information related to changes in commercial insurance carriers for new and existing members. The monitoring of encounter denials identifies variances between AHCCCS and P/GLTC TPL data. Any discrepancies are forwarded to the TPL Specialist for verification and system updates as needed. Overpayments are recouped from the provider, as per AHCCCS guidelines, through the claims system and adjusted encounters are submitted to AHCCCS.

Pertinent information is verified telephonically by the TPL Specialist and entered into both systems. As ALTCS members approach the Case Management review date, the TPL specialist re-verifies information in the system. Data are provided to case management for comparison to information received from the member during their review. The AHCCCS Client Assessment and Tracking System (CATS) is monitored to ensure data is consistent. Variances are reported to AHCCCS via the online notification process.

Insurance information also flows from the claims process. If a member's record reflects other coverage, and the bill is submitted without an EOB from the other carrier, the claim denies pending other coverage information/EOB. If the system reflects no other coverage and there is an EOB attached, the information is routed to the TPL Specialist for coverage verification. The verification date is noted in the member record, the claim is paid, and AHCCCS is notified. The TPL Specialist also forwards new COB information to the Lead Claims Specialist for a claims payment retrospective review to identify any payments made with P/GLTC as primary payor. Whatever the source, P/GLTC pursues post payment recoveries. The claim is adjusted and overpayments are recouped from the provider from future claims submissions. Per the AHCCCS Recoupment policy, recoupments over $50,000 must be pre-approved by AHCCCS; no recoupments are made beyond 12 months after the date of service. Any related encounters are replaced in order to reflect the accurate/adjusted payment or recoupment. If

potential third party payors are discovered, i.e. for motor vehicle accidents, P/GLTC notifies AHCCCS and provides the pertinent information. Claims that contain diagnosis codes 800–999 (trauma codes) are reviewed, investigated, and reported monthly to AHCCCS for subrogation. Other reports reviewed are TPL audits, AHCCCS required Verification of Services, and Cost Avoidance.
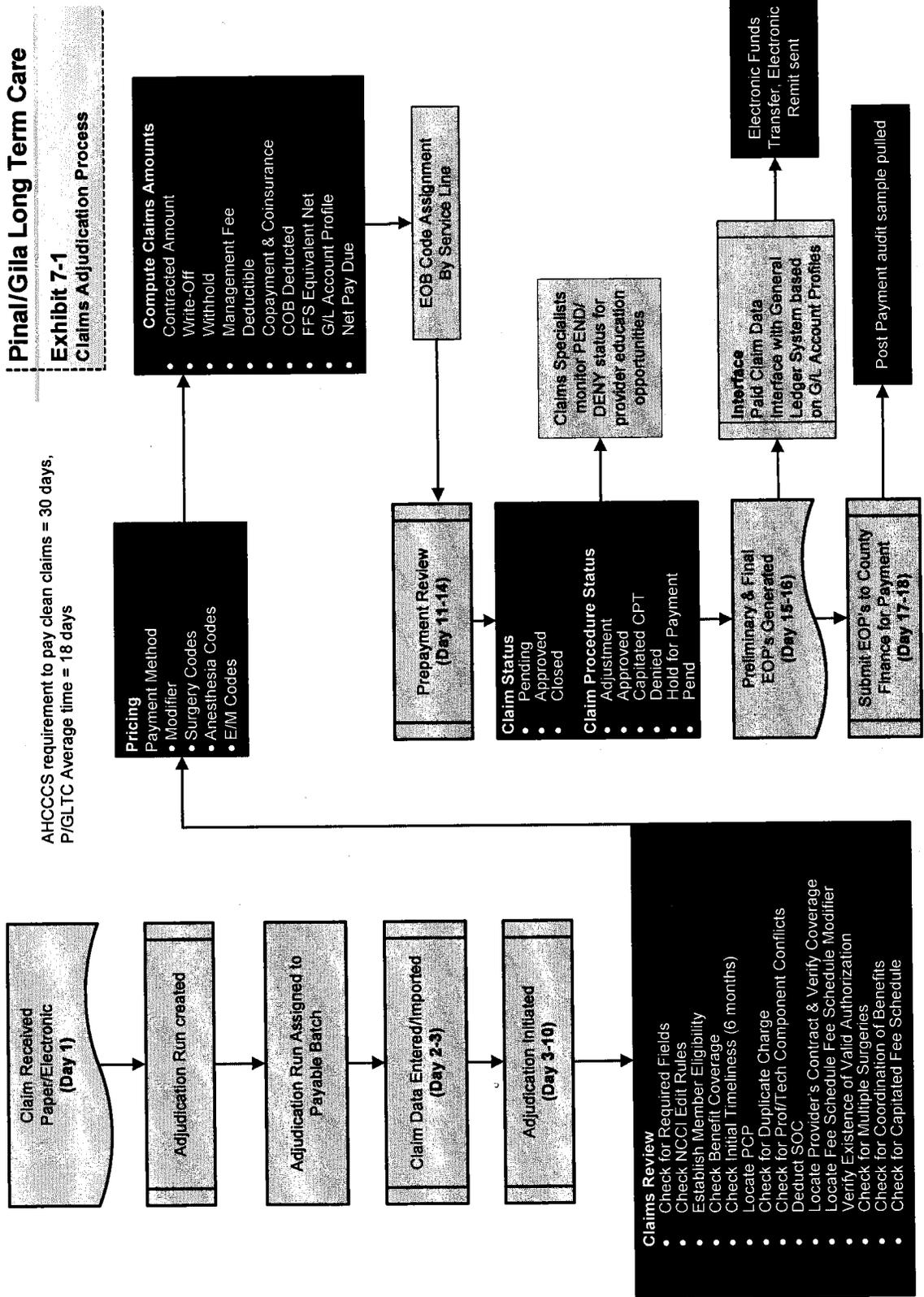
Claims Inquiries

There is a designated Provider Liaison whose responsibilities include response to provider calls regarding claims status, payment information, claims dispute procedures, and provider billing instruction. The Claim Assistance line connects to the direct line of the Provider Liaison, once the call is answered, without cycling through an automated menu. Established inquiry response standards are one to two business days. Current statistics reflect an average inquiry turnaround time of within 24 hours. The Provider Liaison logs all calls and resolutions. The Claims Manager analyzes this log monthly and identifies needs for provider training. This information is relayed to the appropriate Provider Relations Representative and corrective action is discussed. If a call goes to voice mail, the message provides information for accessing the website, faxing multiple claim inquiries and the availability of EFT process.

Providers have direct website access through P/GLTC or Pinal County. Information available includes:
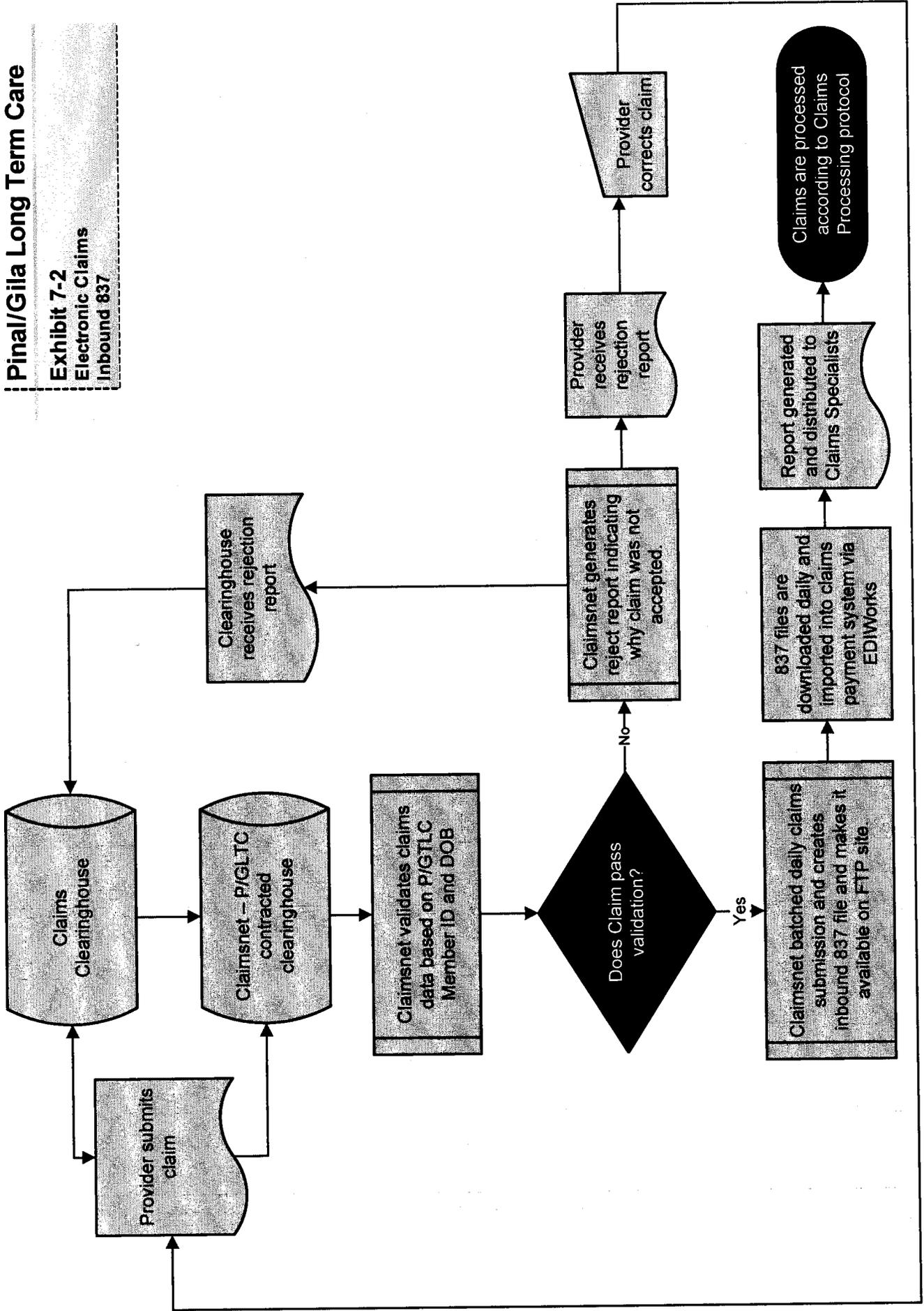• Claims status
• Member eligibility
• Rate codes
• Searchable provider directory

Online inquiry inquiries are directed to the claims unit via e-mail. The issue is researched and an e-mail response/resolution is sent to the provider. In the case of complex issues, a Claims Specialist calls the office directly for a one-to-one conversation with the provider office staff.
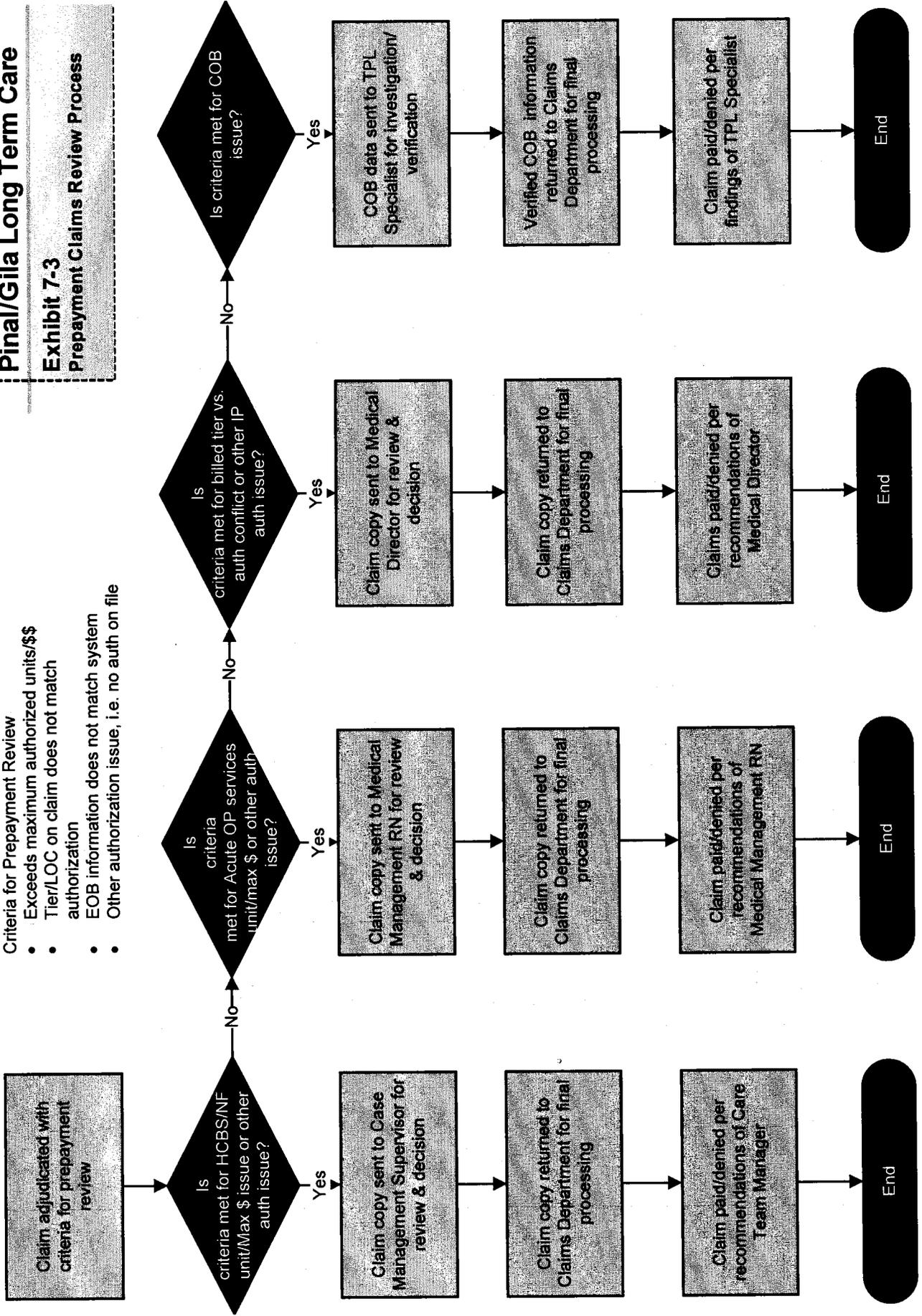
Pinal/Gila Long Term Care

Exhibit 7-1
Claims Adjudication Process

AHCCCS requirement to pay clean claims = 30 days,
P/GLTC Average time = 18 days

Claim Received
Paper/Electronic
(Day 1)

→

Adjudication Run created

→

Adjudication Run Assigned to Payable Batch

→

Claim Data Entered/Imported
(Day 2-3)

→

Adjudication Initiated
(Day 3-10)

→

Claims Review
- Check for Required Fields
- Check NCCI Edit Rules
- Establish Member Eligibility
- Check Benefit Coverage
- Check Initial Timeliness (6 months)
- Locate PCP
- Check for Duplicate Charge
- Check for Prof/Tech Component Conflicts
- Deduct SOC
- Locate Provider's Contract & Verify Coverage
- Locate Fee Schedule Fee Schedule Modifier
- Verify Existence of Valid Authorization
- Check for Multiple Surgeries
- Check for Coordination of Benefits
- Check for Capitated Fee Schedule

→

Pricing
Payment Method
- Modifier
- Surgery Codes
- Anesthesia Codes
- E/M Codes

→

Compute Claims Amounts
- Contracted Amount
- Write-Off
- Withhold
- Management Fee
- Deductible
- Copayment & Coinsurance
- COB Deducted
- FFS Equivalent Net
- G/L Account Profile
- Net Pay Due

→

EOB Code Assignment
By Service Line

→

Prepayment Review
(Day 11-14)

→

Claim Status
- Pending
- Approved
- Closed

Claim Procedure Status
- Adjustment
- Approved
- Capitated CPT
- Denied
- Hold for Payment
- Pend

→

Claims Specialists monitor PEND/ DENY status for provider education opportunities

→

Preliminary & Final EOP's Generated
(Day 15-16)

→

Submit EOP's to County Finance for Payment
(Day 17-18)

→

Interface Paid Claim Data Interface with General Ledger System based on G/L Account Profiles

→

Electronic Funds Transfer, Electronic Remit sent

Post Payment audit sample pulled

Pinal/Gila Long Term Care

Exhibit 7-2
Electronic Claims
Inbound 837

Provider submits claim

Claims Clearinghouse

Claimsnet – P/GLTC contracted clearinghouse

Claimsnet validates claims data based on P/GLTC Member ID and DOB

Does Claim pass validation?

Clearinghouse receives rejection report

Claimsnet generates reject report indicating why claim was not accepted.

Provider receives rejection report

Provider corrects claim

No

Yes

Claimsnet batched daily claims submission and creates inbound 837 file and makes it available on FTP site.

837 files are downloaded daily and imported into claims payment system via EDIWorks

Report generated and distributed to Claims Specialists

Claims are processed according to Claims Processing protocol

Pinal/Gila Long Term Care

Exhibit 7-3
Prepayment Claims Review Process

Criteria for Prepayment Review
- Exceeds maximum authorized units/$$
- Tier/LOC on claim does not match authorization
- EOB information does not match system
- Other authorization issue, i.e. no auth on file

Claim adjudicated with criteria for prepayment review

Is criteria met for HCBS/NF unit/Max $ issue or other auth issue?

No →

Yes ↓

Claim copy sent to Case Management Supervisor for review & decision

Claim copy returned to Claims Department for final processing

Claim paid/denied per recommendations of Care Team Manager

End

Is criteria met for Acute OP services unit/max $ or other auth issue?

No →

Yes ↓

Claim copy sent to Medical Management RN for review & decision

Claim copy returned to Claims Department for final processing

Claim paid/denied per recommendations of Medical Management RN

End

Is criteria met for billed tier vs. auth conflict or other IP auth issue?

No →

Yes ↓

Claim copy sent to Medical Director for review & decision

Claim copy returned to Claims Department for final processing

Claims paid/denied per recommendations of Medical Director

End

Is criteria met for COB issue?

Yes ↓

COB data sent to TPL Specialist for investigation/verification

Verified COB information returned to Claims Department for final processing

Claim paid/denied per findings of TPL Specialist

End

PINAL·COUNTY

Payable to: **Vendor Name**
Street Address
City State Zipcode

Vendor **Vendor's Tax ID Number**	Cap Amount	FFS Amount	Adjustments	Total Payment
	$#,###.##	$#,###.##	$#,###.##	$#,###.##

EOB Descriptions

003	This charge has previously been submitted
072	Paid patient responsibility.
1058	2nd COB amount applied.
935	Required Modifier is missing.
CRNVOID	CRN - Void files
PG003	Duplicate Claim
PG012	Diag. Not Accepted by AHCCCS for Ambulance Svcs
PG020	Non-Covered Service
PG221	No Patient Responsibility
PG229	Adjustment Due to Calculation Error
PG231	Denied per Primary Insurance

Pinal/Gila Long Term Care
Exhibit 7-4

Electronic Funds Transfer (EFT) Services are now available!

Contact Cheryl Davis at Cheryl.Davis@pinalcountyaz.gov or 520-866-6763 for more information.

Claim and member eligibility information are available on-line.
Visit
www.pinalcountyaz.gov/departments/longtermcare

If you have questions regarding your payment/denial please call (520) 866-6775 (option #1) for further information. Claims must be submitted within six months of the date of service, with a third party EOB if necessary. An additional six months is allowed to re-submit a clean claim. Any claim submitted more than 12 months after the date of service will not be honored. If your claim has been denied, you may resubmit with supporting documentation. If you disagree with the outcome of your claim submission/resubmission, you may file a claim dispute with Pinal/Gila Long Term Care. Claim disputes challenging claim payments, denials or recoupments must be filed in writing no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Please refer to your contract for more details or contact us at the number above.

Submit all claims disputes to:
Dispute & Appeals Manager
Pinal Gila Long Term Care
PO Box 2140
Florence, AZ 85132

Pinal/Gila Long Term Care
Exhibit 7-4

Pinal/Gila Long Term Care

Exhibit 7-5
Coordination of Benefits

Claim entered, processing begins

System reflects other insurance coverage

Is EOB attached?

No → Claim adjudicated and enters denied status for other insurance → Claim is denied → End

Yes → Does EOB match system information?

No → COB data sent to TPL Specialist for investigation/verification → TPL Specialist verifies insurance information on EOB → TPL Specialist notes new insurance information in Claims & Medical Management Systems

Yes → Claim is processed → End

TPL Specialist notes new insurance information in Claims & Medical Management Systems → AHCCCS is notified of third party payor if indicated → Lead Claims Specialist performs retro review for potential overpayments → Verified COB information is returned to Claims Department → Claim is processed → End

Requirement 8: Describe what the Offeror will be doing to promote and advance electronic claim submission and assist providers to accept electronic funds transfers.

Pinal/Gila Long Term Care (P/GLTC) is actively engaged in a number of initiatives promoting and advancing electronic claim submission and electronic funds transfers. The overarching goals are administrative efficiency/effectiveness and reduced costs.

Targeted efforts to increase the number of electronic claims submitted by HCBS providers that represent the highest claim volume have yielded solid results. The most recent P/GLTC Claims Dashboard (January 2011) reflects a success rate of 43 % of claims submitted electronically compared to 22.80% in January 2010. P/GLTC's future goals include increasing electronic claims submission by 10% in 2012 and 2013, and 5% annually thereafter.

Building on this success, P/GLTC claims staff, the Electronic Data Analyst (EDA), and Provider Relations Representatives are taking the following steps to promote and advance electronic claims submissions:
- Recruitment of additional high volume providers
- Direct contact with P/GLTC's EDA
- EDA follow up with interested providers
- Provider education by Provider Relation Representatives
- Distribution of marketing materials regarding electronic claims
- Specialized provider training
- New provider orientation at Joint Operations Committees (JOC)
- Promotion of electronic claim submission in P/GLTC's Provider newsletters
- Additional clearinghouse contracts
- Enhanced branding on website
- Additional input from clearinghouse regarding provider inquiries
- Financial incentives

Specific information about these strategies is included in the following paragraphs.

P/GLTC claims staff and Provider Relations Representatives are proactively recruiting Nursing Facilities, another high volume provider type, to seize this opportunity to improve efficiency and effectiveness.

The EDA facilitates the electronics claims submissions process with providers. (S)he responds to provider's technical inquiries regarding connection to the contracted clearinghouse and troubleshoots specific electronic claims submission issues as they arise. The EDA regularly receives calls from providers regarding the electronic process and how to obtain an electronic payer ID. (S)he logs all inquiries and requests additional information from the caller such as their use of other clearinghouses. The EDA follows up within one month of original contact if a provider has indicated interest in electronic submission but no claims have been received. The goal is identification and resolution of root cause issues that prevent providers from submitting electronically including clearinghouse connection issues.

Provider Relations Representatives are also spearheading this initiative through personal education and notification of provider office staff about new and important topics. The Representatives distribute P/GLTC Electronic Claims brochures and/or Quick Reference Guides to providers during office visits. The brochure contains information regarding claims clearinghouses, specific information for registering and contacting the P/GTLC clearinghouse as well as answers to more general questions. The brochure also includes the direct phone and e-mail for the EDA.

In the previous contract year P/GLTC staff convened an all day work session with contracted Assisted Living Facilities (ALFs) to review and highlight specific information about the benefits of electronic claims submission process, versus paper

submissions Often ALFs have less office technology than other providers and as a result, the group benefited greatly from the face-to-face training given by P/GLTC staff. More targeted, technical trainings such as this are scheduled.

Periodically, P/GLTC holds Joint Operating Committee (JOC) meetings with existing/newly contracted providers, particularly those with high volume utilization. The electronic claims process is discussed and encouraged and the EDA is available for specific questions and contact with attendees. JOC agendas include the EFT process as a standing item.

P/GLTC featured a front page story regarding the electronic claims submission process in our Spring 2010 Provider Newsletter. The article focused on the functions of the contracted clearinghouse, its availability to assist P/GLTC providers regardless of the level of technology in their respective offices, the registration process, and specific contact information. The Provider Newsletter is sent semi-annually to all contracted providers. An updated article will appear in the summer 2011 edition of the P/GLTC Provider Newsletter.

The Chief Financial Officer (CFO) and EDA solicit information about evolving electronic claims submission processes on a continuous basis. Contracting with larger and more well-known clearinghouses such as Emdeon could potentially increase provider connectivity and submission.

The EDA is also researching the enhancement of the branded site provided by the contracted clearinghouse. The goal is to make the site easier to identify as a P/GLTC service and more informative regarding the process and the options available to providers. This is particularly important for those providers without strong office technology. In addition, P/GLTC has requested quarterly input from the claims clearinghouse regarding provider

inquiries about services, the process from registration through implementation, and barriers encountered when working with providers. This information should provide better identification of specific providers to target and barriers to provider use of the electronic claims process.

Another way P/GLTC promotes electronic claims submission is through financial incentives. Currently, P/GLTC absorbs the per-claim fee ($.25) associated with electronic claims submissions for all providers. Recently, executive management made the decision to cover the initial, one time registration fee ($150) required to submit electronic claims through the clearinghouse. P/GLTC plans to continue to provide these financial incentives for the foreseeable future. This incentive is communicated in provider newsletter articles, during Provider Relations office visits, and through the EDA.

In January 2011, P/GLTC implemented the provider electronic funds transfer (EFT) process. The EDA is also the primary resource for EFT. This is optimal because providers make direct contact to inquire about the process. There are no arduous menu options or phone trees. For instance, in the event an error occurs during the file transfer process, the EDA contacts the provider office within one business day of notification from the bank. As a result of this local, P/GLTC support, the corrected information obtained from the office usually allows a transfer to occur in the next cycle. EFTs are processed semi-weekly.

In February 2011, Provider Relations sent a blast fax to all contracted provider billing offices to market the EFT process. This resulted in an additional 32 providers requesting EFT within the first week of the fax transmission. The registration form included in the fax contains EDA contact information. This type of "blast fax" continues for both the EFT process and

electronic claim submission on a quarterly basis. The EFT registration form is also available on the P/GLTC website to further allow easy access for the provider network.

Provider Relations Representatives provide a combined Electronic Claims and EFT brochure to providers during routine office visits. The Quick Reference Guide is also distributed to further promote these opportunities.

As in the case of Electronic Claims submission, feature articles highlighting EFT availability and ease of use will be published in the upcoming edition of the Summer, 2011 Provider Newsletter.

P/GLTC remittance advices include information about:
- Online claims status
- Online member eligibility
- Electronic claims submission
- Availability of EFT

This method of communication to the provider network has proven successful in providing updated and ongoing information to providers and billing offices. Recently, EFT language has been added to the claim assistance line voice message. Claims Specialists also promote the EFT process when speaking with provider offices.

P/GLTC is also using provider contracts to further the goal of electronic processes. Strong language encouraging providers to submit claims electronically and receive funds via EFT is included in the standard compensation section of P/GLTC contracts. Recommendations to contractually require EFT have been adopted and implemented.

A mini marketing campaign targeting late adopters is currently under development. While efficiency, effectiveness, and cost savings are still the underlying goal, messaging will be consistent with shifting societal norms emphasizing the importance of being/going green. Using these technologies is good for the environment because it has the potential to exponentially reduce paper waste and saves energy costs.

Requirement 9: Provide a description of the clinical edits and the data related edits included in the claims adjudication process.

The claims system used by Pinal/Gila Long Term Care (P/GLTC), Plexis Claims Manager (PCM), contains clinical and data related edits that are applied during the adjudication process. Some edits are inherent in the system like the National Correct Coding Initiative (NCCI) edits and others are user-defined business rules established via the system administration/setup (i.e. benefit structure and provider contracts). P/GLTC subscribes to a national vendor for quarterly updates to NCCI edits to ensure this essential data is current in PCM.

The PCM review process verifies the following items and assigns a PEND or DENIED status to those procedures lines that do not pass the review and assigns the appropriate Explanation of Benefit (EOB) code:
- Check NCCI Edit Rules
- Establish Eligibility
- Check Benefit Coverage
- Check submission timeliness
- Check for Duplicate Charge
- Check for Professional/Technical Component
- Locate Payment Contract and verify coverage
- Locate Fee Schedule
- Verify Diagnosis code Completeness
- Verify existence of valid authorization
- Check for Multiple Surgeries
- Check for Global Period

National Correct Coding Initiative Edits
PCM checks the procedure code against the National Correct Coding Initiative (NCCI) rules prior to all other adjudication rules. There are two sets of Correct Coding Initiative edit tables: comprehensive/component (correct coding) and mutually exclusive edits. All edits consist of code pairs in column one and column two of the tables. All edits are included in the comprehensive/component table except those meeting the criteria for mutually exclusive edits. The rules apply for services billed by a single provider for a single patient on the same date of service.

Comprehensive/component table edits specify that the column two codes are not payable with the column one codes unless the edit permits use of an appropriate modifier. When a column one code and a column two code are both included on a claim and the column two code doesn't include an acceptable modifier, then the column one code is payable (unless there is some other reason to deny the code), and the column two code is denied. In the comprehensive/component table, the column two code is included in the column one code. Thus, PCM pays the column one code and denies the column two code.

NCCI standards contained in PCM specify procedure codes that providers are not to report together because they are mutually exclusive of each other. The mutually exclusive table identifies two distinct reasons why a provider should not report mutually exclusive column one codes with column two codes:
- Mutually exclusive procedures
- Designation of gender procedures

Per the NCCI, exclusivity is based on the CPT definition or the medical impossibility or improbability that the provider could perform the procedures at the same visit. For example, a global surgical package includes the administration of fluids so the specific codes for IV infusion services should not be reported separately. Similar scenarios occur with anesthesia services, surgical procedures, and multi-channel lab test bundling. The NCCI defines these code pairs in the mutually exclusive data file.

Member Eligibility/Benefit Coverage Edits
PCM checks the member's eligibility to ensure that coverage exists for the date(s) of service on the claim. The date(s) of service on the claim line must fall within the effectiveness periods of any of the following; Benefit Contract, Benefit

Class, Benefit Plan, and code group. Benefit Contracts are created to identify AHCCCS Contract Types (i.e., ALTCS, Acute, and Prior Period Coverage (PPC), QMB). The Benefit Contracts are based on specific Benefit Plans which in turn, house Benefit Classes that define covered and non-covered services. At a minimum, the Benefit Classes are defined by procedure code and/or procedure code groups. Benefit Classes may also be defined by diagnosis, place of service, type of service, minimum and maximum age, and authorization requirements. PCM looks at the Benefit Classes in the Benefit Contract that tie to the date of eligibility/date of service and determines if the procedure code is covered. The system pays or denies based on the coverage determination.

Provider Payment Related Edits

PCM locates the contract for the provider listed on the claim by matching the following: provider ID, procedure's service dates in the From and To fields, the effective and termination dates on the contract assignment, and network assignment (if applicable). Providers can be assigned to networks for reimbursement purposes. For example, per AHCCCS standards, non-contracted providers are to be reimbursed at 100% of the AHCCCS fee schedule. Therefore, all non-contracted providers are assigned to a specific network that is attached to that specific fee schedule. Contracted providers who have not completed the re-credentialing process are assigned to a specific "Non-Credentialed Network". Claims submitted by providers in this network are denied with an Explanation of Benefit (EOB) code with the description "Provider is not credentialed". PCM set up procedures also include AHCCCS timeliness standards via a set up option in the Benefit Contract. Any initial claim submitted by a provider past the six month timeframe automatically enters a DENY status upon adjudication.

Claim payment to the provider is computed based upon that provider's contract and the dates of service on the claim. A specific fee schedule, per the contractual agreement between the provider and P/GLTC, is assigned

to the contract in PCM. The fee schedule is defined by effective and termination dates. Fee schedules can be further defined by place of service or type of service. Once PCM finds the fee schedule, it verifies that the procedure on the procedure detail line of the claim is listed as one of the procedures covered in the fee schedule. If it is included in the fee schedule, then the procedure is covered and adjudication continues. If it is not included in a range of procedures on the fee schedule, the procedure line status sets to DENIED. Individual procedure codes in any given fee schedule can be designated "pend for review" and forwarded for medical review before final processing.

Diagnosis Edits

Individual diagnosis codes are identified as being complete (the highest level of specificity) or incomplete (not the highest level of specificity) in the system tables in PCM. Incomplete diagnosis codes have been set to deny in PCM. Diagnosis codes are handled differently in professional and institutional claims. In professional claims, the diagnosis codes are entered at the claim level and referred to at the claim line level. Each claim line can refer to one or more of the diagnosis codes. However, if the diagnosis code(s) referred to in the claim line is incomplete, the claim line status sets to DENY. A professional claim can have specific lines pay and others deny due to the status of the diagnosis code. Institutional claims have diagnosis codes at the claim level but are not referred to at the claim line level. If any of the diagnosis codes are incomplete, no claim lines pay.

Prior Authorization Edits

Prior authorization requirements are set in the Benefit Classes at the procedure code level. PCM searches for a valid authorization if it is required per the set-up. Once it is determined that an authorization is required, a search for an authorization that matches the information on the claim line is executed. An authorization is valid for a claim if all of the following standards are met:

- The authorization number in the system matches the authorization number on the claim,
- The authorization status is APPROVED in PCM,
- The member on the claim matches the member on the authorization,
- The provider on the claim matches the provider on the authorization, avoiding incorrect payment and authorization assignment,
- The authorization's effective date range completely includes the service dates on each claim line,
- The procedure code(s) on the claim are found in a code group in the Benefit Class.
- The number of visits/units on the claim does not exceed the authorized visits in the authorization, avoiding over utilization.

If PCM finds and verifies a valid authorization on the claim, the claim adjudicates with an APPROVED status and pay. If no match is made, the claim adjudicates with a DENY status. Authorization requirements can be assigned by network. Authorizations are required for services performed by non-contracted providers. Therefore, all non-contracted providers are assigned to a specific network.

At least annually, PA requirements are reviewed and edits are revised accordingly.

Multiple Surgery Edits
PCM contains multiple surgery (depreciation) functionality that provides the ability to automatically depreciate the amount paid for the performance of multiple surgeries during the adjudication process. Depreciation schedules are set up with codes that are subject to depreciation, including the order and amount to depreciate. P/GLTC follows AHCCCS methodology and reimburses the principal procedure at 100% and each secondary procedure at 50% of the contracted rate.

Global Period Edits
PCM assesses all fee-for-service charges for application of global period rules. Global

periods are the amount of time after surgery where standard medical practice considers others services as included in the original procedure's care period. PCM includes a service as part of a surgical procedure if the procedure (other than the surgery being performed) occurs on a date within the global period. PCM assigns a global period to a performed surgery (procedure codes 10000 – 69999) based on the internal complete RBRVS system table global period for the code. The complete RBRVS system table assigns surgery codes based on one of the following global periods:

- 0 days: the day of surgery only
- 10 days: the day of surgery and the 10 days after it
- 90 days: the day of surgery, the day before the day of surgery, and the 90 days after the day of surgery

PCM denies Evaluation/Management (E&M) codes if performed during the global period or the day before the 90 day global period. Use of appropriate modifiers allows PCM to price the procedure separately and not consider it part of the service designated within the global period. Applying one of the following modifiers overwrites the global period rule:

- Modifier 24 - Unrelated E/M service by the same physician during a post-op period
- Modifier 25 – Significant, separate identifiable EM services by the same physician on the day of the procedure
- Modifier 57 – Decision for surgery – when the global period is 90 days and the decision for surgery is on the day before or on the same day as the surgery

Requirement 10:- Submit a description of the Offeror's encounter submission process including, but not limited to, how accuracy, timeliness and completeness are ensured, how data is extracted from the system and the remediation process when AHCCCS standards are not met. The description should include the tracking, trending, reporting, process improvement and monitoring submission of encounters and encounter revisions. Include any feedback mechanisms to the encounter process that improves encounter accuracy, timeliness and completeness.

Pinal/Gila Long Term Care (P/GLTC) recognizes that complete, accurate, and timely encounter data is vital to the success of the AHCCCS Long Term Care program as it supports mutual rate setting, CMS reporting mandates, maximizing reinsurance recovery, and quality indicator projects. The P/GLTC encounter submission and tracking process is documented in policies accompanied by desk top procedures used for reference by any member of the P/GTLC staff.

Data Accuracy, Timeliness, and Completeness
An encounter file is an outbound 837 HIPAA mandated transaction of claims information including billed and paid units and charges, member information, provider data including NPI, procedure codes, diagnosis codes, and other information contained on standard claim forms. All files are formatted according to current HIPAA X12 guidelines as well as requirements contained in the AHCCCS Encounter Manual, the AHCCCS Encounter Companion Documents and the NCPDP Transaction Companion Documents, and Trading Partner Agreements.

Encounter data is extracted from the claims payment system via an EDI Gateway which is an XML-based API (application programming interface) for implementing proprietary import and export routines as referenced in the EDIWorks Export Process. All encounter files are submitted electronically to AHCCCS via Secure File Transfer Protocol (SFTP). Files contain records of medically related services rendered by a registered AHCCCS provider to a P/GLTC member enrolled on the date of service including any prior period coverage. It also includes billed and paid units and charges. Claim form types are submitted in their corresponding transaction:

Form Type	Transaction
Form A	837P
Form B	837I
Form D	837D
Form C	NCPDP

P/GLTC has review and analysis checkpoints in place throughout the data flow that begins with claims receipt and ends with encounter resolution. These are illustrated in Exhibit 10-1. All reviews and checkpoints within the system serve the same purpose – to assure timely, accurate, and complete data. Some occur before claims are received and entered into the claims payment system. Electronic claims are validated against member data by the P/GLTC contract claims clearinghouse. Claims that do not pass this verification procedure are rejected and returned to the provider before creating and in turn sending an inbound 837 file.

During the adjudication process, pre-payment reviews are conducted when Coordination of Benefits (COB) issues are identified. In such situations, COB verification is requested from the P/GLTC TPL Coordinator to assure appropriate determination of payment.

Preliminary Explanations of Payment (EOPs) are generated from the claims payment system before the closing process begins. Claims Specialists review the EOP for data variances such as inappropriate codes, modifiers, or payment amounts. Post Payment reviews are conducted on a sample of adjudicated claims following each semi-weekly closing. This review recognizes claims with third party payment errors such as incorrect coinsurance/co-payment amounts or missed deductibles and assures P/GLTC is processing claims as the payor of last resort. These

reviews may not allow data correction before extraction and submission, however they assure correct processing and data in the future thereby reducing encounter pend potential.

Data Extraction and Submission
P/GLTC extracts encounter data from the claims payment system based on semi-weekly claim runs. This criterion is utilized for reconciliation of the number of claims and billed charges for each run to encounter data thereby assuring all processed claims for rendered services are included for submission to AHCCCS including claims paid for a member's prior period eligibility. Technical details related to the export process are found in Exhibit 10-2.

Files are submitted the month following closing. This measure is in place to assure timely encounter data is received by AHCCCS within 240 days of the end of the month of services, or the date of enrollment, whichever is later. The P/GLTC Contracted Pharmacy Benefits Manager (PBM) pays claims to its network pharmacies and submits pharmacy encounter data to P/GLTC the month following payment. Incorrect unit reporting or format issues are identified by the P/GLTC encounter team who conducts a pre-submission review.

P/GLTC certifies encounter data contained in 837 transactions by the inclusion of an additional PER segment within the 1000A Submitter Name Loop. NCPDP files include the statement in the trailer. This attestation verifies that data included in the file is in compliance with Subpart H of the Balanced Budget Act Certification.

Although the EDI Gateway has the capability to isolate and export denied or non-covered services, development and quality testing is underway to adjust the format of the file to properly identify the encounter as a denied or non-covered service. The submission process is the same regardless if the file contains denied or approved claims data.

Encounter files are named following a P/GLTC convention. All filenames contain the month submitted, a claim form type identifier, a sequence number used to identify transmission of multiple same day files, the submission type, the health plan ID, and the claim run name. Submission types are New Day (ND), TI Corrections (TIC), and Pend Corrections (PC). An example is Feb24ND110065100113.

Following submission to the SFTP site, AHCCCS loads file contents into Transaction Insight (TI) which validates a file's syntactical format and assures that claim payment segments are balanced. Encounter staff review validator results and records them in a monthly reconciliation spreadsheet. This reconciliation compares the number of records contained within a file to the number of records that passed validation. Those that are outstanding are either corrected online and accepted for loading into PMMIS, or flagged for claim correction and resubmission. All bad records that were corrected are added to the successful total. Flagged records are corrected within the claims payment system and forwarded to the Electronic Data Analyst (EDA) for extraction and resubmission to the SFTP. Now considered a TI correction file (TIC), these records are reviewed for success and reconciled against the new day file that originally contained them. This tracking mechanism substantiates that all records contained within new day encounters files are loaded into the PMMIS system. For process details see Exhibit 10-3.

Once new day encounters are loaded into PMMIS a Control Reference Number (CRN) is assigned by the PMMIS system. P/GLTC receives CRN from AHCCCS in the 277U Supplemental file. This file contains the CRN and encounter status (finalized or pended) for all encounters from the most recent encounter processing and is imported into a local database and matched to the claim ID.

Pended Encounters
Pended encounters are resolved by P/GTLC Encounter Staff within 120 days from the date pended as reference in Exhibit 10-4. These are

identified by utilization of the Pended Detail Aging Report available from the AHCCCS SFTP address following each adjudication cycle. Corrections are completed online via the encounter staff desktop terminal emulator which allows access to PMMIS or by submission of a replacement or void encounter. Replacement encounters contain corrected claims data and reference the CRN that corresponds to the new day encounter. Voided encounters reference the original CRN as well and serve to place the new day encounter into a void status.

Tracking Encounters

All deleted, overridden or voided encounters are logged for proper tracking including the date of action, CRN and reason for action taken. AHCCCS denied encounters are extracted from the 277S report. The replacement/void process is utilized to correct these encounter as well.

In the event that a form type A, B or D claim require correction following the initial encounter submission, the CRN is voided in PMMIS as well as the claims payment system and a new claim is adjudicated and assigned to a future claim run assuring the correct claim will be submitted as a new day encounter. Form type C corrections are performed by the PBM and reported within the encounter data file submitted to P/GLTC where the CRN is added file before submitting to AHCCCS.

Throughout the submission and correction process P/GLTC addresses data accuracy and timeliness. In order to monitor completeness, P/GLTC creates and reviews the Encounter Submission and Tracking Report (ESTR) monthly. The ESTR reconciles encounter data by linking claims/claim lines to an adjudicated encounter and shows by form types and month of service, the number of claims converted to encounters, new day encounters submitted and the number of adjudicated and pended encounters returned to P/GTLC.

Encounter Validation

In response to new AHCCCS reporting requirements effective with the April 2011 submission, P/GLTC is developing four reports submitted to the AHCCCS Encounter unit on a monthly basis. The reports capture the number of financial fields for finalized claims subsequently submitted as encounter data, validator submission and success rates, encounter adjudication cycle results, aging pended encounters, and written analysis regarding variances.

To assure claims data is mirrored in PMMIS, P/GLTC uses the AHCCCS Encounter Quarterly Data file to compare claims payment system data to PMMIS data. Omissions and inconsistencies are researched by encounter staff followed by appropriate corrective action, such as submission of a replacement encounter, then analyzed for root cause and trends or anomalies. Additional verification of meaningful data occurs when AHCCCS conducts annual encounter validation studies. P/GTLC encounter staff assists with these studies by reviewing and researching the AHCCCS preliminary report and provides feedback regarding omissions.

Remediation Process

When determining appropriate steps for correction and process or system improvement, P/GTLC staff and management first identify and define the type of issue to understand the appropriate remediation steps to take (see below). The P/GLTC encounter team analyzes pended encounter error types to aggregate and trend procedural and/or system deficiencies. Following analysis, the team shares findings and reports with the CFO and the Claims Manager at bi-weekly cross functional meetings. An Encounter Specialist and System Administrator attend weekly claim team meetings to exchange feedback regarding identified trends and corrective measures. The encounter team stays updated on the most recent changes and updates related to encounters and the technical aspects of the PMMIS system and its edits. They routinely

attend training offered by AHCCCS, review the quarterly Encounter Keys newsletter, and receive Communications E-mail from AHCCCS. In addition, the team meets collaboratively on a quarterly basis with AHCCCS staff to submit and discuss issues such as top errors, trending issues, data anomalies, and solutions.

Internal system-related issues –	P/GLTC System Administrator and EDA determine if issue is related to EDIWorks export logic or system adjudication logic or work with system vendor as needed.
Claims processing issues –	Determine root cause at cross function meetings. Provide additional training to claims staff. Prepare corrective action in collaboration with Claims Manager if necessary.
PMMIS system-related issues –	Provide feedback to Encounter Unit at AHCCCS.

Ultimately, meaningful encounter data begins with the provider. P/GLTC routinely offers provider education/training in several ways:

- Communication with Provider Representatives to provide feedback and resolve issues
- Newly contracted providers are given an orientation specific to billing requirements by a representative of the Claims Department
- The Provider Manual, distributed annually and available online, contains information regarding claims submission requirements, timelines, and the definition of a "Clean Claim". Claim forms are included in the manual to assist in identify required fields and other related information.
- Claims related education is available to providers via a designated phone line which is staffed by P/GLTC Claims Specialists acting in a provider liaison role
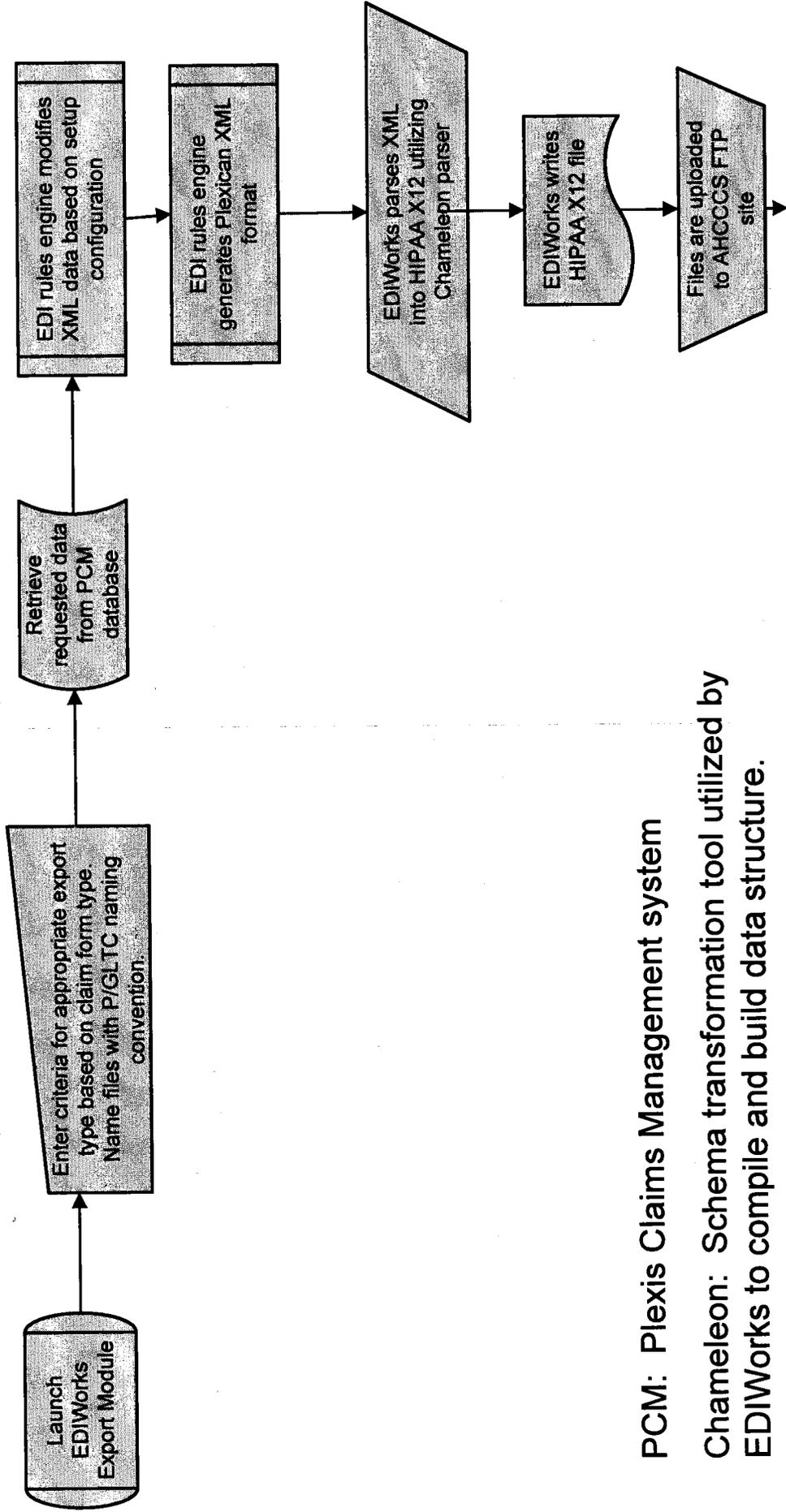
- Registered providers can access claim and member information via the P/GLTC online claims status portal. Detailed explanation of payments can be reviewed including claim line payment/denial explanation and process date. The mailbox component of the portal enables providers to communicate with Claims Specialists through web-mail and conduct root cause analysis of claim denials and re-submission process.

Exhibit 10-1
Feedback Mechanisms Contributing to
Meaningful Encounter Data

P/GLTC Pended Encounter Analysis

ESTR

TPL Verification

Validator Success Rate and Error review

Claims Preliminary EOB Monitoring

Post Payment Claims Review

Timely, Accurate and Complete Encounter Data

Electronic Claims Validation

Monthly Encounter file Submission Reconciliation

AHCCCS Quarterly Data File

Prepayment Claims Review

Adjudication Edits
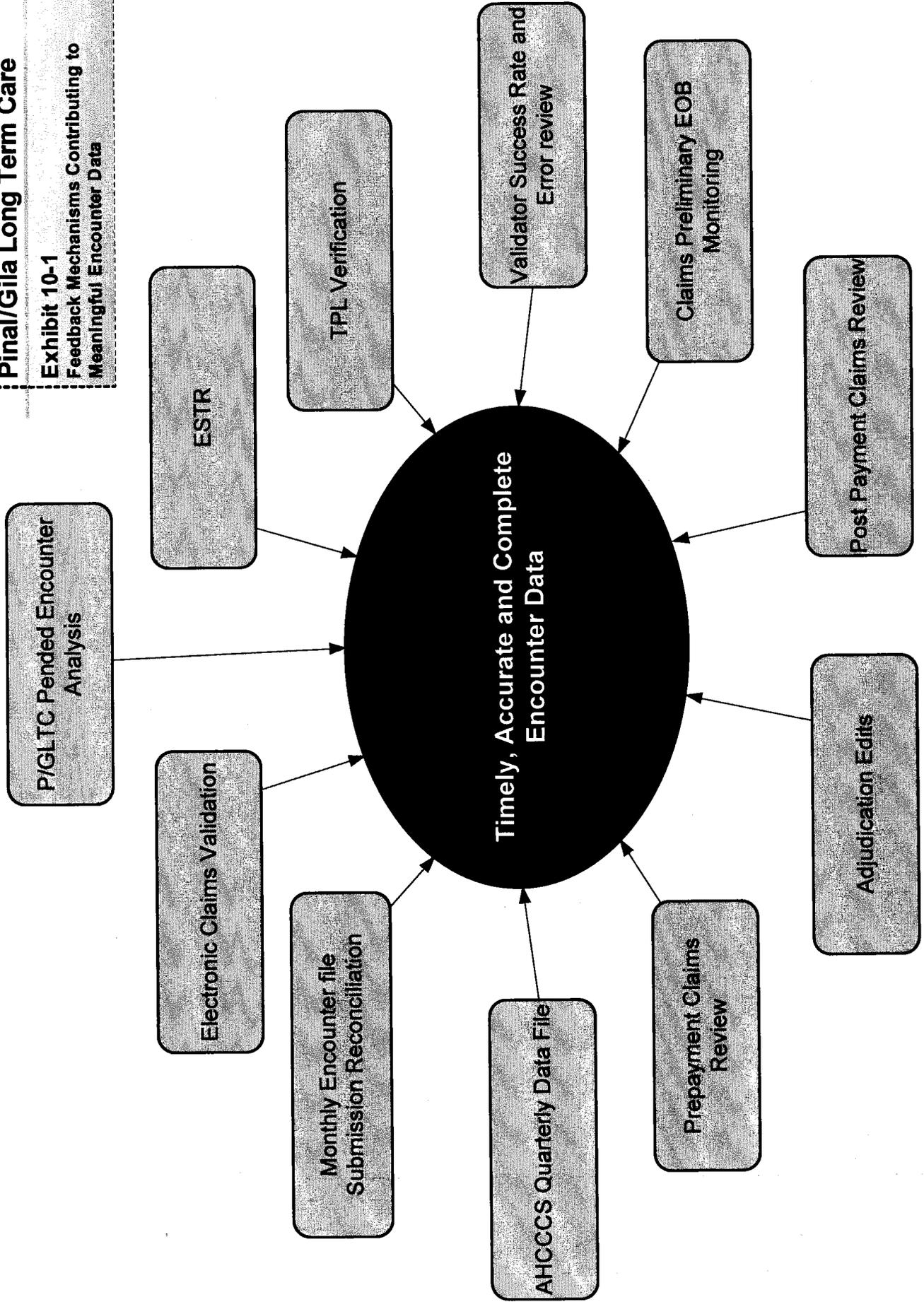
Pinal/Gila Long Term Care

Exhibit 10-2
EDIWorks Export Procedure

Launch EDIWorks Export Module

↓

Enter criteria for appropriate export type based on claim form type. Name files with P/GLTC naming convention.

↓

Retrieve requested data from PCM database

↓

EDI rules engine modifies XML data based on setup configuration

↓

EDI rules engine generates Plexican XML format

↓

EDIWorks parses XML into HIPAA X12 utilizing Chameleon parser

↓

EDIWorks writes HIPAA X12 file

↓

Files are uploaded to AHCCCS FTP site

↓

FTP folder swept and data loaded into Transaction Insight by AHCCCS

PCM: Plexis Claims Management system

Chameleon: Schema transformation tool utilized by EDIWorks to compile and build data structure.

Plexican: Proprietary XML format

Pinal/Gila Long Term Care

Exhibit 10-3
Transaction Insight Error Resolution

AHCCCS sweeps FTP folder and loads data into TI

Records contained within files are processed against TI edits and audits

Did records pass TI validation?

Yes → Records are loaded into PMMIS awaiting adjudication cycle

No ↓

Can record be corrected within the TI Portal?

Yes → Correct record, revalidate and submit → Records are loaded into PMMIS awaiting adjudication cycle

No ↓

Assign record to appropriate encounter staff member

Filter records in the My Tasks tab in TI by assignment for list of claims requiring correction

Correct claims in the claims payment system and assign to correction batch

Forward batch name to EDA

EDA exports claims into TIC file according to EDIWorks Export Process

TI: Transaction Insight – Validation portal
PMMIS: Pre-paid Medical Management Information System
EDA: P/GLTC Electronic Data Analyst
TIC: Transaction Insight Corrections – part of P/GTLC encounter file naming convention

Pinal/Gila Long Term Care

Exhibit 10-4
Pended Encounter Resolution

PMMIS adjudication cycle runs

↓

277S and adjudication reports are received from AHCCCS

↓

277S is imported into CRN Database

↓

AHCCCS denials are extracted from database and reported to P/GLTC Encounter Analyst

↓

EDA forwards results of adjudication cycle and reports to Encounter Analyst

↓

Can encounter be corrected online?

— Yes → Encounter Analyst corrects pended encounter in PMMIS → Encounter Analyst corrects claim in claims payment system

— No ↓

Is pend error for duplicate/near duplicate?

— Yes → **Is duplicate pend due to duplicate file submission to AHCCCS?**

— Yes → Void duplicate encounter in PMMIS → Void the duplicate encounter in PMMIS and log in P/GTLC void log.

— No → Resolve pend in PMMIS by utilization of appropriate override code and note reason for override.

— No (from Is pend error) → New day claim that corresponds to pended encounter is voided in claims payment system and a new corrected claim is entered utilizing an EOB code of "CRNReplace" and referencing original CRN

↓

Claim number is forwarded to EDA for extraction as a PC file type

↓

EDA exports claims into PC file according to EDIWorks Export Process

PMMIS: Pre-paid Medical Management Information System
EDA: Electronic Data Analyst
CRN: Control Reference Number
EDIWorks: EDI Gateway
PC file: Pend Correction File

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Pinal Gila Long Term Care

Requirement 11: Describe the Offeror's information services organization and the hardware and software that will support the AHCCCS line of business, including a diagram of the information system and data processing flow with all existing or planned interfaces.

P/GLTC has successfully used the Plexis Claims Manager (PCM) for the past six years. This is the same system to be used under the new contract. PCM, its upgrades and additional support components, continues to furnish P/GLTC and AHCCCS with the most current hardware and software required to support our long term care business. An overview of the Information Systems Data Process Flow is included as Exhibit 11-1. Exhibits 11-2, 11-3, and 11-4 are noted throughout the text. The Citrix Farm Hardware is shown in Exhibit 11-5.

The Pinal County Information Technology (IT) Department provides constant and direct technical assistance to P/GLTC that supports the business needs. Dedicated, Microsoft certified IT staff work in conjunction with P/GLTC departments and system vendors to ensure system stability. The overview of all P/GLTC systems and data flows can be found in the following narrative.

P/GLTC entered into a contractual relationship with Plexis Healthcare System in June 2004. Plexis software employs a flexible, rules-based engine. This rules-based architecture promotes development of a seamless healthcare information system that is tailored to the needs of P/GLTC. In March 2005, a full system conversion, including claims and benefit administration system, *Plexis Claims Manager* (PCM), and a related EDI gateway product *EDIWorks*, was completed. In January 2008, P/GLTC converted from QuickBooks Pro to *Great Plains*, a Microsoft product An interface tool, *Great Plains Interface* (GPI), designed by Plexis Healthcare Systems, transfers claims data from the general ledger system *Great Plains* into PCM. Great Plains houses all provider payment data from which ACH files are generated to electronically transfer funds to providers.

The Provider Information Management System (PIMS) is a proprietary database that houses provider data including: demographics,

contract information, and provider contact notes/inquires. PIMS also features reporting mechanisms for monitoring contract terminations, contract inclusion (insurance and licensure), and timeliness standards. Provider information is downloaded from PCM to PIMS daily to ensure PIMS contains current and complete contracted provider data.

In conjunction with the implementation of the claims system, a relationship was established with Claimsnet, a claims clearinghouse. to process claims electronically. A business relationship was also developed with TPABenefits – a web based product that interfaces with the PCM database to allow providers access to member eligibility and claim payment status though a web based portal. An online e-mail directly to the Claims Department is available to providers from this portal.

P/GLTC contracted with CH Mack in October 2004 and purchased a case/medical management program – Q Continuum which houses member information including assessments, member demographics, care plans, service plans, and medical management.

These systems are supported by a Citrix Farm of production servers and SQL servers maintained by the Pinal County IT Division. A full time IT staff certified in Microsoft is dedicated to P/GLTC. This staff member works closely with the local systems administrators, front line staff, and vendors.

Each of the systems is outlined in detail in the subsequent pages followed by descriptions of data processing flow, data validation, reporting, and hardware.

Plexis Claims Manager (PCM)

PCM is a complete healthcare claims adjudication and benefit administration system. It supports many different payment contracting and fee schedule types, to achieve high auto-adjudication rates. Its technology platform is Microsoft SQL Server RDBMS, and it has a graphical Windows interface for ease of navigation. PCM runs in a Windows Operating System. PCM is supported on a standard Microsoft SQL Server database and utilizes Visual Basic 6.0 programming language.

The Open Database Connectivity (ODBC) compliant structure allows for ease of data passing to and from various applications. Virtually any ODBC compliant application including MS Office applications such as Access, Word, or Excel can be linked to PCM for routine and ad hoc report generation, query responses, and other administrative functions and data manipulation. PCM also has drill down features which allow movement from screen to screen with no need to close each individual object before viewing the next.

Claims: PCM allows data entry (or import) by form: CMS 1500s for professional services and UB04s for inpatient, outpatient, and institutional services. The screens are formatted to resemble the paper counterpart for ease of entry. Upon entry of a member or provider ID in the claim screens, the system auto fills the corresponding first and last names. Search options are available when member and provider names are entered. Search options are also available for paid claims, by claims number, member name/ID or servicing provider name/ID. The system contains data dictionaries which house CPT4/revenue codes, diagnosis codes, place and type of service. These tables can be modified by the P/GLTC system administrator. Claim numbers are system generated and auto-assigned when the primary data entry screen is opened or upon import of electronic claims files. The numbering convention is sequential and includes the date entered and a "batch code assignment"; three alpha characters

representing the claims processor (i.e., 05012008xxx0001).

Members: PCM houses and stores data for current and termed members. The main member screen reflects demographics, all eligibility spans, benefits through specific Benefit Contracts (ALTCS, PPC, Acute Only), Primary Care Physician (PCP) assignment, case manager assignment, Rate Code, and Member Share amounts. Third Party Liability information (commercial insurance and Medicare), claims history, and authorizations can be accessed via "buttons" that link to the applicable tables.

Providers: PCM is the primary repository of provider data, including provider ID (AHCCCS ID), mailing address, physical address (s), provider category (i.e., PCP, Specialty Care Physician (SCP), or Hospital, and provider specialty (i.e., family practice, cardiologist, or dentist). Searches can be performed by category or specialty, generating on-screen query results. All providers are assigned to a specific network to define reimbursement or medical group affiliations. Vendor information including: tax identification number (TIN), pay-to address, and National Provider Identifier (NPI) are also maintained in PCM.

Medical Management/Authorizations:
Authorization screens contain the same searchable fields for member and provider as the claims entry screens. Several fields have drop-down options that can be defined by the system administrator, including Category, Urgency, and Type. A grid within the screen holds detailed information related to the authorization. This grid contains: referred to provider, requested/approved amounts, type of service, and options for multiple date spans specific by procedure codes. As with the claim number, the authorization number is sequential and includes the date entered and a batch code assignment representing the authorization staff.

Security: Role-based security is locally maintained by the system administrator. Access

is closely guarded and limited by individual and specific function (i.e., claims adjudication, authorization entry, and import/export processes).

EDIWorks
EDIWorks is an EDI gateway of Plexis Healthcare Systems which is HIPAA compliant and Claredi certified. It includes an X12 (HIPAA standard) to XML parser engine and a business logic layer that controls the inserting of data into the PCM SQL database. All X12 formats are Claredi certified and HIPAA EDI compliant. EDIWorks is used for exporting data from the PCM SQL database back out to X12 (HIPAA) and propriety formats. Its import/export functions include:

- The creation and export of AHCCCS required/HIPAA compliant encounter files generated from paid claims data
- The import of AHCCCS Claim Record Number (CRN) and placement into a database which houses encounter data with a direct match to PCM claim numbers
- The import of 834 (eligibility) files containing AHCCCS member eligibility rosters into PCM
- The export of 835 (electronic remittance advice)
- The import of electronic claim files using predetermined rules files to ensure complete and accurate passing of data into the PCM claim forms

PIMS
P/GLTC utilizes a proprietary system known as the Provider Information Management System (PIMS) to track, trend, and analyze both incoming and outgoing provider inquiries and complaints, appointment waiting times, and 'no show' reports. The system stores data that is utilized for several purposes including provider education documentation, provider contract information, provider inquiry trend analysis, and monitoring of concerns and complaints. Additionally, PIMS is used for storing contract monitoring and site visit documentation for physicians, attendant care providers, SNFs, and assisted living homes and centers. Provider data is uploaded from PCM daily.

Claimsnet
Claimsnet is P/GLTC's contracted claims clearinghouse. Providers submit claims data via multiple methods such as spreadsheets, HIPPA compliant 837 file or proprietary online interfaces. This data is batched and translated daily into an inbound 837 file according to claim form type (Professional, Institutional or Dental). P/GLTC downloads files via SFTP and places them in a network folder for importing into PCM. Providers must register to utilize Claimsnet to utilize their services. A link is available on the P/GLTC website.

TPABenefits
TPABenefits is a web-based portal which interfaces daily with the PCM database and allows providers to access member eligibility and claims status. The web site is hosted by TPABenefits. Providers use a secure logon and access member eligibility information (including Rate Code) and claim status. Claims status is searchable based on a variety of criteria; member name, member ID, date of service span, paid date, and claim ID. The on-screen report includes fields found on a standard Explanation of Payment (EOP)/Remittance Advice:
- Member name
- Procedure code
- Units
- Billed Charges
- Paid amount
- Explanation of Benefit (EOB) codes/descriptions
- Paid date

The searchable provider directory can be found within the portal as well as on the P/GLTC website.

An e-mail application is available directly from the website. The mailbox component of the portal enables providers to dialogue with a Claims Specialist through web-mail and conduct root cause analysis of claim denials and the re-submission process.

The portal also serves members. Through a secure registration process a username and password is established by the member. The member's dashboard is customizable and includes a health news and resource gadget, a video library which offers information on a variety of topics ranging from Allergies to Women's Health, and EOB information. The e-mail application is available to members as well.

Q Continuum

Q Continuum system is a SQL program that serves as the primary repository of member information, including all assessments, member demographic information, assigned provider information, medical and health information, service schedules and plans, care plans, and case notes. All case management functions are either contained within or launched from the main member intake window, called the Member Main Demographic Set (MDS) Window. The Member MDS window has several tabs used to store information:

Member Data: Stores the main demographic information of the member.

Address/Confidentiality: Displays the information related to who entered the member data, the user restrictions related to who can access the record, and any outside documents linked to the member record. This window also stores the name and address fields used if separate information is needed for mailing addresses.

Programs: Identifies the medical/social services programs in which the member is currently enrolled; i.e., ALTCS, ALTCS Transitional Program, or Acute Care Program.

Physicians: Lists the PCP who provides medical care for the member.

Other functions accessed through the MDS:

Assessments: These screens hold comprehensive member information gathered according to the area being assessed, i.e.,

activities of daily living (ADLs), instrumental activities of daily living (IADLs), support systems/contacts, insurance information, medications, medical diagnoses, living environment, psychological functioning, and cognitive status.

Case Notes: Documented contact with and about the member is entered in the case notes. The type of note (initial contact, review visit, wounds, hospital admission, etc.) is designated along with the date of occurrence. At the end of each day the note is locked and cannot be altered or deleted. The note identifies the writer's name, the date, and time created.)

Care Plans: The member centered, mutually agreed upon goals for the member is documented in this area, including strengths barriers, and planned interventions. The service plan, including the detailed schedule of services, units, and cost is developed from the problems and goals of the care plan. Once finalized, the service plan is printed with additional information drawn from the database and entered as an authorization in PCM.

Disease Management (DM): This module holds information related to members' chronic conditions, immunization status, and advance directives. Documentation of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits and member education and outreach can also be documented on this screen. Each chronic condition screen includes health status assessment questions, an area to document episodic contacts, and the evidence based performance metrics for that member. The chronic conditions included in the Q system are obesity, osteoporosis, congestive heart failure, and diabetes mellitus. Data are entered by the Medical Management nurses in collaboration with and based on information from the interdisciplinary care team, provider, and member. The DM module documents member status over time, providing a data source for the development and management of prevention, performance improvement, and clinical guideline based initiatives.

EPSDT Monitoring/Reporting:
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) data are entered into Q in order to maintain documentation and track preventive services for members under the age of 21. The system contains data obtained from members, providers, or through paid claims. Reports are generated to identify children who are due for, or have not received required services in the timeline defined in the AHCCCS EPSDT Periodicity schedule. This information is used for targeted outreach to members and providers through letters, postcards, phone calls, or personal contact by outreach staff.

Concurrent Review:
Data collected during Concurrent Review (CR) are entered in the Medical Authorization module on the MDS window. A new screen is opened for each hospitalization. Information collected during CR includes, but is not limited to, date of admission, admission type, actual length of stay, discharge date, facility, service type, and assigned physician. The CR nurse reviews the severity of illness (SI) and intensity of service (IS) needs of the admitted member and compares the member status against the McKesson Inter-Qual admission criteria. Based on the criteria and presenting needs of the member, the admission is approved or pended for medical director review. Approval for subsequent days is based on Continued Stay reviews. All member information supporting the SI or IS status, is reviewed by the CR Nurse and/or medical director, and decisions and findings are documented in the CR module. Reports from the CR module reflect daily review information, medical director consultation, whether the day meets criteria, tracking of review requests and denial letters, and provides a complete picture of the hospitalization.

The Q Continuum system is flexible and allows configuration of dropdown choices. All contracted providers, rates, procedure codes, and AHCCCS ID numbers are fields that can be modified by internal staff. Any field can be annotated so that additional information can be entered and printed out. All screens can be formatted and printed so that customized reports can be generated by individual nurses, case managers, supervisors, and administrators. Reports from the Q system have greatly increased P/GLTC's efficiency and reliability with respect to member specific trends, tracking, and reporting.

Tablets and laptops are an integral component of the utilization of Q Continuum and the case/medical management functions. P/GLTC nurses and case managers use these specialized laptops to download member information from Q Continuum and input pertinent information from a member visit. Upon return to the office, the information is uploaded into the Q Continuum system.

Great Plains
Great Plains is the software application for General Ledger and Accounts Payable activities. Every Type of Service (TOS) in PCM is assigned a G/L account profile which equates to a general ledger number per the P/GLTC chart of accounts. Each procedure line in the paid claim includes a G/L account profile based on the TOS. These numbers interface into Great Plains via a customized module developed by Plexis Healthcare Systems – GPI (Great Plains Interface). The interfaces are specific by adjudication run and paid date semi-weekly. Provider Vendor IDs, synonymous with Tax IDs are also included in the transferred data. The Electronic Data Analyst (EDA) obtains account and routing numbers from providers during the EFT registration process. The P/GLTC Accounts Payable Specialist enters and maintains this information in Great Plains. Once the interface is complete an ACH file is created and transferred via SFTP to the P/GLTC bank for electronic funds transfers to EFT designated providers. The bank faxes an error/rejection report directly to the EDA for correction as necessary.

Data Processing Flow
The data processing flow begins when AHCCCS assigns new members to P/GLTC. (Exhibit 11-1) The EDA retrieves 834 files which contain new member enrollment information and

current member changes from the AHCCCS FTP site. The Electronic Data Analyst imports the files into PCM via EDIWorks. (Exhibit 11-2) To ensure data accuracy, a HIPAA EDI viewer/editor is used to display the contents of the 834. A translated copy is forwarded to P/GLTC Member Service Representatives (MSRs) for data entry in Q Continuum. This information includes; member name, member AHCCCS ID, date of birth, address, rate code, contract type (ALTCS, Acute Care Only and Prior Period), and COB information.

When P/GLTC determines there is a need for a particular provider type or when current contracted providers are due for re-credentialing, the credentialing process is initiated. Utilizing reports from the Arizona Department of Health Services (ADHS), the P/GLTC Credentialing Coordinator assembles credentialing materials of potential and existing providers. The Organizational Credentialing Committee meets monthly to review provider files. The Provider Credentialing Committee meets quarterly. At the same time, the information is sent to a provider relations representative and a QM RN who perform site visits and medical record reviews to determine a provider's ability to meet the credentialing requirements of P/GLTC and AHCCCS. Once the site visit and credentialing are performed, a formal contract is developed. The contract is routed through the Pinal County Board of Supervisors for approval. Upon approval, the contract documents are attached to a Provider Maintenance Form and forwarded to the PCM System Administrator. A copy is transmitted to the provider by the Network Management and Development Department.

The Provider Maintenance Form is a data entry tool and contains provider demographics, specialty, network, and reimbursement specifics. The PCM System Administrator verifies provider status, AHCCCS ID, and NPI in the AHCCCS Prepaid Medical Management Information System (PMMIS). The verified information is then entered into PCM and Q-Continuum. The Claims Manager audits all new and renewal provider contract loads to verify

reimbursement rates are accurately reflected in the designated fee schedule and that providers are assigned to the appropriate network in PCM.

Authorization information is housed in both Q Continuum and PCM. The basis of the authorization data is the member service plan which resides in the source system, Q Continuum. The service plan includes procedures, units, date spans, and providers. An automated daily service plan report is distributed to Member Service Representatives (MSR) who, in turn, update Home and Community Based Services (HCBS), Behavioral Health Services, and nursing facility authorization data in PCM. Medical Management nurses and support staff also enter authorization data into PCM for Acute Care services. They review historical PCM claims data as needed in the authorization process. An automated daily authorization report is sent via secure e-mail to those providers who have requested electronic authorizations. During the claims adjudication process PCM performs a search for valid authorizations which correspond to claims as per the business rules developed during initial system setup.

Providers who have requested proper authorization and provided services to P/GLTC members submit claims for payment. Claims are submitted and received on paper or electronically. (See Exhibit 11-3). Paper claims are entered into PCM. Electronic claims are received through an inbound HIPAA compliant 837 from Claimsnet via SFTP. 837 files are imported into PCM via EDIWorks. Adjudication is initiated in batch mode and predetermined business rules are followed such as eligibility, provider status and appropriate authorization. The system applies clinical and data edits such as NCCI, member eligibility and benefit coverage, provider contract, payment method, fee schedule, and authorization requirements. Historical claims data is stored in PCM and is available as a research tool for Claims Specialists (and other departments such as Medical Management). Search criteria include

member name and ID, claims ID, rendering Provider, DOS, and procedure code. Following adjudication the claims/procedure lines fall into one of three statuses; APPROVED, PEND, or DENIED. Pended claims are reviewed by Claims Specialists and distributed to the applicable department for pre-payment review and paid or denied as per pre-determined criteria.

Upon completion of the adjudication process, Claims Specialists run a preliminary Explanation of Payment (EOP)/Remittance Advice report which is reviewed for accuracy of paid amount, provider tax identification number, and pay-to address. The paid date is closed and the final EOP is generated and reviewed and approved by the Claims Manager. The final EOPs/remittance advices are sorted by provider and submitted to the County Finance Department for check generation and mailing for those providers not registered for EFT services.

Paid claims data is interfaced into Great Plains through the interface application GPI. The interface sends detailed claims information by type of service which translates into specific general ledger account numbers in Great Plains. This information becomes the basis for medical expense included in financial statements. Accounting staff initiate the interface process between Great Plains and PCM and claims expense is translated to the general ledger system accounts. An ACH file is then generated to initiate electronic funds transfers (EFT). The remittances for those providers requesting EFT are transmitted electronically on the day of transfer.

Post payment audits are performed on random samples of processed (paid and denied) claims pulled from each paid date and reviewed for accuracy and timeliness. Areas audited to ensure compliance are timeliness, authorization requirements, Coordination of Benefits (COB), accuracy of provider/vendor information (i.e. Tax Identification Number (TIN), pay-to address), fee schedule accuracy, trauma code identification, and decision/denial

reason. Another category of post payment audits is performed on claims with third party liability (TPL) to ensure P/GLTC is processing claims as the payor of last resort.

The Claims Manager performs contract load auditing for 100% of new and renegotiated contracts. The areas audited include; provider demographics, effective/termination dates, tax identification number, rates and fee schedule assigned in the System. Ongoing audits of claim paid amounts against contract rates are a component of the standard post payment audit process described above.

Encounter files are created utilizing EDIWorks. Encounters are exported based on paid dates to ensure all processed claims are included for submission. The files are formatted in an X12 format in accordance with HIPAA regulation and AHCCCS requirements Encounter files are submitted by claim form type, 837P (Form A), 837I (Form B) and 837D (Form D), NCPDP (Form C), and Plan ID. (See Exhibit 11-4) These files are then placed on the AHCCCS FTP as per protocol. Upon completion of the cycle, AHCCCS places a 277S file on their FTP containing Control Reference Numbers (CRNs) which is imported into a local database to match to PCM claim ID for reporting and analysis purposes.

Member, provider, and claims data is accessed by the provider network via the web based portal, TPABenefits. A daily automated process sends member, provider and claims information to TPABenefits. This information is available for viewing and reporting for registered providers. An online provider directory is accessible to members and providers with no registration requirement.

Data Validation
Data validation occurs throughout the information system organization. P/GLTC Financial Analysts validate data for completeness, accuracy and to ensure staff accountability. Monitoring is continuous and occurs at various intervals quarterly, monthly or more frequently as needed. Areas monitored include:

- Member information
- Authorization Data
- Provider Data
- Encounter Data
- Financial Data
- Quality and Performance Measures

Member Information
Financial Analysts run monthly reports to ensure PCM and Q Continuum contain consistent member information including demographic information, Primary Care Physician (PCP) assignment, AHCCCS contract type (i.e. ALTCS, Prior Period or Acute Care), eligibility/enrollment dates and third party payors. Data from the 834 download is verified in both systems. A date of death report is also run monthly to ensure no claims are paid for dates of service that extend beyond the date of death.

Authorization Data
Service plan information is entered into the medical management system – Q Continuum and the authorization module of PCM. Reports are run monthly and quarterly to verify maximum dollars approved, effective/term dates, procedures approved, units approved and servicing providers. The report is also reviewed to identify duplicate authorizations.

Provider Data
Financial Analysts have also developed reports that compare PCP assignments in PCM and Q Continuum. These reports are distributed to the MSRs for validation and correction.

Encounter Data
Encounters are monitored by Encounter staff and included in the Encounter Submission and Tracking Report (ESTR). This report measures the number of claims in each payable batch and is compared against the number of encounters submitted and validated as a new day encounter. The report assures completeness of all processed claims data, the assignment of a unique CRN and adjudication as encounter data.

Financial Data
Claims expense information is transferred from PCM into the general ledger via an interface via GPI. In order to ensure both completeness and accuracy of the data, the amount of claims data expense is reconciled against the amount of the transferred by paid date/payables batches. The total amount of expense transferred is compared to the total amount of the provider remittance advices for the month. The incurred but not reported (IBNR) methodology is primarily case basis which is authorization driven. The authorization data validation also ensures the amount reported in the IBNR is both accurate and complete.

Quality Data and Performance Measures
P/GLTC validates quality data and performance measures using several outside data sources:
- NCQA - HEDIS for benchmarks, measures of effectiveness AHCCCS Benchmarks - allowable codes, maximum allowable units, payment
- AHCCCS Data Warehouse [over/under utilization]
- Centers for Health Care Strategies - prevalence, Medicaid and chronic illness priorities, integration of care for Medicaid & Medicare dual eligible
- CDC - Benchmarks, prevalence, burden of illness
- Institute for Healthcare Improvement - prevalence, improvement, prioritization, modeling
- Hayes - new therapeutics
- Noridian - criteria for utilization decisions

Reporting
PCM and Q Continuum, both relational databases, are extensively used in providing reports to all departments of the organization on a scheduled or ad hoc basis. Data is routinely "mined" from paid claims, authorizations, and medical management information to provide Executive Management with up-to-date information. This information is then utilized to make informed decisions regarding utilization management, quality management, effectiveness of outreach

initiatives, compliance and financial management.

Following is a summary of the type of reports generated as well as a sample of specific reports used through out the organization. Overall, approximately 150 types of reports are published on a recurring basis. Of these, over 10% are currently automated. P/GLTC 's goal is to automate 25% of all reports within the first contract year.

Finance – Data Validation, Trauma Code, IBNR, Cost Avoidance/Recovery, Patient Days, Member Months, Claims Dashboard

Case Management – Initiation of Services, HCBS services by provider, Member Cost Effectiveness Studies (CES), Universal Assessment tool (UAT), Behavioral Health-Care Plan Report, Admission/Discharge, Disaster Registry

Medical Management - Inpatient re-admits/Discharges, Average Length of Stay, Patient Days, Psychiatric Admission, Referral Turnaround, Clinical Indicator and Performance Measurement, Disease Management, Durable Medical Equipment (DME) Turnaround

Quality Management – Clinical Indicator and Performance Measurement, Pay for Performance (Flu/Diabetic), Diabetic Monitoring, Advance Directive Monitoring, Behavioral Health Advance Directive Monitoring, EPSDT reports, Top Diagnoses

Network Development – Network Summary, Member Demographics, Non-Provision of Service, Provider Turnaround, Unit Cost Report

PIMS is also a relational database and was developed to track contract status, insurance and licensure requirements and provider inquiries. Financial Analysts routinely run contract reports to proactively monitor termination dates for contracts, licenses and insurance policies. Using iteration logic, letters and mailing labels are created and sent to

providers as reminders of upcoming deadlines. Provider Relations staff run additional reports to monitor response and resolution timeliness to provider inquires, three days and 30 days respectively.

Hardware
The hardware that supports the systems described above includes a Citrix Farm (Exhibit 11-5) of six production servers (running in redundancy) which hold the front end programs, i.e., PCM and Q Continuum, and three SQL servers that house the data. Citrix accelerates the performance of the applications, reduces wait times and allows end users the ability to harness the processing power of the servers. Due to the number of servers in the Citrix farm, if any one fails, the end user will not be affected as the auto fail over to one of the other servers is nearly seamless. One production server is reserved for testing along with one SQL server. New application releases are placed on these servers to allow for a safe environment with no danger of data corruption. Once new releases are certified, the Citrix Farm allows for almost instantaneous upgrades and fixes. The production servers running the PCM and Q Continuum products are updated without having to touch workstations, this greatly reduces release time of upgrades and fixes to production software.

P/GLTC utilizes PC tablets and laptops for offsite reviews. The tablets/laptops also act as desktops for Nurses and Case Managers. Data is transferred from the Q Continuum system before an offsite visit and from the tablets back into the system upon return to the office setting.

The specifications of the nine servers and PC tablets are as follows:

SQL Servers (3) – Proliant BL460c G1 Intel® Xeon™ Processor E5450 at 3.00GHz/1MB (blade)
- Intel® Xeon™ Quad-Core Processor E5450 3.00GHz/MB (x2)
- 16GB Base Memory

- Standard SCSI Smart Array E200I Controller
- 72.8 GB HP HSV200 Multi-Path Disk Device
- QLogic Fibre Channel Adapter
- Redundant HP NC373m Multifunction Gigabit Server Adapter
- One (1) 800W Power Supply
- 800W Hot Plug Redundant Power Supply
- Redundant Hot Plug Fans
- Warranty – 5 year next day onsite
- 16381-MB Registered ECC SDRAM Memory Kit (4x 4095 MB)

- 9 Cell Lithium Ion Battery
- WLAN – Bluetooth – Microphone
- Intel Centrino Advanced N6200
- Integrated 1GB Ethernet
- DVD Recordable 8x Max
- 3 year CompleteCare Protection

Citrix Farm-Production Servers (6) - Proliant DL360 G3 Intel® Xeon™ Processor 3.2GHz-2MB (533MHz FSB), 1GB

- Intel® Xeon™ Processor 3.20GHz/2MB
- Intel® Xeon™ 3.20GHz/2MB Processor Option Kit
- 2GB Base memory (2x1024)
- Two 1" Ultra SCSI Hot Plug Drive Bays
- Raid 0 setting
- 36.4 GB Pluggable Ultra320 SCSI 15,000 rpm Universal Hard Drive (1")
- 72.8 GB Pluggable Ultra320 SCSI 15,000 rpm Universal Hard Drive (1") x 2
- Smart Array 5i plus controller (integrated on system board
- Battery Backed Write Cache Enabler Option Kit
- Slim Line CD-RW/DVD-ROM 24X Combo Drive
- 325W HP redundant power supply with IEC cord
- Two (2) NC7781 PC-X Gigabit NICs (embedded) 10/100/100 WOL
- Integrated Lights – Out Management Universal Deployment Rails
- Warranty – 3 year next day onsite

Dell Latitude E6500

- 15.6 inch Anti-Glare LED 512 MB NVidia NVS3100M
- 160 GB Hard Disk Drive – 7200rpm
- 2 GB DDR3-1066MHz SDRAM
- Intel i5-520M (2.4GHz, 3M cache)
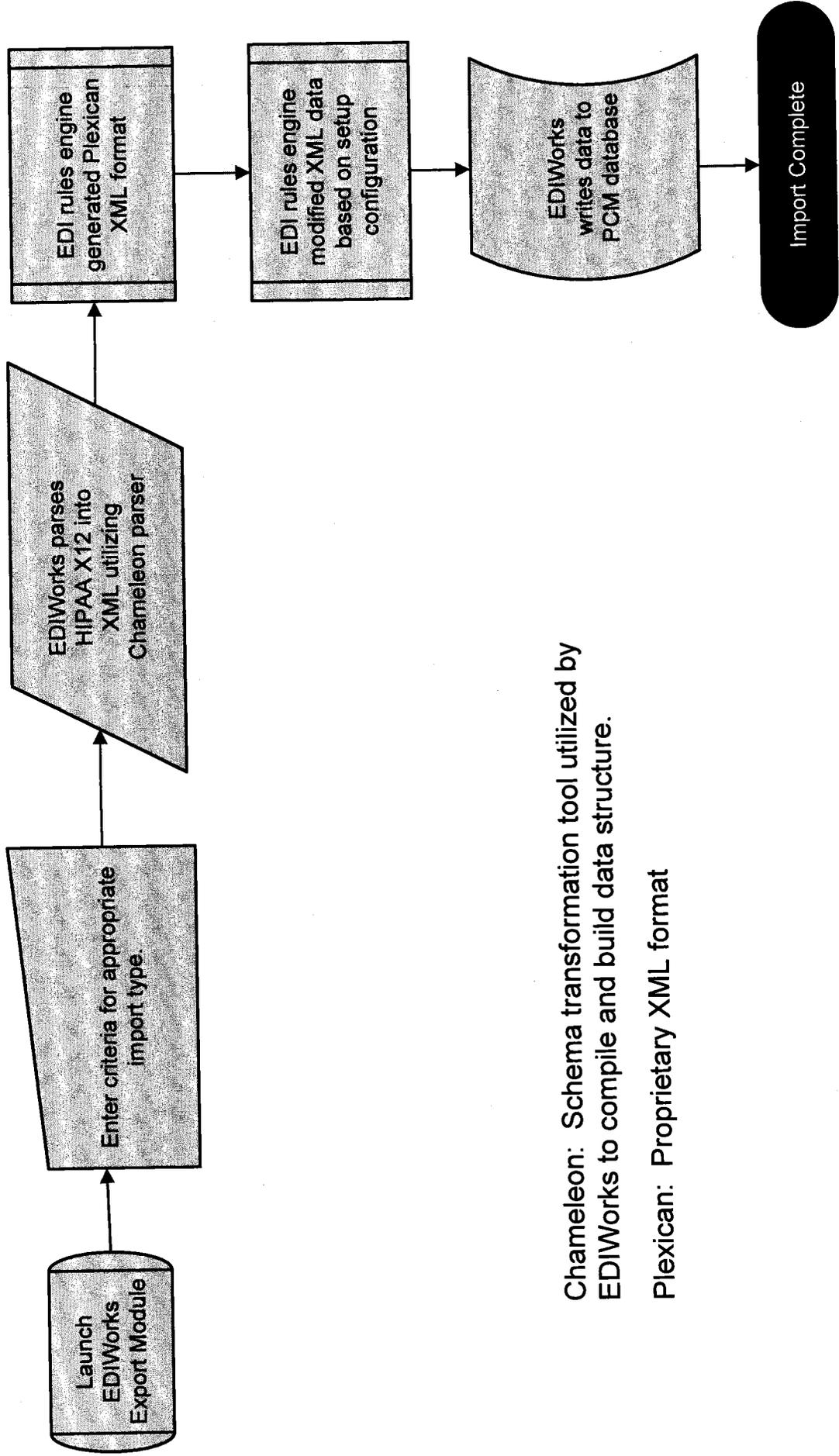

Pinal/Gila Long Term Care

Exhibit 11-1
Information Systems Data Process

EXTERNAL DATA

Service Plan/ Auth Initiation

EPSDT Data

Q Continuum

Tablet/ Q Check-out database

Credentialing/Re-Credentialing Process

Contract Execution

Provider Maintenance form initiated

Provider information verified in PMMIS

Provider information entered into systems

Service plan generated

Service plan entered as auth

New enrollment information entered into Q

Q Data

Data Validation

Claims data is entered into Plexis

Plexis Data

Reporting

Claims file 837 and Member 834 file

Claimsnet

FTP Sites

EDIWorks imports

EDIWorks exports

Prepayment Claims review

Plexis Claims Manager (PCM)

Great Plains Interface

Great Plains General Ledger System

ACH File EFT

Outbound 837

CRN Database

Member information

Claims Information

Provider Information

PIMS

Post payment claim audits

Contract load audits

Financial Statements generated

Paper Claim

Electronic Claims Inbound 837

Eligibility File 834 from AHCCCS

AHCCCS PMMIS

Encounter CRNs

Web based member eligibility, claims status, and provider network

AHCCCS

Pinal/Gila Long Term Care

Exhibit 11-2
EDIWorks Import Process

Launch EDIWorks Export Module

↓

Enter criteria for appropriate import type.

↓

EDIWorks parses HIPAA X12 into XML utilizing Chameleon parser

↓

EDI rules engine generated Plexican XML format

→

EDI rules engine modified XML data based on setup configuration

→

EDIWorks writes data to PCM database

→

Import Complete

Chameleon: Schema transformation tool utilized by EDIWorks to compile and build data structure.

Plexican: Proprietary XML format

Pinal Gila Long Term Care

Pinal/Gila Long Term Care

Exhibit 11-3
Claim Adjudication Process

AHCCCS requirement to pay clean claims = 30 days, P/GLTC Average time = 18 days

Compute Claims Amounts
- Contracted Amount
- Write-Off
- Withhold
- Management Fee
- Deductible
- Copayment & Coinsurance
- COB Deducted
- FFS Equivalent Net
- G/L Account Profile
- Net Pay Due

EOB Code Assignment
By Service Line

Claims Specialists monitor PEND/ DENY status for provider education opportunities

Electronic Funds Transfer, Electronic Remit sent

Interface Paid Claim Data Interface with General Ledger System based on G/L Account Profiles

Post Payment audit sample pulled

Pricing
Payment Method
- Modifier
- Surgery Codes
- Anesthesia Codes
- E/M Codes

Prepayment Review (Day 11-14)

Claim Status
- Pending
- Approved
- Closed

Claim Procedure Status
- Adjustment
- Approved
- Capitated CPT
- Denied
- Hold for Payment
- Pend

Preliminary & Final EOP's Generated (Day 15-16)

Submit EOP's to County Finance for Payment (Day 17-18)

Claim Received Paper/Electronic (Day 1)

Adjudication Run created

Adjudication Run Assigned to Payable Batch

Claim Data Entered/ Imported (Day 2-3)

Adjudication Initiated (Day 3-10)

Claims Review
- Check for Required Fields
- Check NCCI Edit Rules
- Establish Member Eligibility
- Check Benefit Coverage
- Check Initial Timeliness (6 months)
- Locate PCP
- Check for Duplicate Charge
- Check for Prof/Tech Component Conflicts
- Deduct SOC
- Locate Provider's Contract & Verify Coverage
- Locate Fee Schedule Fee Schedule Modifier
- Verify Existence of Valid Authorization
- Check for Multiple Surgeries
- Check for Coordination of Benefits
- Check for Capitated Fee Schedule

Pinal/Gila Long Term Care

Exhibit 11-4
EDIWorks Export Process

Launch EDIWorks Export Module

↓

Enter criteria for export

↓

Retrieval of requested data from PGM database

↓

EDIWorks rules engine modifies XML data based on setup configuration

→

EDI rules engine generates Plexican XML format

→

EDIWorks parses XML into HIPAA X12 utilizing Chameleon parser

→

EDIWorks writes HIPAA X12 file

→

Export Complete

Chameleon: Schema transformation tool utilized by EDIWorks to compile and build data structure.

Plexican: Proprietary XML format

SQL Database cluster
SQL 2005 3+1-Node cluster
Located in Server room

Citrix Farm
4 Production Servers
Win 2003 Load-balanced
Production Plexis and Q

Pinal County
Firewall

End Users
Located in Long Term Care Bldg
Workstation PCs and Tablet users

05SQL1

FDC-CTRX-1

LTC router

LTC Workstation users

05SQL2

FDC-CTRX-3

05SQL3

FDC-CTRX-4

Hub

05SQL4

FDC-CTRX-6

Tape Datadrive Backup Unit

FDC-CTRX-TEST

LTC Tablet users

DEVSQL2005

Development Citrix Server
Win 2K3 OS

DEVSQL03-1

DEVSQL03-2

Pinal/Gila Long Term Care
Citrix Farm Hardware
Exhibit 11-5

Development SQL Database Cluster
SQL 2005 2-node cluster
Located in Server room

136

Requirement 12: Describe the Offeror's information system change order and software modification processes, the date of the last major version update and indicate if there is a planned system conversion with the contract period (five years).

Software Modification Process

Plexis Healthcare System (Plexis)

Plexis Healthcare Systems developed and maintains a software application that allows monitoring and prioritization of all client requests for software enhancements or changes to current functionality. Change control is executed within the Plexis software development process, once base-lined artifacts are produced. For example, if a software enhancement is identified as necessary, then a series of artifacts would be developed, including requirements documents, design documents, etc. If a change is required which affects key assumptions, cost, schedule, functionality, or deliverables, then the change control process is initiated and documented. Pinal/Gila Long Term Care (P/GLTC) is involved at each key decision step and the resulting decision documented. Plexis maintains systems and processes for source code and version control with standard software development systems (Visual Source Safe, CVS, etc). As development work is scheduled for various modules, the application database is reviewed to determine if there are other client requests for functionality that can be included in the scheduled development work in a particular module. Enhancements or changes to functionality are bundled in future updates to the Plexis software. This ensures that all clients benefit from the new functionality added to the system.

Pinal County and other clients may request specific development work. These requests are prioritized and added to the development database. Plexis provides a Scope of Work to determine client specific requirements. Once the analysis is completed, Plexis provides a Scope of Work for the development work and an estimated schedule for completion.

Depending on P/GLTC's priorities, the work can be scheduled immediately. Cost effective solutions are indicated so that if the functionality can be added to the system in a

future release, the client has the option to pay for the functionality immediately or wait until the future release and receive the functionality at no cost. Where possible, Plexis facilitates cost sharing between clients for client specific enhancements that are required immediately.

The Plexis Change Control Board meets weekly regarding product version control and the scheduling of future releases. Their role is to review the scheduled development work and determine priories for inclusion in upcoming releases of the Plexis software. Project Managers participate in these meetings to advocate for their clients and to provide input regarding client priorities and schedules.

The last major update to P was May 2010.

Q Continuum

CH Mack's project management methodology incorporates a strong knowledge of the technical aspects of change order management. Within any given project, each work product developed during the project progresses through a series of stages from initial concept to final release.

Each work product initially begins life in a state of *formative development*. As the work product develops, changes are made informally and work progresses using revision control. When the work product reaches an expected state of completeness, it undergoes formal review and acceptance. At the point where the work product first undergoes this acceptance, it is baselined. Once accepted, the work product enters a state of *acceptance* where changes are no longer permitted to the item without formal change control. Finally, after final acceptance, the work product is frozen in preparation for being *released*.

Whenever any user determines that some aspect of an accepted work product should be changed, then that change is submitted to the

Change Control Board via the Change Proposal, which:

- Identifies the requested change
- Identifies the tasks and costs necessary to perform the requested change
- Includes a description of the impact, from the submitting party's point of view, of leaving the work product as-is compared with incorporating the suggested change.
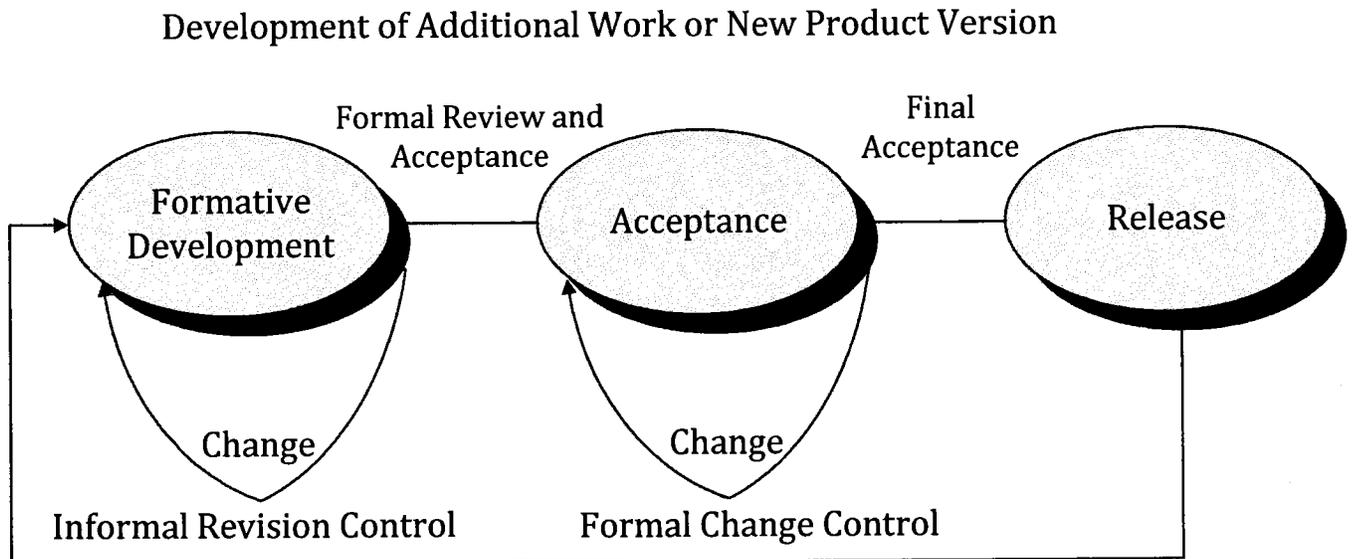- This gives the Change Control Board a better understanding of why the change is being submitted and what importance it has from the perspective of the submitting party

Upon the request of a change or the discovery of a defect, CH Mack will log the request into a Change Control list. The CH Mack Project Manager then tracks this information.

The CH Mack project manager determines when a request needs the formality of the Change Proposal. If the request is a testing error or a production system error, expediting may be a more realistic option. All requests that are not defects must be documented in a formal Change Proposal to be reviewed and accepted by the Change Board.

The last major upgrade to the Q Continuum system was in 2009.

Future System Conversion

There are no plans for any conversions within the next five years for claims and benefit administration or case/medical management systems. There is effort underway, however, for a migration to Plexis' new EDI solution, designed to support all of the HIPAA ASC X12N 5010 document formats required by AHCCCS. The migration will be fully completed with support for all required 5010 documents by the 4th quarter.

Development of Additional Work or New Product Version

Plexis Change Request Management Process

Any Role (Requster)	Plexis Project Office	Project Change Control Board (CCB)	Plexis Change Control Board (CCB)	Project Steering Committee	Project Manager (PM) Design Analysis Technical Writing (DAT) QA Manager (QA) Developers (DEV)

- Submit Change Request to Manager/Lead For Review
- Submit CR for review by Project
- (Incomplete)
- Assess CR Priority, Schedule, Cost, Risk, and Severity
- (Complete)
- Mark CR as a Duplicate
- (Duplicate)
- Determine if Impact Analysis is Required
- Perform Impact Analysis
- (Required)
- Determine if CCB Steering Committee Approval is Required
- (Required)
- Review CR for Scope of Impact
- Determine if Budget and Schedule Estimate is Required
- (Required)
- Review CR for Budget and Schedule Impact
- Update Project Plan (PM)
- Detail Requirements and Dessign (DAT)
- Implement Change (DEV)
- (Rejected via Defect Control Process)
- Test Change and Verify in Build (QA)
- Approve, Reject or Postpone
- (Approved)
- Mark Request as Rejected or Postponed and Notify Requestor
- (Rejected or Postponed)
- Mark Request Complete and Notify Requester

CH Mack Change Procedure

- Client Requests Change
- CHMI Requestee Logs into Issue Tracking System
- Project Manager determines the type of request and verifies that all necessary information is provided
- Testing Error or Production System error?
- Yes
- Determine if formally is required or expedite the change
- Expedite
- No
- Formality Required
- Project Manager creates Change Proposal
- Project Manager submits Change Proposal to Change Board
- Project Manager tracks Status of all Change Proposals

Requirement 13. Indicate how many years the Offeror's IT organization or software vendor has supported the current or proposed information system software version currently operated by the Offeror. If the Offeror's software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

All elements of the information system and supporting systems used by P/GLTC have been in place since before the start of the last contract (2005). All version changes have been tested, installed, and made operational on schedule, without system disruption.

The information systems utilized by Pinal/Gila Long Term Care (P/GLTC) are vendor supported. These systems include: Plexis Claims Manager (PCM), the claim processing and benefit administration system; EDIWorks, an EDI gateway that imports and exports claim payment and member data in an appropriate HIPAA/AHCCCS compliant format; and Great Plains Interface, a tool developed by Plexis Healthcare Systems which transfers claims expense data from PCM to the general ledger accounts in Great Plains. Plexis Healthcare Systems has provided support for the three products; Plexis Claims Manager, EDIWorks, and the general ledger interface since the July 2004 software purchase date and subsequent March 2005 start date. The PCM version currently running is 9.2.02.003 and is fully supported by Plexis Healthcare Systems.

Q Continuum is the case management/medical management system utilized by the P/GLTC case management and medical management sections. CH Mack has provided support for Q Continuum since the purchase date - October 2004 and subsequent start date - March 2005. The Q version currently running is 1.0.15 and is fully supported by CH Mack.

The Provider Information Management System (PIMS) is a proprietary database which houses provider data such as; demographics, contract information, and provider contact notes/inquires. PIMS features reporting mechanisms in order to monitor contract terminations, contract inclusion (insurance and licensure), and timeliness standards. PIMS has been operational since 2009.

The computer network utilized by the Plexis Healthcare Systems, Q Continuum, and PIMS is supported locally by Pinal County designated staff in the Information Technology Department. The databases reside on a four-node SQL cluster with redundancy that maintains hardware integrity and rapid availability for the data source. The database source for Plexis, Q Continuum, and PIMS are maintained and protected on tape media using an industry-standard backup schedule of daily, weekly, monthly, and annual backups that are secured onsite within the Pinal County data protection infrastructure, with a duplicate copy secured at an offsite location.

Plexis Claims Manager, EDIWorks
    Plexis Healthcare Systems, Inc. (www.plexisweb.com)
    385 Williamson Way
    Ashland, Oregon 97520
    877-475-3947
    Steve Belsky, Project Manager
    Current Version - P/GLTC: 9.2.02.003
    Latest Version – Plexis: 10.5.0.02

Q Continuum
    CH Mack Inc. (www.chmack.com)
    10101 Alliance Road, Suite 10
    Cincinnati, Ohio 45242
    513-936-6000
    Nancy Houk, Product Support Specialist
    Holly Atha, Project Manager
    Current Version – P/GLTC: 1.0.15
    Latest version – CH Mack: 1.0.16

Pinal County Information Technology Department
    31 N. Pinal St.
    Florence, AZ 85132
    Keith Sexton, Server Application Supervisor
    520-866-6392

Requirement 14: Describe the Offeror's plans and ability to support current and future IT Federal mandates.

P/GLTC leadership and staff are keenly aware of the importance of the strategic framework for health information exchange. Adoption of more sophisticated models of care translates directly to healthcare system requirements for technology that is readily available, consistent, and useable. P/GTLC is in full compliance with implementation of all standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which establishes national standards for electronic health care transactions, national identifier for providers, health plans and employers, and security and privacy legislation with which healthcare organizations must comply.

P/GLTC Health Information Systems are HIPAA compliant in that they support HIPAA X12 transactions, meet privacy and security requirements, and meet all NPI mandates.

Current Information Exchange Standards
P/GLTC exchanges data with AHCCCS using the HIPAA and AHCCCS requirements as outlined in the HIPAA Transaction Companion Documents & Trading Partner Agreements, the AHCCCS Encounter Reporting User Manual, and the AHCCCS Technical Interface Guidelines. Upon revision of any or all of these procedures, policies, rules, regulations, or statutes, P/GTLC conforms to these changes following appropriate notification by AHCCCS or as mandated by Federal regulations. P/GLTC Information Systems are adaptable to updates in order to support future AHCCCS related policy requirements and/or Federal regulations.

All inbound or outbound HIPAA transactions utilized by P/GLTC adhere to version 004010A1 format guidelines. The NCPDP 3.2 format is used to trade encounter data with AHCCCS. Electronic claims are received from the P/GTLC claims clearinghouse in the 837 version 4010A1 as well. P/GLTC offers electronic payment to providers via EFT services.

Information Exchange Standards Changes
As the deadline for implementation of HIPAA Version 005010 Transactions nears (see table below), development and testing within the claims payment system has begun. Gap analysis accompanied by a cohesive migration plan, developed in conjunction with the claims system vendor, is in place. A new EDI rules engine and XML translation software has been developed, and is being tested by the vendor. This new gateway replaces the current build as each 5010 transaction is implemented.

The P/GLTC Pharmacy Benefit Manager (PBM) is analyzing and developing the NCPDP D.0 transaction. Adoption of this format will ensure P/GLTC meets AHCCCS and CMS mandates and accommodates the ICD-10 code set implementation deadline which is required by CMS on 10/01/2013.

Migration Plan for HIPPA Transactions V. 5010

Transaction V. 5010	Transaction Description	AHCCCS Proposed Implementation	Development Priority	P/GLTC Implementation Deadline
820	Payroll Deducted and Other Group Premium Payment for Insurance Products	07/01/2011	1	04/01/2011
834	Benefit Enrollment and Maintenance	07/01/2011	1	04/01/2011
837 Import	Health Care Claim	05/01/2011	2	10/01/2011

Transaction V. 5010	Transaction Description	AHCCCS Proposed Implementation	Development Priority	P/GLTC Implementation Deadline
837 Export	Health Care Claim	05/01/2011	2	10/01/2011
270	Health Care Eligibility Benefit Inquiry and Response	10/01/2011	3	05/01/2011
271	Health Care Eligibility Benefit Inquiry and Response	05/01/2011	4	05/01/2011
276	Health Care Claims Status Request and Response	05/01/2011	4	05/01/2011
277	Health Care Claims Status Request and Response	05/01/2011	5	05/01/2011
835	Health Care Claims Payment and Advice	05/01/2011	5	10/01/2011
277PSI	Health Care Claims Status Request and Response	05/01/2011	5	10/01/2011
277CA	Health Care Claims Status Request and Response	05/01/2011	5	10/01/2011
275*****	Claims Attachment	01/01/2012	6	10/01/2011
NCPDP	RX Encounters	10/01/2011	7	10/01/2011
278	Health Care Services Review - Request for Review and Response	N/A	8	12/01/2011

ICD-10

On October 1, 2013, medical coding in U.S. health care settings will change from ICD-9 to ICD-10. ICD-10-CM:

- Includes an enhanced level of morbidity classification and diagnostic specificity.
- Provides code titles and language that complement accepted clinical practice.
- Consists of more than 68,000 codes, compared to about 13,000 ICD-9-CM codes
- Has the potential to reveal more about quality of care, so those data can be used in a more meaningful way to:
  - better understand complications
  - better design clinically robust algorithms
  - better track the outcomes of care

- Incorporate greater specificity and clinical detail to provide information for clinical decision-making and outcomes research
- Provide better data to support the demand for an increasingly electronic healthcare environment, quality.

P/GLTC is preparing for implementation of ICD-10, including potential updated software modification or installation, staff training, changes to business operations and workflows, internal and external testing, and reprinting of manuals and other materials. The claims system vendor has begun gap analysis for full ICD-10 support within the claim system and related functions such as the EDI gateway. Schema changes are expected to be released from engineering in early 2012. System engineers for the case/medical management system, the claims clearinghouse,

and the P/GLTC PBM is conducting similar migration analysis.

Electronic Health Records
Electronic Health Records (EHR) facilitate exchange of health information and are a key component to improve the American health system. According to the American Academy of Family Physicians, the potential benefits of an EHR will lead to improvement in the areas of

- productivity
- finance
- quality of care
- job satisfaction
- customer/patient satisfaction

Added benefits of improved patient care and safety, health care cost reductions or stabilization and great transparency through the system are also key to the adoption of EHR.

In 2005, Arizona Governor, Janet Napolitano, issued Executive Order 2005-25 establishing the Arizona Health-e Connection Steering Committee (AzHeC). Formed in January 2007, their mission is to lead Arizona's establishment of health information exchange (HIE) and adoption of health information technology (HIT) by:

- Serving as an educator and statewide clearing house for information
- Researching and developing statewide policies, and model legal agreements
- Support health information exchange and provide adoption of health information technology

As a component of the federally enacted American Recovery and Reinvestment Act of 2009 (ARRA), the Health Information Technology and Clinical Health Act (HITECH) allocated funds for the advancement of electronic use, and exchange of, health information to provide reimbursement incentives for physician and hospital providers who implement EHRs. These payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted

and be actively utilizing EHRs in compliance with the "meaningful use" definition or they will be subject to Medicare financial penalties.

These funds were used by the Arizona Health-e Connection to develop a regional health information technology center, the Arizona Regional Extension Center (REC). The REC offers both general and technical assistance to health care providers to develop electronic health record systems.

The Summary of Electronic Health Record Incentive Program for Arizona Medicaid Providers, presented at the November Acute/ALTCS CEO meeting, is posted on the P/GLTC website. The document contains information regarding Meaningful Use progression, available monetary incentives, and the AHCCCS five year Health Information Technology (HIT)/Health Information Exchange (HIE) goals. Included in these goals are target ranges for eligible professionals, Federally Qualified Health Centers (FQHC) and e-prescribing. The topic of EHR and related incentives is slated for inclusion in the P/GLTC Provider Newsletter spring edition.

Pharmacy chains managed by the P/GLTC PBM are equipped to accept e-prescribing under the NCPDP standards. P/GLTC process and initiatives fully align with AHCCCS's goal to increase use to 40% over the next five years.

To keep current with Healthcare IT changes, P/GLTC staff monitors organizations such as the AzHeC, HSAG – Arizona's Medicare QIO, the Healthcare Information and Management System Society (HIMSS), the Workgroup for Electronic Data Interchange (WEDI) and the National Uniform Claim Committee (NUCC). Additionally, the P/GLTC staff subscribes to the GovHIT Twitter feed and receives updates via Facebook.

Upon AHCCCS adoption of federal guidelines to restrict payment for Hospital Acquired Conditions (HACs), P/GLTC will partner with AHCCCS in implementation of plan-level policies.

Requirement 15. Provide a flowchart and comprehensive written description of the Offeror's grievance system. At a minimum, the description should include the member grievance and appeal process and the provider and subcontractor claim dispute process. Include in the description how data resulting from the grievance system is used to improve the operational performance of the Offeror. The submission requirement will be a maximum of four pages of narrative with a maximum of three pages of flow charts.

P/GLTC has consistently executed grievance policies, based on AHCCCS contractual and regulatory requirements for more than 20 years, ensuring both member and provider rights are preserved. Please refer to the attached flow charts for an overview of the processes included in this response. (Exhibits 15-1, 15-2, and 15-3)

P/GLTC maintains a written grievance system process for our subcontractors, members, and non-contracted providers. The system defines their rights regarding disputes with P/GLTC. Our member grievance processes cover grievances, appeals, and access to Arizona's state fair hearing process. P/GLTC does not delegate the grievance system process to any subcontractor. All Grievance System activities are performed in the state of Arizona, and continue to do so for the term of this contract.

P/GLTC has 3.5 FTEs trained to respond to all Grievances, Member Appeals, and provider Claims disputes. Under direction of Kelly Morgan, Director of Quality and Medical Management, staff has an average of nine years of experience in resolving grievances. Every P/GLTC staff member who interacts with members or providers is trained as least annually in receiving, identifying and verbally responding grievances. Our Chief Medical Officer (CMO), Marlene Bluestein, MD, with over 12 years leading P/GLTC's Medical and Quality Management activities, meets with the team at least two hours per week to review cases and is available on an ad hoc basis, including after hours consultation as needed.

Communication of Member Grievance and Appeal Process Information
Within 10 days of enrollment with P/GLTC, members receive written information on the service request process, grievance process,

appeals process, member rights, and associated timeframes in easily understood language and format via the Member Handbook. Grievance and appeals information is also available on the P/GLTC website's member portal, and is included in Member Newsletters. Appeals information is included with any adverse determination notices. Significant changes to the grievance systems are conveyed to members through written communications at least 30 days before the intended effective date of change.

All grievance systems information is communicated in English and members are informed of the availability of additional oral language and physical impairment interpretive services available upon request. In addition, written documents are translated in the member's language if P/GLTC receives verbal or written information that the member has a limited English proficiency. The English version of the documents cited above include information in Spanish advising the member that each document and associated information is available in Spanish and alternative formats such as Large Print or in other foreign languages, and how the member may obtain the information.

Member Grievances
As reflected in the Grievance Process flow chart, grievances may be filed verbally or through written correspondence to P/GLTC. Grievances may not be filed directly with AHCCCS. Grievances may be filed by members, member representatives, or a provider with written consent of the member. Any P/GLTC staff may receive a grievance. When a P/GLTC staff member receives a grievance filed orally, s/he is responsible to make every effort to immediately resolve the grievance. P/GLTC acknowledges receipt of each enrollee

grievance. When a grievance is filed orally, acknowledgement of the grievance is understood. Grievances received in written form are acknowledged via written communication.

P/GLTC ensures that individuals who make decisions on grievances have not been involved in any previous level of review or decision making. In addition, P/GLTC ensures that the decision makers are qualified healthcare professionals with appropriate clinical expertise in treating the member's condition if the grievance involves clinical issues or is regarding the denial of expedited resolution of an appeal. If a written response is requested, the response is mailed within 10 days of receipt of the grievance. Otherwise, oral responses are communicated to the member as quickly as possible, with over 95% of the responses occurring on the date of the receipt of the grievance.

P/GLTC resolves grievances as quickly as possible per the ACOM Enrollee Grievance Policy, but the resolution never exceeds 90 days. While decisions regarding a grievance cannot be appealed, every effort is made to resolve the issue in a member-centric manner with consideration of the members' benefit design, regulatory requirements, and organizational policies.

Member Appeals
As shown in the flow diagram titled, Appeals/Claims Disputes Process (Exhibit 15-3), we accept appeals up to 60 days from the date of the Notice of Action (NOA). The due date for filing an appeal is always included in the NOA. Providers may file appeals on the members' behalf with written authorization from the member. P/GLTC permits both oral and written appeals and treats oral inquiries about appealing an action as an appeal. Acknowledgement letters are sent within five business days of receipt for standard appeals and within one business day of receipt of an expedited appeal. The aggressive response time frame for expedited appeals is congruent with the urgency of the request and used when life,

health, or ability to regain function is endangered. While expedited status is rarely needed, we address all appeals as quickly as possible with review and determination on member appeals often completed within three business days of receipt regardless of the priority status.

P/GLTC ensures that individuals making decisions on appeals have not been involved in any previous level of review or decision making. P/GLTC requires a qualified health care professional to make decisions regarding an appeal of any denial based on lack of medical necessity or if the appeal involves clinical issues or is regarding the denial of expedited resolution of an appeal.

Our Dispute and Appeals team resolves standard appeals within 30 days from the receipt of the appeal unless an extension is in effect. We resolve expedited appeals within three business days from the date P/GLTC receives the appeal, unless an extension is in effect. Expedited appeals are accepted for those appeals for which the standard resolution timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. P/GLTC makes every attempt to provide an oral notice to the member regarding resolution of an expedited appeal. The notice most often occurs telephonically, but P/GLTC may send a case manager to the home for a personal contact if needed.

If a member or authorized representative files an expedited appeal that does not meet the definition of expedited appeal, Dr. Bluestein or her designee, who is also a qualified P/GLTC healthcare professional, may downgrade the appeal to a standard level, with a 30 day timeframe for resolution. If an expedited appeal is downgraded, P/GLTC notifies the member. P/GLTC tries at least three times to orally notify the member of the status change and follows up with a written notice of the denial of expedited resolution.

Resolution timeframes for standard appeals and expedited appeals may be extended by up to 14 days. The extension may be applied upon member request or if P/GLTC identifies the need for additional information and the extension is in the member's best interest. If P/GLTC elects to extend the resolution timeframe, the member is sent a written notice with the reason for the delay. That notice is mailed within one business day of the decision to extend the resolution. Should we not issue a Notice of Appeal Resolution in a timely manner, the member's appeal is considered denied and the member may request a hearing.

P/GLTC allows the member a reasonable opportunity and time to present evidence and allegations of fact or law in person or in writing. P/GLTC informs members of the limited time available in appeals involving an expedited resolution. Members have the opportunity before and during the appeals process to examine the member's case file. The file may include medical records and other documents considered during the appeal process such as regulatory requirements and evidence-based service criteria. P/GLTC ensures that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal process.

P/GLTC provides written Notice of Appeal Resolution to the member and the member's representative. The Notice includes the result of the resolution process, including the legal citations or authorities supporting the determination the determination date. For those appeals not resolved wholly in favor of the member, the Notice also includes the member's right to request, in writing, a State fair hearing no later than 30 days after the date the member receives the Notice. Information on how to request a State fair hearing is included. The Notice also includes the right to received continued services pending the hearting and how to request the continuation, and the fact that the member may be held financially responsible for the cost of the services if the hearing decision supports the decision from P/GLTC's appeal resolution.

Members may receive continued service during the appeal process. In such instances, grievances must be filed in a timely manner and the member must request that services be continued. The continued services are based on the authorization which was in place prior to the denial, termination, reduction, or suspension which has been appealed. Services continue until the member withdraws the appeal, the appeal is resolved, the original time limits of the service have been met, or a Director's Decision adverse to the member is handed down from AHCCCS.

State Fair Hearing
If the member files a request for State fair hearing, P/GLTC sends the case file with its required components and all supporting documentation to AHCCCS Office of Administrative Legal Services (OALS). If P/GLTC or the State fair hearing reverses a decision to deny, limit, or delay services not furnished during the appeal or the during the time period in which the hearing decision is pending, P/GLTC promptly authorizes and provides the services regardless if P/GLTC contests the decision. If the hearing decision reverses the appeal resolution, P/GLTC pays for the disputed services.

Provider and Sub-Contractor Claim Dispute Process
Provider claim dispute information is a part of all P/GLTC provider contracts. This information is also contained in P/GLTC's Provider Manual. The information is also included in each remittance advice sent for both paid and denied claims. When filing claim disputes, providers must submit written disputes no later than 12 months from the date of service or eligibility posting or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

Lynne Braatz, Dispute and Appeals Coordinator (DAC), under the direction of the Kelly Morgan, Director of Quality and Medical Management and in collaboration with Andi Kennedy, Claims Manager, manages the claim dispute process. The DAC sends a written notice acknowledging

the claim dispute within five days of receipt. Each claim dispute is thoroughly investigated by qualified or Medical Management health professionals using applicable regulatory, contractual, and policies.

As reflected in the Appeals / Claims Dispute Process flow diagram, the claim dispute timeframes and process are similar to those in place for member grievances as referenced in the member grievance and appeal process above. Upon receipt of a provider claim dispute, resolution timeframes are followed and a final decision letter is sent within 30 days. The decision letter includes the nature and issues related to the dispute, the reasons supporting P/GLTC's decision, the provider right to request a State fair. If the dispute is overturned, P/GLTC reprocesses and pays the claim within 15 business days of the decision.

For providers who disagree with the resolution of a claim dispute, the same hearing rights are recognized by P/GLTC and AHCCCS. Providers may appeal P/GLTC's decision by submitting a request for State fair hearing to P/GLTC within 30 days of receipt of the final decision letter. When a provider requests a hearing, the request for the hearing along with a cover letter and the entire claim dispute file is forwarded to OLAS at AHCCCS. A hearing is scheduled before an Administrative Law Judge and that decision is forwarded to AHCCCS for a Director's Decision. Director's Decisions are considered final as shown on the third flow diagram titled Determinations and State Fair Hearing.

Performance Improvement and Reporting
Reporting of Grievance System elements occurs on an ongoing basis within P/GLTC. Grievance System data are collected, analyzed, summarized, and reviewed at least monthly. Findings from the data and analysis are utilized to drive performance improvement (PI) activities through: the application of the P/GLTC Plan-Do-Study-Act (PDSA); use of standard PI processes and analytic tools (e.g. barriers analyses, flow charts, inter-disciplinary PI teams including stakeholders); development and implementation of action plans with

targeted strategies; and the evaluation of the effective of the interventions. For example, a single grievance was received related to a communication to a physician. After additional review, we identified an opportunity for improvement (OFI) in how we identified providers who are assigned to provide care at nursing facilities (NFs). A multi-disciplinary PI team was formed, including case, quality, and medical management staff plus member services representatives. Using PDSA, the team identified a process flaw in the notification of providers of changes made upon a member's admission to the NF setting. Improvements to the process resulted in a streamlined, timelier notification to providers of their members' admission status. Additional inter-disciplinary review, monitoring for effectiveness and recommendations for action occur at the Grievance Committee and at quarterly Medical /Utilization Management Committee meetings. Finally, a formal evaluation of the Grievance System is performed annually, with findings integrated into the subsequent year's grievance system work plan.

P/GLTC provides reports on the Grievance System as required in the AHCCCS Grievance System Reporting Guide, including data on volume and denials of service requests, appeals and claim disputes on a monthly basis. In addition, we submit the Enrollee Grievance Report on a quarterly basis. These reports are submitted within 45 days of the end of the reporting quarter.

VERBAL

WRITTEN

Grievance is noted as resolved at first contact.

Member calls or writes P/GLTC or relates grievance to Case Manager (CM) or other P/GLTC staff

MSR or CM completes the P/GLTC Complaint/Concern form, documenting "FORMAL" Grievance status

Complaint/Concern form with documentation of grievance is forwarded to the QM Department

Receiver of Grievance completes a P/GLTC Complaint/Concern Form

Complaint/Concern form with documentation of grievance is forwarded to the QM Department

NO

YES

Director of Quality reviews the C/C Form and determines initial complaint severity and Quality of Care (QOC) or Quality of Service (QOS) classification

Case Manager or other staff member receiving the grievance asks member if they want to file a formal grievance.

Director of Quality reviews the Grievance Form and determines initial severity and Quality of Care (QOC) or Quality of Service (QOS) classification

Dispute and Appeals Coordinator logs the grievance in the database

Written Grievance?

Quality of Care

Information is forwarded to QM RN for further investigation

Quality of Service

Dispute and Appeals Coordinator issues member an acknowledgement letter within 5 days from the date the grievance was filed.

QM RN sends Member an acknowledgement "open" letter within 5 days from the receipt of the grievance / potential QOC Concern

More Information Needed?

QM RN performs investigation, asking for addition substantiating information based on the QOC issue

YES

Letter of Inquiry sent to Provider / Vendor response form is sent to provider / vendor with return response expected within 7 days.

NO

QM Department completes investigation in a timely manner (See QOC Flow]

QOC/QOS findings reviewed by appropriate staff and Dir. of QM. Close letter meeting AHCCCS criteria is created.

Case is closed and logged

Aggregate Grievance data from database is used for tracking, trending and improving processes.

Member is issued a close letter (case should be resolved within 30 days from receipt date, but no longer than 90 days).

P/GLTC issues Denial, Reduction, or Suspension of Service or Payment

Dispute & Appeals Coordinator (DAC) receives request for a member appeal or provider appeal / claims dispute, date stamping all related documentation

Member Appeal
(60 days to file an appeal from date of NOA)

Member Appeal or Provider Dispute?

Provider Dispute
(filed in writing within approved time frame)

DAC logs the Appeal, keeping separate logs for medical and behavioral service appeals

DAC sends Acknowledgement Letter to appellant within 5 business days for standard and 1 business day for expedited appeals

DAC logs the Dispute, keeping separate logs for medical and behavioral service disputes

Appeal and all documents related to the appealed service are forwarded to Dir. of Med. Mgmt. for identification of reviewer

Provider Dispute forwarded to Claims Section for review by Claims Manager.

Standard or Appropriate Expedited Status — NO →

Forwarded to CMO for potential downgrading to Standard Appeal

Dispute sent to Dir. of Med. Mgmt. who will coordinate the review, ensuring authorized Health Professional review. ← YES

Medical/ Clinical Review Needed?

YES

Appeal thoroughly investigated using all applicable resources, criteria, and medical records

NO

Authorization Review completed by Auth. Health Professional not involved with prior determination

If Downgraded, Member is notified in writing by DAC

Findings returned to Claims

Claim thoroughly investigated using all applicable resources and ensuring facts gathered from all parties

Resolution within 30 days from receipt date for standard appeals and disputes.
Resolution within 3 business days for expedited appeals.
[plus 14 days if extension used]

From Appeals
and Disputes

Appeal Determination?

UPHOLD Denial

REVERSE Denial

Upon determination, DAC sends a Notice of Appeal Resolution for Members or a Notice of Decision for Providers citing decision. Offers 60 days to request State Fair Hearing

Upon determination, DAC sends a Notice of Appeal Resolution for Members or a Notice of Decision for Providers citing decision

Appealed / State Fair Hearing Requested?

Member Appeal or Provider Dispute/Appeal?

Member   Provider

YES   NO

Appeal File and Hearing request forwarded to the Office of Legal Assistance for scheduling of hearing

DAC updates appropriate log with findings and files documents for retention

Reinstate Service

Pay Claim

Office of Legal Assistance scheduled State Fair Hearing and notifies involved parties [P/GLTC & Appellant]

END

Hearing Occurs and both sides state their cases to the Administrative Law Judge (ALJ)

Administrative Law Judge (ALJ) Reviews findings from submitted documents and hearing testimony related to the case

ALJ Decision Letter composed within 20 days of hearing

Reverse P/GLTC's Original Decision

To AHCCCS

Yes   No

Appeal Stands

ALJ / AHCCCS Final Decision Letter sent to P/GLTC and Appellant

Member Appeal ⇒ Reinstate Service
Provider Appeal ⇒ or Pay Claim

END

Requirement 16: Describe the Offeror's Corporate Compliance Program.

Pinal/Gila Long Term Care's (P/GLTC) compliance efforts are fundamentally designed to establish a culture within the organization that promotes the prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, or to federal healthcare program requirements. P/GLTC has operational internal controls, policies, and procedures that are capable of preventing, detecting, and reporting fraud and abuse.

The P/GLTC Corporate Compliance Program has four main components: Corporate Compliance Committee, Corporate Compliance Officer, Corporate Compliance Plan, and policies and procedures. P/GLTC expects that each employee follows the guidance provided in the Corporate Compliance Program.

The components of the Corporate Compliance Plan are inter-related and designed to prevent, detect, trend, and report fraud and abuse and includes the following key elements:

- Oversight and delegation of authority
- Prevention
- Member, employee and provider education and training
- Communication
- Detection
- Monitoring and auditing
- Enforcement and disciplinary mechanisms for staff providers, members and subcontractors
- Prompt response to identified problems
- Corrective action
- Provider Credentialing/ Re-credentialing

The Compliance Officer independently reports suspected member fraud, provider fraud, and member abuse cases to AHCCCS, Office of the Inspector General or other duly authorized enforcement agencies. P/GLTC Policy # 06:01 Corporate Compliance Officer Duties and Responsibilities contains the criteria for selection of a Corporate Compliance Officer. The Corporate Compliance Officer reports directly to the Chief Financial Officer and chairs the Corporate Compliance Committee.

The Corporate Compliance Officer also:
- Has the authority to review and revise the Corporate Compliance Plan and associated policies and procedures;
- Has the authority to independently refer suspected member fraud, provider fraud and member abuse case(s) to AHCCCS, OIG or other duly authorized enforcement agencies;
- Has the authority to represent Pinal County at AHCCCS, Office of the Inspector General meetings;
- Has the authority to interview any member, their family, provider, or staff member, or others as dictated by the situation
- Has the authority to monitor and audit all documents, such as medical records, claims, and Quality Management and Utilization Management data;
- Has the authority as an on-site official to access all employees and contract staff including the Chief Executive Officer, Chief Medical Officer, and Executive Management Team regarding all fraud and abuse issues;
- Has the authority to access legal counsel through the County Attorney's Office; and
- Oversees a comprehensive training program that addresses member fraud, provider member abuse, prevention, and detection for all employees, providers, members and subcontractors. Ensures a well-defined internal reporting procedure is made known to all employees. Ensures the compliance program has well-publicized disciplinary guidelines regarding fraud and abuse.

The Corporate Compliance Committee is comprised of the Executive Management Team and assists the Compliance Officer in monitoring, reviewing, and assessing the effectiveness of the compliance program and timeliness of reporting. The Corporate Compliance Committee has the authority to commit resources needed in the investigation

of potential fraud and abuse cases. The Compliance Officer has access to legal counsel through the County Attorney's Office. Quarterly meetings afford the Compliance Officer an opportunity to report on a regular basis to the Compliance Committee. Additional meetings can be held if emergent situations are identified.

New P/GLTC members receive a copy of the "Member Handbook" explaining fraud and abuse. Members are also provided information about the process by which to report suspected cases of fraud and abuse. P/GLTC members receive newsletters semi-annually containing specific information about fraud and abuse, among other topics.

The Compliance Officer trains all new employees on detection and reporting of fraud and abuse. During orientation, new employees are trained on such topics as the Deficit Reduction Act, False Claim Act, and whistle blower protection. Also, tips on what to look for by provider type are outlined and examples of kickbacks are described. P/GLTC Policy # 06:04 – Corporate Compliance Reporting Provider and Member Fraud and Abuse describing the reporting process for suspected cases of fraud and abuse is provided. The new employee is instructed regarding their duty to report fraud and of their civil immunity when acting in good faith (per A.R.S. 36-2918.01). Further information about how coordination efforts with AHCCCS and other governmental agencies take place is also included. Pinal County has instituted mandatory ethics training for all county employees and installed an anonymous tip line for staff to call with suspected cases of fraud or abuse.

Education about fraud and abuse is offered at least annually during an all-staff meeting. Special attention is given to detecting member neglect and abuse (physical and mental). Case Managers and Member Services Representatives receive initial and ongoing training on how to identify potential exploitation of members. Nurses are provided written guidelines on the investigation of

member abuse cases. Claim processing staff are instructed on key areas related to referrals and claims submission, such as double billing, unbundling, and up-coding. Pre-payment claim reviews are in place when such questions arise during claims processing. Post-payment claim audits can also result in fraud detection.

During new provider and subcontractor orientation, the Provider Manual is distributed. Information on how to prevent, detect and report fraud and abuse issues is included on the site visit monitoring tool utilized by Provider Service Representatives during contract monitoring visits. P/GLTC contracts contain fraud and abuse provisions. These provisions include the requirements to abide by applicable laws, rules, and regulations. Contracts also include language that requires health plan notification of changes to provider credentialing or licensure status. Contracts also require providers to maintain and furnish required records and documents as required by laws, rules, and regulations. The maintenance of professional standards and anti-kickback language is also referenced. Fraud and abuse discussions occur during provider office visits. The Quick Reference Guide contains the location of specific False Claims Act information in the Provider Manual.

P/GLTC's website contains a Corporate Compliance link to the Health Plan Fraud Training module on the AHCCCS website. Another option directs the user to the online fraud and abuse reporting for the public, providers, Contractors and members. In addition, specific links direct users to the AHCCCS Deficit Reduction Act site including False Claims Act training.

During the prior authorization process, inappropriate utilization pertaining to medical necessity, appropriateness of service, benefit limitations and coverage issues are identified prospectively. Concurrent Review nurses track variance days in hospital for denied admissions and subsequent review days. Denied admissions are also tracked and trended by admitting physician. Denied subsequent review

days are tracked and trended by attending physician. Retrospective review also offers the opportunity to identify potential fraud or abuse by comparing the billed services with the clinical documentation. When detected, fraud and misuse of services are reported to the Compliance Officer.

Claim system edits associated with fraud include duplicate claims submission, duplication of services, member eligibility, prior authorization, and invalid procedure codes. All high dollar/inpatient claims are processed by the lead Claims Specialist and forwarded to the Medical Management section for review prior to final adjudication. Post payment claim audits are conducted using a random sample of claims for each payment cycle. Monitoring is performed to review payment methodology, provider demographic information, and authorization requirements. The Claims Manager and Chief Financial Officer analyze the claims data trends. Suspected fraud identified during the post payment claims is reported to the Compliance Officer.

P/GLTC uses the Office Inspector General (OIG) & Excluded Parties List System (EPLS) online databases when credentialing providers. The federal government maintains an online exclusion database which lists providers/entities that have had any issues such as: Patient abuse/neglect conviction, Felony health care fraud conviction, Conviction relating to program or health care fraud, License revocation/suspension/surrender, Federal/state/program exclusion/suspension, quality of care violation, Fraud/kickbacks, The EPLS includes information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the non-procurement common rule, In the 20 years that P/GLTC has been the ALTCS program contractor for the state of Arizona, no provider or entity on this list has ever been found to be under contract.

AHCCCS Compliance Notification e-mails are routinely sent to a number of P/GLTC staff including the Corporate Compliance Officer.

These e-mails contain information concerning facility sanctions, civil penalties, closures, and admission holds, as well as physician specific reportable items including; medical board sanctions, terminations fraud and abuse findings. A provider search is performed in the claims system to determine if the identified provider is contracted or has a claim history with P/GLTC. Appropriate steps are taken depending on the compliance issue.

Grievances and potential quality of care or service concerns are logged by Quality Management staff into a database with a special fraud and abuse case identifier. The tracking system includes the nature of the concern, date received, person making the complaint, sources of the complaint, member name, member ID, status of the case, final disposition and the date of the final disposition. The Director of Quality and Medical Management reviews aggregate data from the grievance and concerns data base monthly. In addition, grievance and concern data are tracked and trended over time providing additional opportunities to identify potential fraud and abuse issues.

Immediately upon notification of suspected fraud, the Director and/or Quality Management Nurse refer the case to the Compliance Officer. P/GLTC is responsible for researching potential overpayments identified by the AHCCCS OIG. Cost benefit analyses are conducted to determine if recovery of overpayment can be justified financially. The Compliance Officer reports the final disposition of the research and any actions taken to the AHCCCS Office of Program Integrity and to the Corporate Compliance Committee.

P/GLTC analyzes compiled data in order to complete the AHCCCS required Verification of Services and Cost Avoidance deliverables. Identification of potential fraud issues are investigated by the Compliance Officer and referred as appropriate to the OIG.

Pinal/Gila Long Term Care

Corporate Compliance Committee
Exhibit 16-1

```
                    AHCCCS
          Office of the Inspector General
                        |
        Corporate Compliance Officer/Compliance
              Committee Chairperson
               Andrea Kennedy, CPM
                        |
              Fraud and Abuse
            Compliance Committee
```

County Attorney
Joe Albo

Donna Beedle
Chief
Executive Officer

Jennifer Kelly
Director
Case Management

Marlene Bluestein, MD,
Chief Medical Officer

Susan Murphy,
Chief
Financial Officer

Andrea Kennedy
Corporate Compliance
Officer

Christine Liberato
Director,
Network
Management
& Development

Kelly Morgan
Director,
Quality Management
& Medical
Management

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Requirement 17: Submit the organization's three most recent audited financial statements and the related parent company financial statements if applicable.

As an existing ALTCS contractor who has met this submission requirement through current contract requirements, Pinal/Gila Long Term Care is not required to submit the three most recent audited financial statements.

Requirement 18: Submit the Offeror's plan for meeting the Performance Bond or Bond Substitute requirement including the type of bond to be posted, source of funding and timeline for meeting the requirement.

Pinal/Gila Long Term Care satisfies the AHCCCS performance bond requirement through the current Pinal County Resolution Number 031611-FS.

The current resolution states that Pinal County pledges its financial assurance, and in the event of default as Program Contractor agrees to pay any damages sustained by the providers by reason of breach of Program Contractor's obligations under its contract, reimburse AHCCCS for any payments made by AHCCCS on behalf of the Contractor and extraordinary administrative expenses incurred by reason of a breach of Program Contractor's obligation under its contract, including, but not limited to, expenses incurred after termination (see following page).

RESOLUTION NO. O3l6ll-FS

A RESOLUTION OF THE PINAL COUNTY BOARD OF SUPERVISORS PLEDGING TO PROVIDE FINANCIAL ASSURANCE AS AN AHCCCS/ALTCS PROGRAM CONTRACTOR

WHEREAS, Pinal County is a political subdivision of the State of Arizona that has been selected by the State to serve as an AHCCCS/ALTCS Contractor for the service area of Pinal and Gila Counties, and;

WHEREAS, the AHCCCS/ALTCS contract for services requires financial assurances by the Contractor; and

WHEREAS, a County Resolution is an acceptable method for fulfilling the AHCCCS performance bond requirement:

NOW, THEREFORE, BE IT RESOLVED that to the extent permitted by Arizona law, Pinal County, as Contractor, makes this pledge of financial assurance that during the term of the contract, and any renewals thereof, Pinal County will meet the minimum AHCCCS capitalization requirements, and that Pinal County has sufficient County funds on hand for the purposes stated herein.

In the event of a default by the Contractor, Pinal County agrees to the following:
1. That Pinal County will pay any damages sustained by providers, contracted or otherwise, because of a breach of the Contractor's obligations under this contract;
2. That Pinal County will reimburse AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and
3. That Pinal County will reimburse AHCCCS for any extraordinary administrative expenses incurred because of a breach of the Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the State by AHCCCS

THE FOREGOING RESOLUTION PASSED AND ADOPTED by the Board of Supervisors
of Pinal County in Florence, Arizona.

_____
Chairman, Board of Supervisors

Date   3/16/11

ATTEST:

_____
Clerk of the Board of Supervisors

_____
Deputy County Attorney

Requirement 19: Submit a plan for meeting the minimum capitalization requirement.

Pinal/Gila Long Term Care (P/GLTC) exceeds the capitalization requirements. Per AHCCCS contract, as a continuing Offeror, P/GLTC meets the AHCCCS required equity per member standard of $2,000 per member for the Geographic Service Area (GSA) 40 including Pinal and Gila Counties.

County	Membership - 12/31/10	Equity Requirement	Total
Pinal	1225	$2,000	$2,450,000
Gila	271	$2,000	$542,000
Total – GSA 40	1,496	$2,000	$2,992,000

P/GLTC Retained Earnings as of December 31, 2010	$ 8,283,545
Less AHCCCS approved equity transfer (02/01/11):	931,569
	$ 7,351,976

D. PROGRAM

Subject Requirement:	Reqmt. Page #	Offeror's Page #
Case Management	20	162
	21	165
	22	168
	23	171
	24A	174
	24B	177
	24C	180
	24D	183
Medical Management	25	186
	26	192
	27	195
	28	198
	29	201
Quality Management	30	204
	31A	207
	31B	210
	32	213
	33	216
	34	219
Oral Presentation	35	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3:00 p.m. on April 8

Requirement 20: Describe how the Offeror has or will implement inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes. Provide an example of how the Offeror improved member health or service outcomes because of inter-departmental coordination.

Pinal/Gila Long Term Care (P/GLTC) provides "comprehensive and coordinated healthcare services to elderly and/or physically disabled individuals who have difficulty taking care of themselves, both financially and physically, so they can live independently as long as possible while maintaining an optimal level of health". Our multi-disciplinary, member-centric approach has been central to our ability to deliver high quality care and services to rural Arizonans for over 20 years.

Care Teams as an Approach to Care

As part of our ongoing effort to improve member health and service outcomes, our Case Management (CM) and Medical Management (MM) sections established our Care Team Model in June of 2007. Each of our Care Teams, co-facilitated by a CM Supervisor and a MM Nurse, and including representatives from CM, Member Services, Behavioral Health, network development, MM, and Quality Management (QM), collectively focus on meeting the complex psycho-social and clinical needs of their assigned members.

Care Teams meet weekly and exemplify inter-departmental cooperation. Each meeting includes discussions related to newly enrolled members, complex members, or regularly scheduled member visit issues. New member reviews involve a presentation by the assigned CM, with a brief overview of the member, functional abilities, support systems, environment, and medical/behavioral needs. Ad hoc discussions related to ongoing members typically involve a member experiencing a change in condition, care plan need, or anticipated transition in placement.

Member specific care plans are created by the member/representatives and the Case Manager to maintain the member in the least restrictive environment. The care plan includes barriers to care and strengths such as natural supports and community resources. The team discusses barrier elimination and substantiates that all goals are measurable. Cultural diversity factors including values, beliefs and environment, are considered in all aspects of the members' care plan.

To improve member health, the care team nurse discusses home health nursing goals, frequency of visits, and continued need for service. Member Services such as durable medical equipment (DME) needs plus items requiring CMO approval (e.g. environmental modifications) are reviewed to ensure timeframes are met. All team members are expected to actively participate, adding information or suggesting interventions. The effectiveness of the care team model is discussed at quarterly Co-Facilitator meetings attended by section representatives of CM, MM, and Quality Management (QM).

Case Management Sectional Meetings

Case Management Meetings are held bi-weekly or as needed. Network Development and Management attends the meeting and provides information regarding newly contracted providers and feedback from providers. Quality Management RNs provide training on performance indicators and disease management.

Behavioral Health Coordinators

Organize behavioral care with medically necessary services, and promote team participation in identifying best practices. The team discusses the behavioral health diagnosis, effectiveness of psychiatric medications and their effectiveness on the member's psycho social symptoms (e.g. Depression, combativeness, anxiety, etc.).

Member Services

Member services and CM collaborate to ensure the members receive medically necessary transportation. Member Services Representatives (MSRs) interface with the members who call in and concurrently problem solve while notifying and engaging the Case Manager and designee to communicate the issue(s) and gain additional feedback as indicated. The MSR's document their interactions to support communications during the Care Team's review of the member's status. The Member Services Section records all incoming calls by specific indicators for tracking, trending and reporting. In addition, MSRs share new member enrollment reports with each case manager and the case management supervisor. The report tracks initial contact, initial visit, and initiation of services to ensure the members' needs are met in a timely manner.

Quality Management (QM)

QM initiatives involve CM and other departmental staff. Reports delineating performance measures and other clinical indicators provide information on the status of each member followed by CM. The reports include preventive services status and current advanced directives.

Medical Management Section

Case Management works closely with the MM Section on the functions of service determinations, Prior Authorization, and Concurrent Review of hospitalizations. The Medical Management (MM) Section identifies potential risk and quality of care issues, health education needs, and discharge planning. The Care Teams address many of these issues in their weekly meetings, including all hospital admissions and discharges, including dates and diagnoses. Our MM nurses and CMs frequently interface with hospital and facility discharge planners to ensure a smooth transition between care sites. The team participates in discharge planning with a focus on returning the member to their least restrictive environment. The team considers member choice, and continuity of care from service providers.

Disease Management and Outreach Sections

Disease Management programs and member outreach aims at improving the health status of members and educating practitioners and providers in a variety of modalities to help them educate their patients. Education modalities may include preventive health literature, educational classes, and wellness programs. CM collaborates with the Disease Management staff to ensure that members understand the programs, their rights to opt out of initiatives, and coordinate opportunities to improve self care of assigned members.

Pharmacy Section

CM, MM, the Pharmacy Benefit Manager, Quality Management, and our Performance Improvement Sections frequently collaborate to enhance specific member pharmacy issues. Together with our disease management and patient safety initiatives such as polypharmacy review and fall reduction, we ensure appropriate pharmacotherapy for our members.

Network Development and Management (NDM) Section

The NDM Section assists case management in obtaining necessary services by providing a comprehensive network of providers. NDM staff serves as key communicators, gathering and disseminating information to practitioners. In addition, the NDM Section staff serves as liaisons between the CM and Practitioners to facilitate education and compliance with approved standards and schedule Joint Operating Committee meetings with contracted providers to ensure timely, open communications.

The following describes how inter-departmental coordination improves the outcomes for one of our members:

Jane Doe is a 54 year old female with advanced Multiple Sclerosis. She has quadriplegia but

remains fully alert and oriented without memory loss. Until five years ago, Jane was successfully living at home supported by home and community based services. She was raising her two children as a single mother, but requiring extensive help. Her son and daughter helped to care for their mother after returning from school; her church provided some additional support. Jane's daughter married and moved to California and her son graduated from high school, joined the military, and was stationed in California. With her home support gone, Jane moved to a nursing facility (NF). She was visited occasionally by church volunteers but missed her children. She began to show signs of depression.

The NF Jane resided in Arizona owns a NF in California close to her children. Jane approached her CM to see if she could move to that NF. Jane's case was reviewed at the Care Team Meetings. The Care Team consisted of staff from the CM, BH, NDM, MM, and QM sections. The team recruited the assistance of the Accounts & Information System (AIS) department. After a team discussion, needs and potential barriers were identified:
- Coordination of out-of state transport;
- Stability of Jane's health condition during transport;
- Effective cost containment;
- Needed DME during transport;
- Getting personal belongings to CA;
- Coordination of care upon arrival in CA; and
- Repairs to Jane's customized wheelchair being made at that time.

Although the use of an ambulance was an option we also considered sending a registered nurse with regular transport. Jane's primary care physician (PCP) and P/GLTC medical director mutually agreed to use regular transportation. Additionally, each care team member was assigned a task to facilitate the move. Jane's case was added to the weekly care team agenda for continuous monitoring.

A NDM Provider Representative worked with the CM, the MM RN, and the CMO to obtain a

nurse to accompany the member, providing nourishment, medications, and respiratory breathing treatments. All of the contracted and non contracted home health nurse providers declined to provide care. NDM worked with a transportation company to hire a registered nurse to accompany the transport. The fee included the nurse for escort. The cost of transport with this provider was significantly cheaper than the cost of an ambulance. The transport provider agreed to take the member's custom wheelchair and personal belongings. NDM worked with the AIS supervisor to ensure P/GLTC authorization and claim system could produce the authorization.

Jane's CM and the team's MM RN worked together to determine all DME and medical supplies needed. A portable suction machine, small volume nebulizer, Oxygen and supplies were ordered to provide care while in transport. The NDM Provider Representative worked with the MM registered nurse to order an overlay mattress for the stretcher which was delivered to the transport company. The CM and the NDM Provider Representative worked with the transport provider and NF to ensure Jane would have pureed meals, juice and water during transport. The CM and the NF completed the application process for Jane to be transferred from AHCCCS to Medi-Cal, the Medicaid provider in CA.

The MM RN worked with the NDM Provider Representative and CM to ensure all repairs to the member's custom wheelchair were completed prior to transfer. Jane reported her symptoms of depression disappeared once a date for transfer was confirmed. One week prior to her date to transfer, she was hospitalized with a diagnosis of pneumonia. The CM coordinated with the hospital regarding discharge planning. When Jane was ready for discharge, she was transported from the hospital straight to the facility in CA. With diligent coordination of several P/GLTC departments, Jane arrived safely at the NF in CA and resides there today.

Requirement 21: Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency among case managers with regard to the assessment of the HCBS member needs and service authorization.

The Case Managers (CM) for Pinal/Gila Long Term Care (P/GLTC) are responsible for continuity of care regarding service authorization decision making. We strive for consistent case handling across all facets of a member's care. The CMs ensure the consistent application of criteria for completing assessments and making decisions for providing care for members to meet their needs. In order to achieve the highest level of consistency, P/GLTC has adopted a process to monitor inter-rater reliability (IRR) for case management staff that measures consensus and identifies areas of improvement for Attendant Care, Personal Care, and Homemaker services for our Home and Community Based members.

During CYE 2009, IRR activities were based on yes/no questions posed to our CMs, which left little room to gather qualitative data. To enhance our process, P/GLTC created an IRR activities policy specific to case management staff. The policy is built on four basic principles:
- The case management staff participates in IRR activities at least quarterly.
- The IRR activities results include services, prior authorizations, and placements.
- A CM Supervisor monitors, reviews, and reports quarterly inter-rater reliability to inter-departmental Utilization Management Committee . This review forum allows for communication between case management, medical management and quality management departments.
- The results of the activities are also reviewed by the case management section in meetings; education/training is provided to all CMs to support consistency in assessments and decision making with members/representatives.

In March of 2010, an IRR Task Force was created to assist the case management section in reaching our highest level of consensus regarding the tools used for assessing member's needs and the decision making

process. The IRR task force is charged with creating the IRR activities (scenarios), presenting the scenarios to the case management section in a "role playing manner", analyzing the data, identifying trends/areas of improvement, facilitating trainings, and reporting the findings back to the case management section. The IRR process is designed so that the five task force members, four CMs, and a CM Supervisor, are still able to participate in the IRR monitoring activity because a correct answer is not discussed during the creation of the scenario. Additionally, the task force meets bi-monthly or as needed to complete these responsibilities.

In order to prepare for an IRR activity, the task force convenes and decides on a member scenario. The member scenario is based on an actual unidentified P/GLTC member and is presented at a case management section meeting. The scenario is "acted" out by two task force members; one person represents the member and the other person represents a CM. The scene unfolds as a CM conducting an interview with a member, in the member's home. The CM is assessing for attendant care hours. As the scenario takes place, the audience (case management staff), completes a Home and Community Based Service (HCBS) Needs Tool. As the scene plays out, the audience is allowed to ask the actor playing the member questions to clarify or obtain more information. This portion of the activity is useful in identifying different approaches when asking a question to find clearer certifiable information.

P/GLTC's goal is to complete an IRR activity at least quarterly. For CYE 2010, we exceeded this goal by 400 percent. Sixteen separate activities were conducted by the case management section allowing for abundant data collection and profuse analysis to ensue.

The first HCBS Needs Tool IRR activity completed in March 2010 yielded results that

were used as a baseline for all case management staff. The data collected for each task in the tool, housekeeping, laundry, meal preparation, eating/feeding, AM/PM grooming, toileting, mobility, transfer, and supervision was analyzed by the IRR task force. The task force looked at the type of assistance needed (minimum, moderate, maximum), the number of tasks per day, minutes per day and minutes per week per task, and total hours per week. The baseline was established at 20 percent consensus, with a variance of plus or minus 16 hours/week of attendant care. With this information, the task force was able to identify specific areas to focus training in order to increase the consistency of member assessments and service authorizations. P/GLTC ensures all CMs assess medical needs for the same member in a consistent manner. If a CM assesses a member for four hours of incontinence care, a different CM should assess that particular member for four hours of incontinence care, not 15 hours.

In June of 2010, an intense case management section workshop was conducted with an emphasis on the HCBS Needs Tool. At this workshop, live demonstrations of the HCBS Needs Tool's task were acted out so that CMs could see how the tasks played out in real time. This enables them to really understand how much time it takes and attendant care worker to complete a task with a member. The demonstration also assisted in getting all the CMs to begin thinking, and therefore assessing, members for attendant care hours in a uniform and consistent manner.

At subsequent case management section meetings, training was conducted that focused on areas such as housekeeping, laundry, meal preparation, toileting, transfers, bathing, and grooming, along with the completion of additional IRR activities. With the compilation of data that is collected from each IRR activity, the IRR task force is able to further analyze the information and begin to identify trends. At this point, P/GLTC is not only able to train the case management section as a whole, but we are

able to focus on individual CMs that may need specific or intense training in certain areas.

Team IRR Activities
In October 2010, the IRR task force implemented the "team" IRR activity. This activity included two CMs pairing up and going to a member's home to complete an HCBS Needs Tool. The goal of the team IRR activity is to assess the member in his/her home setting and for both CMs to hear the same information and ask questions. They completed the HCBS Needs Tool separately. To date, P/GLTC has completed two Team IRR activities. The first activity yielded results of 45 percent consensus and the second activity was 92 percent consensus; a significant improvement.

IRR Activities Results
The chart entitled IRR Activities 2010 illustrates consensus amongst the CMs throughout the IRR activities completed from March 2010 to present, excluding the two team IRR activities described above. Each point represents the results of time given for an individual task of the HCBS Needs tool, such as toileting, housekeeping, laundry, and dressing/grooming. The two low points, four

IRR Activities March 2010 to Present
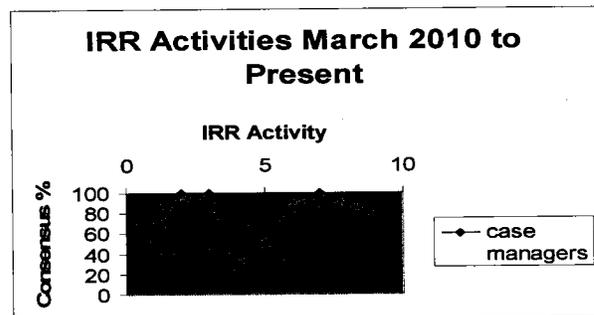
and five, are the results from the same task, toileting, on two separate times when an IRR activity was completed. The results appear to show a downward trending in results, but in actuality, the result increased from one activity to the next, marking improvement. As shown, towards the most recent IRR activity results have begun to show a consistent trend with 80-100 percent consensus. This improvement is attributed to intensive training for case management on each individual task of the HCS Needs Tool.

The chart titled Results of total Hours on HCBS Needs Tool is a compilation of results from three separate IRR activities in which case management completed an IRR activity utilizing all tasks on the HCBS Needs Tool. The results show a significant upward trend in consensus, from 20 percent to 65 percent. Again, this improvement is attributed to intensive training with the case management staff. With continued training, P/GLTC CMs close the gap on inconsistencies in the service authorization decision making process, thus, improving our delivery of services.

Results of Total Hours on HCBS Needs Tool
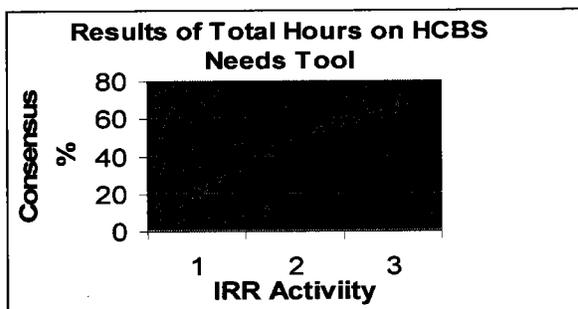
Ongoing IRR Activities

P/GLTC continues to improve consistency in conducting assessments and decision making in our day to day job responsibilities. We have committed to completing the following to continue our quest for consistency:

- Quarterly team IRR activities;
- Any HCBS Needs Tool that is completed at an annual review visit by a case manager is required to be staffed with a case management supervisor prior to approval of hours;
- All newly hired case managers are paired with a peer mentor for the first three weeks of the new employee's on the job training; For skilled nursing facility members that have a recent review visit completed by a CM, a case management supervisor completes a Universal Assessment Tool (UAT) based on the CM's assessment of the member in P/GLTC's member data base; and

- The results of the CM's UAT and the CM Supervisor's UAT are compared for consistency.

P/GLTC completed the UAT IRR Activity for the first time in February 2011; 21 UATs were completed. The results are 76 percent consistent. With these results, P/GLTC comparative data will be collected in subsequent UAT IRR activities so that trends can be recognized and remedied if needed.

The IRR Task Force was created in response to P/GLTC's Operation and Financial Review for the contract year ending (CYE) 2009 and AHCCCS's recommendation that P/GLTC refine the IRR process. Our IRR results are reported to AHCCCS on a quarterly basis for review. Any and all feedback is incorporated back into perfecting our process. Furthermore, we continue to enhance the way we conduct the inter rater reliability study so we remain persistent in improving ourselves and the services we provide to our members.

Requirement 22: Describe the process the Offeror will employ in assessing and meeting the needs of complex care members via service planning and coordination of multiple providers and involved entities specifically for 1) members needing behavior management and 2) members with complex medical care needs.

P/GLTC takes a member-centric approach to assessing, meeting needs, and coordinating services for all of our members. Person-centered case management facilitates the identification of services that meet the member's needs most effectively, particularly those with complex physical or behavioral health requirements.

Assessment
When members are newly enrolled with P/GLTC, our Member Service Representative (MSR) receives the Pre-Admission Screening tool (PAS). That day, the MSR enters the information into P/GLTC's member data base, indentifies prior period coverage (PPC), completes a Pinal County parcel search to verify address and county of residence, and checks for previous services through another AHCCCS contractor. The MSR forwards the PAS to the Case Management Supervisor for assignment. When assigning a Case Manager (CM), the supervisor considers the member's demographics, age, primary language spoken, behavioral and physical health needs, and geographic location.

Within seven business days of enrollment, the assigned CM contacts the member or representative, and provides him/her with the date of enrollment, PPC, AHCCCS identification number, the CM's information and phone number, and explains the use of the back-up CM if the assigned CM is not available. The CM explains an on-call CM is available to the member after business hours if needed. In addition, the CM discusses special needs, such as durable medical equipment, name of Primary Care Physician (PCP), and inquiries about other insurance. If the member's PCP is assigned through another insurance plan or Medicare Advantage Plan (MAP), the CM advises the member to retain that provider. The CM must obtain signed consent to exchange information and coordinate services and benefits with the

other health plans. The CM discusses advance directives, living will, and Mental Health Power of Attorney (MHPOA) and requests copies of any documents the member might have. For Behavioral members, families are encouraged to pursue advanced directives that meet the legal requirements to admit to a Level 1 Psychiatric Unit. The CM then schedules the on-site visit with the member and their chosen natural supports. The visit occurs within 12 business days of enrollment, but is expedited for members with special needs.

The CM utilizes all available documents provided to them at the time of enrollment. Typically available are the PAS and if transitioning, the Program Contractor Change Request (PCCR) form (includes the Enrollment Transition Information [ETI] form, case notes, assessments from previous case manager and other support documents).

Members Needing Behavior Management
If the new member was receiving behavioral health (BH) services from the Regional Behavioral Health Authority (RBHA) or the PAS indicates there may be behavior management issues, the Transition Coordinator or receiving CM consults the Qualified Behavioral Health Professional (QBHP) working closely with the previous program's Case Manager and Transition Coordinator. During this process, all information related to a member's health and welfare is gathered. If appropriate, the member is assigned a Behavioral Health Case Manager (BHCM) at this time.

At the intake visit, the CM familiarizes the member and member's family or informal support system with the P/GLTC Program and answers any questions. The CM assesses the member's current living situation, functional abilities, medical condition, psychological functioning, and current medications. In addition, the CM assesses the member's social,

environmental, cultural factors influencing care as well as financial status, resources, and prior planning. The CM identifies the member's strengths, needs, and goals for use in service planning. The CM collaborates with the member to develop a care plan until the Interdisciplinary Care Team (ICT) meeting occurs to fully review the case. The CM completes the Uniform Assessment Tool (UAT).

The intake and assessment is documented using a PC tablet in CH Mack "Q" Continuum, the electronic medical and case management information system. "Q" includes Assessment, Service Authorization, Disease Management, Assessments, and Case Notes modules, allowing each location and level of care to be documented and reviewed by ICT members.

At the time of the initial visit and assessment, if the CM determines the member meets the criteria for a BH referral, the CM completes a BH Referral form. The member is then transferred to a BHCM. For members with BH needs, the CM requests evaluations from providers involved in the member's care. If no provider exists, the CM requests a specialist evaluation for recommendations on appropriate care. The CM can staff any member internally with their care team, the team nurse, the Chief Medical Officer (CMO), and the QBHP, if appropriate.

Members with Complex Medical Care Needs
If a member is initially identified by the PAS as having complex care needs, the Transition Coordinator or receiving CM works with the ICT nurse, Medical Management (MM) and CMO to optimize the member's health outcomes. Assessments and support services by MM staff include disease management, medical case management, and care coordination needs.

Children enrolling with P/GLTC, either as new or transitioning members from other Program Contractors, are reviewed by the CM Supervisor/Transition Coordinator. The CM Supervisor reviews all cases with the Maternal Child Health and Early Periodic Screening and Diagnostic and Testing (EPSDT) Coordinator.

Members under age 21 are reviewed to ensure their EPSDT screenings are complete and that they are assigned to case managers who specialize in a mixed children/adult caseload. The CM also uses the assessment tools and screen children for eligibility for Children Rehabilitative Services (CRS) and Arizona Early Intervention Program (AzEIP).

Service Planning
Service Planning integrates the results of the PAS scoring tool, the strengths, needs, and preferences of the member, the initial CM assessment, and the medical information from involved providers. Services are identified to allow the member to reach the highest level of independence, maintain dignity, while still being cost effective. Members have a right to accept or decline these services.

To assist in service planning and within three weeks of the member's enrollment, the CM reviews the member's care plan in the weekly ICT meeting. The ICT includes the CM, MSR, CM supervisor, behavioral health coordinator, MM nurse, and a Network Development and Management (NDM) representative. The ICT identifies problems and sets short, intermediate, and long term goals with measurable outcomes.

For Members Needing Behavior Management
The CM initiating BH services for the member reviews the member's request or need for services with the QBHP within three business days of the request. If the member chooses to reside in the community, traditional case management services such as personal care or family support are provided by a contracted HCBS-certified agency. A spouse or parent is not allowed to provide these services

Based on the member's needs, the CM makes a referral to our preferred contracted provider and authorizes services. If none of P/GLTC's contracted providers are able to meet the behavioral health needs of the member, then the CM collaborates with NDM to pursue going out of network. Once an appropriate provider is identified, a single case agreement (SCA) form

is completed by the CM and reviewed by the Chief Medical Officer (CMO) for appropriateness. When the SCA is finalized, the official referral and service authorization are sent to initiate care.

Members with Complex Medical Care Needs
Members with complex medical needs receiving complex, high risk, or multiple medications are discussed in our weekly drug review sessions with our CMO and Pharmacist. Multi-disciplinary staffing session for HIV members and others with complex medical needs occur at least quarterly. These sessions serve to improve the quality and care coordination these members receive.

P/GLTC uses the Managed Risk Staffing process to review members with special needs or those resistant to care. The process is used to:
- Define / review unsafe member choices,
- Identify potential negative outcomes associated with those choices,
- Identify strategies to reduce the potential for or harm related to negative outcomes, and
- Document member, CM and provider collaboration and understanding of unsafe choices.

Coordination with Multiple Providers or Involved Entities
Members with complex care needs and/or intensive behavioral health needs may require coordination of services across the healthcare continuum. The CM contacts all involved providers and ensures information is shared to avoid duplication and gaps in member's services, considering the member's primary insurance as needed. The CM uses multiple forms of communication to ensure all parties stay informed of the member's status - email, faxes, teleconference, voice mail, and in person staffing. The CM follows up with the direct care providers and PCP to ensure appropriate response to medical needs.

Members Needing Behavior Management
The CM for members with intensive BH needs may be requested to attend external discharge planning and individual care planning (ICP) sessions to address member's needs. The CM attends weekly internal care coordination sessions with the CMO and attends outside meetings with the BH providers. CMs initiate communication with the PCP and the BH prescriber to document changes in the member's medication, medical condition, and other significant changes, such as multiple emergency room, urgent care, or hospital visits. Communication is also initiated when there are multiple concerns expressed by involved agencies, crisis calls, or if the member is Court Ordered for Treatment.

Members with Complex Medical Care Needs
P/GLTC CMs refer members requiring home health nursing or attendant care (AC) to our "preferred" contracted providers, Horizon Home Health Care. CM staff and leadership meet with these agencies twice monthly to discuss issues. Since we are co-located, we can address any care issues immediately. We also have other contracted AC agencies that serve and provide choice for our members in both Pinal and Gila Counties. These agencies serve some of our most complex members in the most rural areas.

Considerations for Transitional Members
Services for members attempting transition to P/GLTC from other AHCCCS Program Contractors are arranged prior to "accepting" members to our Plan. The Transition Coordinator confirms with the relinquishing CM and the new service site, PCP, and specialist to ensure member's services are not interrupted. The Transition Coordinator works with the former plan's coordinator for pickup of DME and works with P/GLTC's provider to ensure proper set up and education of the member. P/GLTC's Coordinator works with the relinquishing Coordinator or CM to pre-arrange any vital ongoing blanket transportation. Once confirmation of services is received from all parties, the member is accepted by P/GLTC.

Requirement 23: Describe the Offeror's process for assessment and care planning of members for home based services by case managers.

Case Managers (CM) use a person-centered approach to assessments and care planning, working with the member or representative to establish ALTCS covered services and needed community resources. A respect for the member's rights, preferences, interests, needs, culture, language, and belief system is important to case management services.

Assessment
CMs perform HCBS initial assessments within 12 days of enrollment. Re-assessment is completed at least every 90 days in the member's home by the CM. The assessment includes a review of the member's formal and informal supports such as family and friends and their participation in the members care. The CM evaluates durable medical equipment (DME) being used by the member and possible need for additional adaptive equipment to assist in maintaining independence. The member's home environment is also assessed for modification needs with particular focus on transfer and mobility barriers.

Member activities of daily living (ADLs) are assessed with input from the member or representative. Areas assessed include:
- transfer and mobility
- walking
- bathing,
- dressing
- grooming
- toileting including incontinent episodes
- eating

The following member abilities are also evaluated:
- manage medications
- shop
- prepare their meals
- drive
- communicate
- manage money
- housekeeping
- laundry

The member's ability to be left unsupervised is assessed. The diagnosis of Dementia, Alzheimer's, wandering risk, confusion, disorientation and ability to call for help is strongly considered.

The member's current health status, including laboratory results, physician visit information, current medications and medication changes are updated. If barriers to medical care are identified, the CM provides assistance in scheduling appointments and arranging transportation through P/GLTC's contracted transportation provider.

The member's cognitive functioning is assessed using the Mini-Mental Status Exam tool to check for cognitive loss by examining for orientation, attention, calculation, recall, language, and motor skills. The CM also screens for impaired judgment, anxiety, hostile behaviors, depression, delusions, paranoid thinking, wandering, suicidal tendencies, and member's adaptive coping skills using the BH screening criteria listed in the Behavioral Health Services Referral form. This information is used to identify a need for behavioral health services and/or recognize if the member would benefit from being case managed by one of P/GLTC's Behavioral Health Coordinators.

As part of the assessment process, the CM completes a Uniform Assessment Tool (UAT) based on the information obtained during the in-home visit. The UAT establishes the member's level of care which is used to determine the cost effectiveness of the home and community based services (HCBS) being provided. In addition, the CM explains to the member that HCBS cannot exceed 100% of the cost it would be if the member were placed in a skilled nursing facility.

With the member or representative, the CM discusses the member's advanced directive status, including Mental Health Power of Attorney. The importance of these directives is

discussed with special attention given to the member's belief system and cultural preferences. During the assessment, the CM is always prepared with the appropriate documents, living will, durable medical, and mental health power of attorney documents, so they can be provided to the member and representative if needed. As a result of an unrelenting focus on Advanced Directives, P/GLTC accomplished 73.1% member compliance in December, 2010 – up from 39.4% in December, 2008. This is an 85..4% increase making P/GLTC the most accomplished program contractor in Arizona.

Included in the assessment process, the CM, member and/or representative identify any barriers to the member's independence in regards to education attainment opportunities, housing, and employment goals. P/GLTC works with members to assisting them in attaining greater self-sufficiency in these areas. The CM provides the member with available community resources, such as Department of Economic Security, Vocational Rehabilitation Services for employment, and housing assistance through the Pinal or Gila County Housing Authorities for Section 8.

If attendant care, personal care, or house-keeping is deemed a needed service, the CM informs the member of options for selecting a contracted caregiver or the Self Directed Attendant Care (SDAC) Program. The CM educates the member that they have the option of choosing their spouse to be their paid care giver at a maximum of 40 hours per week.

Care Planning
Care planning is an interactive process of assessment with the member or member representative. The CM, member and representative work as partners to develop the member's goals. Care planning includes a systematic approach to the assessment of the member's strengths and needs in a minimum of the following areas:
- Medical Conditions
- Behavioral Health
- Functional Abilities

- Existing Support Systems
- Social/environmental/cultural factors

The member's goals are member centered and specific to the member. Goals are created by the CM by identifying and recording the needs of the member, formulating a plan of action, and thus, making the goals specific and measurable with desired timeframes. During the development of the care plan the CM provides adequate information to assist the member and or representative in making informed decisions and choices. Recommendations from the member's PCP and other providers are incorporated into the care plans as applicable. In addition, care plans are reviewed at each 90 day visit and as needed to ensure progress towards the individualized goals is documented.

Services are mutually selected to assist members in attaining his/her goals for achieving or maintaining their highest level of self sufficiency. Members are provided with documentation at each 90 day visit that defines the HCBS services P/GLTC is providing to the member.

The CM utilizes the ALTCS Member Service Plan Form to list:
- Services that are provided
- Names and phone numbers of the service providers
- The service schedules, if applicable.

The member or representative signs the form and initials one of two statements; this indicates they agree with the service plan or they do not agree with the service plan. The form is signed by the member/representative and CM at its initial development, when there are changes, and at each review. The member/representative receives the original, and a copy is filed in the member's case file.

In addition to the ALTCS Member Service plan, the ALTCS Member Contingency/Back-up Plan is used for members who receive the following critical services at home: attendant care, personal care, homemaker, or in-home respite.

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Service type, frequency, provider information, and Member Service Preference Level are clearly identified. This plan also indicates how gaps in service are addressed and the member's preference level in filling gaps including family support, if applicable. The CM educates the member and representative on how to report gaps in service by filling out the Critical Service Gap form and submitting it to P/GLTC, calling the CM, calling the provider directly, or calling AHCCCS at (800)218-7509. The CM informs the member and representative how to report other problems or dissatisfaction with service delivery by contacting the CM directly so that the CM can address and remedy the problems as quickly as possible.

Upon the member's or member representative's agreement to the service plan, the CM is responsible for coordinating the services with appropriate providers. The CM acts as an advocate for the member and their family to assist with coordinating services to determine the appropriate use of resources. Case Managers contact providers, members or representatives, and caregivers within 30 days of a referral for new members and within 14 days of a referral for existing members. This contact verifies that the service or intervention described on the care plan has been implemented and is meeting the member's needs. The CM conveys necessary information to providers about changes in the member's functional status to assist the provider in planning, delivering and monitoring services.

Interdisciplinary Care Coordination
P/GLTC uses an interdisciplinary approach to care planning. Following the in-home assessment, the CM discusses the member's information with the care team: a care team nurse, case management supervisor, additional care manager, behavioral health coordinator, member service representative, and a representative from P/GLTC's Network Development and Management department. As part of this review process, the member's Care Plan is discussed and finalized to make sure that it is comprehensive and meets all AHCCCS and P/GLTC requirements. Also, by discussing

the member's information in this forum, the information is looked at from each separate discipline, thus allowing for a broader base of knowledge and resources to benefit the member and service delivery.

The CM has various resources and professionals to consult regarding the members care at any time. P/GLTC uses the expertise of the care team nurse, Case Management Supervisors, the Chief Medical Officer and service providers as needed. By having these resources available to the CM at all times, areas of concern can be addressed immediately through a collaborative effort.

Additionally, the P/GLTC Care Plan Task Force assists in training, monitoring, and mentoring Case Managers in effective care planning. The task force consists of a Case Management Supervisor, Behavioral Health Coordinator and CMs.

P/GLTC's interdisciplinary care coordination process requires Case Management Supervisor review for accuracy and cost effectiveness of attendant care services exceeding 20 hours per week.

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Requirement 24: Case Management Scenario A. Oscar

Interaction with Member
Oscar is a forty-two year old male. He has a wife April and two children under 10 years old at home. He is a recent quadriplegic as a result of a fall from his roof. Prior to his fall he worked in construction. Oscar was admitted to the skilled nursing facility (SNF) two weeks ago after a three month hospital/rehab stay. He is a newly enrolled ALTCS member to Pinal/Gila Long Term Care (P/GLTC). He is dependent for most ADLs and IADLs.

Oscar's State PAS is received by the Case Management Supervisor. The same day that the State PAS is received, a Member Service Representative (MSR) enters Oscar's information into P/GLTC's member management system, identifies prior period of coverage, completes a Pinal County parcel search to verify address and county of residence and checks to see if the member received any services through the Regional Behavioral Health Authority. He is then assigned to a case manager (CM). The case manager, Oscar's demographics, age, primary language spoken, and geographic location are considered. He is assigned to the CM that covers the skilled nursing facility where he currently resides.

Within seven business days of Oscar's enrollment, his assigned CM contacts the social worker at the SNF and informs her of Oscar's enrollment with P/GLTC. The CM also asks to speak with Oscar regarding his enrollment into the program. The social worker assists Oscar in calling the CM back later that day. During this phone call, the CM provides Oscar with his date of enrollment, prior period of coverage, AHCCCS identification number, assigned CM's information and phone number, and explains the use of the back-up CM if the assigned CM is not available. The CM apprises Oscar of an on-call CM that is available to him after business hours if the need arises. In addition, the CM discusses any special needs Oscar may have, such as durable medical equipment or an urgent need to see his primary care physician

(PCP). At this time, Oscar does not report any urgent or special needs and provides the name of his PCP, who is already contracted with P/GLTC. The CM learns that he does not have any other insurance, is no longer employed by his previous employer and his spouse does not have insurance benefits through her job. The initial intake is scheduled within twelve business days of the enrollment date and the CM determines who Oscar wants present at the intake. The CM also offers to contact Oscar's wife April to provide the same information he received today which he agrees to. The CM calls April and provides her with preliminary information about P/GLTC's program, contact numbers, and the intake date and time and confirms the accuracy of the information received. Prior to the intake, the CM consults with Oscar's charge nurse at the SNF, PCP, reviews the SNF chart and obtains a copy of the PASRR and any clinical indicator documents.

Assessment and Intake
The CM meets with Oscar and his family for the intake that is conducted at the skilled nursing facility in a conference room to ensure privacy. Per Oscar's request, his wife and his brother are present for the meeting. The purpose of the intake is to familiarize Oscar and his family with the P/GLTC program and initiate service planning. The CM reviews the initial program orientation regarding the ALTCS program and the Member Handbook in detail. The CM explains the member's rights and responsibilities and the procedure for filing a grievance and/or an appeal. A copy of these rights and responsibilities, the member handbook and a provider directory are given to Oscar and his wife. The CM completes an assessment of Oscar's functional abilities, medical condition, psychological functioning, social/environmental/cultural factors, and medications taking into consideration his religious beliefs, strengths, needs, and goals. The CM completes a Uniform Assessment Tool, a cost effectiveness study and obtains copies of Oscar's living will and power of attorney documents. The CM discusses the importance

of having a mental health power of attorney and provides them with the forms to complete if they choose. The CM explains his share of cost while he is in the SNF and completes a share of cost notification.

As part of the intake process, Oscar and his family are provided detailed information on the Self Directed Attendant Care (SDAC) program, including the skilled component, and spousal attendant care program are available to him once he returns home. The CM informs him of the choice to select his spouse to be the paid caregiver for medically necessary and cost effective services and that the attendant care hours cannot exceed 40 hours in a 7 day period. The CM further explains the 40 hour limit is effective even if the spouse completes only a portion of the 40 hours and another paid attendant care worker completes the rest. The CM informs them of the availability of respite hours to provide rest/relief to unpaid family care givers, not to exceed 720 hours or 30 days per contract year. Oscar and April agree he should return home but feel it would be difficult to care for him, work part time and take care of their two children. April states she is not interested in becoming the spousal attendant care giver. Oscar's brother contributes by stating he is interested in being a paid care giver when Oscar returns home. April informs the CM that Oscar has been home once since his injury. She would like more therapeutic home visits to prepare the family for his homecoming and he agrees. She explains there are accessibility barriers in the home, primarily at the entrance of the home and in the master bathroom. These barriers would prohibit Oscar's wheelchair from getting through the doorways. The CM will assess Oscar's home while he is on therapeutic leave to complete an evaluation for possible environmental modification

The CM discusses his short and long term goals. Oscar reports that he is not happy with his current placement at the SNF because the staff handles him "roughly" and all the other residents are "too old". Oscar requests a complaint be filed regarding the way staff

handle him. Oscar also reports he is not getting enough physical therapy (PT) and that his custom wheelchair is hard to maneuver. The CM explains P/GLTC's complaint/concern process and informs him that an internal complaint will be submitted once the CM returns to the office. The CM further explains that the Quality Management department at P/GLTC will investigate the complaint and follow up as necessary.

Oscar tells the CM that he would like to eventually return to work to help support his family. April inquires about any programs or assistance available to help her obtain a wheelchair accessible van. The CM provides contact information for the Vocational Rehabilitation Independent Living program that may be able to assist with this request. The CM recommends he begin the process of applying for social security disability insurance. The CM informs April and Oscar that P/GLTC provides transportation to all medical appointments through our contracted provider, MTBA. The transportation includes wheelchair accessible vans.

April voices concerns about Oscar's ability to control his anger. In reviewing the SNF medical records and talking with the charge nurse, the CM learns that he presents as angry and depressed. SNF staff report that he occasionally becomes agitated with care givers and orders staff to leave when they arrive to provide care to him. Staff report he sleeps all morning, into the early afternoon, and does not want to be disturbed for care; he has become confused and disoriented recently. The CM manager discusses this information with Oscar and his wife. Behavioral health services, such as individual and family counseling and a psychiatric evaluation, are offered. Oscar states he would like counseling to address his sudden loss of abilities and anger issues.

Oscar's Care Plan/Services

Immediate and Long Term Goals/Outcomes

1. By the next review period, Oscar will report he is satisfied with his current placement and services at the SNF.
2. Oscar will participate in weekly counseling sessions to address issues of anger and depression.
3. Oscar will participate in planned SNF activities two times per week.
4. Oscar will have no more than 2 anger outbursts a month.
5. Oscar will wake up before noon at least 3 days per week.
6. Oscar will report satisfaction with his PT through the next 180 days.
7. Oscar will show progress in his ability to properly use his wheelchair by the next review.
8. Oscar will explore vocational rehabilitation options in the next 180 days.
9. Oscar will move to his family's home in the community.

Services Plan

1. CM provides the member with alternative placement options. (Goal 1)
2. The CM will talk with and request documentation from the physical therapist to find out Oscar's PT progress and how often he is receiving and participating in, PT. The CM will give these notes to the care team nurse to review and provide feedback. (Goal 6, 7)
3. The CM will request a goal of PT be added to his treatment plan, that Oscar will be able to successfully use his wheelchair with the use of his limbs or be able to control the wheelchair with his chin. (Goal 6, 7)
4. The CM will talk with the Director of Nursing and activities director at the SNF and find out what they are doing to involve Oscar in activities. (Goal 3)
5. The CM will talk with SNF staff and PCP about a referral for Occupational Therapy to assist Oscar with improving his abilities to perform his activities of daily living. (Goal 7, 8, 9)
6. The CM will facilitate an appointment for Oscar to see the PCP to rule out a urinary tract infection or any other medical condition that may attribute to his confusion and disorientation. (Goal 4, 5)
7. The CM will staff Oscar's request for counseling and psychiatric evaluation with P/GLTC's Qualified Behavioral Health Professional within three business day of the request. The CM will make a referral for counseling and a psychiatric evaluation within one business day of the staffing. The CM will ensure that services have started within 30 days of the referral. (Goal 2, 3, 4, 5)
8. The CM will confer with P/GTLC's Housing, Education and Employment (HEE) specialist and make a referral to vocational rehabilitation services. (Goal 8)
9. The CM will arrange for Oscar to have a maximum of nine (9) therapeutic visits to his home per contract year. These visits will assist Oscar and his family to prepare for his homecoming. (Goal 9)

Requirement 24: Case Management Scenario B. Magda

Interaction with Member

Magda is an 83 year old woman who relocated from Romania several years ago. She lives with her daughter Raquel, her son-in-law and four grandchildren ages 10 to 16. Her medical history includes diabetes, chronic renal failure requiring dialysis three times per week, and a recent diagnosis of early stage dementia. She is confused and has difficulty ambulating without assistance. Recently she has experienced several ground level falls. Magda speaks very little English; her daughter has limited English skills also. Magda has been a member with P/GLTC for two years.

The case manager (CM) contacts Magda and her daughter to schedule a reassessment. In order to effectively communicate with them, the CM utilizes the P/GLTC contracted Language Line which includes Romanian interpreters. Magda states she wants to meet in her home with her daughter present. The CM coordinates with the Language Line to schedule an interpreter for the reassessment.

Assessment

The CM meets with Magda, her daughter Raquel and the Romanian interpreter via the Language Line at Magda's home. During the visit, the CM assesses her social, behavioral and medical status by utilizing P/GLTC's member management system. Included assessment areas are: Magda's abilities to complete her activities of daily living and her independent activities of daily living, support systems (formal/informal), medications, skin condition, immunizations, psychological functioning, diabetic screening and equipment needs. Due to her recent diagnosis of dementia, with the permission of Magda, the CM completes a Mini Mental Status Exam (MMSE). The CM further assesses her needs by completing the Home and Community Based Services (HCBS) needs tool and Uniform Assessment Tool (UAT). P/GLTC's CM is trained to incorporate Housing, Education and Employment (HEE) into each reassessment with the member. Due to Magda's age and complex health needs,

continuing education and employment are not considered. Housing was discussed and she is not interested since she is comfortable living with her family.

Since the CM has copies of Magda's living will and medical power of attorney documents already on file, the CM discusses the advantages and importance of executing a Mental Health Power of Attorney (MHPOA). The CM provides them with forms to review and complete if they choose. The CM also provides them with pamphlets from Pinal Gila Council for Senior Citizen's Legal Advocacy Program.

Given that Magda is diagnosed with diabetes and is enrolled in the P/GLTC Diabetic Disease Management Program, the CM ensures that they understand the informative pamphlets on disease management. The CM reviews and documents her last HGA1C and Lipid test.

The CM reviews the member handbook, noting any changes or updates. Magda and Raquel are reminded they can reach the CM during business hours and if the CM is not available, a back-up CM is always available to assist with urgent needs. The CM also reminds them P/GLTC has an after hours CM available, 24 hours a day 7 days a week; the on call phone number is provided. The CM completes the description of services, AHCCCS/ALTCS member critical contingency back up plan, and provides Magda and Raquel with a copy of the service GAP reporting form and important member rights notice.

Magda reports she misses getting out and going to church and says her daughter is embarrassed that she can't speak English well. Raquel reports her Mother gets too agitated during the church service and would like to have respite services on these days so she can attend church without her. The CM recommends that they talk to her PCP about her increased agitation. The PCP may refer her to a psychiatrist for a psychiatric evaluation and possible mediation monitoring, which in turn, will help decrease

Magda's agitation and allow her to attend church with her family. The CM acknowledges socialization is important to Magda and will be explored through community resources and support from her church.

Raquel reports that she wants her Mother to have a new PCP because she is having difficulty making appointments with the current PCP. The CM submits a complaint that is investigated by Quality Management at P/GLTC. The CM works with P/GLTC's Network Development and Management department to find a PCP who speaks Romanian. The CM provides them several PCP names to choose from. A new PCP assignment is made within five business days of Magda notifying the CM of her choice of PCP. P/GLTC will notify the previous PCP of her discontinuance and notify the new PCP by providing Magda's demographics.

Raquel reports two gaps in service from the attendant care provider. On these two occasions, the caregiver did not show up on time. Raquel states that she was late for work these days because the caregiver arrived late. Raquel stayed home until the caregiver arrived. Raquel reported both gaps to the CM coordinator at the attendant care agency via the on call number. Both gaps were reported to P/GLTC by the attendant care provider through the non-provision of services log. The CM revisits with them member's rights related to the Ball vs. Betlach order. The CM reviews information on how they can provide notification of a gap in critical services by contacting the CM or completing the critical service gap reporting form and mailing it P/GLTC. Raquel is reminded that informal support/family is not considered the primary source of assistance in gaps unless the member has indentified this as the primary choice. The CM reviews the AHCCCS/ALTCS Member Contingency/Back-up Plan and explains the importance of calling the agency at the time of the gap. The CM reminds them they may change Magda preference level at the time of the gap depending on her level of need. Magda indicates she wishes to remain a preference level 1, so she requires services within 2 hours.

She prefers to have a back up caregiver from the agency and signs her Contingency Back-Up Plan and is provided a new copy.

Raquel reports her Mother's increased confusion and recent falls while using her walker, and a fall in the shower last week that did not result in an injury. Given her fall risk she is enrolled in the P/GLTC Fall Reduction Program. The CM performs an environmental assessment, a review of her medication, and recommendations for any needed durable medical equipment or home modifications that will assist in preventing falls. The CM identifies that grab bars in the shower and a shower chair would help in preventing falls.

Raquel makes a request for an increase in Attendant Care (AC) due to Magda's increased confusion and need for more assistance. With the information obtained for the reassessment visit, the CM utilizes the HCBS Needs Tool and assesses the AC care hours to be less than the hours she is currently receiving. Neither Magda nor Raquel agrees with the currently assessed hours. The CM explains, the assessment of hours will be staffed with the CM supervisor and Chief Medical Officer. If the decrease in hours is approved, a Notice of Action (NOA) letter is mailed to Magda within 14 days of the assessment. The NOA explains the decision to decrease AC as well as the process to appeal this decision. The CM also identifies that P/GLTC will not reduce the AC hours until 10 days after the date of the NOA letter. During those 10 days, the member has the opportunity to appeal for continuation of these services.

The CM completes a preliminary cost effective study (CES) and determines if the requested services fall within the range of 100% or less of nursing home placement. Magda's CES is calculated at 65%. The CM also completes a mutually agreed upon ALTCS Member Service Plan that is signed by Magda and the CM. They are given a copy of the form.

Magda's Care Plan/Services

Intermediate and Long Term Goals/Outcomes

1. Magda will have regular quarterly and annual diabetic screenings and examinations.
2. Magda will be taught to effectively use her fall reduction equipment (e.g. grab bars), provided with assistance with transfers and ambulation/mobility with no hospitalizations required due to falls or injury.
3. Magda will report she receives daily assistance with her ADL/IADL needs and will receive assistance with AM grooming/dressing and meal preparation.
4. Magda will report a 25% decrease in feeling agitated by the next review.
5. Magda will attend be able to tolerate outside activities i.e. Church or Community Services by the next review.
6. Magda will report satisfaction with her PCP by the next review.

Service Plan

1. CM staffs the decrease in AC hours with CM supervisor and if approved, CM sends out NOA to Magda within 14 days.
2. CM notifies the provider agency of the reduced AC hours, and effective date. CM ensures the provider is aware of Magda's contingency/back-up plan and adheres to member's preference level for critical services. (Goal 3)
3. CM contacts the PCP to request orders for grab bars and a shower chair. The CM approves the durable medical equipment within 14 days of receiving the scripts. (Goal 2)
4. CM authorizes 3 hours of Attendant Care on Sunday's when needed. (Goal 3).
5. CM contacts Magda's PCP to problem solve and inquire why there are issues with scheduling appointments. Rectify issue, or change PCP's. (Goal 6).
6. CM will review the Clinical Indicator Performance Measure (CIPM) report monthly to ensure that Magda has her diabetic screening tests completed quarterly and annually. The CM also reviews the report with the CM supervisor and care team Nurse. (Goal 1)
7. CM assists with setting up doctor's appointments and transportation as needed (Goal 1, 6)
8. CM staffs Magda's request for a psychiatric evaluation with PGLTC's Qualified Behavioral Health Professional within 3 business day of the request. The CM makes a referral for a psychiatric evaluation within one business day of the staffing. The CM will ensure that services have started within 30 days of the referral (Goal 4, 5).
9. CM researches Romanian resources/supports in the community by utilizing Arizona's Community Information and Referral line. These resources are provided to Magda. (Goal 5)
10. CM provides Raquel with information on P/GLTC's Caregiver Support Program.

Requirement 24: Case Management Scenario C. Wanda

Interaction with Member

Wanda is a 66 year old female. She is diagnosed with Diabetes, Peripheral Neuropathy, Hypertension, Congestive Heart Failure, and Pelvic Cancer. She has been living in an Assisted Living Facility (ALF) for the last six weeks, prior to that she lived with her son and daughter in-law and was receiving Attendant Care (AC), her son is her designated representative. Wanda has been enrolled with Pinal/Gila Long Term Care (P/GLTC) for the last six months. Her Primary Care Physician (PCP) is assigned through her Medicare Advantage Plan (MAP) and she is satisfied with the PCP. P/GLTC is not contracted with the PCP; however a provider search on the Client Assessment Tracking System (CATS) identified the PCP has an active identification number. This will allow for claims to be processed and prior authorization of services as needed.

HIPAA release forms were signed by Wanda to release HGA1C and Lipid testing along with her foot and retinal eye examination information. The results of the testing and exams were given to the P/GLTC Inter-Disciplinary Care Team nurse for review and tracking for quality management purposes. The Case Manager (CM) was able to assist Wanda's son in setting up a future physician appointment for her next needed lab draws and continued diabetic monitoring. Advanced Directives were addressed during the initial visit and review visits. Her son provided the CM with copies of her Durable, Medical and Mental Health Power of Attorney. A copy of the Advanced Directives was included in Wanda's case file, and forwarded to her PCP.

Her medical, behavioral, and environmental needs were assessed initially at her Initial/Intake visit and again at her 90 days review by her CM. Because Wanda is a fall risk pamphlets from the Area Agency on Aging were also given to Wanda and her son on the counties Falls and Prevention program.

Placement options were reviewed at Wanda's

last home visit. A list of the ALFs contracted with P/GLTC was provided to Wanda and her son per their request and the responsibilities of room and board were discussed at the time. Keeping Wanda at home with additional home services/hours and providing respite care hours to relieve Wanda's son and daughter-in-law were considered. The CM explained the cost effectiveness study results with them and the impact it has on the amount of services that can be provided in the home setting. The CM explained the appeal and grievance process, including the use of the Notice of Action, and who to contact, should they not agree with any health care decisions. The CM provided information on care giver support groups in their area, including the care giver support program provided by Community Programs through the Area Agency on Aging.

Six weeks ago, the member's son moved Wanda into an ALF without the involvement of the CM. The move took place on a Friday evening and the facility reported the move to the CM the next Monday. The CM contacted Wanda and confirmed her wish to maintain ALF placement. The CM contacted Wanda's son, he informed the CM she had several falls at home and they felt she was in need of more care and supervision than the family thought they could handle. The CM used the ALF reimbursement level criteria and Uniform Assessment Tool to determine her level of care need. A residency agreement between Wanda, P/GLTC and the ALF, identifying the room and board responsibility and total daily cost of care was completed by the CM and sent to the ALF for signatures. The CM completed authorizations for the placement and contacted the AC provider to discontinue services and change the authorization end date and total units authorized. An electronic Member Change Report was sent to ALTCS eligibility including reported the member's change of address to the ALF residency. The Placement Maintenance Data screen in CATS was modified recognizing the member's residence change.

Assessment

The CM contacted Wanda and her son to set up a review date. At each review the CM assesses the member's medical, behavioral and environmental needs and determines the member's level of care. The CM works with Wanda and her son to identify her member centered goals and to identify strengths and barriers that might affect Wanda's ability to meet her specific desired outcomes.

Wanda's diabetes can complicate her ability to maintain a stable health condition. Her disease process awareness with the support of her PCP, CM, and IDCT Nurse will achieve and maintain her highest level of functioning. Wanda continues to be a member of the Diabetes Management Program (DMP). Interventions identified by the DMP nurse in collaboration with the CM, focused on maintaining Wanda's nutritional status during her cancer and subsequent therapy. The results of the screens and exams are given to an IDCT nurse for review and tracking for quality management purposes. The CM completes screen and exam follow-up before and after each review.

The CM arranges for Wanda to be seen by her PCP to rule out any medical condition such as a Urinary Tract Infection (UTI) or medication/treatment side effects that may contribute to her confusion and combativeness. If no attributing medical conditions are found, a referral for a psychiatric evaluation will be conducted. Wanda was recently diagnosed with cancer and may develop depression and require counseling and/or psychiatric medication.

Two weeks ago, Wanda was hospitalized following a second fall at the ALF, which resulted in a broken nose. It was during this hospitalization that she was diagnosed with pelvic cancer and began treatment.

The case manager had concerns the medications administered during the inpatient stay could affect Wanda's mental and functional status and discussed it at the Inter-Disciplinary Care Team with the P/GLTC Chief Medical Officer and team nurse.

Prior to DC, the CM coordinated with the hospital's discharge planner, Wanda, her son and Wanda's PCP regarding placement. Wanda and her son wanted her to return to the ALF and the ALF was willing to accept her back. The CM requested the discharge planner consider an order through the MAP for a wheelchair and hospital bed to be delivered before the discharge. The CM confirms that a transfer bench, shower chair and a chair/bed alarm are available for the member at the ALF. Wanda's level of care and reimbursement level were reviewed upon her return to the ALF and a new Residency Agreement was created and signed.

Due to Wanda's continued falls, a Managed Risk Staffing was held at the ALF. Wanda, her son, the CM, and the ALF manager participated. The staffing addressed unsafe choices being made by Wanda and ALF staff, identified and defined potential negative outcomes as well as identified and defined options that can reduce the probability of negative outcomes such as falls. P/GLTC was concerned the member may need placement in a Skilled Nursing Facility (SNF). She is currently non-ambulatory, more confused, sometimes combative and needing near total care, including being fed. The CM has educated Wanda and her son regarding services the SNF can perform above what can be provided at the ALF. The ALF manager assured they will have staff available to meet Wanda's needs. She and her son request she remain at the ALF. The CM informed Wanda and her son they can request a placement change at anytime.

Wanda's Care Plan/Services

Immediate and Long Term Goals/Outcomes

1. Wanda will remain in her least restrictive environment.
2. Wanda will report she receives assistance with her ADL/ IADL needs on a daily basis and will receive assistance with being fed, evident by her maintaining her current weight.
3. Wanda will have regular quarterly/annual diabetic screenings and examinations.
4. Wanda will be provided daily assistance with transfers and ambulation/mobility with no hospitalizations required due to falls or injury sustained while residing at the ALF.

Service Plan

1. The CM provides the ALF with pamphlets on P/GLTC's Fall and Prevention Program. (Goal #1, 4)
2. The CM will enroll Wanda in the P/GLTC's Diabetes Disease Management Program. (Goal # 3)
3. The CM contacts the member's PCP, following her hospitalization, to clarify where the PCP feels the best placement is to meet Wanda's needs. The CM will discuss Wanda's current level of care, PCP recommendations and Wanda/family's preference for placement in order to make an appropriate placement decision. (Goal # 1)
4. The CM performs review visits at least every 90 days, annual reassessment, and reports progress of goals at each visit. (Goal # 1, 2, 3, 4)
5. The CM will arrange PCP visits for regular quarterly/annual diabetic screenings and examinations. (Goal # 3)
6. CM will review the Clinical Indicator Performance Measure (CIPM) report monthly to ensure that Wanda has her diabetic screening tests completed quarterly/annually. The CM will review the report with the CM supervisor and care team Nurse. The results are obtained from the PCP and the care team nurse enters the information into P/GLTC's CIMP tracking system. (Goal # 3)
7. The ALF staff will ensure Wanda wears a chair/bed alarm while in bed or up in a wheelchair to remind her of the need for assistance when she would like to be transferred. The alarm will also alert staff of Wanda's movements and decrease the risk of a potential fall. (Goal # 4)
8. The CM will conduct another Managed Risk staffing with Wanda, her son, and ALF staff if falls continue to be a problem. Family will be made aware of alternative placement options if it is determined that ALF staff cannot meet Wanda's needs. (Goal #1, 2, 4)
9. The CM arranges for her to be seen by her PCP to rule out any medical condition such as a Urinary Tract Infection or medication/treatment side effects that may contribute to her confusion and combativeness. If the Wanda is found to have no attributing medical findings the member may require a psychiatric evaluation. (Goal #1)
10. Since Wanda was recently diagnosed with cancer, she may develop depression and require counseling and/or psychiatric medication in the future. If Wanda or her PCP requests a psychiatric evaluation, the CM will staff the request with PGLTC's Qualified Behavioral Health Professional within three business day of the request. The CM will make a referral for a psychiatric evaluation within one business day of the staffing. The CM will ensure that services have started within 30 days of the referral. (Goal #1)
11. The CM will discuss with Wanda and her son the benefits of Hospice when needed. (Goal #1)

Requirement 24: Case Management Scenario D. Roger

Interaction with Member

Roger is a 39 year old male who is diagnosed with Schizoaffective Disorder and Traumatic Brain Injury. He has moved to Arizona to live with his sister because his mother, who was his Guardian, died. His sister Joyce is now his Legal Guardian. She is struggling to manage his care and does not know about current resources in Arizona.

Roger is assigned a P/GLTC Behavioral Health Case Manager. Initial Contact with Roger and Joyce is made within 7 business days and the Initial visit is scheduled and performed within 12 business days. Joyce informs the CM that Roger was on a Medicaid program in California and they had provided him with some home services. She thinks he went to a day program. Joyce signs a HIPAA Release form allowing Roger's CM to contact the Medicaid program he was previously with. The CM ascertains information about the services Roger received and verifies successes and challenges with Roger's care and services.

The primary care physician (PCP) seeing Roger is contracted with P/GLTC. Joyce states she would like him to continue to see the PCP and verifies his medical records were transferred to the PCP from his previous out of state PCP. The PCP is provided enrollment notification information from the P/GLTC Member Service Representative (MSR).

Assessment and Intake

Roger's intake is conducted in his home. Roger and Joyce are present. The purpose of the intake is to familiarize them with the P/GLTC program and initiate service planning. The CM reviews the initial program orientation regarding the ALTCS program and the Member Handbook in detail. The CM explains the member's rights and responsibilities and the procedure for filing a grievance and or an appeal. A copy of these rights and responsibilities, the member handbook and a provider directory are given to Joyce. The CM completes an assessment of Roger's functional

abilities, medical condition, psychological functioning, social, environmental, cultural factors, medications, taking into consideration his religious beliefs, strengths, needs, and goals. The CM also engages Joyce and Roger in a discussion about any goals they may have regarding housing, education and employment for Roger. Joyce states that at this time, she would like to concentrate on Roger's medical and psychiatric conditions. The CM completes a Uniform Assessment Tool and obtains copies of Roger's Guardian paperwork. The CM discusses the importance of having a Mental Health Power Of Attorney (MHPOA).

They are provided detailed information on the Self Directed Attendant Care (SDAC) Program and Attendant Care (AC), personal care and housekeeping services. Joyce is informed if she chooses the SDAC option for Roger she will need to be available at the home while the care giver is present in order to direct the care. Joyce understands she.cannot be the paid caregiver because she is the member's Guardian. The CM also informs Joyce of the availability of respite care to provide rest relief to informal care givers. Roger is allotted 30 days (720 hours) of respite per contract year and the care can take place in the home, or at an assisted living facility or a nursing facility.

The CM inquires about Roger's current medical conditions and learns that he is having seizures two times per week and his behaviors have escalated in the past month. Joyce also reports that he has fallen each time he has a seizure. Neither fall resulted in injury but she is concerned he may fall again. The CM completes an evaluation of the environment, looking at his bedroom, bathroom and living area. The CM recommends grab bars for the bathroom shower to aide in the prevention of falls. The CM offers to set up a PCP appointment so referrals can be made to any needed specialist using the provider directory, as well as request orders for grab bars. The CM explains that during the PCP visit they can talk to the doctor about member's current medical conditions

and a smoking cessation program.

Joyce reports she would like more information regarding positive reinforcements, because she is currently rewarding Roger for good behavior with cigarettes. The CM provides her with the contact information for support groups in her area to assist her with care giver issues related to taking care of someone with a traumatic brain injury.

The CM discusses with Roger and Joyce his short and long term goals. Joyce reports she is struggling to manage Roger on her own. He is resistive to care at times and has had some verbal and physical aggression toward her. Joyce informs the CM that Roger is fabricating the past and has attempted to leave without supervision. She does not leave him alone because of his impaired judgment, need for redirection and risk of injury related to his potential aggression. She reports that Roger does not take his medications as prescribed. The CM explores behavioral health treatment options with Joyce and Roger. They are interested in attending counseling services and exploring psychiatric treatment for possible psychiatric medication. Additionally, the CM discusses home health nurse (HHN) options to assist Roger with taking his medications as prescribed. The CM explains that orders from the PCP are needed for HHN services. Joyce states that she is interested in this service.

Roger reports he is bored and stays in his room most of the day watching TV. The CM explores available services that would allow Roger to get out of the home and increase his socialization. Due to Roger's diagnosis of traumatic brain injury, the CM offers Adult Day Health Care (ADHC) at Daybreak; the program is designed for traumatic brain injury members. The program is discussed in length with Roger and Joyce who both feel this would be good for Roger. The traumatic brain injury ADHC can assist Roger with activity involvement two times per week. If Roger has good behavior reports from the traumatic brain injury ADHC, then he may be able to attend 3 additional days of regular (non TBI) ADHC.

The CM completes an HCBS Needs Tool to assess for attendant care hours based on the information provided from the intake, taking into consideration that Roger will attend ADHC 2 days per week. Twenty-five hours per week are assessed. Joyce explains to the CM that she would like to have assistance from an outside care giver on the days Roger does not attend ADHC. She wants to remain his informal care giver and feels the combination of support from ADHC and AC will help her not get burnt out.

The CM, Joyce and Roger work together to develop Roger's care and service plans. Mutually agreed upon, member centered goals are created based on Roger's strengths that enable him to reach his highest level of independence. A cost effective study is also completed to ensure HCB services do not exceed 100% of the institutional cost. Joyce is asked to mark agree or disagree to each service and schedule listed on the ALTCS Member Service Plan document and sign; she is provided a copy of the form for her records. The AHCCCS/ALTCS Member Critical Contingency/Backup Plan is also discussed. The CM assists Joyce in choosing a preference level of care. Joyce chooses preference level 1, stating that Roger will need services within 2 hours due to his impaired judgment and need for supervision. The CM informs Joyce that she does not have to be the back up worker for the paid care giver; it would be her choice at the time of service. The CM explains that since AC is a critical service, Joyce is instructed to call the attendant care agency, the CM and or AHCCCS immediately if a scheduled care giver does not show up to the home at the scheduled date and time. Joyce is also given a copy of the Critical Service Gap Report Form, and informed to fill out the form and give it to the CM if a gap occurs.

Roger's Care Plan/Services

Immediate and Long Term Goals/Outcomes

1. Roger will remain in the community with his sister.
2. Roger will have good daily hygiene as evidenced by daily bathing and clean clothes.
3. Roger will attend Daybreak, ADHC, 2 times per week to increase socialization.
4. Joyce will report that Roger has less than two episodes of aggressive behaviors per month and less than two episodes of resistive behaviors per week
5. Roger will not leave the home without supervision in the next 90 days.
6. Roger will not have any psychiatric hospitalizations in the next 90 days.
7. Roger will be seen by contracted PCP with in two weeks of intake date to discuss his recent seizures and respiratory infections.
8. Roger will not have seizures or hospitalizations related to unstable medication or diagnosis with in the next 90 day review.
9. Roger will have no falls resulting in injury in the next 90 days.
10. Roger will take his medications as prescribed on a daily basis.

Service Plan

1. The CM staffs Joyce's request for counseling and psychiatric services with P/GLTC's Qualified Behavioral Health Professional within three business days of the request. The CM then makes a referral for counseling and psychiatric services within one business day of the staffing. The CM ensures that services have started within 30 days of the referral. (Goal 1, 4, 6)
2. The CM faxes signed HIPPA release forms to all applicable out of state providers 5 days from the date of intake, collects and reviews the documents and forwards the documents to the PCP within 5 days of receiving the documentation.
3. The CM assists Joyce with setting up transportation and the initial PCP visit, within 3 days from intake, to obtain orders for ADHC and referral for specialists. The case manager will then follow up to insure specialists are able to see member within 45 days of PCP referral date. (Goal 4, 6, 7, 8)
4. The CM sends a referral to AC agency and ADHC agency, with in 2 days of intake along with schedule and times. The back up plan and preference level of the critical service is also sent to the AC agency. The case managers insures services for member are started with in 30 days of enrollment and follow up with member to ensure satisfaction with services. (Goal 1, 2, 3, 5)
5. CM staffs the HCBS Needs Tool with the CM supervisor since the assessed hours are over 20 hours/week. (Goal 1, 2, 5)
6. The CM contacts the PCP to request HHN and grab bar orders. Once the orders are received the CM will approve or deny the orders within 14 days of receipt. If approved, the CM will contact Joyce to ensure services have been started and that she and Roger are satisfied with the services. (Goal 6, 8, 9, 10)
7. The CM conducts an environmental assessment of the home to determine the need for any home modifications. If modifications are needed, the CM staffs the environmental modifications with Chief Medical Officer for approval. CM then requests PCP orders and coordinates the modifications. Environmental modifications will be completed within 90 days of being approved by the Chief Medical Officer.

Requirement 25: Describe how utilization data is gathered, analyzed, and reported by the Offeror. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Additionally, the Offeror must include three sample utilization reports that demonstrate how data is gathered, analyzed, monitored and evaluated when a variance has been identified.

P/GLTC demonstrates its commitment to ensuring high quality of care and services in a cost effective manner through its Medical Management (MM) Department activities. These activities use the analysis of valid utilization data to monitor over and under use of services and identify opportunities to improve the appropriate use of financial and human resources. The goal of the Program is to improve service delivery, decrease barriers to care, and increase coordination among members, providers, and P/GLTC, while targeting care to members needs.

Data Gathering
P/GLTC gathers utilization data from multiple sources: 1) The Q Continuum System, which is a case management and medical management software program that contains detailed member information entered both as member-specific case notes and via automatic downloads; 2) The Plexis claims system which contains claims data, authorization information, provider specific information, such as contracted vs. non-contracted, panel capacity and current member assignments; 3) Customized databases that use Microsoft Access to integrate member-specific data collection with automated data collection. 4) AHCCCS Data Warehouse. The methodology of data collection/gathering is categorized by functional topics and program elements below.

P/GLTC prior authorization staff enters service authorizations data into our Q and Plexis information systems. The systems track: 1) compliance with mandated timeframes for processing, notification, and actions; 2) consistency through quarterly inter-rater reliability activities; and 3) number of referrals and denials by service type. Additional customized or "ad hoc" reports are added to the monitoring process for specific review of

services as needed. In addition, MM Team, led by the Chief Medical Officer (CMO) and Director of Quality and Medical Management (DQMM) monitors, analyzes, and reports wheelchair service request and delivery. The wheelchair referral reporting includes the timeliness of prior authorization and average time frame from approval to delivery, timeliness of wheelchair repairs, and an ongoing evaluation of wheelchair denials against clinical criteria.

P/GLTC MM tracks and trends multiple aspects of the Concurrent Review (CR) process. The monitoring program reviews the competency of the P/GLTC staff, regulatory compliance, adherence to member rights, and provider performance. All monitoring aspects are reported to the M/UM Committee and used for systemic improvement. Variance days are tracked in order to manage inpatient utilization and identify provider network issues, effectiveness of discharge planning, quality of services, as well as the success levels of case management (see exhibit 25-1). Once identified, the DQMM forwards the information to the Director of Network Management and Development (DNMD). The two collaborate and determine if intervention is needed, and if so, the appropriate level of intervention. Variance days are tracked by the hospital, attending physician (for denied subsequent review days) and admitting physician (for denied admissions). P/GLTC gathers data on the timeliness in which facilities provide concurrent review information. The purpose of tracking this information is to identify potential desirable hospital partners or hospitals that may need additional information or contractual counseling from P/GLTC Network staff. Access to timely CR information is essential in the effective management of resources, identification of at risk members, and in supporting the reinsurance process.

Strong emphasis is placed on data related to inpatient utilization. Inpatient utilization metrics include inpatient days per 1000 members, average length of stay, median length of stay, and five most frequent inpatient diagnoses. The five most frequent inpatient admission diagnoses are tracked to assess opportunities to improve service delivery and to identify trends that may be related to admissions and/or coding (e.g. high frequency primary admission diagnoses of urinary tract infections).

Our MM, CM, and Behavioral Health teams collaborate in applying criteria and evidence-based utilization review system for members needing inpatient behavioral health care. McKesson InterQual criteria sets are used to determine the appropriateness of all behavioral health admissions and continued hospital stays for members that have P/GLTC as their only payor source. P/GLTC also collects and evaluates the timeliness of BH services, access to HCBS services for this high risk population, and the impact of these services on physical health conditions.

Condition-specific utilization targets members enrolled in identified disease management programs. We collaborate with the member, provider, and community resources to provide individualized support and care coordination services to improve the member's condition and self management. Member interventions are based on a risk stratification model and national clinical practice guidelines and include receipt of culturally sensitive educational materials, care plans, routine, and professional nurse case management services. For example, we identified that members with high HbA1 (>9) were under utilizing their PCP. These members had fewer PCP visit than those members in good control. No specific PCP trend was identified, so efforts were focused at the members. Through education and case management support, those members were encouraged to visit their PCPs at least quarterly (see exhibit 25-2).

The MM Leadership and Disease Management teams use utilization data to monitor the clinical and environmental safety of our members. The Member Safety Program uses nationally-recognized strategies. The program includes polypharmacy review, high risk medication management, and fall prevention.

The Polypharmacy Review targets P/GLTC members who receive 10 or more medications or have a pharmacy expense greater than $500 per month. In collaboration with the P/GLTC pharmacists, the Pharmacy Benefits Manager (PBM), and case management, a clinical pharmacy review of all members meeting the criteria is performed on a semi-annual basis. Our Care Teams discuss polypharmacy review findings in the Interdisciplinary Care Team (ICT) meetings. Primary Care Providers (PCPs) receive copies of findings for follow up. Our CMO contacts the PCPs as indicated to ensure prompt attention to urgent needs, e.g. the CMO contacts the PCP when polypharmacy review indicates the member receives multiple types and excessive amounts of pain medications in addition to sedatives and anti-depressants. Member interaction strategies include member assessments, care coordination, and culturally sensitive education. Provider interaction strategies include notification of the poly-pharmacy review, findings, and recommendations if the potential for adverse events or interactions exists.

The High-Risk Medication Management targets those members receiving long term Warfarin therapy, identified through PBM reports. Case Managers with additional training on Warfarin risks and complications provide focused care coordination, including reminders for or home-based access to coagulation testing. Members with questions about their therapy are referred to clinical pharmacists or nurse CMs. Narcotic dispensing reports are reviewed to identify potential over-utilization of narcotics. These reports cite the member, medication, ordering provider(s), date, and the number dispensed. Interventions are aimed at the provider from a notification perspective. The CMO may review alternatives with the ordering providers. Members are subject to a Narcotic Use

agreement, developed in collaboration with their PCP and CMs. In addition, they may face limitations in all of their dispensing sites (see exhibit 25-3).

The impact of falls on our member population was identified through a review of Emergency Department (ED) utilization. ED visits are routinely monitored for the following: utilization frequency, appropriateness, and causative factors. During the measurement period, a trend was identified related to the number of ED visits related to falls. The P/GLTC Fall Prevention Program, based on Community Health Foundation's "Falls Prevention – Step Up to Stop Falls" program, also aligns with the Arizona Case Management Handbook (DES Division of Aging and Adult Services, April 2010). The Program, implemented in March 2011, serves to prevent falls with and without injury, supports our members in remaining in a home based setting, and avoids healthcare costs associated with the treatment of fall related injuries. The Falls Prevention program is evaluated by the volume of environmental screens, the volume of ED visits, and a decrease in reported fall frequency and resulting injuries.

Actions Taken When Variances in Utilization are Identified
P/GLTC identifies variances in process and outcome data through monthly data review sessions, and quarterly M/UM Committee meetings. Desirable variances are examined to identify best practices that can be spread to others. Success is shared with and celebrated among the stakeholders. For example, recently it was noted that the utilization of targeted evidence-based out-patient testing had improved across the health plan. In addition to reporting the gain at the M/UM meeting, "Congratulation" notices were sent to health plan staff and included on the P/GLTC web site. Provider Recognition initiatives include awards given to those providers with 100% generic utilization, with one to two awards being issued quarterly.

Undesirable variances are identified, evaluated by stakeholders, and action plans developed and implemented to address the variance and its root causes. For example, through the evaluation of inpatient discharge data, an undesirable variance was noted in the discharge diagnoses. Data reflected a greater than desired number of discharge diagnoses related to non-specific urinary tract infections (UTIs). A focus review that revealed each of the inpatient stays, while appropriate, were incorrectly coded. Discussions were held with the facility to improve the coding to appropriately reflect the members' condition.
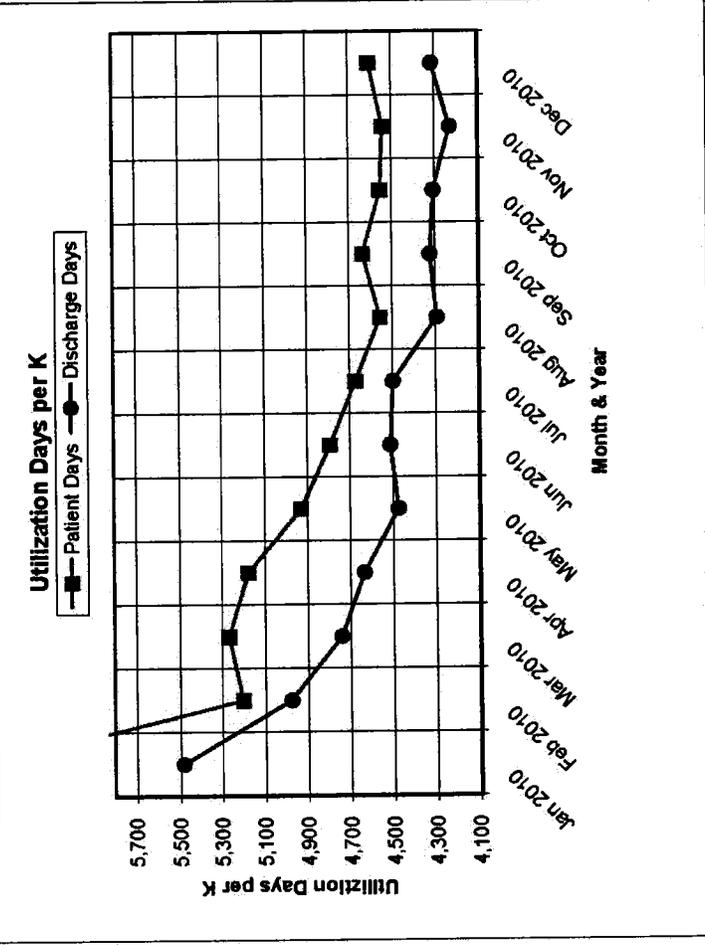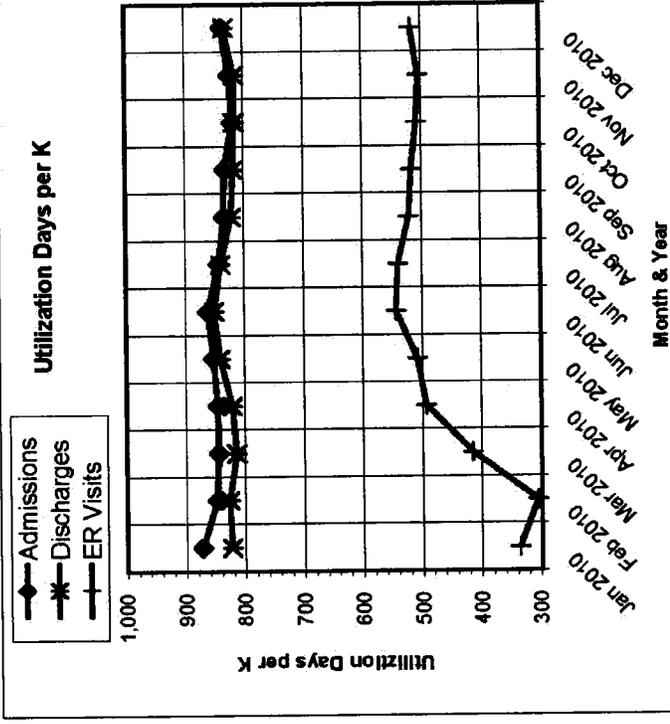
P/GLTC, through its quarterly M/UM committee meetings, assesses, monitors, and reports medical decisions to assure compliance with timeliness, language and Notice of Action intent, and that the decisions complies with all Contractor coverage criteria. The DQMM, in collaboration with the CMO, Medical Management staff, and Data Analyst, analyzes M/UM data and reports findings to the M/UM Committee. The Committee makes recommendations for action and monitors the effectiveness of actions.

P/GLTC develops and maintains a written Medical Management plan that addresses the strategy, structure and processes for monitoring MM activities. The annual work plan serves as a roadmap that includes key performance indicators (KPIs) and reflects the progress of each MM strategy. The MM Workplan Evaluation reviews the effectiveness of the MM strategies and serves as the annual evaluation of the MM activities and the basis of the subsequent year's workplan. The MM plan, evaluation, and workplan are submitted to AHCCCS Division of Health Care Management (DHCM) annually, on or before December 15th.

FY2010 Utilization Days per K Consolidated

published 2/01/2011

Utilization Days per K	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	Jun 2010	Jul 2010	Aug 2010	Sep 2010	Oct 2010	Nov 2010	Dec 2010	YTD
Admissions	873.30	848.35	845.22	846.48	853.30	862.65	844.12	834.32	832.93	819.48	824.55	837.02	837.02
Patient Days	6,406.99	5,204.61	5,268.73	5,178.69	4,930.55	4,794.36	4,674.03	4,556.61	4,637.86	4,553.56	4,542.56	4,605.66	4,605.66
Discharges	822.92	827.14	814.64	821.52	841.68	851.59	840.57	821.87	818.18	816.16	815.50	832.88	832.88
Discharge Days	5,483.31	4,979.80	4,743.25	4,635.87	4,475.67	4,512.34	4,498.82	4,293.03	4,323.32	4,306.39	4,229.02	4,314.70	4,314.70
Emergency Room Visits	335.88	305.41	414.27	492.91	508.00	543.31	539.86	520.93	516.55	507.61	504.23	516.41	516.41

Utilization Days per K

— Patient Days — Discharge Days

Utilization Days per K

— Admissions — Discharges — ER Visits

Summary – Clinical Indicator Performance Measurements

Numbers Represented in this report may differ from the Quarterly Clinical Indicator Reports due to Member Enrollment Begin Dates and End Dates.

	# with Clinical Indicator	# of All	% with Clinical Indicator	# with Clinical Indicator	# of All	% with Clinical Indicator	
Advanced Directives	1204	1469	81.96%	1203	1442	83.43%	Meets or Exceeds Goal of 75%
Vaccinations Influenza	968	1469	65.90%	907	1381	65.68%	Goal of 90% Not Met
Pneumococcal	541	1469	36.83%	541	980	55.20%	Goal of 75% Not Met

	# with Clinical Indicator	# of All	% with Clinical Indicator	# with Clinical Indicator	# of All	% with Clinical Indicator	
Diabetes HGA1C	324	555	58.38%	230	321	71.65%	Goal of 80% Not Met
LIPID	294	555	52.97%	219	321	68.22%	Goal of 80% Not Met
RETINAL	318	555	57.30%	211	321	65.73%	Goal of 70% Not Met
FOOT	143	555	25.77%	96	321	29.91%	No Goal Set

	# with MH POA	# of All	% with MH POA	# with MH POA	# of All	% with MH POA	
MH Power of Attorney	95	1469	6.47%	95	443	21.44%	Meets or Exceeds Goal of 20%

VACCINATION DOCUMENTATION SUMMARY

Vaccines documented as GIVEN	# Given Vac.	# with Clinical Indicator	%Doc.	Vaccines documented as Refused	# Given Vac.	# with Clinical Indicator	%Doc.	Vaccines documented as contraindicated/medical area	# Given Vac.	# with Clinical Indicator	%Doc.
Influenza	714	907	78.72%	Influenza	182	907	20.07%	Influenza	11	907	1.21%
Pneumococcal	366	541	67.65%	Pneumococcal	175	541	32.35%	Pneumococcal	0	541	0.00%

PINAL GILA COUNTY LTC
PHYSICIAN REPORT CARD - 1Q, 2010 - 2011

Name	DEA Number	Number of	Members	AvgRx/Util Member	Total Ingred Cost	Avg Cost/RX	PMPM	Generic %	Avg Cost/ Generi	Brand %	Avg Cost/ Brand	Daw 1 %	Controlled Med %	Formulary %
Totals (Average):		2	2	1.00	7,701.30	3,850.67	0.22	0.00	$0.00	100.00	,850.67	0.00	0.00	0.00
FAMILY NURSE														
MASON, ARLYN	19624031	112	24	4.67	$1,076.00	$9.61	$14.94	95.54	$7.16	4.46	$61.98	0.89	11.61	100.00
Totals (Average):		112	24	4.67	1,076.00	$9.61	4.94	95.54	$7.16	4.46	$61.98	0.89	11.61	100.00
FAMILY PRACTITIONER														
CHUNG, DANIEL	18210919	233	28	8.32	$6,811.10	$29.23	$81.08	84.55	$14.00	15.45	112.57	0.00	7.30	96.50
CRUZADO, FERNAND	11543744	64	4	16.00	$3,881.40	$60.65	$323.45	82.81	$39.62	17.19	161.96	0.00	21.88	95.30
FOSDICK, CLAUDE	15684085	166	23	7.22	$1,900.00	$11.45	$27.54	85.54	$7.14	14.46	$36.92	0.00	3.61	100.00
FRAYSER, ROBERT	15785165	32	6	5.33	$700.90	$21.90	$38.94	90.63	$6.46	9.38	171.17	0.00	15.63	100.00
HUDAK, DEBORAH	17604858	42	7	6.00	$871.50	$20.75	$41.50	92.86	$9.34	7.14	169.13	0.00	19.05	100.00
LIZARRAGA, DARIO	16493494	42	4	10.50	$1,262.60	$30.06	$105.22	90.48	$13.73	9.52	185.22	0.00	11.91	92.80
LOWE, MICHAEL	13069967	176	9	19.56	$3,094.90	$17.58	$114.63	92.61	$12.06	7.39	$86.88	0.00	12.50	100.00
PAUL, JEAN	19321026	67	10	6.70	$1,190.60	$17.77	$39.69	94.03	$9.09	5.97	154.50	0.00	25.37	100.00
RUESCH, MCLAREN	12059255	52	2	26.00	$822.30	$15.81	$137.05	84.62	$9.16	15.39	$52.40	0.00	5.77	100.00
ZAMANI, PAYAM	15189156	19	6	3.17	$1,656.30	$87.18	$92.02	78.95	$19.58	21.05	340.68	0.00	0.00	78.90
Totals (Average):		893	99	10.88	2,191.60	$31.24	0.11	87.71	$14.02	12.29	$147.14	0.00	12.30	96.35

GENERAL PRACTICE

Requirement 26: Provide an example of how the Offeror's analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

P/GLTC maintains a Medical/Utilization Management (M/UM) Committee, chaired by Marlene Bluestein, MD, Chief Medical Officer (CMO). The M/UM Committee reviews information based on data, collected and analyzed by staff, to improve the quality, effectiveness, and value of the care and services delivered to our members. As a board certified geriatrician with over 18 years of managed care experience and 25 years as a provider of services to Medicaid members, Dr. Bluestein provides a unique perspective in interpretation of utilization patterns of our Elderly and Physically Disabled population.

Data are gathered from all utilization functional areas, including but not limited to pre and post-service authorization, concurrent review, pharmaceutical review, discharge planning, and retrospective claims review. The data are then analyzed, tracked, and trended over time by the M/UM team under Kelly Morgan, Director of Quality and Medical Management (DQMM). She is a masters prepared nurse with 15 years in utilization decision support analytics and a Certified Professional in Healthcare Quality (CPHQ). Data analysis prompts the identification of operational strengths and opportunities for improvement. The identification of these improvements, and their subsequent resolution through systemic changes, provides new, enhanced, and value-added services to our members.

P/GLTC conducts ongoing analysis of Medical/ Utilization Management (M/UM) data through a formal monitoring process that provides the structure and format to facilitate thorough understanding of the data and associated findings. The monitoring process includes the activity specific goals, metrics, analyses, data trended over time, and names specific staff responsible for the activity. A full analysis is performed quarterly by the assigned team member, who then reviews the activity with Kelly Morgan and Dr. Bluestein, who provide feedback and an additional level of analysis.

The Activity is then presented to the Medical Utilization Management Committee for review, discussion of potential opportunities for improvement, and actions to be taken prior to the next quarterly review.

During review of the Inpatient and Prior Authorization Monitoring Activities and associated data over time, several opportunities for improvement (OFI's) have been noted. These OFI's involved the percent of readmissions within 15 and 30 days and the prevalence of fall related injuries. Given the previous stability of concurrent and retrospective reviews, these findings were of concern to P/GLTC. These findings were reviewed at a Medical Management Team meeting where the Team, with an average of over seven years of managed care experience, suggested additional analysis focusing on the readmission diagnoses. The initial analysis with added drill-down was presented and discussed at a quarterly M/UM Committee meeting. Following the meeting, P/GLTC embarked on a three-pronged approached to reversing the undesirable utilization trends. The improvement process, including the analyses, interventions, and evaluations of effectiveness are the focus of this response.

Readmissions Within 15 and 30 Days of Discharge
The process by which patients move from hospitals to other care settings is increasingly challenging as care becomes more fragmented. The CMS Quality of Care from the Consumer Hospital Survey recently reported the lowest level of satisfaction with discharge-related care than in any other aspect of care that CMS measures. Reporting to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that up to 76 percent of readmissions may be preventable.

P/GLTC has identified 15 and 30 day readmissions as an opportunity for improvement. The initial review of data

revealed a 16.9% readmission rate within 30 days of discharge, as compared to a national benchmark for all non-obstetric adults ages 21-44 of 9.5% and 11.8% for ages 45-64. Of even greater concern was the number of readmissions occurring within 14 days post discharge with 14.3% of the readmissions occurring in that timeframe. The Healthcare Cost and Utilization Project (HCUP) benchmarks are: 6.3% for 14 day non-obstetric adult readmissions, 9.5% for readmissions within 30 days for all non-obstetric adults ages 21-44, and 11.8% for ages 45-64. P/GLTC clearly needed to reverse this negative quality of care indicator. (Source: H-CUP Statistical Brief #89, 4/2010)

Interventions–The need for better coordination of care and services provided to our members served as the basis of the interventions taken to address this issue. Both short and longer term strategies were developed. A focus study was implemented to include review of all readmissions within 15 and 30 days after discharge. New significant event criteria were developed, approved by the M/UM Committee, and applied to readmission reviews. The use of both the focused review process and application of the significant event criteria (aka Never Event list) provide P/GLTC with a better understanding of the readmission causative factors. In addition, we use Multi-Disciplinary Staffing (MDS) where Case Managers (CM) and medical management nurses meet with the CMO to review the most recalcitrant members. Dr. Bluestein contacts involved providers to develop a coordinated plan to address the needs of the member.

The data on readmissions were shared with the Inter-Disciplinary Care Teams (ICT). These teams are comprised of a Care Team Manager (Case Management Supervisor), a Medical Management Coordinator (RN); CMs, a Behavioral Health Coordinator, a Member Services Representative, and a Provider Services Coordinator. Each team is responsible for the members who are assigned to the team's CMs and meet weekly to exchange information and resolve issues as the conditions and needs

of members change. Based on the ICTs feedback, we identified facilities with the highest readmission rates and focused our initial efforts on those facilities.

The teams focused more on the members, with additional emphasis on discharge planning for hospitalized members. Concurrent team management, involving the concurrent review nurse, the hospital case manager, and the P/GLTC CM, ensure all post discharge services are established prior to the member leaving the facility. These services include, but are not limited to, discharge medications, home health nursing, rehabilitative services, transfer to an intermediate level of care, attendant care support, and patient teaching. Post hospitalization, the member is contacted to identify any additional needs. Short term, readmission rates have dropped to 11.5% within 30 days, and 6.3% for readmissions within14 days post discharge.

From a longer term perspective, we identified the need to provide more choices for our dual-eligible members that have a greater impact on the coordination and facilitation of those members' care. While we implemented short term interventions to decrease re-admissions to acute care, the majority of the readmissions had Medicare primary coverage. Despite our agreements with an existing SNP, we feel we can better support our dual eligible members by applying to become a Medicare Advantage Special Needs Plan (SNP). Medicare Part C and Part D applications have been submitted to CMS, with implementation of the LifeMatters of Central Arizona SNP expected to occur on January 1, 2012. While the SNP implementation will not begin until after the next AHCCCS Contract Year begins, we fully anticipate a decrease in readmissions and increased satisfaction with care and services.

Fall related injuries requiring acute care and treatment
During Contract Year 2010, a trend was identified related to the number of ED visits related to falls. Based on CDC data, one in three adults age 65 and older fall each year. Of those

that fall, 20-30% suffer moderate to severe injuries that negatively impacts their ability to live independently and increases their risk of death. Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes. Nationally, in 2009, ED visits for non-fatal fall injuries among older adults numbered 2.2 million; over 582,000 of those required inpatient hospitalization. In 2002, about 22% of community-dwelling seniors reported falling in the prior year. Medicare costs per fall averaged between $9,113 and $13,507.

Based on a monthly sample of P/GLTC ED records during contract year 2010, falls with injuries accounted for 12% of the visits and 15% of the members seeking ED care. Other diagnoses driving ED visits included chest pain (10% of visits), abdominal pain (8% of visits), and pain excluding fall related, chest, and abdominal pain 12% of visits. Early CYE2011 data reflect 13.8% of ED visits due to falls with injuries over a three-month period. This analysis reflects that little improvement has occurred with interventions focused on existing processes, thus requiring the development and implementation of additional strategies.

Upon review, it was decided that interventions may need to vary based on location of care. A different strategy may be required for P/GLTC members who receive home and community based services compared to those who reside in a nursing facility. For those HCBS members, P/GLTC has expanded its disease management program to include Member Safety initiatives. One of these is the P/GLTC Fall Prevention Program, based on Community Health Foundation's "Falls Prevention–Step Up to Stop Falls" program, which also aligns with the Arizona Case Management Handbook (DES Division of Aging and Adult Services, April 2010). The Program, implemented in March 2011, serves to prevent falls with and without injury, supports members in remaining in home based settings, and avoids healthcare costs associated with treatment of fall related injuries. The "Falls Prevention" program is evaluated by the volume of environmental

screens, the volume of ED visits, and a decrease in reported fall frequency and resulting injuries.

Additionally, for members residing in nursing facilities, we have implemented a pilot program based on the Joint Commissions Patient Safety Goals (JCPSGs) for Long Term Care (LTC). Goal nine (9) of the LTC JCPSG is to "Reduce the risk of resident harm resulting from falls." It reads: "Reduce the risk of falls. Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate the resident's risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation could include a resident's fall history; review of medications and alcohol consumption; gait and balance screening; assessment of walking aids, assistive technologies, and protective devices; and environmental assessments." The elements for performance include:

• Assess the resident's risk for falls;
• Implement interventions to reduce falls based on the resident's assessed risk;
• Educate staff on the fall reduction program in time frames determined by the organization;
• Educate the resident and, as needed, the family on any individualized fall reduction strategies; and
• Evaluate the effectiveness of all fall reduction activities, including assessment, interventions, and education.

The evaluation of effectiveness related to this goal includes a decreased number of falls and decreased number and severity of fall-related injuries. Preliminary findings from this pilot project have not identified any improvement in outcomes, but feedback from staff indicates an appreciation for the structure and guidance provided by the programs.

Requirement 27: Describe existing or planned Chronic Care/Disease Management programs that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by the Offeror to improve member outcomes.

P/GLTC's disease management services assist members better communicate with providers and learn new, effective ways to manage their chronic illnesses through a combination of nurse-directed activities and self-management tools. This cost-effective program provides a member-centric approach to improving the physical and mental health outcomes of members with selected medical conditions. These conditions include diabetes and congestive heart failure. Weight control and smoking cessation are integrated into all disease management topics to promote healthy lifestyle choices. Behavioral health is also an essential component of disease management. Disease management topics are chosen based on prevalence, associated risks, availability of treatment guidelines, variety of treatment modalities, frequency of preventable events associated with the topic, definable outcome measurements, and overall ability to impact member health status. For example, approximately 36 percent of P/GLTC members have a diabetes diagnosis, as compared to 8.3 percent (2010) of the US population and 8.1 percent (2009) of Arizona's population. Our diabetes management program aims at improving self care, engaging the member and family/social support systems in managing disease symptoms, providing nutritional tips and recipes for low glycemic food choices, improving adherence with treatment plans, and professional nurse case management and guidance to members struggling with their disease. Standard diabetic performance measures are used to evaluate the effectiveness of the Diabetes Disease Management Program. As of CYE09, 81.1 percent of our members received annual HbA1c blood tests, 90.4 percent received biennial lipid screening, and 78.3 percent receive biennial retinal screening.

Congestive heart failure (CHF) is one of the most frequently associated co-morbidities of diabetes, and is another leading diagnosis for members, over 30 percent. Of those, over 33 percent of members have a co-morbidity of diabetes. Heart Failure related admissions and re-admissions are routinely identified as one of the top five reasons for admission to acute care among P/GLTC members, making it a priority.

In concert with our Disease specific programs, P/GLTC offers a Member Safety program, with specific initiatives related to medication management and fall prevention. While these initiatives are not the focus of traditional disease management programs, P/GLTC includes them due to their potential positive impact on our entire elderly and physically disabled membership. Effective medication management programs, including drug / drug interactions, polypharmacy, and use of combination medications including Tylenol or pseudoephedrine, serve to decrease risk and improve the efficacy and coordination of therapeutic modalities. The impact of falls on our member population was identified through a review of Emergency Department (ED) utilization.

The P/GLTC Fall Prevention Program, based on Community Health Foundation's "Falls Prevention – Step Up to Stop Falls" program, also aligns with the Arizona Case Management Handbook (DES Division of Aging and Adult Services, April 2010). The Program, implemented in March 2011, serves to prevent falls with and without injury, supports our members in remaining in a home based setting, and avoids healthcare costs associated with the treatment of fall related injuries. The Falls Prevention program is evaluated by the volume of environmental screens, the volume of ED visits, and a decrease in reported fall frequency and resulting injuries.

P/GLTC has adopted the Wagner Chronic Care Model as our guiding philosophy for disease management. The Model aims at an evidence-

based, data driven, yet member-centric care delivery system. The delivery of care is achieved through the collaboration between members, primary and specialty healthcare providers, P/GLTC CMs, community resources, social services, and the continuity of care gained through an established relationship among the collaborators. Our interpretation of this model as it relates to disease management is found at the end of this narrative.

Disease Specific Programs - Members are automatically enrolled in appropriate disease management programs yet given the opportunity to opt out of the program if they are not interested in participating. Member selection is based on information from initial health risk assessments and ICD-9 codes on provider claims. Referrals from providers, case managers, or member self-referrals are also used. Once enrolled in the program, each participant is evaluated to identify specific needs and an individualized care plan is developed in conjunction with the member's PCP and inter-disciplinary care team. The care plan serves as the road map to ongoing care delivery and is re-evaluated at least annually.

A cornerstone of our disease management is our self-management program. We have two Chronic Disease Self-Management Program (CDSMP) Leaders on staff, certified through Stanford University in partnership with the Arizona Living Well Institute. The CDSMP is an evidence-based promotion program aimed at teaching adults how to manage their chronic health conditions. The program consists of six weekly sessions that run 2.5 hours each. Participants are encouraged to take control by managing symptoms, setting goals, and developing action plans; ultimately boosting self-confidence and empowering them to actively manage their health. P/GLTC is currently the only health plan in Pinal and Gila Counties that offers this program. We collaborate with Sun Life Family Health Center in Casa Grande to utilize the program with our members with chronic conditions who have Sun Life as their medical home.

P/GLTC works closely with providers to improve member care. Our Pay for Performance Program rewards providers for timely care and appropriate utilization of services. Disease management staff facilitates referrals, increases member access to services, and assists providers with questions and concerns regarding the disease management program. Evidence-based practice guidelines are endorsed for use by the M/UM and Peer Review Committees and disseminated to providers in a variety of ways, including the Provider Manual and the P/GLTC website. Provider adherence is strongly encouraged through regular monitoring with provider feedback and pay for performance initiatives. Provider non-compliance with guidelines is addressed by the P/GLTC CMO, Quality and Medical Management Staff in collaboration with the P/GLTC Provider Services and the involved provider, with the possibility of progressing to peer review if no improvement is seen.

While we believe that each primary care provider serves as a medical home to their assigned members, designated Medical Homes may provide a greater range of services. P/GLTC has collaborated with two different provider groups to establish medical homes for our members with chronic conditions. Each of our Medical Homes is utilizing Electronic Medical Records (EMRs) with clinical prompts to foster adherence with outcome measures.

The first, an integrated Behavioral Health/ Primary Care Provider in suburban Apache Junction, serves as a pilot site for our health promotion initiatives, including fall reduction, and medication management initiatives and early identification and treatment of depression in our medically complex population, particularly following a stroke.

We have identified a Diabetic Medical Home at Sun Life, the community-based primary care organization where the majority of our members with diabetes receive care. This collaboration promotes greater coordination of care while also reducing overall costs. Sun Life has a certified diabetic educator on site along
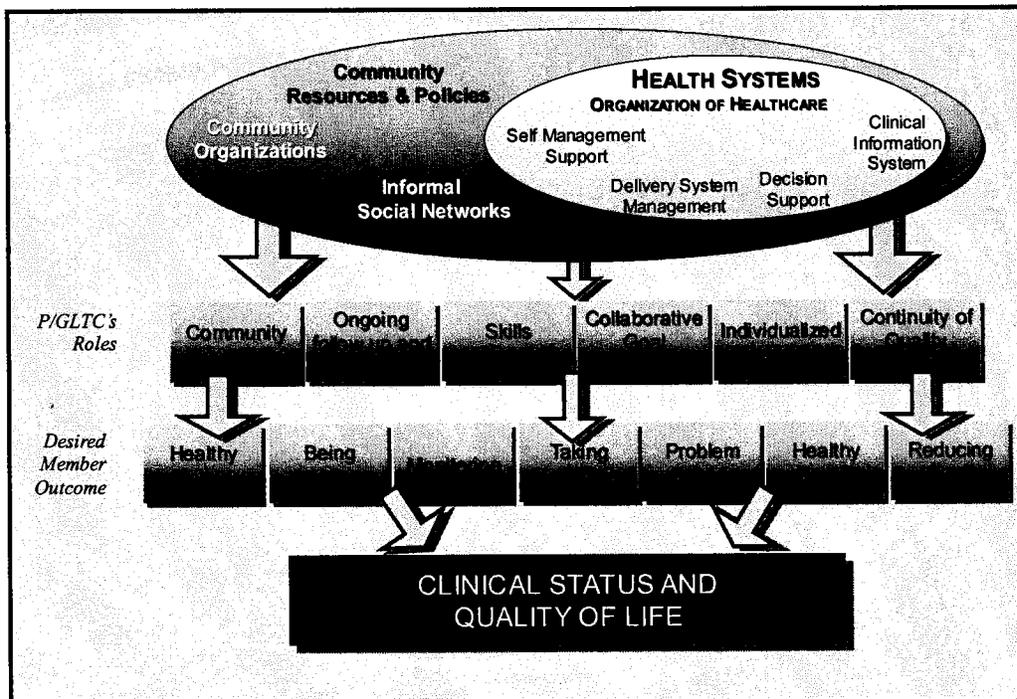
with onsite lab draw capabilities. Specific days throughout the year are set aside for diabetic P/GLTC members to visit the PCP, discuss questions and concerns related to their disease, receive education and support from the diabetic educator, and complete any necessary lab work needed to evaluate control. P/GLTC staff members are also on hand to update care plans, assist members as necessary, and facilitate a consistent data collection and feedback loop between the two organizations.

Ongoing data collection and program evaluation are imperative to assess efficiency and effectiveness of interventions. Specific outcome measures have been established to measure the success of the disease management program. Member-focused outcomes include compliance with care plans and increased satisfaction. Organizational outcomes include achievement of pre-determined clinical indicators, effective utilization of targeted services, and reduction of avoidable emergency department visits and hospitalizations. Data analysis is the cornerstone of measuring outcomes and determining necessary modifications to the program.

focuses on over and under service utilization and costs associated with members in the Disease Management Program. In addition, the findings of the analyzed data are reviewed by one of two multi-disciplinary task force groups. Our Quality Task Force ensures that timely and appropriate interventions are developed for members, communicated across all departments, supported by sister agencies and community organizations when possible, and reviewed for organizational process effectiveness both during and after the intervention period. The Disease Management Task Force functions in a similar manner to the Quality Task Force, with the exception being a more member-focused evaluation of interventions. The Task Forces have some joint membership for continuity purposes and each is attended by the CMO and the QM/MM Director.

The organization's executive management team, who is ultimately accountable for oversight and evaluation of organizational activities, is actively involved in data review and analysis. Operational processes are reviewed on a monthly basis to highlight methods for sustained success and address any barriers that hinder performance.

P/GLTC takes a two-pronged approach to data analysis, focusing first on what the data means to and for the members, and secondly, how the data affects our organizational operations. The Medical/Utilization Management (M/UM) Committee

Requirement 28: Describe the process used by the Offeror for the adoption and dissemination of clinical criteria used for decision making that would ensure consistent application of the criteria for clinical decision making.

P/GLTC values standardized criteria and the role they play in clinical decision making, member safety, and the provision of high quality care and services. We recognized the role our prudent selection and consistent application of evidence-based criteria, in concert with long term relationships among our healthcare partners, plays in our member-centric, cost effective, medical and utilization management (M/UM) program. Our Inter-Disciplinary Care Team (ICT) collaborates with our PCPs, members, and county based community services to ensure members receive the services needed to support our mission of providing "comprehensive and coordinated healthcare services to elderly and/or physically disabled individuals who have difficulty taking care of themselves both financially and physically so they can live independently as long as possible while maintaining an optimal level of health."

Identification and / or Development of Criteria Sets
Under the direction of Kelly Morgan, Director of Quality and Medical Management (DQMM), with oversight by Dr. Marlene Bluestein, Chief Medical Officer (CMO), the Medical Management Team reviews and evaluates criteria sets on an annual basis. The sources of criteria reviewed include but are not limited to McKesson InterQual criteria, Hayes criteria, Medicare coverage determinations; AHCCCS benefit guidelines, and evidence-based clinical practice guidelines. The application of these criteria cover the M/UM functional areas of prior authorization (PA), concurrent review, retrospective review, medication utilization evaluation (MUE), Home and Community Based Services (HCBS) determination, and claims processing rules (e.g. identifying types of pre-payment or post-payment claims requiring clinical review).

Selection of Criteria
Multiple parameters contribute to the selection of appropriate criteria. Essentially criteria must be evidence- based, applicable to our medically complex member population, broad enough to address multiple conditions yet specific enough to guide an individual member's care. The variety of care sites such as home based, alternative residential, and nursing facilities demands flexibility in our criteria selection. Needs associated with our integrated physical and mental health model of care also play into the selection process.

One of the goals of the P/GLTC Medical Management function is to ensure that our members receive the right care at the right time in the right care setting. We use McKesson InterQual criteria as its primary clinical decision support tool. The decision to use these standardized criteria that are also used by many of our healthcare partners in acute, long-term, and outpatient settings improves communication of expectations, aligns decision making processes, and allows the focus to be on determination of clinically appropriate care. In addition, InterQual aligns with Medicare guidelines, allowing us to integrate those reviews.

P/GLTC uses InterQual criteria as guidelines upon which member-specific evidence-based care delivery decisions can be made. The inpatient criteria goal is balancing the member's condition, severity of illness (SI), and intensity of service (IS) requirement to ensure care is delivered in the appropriate setting. The SI/IS serve to reduce over and underutilization, optimize inpatient services, and reduce inappropriate re-admissions. Additionally the member's special health needs are considered in the decision making.

P/GLTC uses InterQual criteria sets for durable medical equipment (DME), behavioral health services, clinical procedures, home and

community based services, and therapies. When applied in coordination with our Prior Authorization criteria and Medicare and AHCCCS benefit structures, the criteria result in medically necessary, cost effective, high quality care and service delivery.

Collectively, when reviewing acute, sub-acute, inpatient, and outpatient utilization data supported by standardized criteria, P/GLTC is able to identify practice trends. These trends may be used as a basis for provider recognition of high-quality care provision or for internal and external quality improvements activities.

Clinical Practice Guidelines

P/GLTC Clinical Practice Guidelines are recommendations to clinical decision-making. We expect primary care physicians (PCPs), specialists, and other healthcare providers to collaborate with their patient or the patient's surrogate to develop and implement individualized treatment plans to meet each patient's specific needs. This collaboration allows deviation from guidelines in unique clinical situations and when clearly substantiated in the medical record.

P/GLTC endorses or develops clinical practice guidelines to support physicians and other clinical providers in the assessment, diagnosis, and treatment of P/GLTC members. P/GLTC Clinical Guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in that field; selected with consideration of the needs of P/GLTC members; adopted in consultation with P/GLTC providers; based on National Practice Standards; and developed by health care professionals and based on a review of peer-reviewed articles published in the United States when national practice guidelines are not available. P/GLTC Clinical Practice Guidelines are endorsed or developed with designated, desired outcomes and associated, standardized measures of effectiveness. P/GLTC Practice Guidelines are disseminated to all affected providers and are available to all providers, members, potential members, and affiliated allied health professionals upon request.

Evaluation of Criteria

Our annual evaluation process includes a comprehensive review of the criteria and its utilization. Aspects of criteria evaluation include: available updates to criteria based on changes in practice, application to our member population, review of adverse determinations, use of emergency services, avoidable days, and provider adherence, member health outcomes and cost effectiveness. Data sources used in the evaluation include: appeals, provider claim disputes, grievances, provider adherence, and satisfaction surveys. Examples of evaluation of criteria include:

- PA criteria review evaluates criteria's appropriateness and resulting determinations. If a service requiring PA is approved over 95% of the time, the service is analyzed and may be dropped from the list of services requiring PA.
- Identification of frequent requests for medically unnecessary magnetic resonance imaging (MRIs) by PCPs and consistent appropriate MRI requests by neurologists may retain MRI PA for the PCPs while allowing contracted neurologists to order MRIs without going through the PA process.

Assessing Inter-rater Reliability

Under direction of the Director of Quality and Medical Management and Jennifer Kelly, the Director of Case Management, Inter-rater reliability (IRR) testing is performed on a regular basis. This testing ensures consistent application of clinical review and all other criteria used in determining the care and services our members receive. Quarterly IRR assessments apply to physicians, nurses, behavioral health and case management staff, peer reviewers and any other staff involved in the application of service criteria. Appropriate use of approved criteria is evaluated at the individual and group levels using chart audits, administrative data, and managerial oversight, with Kelly Morgan and Jennifer Kelly responsible for IRR testing and for the follow-up training, activities, performance management, and action plans when variances are identified.

Criteria and Guideline Adoption

With the exception of peer review and credentialing criteria, potential criteria for use in clinical decision making must be presented for review, discussion and endorsement/adoption by the P/GLTC Medical/Utilization Management (M/UM) Committee which is chaired by the CMO. The potential criteria sets, benefits and barriers to the use of the criteria, and a draft implementation plan are included in the Committee presentation. In addition, our Peer Review Committee must review and approve all clinical practice guidelines, Peer Review, and Credential criteria. The Executive Team subsequently reviews and provides final approval of Peer Review and Credentialing criteria.

Dissemination of Criteria

P/GLTC practices transparency and encourages the same in our healthcare partners. We make the criteria from which we base our decisions readily available. Approved Clinical criteria sets are disseminated using verbal, print, and web based methods based on the needs of our customers.

Health plan staff is advised of new criteria through standing Quality Management/ Performance Improvement (QM/PI) and M/UM Committees, the Quality and Disease Management Task Forces, training sessions, emails, departmental staff meetings, and IDEAS TOGETHER (all staff) meetings. Changes in criteria such as updated versions of existing criteria sets may be communicated verbally or in writing to all health plan staff upon release and prior to implementation. Training on the criteria is provided to all staff using the criteria upon orientation and at least annually thereafter.

P/GLTC members have access to criteria through their providers. In addition, they may access criteria sets on the health plan's web site. Criteria are also available through their CMs, member services, included in notices sent to members, and in member newsletters.

Finally, members may access criteria sets by asking P/GLTC for them.

P/GLTC engages providers and encourages their participation in health plan committees and activities. Even if no provider is involved in the criteria selection process, at least one provider must be involved in criteria approval. All providers are informed about the criteria applicable both to them and our members. For example, the PCPs of our Disease Management program participants are notified of the members' enrollment, receive complementary information related to the program's components, and updates to member self goals. Criteria are available to providers per the provider representatives, Provider Manual, provider newsletters, the P/GLTC web site, blast faxes, check inserts, and joint operations committees. We communicate any substantial changes in criteria, such as a new prior authorization grid, to our contracted providers that will be impacted by the change at least 30 days before implementation to allow them time to revise processes to accommodate the change.

We also communicate plans for any substantial changes in clinical criteria with AHCCCS. For example, we would provide at least a 60 day notice to AHCCCS, Division of Health Care Management Operations and our Compliance Officer. This notification allows adequate time for AHCCCS to review and seek clarification on these changes. In addition, we collaborate to ensure the changes are congruent with contractual and other regulatory requirements, anticipate barriers to implementation and resolve any identified issues. Finally, revised criteria or practice guidelines may identify new technology or new uses for existing technology. If so, the reviewer refers the finding to the Technology Assessment Committee for evaluation.

Requirement 29: Describe how the Offeror identifies quality improvement opportunities. Describe the process utilized to select a performance improvement project, and the process utilized to implement or enhance multi-departmental interventions to improve care or services. Include information on how interventions will be evaluated for effectiveness.

P/GLTC provides accessible, quality healthcare to a diverse membership in a variety of settings. To ensure that the level of quality remains high, P/GLTC uses continuous quality improvement (CQI) processes to monitor the quality of services on an ongoing basis, to identify areas that need improvement and to implement Performance Improvement Projects (PIP). In addition to projects mandated by AHCCCS, P/GLTC identifies and implements its own PIP topics based on the processes described below.

Identification of Quality Improvement Opportunities- Quality improvement opportunities are selected to improve health care outcomes and member satisfaction. Topics are identified by the Quality Management (QM) and Medical/Utilization Management (M/UM) Committees. These committees, chaired by the CMO and staffed by the Director of Quality and Medical Management (DQMM), serve as the core of our formal CQI programs. They include leadership, nurses, case management, data analysts, and outside providers. Topic selection is based on achieving the greatest practical benefit for the most members or targeting areas providing members the greatest risk.

Identification of areas for improvement begins with assessing care and determining which services meet required guidelines, standards of care, and contract expectations and which, both clinical and non-clinical fall below standards and need improvement. The following tools are used to assess the quality of services provided by P/GLTC and contracted providers.

Quality of Care Monitoring
P/GLTC monitors, measures, and assesses quality of services. Monitoring tools include member satisfaction surveys, provider profiling, grievances, quality of care concerns, disease management, and medical management activities. The following describes these in more detail.

Member Satisfaction Surveys - Members are asked about their satisfaction with services received. The surveys are sent to members by mail or conducted by telephone. The Member Satisfaction Survey is sent to all members on an annual basis and is designed to measure satisfaction with the CM, physician, transportation services, appointment wait times, and urgent or emergency services. Additional surveys may be administered to a random sample of members receiving a service or to all members seen or contacted in a given month. The data are summarized, analyzed, and reported to the CMO and DQMM as part of provider profiling and re-credentialing. Significant trends in member survey responses may suggest the need for a focused study or a PIP. A current PIP, developed from a member satisfaction survey is "Improving Transportation Services for Members." The need for a PIP was identified by the satisfaction survey and the aggregated complaint log.

Provider Profiling - A report card is developed for each provider by type, summarizing their performance related to the terms of their contracts, other guidelines selected by P/GLTC or recommendations by national professional organizations. Examples of these would be the use of generic equivalents in prescribing practices, or comparing the mortalities in contracted Skilled Nursing Facilities to the Medicare Nursing Home Compare data. Additional profiling on the use of evidence-based care is the basis for the P/GLTC Pay for Performance Program. For example, we compare diabetic testing among PCPs with the HEDIS mean and AHCCCS minimum performance standards. The profile is shared with each PCP and compares each PCP to their unidentified colleagues.

Grievances and Quality of Care (QOC) and Service Concerns - Grievances received from members are logged as they occur, identifying

the type of problem, the provider, and the outcome. They are reviewed monthly by management and summarized quarterly at QM meetings. Potential QOC concerns are written as staff become aware of issues negatively impacting members. Complaints are aggregated by provider in 6-month summaries and reported to QM nurses to review for trends. Trends in adverse practice patterns are turned into concerns and investigated. An example of this is an Assisted Living Home from which several residents have required emergency or urgent treatment after falling. The trend would be submitted as a QOC concern, investigated, subjected to an environmental assessment, and the ALH would be required to remove all scatter rugs from the home, if that were the root cause. Quarterly reports for both complaints and concerns are evaluated by the Grievance Committee and reported back to QM.

Disease Management Program Activities - These activities increase self-management and optimize health outcomes for members with targeted chronic diseases. The Disease Management Program, based on Wagner's Chronic Care Model, focuses on coordination among the member, provider, health promotion activities, and community resources to achieve the improvement. Examples of activities monitored include, the use of diabetic educators, change in Hemoglobin A1c levels reflecting glycemic control, provider adherence to evidence-based practice guidelines, and weight management.

Utilization Management Monitoring - Quality of care or service issues may be identified during utilization management monitoring, such as concurrent reviews, discharge planning, medical necessity reviews, and over/under utilization. High cost services such as inpatient hospitalizations may be avoided through improved medical management. Of particular importance are potentially avoidable readmissions. If there are trends by hospital or physician, a PIP is implemented. For example, a trend in admissions for urinary tract infections led to a focus study of the involved providers. These reports are generated monthly and

reviewed by the CMO, the DQMM, and the Director of Case Management.

External Sources of Identification
External data are also used to identify quality improvement opportunities. These include concerns voiced by residents during town hall meetings and opportunities identified during member or provider meetings. The quarterly Member Council meetings are attended by members and providers to encourage discussion about P/GLTC's services and issues of concern.

AHCCCS may provide topics for performance improvement studies required for all program contractors. Projects may be of significant statewide applicability or deemed of national interest by CMS. They may also be projects specific to P/GLTC, identified by AHCCCS.

Performance Improvement Projects - PIPs focus on a wide variety of clinical and non-clinical areas. Clinical areas may include:
• Chronic disease prevention and education
• Ongoing care of targeted chronic conditions
• High risk services
• Continuity and coordination of care
Non-clinical areas include:
• Availability, accessibility and adequacy of the service delivery system
• Cultural competency of services
• Interpersonal aspects of care (e.g. The quality of provider/member encounters)
• Appeals, grievances and other complaints.

Selecting The Topic - Annually, the QM Committee and the Medical Programs Sections meet to review the results of the QM monitoring (i.e., member survey results, provider profiling, contract compliance audits, grievance data, disease management findings for chronic care and demand-side, UM findings, and the nature of cases brought to the inter-disciplinary Care Teams). Areas for improvement are identified and agreed upon by the QM/PI Committee. PIPs are selected, goals established, responsible party identified, annual objective determined, methodologies

devised and a work plan created.

When formulating PIPs, P/GLTC makes sure that they are measurable, objective, and based on current clinical knowledge and practice. Measurements include change in health status, functional status, member satisfaction or process. Whenever possible, quality indicators are selected that have data available to allow for comparison of P/GLTC's results to that of a similar organization's performance, or to local, state, or national benchmarks.

Multi-Departmental Interventions - Once a topic for a project has been selected, the sections involved in the PIP meet to establish goals, determine measurable, objective performance indicators, identify responsible parties, determine the evaluation plan, and develop its work plan with prescribed timelines. If AHCCCS provides benchmarks or goals, these are incorporated. PIPs may involve staff from several sections of P/GLTC and providers. Roles are clearly defined.

CMs and QM nurses carry out the interventions A Data Analyst from Accounting and Information Systems (AIS) develops and produces the reports needed to track the data. The data collected are put into the case/medical management system shared by CMs and QM nurses. All PIPs are reported on and reviewed quarterly by the QM Committee.

While major PIPs require a structured, long term multi-disciplinary approach, many daily activities are improved using the PDSA process. Examples include:
- Review of our diabetic disease management indicator performance indicated a two quarter decline in HgbA1C levels. In the detail, we noticed changes related to one provider. Upon further review, we found the provider had changed his appointment availability. Working with the provider to improve scheduling for his diabetic members enabled more frequent visits for those with HgbA1C -levels over seven.
- The non-emergent transportation vendor voiced frustration when they arrived at a

home to find the member hospitalized. The Medical Management team developed a process to communicate daily admissions and discharges to the vendor so they could adjust trip sheets as indicated.

Evaluating the Effectiveness of Interventions - Effectiveness of interventions is evaluated over time. When a PIP is first identified and after it has been approved by AHCCCS, data is collected and analyzed for at least two years before expectation of significant improvement. During this period, reports are generated each quarter to follow progress.

Initially, the data is analyzed to determine baselines. The baseline is analyzed in relation to the annual goals, AHCCCS determined benchmarks, or national standards. Each quarter, a summary report is presented to the QM Committee and includes outcome data and progress toward goals. When appropriate, we use measures of statistical significance. The committee analyzes the results, discusses barriers and makes suggestions for any modifications in interventions or approaches. It is expected that there will be a sustained and demonstrated improvement in performance maintained for at least a year after the initial improvement is achieved.

Annually, progress for each PIP is reviewed. An annual report summarizing the year's outcomes and progress towards goals is completed by the responsible party for the PIP. This report identifies trends, suggests changes or modifications to the goals, interventions or methodologies. The significance of each existing PIP is reviewed for continuation based on finding from the previous year. Trends are identified and documented in an annual report by the responsible party. A decision is made to continue, change, or delete the PIP with the rationale documented. Once the existing PIPs are accepted for continuation, the modified methodologies and adjusted work plans are developed and approved. New PIPs are added as new areas are identified.

30. Describe how the Peer Review Committee is structured and utilized by the Offeror and how its reviews/decisions are made and incorporated into the Offeror's quality management process.

Structure and Utilization of Peer Review Committee

Pinal/Gila Long Term Care (P/GLTC) utilizes a peer review process to improve the quality of medical care provided to members by practitioners and providers. The Peer Review Committee (PRC) was established by and reports to the Executive Committee (EC). The PRC is responsible for the P/GLTC practitioner Peer Review function. The scope of peer review includes cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or service by a participating or non-participating healthcare professional or provider.

Marlene Bluestein, MD, our Chief Medical Officer (CMO) chairs the Committee and is responsible for oversight of the peer review program. With over 12 years as the P/GLTC CMO, Dr. Bluestein directs the PRC meetings, reports Committee activities at least annually to the EC, and acts on behalf of the committee on issues that arise between meetings. The Peer Review Committee (PRC) meets quarterly to review concerns submitted to the PRC through the Quality of Care (QOC) process, makes decisions whether the care delivered was appropriate, determines if further action is needed to reduce or eliminate the likelihood of reoccurrence, and determines methods to further monitor the concern. The PRC can meet more frequently on an ad hoc basis to accomplish the committee's objectives.

In addition to the CMO, the PRC consists of contracted providers from the community. Committee members are appointed on an annual basis or as vacancies arise and are staggered to protect continuity of committee functions. Throughout the Peer Review process, P/GLTC ensures that providers of the same or similar specialty participate in the review and recommendation of individual peer review cases. If necessary, an external consultant may be used in the Peer Review

process should there be a need for a particular specialty that is not represented on the Peer Review Committee. If a behavioral health specialty is under review, P/GLTC ensures that a behavioral health provider is part of the Peer Review process.

Only physician members are allowed to vote. A quorum consists of a minimum of three physicians. Approval of actions is by majority vote. A committee member with a conflict of interest, which might impair objectivity in any review or decision process, shall not participate in any deliberation involving such issues and shall not cast a vote on any related issue. In the event that the PRC is unable to constitute a quorum for voting purposes because of conflicts of interest, alternate committee member(s) are selected as needed, at the discretion of the Chairperson.

Kelly Morgan, RN, Director of Quality Management and Gerardo Huerta, Credentialing Coordinator attend the Peer Review Committee to provide support to the process and deliberations. Non-Physician members of the PRC do not vote. Representatives and other guests may attend the meetings upon invitation and prior approval.

All committee members and participants, including network practitioners, consultants and others, maintain the standards of ethics and confidentiality regarding both patient information and proprietary information. All members and invited guests to PRC meetings sign Confidentiality and Conflict of Interest Statements at each peer review meeting.

Activities and minutes of the PRC are for the sole and confidential use of P/GLTC Health Plan and are protected by State and Federal laws and the Health Information Portability and Accountability Act (HIPAA).

Reviews and Decisions

Peer review activities are coordinated by the P/GLTC Quality Management (QM) Department. The peer review process begins with a referral of a potential QOC to the QM Department. Sources of potential QOCs include, but are not limited to, members or their representatives in the form of a grievance, concurrent review findings, case management, other providers, and AHCCCS.

Potential QOCs are reviewed initially by the Director of Quality and Medical Management (DQMM). The Director applies consistent severity criteria, and forwards the potential QOC to a QM nurse for investigation as indicated. The subsequent investigation includes review of medical records, claims, administrative data, evidence-based practice guidelines, provider responses, and associated documentation.

All providers are notified in writing, if an allegation is received regarding a potential quality of care issue against them by a member/provider. The provider is given the opportunity to respond through a Letter of Inquiry (LOI). Providers must respond in writing to the LOI within 14 days. Once the initial investigation is completed, the QM nurse reviews the QOC with the DQMM to identify additional areas that may need exploration. The QOC is referred to the CMO for final review, substantiation, and recommendations.

Each case presented to the PRC contains a copy of all pertinent information, including but not limited to: a case summary, medical records, medical charts, consultant reports, copy of quality issue documentation, member complaint (if appropriate), journal articles or other published information, and any other pertinent information required to complete the peer review evaluation.

The practitioner (PCP or Specialist) for a peer review case under review may attend the meeting where the case is reviewed. The practitioner also has the option to respond to the case in writing in lieu of attending the PRC.

The involved provider presents and defends the case, including evidence-based criteria used by the provider during the delivery of care and services. That Practitioner does not vote nor engage in the Committee's discussion occurring in the PRC. No Practitioner member of the Committee votes on any case in which s/he has been a participant.

The PRC takes all actions necessary in the interest of quality health care of members and/or the orderly functioning of P/GLTC. These actions include taking no action and closing the case; recommending system changes to improve patient care, recommending education of the provider or associated facility; and referral of the provider to a psychologist or psychiatrist for counseling. The PRC makes referrals to appropriate regulatory agencies.

P/GLTC may issue a recommendation that affects the provider's privileges within P/GLTC. Such recommendation may include requiring prior authorization (PA) for selected procedures usually not requiring PA, closing a provider's panel temporarily or permanently, requiring a second opinion/observation of the provider's treatments, limiting a provider's care to specific diagnoses, or termination of the provider's contract. All limitations of a provider's privileges or termination of a provider's right to practice within P/GLTC are reported to their appropriate Licensing Board, the National Practitioner Data Bank (NPDB), or other regulatory bodies according to the law.

Results of the PRC are documented and a letter sent to the provider involved, notifying the provider of the Committee's findings and recommendations. All providers are given due process in the form of appeal rights related to any recommendation that may affect or limit their ability to practice within P/GLTC. If the provider wishes to appeal, s/he files the appeal with the CMO.

The CMO reviews the appeal and may refer the case out to an independent reviewer prior to making a final determination. That final

determination is communicated to the provider through written correspondence. All PRC decisions and interventions are documented, trended, and retained as required.

Integration of Peer Review Activities into the Quality Management Program

The P/GLTC Quality Management Department ensures the integration of quality management processes through all areas of the Plan. Peer review activities are incorporated into the P/GLTC QM activities in several ways.

- From a credentialing perspective, PRC decisions or interventions are forwarded to Credentialing for filing in the provider's profile for consideration in the credentialing and re-credentialing process.
- Aggregate data from peer review findings are used in the analysis and improvement of clinical care.
- Procedures from which peer review cases are identified may be forwarded through the Director of Quality and Medical Management for review by the Technology Assessment Committee to allow additional research and analysis on the efficacy, risks, and benefits of that procedure.

For example, a Behavioral Health Provider's progress notes did not reflect changes in the condition of his patient. Upon investigation, discussion, and review at the PRC, it was identified that the provider routinely documented in a self designed electronic medical record (EMR). The EMR pre-populated the information from the last patient's visit to facilitate rapid documentation by the provider. Per the PRC recommendation, the provider was strongly encouraged to change his EMR to prevent episodic clinical data fields from being pre-populated with the assessment or physical examination findings from prior visits. The provider made the requested change to his system. The provider's medical records were monitored for a pre-determined period of time and no further discrepancies were noted. Finally, the review of each provider's EMR system was added to the medical record audits performed for credentialing, re-credentialing, and ad hoc reviews.

Provider Education – The Peer Review Process

All P/GTLC providers are educated about the Peer Review process, including the peer review grievance procedure. Providers receive a copy of Policy 07-02 Peer Review, P/GLTC's peer review policy, as part of their individual provider manual, and on an individual basis as part of the peer review process. In addition, the Peer Review information is available on the P/GLTC web site.

Requirement 31A: The Offeror is notified of an immediate jeopardy at a facility in a rural county that has been operating without a license for several months. Efforts by the Offeror and the Arizona Department of Health Services to assist the owner in submitting the license renewal and supporting documentation have been unsuccessful. Six Medicaid members reside in this facility, two of which are enrolled with another Medicaid Contractor. The only other placement in the service area, an assisted living home, was recently shut down due to abuse and neglect of residents. There is one nursing facility in the geographic service area.

In order to achieve our mission, we must ensure that our members receive high quality care and services from our contracted providers. We view this responsibility as a collaborative effort among P/GLTC, our providers, regulatory agencies, and other ALTCS and AHCCCS plans.

As an ALTCS contractor in rural Arizona, we are well versed in addressing and facilitating joint resolution of issues with our individual and organizational providers. P/GLTC remains aware of provider contracting, credentialing and associated problems through the Organizational Credentialing and Provider Watch Committees. In addition, our business continuity plan was developed and has been tested with similar rural challenges. We are able to respond promptly and with adequate human and physical resources when urgent and emergent needs arise. Based on our knowledge of the scenario, and considering our existing processes, the following describes our approach.

Notification of Immediate Jeopardy Status
The Director of Quality and Medical Management (QMM), the Chief Medical Officer (CMO) and Chief Executive Officer (CEO) are identified as recipients of information from AHCCCS. They receive the email from AHCCCS of the notification of Immediate Jeopardy (IJ). Immediately, the QMM Director informs the Director of Case Management (CM) and the Director of Network Development and Management (NDM) of the notification and status of the facility, likely an Assisted Living Facility (ALF). An urgent Provider Watch Committee (PWC) meeting is convened to discuss the issue and develop a plan of action. The PWC consists of the Directors, the Quality Management (QM) Nurse, and the Supervisor of

Providers Services. Given the locale of the facility, the Case Management Supervisor for that area attends the meeting.

Action Planning
The facility had already been discussed by the PWC because of reports of late licensure re-application. Initially the PWC directed efforts for a timely response by the facility through collaboration among QM, Provider Services staff, and facility leadership. The QM nurse had performed annual quality monitoring of the facility and, when notified of a lapse in licensure, had visited the facility again to validate that the historically high quality of care and service delivery continued. Instead, that review assessed potential for abuse or neglect, medication use, staffing, supervision, care of members with special needs, patient safety, restraint use, or other events that might trigger QOC concern and investigation. Negative findings were shared with the QMM Director and the CMO. In addition, ongoing reviews of all grievances and QOC concerns by the QMM Director reflected no complaints or reports of issues.

The Supervisor of Provider Services and the facility's Provider Relations Representative were in meetings with the facility leadership to develop and implement a work plan to ensure the facility was compliant with licensure requirements. Provider Services provided reminders and assisted the facility in gathering the documents necessary for license renewal. Weekly updates to the PWC from the Provider Relations Representative kept PWC apprised of the licensure status.

While the initial work plan was implemented, the Committee developed a contingency plan based on the P/GLTC business continuity plan