCCS will be using to evaluate the adequacy of the Offeror's Medicare Network?	Under the CMS Capitated Financial Alignment Demonstration process, AHCCCS will work with CMS, to evaluate the Offeror's Medicare network.
86.	Section D1	10	38	With regard to CRS eligibility – section D1 states that an acute plan would refer a member for CRS through notification to AHCCCS Division of Member Services but members are determined eligible by the CRS contractor. The 11/19 presentation, slide 106, stated that AHCCCS would determine medical eligibility for the CRS program. Which is accurate?	Section D1, Paragraph 10, Scope of Services, page 38 is amended to clarify that the Contractor is responsible for care of members until those members are determined eligible by AHCCCS, Division of Members Services. This change will appear in a future version of Section D of the contract.
87.	Section D1 and D2	16	50 and 135	Paragraph 16 states that Contractor shall "employ" certain Key Personnel. May the Contractor also arrange for the provision of these personnel through a Contractor's Management Services Subcontractor provided that the State prior approves the Management Services Subcontractor in advance?	Yes, the Key Personnel requirements may be fulfilled through a management services agreement subject to prior approval by AHCCCS.

Question #	Section	Paragraph #	Page #	Question	Response
88.	D.1.	Paragraph 5	51	Please define "multiple lines of business." For example, may a Key Staff member, such as the Dispute and Appeal Manager position, serve the bidding entity's affiliated entities depending upon work load?	AHCCCS considers multiple lines of business as a company/corporation/ organization that provides healthcare coverage under several product lines, among several markets, or multiple contracts. For example a company/ corporation/organization that provides Medicaid services in Arizona, New Mexico and Utah and also operates a commercial business and/or Medicare product. The Dispute and Appeals Manager could serve the Offeror's affiliated entities, as long as all staffing requirements are met.
89.	D.1.	Paragraph 6, Key Staff Positions	51	Must each of the key staff positions be employees or can the bidder use contractors to fill these roles? Can the Contractor use employees of a parent company or affiliated company to fill these roles? Can these individuals share more than one role, either within the Contractor or between related entities?	Yes, the Key Staff positions must be employees of the Offeror, or contracted/employed under an administrative service subcontract, as outlined in Section D1, Paragraph 37 Subcontracts. Yes, under Section D1, Paragraph 37, Subcontracts of the RFP administrative services subcontracts includes all Service Level Agreements with any Division or Subsidiary of a corporate parent owner. However, all staffing requirements outlined in Section D1, Paragraph 16, Staff Requirements and Support Services must be met. Yes, an individual can occupy a maximum of two of the Key Staff Positions.

Question #	Section	Paragraph #	Page #	Question	Response
90.	H, Key Staff Positions and Corporate Compliance	N/A	51 and 99	Regarding Page 51, item "Key Staff Positions" and page 99, item "Corporate Compliance;" If the Corporate Compliance Officer can be shared with a related organization as indicated on page 51, please explain the requirement that the Compliance Officer must be "onsite" per page 99. Does "onsite" refer to part of the time, all of the time; presence in Arizona or presence in the office location of the contractor?	The Corporate Compliance Officer can be shared with a related organization; however, this position must be physically located in Arizona to conduct business during business hours.
91.	Section D1 and D2	Paragraph 23	59 and 144	RFP states: "The contractor must ensure that the QM/PI unit within the org structure is separate & distinct from any other units of departments such as Medical Management or Case Management...." "QM/QI Positions performing work functions related to the contract mush have a direct reporting relationship to the CMO and the local CEO...." **Question**: Is State requiring the contractor to have two separate QM/PI units within the organization - 1 unit that is specific to Acute and 1 unit that is specific to CRS? Or is it permissible to have one QM/PI unit that supports both Acute and CRS Quality Management & Performance Improvement?	It is permissible to have one QM/PI unit that supports both Acute and CRS. Key staff members are limited in the number of key staff positions they may hold (see Section D1 and D2, Paragraph 16, Staff Requirements and Support Services.)

Question #	Section	Paragraph #	Page #	Question	Response
92.	Section D1	Paragraph 23, QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT (QM/PI),	61	When does AHCCCS anticipate releasing the "next generation" of quality performance measures?	The next generation of Performance Measures has been included in the RFP. AHCCCS will continue to monitor CMS quality measure expectations, review the availability of additional data sources such as Health Information Exchange, Electronic Health Records, etc. and consider implementing additional measures from the CMS measure sets based on penetration and use of these technologies within Arizona health care systems in future contract years.
93.	Section D1	23	62-64	When does AHCCCS expect to develop or release more specifics on the new Performance Measure methodologies and how it established or will establish Minimum Performance Standards for some of them?	Performance Measures were selected from NCQA HEDIS measure sets and from the CMS measure sets being established for CHIPRA, Well Child, Adult, Dual, and LTC. The methodologies are publically available on the measure set developers' websites and through links on the CMS website. For those Performance Measures listed with a TBD for the Minimum Performance Standard (MPS), national Medicaid rate data is not currently available. AHCCCS will utilize national Medicaid rate data should it become available. If not available, AHCCCS will establish the MPS based on a stated CMS goal or where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
94.	D1	23	62-64	Please provide performance measures by GSA and risk group for the base period as well as the most current measurement period.	AHCCCS will not provide additional data related to performance measures by GSA or risk group. Offerors may reference the Performance Measure results published on the AHCCCS website.

Question #	Section	Paragraph #	Page #	Question	Response
95.	Section D1	23	64	For those performance measures that are in a TBD status, what time period does AHCCCS anticipate using for the baseline data?	Data from the first six months of operation of CYE 2014 will be reviewed to determine the appropriate Minimum Performance Standards and Goals. In instances where data is already available to the Agency, AHCCCS will analyze historical encounter data as part of the rate determination.
96.	D.1	27. Network Development	69	The RFP states, "The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services." Please provide a listing of the AzEIP providers or advise where it can be obtained.	Arizona Early Intervention Program (AzEIP) provider (vendor) information is available on the Department of Economic Security, Arizona Early Intervention website.
97.	D.1	27. Network Development	69	The RFP states, "Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-for-Service rate for Primary Care services." Please provide a listing of the Homeless Clinics in Maricopa County.	AHCCCS will provide a list of Homeless Clinics in Maricopa and Pima County upon award of the contract.
98.	D.1.	Homeless Clinics, Item Number 2.	69	What is the definition of "needed specialty services?" Does this requirement apply when such services are available in-network?	Contractors must utilize in-state, contracted network providers. If the needed specialty services are not available in-network, the Contractor must make the services available through an out-of-network provider. In Section D1, Paragraph 27, Network Development, "needed specialty services" refers to services considered outside of standard medical-surgical services because of the specialized knowledge required for service delivery and management.

Question #	Section	Paragraph #	Page #	Question	Response
99.	Section C, Definitions	Day – Business/ working	8	Is the word "day" left out of the first sentence?	Yes, the definition is amended to read "A business day means a Monday, Tuesday…". This change will appear in a future version of the contract.
100.	D1	42	82	Will the data book include amounts for physician incentive payments (assuming such programs existed)?	The Data Books include expenditures by category of service, including several for physician services. If physician incentive payments were incorporated in adjudicated encounter data, then such payments are included.
101.	D.1	43. Management Services Agreement and Cost Allocation Plan	83	The RFP states, "If a Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management." Does AHCCCS expect a new contractor to submit the management services agreement with its proposal?	Administrative services contracts will not be submitted with proposals. Once awards are made, any Administrative Services Agreements meeting the criteria in D1, ¶ 37 Subcontracts, pages 76 will be submitted for approval.
102.	D1	50-Financial Viability	86	This paragraph references ACOM Draft Policy 305. Is this the correct Policy reference? Should this be Policy 313?	Both ACOM Draft Policy 305 and ACOM Policy 313 should be included. D1 is amended to include ACOM Policy 313 in Paragraph 50, Financial Viability Standards. This change will appear in a future version of Section D of the contract.
103.	D1	51	86	Regarding the separate incorporation requirement, will the establishment of a limited liability corporation satisfy the separate corporation requirement?	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an "affiliated corporation."
104.	D.1.	51. Separate Incorporation	86	The RFP states that, "Contractor shall establish a separate corporation for the purposes of this contract." Please clarify whether the requirement permits a bidder to establish a separate entity that is a limited liability company (LLC) rather than a corporation.	No, a limited liability company is not a corporation. A.R.S. §36-2906.01 requires the establishment of an "affiliated corporation."

Question #	Section	Paragraph #	Page #	Question	Response
105.	Section D1 and D2	51	86 and 172	Paragraph 51 states: "Within 120 days contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." Would the State consider adding "or other contracts with CMS, AHCCCS, and/or another State regulatory agency," to accommodate a plan offering multiple programs (e.g., ALTCS, Medicare, etc.) through AHCCCS and/or CMS?	AHCCCS will add "or other contracts with AHCCCS" at the end of this sentence. The statute does not allow the addition of CMS or another State regulatory agency. Section D1 and D2, Paragraph 51, Separate Incorporation, are amended to include this additional language. This change will appear in a future version of Section D of the contract.
106.	D.1. and H		86, 302	*Administrative Expense Limits:* We note an apparent conflict between RFP Sections D.1. and H regarding the issue of limitation on administrative expenses. Section D.1. page 86: "Administrative Cost Percentage = Total administrative expenses divided by the sum of total PPC and prospective capitation + Delivery Supplement + All Reconciliation Settlements + Reinsurance less premium tax. Standard: No greater than 10%." Section H page 302: "Acute Care Program Capitation Bid Submission; item #2 – Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration/Gross Medical Component. Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points." Does this mean that the standard for actual	There is no conflict. There is one methodology to compute the administrative expense standard, and at this time AHCCCS allows a Contractor to report up to 10% according to the formula contained in D1, paragraph 50, Financial Viability Standards. Despite this, it is correct that an Offeror with an administrative component bid exceeding 8% according to the formula provided in Section H, Instructions to Offerors, Paragraph 16.C. will receive a score of zero points. Premium Tax is not considered an administrative expense; however, because it is included in the capitation paid, it is subtracted in the denominator according to the formula contained in D1, Paragraph 50, Financial Viability Standards. Premium Tax should not be included in the administrative component bid.

Question #	Section	Paragraph #	Page #	Question	Response
				administrative expenses is 10% of total revenue, but that if a carrier bids more than 8%, they score zero points on the administrative component of the bid score? In addition, when determining the measure of administrative expense is premium tax considered part of administrative expense or is it not considered part of administrative expense?	
107.	Section D1	50	86/86	Excluding the equity per member requirement, will AHCCCS consider an MA plan certified by AHCCCS out of compliance if the ratios for the contractor's Medicare line of business fall outside of the guidelines listed for the acute care ratios?	No, AHCCCS will not apply the AHCCCS Acute Care standards to the financial viability ratios for the Contractor's Medicare line of business. AHCCCS will review the ratios included in D1, Paragraph 50, Financial Viability Standards but will only consider the Contractor out of compliance for the standards explicitly described for the Medicare Advantage Plan Certified by AHCCCS.
108.	Section D1	Paragraph 53, COMPENSATION,	87	Which national episodic/diagnostic risk adjustment model does AHCCCS use to establish prospective capitation rates?	AHCCCS has used the Optum (formerly Ingenix) Symmetry Episode Risk Groups (ERG) tool. More information on risk adjustment is now available in the Bidders' Library, Data Supplement, Section I, *Risk Adjustment Information*.

Question #	Section	Paragraph #	Page #	Question	Response
109.	D.1.	53, Question 1.	87, 2nd paragraph under Compensation.	"AHCCCS provides the following data to its actuaries for the purposes of rebasing and/or updating the capitation rates... d. AHCCCS fee-for-service schedule pricing adjustments…" In its range of capitation rates expected to be released on December 14, 2012, has AHCCCS taken into account the recently released CMS ruling that Medicaid PCP reimbursement would be increased to at least the same as Medicare? If not, will there be an adjustment to capitation rates for this at a later date? Should carriers assume an increase in the PCP reimbursement from prior experience to account for this increase?	No, the rate ranges provided will not consider PCP rate parity. Additionally, the capitation bid should not include the cost increase necessary to pay PCPs 100% of the Medicare rates. Section B of the Data Supplement for Offerors – Acute Care/CRS, includes a Program and Fee Schedule Changes document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
110.	D.1.	53, Question 2.	87, 2nd to last paragraph under Compensation.	The second to last paragraph notes, "In instances in which AHCCCS has specialty contracts of 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." Do bidders have information on all specialty contracts and all legislation/policy limits AHCCCS has so we may create a bid which appropriately reflects these limits? If bidders do not, when will they become available?	AHCCCS did not provide Offerors with information on specialty contracts or legislation/policy limits, but intends to provide such information prior to the start date of the contract. The encounter data in the Data Books is reflective of Contractors' costs for related services and is the base data for the AHCCCS rates and/or rate ranges.

Question #	Section	Paragraph #	Page #	Question	Response
111.	D.1.	53, Compensation - Payment Reform – Shared Savings	88, 2nd to last paragraph.	The second to last paragraph states, "AHCCCS anticipates that capitation rates will be reduced by a withhold of no less than 1% in CYE14, 100% of which will be paid to one or more Contractors according to relative Contractor performance." Is this program an incentive program for Contractors who do the right thing based on what AHCCCS wants them to do? Or is this an incentive arrangement for Contractors to pass on to providers? Does AHCCCS assume that additional revenue to Contractors will be based on innovative arrangements between the Contractor payer and the providers, with this payment meant to be shared with providers of the awarded Contractor?	AHCCCS is currently developing the payment reform policy with the intent to drive innovative arrangements that will further enhance cost control and result in quality improvements, while also offering providers incentive to participate in these arrangements. AHCCCS will release the policy no later than six months prior to the start date of the contract.
112.	D1	57- Reinsurance	91	Why is the Reinsurance language different between D1 and D2 (p. 178)? The language regarding Catastrophic Reinsurance case notification states that the Contractor must notify Medical Management Unit of cases identified 'within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually within 30 days of the beginning of each contract year,' but D1 language refers to the Chart of Deliverables.	The Chart of Deliverables referenced in D1, Acute Care Program Requirements, ¶57 Reinsurance, contains the same notification requirements as the language in D2, CRS Program Requirements, ¶57 Reinsurance. D1, ¶57 is amended to include the notification information and to delete the reference to the Chart of Deliverables. This change will appear in a future version of Section D of the contract. Notification/reporting requirements for both Programs are the same.

Question #	Section	Paragraph #	Page #	Question	Response
113.	D.1.	58, Coordination of Benefits/Third Party Liability	96, Retroactive Recoveries, Paragraphs 1 and 2.	Paragraphs 1 and 2 state, "The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service…After two years from the service date, AHCCCS will direct recovery efforts…Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS…The total recovery period…is limited to three years after the date of service…" We understand there currently is a three year retroactive recovery period. Does this section change the current period from a full Contractor recovery period of 3 years to only 2 years, and then AHCCCS gets the value of recoveries in the third year? This issue will be important to understand as we develop our medical expense bid.	Yes, current policy (ACOM Policy 412, Claims Reprocessing) permits Contractors to engage in retroactive third party recovery for three years after the date of service. Effective October 1, 2013, in accordance with Section D1, Paragraph 58, Coordination of Benefits/Third Party Liability and ACOM Draft Policy, Coordination of Benefits/Third Party Liability, the Contractor is required to engage in retroactive third party recovery for up to two years from the date of service.
114.	Exhibit D-Medicare Requirements	General Question	n/a	General Question about CMS/DOI regulatory oversight going forward. If a Plan currently has a DOI reporting relation for Medicare, with the dual integration proposal, will AHCCCS take over the oversight (i.e. NAIC DOI financial reporting requirements)?	No, AHCCCS does not intend to take over the oversight of the NAIC DOI financial reporting requirements or any other DOI requirements.
115.	D.1 Attachment B.1. Deliverables	37. Subcontracts Administrative Services subcontracts	pp. 75-76 and 252	The RFP states, "All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in Attachment B1, Acute Care Program Contractors' Chart of Deliverables. Administrative Services Subcontracts: 1. Delegated agreements that subcontract;	Administrative services contracts will not be submitted with proposals. Once awards are made, any administrative services contracts meeting the criteria in D1, ¶ 37 Subcontracts, page 76 will be submitted for approval. The Chart of Deliverables requires Administrative Service Agreements to be submitted to AHCCCS for approval 60 days prior to the start date of the Agreement.

Question #	Section	Paragraph #	Page #	Question	Response
				a. Any function related to the management of the contract with AHCCCS, b. Claims processing, including pharmacy claims, c. Credentialing including those for only primary source verification (CVO). 2. All Management Service Agreements; 3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner." Does AHCCCS expect a new contractor to submit any administrative services subcontracts, i.e. Medical Management, Quality Assurance, etc. with the proposal or are these to be submitted after contract award for AHCCCS prior approval? The chart of deliverables is not clear regarding this requirement for new contractors (page 252).	
116.	IT Systems Demonstration Provision and Calendar	6TH Bullet under provisions and 4th Row Under Calendar AHCCCS to Offeror	Provisions and Calendar	Will initial and subsequent claims scenarios include retail pharmacy drug (NCPDP) claims? The calendar suggests only paper and electronic 837 claims. Retail pharmacy drug claims are processed and adjudicated via point of sale by pharmacy benefit manager. It would be administratively burdensome to process and adjudicate retail pharmacy drug test claims manually for the IT Systems Demonstration.	No, it is not AHCCCS' intent to include NCPDP/Pharmacy based scenarios as a component of this process. The Bidders' Library, Information Technology (IT) Systems Demonstration, *Provisions* are amended to clearly reflect this intent.

Question #	Section	Paragraph #	Page #	Question	Response
117.	IT Systems Demonstration Provision and Calendar	8TH Bullet under provisions and 5th Row Under Calendar AHCCCS to Offeror	Provisions and Calendar	Trading partner set-ups and interface systems are often idiosyncratic for each trading partner. Currently we do not exchange 270/271 and 276/277 transactions with AHCCCS. Are we allowed to test with AHCCCS prior to the IT Systems Demonstration start date? If so, would that include testing with Transaction Insight?	No, the Offeror will not perform any testing with AHCCCS prior to the IT Demonstration start date. It is not AHCCCS intent that Offerors develop a process to exchange 270/271 or 276/277 transactions with AHCCCS. Offerors may exchange this data utilizing an automated system or a manual process. The intent of these demonstrations is to mimic key data exchanges related to eligibility and claims status inquiries that would occur between the Offeror and a provider or clearinghouse.

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 2 **(Two)** Solicitation Due Date: **January 28, 2013** **3:00 PM (Arizona Time)**	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows, and supersedes any information previously provided that is inconsistent:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Resources*, page 303 is amended as follows:

   On or about December 14, 2012, AHCCCS will publish an actuarially-sound capitation rate range for the medical component for each risk group that will be bid by GSA. These ranges will be equivalent to the bottom half of the actuarially sound rate ranges, from ~~the~~ an adjusted minimum to the midpoint. The minimum of each published range was increased by 1% to account for the future Payment Reform capitation withhold of at least 1%. AHCCCS' actuaries set rate ranges based on average expenditures. The rate ranges will exclude reinsurance offsets and will not reflect any withheld amounts for payment reform initiatives.

2. The Bidders' Library, Information (IT) Technology Systems Demonstration *Provisions* and *Calendar* have been revised.

3. Section H: Instructions to Offerors, Paragraph 16, Submission Requirements, E. *Oral Presentations*, page 309, is amended as follows:

   All presentations will be scheduled to occur during the weeks of February 18 ~~and~~ through March 6, 2013.

4. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 19th **day of December, 2012,** in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** **SIGNED COPY OF FILE**
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 2 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.	Data Supp. C			Please provide a data supplement splitting out Rx by generic, pref brand, non-pref brand and specialty. If possible, please provide the same level of detail currently in the data book. At a minimum, please provide GRD by risk group, GSA and CYE.	No additional information will be provided.
2.	Data Supp. F			Please provide a cross walk from the data book service categories to those in the capitation bid template.	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
3.	G	N/A	279-286 And all Excel Spreadsheet Pages	Should Offerors create a separate pdf file for Section G, Representations and Certifications of Offeror?	Yes. Create a separate .pdf file to include ALL of the required Section G documentation, including the spreadsheet information, in order for Section G to be removed from the published version of the proposal as stated on page 296, Instructions to Offerors.
4.	H			Can the state confirm that TPL offsets are incorporated into the Acute and CRS Data Book costs and will be included in the gross medical component PMPMs used to construct the rate ranges?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data.

Question #	Section	Paragraph #	Page #	Question	Response
5.	Instructions to Offerors			Will the same evaluators scoring this RFP also score the Maricopa behavioral health RFP?	AHCCCS is not providing any detailed information regarding evaluators scoring the Acute/CRS or Maricopa RBHA RFP.
6.	Data Supp. C			CYE12 appears to be incomplete. If possible, please provide average completion/IBNR for CYE12 and CYE11.	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14.
7.	Data Supp. F	Bid Template Tool		When using an original version of the template (i.e. unsaved) and cycling through the GSAs and Risk Groups (Select_GSA_Group tab), the template will occasionally load inputs (into the Input tab) even if the user has not stored any inputs for the selected GSA/Risk Group combination. While the inputs tab does not always clear when an un-stored combination is selected, it does not appear to impact the Summ_Bids tab. Can AHCCCS please confirm these obseravations?	The template as released to Offerors does not contain any stored inputs. Quality control testing took place before the release of the template. Subsequent testing was unable to recreate the scenario described. If you need further technical assistance please see Bidders' Library, Data Supplement, Section F, Bid Submission Information, Bid Template Overview for instructions on how to contact ISD.
8.	Data Supp. B	Attachment A		If possible, please provide general methodologies used to develop the PMPM program change estimates. For example, are the inpatient day limit PMPMs estimated using CYE11 data or projections of CYE12? Any information you can provide that will aid in the appropriate application of the program change impact estimates is greatly appreciated.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
9.	Data Supp. C	Data Book		Based on a cursory review of certification letters, it appears as if trend factors are developed based on normalized encounter data. Would AHCCCS be willing to share encounter data normalized for program changes?	No additional information will be provided.
10.	Data Supp. C	Data Book		There are a number of large PMPM changes by service category, risk group and GSA. For example: For TANF <1 in GSA 12, the All Other Hospital Days PMPM changed from $13.21 PMPM in CYE09 to $10.10 in CYE10 to $21.89 in CYE11. For AHCCCS Care in GSA 12, the Inpatient ICU Tier PMPM decreases consistently from CYE2009 to CYE2011 (from $32.30 to $25.79 to $20.88). A similar trend exists in the IP Routine Tier service category (for this same risk group and GSA). We do not believe these year-to-year changes are fully explained by program changes. Any information you can provide to help us understand the underlying reason for these changes is greatly appreciated.	AHCCCS will not provide additional information regarding utilization or cost changes.

Question #	Section	Paragraph #	Page #	Question	Response
11.	Data Supp. F	Pending Ranges		Does AHCCCS anticipate applying any Demonstration specific adjustments to the rate ranges? If so, please provide these adjustments and reasoning for said adjustments.	No, AHCCCS will not apply any adjustments to the rate ranges for the Duals Demonstration. The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
12.	Round 1 Questions Amendments	General (several locations)		If a specific adjustment made to capitation rates differs from the actual financial impact of the related program change in a manner that results in losses for the contractor, will the contractor be responsible for these losses that result from this specific divergence, or will there be some limitation on contractor liability? We are concerned that single or multiple program changes that cost the contractor more than the additional revenue obtained from the related capitation rate adjustments could eliminate significant profit margin (or result in losses), even if the resulting overall revenue remains within the defined risk corridor for profit and loss.	No, there will not be a limit on Contractor liability beyond the risk corridor defined in the RFP in Sections D1 and D2, Paragraph 53, Compensation.
13.	Data Supp. I	Risk Factors	1	Can you provide the risk factor ranges (min/max) for the previous 2-3 CYEs?	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
14.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Is AHCCCS considering changing the risk assessment tool that uses ETGs (for example, move to the federal model using Medicaid weights)?	Yes, AHCCCS plans to research risk adjustment tools and is not certain at this time if we will continue using the current tool or will switch to another risk adjustment tool.
15.	Data Supp. I	Proposed CYE14 and CYE15 Risk Adj.	1	Will AHCCCS develop new risk weights for the retrospective risk scores in CYE14? Similarly, will new prospective risk weights be recalibrated for CYE15?	Yes, AHCCCS plans to develop new retrospective risk weights for CYE 14 and new prospective risk weights for CYE 15.
16.	Document J	1	1	Are medical expenses or third party liability removed from the databook text files when a contractor is no longer active in the GSA in which the expenses were reported to be incurred (in a similar manner to Document J)?	Data was only removed from the financial statement reports if a Contractor reported medical expenses or TPL in a GSA *in a year* when they were no longer contracted in that GSA (e.g. prior period adjustments). Data Book files cannot include medical expenses in a GSA *in a year* where a Contractor is no longer contracted due to encounter edits which would reject the encounter.
17.	Document M	1	1	Please provide the necessary information to complete reinsurance amounts.	See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section M, Reinsurance Information. No additional information will be provided regarding reinsurance. The reinsurance offsets will be determined by AHCCCS' actuaries prior to October 1, 2013. This is stated in Section H, Instructions to Offerors.

Question #	Section	Paragraph #	Page #	Question	Response
18.	Document C – Databook Introduction	1	1	Please provide the appropriate completion factors by Category of Service for utilization and cost amounts in the databook, preferably by month, but at a minimum by year. This information is required in order to develop actuarially sound rates.	For information about completion factors used in developing the capitation rates/rate ranges, refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14.
19.	Document B	2	1	If the fiscal impact listed for any program change in Document B is not reflective of the population targeted in this RFP, please provide specific details for the population reflected, including membership counts by Category of Aid and GSA, total cost and utilization by GSA, Category of Aid, and Category of Service, and any other information necessary to adjust the impact of each program change.	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that states on page 1 that the fiscal impacts provided are statewide figures that are not specific to the populations addressed in this RFP. Page 1 also states that Offerors can find additional information in the Actuarial Certifications and that those impacts, too, are not specific to the populations included in the RFP. AHCCCS will not provide the requested information.
20.	Document B	1	10	Will capitation rates be adjusted by AHCCCS for the effect of the expansion of the Breast and Cervical Cancer treatment Program (effective 8/2/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.

Question #	Section	Paragraph #	Page #	Question	Response
21.	Document B	2	10	Will capitation rates be adjusted by AHCCCS for the effect of the shift to Ambulatory Surgical centers (effective 10/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
22.	Document B	4	10	Will capitation rates be adjusted by AHCCCS for the effect of Out of Network QMB Duals (effective 1/5/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
23.	D1 & D2	62	101 & 86	Has the Corporate Compliance Disclosure of Information changed?	Yes, sections D1 and D2, Paragraph 62, Corporate Compliance and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&A, Response #28 and #29 have been amended as follows: • Under the subparagraph titled, Disclosure of Ownership and Control, Contractors will no longer be required to collect ownership and control information for its subcontracted providers. Contractors will still be required to collect such information for all individuals with an ownership or control interest in the Contractor as well as the Contractor's fiscal agents. • Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to

Question #	Section	Paragraph #	Page #	Question	Response
					determine the exclusion status of its subcontracted providers or persons associated with its subcontracted providers. Contractors will still be required to determine the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor as well as the Contractor's fiscal agents. • Under the subparagraph titled, Disclosure of Information on Persons Convicted of Crimes, Contractors will no longer be required to query the Social Security Administration DEATH MASTER FILE or the National Plan and Provider Enumeration System (NPPES) databases when determining the exclusion status of persons which have an ownership or control interest or managing employee interest in the Contractor or the Contractor's fiscal agents. Additionally, letter "d" in this paragraph will be changed to read: "The System for Award Management (SAM) formerly known as the Excluded Parties List (EPLS)." This change will appear in a future version of the contract.

Question #	Section	Paragraph #	Page #	Question	Response
24.	D1 Section 64	6	103	Section 64 states "HIPAA Privacy and Security: The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements." Considering that this provision is being reviewed by AHCCCS under the current contract, are there any additional guidelines pertaining to HIPAA Privacy and Security Audit?	As noted this provision is under review by AHCCCS and further detailed guidance will be provided.
25.	Document I	1	11	Will risk contingency be adjusted for any years other than CYE10?	Risk contingency was adjusted in the CYE 10 risk adjustment methodology to recognize the change to risk contingency that same year. If risk contingency is changed in the future, AHCCCS would anticipate that an adjustment would be necessary.
26.	Document B	2	11	Will capitation rates be adjusted by AHCCCS for the effect of Part D drug changes (effective 1/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.

Question #	Section	Paragraph #	Page #	Question	Response
27.	Document B	3	11	Will capitation rates be adjusted by AHCCCS for the effect of Behavioral Health Services provider rate changes (effective 4/1/2013), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
28.	Document B	4	11	Will capitation rates be adjusted by AHCCCS for the effect of Medicare Dual Demonstrations (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.

Question #	Section	Paragraph #	Page #	Question	Response
29.	Document B	5	11	Will capitation rates be adjusted for the effect of ACA Health Insurer Fee (effective 1/1/2014), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details already known costs that will not be included in the capitation rate ranges computed by AHCCCS. Therefore they should not be considered by Offerors. These costs will be included in a future capitation rate adjustment for 10/1/2013. See pages 3 and 11 of the Program and Fee Schedule Changes document for more information on costs excluded from the rate ranges.
30.	Document B	6	11	Is the databook data adjusted for the effect of any other programs effective on or after 10/1/2013?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

Question #	Section	Paragraph #	Page #	Question	Response
31.	Data Supp. B		12	We assume all MCOs were expected to modify their provider contracts to match the fee schedule changes outlined on page 12 or absorb the loss. Is this a fair assumption?	Capitation rates were developed assuming that Contractors would modify payment rates, though there was no contractual mandate to lower rates. Contractors that did not reduce rates would have to absorb losses as the capitation rates were reduced.
32.	Document B	1	12	Is the databook data adjusted to account for the fee schedule changes listed in the "Fee Schedule Changes" table?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
33.	Document B	1	12	Please provide a mapping between the service categories listed in the table of fee schedule changes and the Categories of Service in the Databook.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
34.	Document B	1	12	Please provide total costs and utilization by Category of Aid, GSA, and the service categories listed in the "Fee Schedule Changes" table.	No additional information will be provided.
35.	Document C	1	1-2	Please provide the most current analyses performed by AHCCCS' actuaries to gauge the completeness of encounter data and to ensure the appropriateness of payment data.	No additional information will be provided.
36.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the utilization trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
37.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 utilization trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.
38.	Acute Care Actuarial Certification CYE13	Appendix I	13	Are the unit cost trends in Appendix I appropriate for use in CYE14?	No, the trends used to build the CYE 13 rates will not be the same trends use to build the CYE 14 capitation rate ranges. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
39.	Acute Care Actuarial Certification CYE13	Appendix I	13	If the CYE13 unit cost trends in Appendix I are not appropriate for use in CYE14, please quantify the amount of deviation from the CYE13 trends that AHCCCS expects in its CYE14 certification	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
40.	D-2	CRS Performance Measures	148	In the performance measure table on page 148, the language in the third and fourth rows, regarding access to a behavioral health provider (encounter for a visit) has different timeliness standards (7 days vs 23 days) and different MPS (75% vs 90%) and goals (85% vs 95%). Please clarify which standard should be used for this measure.	The Performance Measures are stated correctly in the RFP document. The Performance Measure requirements include two separate behavioral health access to care measures.
41.	DocC_Databook Introduction	9	2	The data book does not have inpatient admit information. Admit information would be very helpful to understand and project the effect of care management on admissions and the October 2014 change in hospital reimbursement from per diems to DRGs. Even though the change is not effective until October 2014, we would like to have admit information to project results from 2013 to 2014, to determine what risks may result from the change. Planning ahead will be helpful for setting our bid. Can AHCCCS please provide admit information for the same time period and rate categories as the data book?	AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, Supplemental *Data Book Reports*. Please watch for updates to this Section.

Question #	Section	Paragraph #	Page #	Question	Response
42.	Document C	1	2	Please explain the review processes that AHCCCS performs to ensure timeliness, accuracy and completeness of its encounter data.	Encounter staff review encounter submission patterns, including per member statistics, in addition to validation studies. Actuarial and finance staff analyze expenditures by month, quarter and/or year of service: • Across Contractors • Across GSAs • Across risk groups • By form type • Compared to financial statements • In total and PMPM basis
43.	Document D	All	2	Please define "Pay Code" as listed in the Outpatient Facility service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type) and the coding logic for assigning each pay code.	In this instance, Pay Code indicates an encounter which appears to be an inpatient claim but, using the codes provided, should be classified as an outpatient claim. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.

Question #	Section	Paragraph #	Page #	Question	Response
44.	Document D	All	2	Please define "Reimbursement Type" as listed in the Hospital Days service category and any other service categories. Please include any relevant medical coding in this definition (ex. Bill Type).	In this instance, Reimbursement type indicates the inpatient tier to which the claim is associated. No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.
45.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	5 (page 2) and 1-5 (page 3)	2 and 3	Is our interpretation correct in that the Acute care contractor is responsible for having HCBS providers included in its Medicaid network?	Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.

46.	Prospective Offeror's conference presentation 11/8		22	How will the managed care industry fee in 2014 be considered in reimbursement rate development? Since the tax is not deductible, will the pre tax amount be reimbursed to the plans?	AHCCCS will add the full amount of the Health Insurer Fee to the capitation rates.
47.	CYE2013 Certification	Page 2, Paragraph 4 – Page 3, Paragraph 1	2-3	Please provide Co-ordination of Benefits amounts for each contract year by Category of Aid, Category of Service, and GSA	No additional information will be provided.
48.	SECTION F, Attachment A1	25	236	Item 25 ends with the incomplete sentence, "For service authorization decisions, the". Could the State please clarify whether this is a mistake or the sentence was meant to read into Item 26 on the following page?	This was a typing error, the language from page 236 will continue and the number 26 will be removed. The RFP is amended. Section F, Attachment A1, Enrollee Grievance System Standards will read as follows "…For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service."
49.	SECTION G	4	278	**Section G, Question 4.b states:** "License/Certification: Attach a list of all licenses and certification (e.g. Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates." **Question:** For purposes of this item, does "organization" refer to Offeror, or to Offeror and its affiliates?	For purposes of Section G, Question 4.b, the term "organization" refers to the Offeror.

50.	SECTION G	4,5 & 6	278-282	**This is a follow-up to State's response to Round 1 Question:** "When completing SECTION G, can responses requiring narrative (for example 4.c - Accessibility Assurance) be attached as a separate document if it is longer than the space provided on the form?" **State's Response from Amendment 1:** "The form boxes expand to include the narrative response as it is typed. No additional pages are necessary." **Follow-up question:** When inserting text into the current, locked word document provided for Section G, the full paragraph can be seen only by selecting text and dragging mouse down, however the text box itself will not expand. When the document is PDFd or printed, the response cuts off. Can the State release a revised word document that allows the text boxes to expand to show all text?	The RFP is Amended for the following areas: Section G Representations and Certifications of Offeror and Amendment 1, Question #39. If Offerors require additional space to answer a question, a separate Word document may be submitted with the response in its entirety. The document must clearly identify which section the response is for. Example, Section G, Offeror Representations and Certifications, #4b License/Certification.

51.	SECTION G	5	280	**Section G, Question 5.c** defines "Managing Employee" as "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." **Question:** For purposes of this RFP, may we understand one "who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency" to mean (i) any of the key staff positions listed in Section D, paragraph 16, together with (ii) any individuals to whom those key staff positions report either directly or indirectly?	The definition of "managing employee" in Section G, Question 5.c is a federal definition, codified at 42 C.F.R. §455.101. An Offeror should consult with its attorneys and/or other professionals if the Offeror needs additional guidance in interpreting this definition.
52.	SECTION G	5	280	**Section G, Question 5.e states:** "Long-Term Business Transactions: List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end." **Question:** Is this section intended to include the phrase "wholly-owned" before the word "subcontractor"? If not, does "subcontractor" in this instance include health care provider contracts?	No. The phrase "wholly-owned in Section G, Question 5.e was not intended to be placed before the word "subcontractor". For purposes of Section G, Question 5.e the word "subcontractor" does not include health care provider contracts.
53.	SECTION G	6	281	Question 6, subsection (a) states: a. Board of Directors: List the Names, SSN, DOB, and Addresses of the Board of Directors of the Offeror **Question**: We understand the State's need for	No. The AHCCCS Administration will receive and secure this data as we do with all other confidential and sensitive information.

				this information, however given the environment related to identity theft, would the State agree to reimburse Plan for the cost of all liabilities that may be incurred by these individuals as a result of disclosing this information?	
54.	RFP H	9	291	Please verify that Offerors should not provide separate bid rates for Pima and Santa Cruz.	The Offeror should not provide separate bid rates for Pima and Santa Cruz counties. The Offeror should bid assuming they will win both Pima and Santa Cruz. If the Offeror wins Pima only, those rates will be adjusted after award.
55.	H	15	296	Is a footnote citation required to be **outside** of the ½ inch margin or may it be included **within** the ½ inch margin?	Yes, the footnote citation is required to be outside of the ½ inch margin.
56.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	13-16	3	Our question relates to iii. Is it AHCCCS' expectation that an acute care contractor have Assisted Living Facilities, alternative residential settings, or home and community based services (minimum one per listed GSA) as required by contract, providers in its network?	Acute Care Contractors must be able to provide HCBS services as appropriate. Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility.

57.	Data Supp. F		3	According to the bid template instructions, "when the Offeror chooses the Delivery Supp risk group…then only the service categories relevant to the delivery supplemental payment will appear…" A number of the hidden service categories contain data in the data book. For example, the Delivery Supp. risk group does show experience for transportation and Rx encounters. By hiding the transportation and Rx service categories in the bid template tool, is AHCCCS implying that these costs are not part of the delivery supp. and thus should be excluded (and possibly include them in cap rates)? Or, does AHCCCS intend for bidders to put these types of costs in the Misc. category?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
58.	Document B	1	3	Is the databook data adjusted for the discontinuation of dental sealant coverage (effective 5/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
59.	Document B	1	3	Do the PMPM impact amounts in Attachment A for discontinuation of dental sealant coverage represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $2.40 PMPM impact ($1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
60.	Document B	2	3	Is the databook data adjusted for DDD State only Transfers (effective 5/1/2009).	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
61.	Document B	2	3	Do the PMPM impact amounts in Attachment A for DDD State Only Transfers represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $2.40 PMPM impact ($1200/(100 members*5 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

62.	Document B	3	3	Is the databook data adjusted for changes related to High Needs Children (effective 7/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Crae/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
63.	Document B	3	3	Do the PMPM impact amounts for High Needs Children in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
64.	RFP H	16	302	When checking the administrative component	When the Offeror clicks the Save Bid button on

	And Data Supp. F			(to determine if it is less than the 8% max) will AHCCCS use the rounded values produced by the Summ_Bids tab (in the bid template) or will AHCCCS use unrounded values entered into the Input tab? If rounded, please provide the rounding formula used in the bid template. Lastly, assume a bidder applies 8% admin to unrounded values. Furthermore, assume AHCCCS uses rounded values and calculates a bidder's admin component at 8.001% then will said bidder receive 0 points in this case?	the Input tab in the bid template, a warning box is produced if the value entered for admin exceeds 8% of the gross medical component. This box uses PMPM values rounded to four decimal places for admin and gross medical, but it is strictly informational. The scoring process will use the gross medical and admin component PMPM figures as shown on the Summ_Bids tab, and therefore found in the hard copy format, which are rounded to two decimal places. For scoring purposes, the ratio used to calculate if an Offeror's admin exceeds 8% of gross medical will not be rounded. The ratio will be calculated as: (admin PMPM rounded to two decimal places) / (gross medical PMPM rounded to two decimal places). If this ratio exceeds 8% the Offeror will score zero for that admin bid. For example, if an Offeror's admin component bid is $8.01 and the medical component bid is $100.00, the admin ratio would be $8.01 / $100.00 = 8.01% which is greater than 8%; thus this bid would be scored zero.
65.	Section H	E. Narrative Submissions	306 (question 3)	It is our understanding that AHCCCS is going to move to HEDIS criteria for the performance measures. Since the current reporting period is the contract year (Oct. 1 through Sept. 30) and HEDIS is Jan. 1 through Dec. 31, how does AHCCCS plan to make this change?	AHCCCS does not intend to transition from contract year to calendar year for Performance Measure purposes. Please also note that Measure methodology owners vary within the CMS measure sets being implemented. Only a portion of the measures are NCQA HEDIS measures.
66.	Section H	E-Narrative Submissions	306-307	In question 4, the scenario refers to the individual in question as a member of the Offeror's health plan. In question 5, the scenario refers to the individual as an "AHCCCS member." For the purposes of responding to the scenario, since a member is required to be a member of an AHCCCS-contracted health plan, should Offerors	Yes, the Offeror should assume the individual is currently a member of the Offeror's health plan.

				assume that individual in question is in fact a member of the Offeror's health plan?	
67.	Section H	E-Narrative Submissions	307	What is the State's definition of waste relative to this question?	"Waste" includes but is not limited to: fraud, excess administration, costs associated with failure to implement effective methods for prevention of disease, disability, or adverse health condition, and services provided to individuals which are either not medically necessary, not cost effective, or both.
68.	H (IT Demo)		308	Page 92 of Prospective Offerors' Technical Interface Meeting presentation: All Offerors will receive the same "mock" data files and scenarios ***Question: How do we get the scenarios, are they implied in the inbound 837 file per say, or do they provide an English description of the various scenarios in separate Microsoft excel/word document?***	AHCCCS will provide the Offeror with a paper claim form or an electronic 837 claim record.

69.	H (IT Demo)		308	Page 93 of Prospective Offerors' Technical Interface Meeting presentation: Encounter submissions will be based upon claims adjudicated by the Offeror as part of the claims scenarios exercises *Question: Assuming this means submissions from Offerer to AHCCCS?*	Correct, AHCCCS will expect encounter submissions based upon approved/paid claims scenarios.
70.	H (IT Demo)		308	Page 93 of Prospective Offerors' Technical Interface Meeting presentation: First and second eligibility and claims status inquires will not exceed 5 records per iteration. *Question: Assuming this means the HIPAA transaction inbound and outbound data files?*	It is not AHCCCS intent that Offerors develop a process to exchange 270/271 or 276/277 transactions with AHCCCS. Offerors may exchange this data utilizing an automated system or a manual process. Additionally, note that AHCCCS will not, as a component of the demonstration, be asking for eligibility or claims status inquiries on more than 5 members or claims.
71.	Section H	E-Narrative Submissions	308	With respect to the IT Demonstration, will CRS eligibility and benefits data be part of the 834 file the Offeror will receive from AHCCCS?	No, CRS scenarios will not be included for purposes of this demonstration.
72.	Section H	E-Narrative Submission	308	Will we be expected to provide a paper provider remittance advice as part of the IT Demonstration?	No remittance advice will be required for purposes of this demonstration.
73.	Section H	E-Narrative Submissions	308	Can you confirm from an encounters perspective, will an 837 file be required or will the response be in the form of a summary template as all others?	AHCCCS will supply the Offeror with an 837 Template for purposes of encounter submission and will require that the Offeror submit the completed 837 Template and Summary of Encounters Processing. Refer to the revised Information Technology (IT) Systems Demonstration *Calendar* for additional information posted December 19.

74.	Section H	E-Narrative Submissions	308	Will the encounter initial cycle results be provided in a 277 format or in a spreadsheet? Will corrected encounters from initial cycle be permissible or expected in the second encounter cycle submission?	The cycle results were incorrectly included in the Final 10/29 version of the Information Technology (IT) Systems Demonstration *Calendar*. The revised IT Systems Demonstration *Calendar* posted on 11/27 and revised again on 12/19 is correct and supersedes the 10/29 version.
75.	Section H	E-Narrative Submissions	308	For reference data extracts will this include a sample of reference files or a complete set of reference files, such as transition of care, COB, provider and fee schedule?	The reference data extract will include the full set of Reference and Provider data exchanges as outlined in the AHCCCS Encounter Manual.
76.	Section H	E-Narrative Submissions	308	If Encounter Submissions Response Files are required in an 837 format, are new TSNs required for system demonstrations?	No, new TSN's will not be required for purposes of this Demonstration.
77.	Section H	E-Narrative Submission	308	What is the earliest date/time that all the Offeror's will be able to view the Process Summary Templates for the each transaction	This information is included in the Information Technology (IT) Systems Demonstration *Calendar*.
78.	Section H	E-Narrative Submission	308	Will the summary of the initial 820 be inclusive of the first two daily 834 files only?	Yes, the information in the initial 820 will be inclusive of the enrollment information in the 834 files.
79.	SECTION H	E (Oral Presentation)	309	During the Oral Presentations, will AHCCCS pose "solutions to health care situations and operational challenges" for Acute Care, CRS populations or a combination of both groups?	AHCCCS is not providing assistance or clarification related to the submission requirements or the oral presentations.
80.	Document B	All	3-26	Please provide the impact to utilization and charge for each fee schedule and program change adjustment based on actual historical data.	No additional information will be provided.

81.	D1	10	38	It is our understanding that AHCCCS will assume responsibility for determining CRS eligibility. Please verify this will be effective as of 10/1/2013.	AHCCCS will assume CRS eligibility determination processes as of 10/1/2013.
82.	Arizona Medical Policy Manual, 520 Member Transitions	4 and 5	4	In section D.1 it discusses transition from an ALTCS to an acute care contractor. The paragraphs referenced imply that an acute care contractor does not have to cover attendant care or home delivered meals as a part of its network or benefits? Our understanding was that an acute care contractor has to provide for necessary HCBS as a part of its network. Does an acute care contractor have to have attendant care, meals on wheels and other types of LTSS in its network? Please clarify this.	Acute Care Contractors must be able to provide HCBS services as appropriate, including those specifically identified (e.g. attendant care, home delivered meals). Section D1, Paragraph 10, Scope of Services, *Nursing Facility*, states that members requiring convalescent care may be placed in an assisted living facility, an alternative residential setting or receive home and community based services (HCBS) for up to 90 days in lieu of receiving care in a nursing facility. .
83.	AHCCCS Operations Manual, Section 415-Provider Network and Development Plan-DRAFT-IV. Procedure	7	4	Please clarify the following: After number 15, there is a bold statement-"(For ALTCS EPD and DDD Contractors Only)" prior to number 16. Does this statement only apply to Number 16 or does it apply to items 16 through 23 which seem to apply to ALTCS contractors.	Yes, items 16 through 23 apply only to ALTCS Contractors.

84.	Document B	1	4	Is the databook data adjusted for changes related to Transition Age Youth (effective 7/1/2009).	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
85.	Document B	1	4	Do the PMPM impact amounts in Attachment A for transition Age Youth represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

86.	Document B	2	4	Please provide a breakout of the $2.5 million increase (CYE09 to CYE10) and $2.5 million decrease (CYE10 to CYE11) caused by H1N1 Influenza by category of service, category of aid and GSA.	No additional information will be provided.
87.	Document B	3	4	Is the databook data adjusted for changes related to outlier hospital reimbursement rates (effective 10/1/2009)? Please provide the adjustment?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
88.	Document B	3	4	Which contract year of capitation rates was originally updated with the impact of changes for outlier hospital reimbursement rates?	CYE 08, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes.
89.	Document B	3	4	Please define "extraordinary operating costs per day"	Outliers are claims with extraordinarily high costs per day that exceed thresholds established by AHCCCS

90.	Document B	4	4	Is the databook data adjusted for changes related to dental service changes (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
91.	Document B	4	4	Which contract year of capitation rates was originally updated with the impact of changes for dental service changes?	CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.

92.	Document B	5	4	Is the databook data adjusted for medical management changes (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
93.	Document B	5	4	Which contract year of capitation rates was originally updated with the impact of medical management changes?	CYE 10, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 10.
94.	CYE13 Acute Care Actuarial Certification	Section IV	4	Please provide a list of experience adjustments made to capitation rates for the CYE13 contract year.	No additional information will be provided.

95.	Document I	1	5	How frequently will risk weights be recalibrated? Please describe the recalibration process.	AHCCCS plans to develop new retrospective risk weights for CYE 14 and also new prospective risk weights for CYE 15. See Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section I, Risk Adjustment Information, *CYE 09 Risk Adjustment Whitepaper* for a brief description on the recalibration process.
96.	Document B	1	5	Is the databook data adjusted for changes in ADHS regulated transportation rates (effective 10/1/2009)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

97.	Document B	3	5	Is the databook data adjusted for the KidsCare Freeze (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

98.	Document B	4	5	Is the databook data adjusted for changes regulations related to the HPV Vaccine (effective 7/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
99.	Document B	4	5	Do the PMPM impact amounts for HPV Vaccine administration in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

100.	Document B	4	5	Is the databook data adjusted for the benefit redesign change (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
101.	Document B	4	5	Which contract year of capitation rates was originally updated with the impact of the benefit redesign change?	CYE 11, as stated in Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.
102.	D1	16	51	Will the State consider the CRS awarded Contractor's contract for both CRS and Acute services as one line of business for the purposes of Key Staff?	The CRS contract for both CRS specialty and acute services (and behavioral health services) is considered one line of business for purposes of Key Staff.

103.	Prospective Offeror's conference presentation 11/8		52	What does "current rate setting methods" mean? If a dual eligible demonstration is approved, what savings rate will the state assume – either 1, 3, or 5% versus fee for service as preliminarily proposed by CMS?	For the Medicaid portion of the Dual Demonstration rate AHCCCS is proposing to use the same capitation rate setting methodology used for the Acute population. This methodology is subject to CMS approval. See the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document* for more information regarding the Acute rate setting methodology. AHCCCS and CMS have not finalized the savings target percentages.
104.	D1 & D2	18	55-56 (D1) 141-142 (D2)	Is the CRS Contractor permitted to develop one set of member materials for Acute and CRS that highlight differences in procedures and network (similar to DDD information); or must the CRS members receive a separate set of CRS specific materials?	The CRS contract and the Acute Care contract are separate lines of business. Each line of business requires unique member materials.
105.	D1 & D2	21	57-58 (D1) 143 (D2)	For the purposes of care coordination, records may be shared with care team members. Will there be a definition of care team and what are the requirements for member/guardian acknowledgement/authorization?	Care teams are unique to the needs of each individual member. Participants in a care team for a member with cleft lip would be different than those needed in a care team for a member diagnosed with cystic fibrosis. AHCCCS is not anticipating establishing specific requirements for the composition of the care team at this time. The CRS Program is designed to include the member and the member's parent/guardian as part of the team with the ability to participate in the health care decision making process.

106.	CYE12 Cert Letter		6	The cert letter indicates a savings of $28.2 million for hospital outliers. What is the basis year for this savings estimate? In addition, please provide the detailed adjustments applied to the CYE12 rates to account for this change.	This savings was estimated by using CYE 09 (10/01/08 - 09/30/09) outlier encounter data and CYE 09 member months. A PMPM was calculated and trended forward to estimate the savings. The CYE 12 actuarial certification explains that capitation rates would have increased by approximately $28.2 million if AHCCCS had not made this change to outlier. AHCCCS did not apply an adjustment factor to the CYE 12 rates for this change, but assumed the future outlier trend would stay at the CYE 11 levels rather than growing as it had in the past.
107.	Document B	1	6	Is the databook data adjusted for changes in copay amounts (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

108.	Document B	2	6	Is the databook data adjusted for the shift to Ambulatory Surgery Centers (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
109.	Document B	2	6	Which contract year of capitation rates was originally updated with the impact of the shift to Ambulatory Surgery Centers?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

110.	Document B	3	6	Is the databook data adjusted for the change in first 72 hours coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
111.	Document B	3	6	Which contract year of capitation rates was originally updated with the impact of the change in first 72 hours coverage?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

112.	Document B	4	6	Is the databook data adjusted for the change in Behavioral Health Services prior period coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
113.	Document B	4	6	Which contract year of capitation rates was originally updated with the impact of the change in Behavioral Health Services prior period coverage?	CYE 11, as stated in the Data Supplement for Offerors'– Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the Acute Care Actuarial Certification for CYE 11.

114.	Document B	5	6	Is the databook data adjusted for the change in Cochlear Implants coverage (effective 10/1/2010)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
115.	Document B	5	6	Which contract year of capitation rates was originally updated with the impact of the change in Cochlear Implants coverage?	CYE 11, as stated in the Data Supplement for Offerors' – Acute Care/CRS, Section B, Program and Fee Schedule Changes, and the CRS Actuarial Certification for CYE 11.

116.	Document B	6	6	Does the databook contain data for MED program enrollees prior to the elimination of the program (effective 10/1/2011)?	No, data for MED members is not contained in the Data Book files. This information is stated in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Layout/File Description*: "All Data Book Files exclude utilization, cost and member information for those populations that will no longer be covered by Acute Care Contractors, and by the CRS Contractor, as of October 1, 2013. For additional information on the excluded populations please refer below to "Data Book Files Exclusions" section." **"**Data Book Files Exclusions Acute Care Bid All Data Book Files and member information exclude the following populations…. Those members in the HIFA or MED risk groups which are no longer covered."
117.	Document B	6	6	If the databook does contain data for MED program enrollees, please provide the volume of utilization and cost data by Category of Service, Category of Aid, and GSA associated with the MED program.	Data for MED members is not contained in the Data Book files.

118.	Document B	7	6	Is the databook data adjusted for the transition of pediatric costs (effective 6/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
119.	Document B	7	6	Which contract year of capitation rates was originally updated for the transition of pediatric costs?	CYE 12, as stated in both the Acute Care Actuarial Certification for CYE 12 and the CRS Actuarial Certification for CYE 12.

120.	Document B	7	6	Do the PMPM impact amounts for transition of pediatric costs in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100 members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $3.00 PMPM impact ($1200/(100 members*4 months of program in effect)) to account for the costs after the program has gone into effect.	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.
121.	D1	23	60	Credential Verification Organization Contract: Is AHCCCS able to provide information regarding the Alliance? We are having difficulty in learning about the Alliance and its costs and because using it will entail cancelling other contracts potentially and additional work in switching to the Alliance any assistance on pricing, structure etc would be helpful.	AHCCCS does not have a copy of the AzAHP Credentialing Alliance contract nor the terms of the contract. Information may be available through the Executive Director of the Arizona Association of Health Plans, Deb Gullett, Gallagher & Kennedy P.A. Law Offices, Senior Government Relations Specialist, deb.gullett@gknet.com.
122.	D	23	60	"The CVO is also responsible for conducting annual delegated entity site visits to ensure compliance with AHCCCS requirements." Our understanding is that the AzAHP credentialing alliance does not include providers that plans have delegated credentialing to – but the above sentence refers to 'annual delegated entity site visits'. Can you please clarify?	The RFP has been amended and the word "delegated" has been removed. The CVO is required to conduct annual entity site visits. The sentence now reads, "The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements." This change will appear in a future version of the contract.

123.	D	23	60	"The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and recredentialing process regardless of membership in the AzAHP." Does this mean that the Contractor must participate in the AzAHP credentialing alliance or simply utilize the same CVO that AzAHP uses for its credentialing alliance?	Contractors shall be required to participate in the AzAHP credentialing alliance.
124.	D1 & D2	23	60 (D1) 146 (D2)	The CVO is a delegated entity that will oversee the credentialing process for Acute Care contractors. Please verify that each contractor will not be required to evaluate the CVO in accordance with AHCCCS guidelines for delegated entities.	The AzAHP Credentialing Alliance has contracted with a Credential Verification Organization (CVO) to conduct primary source verification and site visit requirements related to the required credentialing processes. Contractors are required to use the information provided by the CVO and complete the credentialing process which includes a review of quality, utilization, performance data, etc. As is required for all delegated functions, Contractors are required to validate that the delegated entity is meeting the AHCCCS requirements. AHCCCS anticipates that the AzAHP will establish a collaborative process to meet this requirement.
125.	D1 & D2	23	63-64 (D1) 148-149 (D2)	Please clarify if AHCCCS will determine separate performance measures for CRS and Acute Care members. It is our understanding that CRS and Acute Care membership will be segregated for the purpose of determining responsiveness to the performance measures. Is this correct?	AHCCCS has established a separate performance measures set for each line of business. The CRS and the Acute Care programs are separate lines of business. Performance Measures for each of these lines of business contain measures specific to the population served. The results for each population will be calculated independently.

126.	D1	27	68	Regarding paragraph 27 "In accordance with the requirements specified in the ACOM Draft Policy, Acute Network Standards the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing Pima and Maricopa counties do not have to travel more than 15 minutes or 10 miles to visit a PCP, dentist or pharmacy, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Draft Policy, Acute Network Standards." Please validate that Offerors are not required to submit GeoAccess reports with the proposal to document that network responsibility and availability criteria have been met. Also, please validate that Offerors will not be required to submit a listing of their contracted network of providers with the proposal.	Offerors are not required to submit GeoAccess reports or a listing of their contracted network of providers with their offer. Adherence to network sufficiency standards will be assessed during the readiness review process.
127.	Data Supp. B		7	Please provide the methodology used to develop the estimated percentage impact for the Childless Adult Freeze change. In particular, what assumptions were used to convert an enrollment freeze into a PMPM impact?	As stated in the Bidders Library, Data Supplement, Section B, Program and Fee Schedule Changes, as part of the freeze, the elderly and individuals meeting the federal definition of disability (including SMI members) were transitioned to either the SSI with or without Medicare risk groups. In order to account for this movement, AHCCCS analyzed historical encounter and member data for those individuals who were transitioning to SSI with or without Medicare. The data for those members was moved to the appropriate groups to calculate the percentage impact by comparing the PMPM before the move to the PMPM after the move.

128.	Document B	1	7	Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
129.	Document B	1	7	Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?	While this behavioral health program was effective July 2011, the capitation rates were not adjusted until July 2012, thus impacting the CP (contract period) 13 capitation rates. Refer to the Behavioral Health Actuarial Certification for CYE 13 found in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section K, Capitation Rates.
130.	Document B	1	7	Do the PMPM impact amounts for changes in the Best for Babies Program in Attachment A represent adjustments to capitation rates for an entire contract year, or just the period after the effective date of the changes? For example, suppose a program has 100	The PMPM amounts in Attachment A represent the impact for an entire contract year. Assuming the 100 members are enrolled for the entire twelve months, the amount reflected in Attachment A would be $1.00 PMPM.

				members and costs will increase by $1200 over the contract year. Would the table show a $1 PMPM impact to account for the cost impact over the entire contract year, or a $4.00 PMPM impact ($1200/(100 members*3 months of program in effect)) to account for the costs after the program has gone into effect.	
131.	Document B	1	7	Please define the "CMDP Child Population" and provide enrollment counts for historical contract years.	Children Enrolled in the Comprehensive Medical and Dental Program (CMDP).
132.	Document B	1	7	Please provide a list of members involved in the "Best for Babies" program in the same format as any detailed claims, encounter, or membership data provided.	No additional information will be provided.

133.	Document B	1	7	Please provide a detailed list of services provided within the "Best for Babies" Program.	The same services are available for all populations; however, the timeline is more structured for children in CPS custody and enrolled in CMDP. The difference for children in CPS custody and enrolled in CMDP is that timelines for certain services, primarily behavioral health (BH) are written into the CPS protocols. For example, children taken into custody must have a BH assessment within 72 hours. A follow-up full BH assessment must be completed within 30 days and services initiated based on those assessments. The CRS Contractor will need to meet those requirements. All other physical health needs should be consistent with other AHCCCS populations. Best For Babies does also have the tendency to have active judicial involvement. Judges overseeing the custody cases often order and expect care to be delivered in a specific manner, frequency and volume. The CRS Contractor would be responsible for considering the judge's order, but must only approve services that are medically necessary (not necessarily because it was ordered by the judge). Those care/services ordered by the judge that are not determined to be medically necessary would become the responsibility of the State (CPS).
134.	Document B	1	7	Is the databook data adjusted for changes to the Best for Babies program (effective 7/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-

					capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
135.	Document B	1	7	Which contract year of capitation rates was originally updated for changes in the Best for Babies Program?	Duplicate question: #159
136.	Document B	2	7	Is the databook data adjusted for the AHCCCS Care freeze (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is

					used to populate the cost field."
137.	Document B	3	7	Is the databook data adjusted for the effect of the inpatient day limit (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

138.	Document B	1	8	Is the databook data adjusted for the effect of changes related to hospital outliers (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
139.	Document B	1	8	Please provide hospital outlier cost thresholds before and after the changes effective 10/1/2011	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section N, Hospital Rate Overview, *Outlier Cost Thresholds* posted December 18.

140.	Document B	2	8	Is the databook data adjusted for the effect of changes related to transportation services (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
141.	Document B	4	8	Is the databook data adjusted for the effect of new drug approvals for Hepatitis C (effective 10/1/2011)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
142.	D1 & D2	51	86 (D1) 172 (D2)	Section D1 and D2, Paragraph 51 of the RFP originally stated: "Within 120 days contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." The State has agreed to revise to state: "Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract or other contracts with AHCCCS." Would the State consider further revising the end of this sentence so that it reads: "Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract or other contracts with or approved by AHCCCS"?	No, the amended language stands. No further revisions will be made.
143.	D-1-acute	53	88	Is the 4.5% profit cap on a pretax or after tax basis?	Income tax is not considered in reconciliations. Please refer to ACOM draft Policy 311 - Acute Program Tiered Prospective Reconciliation in the Bidders' Library for a detailed explanation of the reconciliation calculation, as well as the example provided.

144.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS provide the Contractor with detailed information to determine if the adjusted rates or rate range offered meet the requirements of the Social Security Act § 1903(m)(2)(A); 42 CFR §438.6(c)(1)(i)(2009); Pub. L. No 111-3, 123 Stat.8, 103; and the American Academy of Actuaries practice note on guidance for certifying Medicaid managed care rates?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
145.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will AHCCCS fully disclose its actuarial assumptions, including justification for why these assumptions were not included in the RFP capitation rate ranges published?	With the exception of hospital admits and length of stay data, all information regarding capitation rates/ranges has been posted to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

146.	Sections D1 and D2 and Section H	55, and C respectively	89 and 175; and 303 ("Acute Care Program Capitation Adjustments After Award) and 305 ("CRS Program Capitation Adjustments After Award")	Will amendments, clarifications or program changes expressly require the consent of the Plan (at least if they have a material, adverse effect on compensation or scope of work)?	The Contractor has the choice to sign or not sign contract amendments that include clarifications or program changes within a specified time period. No other express consent will be granted.
147.	Data Supp. B		9	KidsCare II program change – it appears as if the CYE13 rates were not adjusted for the KidsCare II program expansion. Please verify this is correct. Also, please provide cost and utilization relativities for those enrolled under the expansion (compared to those already in the program).	For CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates. No additional information will be provided.

148.	Document B	1	9	Is the databook data adjusted for the effect of changes to claims processing standards (effective 1/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
149.	Document B	2	9	Is the databook data adjusted for the effect of increased reimbursements for family planning devices (effective 2/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
150.	Document B	3	9	Is the databook data adjusted for the effect of changes in taxi copays (effective 2/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."

151.	Document B	4	9	Is the databook data adjusted for the effect of changes to 340B pharmacy pricing (effective 4/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
152.	Document B	5	9	Is the databook data adjusted for the effect of changing responsibility for psychiatric consultations (effective 7/1/2012)?	No, Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used

					in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field."
153.	Document B	5	9	Will capitation rates be adjusted by AHCCCS for the effect of changing responsibility for Emergency Room transportation (effective 7/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid.
154.	Document B	5	9	Will capitation rates be adjusted by AHCCCS for the effect of the KidsCare II expansion (effective 5/1/2012), does the contractor need to make adjustments to capitation rates before submitting a bid, or are adjustments to account for this program change already present in the databook data provided?	The Bidders' Library, Section B of the Data Supplement for Offerors' – Acute Care/CRS, includes a *Program and Fee Schedule Changes* document that details program change items considered in the development of the capitation rate ranges computed by AHCCCS. Therefore they should be considered by Offerors when developing a bid. Please note that, for CYE 13 rates, AHCCCS analysis indicated that the impact of additional KidsCare II members would not materially impact the rates.

155.	Document D/Document E-3 – Provider Types	All	All	Please provide coding criteria for grouping services by provider type. For example, the Physical Therapy section in Document D includes the selection criteria "Select all HCPCS that meet Provider Type requirements". A list of the HCPCS codes referenced and the logic used to assign provider type would assist in our analysis of the data.	No additional coding information will be provided. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D**,** Service Matrix/Selection Criteria for Data Book and Section E, AHCCCS Category of Service, Form Types, Provider Type List of Codes and Descriptions.
156.	IT SYSTEM DEMONS-TRATION CALENDAR	DATA FROM AHCCCS	Calendar	The IT Systems Demonstration Calendar Final 10/29 included the 277U – Encounter Adjudication; Pend and Encounter Cycle Results' Initial Cycle Results on Monday, February 4th and Second Cycle Results on Friday, February 8th. However the encounter cycle results for both the initial and second cycles were excluded from the Information Technology Systems Demonstration Calendar Final 11/27. Was the exclusion from the 11/27 Calendar deliberate? Adjudication/pend files and reports from each encounter cycle automatically provides feedback to Offerors. In addition, the pend correction files allow us to revise encounter submissions for a second cycle.	The revised Information Technology (IT) Systems Demonstration *Calendar* posted on 11/27 (and revised again on 12/19) is correct and supersedes the 10/29 version.

157.	Document J	General	General	Does the data in Document J include claims for all services to be covered in the contract year?	Section J of the Data Supplement contains Contractors' unaudited financial statement data. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. See the Introduction for Section J for more information about these reports. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
158.	Document C	General	General	Does the data in the databook text files include claims for all services to be covered in the contract year?	Yes, the Data Book files contain all adjudicated encounters for covered services submitted to AHCCCS for the years included in the Data Books.
159.	Document A-Document O	General	General	Were there any significant issues regarding existing health plan data?	There were no significant issues regarding existing health plan data for the Acute Care data. Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute Care/CRS, which was posted to the Bidders' Library on December 14 to read about the true-up factors AHCCCS used to develop the CRS rates.
160.	Document C, Document J	General	General	Please provide a list of the adjustments made for any anomalies present in the databook text files and Document J.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-

					capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field." Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
161.	Document J	General	General	Are the PMPM amounts in Document J gross or net of copays?	For questions regarding the data contained in Contractors' self-reported financial statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals. This data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
162.	Document C	General	General	Are the total cost amounts in the databook text files gross or net of copays?	Data Books reflect expenditures using encounter data as reported by Contractors. If payments were reduced due to copays, the Contractor should have reported paid amounts net of copays.

163.	Document C, Document J	General	General	Please provide the dollar amount of the beneficiary copayments and cost sharing associated with total cost amounts in Document J and the Databook text files by fiscal year, region, rate cell, and covered service.	No additional information will be provided.
164.	Document C	General	General	Are third party liability payments included in the databook text files?	TPL payments are not separately reported in the Data Book text files. Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made.
165.	Document C, Document J	General	General	Please provide the dollar amount of any other adjustments made to the claims experience included in the databook text files and Document J for reasons other than third party liability by fiscal year, region, rate cell, and covered service.	Data Book data is not adjusted, unless the Contractor has a sub-capitated or block purchasing arrangement. From Data Supplement for Offerors' – Acute Care/CRS, Section C, Data Book Information, *Data Book Introduction*: "The costs included in the Data Book Files are actual costs reported by the Contractor unless the Contractor has a sub-capitated or block purchasing arrangement. This type of arrangement would be noted by the sub-capitation code on the encounter. If there is a sub-capitated arrangement in the Acute Care or CRS programs and the "Health Plan Paid Amount" is zero, the lesser of the "AHCCCS Allowed Amount" or "Billed Amount" is used in place of the zero. For BH encounters, the "Health Plan Paid Amount" is used if available. If there is no "Health Plan Paid Amount" then

					the "Health Plan Approved Amount" is used. If neither field is available, the lesser of "AHCCCS Allowed" or "Billed Amount" is used to populate the cost field." Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted.
166.	Document C	General	General	Please provide the number of inpatient claim outliers and the associated utilization and cost in the development of the databook text files by fiscal year, region, and rate cell.	No additional information will be provided.
167.	Document C, Document J	General	General	Did the state do any smoothing of large claims in the development of the data?	No, the data provided was not smoothed.
168.	Document C	General	General	Were there significant changes (such as a noted increase or decrease) to utilization since the data period ended?	AHCCCS has not noticed significant changes to utilization since the data period provided ended.
169.	Document J	General	General	Please provide completion factors by Category of Aid, Category of Service and GSA for utilization and expenditures in Document J.	Document J reports are self-reported financial statements submitted by AHCCCS Contractors. Completion factors are not included in this data. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
170.	Document C	General	General	Please provide the experience period paid-through date.	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.

171.	Document J	General	General	Please indicate whether PMPM expenditures in Document J have completion factors applied.	Contractors' self-reported financial statement data was not adjusted by AHCCCS other than to remove amounts reported by Contractors for medical expenses or TPL in a GSA where they are no longer contracted. For questions regarding the data contained in Contractors' self-reported statements, see the *Financial Reporting Guide for Acute Health Care Contractors* in the Bidders' Library, Current Reporting Guides and Manuals.
172.	Document C	General	General	What flexibility does the MCO have in developing the formulary?	Refer to AMPM, Chapter 300 Medical Policy for Covered Services, Policy 310-V, Prescription Medication/Pharmacy Services.
173.	Document C	General	General	Are there any services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program?	Information regarding known program changes is provided in various sections of the RFP and supplemental documents.
174.	Document C	General	General	If there are services provided to members through other departments or programs that have been cut this year or expect to be cut in the near future causing the services to be pushed into this program, how is the base experience data adjusted to take into account these changes in services since the base period?	AHCCCS rebases the capitation years every five years as part of the RFP process. Program changes that occur after a rate rebase result in adjustments to the capitation rates.

175.	General	General	General	How will the State account withhold for quality incentives in the risk sharing arrangement calculation?	The question is unclear. Assuming the Offeror is asking how AHCCCS will account for the Payment Reform/Shared Savings withhold in the risk sharing calculations, the withheld capitation revenue will be excluded from the reconciliation. For example, if capitation is $100 and AHCCCS withholds $1, revenue equal to $99 would be used for the reconciliation.
176.	General	General	General	Will withhold for quality incentives be excluded from the gain sharing calculations?	The question is unclear.
177.	General	General	General	Please provide an estimate of reimbursement as a percentage of Medicaid allowable reflected in the dataset, by service category.	No additional information will be provided.
178.	General	General	General	How are Medicaid fee schedule increases developed for hospital, physician, emergency room and pharmacy rates?	Generally, when setting the capitation rates, the unit cost trend will be based on changes to the AHCCCS fee schedule for the categories of service which are impacted by these fee schedule changes. Categories that are not impacted by the AHCCCS fee schedule, include, but are not limited to: Pharmacy, Hospice and CRS Clinic Fees. The AHCCCS fee schedule rates are based primarily on changes to Medicare fee schedules, national trends, access to care and budgetary decisions.
179.	Document C, Document J	General	General	Are there other payments/settlements made outside of the claims system that will be the responsibility of the plans?	All expenditures for covered medical services are required to be submitted as encounters to AHCCCS. However, AHCCCS cannot speak to any Contractor-specific arrangements or circumstances which could result in payments/settlements outside of the claims' system.

180.	Document C, Document J	General	General	If other payments/settlements made outside of the claims system are the responsibility of the plans, will these be built into the rates?	No, payments outside of the claim's system will not be built into the medical component of the capitation rates. This component is developed based on adjudicated encounter data. Payments/settlements made outside the claims' system may be reflected in the Contractor's administrative expenditures and therefore may be accounted for in the administrative component.
181.	Document I	General	General	How many times per year will the Average MCO risk score be updated?	AHCCCS anticipates updating the risk scores one time per year.
182.	Document I	General	General	Please provide additional detail on how members who have enough months of enrollment to be scored, but who have no claim experience will be included in the risk adjustment process.	No additional information will be provided regarding risk adjustment. All information necessary to formulate a bid is posted in the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section I, Risk Adjustment Information.
183.	Document I	General	General	If risk adjustment is designed to be budget neutral to the state, will the budget neutrality be on a statewide or regional basis?	Yes, risk adjustment is designed to be budget neutral to the state on both a statewide and GSA basis.
184.	General	General	General	Is premium tax included in the administrative expense level (excluding gain) in the actuarially sound rate ranges rate ranges that will be used for scoring purposes?	This question is unclear. The rate ranges developed by AHCCCS are for the medical component of the capitation rates. There is no administrative expense in the rate ranges. The administrative component bid excludes premium tax. For more information, see the RFP, Section H, Instructions to Offerors, and Acute/CRS RFP YH14-0001 Bidders' Library, Solicitation Amendment No. 1 Q&A, Response # 106.
185.	General	General	General	Please explain how the actuarially sound rate range will be developed by the state	Refer to the Rate Setting Document in Section C of the Data Supplement for Offerors' – Acute

				actuaries.	Care/CRS which was posted to the Bidders' Library on December 14.
186.	General	General	General	Please specify all assumptions including, but not limited to the experience period, trend assumptions, managed care saving assumptions, program changes considered (retrospective and prospective), and non-medical loads in the development of actuarially sound rates by the state actuaries.	Refer to the *Rate Setting Document* in Section C of the Data Supplement for Offerors' – Acute Care/CRS which was posted to the Bidders' Library on December 14. Also see the Bidders' Library, Section B, Program and Fee Schedule Changes. No additional information regarding assumptions will be provided.
187.	Document C, Document J	General	General	Are there any pass-through payments reflected in the data? If so, please quantify these payments.	Data Books reflect expenditures using encounter data as reported by Contractors. To the extent encounter data includes pass-through payments, those payments would be reflected in the data. Likewise, if Contractors' financial statement data include pass-through payments, those payments would be reflected in the self-reported financial data. AHCCCS cannot quantify these payments.
188.	Databook, Document J	General	General	Please provide a reconciliation of membership and PMPM costs for all available years between the Databook and the financial summaries in Document J, including a summary of any data that is only included in one of these items.	AHCCCS will not provide a reconciliation. The Offeror may perform the requested reconciliation based on the data provided.
189.	Databook	General	General	We've observed significant negative changes in inpatient utilization across contract years. Please explain and quantify the primary factors driving these changes.	AHCCCS will not provide additional information regarding utilization changes.

190.	Databook	General	General	We've observed consistent reductions in Emergency Room utilization across contract years. Are there any Emergency Room avoidance measures in place beyond the change in copayments (effective 10/1/2010) that could be driving this change. If so, please quantify them.	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
191.	Databook	General	General	Please provide the utilization and charge trends used to develop the actuarially sound rate ranges for CYE14 by Category of Service for each category of aid and GSA.	Refer to the *Rate Setting Document* in Section C of the Data Supplement for Offerors'– Acute Care/CRS which was posted to the Bidders' Library on December 14. No additional information will be provided.
192.	Databook	General	General	We've observed consistently negative and dramatic changes in utilization for Physician/OBGYN services across contract years	Observation noted.
193.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Maternity Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

194.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by NICU Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
195.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by ICU Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
196.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Surgery Tier between CYE09 and CYE10. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

197.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Nursery Tier between CYE10 and CYE11. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
198.	Databook	General	General	Please explain the significant decrease in utilization rates for Hospital days by Routine Tier over all contract years. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted decreases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.
199.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Hospital Days by Routine Tier" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section N, Hospital Rate Overview, *Introduction*.
200.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "All Other Hospital Days" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*, and Section N, Hospital Rate Overview, *Introduction*.
201.	Databook	General	General	Please explain the spike in utilization rates for All Other Hospital Days in CYE10 within the TANF program, and overall. For example, is this change a result in a decrease in hospital admits or a decrease in average length of stay; is the decrease related to program changes?	Noted increases could be due to a variety of factors. AHCCCS will not provide additional information regarding utilization changes. AHCCCS intends to provide information related to hospital admits and length of stay in the Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Supplemental Data Book Reports*. Please watch for updates to this Section.

202.	Databook	General	General	Please explain the decreasing utilization rate trend over contract years for Physician Surgery.	AHCCCS will not provide additional information regarding utilization changes.
203.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Physician Other" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*.
204.	Databook	General	General	Please provide coding criteria and a list of prominent services for the "Other Professional" service line.	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Acute Care/CRS Service Matrix*.
205.	Databook	General	General	Please explain the spike in utilization rates for Other Professional Services in CYE10.	AHCCCS will not provide additional information regarding utilization changes.
206.	Databook	General	General	The utilization rate trend for Other professional services from CYE11 to CYE12 appears to be significantly positive. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for Other Professional services could be quite high after completion. Please explain the implied high utilization rate trend for this service category.	AHCCCS will not provide additional information regarding utilization changes.
207.	Databook	General	General	Please explain the significant decrease in utilization rates for Laboratory and Radiology Services between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.

208.	Databook	General	General	Please explain the significant increases and decreases for rentals and purchases of DME and Medical Supplies over contract years. For example, has there been an effort to shift DME and Medical Supplies expenses from purchases to rentals?	The Offeror has access to information on program changes and AHCCCS initiatives across the years included in the Data Books. AHCCCS will not provide additional information regarding utilization changes.
209.	Databook	General	General	Please explain the significant decrease in utilization rates for Dental Services between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
210.	Databook	General	General	Please explain the significant increase in utilization rates for Non-Emergency Transportation between CYE09 and CYE10.	AHCCCS will not provide additional information regarding utilization changes.
211.	Databook	General	General	Please explain the significant decrease in unit cost for Non-Emergency Transportation between CYE09 and CYE10. The list of program changes in Document B specifies a 5% reduction in rates between these years; we observe a much more significant negative trend.	AHCCCS will not provide additional information regarding unit cost changes.
212.	Databook	General	General	Please explain the significant decrease in utilization rates for Pharmacy Encounters between CYE10 and CYE11.	AHCCCS will not provide additional information regarding utilization changes.
213.	Databook	General	General	The databook groups membership and claims for members age 14-44 by gender only. Because there are variations in coverage for children and adults within this population, utilization and cost patterns may be substantially different between these two groups. Please provide databook data, enrollment counts and enrollment projections broken out between adults and children for these groups.	No additional information will be provided.

214.	Acute Care Actuarial Certifications CYE09-CYE12	General	General	Please provide a list of experience adjustments made to capitation rates in CYE09-CYE12,	No additional information will be provided.
215.	Acute Care Actuarial Certifications CYE09-CYE13	General	General	Please provide a list of all adjustments other than experience adjustments made to capitation rates after bids had been made, for each contract year.	No additional information will be provided.
216.	Databook	General	General	Does AHCCCS anticipate any difference in utilization trend rates from the utilization trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
217.	Databook	General	General	Does AHCCCS anticipate any difference in unit cost trend rates from the unit cost trends apparent in the current databook based on emerging experience?	No, AHCCCS does not anticipate any difference in trends based on emerging experience. Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*.
218.	Databook	General	General	Please provide a definition for "Pharmacy Encounters" (ex. prescriptions, or 30 day equivalents)	Refer to the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section D**,** Service Matrix/Selection Criteria for Data Book.
219.	Databook	General	General	The utilization rate trend for TANF < 1 overall appears to be slightly positive between CYE11 and CYE12. Because of the timing of the data release, we assume that the CYE12 data is relatively incomplete. This would suggest that the CYE11 to CYE12 utilization trend for TANF < 1 could be quite high after completion. Please explain the implied high utilization trend for this category of aid.	AHCCCS will not provide additional information regarding utilization changes.

220.	Document H-3	General	General	Which category of aid will the members in the "PPACA Child Expansion" column be included in?	PPACA child expansion members are included in the column labeled "ACA Child Expansion" on H-3, Enrollment by Month (Historical and Projected), which can be found in the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section H, Enrollment Information.
221.	Document H-3	General	General	It appears that the enrollment projections include the assumption that Arizona will participate in the PPACA Medicaid expansion. Please verify this assumption.	The Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section H, Enrollment Information includes an Introduction document which states on page 1: "The projected member months assume the following: • Child expansion is mandatory beginning January 1, 2014 • Restoration of the AHCCCS Care (Childless Adults) population beginning January 1, 2014 • Some categorical woodwork beginning July 1, 2013 • Increase due to streamlined redetermination beginning January 1, 2014 • Kidscare II will end December 31, 2013, but it is anticipated that half of the population will move to child expansion"

222.	Document H-3	General	General	If the state's position on adopting the PPACA Medicaid expansion changes, will AHCCCS publish adjusted enrollment projections, or adjust capitation rates in any way?	As stated in the RFP, Sections D1 and D2, Paragraph 75, Pending Legislation/Other issues: "Governor Brewer and State lawmakers have yet to determine the course for the Medicaid program as it relates to options under the ACA." If something changes before the proposal due date, AHCCCS may choose to publish adjusted enrollment projections, if available. Also as stated in the RFP, Sections D1 and D2, Paragraph 55, Capitation Adjustments, "AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following: • Program changes • Legislative requirements…"
223.	N/A	N/A	N/A	We want to make sure we provide appropriate bids for the populations covered, and want to be clear on which populations are to be included in the Dual SNP or Pilot program. There is a category of dual eligible called SSI with Medicare. These members and this category seem to continue to be included in the acute bid. Will these members be moved to the Dual SNP or Pilot? Should we include a bid for them in the acute bid?	Yes, include a bid for members who are in the SSI with Medicare risk group. If the Dual SNP continues, these members will be paid a Medicaid rate based on the bid. If the Dual Demo is implemented, the members are permitted to opt out of the Demo, thus the Medicaid rate paid for these members will be based on the bid.

224.	N/A	N/A	N/A	In addition, we understand that members in the SMI category have been removed from the data book for the acute population. Are there any SMI members with dual eligibility also included in the SSI with Medicare? If so, have they been removed from the data book also?	Only County 13 (Maricopa) SMI members have been removed from the Data Book for the acute population. However, the Acute Care Data Book will contain minimal County 13 SMI services, costs and member months for those members accounting for the transition window from the Acute Care program to the Maricopa RBHA. Example: If a member is in County 13 and determined SMI, there is a 14 day window to move the member from the Acute Care program to the Maricopa RBHA. During that 14 day period the member will still be on the Acute Care program, thus that data was not removed from the Data Book.
225.	Supplemental Data Book Reports	N/A	N/A	The data book does not break out prescription drug information into generic, brand, retail or mail. Can utilization and cost information be broken out by these additional categories and provided to bidders?	No additional information will be provided.
226.	Document F – Capitation Bid Template Acute Care and Document C – Data Book Files Acute Care Delivery Supplement Cost and Utilization.txt	N/A	N/A	When Delivery Supplement is selected as the risk group in the bid template (Data Book file 'Document F – Capitation Bid Template Acute Care.xlsm'), only limited service categories are shown; however, the Data Book file 'Document C- Data Book Files Acute Care Delivery Supplement Cost and Utilization.txt' includes Delivery Supplement utilization and costs in other service categories (e.g., Pharmacy). Should costs in those additional categories be included in Miscellaneous in the bid?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.

227.	Document G – CrosswalkAcuteCare CRS Service Matrix Financial Statements	N/A	N/A	Document G provides a crosswalk between most service categories, but does not specifically show how Physician OB/GYN Services, Physician Surgery, and Physician Other map to Primary Care Physician and Referral Physician, which are service categories in the bid template. Is there a direct mapping for these categories, or can you provide additional information on primary care vs. referral physician utilization?	Refer to the Bidders' Library, Data Supplement for Offerors' – Acute Care/CRS, Section D, Service Matrix/Selection Criteria for Data Book, *Crosswalk Acute Care Service Matrix to Capitation Bid Template* posted on December 14.
228.	Document C – Databook Introduction	N/A	N/A	We understand that the data book contains services provided through 3/31/12, and is not adjusted for completion factors. DocC_DatabookIntroduction.pdf indicates that the Data Book Files were run after the first July 2012 encounter cycle. Can you provide a specific "paid-through" date?	The Data Book files were run after the first July 2012 encounter cycle. Paid dates could include any date up to the deadline date for encounter submissions for this cycle, which was July 5, 2012.
229.	Document C – Databook Introduction	N/A	N/A	Is there information available on Third Party Liability (TPL) recoveries, beyond the PMPM values in Section J? Can lag tables be provided? Are TPL recoveries included in the data book?	Expenditures included in the Data Books reflect the encounter data reported by Contractors. Data Book data is not adjusted unless the Contractor has a sub-capitated or block purchasing arrangement. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data. No additional information will be provided.

230.	Amendment 1	N/A	N/A	Please confirm that the entity awarded a contract must be a c corporation. Please also confirm that a successful incumbent bidder that is currently organized as an LLC would be required to reorganize as a corporation. If so, what is the deadline for such reorganization?	Within 120 days of contract award, a non-governmental Contractor shall have established a separate corporation. This corporation does not have to be a c corporation. A successful incumbent that is currently an LLC would be required to become a corporation within the same timeline.
231.	Databook	Utilization Data	Utilization Data	Please explain the large drop in utilization for AHCCCS Care between 2010 and 2011	AHCCCS will not provide additional information regarding utilization changes.

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 3 **(Three)** Solicitation Due Date: **January 28, 2013 3:00 PM (Arizona Time)**	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows, and supersedes any information previously provided that is inconsistent:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the **4th day of January, 2013,** in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** **SIGNED COPY ON FILE**
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS

ACUTE/CRS QUESTIONS AND RESPONSES AMENDMENT No. 3 TO RFP YH14-00014

Question #	Section	Paragraph #	Page #	Question	Response
1.				For the final capitation rate to be paid to the MCOs, can the state specify whether both the admin and risk margin will be calculated as a percent of the medical rate or as a percent of the final capitation rate? Please confirm or correct the following capitation rate calculation: (Medical rate x (1 + admin% + 1% risk) + Reinsurance offset) / (1 - 2% premium tax) = Final capitation rate	The admin used will be the admin that is bid, except for the capitation rates that are not bid (i.e. PPC). The risk margin is a % of the medical rate. For rates that are bid: (Medical rate x (1+ 1% risk) + Admin Bid + RI Offset (set by AHCCCS)) / (1-2% premium tax) For rates that are not bid (RI does not apply to these rates thus there is no RI Offset in the formula): (Medical rate x (1+ 1% risk+ admin% (8%)) / (1-2% premium tax)
2.				What is the projected membership distribution for the 4 CRS coverage types?	Projected FFY14: 70.7% CRS Fully Integrated 0.7% CRS Partially-Integrated – Acute 24.7% CRS Partially-Integrated – BH 3.9% CRS Only
3.				Will TPL be factored into the final capitation rate development? If so, at what point in the calculation will it be incorporated?	AHCCCS uses the Data Book files as a basis to calculate the final capitation rates. The Data Book files are based on Contractor submitted encounters. If a Contractor's payment on a claim is reduced due to existence of a third party payer, the Contractor's payment should be net of the third party payment. Contractors are required to adjust previously adjudicated encounters when a post-payment recovery is made. Capitation rate ranges were developed based on the Data Book data.
4.				Can the state provide the trend factors, historical and prospective, used in the medical rate range development?	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
5.				Can the state provide the medical codes and criteria used to identify the expenses for the Delivery Supplement categories of service?	Refer to the Acute Care/CRS Service Matrix and the Crosswalk Acute Care Service Matrix to Capitation Bid template in Section D of the Data Supplement for Offerors in the Bidders' Library.
6.				Will the Payment Reform Withhold be applied as a percentage of the medical rate only or as a percentage of the final capitation rate (medical rate + risk + admin + reinsurance + premium tax)?	AHCCCS anticipates that the payment reform withhold will be applied as a percentage of the final capitation rate. The draft Policy will be released 4/1/13 with more information.
7.				Can the state provide the true-up factors used to adjust the CRS data?	The BHS factors are 8.83% for CYE09, 4.40% for CYE10 and 2.63% for CYE11. For CRS Specialty Care, from the Bidders' Library, Data Supplement for Offerors'– Acute Care/CRS, Section C, Data Book Information, *Rate Setting Document*, "AHCCCS elected to use clinic fee expenditures from the financial statement data."
8.				Can the state provide the rationale for using equal weights on each contract year of databook data to build the prospective medical rate ranges?	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
9.	F – Acute Care Medical Component Ranges			Which rate ranges will be applicable to ACA Child Expansion enrollees shown in document H-3?	ACA Child Expansion enrollees would be included in the TANF rate ranges appropriate to their ages.
10.	F – Acute Care Medical Component Ranges			Do the rate ranges assume that under the RFP assumption that AHCCCS Care is restored for January 1, 2014, individuals who were transitioned to SSI categories as part of the freeze will transition back to AHCCCS Care?	No, AHCCCS Care rate ranges do not assume individuals who were transitioned to SSI Categories a part of the freeze will be transitioned back to AHCCCS Care since they are now in the appropriate category.

Question #	Section	Paragraph #	Page #	Question	Response
11.	Rate Ranges			Did AHCCCS make any adjustments to account for risk changes associated with ACA related membership growth?	No, AHCCCS did not make any adjustments to account for risk changes associated with ACA related membership growth. If AHCCCS determines such adjustments are necessary, the awarded capitation rates will be adjusted appropriately.
12.	Rate Ranges			Please provide the program change adjustments applied (by CYE, risk group and data book service category).	Refer to the Bidders' Library, Section B, Program and Fee Schedule Changes. No additional information will be provided.
13.	Rate Ranges			For some rate ranges (e.g. SSI W), the program changes (e.g. OON QMB Duals adjustment combined with other smaller program changes) significantly add costs. In order to get within the rate ranges provided (after program changes and completion are applied), significantly negative trends would be need to be assumed. Any insights you can provide to help us understand if other factors are being applied or if there is a justification for large negative trends would be appreciated.	AHCCCS did not apply significant negative trends. The average statewide total trend for the SSIW population is 1.70% varying by GSA from -0.11% to 2.85%.
14.	Rate Ranges			Were the rate ranges adjusted for additional COB/TPL recoveries (outside of those reported in the data book) or supplemental payments? If so, please provide said adjustments.	No, the rates were not adjusted for additional COB/TPL recoveries or supplemental payments outside of the Data Books.
15.	Section B Program and Fee Schedule Changes	general		In order to make sure we are applying the program changes to the rates appropriately and consistently with what is done with the rate ranges, can you clarify if savings estimates provided are based on the full contract year or just the portion of the contract year if a mid contract year adjustment. For example, if a program change was implemented 4/1 with savings of $1 million from 4/1 through 9/30, are the savings shown as $1 million for the entire contract year or will the savings stated be roughly $2 million?	Section B numbers are stated as a full year of savings although most of the numbers in Section B are on a PMPM basis and not a total dollar basis. In the example provided, if the total dollar savings were provided rather than a PMPM, the document would show a savings of $2 million.

Question #	Section	Paragraph #	Page #	Question	Response
16.	Section C – Rate Setting Document	Historical Program and Fee Schedule Changes	4	This section indicates that "the base data was adjusted for historical program and fee schedule changes". Does this mean that adjustments were made to reflected current AHCCCS fee schedule levels, or only to reflect the changes in levels over time?	The base data, which is historical encounter data (i.e. data books), was adjusted for historical AHCCCS fee schedule changes to get the data to the current AHCCCS fee schedule levels.
17.	Section C – Rate Setting Document	Capitation Rates and Components Set by AHCCCS	5	Will AHCCCS adjust the final 10/1/2013 capitation rates to reflect the change in the third party recovery period?	Prior to 10/1/2013 AHCCCS will review and determine if the awarded rates need to be adjusted for any material changes including the third party recovery period.
18.	Section C – Rate setting document	1	2	In the absence of lag triangles, please describe the methodology used to develop completion factors in the development of the rate ranges and provide lag triangles for the periods under consideration by form type and GSA.	No additional information will be provided.
19.	Section C – Rate setting document	4	1	Please provide justification for weighting the partial CYE2012 experience equally with full contract year data from earlier contract periods.	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.

Question #	Section	Paragraph #	Page #	Question	Response
20.	Section C – Rate setting document	4	1	Please provide justification for weighting older historical periods (CYE2009 and CYE2010) equally with the most recent full contract period data (CYE2011).	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
21.	Section C – Rate setting document	4	4	Did AHCCCS adjust historical data for program and fee schedule changes in the delivery supplement category of the bid?	Yes, AHCCCS adjusted historical data for program and fee schedule changes for all risk groups including delivery supplement. For simplicity sake, AHCCCS assumed the same program changes that impacted the TANF 14-44 F risk group would also impact the Delivery Supplement rates for the following categories of service (COS): Hospital Inpatient, Physician, Other Professional and Transportation.
22.	Section C – Rate setting document	4	4	If historical data was adjusted for program and fee schedule changes, please provide the adjustment amounts on a per-delivery basis	For simplicity sake, the TANF 14-44 F risk group PMPM program change impacts were applied to the delivery supplement per delivery per month rates. The fee schedule changes were left as percentage adjustments impacting the unit cost similar to all other risk groups. No additional information will be provided.
23.	Section C – Rate setting document	4	4	Were any of the PMPM adjustments provided in Section B of the Data Supplement recalculated based on actual historical experience in development of the rate ranges?	No, none of the PMPM adjustments provided in Section B of the Data Supplement were recalculated based on actual historical experience.

Question #	Section	Paragraph #	Page #	Question	Response
24.	Section C – Rate setting document	4	4	If any of the PMPM adjustments in Section B of the Data Supplement were recalculated based on actual historical experience, please provide the revised assumptions.	Not applicable.
25.	Section C – Rate setting document	4	4	On what summary level were base trends and projection trends applied in development of the rate ranges. For example, was each combination of GSA and category of aid given a trend assumption, were regional trends applied separately from trends for each Category of Aid, was there a single trend applied across all GSAs and all categories of aid, etc.?	In general, trends were developed and applied based on COS, by GSA and by risk group. All trends had thresholds applied to exclude abnormally high positive or negative trends. The thresholds for the negative trends were set fairly low to allow only small negative trends to continue. If a risk group within a GSA did not have enough credibility, the trends were blended with statewide trends.
26.	Section C – Rate setting document	5	5	As a point of clarification, the rate setting document states that the offeror should not consider risk contingency or premium tax in the bid; does this mean that risk contingency and premium taxes are not considered in the actuarial sound rate ranges?	Correct. The rate ranges are only for the medical component and do not contain risk contingency or premium tax components.
27.	Section C – Rate setting document	5	5	Are there any other items (similar to premium task or risk contingency), which would commonly be included in capitation rate calculations, that should not be included in the calculation of the offeror's bid rates?	As stated in the RFP, Section H, Instructions to Offerors, "Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid."
28.	Section C – Rate setting document	6	4	Please provide the thresholds used for abnormally high or low utilization or cost trends in the rate development process.	No additional information will be provided.

Question #	Section	Paragraph #	Page #	Question	Response
29.	Section C Data Book Information Rate Setting Doc	Paragraph 4	1	Please provide support for giving equal weight to all four years of data. In your response, please address the following concerns: • Using CYE09 introduces uncertainty due to the number of program adjustment estimates required for normalization and 5 years of trend. • Given the relatively large completion factors, using CYE12 also introduces uncertainty.	AHCCCS reviewed multiple methods of weighting the adjusted base year data and for most risk groups/GSAs the results were very similar for all methods. Including the CYE12 data equally helps reduce uncertainty regarding the impact of the 25 day limit since CYE12 was the first year for that program change. Including the most recent data also reduces the number of months that would be included in a trend based on older data. And while CYE09 data is fairly old, it is complete. Overall the base would be lower if CYE09 were excluded.
30.	Section C Data Book Information Rate Setting Doc	Paragraph 5	4	The Rate Setting Doc states: "Please note that the SSIW category was not adjusted for most fee schedule changes…" Please list the fee schedule changes that were applied to the SSIW category.	Categories for SSIW that had AHCCCS fee schedule adjustments applied were: Dental, Transportation and Nursing Facility and Home Health.
31.	Section C Data Book Information Rate Setting Doc	Paragraph 5	4	Which program changes did AHCCCS apply to the delivery supplement payment ranges?	For simplicity sake, AHCCCS assumed the same program changes that impacted the TANF 14-44 F risk group would also impact the Delivery Supplement rates for the following categories of service (COS): Hospital Inpatient, Physician, Other Professional and Transportation.
32.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	We recognize that you will not be providing the trend factors applied but can you state whether the trend factors vary by the CYE to which they are applied or is one set of factors used and applied to all CYEs?	One set of trend factors are applied to the adjusted base data. The adjusted base data is a blend of all contract years.
33.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	Similarly can you state if negative trends are applied?	Negative trends were allowed, but they were capped at a lower limit (thus not allowing large negative trends) than the cap on positive trends.

Question #	Section	Paragraph #	Page #	Question	Response
34.	Section C Data Book Information Rate Setting Doc	Paragraph 6	4	If negative trend factors were used in the development of the rate ranges, please provide justification as to why AHCCCS believes negative trends are reasonable and sustainable.	AHCCCS did not allow large unsustainable negative trends to continue, but did feel it was reasonable to allow for some small negative trends to continue. After factoring in historical reimbursement (AHCCCS fee schedule changes) and program changes, negative trends by COS are reasonable in the short term due to changes in enrollment or service mix (e.g. reduced readmission rates, improved ER steerage).

	**SOLICITATION AMENDMENT** Solicitation No.: **RFP YH14-0001** Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page shall be included with the proposal, which must be received by AHCCCS no later than the Solicitation due date and time.

This solicitation is amended as follows:

1. Section H: Instructions to Offerors, Paragraph 16, Capitation, *Acute Care Program Capitation Bid Submission (Submission Requirement No. 1)*, page 302 is amended as follows:

***Acute Care Program Capitation Bid Submission* (Submission Requirement No. 1)**

All GSAs for which an Offeror bids will require a capitation rate bid submission for each risk group. Each bid will encompass two components; a gross medical component and an administrative component. Each component will be scored separately. In addition, the combined components (i.e. the gross medical and administrative components) may be scored for each risk group and GSA. The lowest bid within each GSA and risk group will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable, either for the scoring of the administrative component and/or the combined components. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

1. Offerors will submit a gross medical component PMPM bid for each risk group by GSA. Neither reinsurance offsets nor capitation withheld for payment reform initiatives should be considered in the medical component bid. Prior to October 1, 2013 AHCCCS will develop projections for reinsurance offsets and will adjust awarded capitation rates accordingly.
    - Capitation bids submitted with a medical component outside of the published ranges (described below) will earn a medical component score of zero points.
2. Offerors will submit an administrative component PMPM bid for each risk group by GSA. The administrative component is limited to a maximum of 8%. The administrative component percentage shall be calculated as: Administration / Gross Medical Component.
    - Capitation bids submitted with an administrative component exceeding 8% will earn an administrative component score of zero points.
3. In the event that AHCCCS elects to score the combined components, in any instance where zero points are awarded for either the medical or administrative component, the combined component score will be zero.
4. In any instance where zero points are awarded for either the medical or administrative component and the Offeror is awarded a contract, the awarded capitation rate for the impacted GSA/risk group will be as follows:
    - For a medical component score of zero points: the bottom of the actuarial rate range for the medical component for that GSA/risk group (as adjusted by Section D, Paragraph 53, Compensation and Section D, Paragraph 55, Capitation Adjustments); and
    - For an administrative component score of zero points: the lowest awarded administration rate for that GSA/risk group.

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 4 (Four) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

2. Section H: Instructions to Offerors, Paragraph 16, Capitation, *CRS Program Capitation Bid Submission (Submission Requirement No. 2)*, page 304 is amended as follows:

***CRS Program Capitation Bid Submission* (Submission Requirement No. 2)**

The Offeror will submit a capitation rate bid submission for the administrative component. The lowest bid will receive the maximum allowable points. However, AHCCCS may award the maximum allowable points to any bid for the administrative component equal to or below a minimum threshold considered by AHCCCS to be reasonable. ~~Conversely, the highest bid will receive the least number of points.~~

Bid component requirements:

1. Offerors will submit a single administrative component bid that will be added to the total medical component by coverage type. The administrative component will not vary by coverage type.
2. The administrative component bid will be stated as a per member per month (PMPM) figure.
   - Capitation bids submitted with an administrative component PMPM value exceeding $60 PMPM will earn an administrative component score of zero points.
3. In any instance where zero points are awarded for the administrative component and the Offeror is awarded a contract, the awarded administrative component will be $52.00 PMPM.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 10th day of January, 2013, in Phoenix, Arizona.
OFFEROR		**AHCCCS**
Signature	**Date**	**Signature**
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS

	SOLICITATION AMENDMENT Solicitation No.: **RFP YH14-0001** Amendment No. 5 (Five) Solicitation Due Date: January 28, 2013 3:00 PM (Arizona Time)	**AHCCCS** Arizona Health Care Cost Containment System 701 East Jefferson, MD 5700 Phoenix, Arizona 85034 Meggan Harley Contracts and Purchasing Section E-mail: Meggan.Harley@azahcccs.gov

Receipt of solicitation amendments must be acknowledged by signing and returning the signature page of the amendment to the Solicitation Contact Person. A signed copy of this signature page must be received by AHCCCS no later than the Solicitation due date and time. Notwithstanding, Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, for Amendment No. 5 only, one copy of signed Amendment No. 5 is required which may be submitted separately from the remainder of the proposal. However, the signed Amendment No. 5 must still be submitted by 3:00PM (Arizona Time) on the January 28, 2013 deadline. Offerors may submit the signed amendment electronically to the Offeror's SFTP folder noted in Section H: Instructions to Offerors, Paragraph 15, *Contents of Offerors Proposal*, or by hard copy to the Solicitation Contact Person.

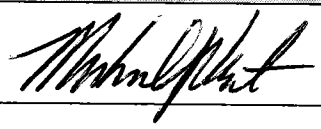
This solicitation is amended in response to the following question which was received by the Technical Support Help Desk regarding the Capitation Bid Template:

> *It appears that macros within the Bid Template are rounding unit costs entered with more than two decimal places to two decimal places. Are we limited to two decimal places for unit cost entry?*

AHCCCS Response:

> Offerors are not limited to two decimal places when entering unit cost. The first time you enter and store a risk group/GSA you have unlimited decimal places. However, if you retrieve that same risk group/GSA the model will round to two decimal places for unit cost.

No questions will be accepted by the Technical Support Help Desk regarding the Capitation Bid Template on or after January 25, 2013 at 12:00PM (Arizona Time) .

OFFEROR		**AHCCCS**
Signature	**Date**	**Signature** 
Typed Name		**Typed Name** Michael Veit
Title		**Title** Contracts and Purchasing Administrator
Name of Company		**Name of Company** AHCCCS