INTERAGENCY SERVICE AGREEMENT (ISA)

Contract between the Arizona Department of Economic Security ("ADES") and the Department of Health Services (ADHS) ("Contractor")

WHEREAS, A.R.S. §35-148 (A) authorizes a State Agency to provide for reimbursement for services performed or to advance funds to another State Agency for services to be performed pursuant to an Interagency Service Agreement and (B) authorizes such funds to be credited to the appropriation account of the agency performing the services for use by such agency;

THEREFORE, it is agreed that the ADES and the Contractor shall abide by all the terms and conditions of this agreement.

BY SIGNING THIS FORM ON BEHALF OF THE CONTRACTOR, THE SIGNATORY CERTIFIES HE/SHE HAS THE AUTHORITY TO BIND THE CONTRACTOR TO THIS CONTRACT.

FOR AND ON BEHALF OF THE ARIZONA DEPARTMENT OF ECONOMIC SECURITY:

Elizabeth G. Csaki, CPPB

FOR AND ON BEHALF OF THE ARIZONA DEPARTMENT OF HEALTH SERVICES:

Christine Ruth

Printed Name: Professional Services Procurement Manager

Title 6/29/2010

Date

ADES Contract No. DE111090001

Date

ADHS Contract No. HS032229

Revised: 5/10/10
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2. DD UTILIZATION MANAGEMENT REPORT
3. ADULT SYSTEM OF CARE
4. SYSTEM OF CARE PRACTICE REVIEW
5. PROVIDER NETWORK REPORT
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7. QUARTERLY ADHS/DBHS FINANCIAL STATEMENT

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3. COORDINATION OF CARE #2
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6. MEMBER SURVEY

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2. SUBCONTRACTOR FINANCIAL AUDITS
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5. MEMBER SURVEY
6. ADHS/DBHS MEMBER HANDBOOK TEMPLATE
7. SUBCONTRACTOR MEMBER HANDBOOKS
8. PERFORMANCE IMPROVEMENT PROJECT PROPOSALS AND INTERIM REPORTS
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SUMMARY OF DUE DATES

MONTHLY REPORTS

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VERSION 1.11

34
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SECTION B: CAPITATION RATES

The Arizona Department of Health Services (ADHS) shall provide services as described in this contract. The Department of Economic Security/Division of Developmental Disabilities (Division) will pay monthly capitation to ADHS in accordance with the terms of this contract at the following rates:

$100.66 pmplt

* Any subsequent changes in the rates paid will be made through contract amendment Section D, Paragraph 26, Capitation and Paragraph 27, Method of Payment.
SECTION C: DEFINITIONS

ACOM  

ADHS/AHCCCS Contract  
Contract YH8-00022/ADHS # 832007, Amendment 35, effective July 1, 2009 and any and all subsequent amendments

ADHS/DLS/ OBHL  
The Arizona Department of Health Services/Division of Licensing Services/Office of Behavioral Health Licensing

AGENT  
Any person who has been delegated the authority to obligate or act on behalf of another person or entity

AHCCCS  
Arizona Health Care Cost Containment System, which is composed of the Administration, Contractors, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq

AHCCCS Rules  
See Arizona Administrative Code (A.A.C)

AHCCCS STANDARDS  
The standards established by AHCCCS in AHCCCS policies, the Title XIX State Plan, the Title XIX waiver, applicable federal and state statutes and rules, and any subsequent amendments thereto

ALTCS  
The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute and behavioral health care and case management services to members, as authorized by A.R.S. § 36-2932 et seq

DD-ALTCS  
The Arizona Long Term Care System program serving individuals with developmental disabilities

AMPM  
AHCCCS Medical Policy Manual

APPEAL RESOLUTION  
The written determination by the Contractor concerning an appeal

ARIZONA ADMINISTRATIVE CODE (A.A.C.)  
State regulations established pursuant to relevant statutes For purposes of this contract, the relevant sections of the AAC are referred to throughout this document as “AHCCCS Rules”.

A.R.S.  
Arizona Revised Statutes

BEHAVIORAL HEALTH PROFESSIONAL  
As specified in A.A.C. Title 9, Chapter 20, a psychiatrist, psychologist, social worker, counselor, marriage and family therapist, certified psychiatric nurse practitioner, registered nurse, behavioral health medical practitioner or physician assistant

BEHAVIORAL HEALTH RECIPIENT  
An DD-ALTCS member who is eligible for and 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 “COVERED SERVICES”.

BEHAVIORAL HEALTH TECHNICIAN  
A staff member of a licensed behavioral health service agency as specified in A.A.C. Title 9, Chapter 20

CAPITATION  
The method by which ADHS is paid to deliver covered services under this contract to members based on a fixed rate per member per month notwithstanding (a) the actual number of members who receive care from ADHS, and (b) the amount of health care services provided to any member.

CLAIM  
A service billed under a fee-for-service arrangement.
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 reinsuranc

The oversight, guidance and direction for the delivery of behavioral health treatment services that are provided by a licensed psychiatrist, a psychologist, licensed behavioral health professional or clinical supervisor meeting the requirements of AAC Title 9, Chapter 20

Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children’s Health Insurance Program

See "COVERED SERVICES".

Corresponds to State fiscal year (July 1 through June 30). For example, Contract Year 09 is 7/01/08 - 6/30/09.

An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by contract in conformance with the stated contract requirements, AHCCCS statute and rules and federal law and regulations

Those medically necessary Title XIX behavioral health services to be delivered by ADHS to members as defined in AHCCCS Rules 9-22, Article 12 and Section D of this contract.

Calendar days unless otherwise specified in the text, as defined in R9-22-101.

Division of Health Care Management, a division within the Arizona Health Care Cost Containment System (AHCCCS) Administration

The Division of Developmental Disabilities within the Department of Economic Security

A member who is eligible for both Medicare and Medicaid

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)]

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)]

An encounter is a record of a medically related service rendered by a provider or providers registered with AHCCCS to a behavioral health recipient

A Medicaid recipient who is currently enrolled with the Division by AHCCCS as part of the DD-ALTCS program. For purposes of this contract, see definition of Member.

Early and Periodic Screening, Diagnosis and Treatment: services for persons under 21 years of age as described in AHCCCS rules R9-22, Article 2. Mandatory preventive child health services required to be provided to Title XIX children. The behavioral health component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract

A method of payment to registered providers on an amount-per-service basis

A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system
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.

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) requires states to comply with the Administrative Simplification requirements in Subpart F and the safeguarding of confidential information pursuant to 42 CFR Part 431, Subpart F, ARS §§36-107, 36-2903, 41-1959 and 46-135, and AHCCCS Rules.

Incurred But Not Reported claims; liability for services rendered for which claims have not been received.

Intergovernmental Agreement. 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.

Institution For Mental Disease; An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases [(42 CFR 435.10)]

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

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 care and treatment provided by a Primary Care Provider, 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.

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.

A Federal program authorized by Title XVIII of the Social Security Act, as amended.

For this document, a person eligible for AHCCCS who is enrolled with the Division of Developmental Disabilities under the DD-AL.TCS program for whom ADHS has responsibility to provide behavioral health services.

Any materials given to behavioral health recipients. This includes, but is not limited to: member handbooks, member newsletters, surveys, and health related brochures and videos. It includes the templates of form letters and website content as well.
PCP
Primary Care Provider: An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of a 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 person licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

PERFORMANCE STANDARDS
A set of standardized indicators designed to assist the Division in evaluating, comparing and improving the performance of its Contractors. Specific descriptions of health services measurement goals are found in Section D, Paragraph 22, Quality Performance Standards.

POST STABILIZATION SERVICES
Medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location (42 CFR 438.114(a)).

PRIOR AUTHORIZATION
The process by which the appropriate entity approves a service subject to medical review later for appropriateness and covered for payment.

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

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)
An organization under contract with ADHS 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 (TRBHA) for the provision of behavioral health services to American Indian members living on-reservation.

REHABILITATIVE SERVICES
Rehabilitative services as specified in 42 CFR 440.130(d) include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of this practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. Rehabilitative services do not include room and board in an institution.

SMI
Seriously Mentally Ill; A person 18 years of age or older who is seriously mentally ill as defined in A.R.S. §36-550.

SERVICE PROVIDER
An organization and/or behavioral health professional who meets the criteria established in this contract, has a contract with ADHS or a subcontractor, AHCCCS Health Plan, Program Contractor or Tribal Government, as applicable, and is registered with AHCCCS to provide behavioral health services.

SPECIAL HEALTH CARE NEEDS
Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that required by members generally.

STATE
The State of Arizona

STATE PLAN
The written agreements between the State of Arizona and CMS which describe how the AHCCCS programs meet all CMS requirements for participation in the Medicaid program and the Children’s Health Insurance Program.

SUBCONTRACT
An agreement entered into by ADHS with a provider of behavioral health services who agrees to furnish covered services to members or with any other organization or person who agrees to perform any administrative function or service for ADHS specifically related to fulfilling ADHS' obligations to the Division under the terms of this contract.

SUBCONTRACTOR
(1) A provider of health care who agrees to furnish covered services to members (2) A person, agency or organization with which ADHS 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 this agreement.
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.

THIRD PARTY LIABILITY
The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise liable to pay all or part of the medical expenses incurred by an DD-ALTCS member.

TITLE XIX
Title XIX of the Social Security Act, an entitlement program under which the federal government makes matching funds available to states for health and long term care services for eligible low-income individuals.

TITLE XIX MEMBER
Member eligible for federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under section 1931 provisions of the Social Security Act (previously AFDC-related), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver Groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.

TREATMENT
The range of behavioral health care received by a member that is consistent with the therapeutic goals.

TRIBAL SUBCONTRACTOR
A subcontractor operated by a Tribal government, through an IGA with ADHS for the provision of behavioral health services to a Native American member.
SECTION D: PROGRAM REQUIREMENTS

1. SCOPE OF RESPONSIBILITY
ADHS shall be responsible for the performance of all contract requirements. ADHS may delegate responsibility for services and related activities under this contract, but remains ultimately responsible for compliance with the terms of this contract (42 CFR 438.230(a)).

2. SCOPE OF SERVICES
ADHS, either directly or through subcontractors, shall be responsible for the provision of all medically necessary covered behavioral health services to DD-ALTCS eligible members in accordance with applicable federal, state and local laws, rules, regulations and policies, including services described in this document and those incorporated by reference throughout this document and AHCCCS policies referenced in this document. ADHS shall ensure that policies and procedures are made available to all contracted service providers. ADHS shall provide technical assistance to subcontractors regarding covered services, encounter submission and documentation requirements on an as needed basis. The services are described in detail in AHCCCS Rules R9-22, Articles 2 and 12, and R9-31, Article 12, and the AHCCCS Medical Policy Manual (AMPM), all of which are incorporated herein by reference. The DBHS Covered Behavioral Health Services Guide is also available on the DBHS website at: http://www.azdhs.gov/dhsc/FNLguide_v67.pdf and is updated on a quarterly or as needed basis. Covered services must be medically necessary and rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as AHCCCS providers. ADHS must ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. Medically necessary behavioral health services must be related to the member’s ability to achieve age-appropriate growth and development, and to maintain, maintain, or regain functional capacity.

ADHS may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. ADHS 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)(1),(3), and (4)).

Eligibility
All DD-ALTCS members are eligible to receive covered behavioral health services. Covered services include:

a) Behavior Management (behavioral health personal assistance, family support, peer support)
b) Case Management Services only as outlined in the attached Case Management Matrix
c) Emergency/Crisis Behavioral Health Services
d) Emergency Transportation
e) Evaluation and Screening (initial and ongoing assessment)
f) Group Therapy and Counseling
g) Individual Therapy and Counseling
h) Family Therapy and Counseling
i) Inpatient Hospital (ADHS/DBHS may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBI-II., in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.)
j) Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
k) Institution for Mental Disease (IMD). A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Office of Behavioral Health Licensure licensed Level I facilities with more than 16 beds are considered IMDS. Reimbursement for services provided in an IMD to Title XIX persons age 21 through 64 years is limited to 30 days per inpatient admission, not to exceed a total of 60 days per contract year. For Title XIX members under age 21 and 65 years of age or over, there is no benefit limitation. A Title XIX member 21 - 64 will lose eligibility for covered services if an IMD stay extends beyond 30 days per admission or 60 cumulative days per year (July 1 through June 30). A Title XIX member who is receiving services in an IMD who turns 21 may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. AHCCCS provider types B6 and 71 are IMDS.
l) Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
m) Non-Emergency Transportation
n) Partial Care (Supervised day program, therapeutic day program and medical day program)
o) Psychosocial Rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)
ADHS must notify AHCCCS if, on the basis of moral or religious grounds, it elects not to provide, reimburse for, or provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2). In the event that ADHS is notified that any of its contractors elects not to provide, reimburse for, or provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2), ADHS must ensure that its contractor makes alternative arrangements with another entity to provide the service. ADHS must submit notification prior to entering into a contract with AHCCCS or whenever it adopts the policy during the term of the contract. In turn, the RBHAs must submit notification to ADHS prior to entering into a contract with ADHS or whenever it adopts the policy during the term of the contract. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to behavioral health recipients during their initial appointment; and must be provided to behavioral health recipients at least 30 days prior to the effective date of the policy.

Cooperative arrangements between Regional Behavioral Health Agencies and the Division of Developmental Disabilities: The Department of Economic Security, Division of Developmental Disabilities and the Department of Health Services, Division of Behavioral Health Services have a responsibility to ensure that persons with developmental disabilities are timely and promptly discharged from in-patient psychiatric settings to community living. To achieve this, the Division of Developmental Disabilities in partnership with the Regional Behavioral Health Authority (RBHA) will operate Step Down/Transitional Living Facility(s) and/or other appropriate supports for consumers who are seriously mentally ill, generally mentally healthy and/or have significant behavioral health challenges, have developmental disabilities and are at risk of in-patient hospitalization.

Step Down/Transitional Living Facility(s) are not intended for use in lieu of in-patient psychiatric settings.

The specific details of the transitional setting will be determined in a joint arrangement between the RBHA and the Division of Developmental Disabilities.

3. COVERED SERVICES FOR NATIVE AMERICANS

ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.


The Division will provide ADHS monthly listing of all DD-ALTCS eligible consumers. ADHS will provide subcontractors and Tribal subcontractors a listing of the DD-ALTCS eligible consumers.

In addition, the Division will provide periodic reports to ADHS for purposes of describing the demographics of the eligible population for which ADHS is at risk. These reports are to be defined jointly by the Division and ADHS.

5. ELIGIBILITY AND BEHAVIORAL HEALTH RECIPIENT VERIFICATIONS

ADHS shall be responsible for verifying the DD-ALTCS eligibility status of members who require behavioral health services. ADHS shall also respond to inquiries from AHCCCS acute Contractors, their PCPs, ALTCS Contractors, service providers and eligible persons regarding specific information about eligibility for DD-ALTCS and behavioral health coverage. ADHS shall ensure notification to the Division, if ADHS becomes aware of a member’s death, incarceration or out-of-state move that may impact a member’s eligibility status. ADHS shall ensure that confidentiality safeguards as defined in the User Affirmation Statement are strictly followed.

Providers may use AHCCCS’ web-based verification and/or AHCCCS’ contracted Medicaid Eligibility Verification Service (MEVS) to verify DD-ALTCS eligibility 24 hours a day, 7 days a week. Also available is the Interactive Voice Response (IVR) system, 24 hours a day, 7 days a week. For specific problems, the Communication Center is open Monday through Friday from 7:00 am through 7:00 pm. Availability of the Center varies for each holiday.

6. MEMBER INFORMATION AND MEMBER RIGHTS Ref. PM Section 5.0 - Member Rights and Provider Claims Disputes - http://www.azdhs.gov/bhs/provider/sec5_1.pdf

Member Information Materials: ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.
ADHS shall ensure that within 10 days of their first service, members are provided with a description of the provider network. ADHS shall ensure that the following information is provided to all behavioral health recipients:

1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the behavioral health recipient's service area, including identification of providers that are not accepting new referrals.
2. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
3. The fact that the behavioral health recipient has a right to use any hospital or other setting for emergency care.
4. The names and locations of the pharmacies to be used for filling prescriptions for psychotropic medications.

ADHS shall ensure that written notice about termination of a contracted provider is given, within 15 days after receipt or issuance of the termination notice, to each member who received their behavioral health care from, or was seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. 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)].

Member Handbook
ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

Member Rights:
ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

Consent and Authorization: ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

Emergency Referrals:
ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

8. SERVICE DELIVERY
ADHS is responsible for the provision of non-emergency behavioral health services and emergency non-inpatient behavioral health services to DD-ALCDS members whether or not there has been a determination of behavioral health recipient status. Additionally, ADHS is responsible for providing emergency inpatient behavioral health services to members enrolled with an acute care contractor from the earlier of the following:
   1) the date on which the member becomes a behavioral health recipient or
   2) the seventy-third hour after admission for inpatient behavioral health services. Refer to A A C R9-22- 210.01 and A A C R9-22-Article 12 for additional information.

ADHS' responsibility under this contract is limited to coverage and payment of medically necessary behavioral health services as described in Paragraph 2 of this Section, provided to members with behavioral health (mental and substance abuse) conditions.

Authorization of Services: For the processing of requests for initial and continuing authorizations of services, ADHS shall have in place, and follow, written policies and procedures. ADHS shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with requesting providers when appropriate. 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.

Notice of Adverse Action [42 CFR 438.210(c)] ADHS shall include an operational definition of medically necessary behavioral health services in policy [42 CFR 438.210(a)(4)]. ADHS shall ensure notification to requesting providers and give the behavioral health recipient written notice of any decision to deny a service authorization request or to authorize a service in an amount.
duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, except for the requirement that the notice to the provider must be in writing.

Per the Balanced Budget Act of 1997, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency and post-stabilization services:

ADHS must ensure coverage and payment for emergency medical services for behavioral health recipients regardless of whether the provider that furnishes the service has a contract with ADHS or the subcontractors.

ADHS must ensure that payment is not denied for treatment obtained under either of the following circumstances:

1. A behavioral health recipient 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 in 42 CFR 438.114.
2. A representative of ADHS (an employee, subcontractor or provider) instructs the behavioral health recipient to seek emergency medical services.

Additionally, ADHS may not:
1. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114(d)(1)(i), on the basis of lists of diagnoses or symptoms
2. Refuse to cover emergency medical services based on the failure of the provider, hospital, or fiscal agent to notify ADHS or the subcontractors of the behavioral health recipient’s screening and treatment within 10 calendar days of presentation for emergency services. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)]

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

The attending emergency physician, or the provider actually treating the behavioral health recipient, is responsible for determining when the behavioral health recipient is sufficiently stabilized for transfer or discharge and such determination is binding on ADHS [42 CFR 438.114(d)(3)].

The following conditions apply with respect to coverage and payment of post-stabilization care services. ADHS must cover and pay for post-stabilization care services without authorization, regardless of whether the provider that furnishes the service has a contract with ADHS or the subcontractors, for the following situations:
1. Post-stabilization care services that were pre-authorized by ADHS or the subcontractors; or
2. Post-stabilization care services that were not pre-approved by ADHS or the subcontractors because ADHS or the subcontractors 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
3. ADHS or the subcontractor’s representative and the treating physician cannot reach agreement concerning the member’s care and an ADHS or subcontractor physician is not available for consultation. In this situation, ADHS or the subcontractor must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the criteria in CFR 422.113(c)(3) is met.

Pursuant to CFR 422.113(c)(3), ADHS or the subcontractor’s financial responsibility for post-stabilization care services that have not been pre-approved ends when:
1. An ADHS or Subcontractor’s physician with privileges at the treating hospital assumes responsibility for the member’s care;
2. An ADHS or Subcontractor’s physician assumes responsibility for the member’s care through transfer;
3. A representative of ADHS or the subcontractor and the treating physician reach an agreement concerning the member’s care; or
4. The member is discharged.

When a DD-ALTCS member presents in an emergency room setting, the member’s AHCCCS acute health plan is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. ADHS is responsible for medically necessary psychiatric and/or psychological consultations provided to DD-ALTCS behavioral health recipients in emergency room settings. ADHS is responsible for transportation of DD-ALTCS behavioral health recipients to the emergency room in situations where the behavioral health recipient is directed by a representative of ADHS to present to this setting to resolve a behavioral health crisis.
A member shall be immediately identified as a behavioral health recipient when a network provider delivers a covered service, including emergency or crisis services. The effective date of identifying a member as a behavioral health recipient shall be no later than the date on which the first behavioral health service was delivered.

To the extent possible and appropriate, ADHS must allow members to choose their behavioral health provider(s) [42 CFR 438.6(m)].

ADHS shall ensure that the following activities are performed for all DD-ALTCS members:

a. Assessments and treatment recommendations are completed in collaboration with member/family, Division Support Coordinator and with clinical input from a clinician who is credentialed and privileged and who is either a behavioral health professional or a behavioral health technician under the supervision of a behavioral health professional [42 CFR 438.208(c)(2) and (3)].

b. A clinician deemed competent, privileged and credentialed by ADHS is assigned and responsible for providing clinical oversight, working in collaboration with the member and his/her family or significant others to implement an effective treatment plan, and serving as the point of contact, coordination and communication with other systems where clinical knowledge of the case is important [42 CFR 438.208(b)(1)].

c. Responsibility is defined or assigned to ensure the following activities are performed as part of the service delivery process:

1. Ongoing engagement of the member, family, Division Support Coordinator and others who are significant in meeting the behavioral health needs of the member, including active participation in decision-making process.

2. Assessments are performed to elicit strengths, needs and goals of the member and his/her family, identify the need for further or specialty evaluations that lead to a treatment plan which will effectively meet the member’s needs and result in improved health outcomes.

3. For members referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, ensure the review of the initial assessment and treatment recommendations by a licensed medical practitioner with prescribing privileges.

4. Provision of all covered services as identified on the treatment plan that are clinically sound, medically necessary, include referral to community resources as appropriate and for children, services are provided consistent with the Arizona Vision and Principles.

5. Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the member and input from the member, Division’s Support Coordinator and other relevant persons resulting in modification to the treatment plan, if necessary.

6. Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is important to achieving positive outcomes, e.g., Division Support Coordinator, primary care providers, school, child welfare, juvenile or adult probation, other involved service providers.

7. Clinical oversight to ensure continuity of care between inpatient and outpatient settings, services and supports.

8. Transfers out-of-area, out-of-state, or to an ALTCS Contractor.

9. Development and implementation of transition, discharge, and aftercare plans prior to discontinuation of behavioral health services.

10. Documentation of the above is maintained in the member’s behavioral health record by the point of contact as identified in (b.) above.

ADHS shall provide ongoing technical assistance regarding required training for subcontractor staff and providers who serve DD-ALTCS members. ADHS must ensure that training occurs for subcontractor’s staff and within the provider network including, but not limited to, the following:

a. How to conduct a comprehensive assessment.

b. Coordination of care requirements (including coordination with PCPs and other state agencies).

c. Sharing of treatment/medical information.

d. Behavioral health record documentation requirements.

e. Confidentiality/HIPAA.

f. Fraud and abuse requirements and protocols.

g. Best practices in the treatment and prevention of behavioral health disorders.

h. Managed care concepts.

i. Title XIX covered services (including information on how to assist members in accessing all medically necessary services regardless of a members’ mental health indicator or involvement with any one type of service provider).

j. Grievance system standards and procedures.

k. Member’s rights and responsibilities.
ADHS shall develop and implement policies and procedures to monitor the availability and timeliness of appointments as well as disseminate information regarding appointment standards to members, subcontractors and service providers. ADHS shall ensure appointments are provided as follows:

a. Emergency appointments within 24 hours of referral (including but not limited to the requirement to respond to referrals for hospitalized members who are not yet identified as behavioral health recipients);

b. Routine appointment for initial assessment within 7 days of referral;

c. Routine appointments for ongoing services within 23 days of initial assessment; and

d. For members referred by a PCP / Health Plan Behavioral Health Coordinator for psychiatric evaluation / medication management, appointments with a psychiatric prescriber (MD, DO, NP, PA), according to the needs of the member, and within the appointment standards described above, and ensuring that the member does not experience a lapse in medically necessary psychotropic medications.

ADHS shall monitor compliance with these standards and shall require corrective action when appointment standards are not met.

Appointments shall be scheduled in a timely manner according to the needs of the member and in accordance with the requirements in Section D, Paragraph 7 and Paragraph 8 of this contract. The waiting time for an established appointment shall not exceed 45 minutes except when the service provider is unavailable due to an emergency. Emergency appointments may be triaged.

Disputes regarding the need for emergency or routine appointments between the subcontractor and the referring source that cannot be resolved informally shall be promptly resolved by ADHS.

If a DD-ALTCS member needs medically necessary transportation, ADHS shall ensure that transportation is provided and that the member arrives no sooner than one hour before the appointment, and does not have to wait for more than one hour after the conclusion of the appointment for transportation home.
10. MEDICAL INSTITUTION NOTIFICATION

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

11. COORDINATION WITH DIVISION ACUTE CONTRACTORS AND OTHER AGENCIES  

Ref. PM Section 4.0 Communication and Care Coordination - [http://www.azdhs.gov/hhs/provider/sec41.pdf](http://www.azdhs.gov/hhs/provider/sec41.pdf)

DIVISION Acute Contractors. ADHS is responsible for coordination of care with Division acute Sub-Contractors. ADHS shall also ensure that behavioral health recipient care is coordinated with other state agencies providing services to DD-ALTCS members. ADHS shall establish policies and procedures regarding confidentiality and for coordination between subcontractors, behavioral health providers, and other state or county agencies.

ADHS shall ensure that the behavioral health records (copies or summaries of relevant information) of each DD-ALTCS member are forwarded to the member’s PCP as needed to support quality medical management and prevent duplication of services. At a minimum, for all members who are behavioral health recipients who are referred by the PCP or are determined by ADHS to have a serious mental illness, the member’s diagnosis, critical labs as defined by the laboratory and prescribed medications, including notification of changes in class of medications must be provided to the PCP [42 CFR 438.208(b)(3)]. Information must be provided to the PCP upon request for any behavioral health recipient and no later than 10 days of the request.

ADHS must approve any standardized forms that may be utilized to meet these requirements. ADHS must monitor to ensure compliance with these notification requirements through periodic case file review, trends in grievance and appeal and problem resolution data and other quality management activities.

In order to ensure effective coordination of care, proper consent and authorization to release information to Health Plans should be obtained. For medical records and any other health and member information that identifies a particular behavioral health recipient, ADHS must establish and implement procedures consistent with confidentiality requirements in 42 CFR 431.300 et. seq., 42 CFR 438.224 and 45 CFR parts 160 and 164, and A.R.S. §36-509. Unless prescribed otherwise in federal regulations or statute, it is not necessary for subcontractors or providers to obtain a signed release form in order to share mental health related information with the PCP or the member’s Health Plan Behavioral Health Coordinator acting on behalf of the PCP.

ADHS will ensure consultation services are available to health plan PCPs and have materials available for the sub-contracted Health Plans and PCPs describing how to access consultation services and how to initiate a referral for ongoing behavioral health services. Behavioral health recipients currently being treated by ADHS for depression, anxiety or attention deficit hyperactivity disorders may be referred back to the PCP for ongoing care only after consultation with and acceptance by the member and the member’s PCP. ADHS must ensure the systematic review of the appropriateness of decisions to refer members to PCPs for ongoing care under the psychotropic medication initiative. Upon request, ADHS shall ensure that PCPs are informed about the availability of resource information regarding the diagnosis and treatment of behavioral health disorders.

12. COORDINATION WITH DBHS SUBCONTRACTORS:

As required in AHCCCS Medical Policy Manual section 1620-VII, DDD support coordination for a member receiving behavioral health services must be provided in consultation/collaboration with a qualified behavioral health professional.

An initial consultation between the DDD support coordinator and the qualified behavioral health professional is required for all members receiving/need behavioral health services.

Quarterly consultations are required thereafter as long as the member continues to receive/need behavioral health services.

Collaborative agreements: DDD and DBHS shall address and attempt to resolve coordination of care issues at the lowest possible level of each organization. DDD will update the existing collaborative agreements with each RBHA at least annually.
13. BEHAVIORAL HEALTH RECORDS

The Division has access to records for members provided services under this agreement including services through subcontractors and as outlined in Behavioral Health Policy. AHCCCS has access to information as outlined in the contract between the Division and AHCCCS.

14. TRANSITION OF DD-ALTCS MEMBERS

ADHS shall develop and implement policies and procedures regarding the transition of DD-ALTCS members between subcontractors and the transition of DD-ALTCS members to ALTCS-EPD Contractors as appropriate. ADHS shall, no less than monthly, provide each subcontractor with a listing of DD-ALTCS members who are behavioral health recipients and have become DD-ALTCS eligible. To ensure that DD-ALTCS members who need behavioral health services receive them, ADHS and the subcontractors shall cooperate when a transition from one subcontractor to another including an ALTCS-EPD Contractor if necessary. This shall include identification of transitioning members, provision of appropriate referrals, forwarding of the medical record, as allowed under federal law, and transferring responsibility for court orders, as applicable.

15. OUTREACH AND FOLLOW-UP ACTIVITIES  Ref. PM 3.8 – Outreach, Engagement, Re-Engagement and Closure-


ADHS shall ensure the provision of outreach activities designed to inform DD-ALTCS members of the availability of behavioral health services. ADHS shall utilize penetration rates and other quality management measures to assess the effectiveness of outreach efforts.

ADHS shall develop and implement a policy and procedure regarding required outreach activities, including outreach in cases involving transfers between subcontractors. ADHS shall ensure active participation in outreach activities to DD-ALTCS members in high-risk groups, including but not limited to the homeless, seriously mentally ill members, members with co-morbid medical and behavioral health disorders. ADHS shall ensure initiation of follow-up activities consistent with ADHS policy for DD-ALTCS members who do not appear for scheduled appointments. ADHS shall ensure initiation of follow-up activities for individuals for whom a crisis service has been provided as the first service to ensure engagement with ongoing services as clinically indicated.

Upon request, ADHS shall ensure outreach and dissemination of information to the general public, other human service providers, county and state governments, school administrators and teachers and other interested parties regarding behavioral health services available to DD-ALTCS members.

16. DISSEMINATION OF INFORMATION

ADHS shall assist the Division in the dissemination of information prepared by AHCCCS, to its members. The cost of such dissemination shall be borne by ADHS. All advertisements, publications and printed materials, which are produced by ADHS and refer to covered services, shall state that such services are funded through AHCCCS.

17. STAFF REQUIREMENTS

ADHS shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements. At a minimum, the key staff identified in ADHS' contract with AHCCCS are required:

ADHS shall inform the Division, Behavioral Health Unit, in writing within seven days when an employee leaves one of the key positions responsible for liaison with the Division.

18. ADHS DEVELOPMENT OF TITLE XIX POLICIES

All policies (which may include requirements, manuals or standards) pertaining to DD-ALTCS members must be reviewed by the Division of Developmental Disabilities prior to implementation and shall be subject to monitoring. Any policy adopted by ADHS pertaining to fulfilling the requirements of this contract shall be incorporated by reference in each subcontract.

In the event of discrepancy between ADHS policies and this contract, the contract shall take precedence.
19. PROVIDER NETWORK REQUIREMENTS

ADHS shall develop and implement policies, procedures and standards to monitor the adequacy, accessibility and availability of its provider network to meet the needs of DD-AL.TCS members as outlined in the ADHS/AHCCCS Contract. ADHS is responsible for the provider network requirements and must analyze information and make assessments regarding the sufficiency of the network. ADHS must monitor subcontractors to ensure that the provider network is sufficient to provide all behavioral health covered services to TXIX members.

**Network Development**

ADHS shall establish and maintain a statewide network of providers that is sufficient to provide all covered behavioral health services under this contract and as outlined in the ADHS/AHCCCS Contract. ADHS shall develop a network that includes all necessary providers to meet the needs of DD-AL.TCS-ALTCS members. DOD will participate in the process by providing input and review of the plan annually at RBHA/DD District level focus groups, central review of draft plans and through annual surveys outlining the needs of DD-AL.TCS members.

**Network Management**

ADHS shall develop provider selection criteria based on licensure and certification standards and privileging and credentialing activities that are consistent with AHCCCS Contractor Operations Manual (ACOM) and contract. At a minimum, these criteria must be consistent with state and federal regulations governing the professional areas for those providers involved in the performance of this contract and shall indicate that ADHS shall monitor licensed providers for continued compliance with these criteria.

ADHS shall submit an Annual Provider Network Development and Management Plan and quarterly provider network status updates as required in its contract with AHCCCS to the Division. The Annual Provider Network Development and Management Plan shall be evaluated, updated annually and submitted to the Division at the same time that the information is submitted to AHCCCS.

20. PROVIDER REGISTRATION

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

21. QUALITY MANAGEMENT PLAN

ADHS shall ensure provision of quality behavioral health care to ALTCS-DD recipients. ADHS shall promote improvement in the quality of care provided to recipients through established quality management and performance improvement processes. ADHS shall utilize processes to assess, plan, implement and evaluate the quality and appropriateness of care provided by subcontractors to ALTCS-DD members.

During its annual operational review process, ADHS shall assess the subcontractor’s quality management and performance improvement program and evaluate compliance with federal regulations and with AHCCCS and ADHS requirements.

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract. ADHS quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AHCCCS Medical Policy Manual (AMP).

A. Quality Management (QM) Program

ADHS shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPChapter 900 and following the AHCCCS contract requirements where applicable.

B. Performance Improvement

ADHS’ quality management program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical care and non-clinical care that are expected to have a favorable effect on health outcomes and member satisfaction.

**Performance Measures**

ADHS shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures.

ADHS must comply with national performance measures and levels that may be identified and developed by the Centers for Medicare and Medicaid Services in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid and SCHIP programs. The current AHCCCS-established performance measures may be subject to change when these core measures are finalized and implemented.
ADHS must have in place a process for internal monitoring of Performance Measure rates, using a standard methodology established or adopted by AHCCCS, for each required Performance Measure. ADHS shall conduct analysis and trending, including its findings in the Semi-Annual Performance Improvement Report. ADHS’ Quality Management/Performance Improvement Program will report its performance on an ongoing basis to its Administration.

### ADHS Performance Standards

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Minimum Performance Standard</th>
<th>Goal</th>
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</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>Behavioral Health Service Plan</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>Behavioral health Service Provision</td>
<td>85%</td>
<td>95%</td>
</tr>
<tr>
<td>Coordination of Care #1 - Referral</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>Coordination of Care #2 - Communication</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>Follow Up after Hospitalization for Mental Illness within 7 Days</td>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>Follow Up after Hospitalization for Mental Illness within 30 Days</td>
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<td>90%</td>
</tr>
<tr>
<td>Treatment of Depression*</td>
<td>TBD</td>
<td>90%</td>
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</tbody>
</table>

* AHCCCS will develop a Minimum Performance Standard for Treatment of Depression after the baseline measurement for this measure.

### Performance Improvement Program

ADHS 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:

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

ADHS will review the Annual Performance Data to determine if there is a significant correlation between the DD-ALTCS population and the general behavioral health population.

### MEDICAL MANAGEMENT

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract where applicable.

ADHS shall comply with Chapter 1000 of the AHCCCS Medical Policy Manual (AMPM). ADHS shall comply with federal utilization control requirements, including the certification of need and re-certification of need for continued stays in inpatient settings. ADHS shall also ensure that hospitals and inpatient psychiatric facilities (residential treatment centers and sub-acute facilities) comply with federal requirements regarding utilization review plans, MM committees, plan of care and medical care evaluation studies as prescribed in 42 CFR, parts 441 and 456. ADHS shall actively monitor subcontractors’ medical management activities to ensure compliance with federal regulations, AHCCCS and ADHS requirements, and adherence to its medical management plan.

ADHS must develop, adopt and disseminate practice guidelines that consider the needs of enrolled members and are (AMPM Chapter 1000, 1020-E):

1. Based on valid and reliable medical evidence or a consensus of health care professionals in the field;
2. Have considered the needs of DD-ALTCS members;
3. Are adopted in consultation with contracting health care professionals and National Practice Standards; or
4. Are developed in collaboration with health care professionals and other stakeholders knowledgeable in the specific topic. Available literature should be reviewed and incorporated as indicated in the practice guidelines. Practice guidelines require AHCCCS approval 30 days prior to implementation.
5. Are disseminated by ADHS to all affected providers and, upon request, to members and potential members; and
6. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply.

ADHS must annually evaluate the Practice Guidelines through a multidisciplinary committee to determine if the guidelines remain applicable and represent the best practice standards and reflect current psychiatric/behavioral health standards; and
ADHS will document the review and adoption of practice guidelines as well as the evaluation of efficacy of the guidelines.

Guidelines, including any admission, continued stay and discharge criteria used by ADHS or subcontractors, must be communicated to all affected providers and, to DD-ALTCS members when appropriate, and to individual DD-ALTCS members upon their request. Decisions regarding utilization management, behavioral health recipient and provider education, coverage of services, provision of services, and other areas to which guidelines are applicable must be consistent with the guidelines.

During its annual operational review process, ADHS shall assess subcontractor’s medical management activities to measure compliance with federal regulations and AHCCCS and ADHS requirements.

ADHS must provide the subcontractors and their providers with technical assistance regarding medical management as needed and shall impose sanctions, including financial sanctions, for subcontractors who consistently (for three or more consecutive reporting periods or at ADHS’ discretion) fail to meet medical management objectives, including, but not limited to, the submission of complete, timely and accurate utilization/medical management data.

ADHS shall ensure compliance with the following requirements related to medical management:

a. Annual Medical Management Plan: ADHS shall submit a written Medical Management Plan with measurable goals and objectives and Utilization Management evaluation of the previous year’s Medical Management plan by October 1st of each contract year that conforms with the requirements of Chapter 1000 of the AHCCCS Medical Policy Manual. The Annual Medical Management Plan shall include an annual appraisal that assesses progress made by ADHS in achieving the goals and objectives identified in the previous years Medical Management Plan. The plan must be submitted to the Division and must include a change matrix that identifies changes in those sections required by AHCCCS contract and policy. ADHS shall ensure that subcontractors develop an annual medical management plan that is consistent with federal regulations and AHCCCS requirements.

b. ADHS shall ensure that all admission and continued stay authorizations for hospitals and inpatient psychiatric facilities (residential treatment services and sub-acute facilities) are conducted by behavioral health professionals. All decisions that the criteria for admission or continued stay are not met must be reviewed and approved by a physician prior to issuing such a decision.

c. ADHS shall have mechanisms in place to monitor and evaluate over and/or underutilization of services in compliance with AMPM Chapter (1000

d. For the processing of requests for initial and continuing authorizations of services for hospitals, mental hospitals, and inpatient psychiatric facilities (residential treatment centers and sub-acute facilities), ADHS shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and for consultation with the requesting provider when appropriate.

e. Medical Care Evaluation (MCE) Studies: ADHS shall ensure that network inpatient facilities (including inpatient hospitals and mental hospitals) conduct MCE studies which meet the requirements of 42 CFR Part 456 subparts C and D, and that inpatient psychiatric facilities (including RTCs and sub-acute facilities) conduct MCE studies which meet the same requirements. ADHS shall develop a process for annual review of subcontractors’ analyses of results of facility MCE studies. ADHS will ensure results are used to improve member care and services and to assess the provider facility performance.

ADHS shall have a process to report Medical Management data and management activities through a MM Committee. ADHS’ MM Committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. ADHS shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

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

ADHS shall maintain a written MM plan that addresses its plan for monitoring MM activities described in this section. The plan must be submitted to the Division’s Behavioral Health Unit within timelines specified in Attachment A.

ADHS must proactively and regularly review complaint, grievance and appeal data to identify members who have filed multiple complaints, grievances or appeals regarding services. In the event a particular member is identified as an outlier, ADHS shall coordinate to ensure that any necessary clinical interventions or service plan revisions are effectuated.

23. OPERATIONAL AND FINANCIAL REVIEWS
The Division will work cooperatively with AHCCCS to conduct joint Operational and Financial Reviews.

24. RECORDS RETENTION

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract

25. CAPITATION

AHCCCS will transfer to ADHS, on behalf of DES/DD, the capitation rate for behavioral health services to Title XIX DES/DD ALTCS members. ADHS shall be responsible for the state match for Title XIX ALTCS behavioral health expenditures:

- The capitation payment for Title XIX DD-ALTCS eligible members, which represents the cost of providing all covered behavioral health services

The capitation amount will be based on the number of DD-ALTCS members as of the monthly capitation processing including any adjustment to be made through the monthly activity of enrollment and disenrollment as outlined by AHCCCS. The capitation received shall represent payment in full for any and all covered services provided to eligible DD-ALTCS members, including all administrative costs of ADHS, subcontractor and providers during the month. Payment will be deposited as near to the first day of the month as is practicable except that payment will not be deposited later than the fifth business day of the month for which payment is due. ADHS shall provide a monthly capitation distribution report showing the distribution of capitation to subcontractors.

ADHS shall receive additional payments such as lien recoveries and third party payments to which it is entitled pursuant to AHCCCS Rules and AHCCCS policies and procedures.

If ADHS is in default in its performance under this contract, the Division may, at its option and in addition to other remedies, adjust the amount of payment until there is satisfactory resolution of the default.

ADHS and the Division will meet in advance of the Division’s rate negotiation with AHCCCS to review cumulative cost data, supporting encounter data and other reports necessary to develop a proposed capitation which incorporates cost experience, utilization experience and program changes.

26. METHOD OF PAYMENT

Compensation: The method of compensation under this contract shall be prepaid capitation as described herein. AHCCCS shall transfer the capitation payments on behalf of the Division, both federal and state match, to ADHS, in accordance with General Accounting Office guidelines, the Cash Management Improvement Act (CFR 31, Part 205) and the State’s Cash Management Improvement Act contract provisions.

Payments made by AHCCCS to ADHS are conditioned upon the receipt by the Division of applicable, timely, accurate and complete reports required to be submitted by ADHS under this contract.

All funds received by ADHS and the subcontractors pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles and procedures.

The legislative authorization for payments made under this contract governs the source of the state match that is required in order to draw Federal Financial Participation. The Title XIX – DD-ALTCS program is funded under this contract where the source of the state match is ADHS.

An error discovered by the state with or without an audit in the amount of fees paid to ADHS will be subject to adjustment or repayment by ADHS by making a corresponding decrease in a current payment or by making an additional payment by AHCCCS to ADHS.

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

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services [Section 1932(d)(4) of the Social Security Act]
Collection of Co-payments: ADHS or the subcontractors shall collect any permitted co-payment from Title XIX members in accordance with AHCCCS Rules R9-22-711 and 42 CFR 447, but service will not be denied for inability to pay the co-payment. Except for permitted co-payments, ADHS or the subcontractors shall not bill or attempt to collect any fee from, or for, a DD-ALTCS member for the provision of covered services. Any required co-payments collected shall belong to ADHS or the subcontractors, as appropriate. ADHS or the subcontractors shall not bill a member for more than the statutory co-payment amount. Refer to Section D, Paragraph 34, Coordination of Benefits and Third Party Liability, Paragraph 35, Medicare Services and Cost Shring, and R9-22-702 for exceptions.

Liability for Payment: ADHS must ensure that DD-ALTCS behavioral health recipients are not held liable for:

a. ADHS or subcontractor’s debts in the event of ADHS’ or the subcontractor’s insolvency [42 CFR 438.116(a)(1)],

b. covered services provided to the behavioral health recipient, for which AHCCCS does not pay ADHS and ADHS does not pay subcontractors [42 CFR 438.106(b)], or,

c. payments to ADHS or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the behavioral health recipient would owe if ADHS or the subcontractor provided the services directly [42 CFR 438.106(a)(b)(c) and 438.230].

Tribal Subcontractor Claims and Encounters: ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.

27. CAPITATION RECOUPMENT

Any recoupments imposed by the federal government and passed through to ADHS shall be reimbursed to AHCCCS upon demand.

28. BUDGET CAP

The Division and AHCCCS will not be responsible for costs incurred by ADHS which exceed the budget cap associated with its legislative appropriation.

29. MEDICARE SERVICES AND COST SHARING

ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.

30. DATA EXCHANGE

Encounter Data: ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.

Member Match: ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.

Third Party Liability/Medicare File (TPL): ADHS shall follow procedures as outlined in the ADHS/AHCCCS Contract.

Health Insurance Portability and Accountability Act (HIPAA): ADHS 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 ADHS by the dates required by the implementing federal regulations as well as all subsequent requirements and regulations as published.

31. SANCTIONS

Cure Notice Process: In the event AHCCCS issues a written cure notice to the Division for acts or omissions that are ADHS’ responsibility, ADHS shall be responsible to bring its performance into compliance or to pay any sanctions imposed on the Division that are related to ADHS’ non-compliance as set forth in the cure notice.

32. GRIEVANCE SYSTEM

ADHS shall follow their administrative process for the grievance system requirements as outlined in the ADHS/AHCCCS Contract.

All costs associated with any appeals and state fair hearing decisions for medically necessary behavioral health services will be ADHS responsibility and shall not be the responsibility of the Division. Any appeal decision or hearing decision will not assign responsibility to the Division for medically necessary behavioral health services without the prior approval of the Division.
ADHS shall develop a reporting process during the next twelve (12) months for capturing all appeals and claim disputes related to individuals with developmental disabilities enrolled with ADHS through this agreement.

33. SUBCONTRACTS

ADHS shall be responsible for compliance with all terms in this Agreement, regardless of whether ADHS enters into a subcontract to delegate performance of the terms in this Agreement.

34. SUBCONTRACTOR COMPLIANCE WITH CONTRACT REQUIREMENTS

ADHS shall be held fully liable for the performance of all contract requirements and shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. ADHS shall advise AHCCCS in writing within five business days of any subcontractor non-compliance and of the corrective measures taken, including the amount and duration of sanctions, to ensure subsequent compliance. If these performance issues impact services to DD-ALTCS members, ADHS will notify the Division.

35. COORDINATION OF ADHS REQUESTS FOR PROPOSALS

ADHS shall coordinate with the Division on the development of any Requests for Proposals (RFPs) soliciting offers from entities wishing to contract to provide covered services as described in this contract. The coordination shall be designed to ensure that issues relevant to DD-ALTCS services and members are adequately addressed in the RFPs.

36. ADVANCE DIRECTIVES Refer to PM 3.12-Advance Directives

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

37. CULTURAL COMPETENCY Refer to PM 3.23-Cultural Competency

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

38. CORPORATE COMPLIANCE

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

39. MEDICARE MODERNIZATION ACT (MMA)

The Medicare Modernization Act of 2003 (MMA) created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. Beginning January 1, 2006, Medicaid will no longer cover prescription drugs that are covered under Part D for dual eligible members. Medicaid will not cover prescription drugs for this population whether or not they are enrolled in Medicare Part D. Capitation rates do reflect this.

Drugs Excluded From Medicare Part D: Medicaid does cover those drugs ordered by an authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, contractor formularies and 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 Plans formulary are not considered excluded drugs and will not be covered by AHCCCS.

40. PHYSICIAN INCENTIVES

ADHS shall follow requirements as outlined in the ADHS/AHCCCS Contract.

[END OF SECTION D]
SECTION E: CONTRACT CLAUSES

1. APPLICABLE LAW

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

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

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 ADHS shall not be entitled to any claim under this contract based on those changes.

2. ORDER OF PRECEDENCE

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

3. 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.

4. SEVERABILITY

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

5. RIGHT TO ASSURANCE

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

6. SANCTIONS AND UNALLOWABLE COSTS

The Division shall pass on any sanction to ADHS due to noncompliance with any of the requirements of this Agreement. The Division shall notify ADHS in writing regarding any non-compliance issues and the amount of and basis for any sanctions imposed on the Division by AHCCCS. The Division may ask AHCCCS to withhold future payments to ADHS.
7. NON-DISCRIMINATION

ADHS shall comply with State Executive Order No 99-4, which mandates that all persons, regardless of race, color, religion, sex, 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. ADHS 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.

8. AMERICANS WITH DISABILITIES ACT

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting AHCCCS Administration.

9. EFFECTIVE DATE

The effective date of this contract shall be the date that the Contracting Officer signs the award page (page 1) of this contract.

10. TERM OF CONTRACT AND CONTRACT EXTENSION

The initial term of this contract shall be for one (1) year, with annual options to extend. 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. When the Division issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted sixty (60) days from the date of mailing by the Division, even if the extension has not been signed by ADHS, unless within that time ADHS notifies the Division in writing that it refuses to sign the extension. Any disagreement between the parties regarding the extension of the contract or the terms of its renewal will be considered a dispute within the meaning of Section E, Paragraph 11, Disputes, and administered accordingly.

11. DISPUTES

ADHS may assert any claim, grievance, dispute or demand against the Division by elevating the dispute to the Division of Developmental Disabilities Assistant Director. If the dispute cannot be resolved at this level, the dispute may be elevated to the respective Department Director's or ADHS may assert their claim in accordance with ARS 36-2903.01.B4. Pending the final resolution of any disputes involving this contract, ADHS shall proceed with performance of this contract in accordance with the Division's instructions, unless the Division specifically, in writing, requests termination or a temporary suspension of performance.

12. CHANGES

The Division may at any time, by written notice to ADHS, 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, ADHS may assert its right to an adjustment in compensation paid under this contract. ADHS must assert its right to such adjustment within thirty (30) days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 11, Disputes, and be administered accordingly. When the Division issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted sixty (60) days after the date of mailing by the Division, even if the amendment has not been signed by ADHS, unless within that time ADHS notifies the Division in writing that it refuses to sign the amendment.

13. DISCLOSURE OF CONFIDENTIAL INFORMATION

The Division and ADHS shall observe and abide by all applicable state and federal statutes, rules and regulations regarding use or disclosure of information, including, but not limited to, information concerning applicants for, and recipients of services.

14. TERMINATION

In the event the contract or any portion thereof, is terminated for any reason, or expires, ADHS shall assist the Division in the transition of its members to other contractors. In addition, the Division reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. ADHS shall make provision for continuing all management and
administrative services until the transition of all members is completed and all other requirements of this contract are satisfied [42 CFR 438.610(c)(3) and 434.6(a)(6)] ADHS 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. Notification of subcontractors and members
b. Payment of all outstanding obligations for medical care rendered to members
c. Until AHCCCS is satisfied that ADHS has paid all such obligations, ADHS shall provide the following reports to AHCCCS:
   1. A monthly claims aging report by provider/creditor including IBNR amounts;
   2. A monthly summary of cash disbursements;
d. Such reports shall be due on the fifth day of each succeeding month for the prior month.
e. In the event of termination or suspension of the contract by AHCCCS, such termination or suspension shall not affect the obligation of ADHS to indemnify AHCCCS for any claim by any third party against the State or AHCCCS arising from ADHS’ performance of this contract and for which ADHS would otherwise be liable under this contract.
f. Any dispute by ADHS, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E, Paragraph 15, Disputes.
g. Any funds, advanced to ADHS for coverage of members for periods after the date of termination, shall be returned to AHCCCS within 30 days of termination of the contract.

[END OF SECTION E]

SECTION F - LIST OF ATTACHMENTS

Attachment A -- Periodic Reporting Requirements
Attachment B -- Grievance and Request for Hearing Process and Standards
Attachment C -- Covered Behavioral Health Services Guide
Attachment D -- Reference Section
Attachment E -- Case Management Matrix
MONTHLY REPORTS

1. MONTHLY CAPITATION DISTRIBUTION REPORT
The Monthly Capitation Distribution Report shows the distribution of capitation to subcontractors. This report is due within forty-five days from receipt of capitation from AHCCCS.

2. DD SUMMARY REPORT
Totals the number of dually enrolled members statewide who are also members of the behavioral health system.

3. GRIEVANCE SYSTEM REPORT (APPEALS AND CLAIM DISPUTES)
ADHS shall, subject to time and staff resource constraints resulting from state budget deficits, develop a Monthly Grievance System Report which shall capture all appeals and claims disputes related to individuals with developmental disabilities enrolled with ADHS through this agreement. The Monthly Grievance System Report, at a minimum, will include the number of grievances, appeals and claims disputes filed and adjudicated by each RBHA or by ADHS.

QUARTERLY REPORTS

1. SUBCONTRACTOR FINANCIAL INFORMATION
ADHS shall be responsible for providing the Division Quarterly Subcontractor Financial statements.

2. ACCESS TO CARE – 23 DAY
This report is DD-ALTCS population specific. It depicts access to care for Children and Adults statewide. The report identifies the timeframe from the initial assessment to the delivery of the first behavioral health covered service with 23 days being the standard. The data is categorized by each RBHA.

3. COORDINATION OF CARE #2
This data report is DD-ALTCS specific and examines behavioral health service providers and their communication and coordination with the member’s acute health plan’s Primary Care Physician. The RBHA should be in compliance with AHCCCS contract requirements.

4. DD UTILIZATION MANAGEMENT REPORT
This data report depicts statewide behavioral health service utilization for DD-ALTCS members who are enrolled with the behavioral health system. This report contains basic demographics, diagnoses categorized by multi-axial dimensions, referral and disenrollment statistics, utilization by behavioral health category and sub-categories, and identifies days from assessment to first service. This report contains statewide statistics as well as a break-out that is specific to each T/ RBHA.

5. ADULT SYSTEM OF CARE
This plan provides a comprehensive analysis of the availability and accessibility of behavioral health services in Arizona. The plan examines the adequacy and sufficiency of the statewide behavioral health provider network and that each regional Contractor. The plan offers an appropriate range of covered behavioral health services that is adequate for the anticipated number of behavioral health members and DD-ALTCS members in each geographic service area. The plan also identifies a network of providers that is sufficient in number, mix and geographic distribution to meet the accessibility and service needs of behavioral health members and DD-ALTCS members in each geographical service area of Arizona.
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The System of Care Practice Review (SOCPR) is a method of measurement used to explore and document the degree to which service and support planning and delivery is consistent with system of care values and its' approach to care. A DD-ALTCS specific identifier has been added to the tool.

Providers lost and gained by GSA or subcontractor, specifying provider name, AHCCCS provider identification number, type and capacity, and an analysis by GSA or subcontractor, of the impact on the sufficiency of the network. Where, as a result of the losses, material gaps are identified, ADHS must include a plan for addressing the gaps and status of the transfer of members to appropriate alternate services.

ADHS shall provide the Division with a copy of the quarterly financial statement for Title XIX at the same time it is submitted to AHCCCS.

ADHS shall submit to AHCCCS, a Quarterly Contractor Performance Improvement Activity Report, in a format approved by AHCCCS.

At a minimum, the Contractor Performance Improvement Activity Report shall include:

a. Performance and analysis, by GSA or subcontractor, on all performance measures/indicators as specified in Section D – Program Requirements, Paragraph 22, Quality Performance Standards, of this contract
b. Status updates on ADHS’ performance improvement activities during the reporting period
c. Analysis of data elements that further inform on performance measures, including member complaints, mortalities, grievances, appeals, incidents, accidents, and quality of care concerns

AHCCCS may, upon notice to ADHS, no less than 30 days prior to the report due date, request information on additional items, as may be necessary to fully inform AHCCCS of ADHS’ actions and plans related to requirements under this contract.

Additionally, ADHS shall participate in a bi-monthly meeting with AHCCCS. The topics of the bi-monthly meetings between AHCCCS and ADHS will be jointly developed.
ANNUAL REPORTS

1. PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN

The Annual Provider Network Development Plan shall be evaluated, updated annually and submitted to the Division at the same time it is submitted to AHCCCS.

The purpose of the plan is to identify the current status of the network at all levels and to identify network development and/or enhancement needs for the contract year based on the assessment of the current status of the network and multiple sources of information about current and projected network needs. At a minimum, the plan shall include the following:

A narrative analysis statewide and by subcontractor, of the sufficiency of the DD-ALTCS network. Criteria for assessing the network should consider analysis of multiple data sources including, but not limited to: performance on appointment standards/appointment availability; DD-ALTCS eligibles and penetration rates; utilization data; member satisfaction surveys; provider appeals; demographic data and information on the cultural needs of the communities and analysis of national data elements.

2. SUBCONTRACTOR FINANCIAL AUDITS

ADHS shall provide the Division a copy of the Final Annual Subcontractor Financial Audits.

3. SUBCONTRACTOR OPERATIONAL AND FINANCIAL REVIEWS

ADHS or an independent external agent shall conduct an annual Operational and Financial Review of each subcontractor using protocols consistent with the CMS Protocols For External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans (42 CFR 438.230(b)(3) and (4) and 438.240(E)(2)). At a minimum, the OFR shall include the review of the strengths and weaknesses with respect to the quality outcomes, timeliness, and access to health care services furnished to DD-ALTCS behavioral health recipients; clinical and business practices and policies; and financial reporting systems and any other operational and program areas identified by ADHS. The reviews provide one venue for ADHS to understand and monitor subcontractor operational practices, recognize areas of noteworthy performance and ensure compliance with federal and state regulations and contractual requirements.

ADHS will provide a proposed review guide and proposed review schedule to AHCCCS for review and approval at least 60 days prior to commencement of the reviews. ADHS shall provide AHCCCS a summary and analysis of findings by February 1. ADHS shall utilize the findings to assist in improving subcontractor operations and the care and services delivered to members and submit a report detailing the status of corrective actions taken as a result of the OFR at least annually by August 1.

4. QUALITY MANAGEMENT PERFORMANCE IMPROVEMENT PLAN AND MEDICAL MANAGEMENT PLAN

The Quality Management Performance Improvement (QM/PI) Plan shall be submitted by ADHS by September 15th of each contract year. ADHS must submit the QM/PI Plan to the Division and submit a change matrix with the plan that identifies changes in those sections required by AHCCCS contract and policy. The Annual Quality Management/Performance Improvement Plan shall comply with all requirements as stated in the AHCCCS AMPM Chapter 900 and include an annual appraisal that assesses progress made by ADHS in achieving the goals and objectives identified in the previous year’s QM/PI Plan. The plan must address quality of care for both clinical processes as well as administrative functions. The plan must also include the development of an effective system to monitor subcontractors’ compliance with requirements. ADHS shall ensure that each subcontractor develops and adheres to a quality management/performance improvement plan that is consistent with contract and AHCCCS requirements. The scope of this annual plan, and ADHS activities around quality management must follow requirements as outlined in the ADHS/AHCCCS Contract.

ADHS must develop a written MM plan which complies with all requirements as stated in the AHCCCS AMPM Chapter 1000 and must follow requirements as outlined in the ADHS/AHCCCS Contract.

The initial plan and any subsequent modifications to the plan must be submitted to the Division annually, by October 1. ADHS must submit an evaluation of the MM plan with a newly developed or revised MM plan which incorporates revisions as a result of the evaluation. The UM plan and annual evaluations and revisions may be combined with the quality management/performance improvement plan or be written separately as long as all components are addressed.

5. ANNUAL CONSUMER SATISFACTION SURVEY
The survey solicits independent feedback from behavioral health enrolled members, DD-ALTCS members included; who receive services through Arizona’s publicly funded behavioral health system. The survey measures a members’ perception of behavioral health services in relation to general satisfaction, access to services, service quality/appropriateness, participation in treatment, outcomes, cultural sensitivity, improved functioning and social connectedness.

6. ADHS/DBHS MEMBER HANDBOOK TEMPLATE
ADHS shall submit to AHCCCS, a Member Handbook Template that contains at a minimum, the items specified in Section D, paragraph 6, as well as documentation of the location within the template of the required items (review tool with corresponding section titles and page numbers), annually by September 15 and within 30 days of any handbook updates.

7. SUBCONTRACTOR MEMBER HANDBOOKS
ADHS shall provide copies of each subcontractor’s member handbook annually or when changes are made to the handbook(s).

8. PERFORMANCE IMPROVEMENT PROJECTS PROPOSALS AND INTERIM REPORTS
ADHS shall submit to the Division, a copy of the Semi-Annual Performance Improvement Report, in a format approved by AHCCCS, due within 60 days after the end of the semi-annual reporting period (July 1 through December 31 and January 1 through June 30).

9. QUALITY MANAGEMENT PLAN AND EVALUATION
The Quality Management Performance Improvement (QM/PI) Plan shall be submitted by ADHS by September 15th of each contract year when it is due to AHCCCS.

10. MEDICAL MANAGEMENT PLAN AND EVALUATION
Annually, by October 1, ADHS must submit an evaluation of the MM workplan with a newly developed or revised MM workplan which incorporates revisions as a result of the evaluation.

11. ADMINISTRATIVE EXPENDITURE PLAN
ADHS shall provide the Division with a plan (annual administrative and expense budget) for allocating cost for the Title XIX administrative services in accordance with 45 CFR 95.501, Subpart E. This information will be given to AHCCCS by August 15 of the contract year.

12. ANNUAL ADHS/DBHS CERTIFIED FINANCIAL AUDIT REPORTS
In accordance with section E paragraph 24 contained in this contract, ADHS shall provide the Division a copy of the annual certified audited financial reports for Title XIX.

13. ANNUAL REPORT AND ANALYSIS OF PREVIOUS YEAR CAPITATION RATE REPORT
ADHS shall submit to the Division annually by January 15, a report consisting of the previous years’ raw behavioral health encounter data which can be used by the Division to develop the current years’ capitation rates. The scope of such a report will be mutually agreed upon by ADHS and the Division.
1. UNEXPECTED CHANGES IN PROVIDER NETWORK

ADHS shall inform the Division anytime there is an unexpected change in the provider network which impacts services to the DD-ALTCS members in the affected GSA.
### SUMMARY OF DUE DATES

<table>
<thead>
<tr>
<th>Monthly Reports</th>
<th>When Due</th>
<th>Source/Reference</th>
<th>Send To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Capitation Distribution Report</td>
<td>Due 45 days from receipt of capitation from AHCCCS</td>
<td>Section D, ¶26</td>
<td>Bus. Operations Manager</td>
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<td>DD Summary Report</td>
<td>Due 15 days after the end of the reporting month</td>
<td>(Attachment A, Monthly Reports, ¶7)</td>
<td>Behavioral Health Manager</td>
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<table>
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<tr>
<th>Quarterly Reports</th>
<th>When Due</th>
<th>Source/Reference</th>
<th>Send To</th>
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</thead>
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<tr>
<td>Access to Care - 23 Day</td>
<td>45 Days Post - Quarter</td>
<td>(Attachment A, Quarterly Reports, ¶2)</td>
<td>Behavioral Health Manager</td>
</tr>
<tr>
<td>Coordination of Care #2</td>
<td>45 Days Post - Quarter</td>
<td>(Attachment A, Quarterly Reports, ¶3)</td>
<td>Behavioral Health Manager</td>
</tr>
<tr>
<td>DD Utilization Management Report</td>
<td>45 Days Post - Quarter</td>
<td>(Attachment A, Quarterly Reports, ¶4)</td>
<td>Behavioral Health Manager</td>
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<tr>
<td>Adult System of Care</td>
<td>October 30th January 30th April 30th July 30th</td>
<td>(Attachment A, Quarterly Reports, ¶5)</td>
<td>Behavioral Health Manager</td>
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<tr>
<td>Children's System of Care</td>
<td>October 30th January 30th April 30th July 30th</td>
<td>(Attachment A, Quarterly Reports, ¶6)</td>
<td>Behavioral Health Manager</td>
</tr>
<tr>
<td>System of Care Practice Review</td>
<td>45 Days Post - Quarter</td>
<td>(Attachment A, Quarterly Reports, ¶7)</td>
<td>Behavioral Health Manager</td>
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<td>Providers Network Report</td>
<td>TBD</td>
<td>(Attachment A, Quarterly Reports, ¶8)</td>
<td>Behavioral Health Manager</td>
</tr>
<tr>
<td>Quarterly ADHS/DBHS Financial Statements</td>
<td>November 29 March 1 May 30 August 29</td>
<td>(Attachment A, Quarterly Reports, ¶9)</td>
<td>Bus. Operations Manager</td>
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<tr>
<td>Semi-Annual Reports</td>
<td>When Due</td>
<td>Source/Reference</td>
<td>Send To</td>
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<td>Performance Improvement Activity Report</td>
<td>TBD</td>
<td>(Attachment A, Semi-Annual Reports, ¶1)</td>
<td>Behavioral Health Manager</td>
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<td>Annual Reports</td>
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<tr>
<td>Provider Network Development and Management Plan</td>
<td>October 9</td>
<td>(Attachment A, Annual Reports, ¶1)</td>
<td>Behavioral Health Manager</td>
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<td>Subcontractor Operational &amp; Financial Reviews</td>
<td>February 1</td>
<td>(Attachment A, Annual Reports, ¶3)</td>
<td>Behavioral Health Manager</td>
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<tr>
<td>Annual Consumer Satisfaction Survey</td>
<td>June 30</td>
<td>(Attachment A, Annual Reports, ¶5)</td>
<td>Behavioral Health Manager</td>
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<td>ADHS/DBHS Member Handbook Template</td>
<td>September 15</td>
<td>(Section D, ¶6, Attachment A, Annual Reports, ¶6)</td>
<td>Behavioral Health Manager</td>
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<td>Subcontractor Member Handbooks</td>
<td>December 31</td>
<td>(Attachment A, Annual Reports, ¶7)</td>
<td>Behavioral Health Manager</td>
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<td>Performance Improvement Project (PIP) Proposals and Interim Reports</td>
<td>February 28, August 30</td>
<td>(Attachment A, Annual Reports, ¶8)</td>
<td>Quality Management Administrator</td>
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<td>Performance Improvement Project (PIP) Proposal</td>
<td>September 15</td>
<td>(Attachment A, Annual Reports, ¶8)</td>
<td>Quality Management Administrator</td>
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<tr>
<td>Quality Management Plan and Evaluation</td>
<td>September 15</td>
<td>(Attachment A, Annual Reports, ¶9)</td>
<td>Quality Management Administrator</td>
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<tr>
<td>Medical Management Plan and Evaluation</td>
<td>October 1</td>
<td>(Attachment A, Annual Reports, ¶10)</td>
<td>Quality Management Administrator</td>
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<td>ADHS Administrative Expenditure Plan</td>
<td>August 15</td>
<td>(Attachment A, Annual Reports, ¶11)</td>
<td>Bus Operations Manager</td>
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<td>Annual Report and Analysis of Previous Year Capitation Rate Report</td>
<td>April 1</td>
<td>(Attachment A, Annual Reports, ¶13)</td>
<td>Bus Operations Manager</td>
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<td>Ad Hoc Reports</td>
<td>Reporting Period</td>
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<tr>
<td>-----------------------------------------------------</td>
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</tr>
<tr>
<td>Unexpected changes impairing provider network</td>
<td>Within 1 business day of awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Section D, ¶18)</td>
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</table>

(END OF ATTACHMENT A)
ADHS 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. ADHS shall provide the Enrollee Grievance System Policy to all providers and subcontractors at the time of contract. ADHS shall also furnish this information to behavioral health recipients within a reasonable time after ADHS receives notice of the behavioral health recipient’s enrollment. Additionally, ADHS 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 behavioral health recipients describing the Grievance System including the grievance process, enrollee rights, grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the subcontractor’s service area and in an easily understood language and format. ADHS shall inform behavioral health recipients that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how behavioral health recipients may obtain this information.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be translated in the behavioral health recipient’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. This information must be in large, bold print appearing in a prominent location on the first page of the document.

At a minimum, ADHS’ Grievance System Standards and Policy shall specify:

1. That ADHS shall maintain records of all grievances and appeals.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes describing the right to hearing, the method for obtaining a hearing, the rules which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal.
3. 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 if requested by the enrollee.
4. That the Contractor shall acknowledge receipt of each grievance and appeal, to include legal representation. 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.
5. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.
6. 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.
7. The resolution timeframes for grievances, 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.
8. 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.
9. The definition of grievance as a member’s expression of dissatisfaction with any aspect of their care, other than the appeal of actions.
10. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with the AHCCCS Administration.
That the Contractor must dispose of each grievance in accordance with the ACOM Enrollee Grievance Policy, but in no case shall the timeframe exceed 90 days.

The definition of action as the [42 CFR 438.400(b)]:

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

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

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

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

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

The definition of a standard authorization request and that 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 or an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

The definition of an expedited authorization request and that 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 3 business days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest.

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.

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 in writing.

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.

The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not 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.

23. 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.

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

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 5 days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail the 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; or

e. The enrollee has been accepted for Medicaid in another local jurisdiction.

26. 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.

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 request continued benefits pending resolution of the appeal. The Notice of Action shall comply with ACOM Policy 414.

28. That the Notice of Action shall 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 received the Contractor’s notice of appeal resolution and how to do so, b) the right to receive 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

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

34. 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.

35. 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 (as defined in paragraph 32, above);
   d. Other information relevant to the resolution of the appeal.

36. 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 during the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee’s health condition requires irrespective of whether the Contractor contests the decision.

37. That if 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.

38. 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.

[END OF ATTACHMENT B (1)]
VERSION 1.11
ATTACHMENT C: BEHAVIORAL HEALTH SERVICES GUIDE

This document is also available on the ADHS/DBHS Website at: http://www.azdhs.gov/bha/FNLguide_v6.7.pdf


AHCCCS Medical Policy Manual –

### ATTACHMENT E: CASE MANAGEMENT MATRIX

<table>
<thead>
<tr>
<th>Identification (Prior to Behavioral Health Referral)</th>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify current Title XIX eligibility</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Identify that there is a potential third party resource available using the information supplied by AHCCCS on the eligibility roster</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Determining the need for referral to Covered Behavioral Health Services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### Intake & Core Assessment

<table>
<thead>
<tr>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete core assessment</td>
<td>X</td>
</tr>
<tr>
<td>Complete consent to treat forms</td>
<td>X</td>
</tr>
<tr>
<td>Complete release forms</td>
<td>X</td>
</tr>
<tr>
<td>Complete client rights and grievance notification procedures</td>
<td>X</td>
</tr>
<tr>
<td>Develop Interim Service Plan</td>
<td>X</td>
</tr>
<tr>
<td>Provide background information including existing behavioral health records, demographic information and social history</td>
<td>X</td>
</tr>
</tbody>
</table>

### Service Plan Development and Approval

<table>
<thead>
<tr>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in Individual Service Planning, Child Family Team or Adult Clinical Team</td>
<td>X</td>
</tr>
<tr>
<td>Develop a cost-effectiveness study that includes covered behavioral health services designated by AHCCCS</td>
<td>X</td>
</tr>
<tr>
<td>Identify covered behavioral health services (ongoing)</td>
<td>* X</td>
</tr>
<tr>
<td>Approve and sign the service plan indicating agreement with the beginning level of services on the service plan. Each agency has a service plan that the other agency should sign</td>
<td>X</td>
</tr>
<tr>
<td>Maintain a behavioral health ISP and update as needed</td>
<td>* X</td>
</tr>
<tr>
<td>Coordinate behavioral health ISP with:</td>
<td>X *</td>
</tr>
<tr>
<td>* PCP</td>
<td></td>
</tr>
<tr>
<td>* Family</td>
<td></td>
</tr>
<tr>
<td>* School</td>
<td></td>
</tr>
<tr>
<td>* DES/DDD Eligible Person</td>
<td></td>
</tr>
<tr>
<td>* Courts</td>
<td></td>
</tr>
<tr>
<td>* Ancillary Providers</td>
<td></td>
</tr>
</tbody>
</table>

Monitor behavioral health services that the DES/DDD Eligible Person is receiving | X                       |

Incorporate information from the behavioral health diagnosis, treatment plan and behavioral health ISP into the person’s DES/DDD ISP | X                       |

Develop and implement the behavioral health ISP | X                       |
## Foster Care

<table>
<thead>
<tr>
<th>Task</th>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate behavioral health information with the court and other relevant parties, as appropriate</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Attend Foster Care Review Board hearings, as required</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Attend Court hearings</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Receive and review court minutes</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide quarterly reports to the DES/DDD Case Manager and as necessary to comply with Court requirements.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

## Service Integration

<table>
<thead>
<tr>
<th>Task</th>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate the behavioral health ISP into the DES/DDD ISP based on the principles of a family centered approach.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Obtain ancillary services, benefits, state-only services, ALTCS services or entitlements that may augment individual progress.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Participate in the development of the Individual Education Plan (IEP)</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Monitor DES/DDD Eligible Person’s progress on the behavioral health ISP and DES/DDD ISP goals. (ongoing)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Serve as primary contact and resource person to resolve issues which impede the DES/DDD Eligible Person’s progress and access to behavioral health services.</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Serve as primary contact and resource person to resolve issues which impede the DES/DDD Eligible Person’s progress and access to service related to the DES/DDD ISP, other than behavioral health.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ensure appropriate interface with the family, foster family, courts, schools and other relevant parties</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Notify the DES/DDD Support Coordinator of changes required in the behavioral health ISP.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Notify the RBHA Case Manager of changes required in the DES/DDD ISP.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Participation in quarterly consultations with a behavioral health professional.</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

## Discharge Planning

<table>
<thead>
<tr>
<th>Task</th>
<th>DES/DDD Support Coordinator</th>
<th>Behavioral Health Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinate care for individuals with complex needs who discharge from behavioral health facilities to community outpatient services and involve local DDD and RBHA staff members.</td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>Coordinate discharge from behavioral health services if no longer medically necessary.</td>
<td>*</td>
<td>X</td>
</tr>
<tr>
<td>Close the behavioral health ISP.</td>
<td>*</td>
<td>X</td>
</tr>
</tbody>
</table>

* Involvement in activity when appropriate