Arizona Regulatory Compliance Addendum
Medicaid Program

This Regulatory Compliance Addendum governing Arizona Medicaid (the "Addendum") shall govern the provision of Covered Services to Members who are eligible and covered under the managed care contract(s), as amended or restated, between Mercy Care (the "Company") and one or more Government Sponsors under which contract(s) Company serves as a managed-care organization, as well as the provision of any administrative or health-benefit management services/functions that relate to those Covered Services or any of the contracts with a Government Sponsor. A Government Sponsor is a federal or state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product. All capitalized terms not defined in this Addendum shall have the respective meanings that are ascribed to them in the Agreement.

Company's Government Sponsors require that specific terms and conditions be incorporated into the Agreement. Accordingly, this Addendum is incorporated by reference into the Agreement between Company and the Provider. The Addendum, as amended from time-to-time, is located on Company's website.

For purposes of this Addendum, "Provider" means the health care provider, group, facility, hospital, delegated entity, including any other entity (as identified on the first page of the Agreement). Provider acknowledges and agrees that all provisions of this Addendum shall apply equally to its/their employees, independent contractors, subcontractors, downstream entities, or related entities that provide Covered Services to Members, or that provide administrative or health-benefit management services/functions relating to those Covered Services or to the Government Sponsor contract(s), and it/they represent and warrant that it/they shall take all steps necessary to cause such employees, independent contractors, subcontractors, downstream entities, or related entities to comply with this Addendum and all applicable laws and regulations.

Each provision contained in this Addendum shall apply to Provider only to the extent applicable to the services rendered by Provider pursuant to the Agreement.

REQUIREMENTS FOR ALL MEDICAID PROGRAMS

1. **All Providers.** The following provisions apply to all Providers (except as otherwise designated) who participate in the AHCCCS program, or programs offered by AHCCCS Subcontractors, including but not limited to DES/DDD and DCS/CHP:

    1.1. Provider shall comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and Contract provisions [42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(2), 42 CFR 438.3(k)].

    1.2. Provider shall register with AHCCCS as an approved service provider (i.e. AHCCCS registered provider) consistent with provider disclosure, screening, and enrollment requirements [42 CFR 457.1285, 42 CFR 438.608, 42 CFR 455.100-106, 42 CFR 455.400 - 470]. Additionally, any provider terminated from participation in the AHCCCS Medicaid Program, other XIX programs, Title XVIII or XXI programs, shall be terminated from participating with Company as a provider in any of Company's network of providers who render services to individuals eligible to receive medical assistance pursuant to Title XIX. Providers shall refer to the AHCCCS website for specific requirements for Provider Registration.

    1.3. Providers shall comply with the AHCCCS Minimum Subcontract Provisions (MSPs) which can be located on AHCCCS's website (www.azahcccs.gov). The MSPs are incorporated into this Addendum by reference as updated from time-to-time by AHCCCS.

    1.4. Provider's responsibilities with respect to coordination of benefits and third-party liability are stated in Company's Policies. In addition, Provider agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Company.

    1.5. Provider shall coordinate the care of all members as required by Company's policies.

1.6. A description of Provider's patient medical, dental and cost record keeping system:

Electronic: _____ Paper: _____

If electronic, name of system: _____

1.7. Provider shall cooperate with quality management programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM, or for DDD services in compliance with the AdSS Medical Policy Manual.

1.8. If Provider is delivering Administrative Services, a Change in Organizational Structure of Provider shall require a contract amendment and prior approval of AHCCCS, DDD or DCS/CHP, as applicable.

1.9. Provider acknowledges that AHCCCS is responsible for enrollment, re-enrollment, and disenrollment of the covered population; for DCS/CHP services, DCS/CHP and AHCCCS are responsible for enrollment, re-enrollment, and disenrollment of the covered population; and for DDD services, DDD is responsible for enrollment, reenrollment and disenrollment of the covered population.

1.10. Provider shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under the Agreement, for itself and its employees, and AHCCCS has no responsibility or liability for any such taxes or insurance coverage.

1.11. Provider shall obtain any necessary authorizations from Company, AHCCCS, or DCS/CHP, as applicable, for services provided to eligible and/or enrolled members.

1.12. Provider shall comply with encounter reporting and claims submission requirements as described in the Agreement.

1.13. Company may suspend, deny or refuse to renew or terminate the Agreement in accordance with the terms of the State Contract and applicable law and regulation.

1.14. As applicable, Company may revoke the delegation of activities or obligations or specify other remedies in instances where Company, AHCCCS or DCS/CHP, as applicable, determines that Provider has not performed satisfactorily [42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(1)(iii), 42 CFR 438.3(k)].

1.15. Provider may provide Members with factual information, but is prohibited from recommending or steering a Member in the Member's selection of a contractor.

1.16. Compensation provided to individuals or entities that conduct utilization management and concurrent review activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee [42 CFR 457.1230(d), 42 CFR 438.210(e)].

1.17. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Company's Contract(s) with the State. [42 CFR 457.1201(i), 42 CFR 457.1201(i), 42 CFR 457.1233(b), 42 CFR 438.230(c)(3)(i)-(iv)].

1.18. Provider shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member [42 CFR 438.210(a)(3)(ii)].

1.19. Provider shall assist members in understanding their right to file grievance and appeals in conformance with all AHCCCS Grievance and Appeal System and member rights policies. Provider may locate additional member grievance and appeal information on Mercy Care's website (www.mercycareaz.org), including but not limited to, the member's right to file grievances and appeals; the requirements and time frames for filing a grievance or

appeal; the availability of assistance in the filing process; the right to request a State Fair Hearing after a member has received an adverse appeal decision; and that members may be required to pay the cost of services provided while the appeal or State Fair Hearing is pending.

1.20. Provider will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 CFR 438.230, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Members. [42 CFR 457.1233(b), 42 CFR 457.1201(i), 42 CFR 438.230(c)(3)(iv)].

1.21. The right to audit under (c)(3)(i) of 42 CFR 438.230 will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. [42 CFR 438.230, 42 CFR 457.1233(b), 42 CFR 457.1201(i).]

1.22. If Company and Provider have a capitated arrangement/risk sharing arrangement, then the following provision is made part of the Agreement:

> If the Provider does not bill the Company (e.g., Provider is capitated), the Provider's encounter data that is required to be submitted to the Company pursuant to contract is defined for these purposes as a "claim for payment". The Provider's provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) § 36-2918, §36-2932, and §36-2957.

1.23. Provider must train its staff (including management, contractors, students, and agents) on the following aspects of the Federal False Claims Act provisions: (a) Detailed information about the Federal False Claims Act, (b) The administrative remedies for false claims and statements, (c) any State laws relating to civil or criminal liability or penalties for false claims and statements, and (d) whistleblower protections under such laws.

1.24. Provider shall adhere to the requirements of the Arizona Opioid Epidemic Act SB1001, Laws 2018. First Special Session.

1.25. Providers shall adhere to the provider requirements and qualifications outlined in AHCCCS Medical Policy Manual, Chapter 600; or for DDD services the AdSS Medical Policy Manual Chapter 600.

1.26. **Providers licensed as an inpatient facility, Behavioral Health Residential or Therapeutic Foster Care (TFC)** must comply with Contractor's quality management and medical management programs.

1.27. Provider must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R.§483.75(e)3 and (g)2. Such registry personnel shall also be fingerprinted as required by A.R.S. §36-411.

1.28. **Immigration Laws.** Provider shall comply with all State, Federal, and local immigration laws and regulations relating to the immigration status of their employees during the term of the Contract.

ALTCS PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in the AHCCCS ALTCS program (except as designated).

2. **License and Certification.** If licensed or certified by ADHS, Provider must submit to Company its most recent ADHS licensure review, copies of substantiated complaints, and other pertinent information that is available and considered to be public information from oversight agencies.

3. **Nursing Facility Providers.** The following provisions apply to nursing facility Providers.

3.1 Provider shall refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

3.2 Provider shall not admit a member to a nursing facility without the member first undergoing a Preadmission Screening and Resident Review (PASRR) Level I, and, when indicated, that the appropriate entity has performed a PASRR Level II evaluation as specified in the AMPM Policy 680-C. When the result of the PASRR Level I screening indicates that the member has an intellectual disability, DES conducts the Level II evaluation. When the result of the PASRR Level I screening indicates that the member has a mental illness, the ACC-RBHA conducts the Level II evaluation. The purpose of the PASRR Level II evaluation is to determine whether a member who has a mental illness or an intellectual disability needs the level of care provided in a nursing facility and/or needs specialized services. When the PASRR Level II evaluation determines that the member needs a different level of care than can be provided in a nursing facility, the Contractor shall arrange for the provision of other covered services appropriate to the member's needs. When the PASRR Level II evaluation determines that the member needs specialized services while in the nursing facility, the Contractor shall arrange for the provision of covered specialized services appropriate to the member's needs. Failure to have the proper PASRR screening prior to placement of members in a nursing facility may result in Federal Financial Participation (FFP) being withheld from AHCCCS. Should withholding of FFP occur, AHCCCS will recoup the withheld amount from a Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the nursing facility, that admitted the member without the proper PASRR [42 CFR Part 483, Subpart C].

4. **Nursing Facilities or Alternative HCBS Setting.** The following provisions apply to Providers that are nursing facilities or an alternative HCBS setting.

4.1 To the extent the Agreement covers specialty services, such services shall be provided under a Work Statement that sets forth the special services being purchased, including admissions criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description, and other non-clinical services such as increased activities.

AHCCCS COMPLETE CARE PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in the AHCCCS Complete Care (ACC) program (except as designated).

2. **Homeless Clinics.** Only those members who request a homeless clinic as their PCP receive such assignment. Members assigned to a homeless clinic may be referred to out-of-network providers for needed specialty services.

3. **Residential Facilities.** For providers that are a residential facility that serves juveniles, the provider shall comply with all relevant provisions of ARS § 36-1201.

ACC-RBHA PROGRAM

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in Company's AHCCCS ACC-RBHA program.

2. Providers that are not a part of Company's crisis network are required to deliver crisis services, or be involved in crisis response activities during regular business operation hours.

3. **Residential Facilities.** For providers that are a residential facility that serves juveniles, the provider shall comply with all relevant provisions of ARS § 36-1201.

4. **Homeless Clinics**. Only those members designated as SMI that request a homeless clinic as their PCP receive such assignment. SMI members assigned to a homeless clinic may be referred to out-of-network providers for needed specialty services

5. **Nursing Facilities.** Providers that are a nursing facility must ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e)(3) and (g)(2). Provider shall also ensure that these registry personnel are fingerprinted as required by A.R.S. § 36-411.

6. **Member Handbooks**. Providers shall have Mercy Care Member Handbooks available and easily accessible to members at all Provider Locations.

ADES/DDD PROGRAM

1. **All Providers**. In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers that are contracted to provide Acute Care Services to individuals who are eligible for services through the Arizona Department of Economic Security/Division of Developmental Disabilities ("ADES/DDD") programs to provide long term and medical care to persons with developmental disabilities who are eligible for ALTCS.

   1.1 Provider shall comply with all requirements applicable to all Medicaid programs as described above. Additionally, and to the extent applicable, where a government payor, including but not limited to, AHCCCS, CMS, etc., is identified in the requirements for all Medicaid programs, that provision shall be deemed to also include ADES/DDD in addition to any other government payor.

   1.2 The Agreement incorporates by reference all applicable terms and conditions of the contract between Company and ADES/DDD.

   1.3 **Standards for Managing Behaviors**. Providers must comply, to the extent applicable, with A.A.C. R6-6-Article 9 requirements, including the use and restrictions of behavioral intervention techniques, behavior modifying medications, emergency measures, and training, as well as the development, monitoring and approval process for a behavior plan.

2. **Nursing Facility Providers.**

   2.1 Nursing facility providers must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility, to the member/resident, or family member who made the payment.

   2.2 **HCBS Certification.** Providers providing Physical Therapy Services for the habilitative needs of members twenty-one (21) years of age and older must be HCBS certified by DES/DDD as required in A.A.C. R6-6-1501 through R6-6-1533.

DEPARTMENT OF CHILD SAFETY COMPREHENSIVE HEALTH PLAN

1. **All Providers.** In addition to those requirements that apply to all AHCCCS programs, as identified above and incorporated herein, the additional provisions below apply to all Providers who participate in Company's DCS/CHP program.

2. **Fingerprinting and Background Verifications**.
   2.1 Provider shall comply with all legal requirements relating to fingerprinting, certification, and criminal background checks, including but not limited to, A.R.S. § 36- 594.01, 36-3008, 41-1964, and 46-141. All applicable legal requirements related to fingerprinting, fingerprint clearance cards, certifications regarding pending or past criminal matters, and criminal records checks are hereby incorporated in their entirety as provisions of this Agreement. Provider is responsible for knowing which legal requirements related to fingerprinting, fingerprinting clearance cards, certifications regarding pending or past criminal matters, and criminal records checks related to performance under the Agreement.

2.2 To the extent A.R.S. § 46-141 is applicable to Contract performance or the services provided under this Contract, the following provisions apply:

2.2.1 Personnel who are employed by Provider, whether paid or not, and who are required or allowed to provide services directly to juveniles or vulnerable adults shall have a valid fingerprint clearance card or shall apply for a fingerprint clearance card within seven working days of employment.

2.2.2 Except as provided in A.R.S. § 46-141, this Contract may be cancelled or terminated immediately if a person employed by the Contractor and who has contact with juveniles certifies pursuant to the provisions of A.R.S. § 46-141 (as may be amended) that the person is awaiting trial or has been convicted of any of the offenses listed therein in this State, or of acts committed in another state that would be offenses in this State, or if the person does not possess or is denied issuance of a valid fingerprint clearance card.

FAMILY PLANNING BENEFITS

Notwithstanding any other provision of the Agreement, and exclusively with respect to Family Planning services rendered by Provider pursuant to the Agreement, any reference in the Agreement or Company's policies and procedures to "Mercy Care" or to "Mercy Care Advantage" shall be replaced with "Plan Administrator" for purposes of: (i) performing obligations or enforcing rights directly connected to the administration of Family Planning services; (ii) exchanging any payment, correspondence, information (including without limitation Encounter Data and claims data) or reports between Company and Provider.

"Plan Administrator" shall mean Aetna Medicaid Administrators LLC, or such other entity designated by Company and identified to Provider in writing. Notices and other correspondence submitted to Plan Administrator under the Agreement shall be sent to the following address:

Aetna Medicaid Administrators, LLC
Attention: Legal Department
4750 S. 44th Place, Suite 150
Phoenix, Arizona 85040

With copy to:

Mercy Care
Attention: Network Management
4750 S. 44th Place, Suite 150
Phoenix, AZ 85040

For purposes of the Agreement, Family Planning services shall mean those services in accordance with the AHCCCS Medical Policy Manual for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, shall also be included.

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