

Response to Arizona Health Care Cost Containment System Solicitation No. YH12-0001

# Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled (E/PD) Contract For Contractors

**April 1, 2011**



**Submitted By:**  
SCAN Long Term Care  
1313 East Osborn Road  
Suite 150  
Phoenix, Arizona 85014

April 1, 2011

Ms. Jamey Schultz  
Contracts and Purchasing Section  
Arizona Health Care Cost Containment System  
701 E. Jefferson, MD 5700  
Phoenix, AZ 85034

Dear Ms. Schultz:

SCAN Long Term Care (SCAN) is pleased to submit the enclosed proposal to renew its participation in the Arizona Long Term Care System (ALTCS) program for elderly and physically disabled beneficiaries. This proposal is in response to the Request for Proposal, Solicitation number YH12-0001.

During the last six years, SCAN has built a team of more than 150 individuals who are experienced in the integration of acute, behavioral health and long term care services. These dedicated individuals are committed to assuring that our ALTCS members have access to appropriate high quality program services. The team's efforts are focused on assisting our members to meet their individual medical, functional, social, cultural and behavioral health needs.

SCAN has been honored to serve our ALTCS members in Maricopa County as a current plan contractor. The SCAN family of companies was formed more than thirty years ago as a non-profit enterprise dedicated to meeting the health and independence needs of our most vulnerable elderly and physically disabled citizens. As a non-profit, SCAN directs its financial returns to meeting the needs of our stakeholders, not shareholders. *Our Members are our Mission.*

We appreciate AHCCCS consideration of our proposal to continue to serve the ALTCS beneficiaries in Maricopa County.

Sincerely,



Elizabeth Russell  
Chief Executive Officer  
SCAN Long Term Care

SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

## TABLE OF CONTENTS

## SECTION A – GENERAL MATTERS

Table of Contents: Section A – General Matters	1
Offeror’s Signature Pages – Solicitation No. YH12-0001	
Offer and Acceptance – Issue date: January 31, 2011	2
Amendment Number 1 (One) – Issue date: February 24, 2011	3
Amendment Number 2 (Two) – Issue date: March 11, 2011	4
Offeror’s Checklist	5
Section G – Representations and Certifications of Offeror	8

## SECTION B – CAPITATION

Table of Contents: Section B – Capitation	28
Capitation Bid Submission	
<i>Requirement 1: Capitation Rate Bid</i>	29
Actuarial Certification	30
Capitation Rate Bid Template – GSA 52	32

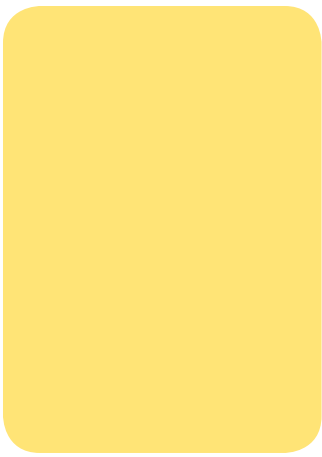
## SECTION C – ORGANIZATION

Table of Contents: Section C – Organization	33
Moral and Religious Objection Submission	
<i>Requirement 2: Statement of Moral and Religious Objections</i>	34
Organization and Staffing Submissions	
<i>Requirement 3: Resumes of Key Personnel</i>	35
<i>Requirement 4: Justification for Key Positions Not Full Time</i>	84
<i>Requirement 5: Functional Organizational Chart</i>	88
Sanctions Submission	
<i>Requirement 6: Sanctions since January 1, 2008</i>	91
Claims Submissions	
<i>Requirement 7: Claims Adjudication Process</i>	93
<i>Requirement 8: Promoting and Advancing EDI and EFT</i>	105
<i>Requirement 9: Clinical and Data Edits</i>	108

Encounters Submissions	
<i>Requirement 10: Encounters Submissions Process</i>	111
Information Services Submissions	
<i>Requirement 11: Information Services Structure and Support</i>	118
<i>Requirement 12: Information Systems Changes and Modifications</i>	130
<i>Requirement 13: Software Vendor Information</i>	133
<i>Requirement 14: Support of IT Federal Mandates</i>	136
Grievance System Submission	
<i>Requirement 15: Grievance System</i>	138
Corporate Compliance Submission	
<i>Requirement 16: Corporate Compliance Program</i>	145
Finance and Liability Management Submissions	
<i>Requirement 17: Audited Financial Statements</i>	149
<i>Requirement 18: Performance Bond Requirement</i>	150
<i>Requirement 19: Minimum Capitalization Requirement</i>	151
<b>SECTION D – PROGRAM</b>	
Table of Contents: Section D – Program	152
Case Management Submissions	
<i>Requirement 20: Inter-departmental Coordination</i>	153
<i>Requirement 21: Level of Consistency among Case Managers</i>	156
<i>Requirement 22: Assessing and Meeting Needs of Complex Care Members</i>	159
<i>Requirement 23: Assessing and Care Planning for Home-Based Services</i>	162
<i>Requirement 24A: Case Management Scenarios – Case A: Oscar</i>	165
<i>Requirement 24B: Case Management Scenarios – Case B: Magda</i>	168
<i>Requirement 24C: Case Management Scenarios – Case C: Wanda</i>	171
<i>Requirement 24D: Case Management Scenarios – Case D: Roger</i>	174
Medical Management Submissions	
<i>Requirement 25: Utilization Data Management</i>	177
<i>Requirement 26: Successful Interventions in Over-/Under-Utilization</i>	183
<i>Requirement 27: Chronic Care/Disease Management Programs</i>	186
<i>Requirement 28: Consistent Application of Clinical Criteria</i>	189
Quality Management Submissions	
<i>Requirement 29: Quality Improvement Opportunities</i>	192
<i>Requirement 30: Peer Review</i>	195
<i>Requirement 31A: Quality of Care Scenarios – Case A: Licensure Risk</i>	198
<i>Requirement 31B: Quality of Care Scenarios – Case B: Environmental Risk</i>	201
<i>Requirement 32: Improving Quality of Care and Performance</i>	204

---

<i>Requirement 33: Member and Provider Feedback</i>	207
<i>Requirement 34: Monitoring Home Services</i>	210
<i>Requirement 35: Oral Presentation</i>	213
<b>SECTION E – PROVIDER NETWORK</b>	
Table of Contents: Section E – Provider Network	214
Provider Network Submissions	
<i>Requirement 36: Network Development and Management Plan</i>	215
<i>Requirement 37: Network Launch</i>	245
<i>Requirement 38: Provider Communications</i>	246
<i>Requirement 39: Communicating Information about Providers</i>	248
<i>Requirement 40: Inquiries, Complaints and Requests for Information</i>	251
<i>Requirement 41: Provider Services Staff Training</i>	254
<i>Requirement 42: Provider Services Staffing Levels</i>	257
<i>Requirement 43: Handling the Loss of Network Facilities</i>	259
<i>Requirement 44: Provider Performance Issues</i>	262
<i>Requirement 45: Network Summary and Attestation Statement</i>	265
Network Attestation Statement (copy)	266



## Our Members are Our Mission


SCAN Long Term Care is part of the SCAN family whose mission is to provide quality care to meet the needs of the elderly and physically disabled.

SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

TABLE OF CONTENTS

SECTION A – GENERAL MATTERS

Table of Contents: Section A – General Matters	1
Offeror’s Signature Pages – Solicitation No. YH12-0001	
Offer and Acceptance – Issue date: January 31, 2011	2
Amendment Number 1 (One) – Issue date: February 24, 2011	3
Amendment Number 2 (Two) – Issue date: March 11, 2011	4
Offeror’s Checklist	5
Section G – Representations and Certifications of Offeror	8

	<b>Notice of Request for Proposal</b>		<b>AHCCCS</b>
			Arizona Health Care Cost Containment System
	SOLICITATION NO.: <b>YH12-0001</b>	PAGE 2	701 East Jefferson, MD 5700
	OF 160	Phoenix, Arizona 85034	

**OFFER**

The undersigned Offeror hereby agrees to provide all services in accordance with the terms and requirements stated herein, including all exhibits, amendments, and best-and-final offers (if any). Signature also acknowledges receipt of all pages indicated in the Table of Contents.

Arizona Transaction (Sales) Privilege Tax License No.:

Not Applicable

For clarification of this offer, contact:

Name: Elizabeth Russell, CEO

Federal Employer Identification No.:

20-4607594

Phone: 602-778-3300

E-Mail Address: ERussell@scanhealthplan.com

Fax: 602-778-3333

**SCAN Long Term Care**

Company Name

 3/30/11  
Signature of Person Authorized to Sign Offer

1313 East Osborn Road, Suite 150

Elizabeth Russell

Address

Printed Name

Phoenix                      AZ                      85014

Chief Executive Officer

City                      State                      Zip

Title

**CERTIFICATION**

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

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

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

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

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

**ACCEPTANCE OF OFFER (to be completed by AHCCCS)**

Your offer, including all exhibits, amendments and best-and-final offer (if any), contained herein, is accepted.


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

This contract shall henceforth be referred to as Contract No. YH12-0001-

Awarded this \_\_\_\_\_ day of \_\_\_\_\_ 2011



\_\_\_\_\_  
Michael Veit, as AHCCCS Contracting Officer and not personally




	<b>SOLICITATION AMENDMENT</b>		Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034
	Solicitation Number:	<u>RFP YH12-0001</u>	Contract Management Specialist: Jamey Schultz, CMS
	Amendment Number 1 (One)		E-mail: <u>Jamey.Schultz@azahcccs.gov</u>
	Solicitation Due Date:	April 1, 2011 3:00 PM (MST)	

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:



1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 24 <sup>th</sup> day of February, 2011, in Phoenix, Arizona.	
Signature 		Date 3/30/11	
Elizabeth Russell, Chief Executive Officer			
Typed Name and Title		Michael Veit	
SCAN Long Term Care		Contracts and Purchasing Administrator	
Name of Company			

	<b>SOLICITATION AMENDMENT</b>		Arizona Health Care Cost Containment System (AHCCCS) 701 East Jefferson, MD 5700 Phoenix, Arizona 85034  Contract Management Specialist: Jamey Schultz, CMS E-mail: <a href="mailto:Jamey.Schultz@azahcccs.gov">Jamey.Schultz@azahcccs.gov</a>
	Solicitation Number: <u>RFP YH12-0001</u>		
	Amendment Number 2 (Two)		
	Solicitation Due Date: April 1, 2011 3:00 PM (MST)		

A signed copy of this amendment shall be included with the proposal, which must be received by AHCCCSA no later than the Solicitation due date and time. This solicitation is amended as follows:

1. The attached Answers to Questions are incorporated as part of this solicitation amendment.

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11 <sup>th</sup> day of March, 2011, in Phoenix, Arizona.	
Signature 	Date 3/30/11		
Elizabeth Russell, Chief Executive Officer		Michael Veit	
Typed Name and Title		Contracts and Purchasing Administrator	
SCAN Long Term Care			
Name of Company			

### OFFEROR'S CHECKLIST

Offerors must submit all items below, unless otherwise noted. In the column titled "Offeror's Page #," the Offeror must enter the appropriate page number(s) from its proposal where the AHCCCS Evaluation Panel may find the Offeror's response to the specified requirement. AHCCCS will only consider the information provided within the allotted page limit and permitted attachments, if any, in response to a specific submission requirement when evaluating the Offeror's proposal. At no time will AHCCCS consider information outside the allotted page limit and permitted attachments, or any other information provided elsewhere in the proposal when reviewing a specific response to an individual submission requirement.

#### A. GENERAL MATTERS

<i>Subject</i>	<i>Reference</i>	<i>Offeror's Page #</i>
Offeror's signature page	(Front Page)	N/A
Offeror's Checklist (this attachment)	N/A	N/A
Completion of all items in Section G of the RFP	Section G	N/A

#### B. CAPITATION

<i>Subject</i>	<i>Requirement #</i>	<i>Offeror's Page #</i>
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	29

#### C. ORGANIZATION

<i>Subject</i>	<i>Requirement #</i>	<i>Offeror's Page #</i>
Moral and Religious Objection	2	34
Organization and Staffing	3	35
	4	84
	5	88
Sanctions	6	91
Claims	7	93
	8	105
	9	108
Encounters	10	111
Information Systems	11	118
	12	130
	13	133
	14	136
Grievance System	15	138

<i>Subject</i>	<i>Requirement #</i>	<i>Offeror's Page #</i>
Corporate Compliance	16	145
Finance and Liability Management	17	149
	18	150
	19	151

D. PROGRAM

<i>Subject</i>	<i>Requirement #</i>	<i>Offeror's Page #</i>
Case Management	20	153
	21	156
	22	159
	23	162
	24A	165
	24B	168
	24C	171
	24D	174
Medical Management	25	177
	26	183
	27	186
	28	189
Quality Management	29	192
	30	195
	31A	198
	31B	201
	32	204
	33	207
	34	210
Oral Presentation	35	The Offeror shall submit the names and resumes of the participating individuals via the EFT/SFTP server by 3 p.m. on April 8.

E. PROVIDER NETWORK

<i>Subject</i>	<i>Requirement #</i>	<i>Offeror's Page #</i>
Provider Network	36	215
	37	245
	38	246
	39	248
	40	251
	41	254
	42	257
	43	259
	44	265
Network Summary via EFT/SFTP	45	N/A

**SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR**

*The Offeror must complete all information requested below.*

**1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED**

By signing this offer the Offeror certifies, under penalty of law, that the information provided herein is true, correct and complete to the best of Offeror's knowledge and belief. Offeror also acknowledges that should investigation at any time disclose any misrepresentation or falsification, any subsequent contract may be terminated by AHCCCS without penalty to or further obligation by AHCCCS.

**2. CERTIFICATION OF NON-COERCION**

By signing this offer the Offeror certifies, under penalty of law, that it has not made to any provider any requests or inducements not to contract with another potential Contractor in relation to this solicitation.

**3. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK / LABORATORY TESTING**

By signing this offer, the Offeror certifies that it has not engaged and will not engage in any violation of the Medicare Anti-Kickback or the “Stark I” and “Stark II” laws governing related-entity and compensation therefrom. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

**4. AUTHORIZED SIGNATORY**

Authorized Signatory for SCAN Long Term Care  
[OFFEROR'S Name]

Elizabeth Russell Chief Executive Officer  
[INDIVIDUAL'S Name] [Title]

is the person authorized to sign this contract on behalf of Offeror.

**5. OFFEROR'S MAILING ADDRESS**

AHCCCS should address all notices relative to this offer to the attention of:

<u>Elizabeth Russell</u>	<u>Chief Executive Officer</u>
Name	Title
<u>1313 East Osborn Road, Suite 150</u>	<u>602-778-3300</u>
Address	Telephone Number
<u>Phoenix AZ</u>	<u>85014</u>
City	State
	ZIP

**6. OFFEROR GENERAL INFORMATION**

**a. If other than a government agency, when was your organization formed?** SCAN Long Term Care was formed in 2006 for the sole purpose of administering the ALTCS line of business.

**b. License/Certification:** Attach a list of all licenses and certification (e.g. federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper listing the license requirements and the renewal dates. Please see attached Exhibit A for licenses and certifications.

Have any licenses been denied, revoked or suspended within the past 10 years? Yes  No   
If yes, please explain.

---

**c. Civil Rights Compliance Data:** Has any federal or state agency ever made a finding of noncompliance with any civil rights requirements with respect to your program? Yes  No  If yes, please explain.

---

**d. Accessibility Assurance:** Does your organization provide assurance that no qualified person with a disability will be denied benefits of or excluded from participation in a program or activity because the Offeror's facilities (including subcontractors) are inaccessible to or unusable by persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements). Yes  No  If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.

SCAN complies fully with the Federal ADA Standards for Accessible Design (28 CFR Part 36).

SCAN routinely monitors subcontractors, especially providers of care, to comply with accessibility requirements.

---

**e. Prior Convictions:** List all felony convictions within the past 15 years of any key personnel (i.e., Administrator, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.

None

---

**f. Federal Government Suspension/Exclusion:** Has Offeror been suspended or excluded from any federal government programs for any reason? Yes  No  If yes, please explain.

---

**g.** Provide the name(s) of the in-house or independent actuary, or actuarial firm used to assist in developing capitation rates and / or reviewing published capitation rate information.

Thomas D. Snook, FSA, MAAA                      Actuary Firm: Milliman Inc.

Name

15333 N. Pima Road, Suite 375

Scottsdale

AZ

Address

City

State

**h.** Did any other firm or organization provide the Offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance and/or reviewing published capitation rates)? Yes  No  If yes, what is the name of this firm or organization?

Name

Address

City

State

**i.** Has the Offeror contracted or arranged for Management Information Systems, software or hardware, for the term of the contract? Yes  No  If yes, is the Management Information System being obtained from a vendor? Yes  No  If yes, please provide the vendor's name, the vendor's background with AHCCCS, the vendor's background with other HMOs or managed care entities, and the vendor's background with other Medicaid programs.

By way of Administrative Services Agreements, SCAN Health Plan will provide Management Information Systems to SCAN Long Term Care for the term of the contract. These management information systems include a comprehensive managed care functional business operating platform and complementary care management applications and information reporting mechanisms. SCAN Health Plan has nearly thirty years of experience with federally funded programs working with long-term care populations such as Medicare and Medicaid, both as a managed care organization and contracted care management coordinator. SCAN Health Plan is the 3<sup>rd</sup> largest Medicare Advantage (MA) plan in its service area and, on an aggregated basis, the 4<sup>th</sup> largest non-profit MA plan in the United States. SCAN Health Plan currently has more than 125,000 members in eleven California and two Arizona counties. Of this membership, more than 20,000 are qualified as Nursing Facility Level of Care. In addition to the nearly 3,000 ALTCS members served in Maricopa County, SCAN Health Plan also serves more that 7,500 Medicare and Medicaid Dual Eligible individuals providing them with case management services and a range of home and community based benefits designed to maintain the members in a residential setting of their choosing through a contract with the California Department of Health Care Services.

**7. FINANCIAL DISCLOSURE STATEMENT**

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of December 31, 2010. However, continuing Offerors who have filed the required Financial Disclosure Statement to AHCCCS within the last 12 months need not complete this section if no significant changes have occurred since the last filing.

**a. Ownership:** List the name and address of each person with an ownership or controlling interest, as defined by 42 CFR 455.101, in the entity submitting this offer:

Please see Exhibit B for an Organization Chart of the Offeror, its parent company, and affiliates.

Name	Address	December 31, 2010 Percent of Ownership or Control
SCAN Health Plan Arizona	1313 East Osborn Rd., Suite 150 Phoenix, AZ 85014	100 percent
Ryan Trimble, D.D.S.	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Chairman, Board of Directors, SCAN Long Term Care
Linda Strike	1601 Sepulveda Blvd, Suite 723 Manhattan Beach, CA 90266	Board Member, SCAN Long Term Care
Douglas Jaques	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Corporate Secretary and Board Member, SCAN Long Term Care
Timothy Schwab, M.D.	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Board Member, SCAN Long Term Care
Dennis Eder	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Board Member, SCAN Long Term Care
Henry W. Osowski	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Board Member, SCAN Long Term Care
Leonard Kirschner, M.D.	1313 East Osborn Rd., Suite 150 Phoenix, AZ 85014	Board Member, SCAN Long Term Care



Elizabeth Russell	1313 East Osborn Rd., Suite 150 Phoenix, AZ 85014	CEO, SCAN Long Term Care
Rajeev Narula	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	CFO, SCAN Long Term Care

**b. Subcontractor Ownership:** List the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Address	Percent of Ownership or Control
None		

Names of above persons who are related to one another as spouse, parent, child or sibling:  
Not Applicable

**c. Ownership in Other Entities:** List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest:

None		

**d. Long-Term Business Transactions:** List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end:

SCAN Long Term Care does not have any ownership interest in any organization that provides services to SCAN Long Term Care. SCAN Long Term Care has received services during the five-year period ending December 31, 2010, directly or indirectly, from SCAN Health Plan Arizona, SCAN Group and/or SCAN Health Plan that constitute significant business transactions including delegation of management and other administrative services. (See response at 8.b, below)

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
--------------------------------------	--	------------------------------

Please see attached Exhibit C for the details of SCAN Long Term Care's payments to providers for ALTCS covered services totaling \$25,000 or more per year. The aggregate amount of payments to these providers for each of the five 12-month periods ending December 31, 2010 is summarized in the following table.

Year	Number of Providers	Dollars Paid
2006	12	\$608,007
2007	153	\$29,128,977
2008	218	\$65,495,042
2009	274	\$88,265,247
2010	279	\$105,295,952

Please see attached Exhibit D for the list of subcontractors, other than a related organization, to whom SCAN Long Term Care paid \$25,000 or more for administrative support services in any one of the five 12-month periods ending December 31, 2010.

**e. Criminal Offenses:** List the name of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Name	Address	Title
None		

**f. Creditors:** List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror's company.

Name	Address	Description of Debt	Amount of Security
None			

**g. Outstanding Legal Actions:**

1. Are there any lawsuits, judgments, tax deficiencies or claims pending against your organization?  
Yes  No  If yes, provide details including the dollar amount.

2. Has your organization ever gone through bankruptcy? Yes  No  If yes, provide the year.

**8. RELATED PARTY TRANSACTIONS**

**a. Board of Directors:** List the names and addresses of the Board of Directors of the Offeror.

At April 1, 2011, names and addresses of the SCAN Long Term Care Board of Directors are:

Name/Title	Address
Ryan Trimble, D.D.S., Chair Chief Executive Officer, SCAN Health Plan	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806
Dennis Eder, Member Chief Financial Officer, SCAN Health Plan	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806
Douglas Jaques, Member Secretary and General Counsel, SCAN Long Term Care	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806
Elizabeth Russell, Member Chief Executive Officer, SCAN Long Term Care	1313 East Osborn Road, Suite 150 Phoenix, AZ 85014

**b. Related Party Transactions:** Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to (1) the reasonableness of the transaction, (2) its potential adverse impact on the fiscal soundness of the disclosing entity, and (3) that the transaction is without conflict of interest:

Please see attached Exhibit E for the list of transactions between the Offeror and related parties for each of the five 12-month periods ending December 31, 2010.

Justification:

SCAN Health Plan Arizona provides certain managerial, staffing, financial, legal, administrative, information technology and other support services to the Offeror pursuant to an Administrative Services Agreement, effective October 1, 2006, between the Offeror and SCAN Health Plan Arizona. SCAN Health Plan Arizona directly or indirectly subcontracts with SCAN Group and/or SCAN Health Plan, also related parties with respect to SCAN Long Term Care, for some of the aforementioned services. The consideration to be paid by the Offeror to SCAN Health Plan Arizona under the Administrative Services Agreement represents SCAN Health Plan Arizona's and/or its affiliates' estimated costs, without the inclusion of any additional mark-up or margin, for the provision of services to the Offeror. Since the amount paid by SCAN Long Term Care solely reflects a reimbursement of costs incurred, it is reasonable and neither adversely affects the fiscal soundness of SCAN Long Term Care nor represents a conflict of interest. The current monthly payment by Offeror to SCAN Health Plan Arizona is approximately \$ 915,000.

**i)** Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party. This type of transaction requires review and approval in advance by the Office of the Director:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
2009 – Equity Distribution of Funds	SCAN Health Plan Arizona	\$6 million

Justification:

In December 2009 the Offeror transferred funds to its parent, SCAN Health Plan Arizona. SCAN reported the transfer to AHCCCS in March 2010 and, subsequently, received a sanction for not seeking AHCCCS' prior approval of the equity distribution.

ii) List the name and address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e. formulates, determines or vetoes business policy decisions):

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No
Ryan Trimble, D.D.S.	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Chief Executive Officer, SCAN Health Plan	Yes
Dennis Eder	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Chief Financial Officer, SCAN Health Plan	Yes
Douglas Jaques	3800 Kilroy Airport Way, Suite 100 Long Beach, CA 90806	Secretary & General Counsel, SCAN Long Term Care	Yes
Elizabeth Russell	1313 East Osborn Rd., Suite 150 Phoenix, AZ 85014	Chief Executive Officer, SCAN Long Term Care	Yes

**9. OFFEROR'S OFFSHORE PERFORMANCE OF WORK PROHIBITED**

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or “overhead” services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers. **Offerors shall declare all anticipated offshore services in the proposal.**

All services expected to be performed in the United States (California and Arizona) in compliance with AHCCCS requirements.

END OF SECTION

**SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR**

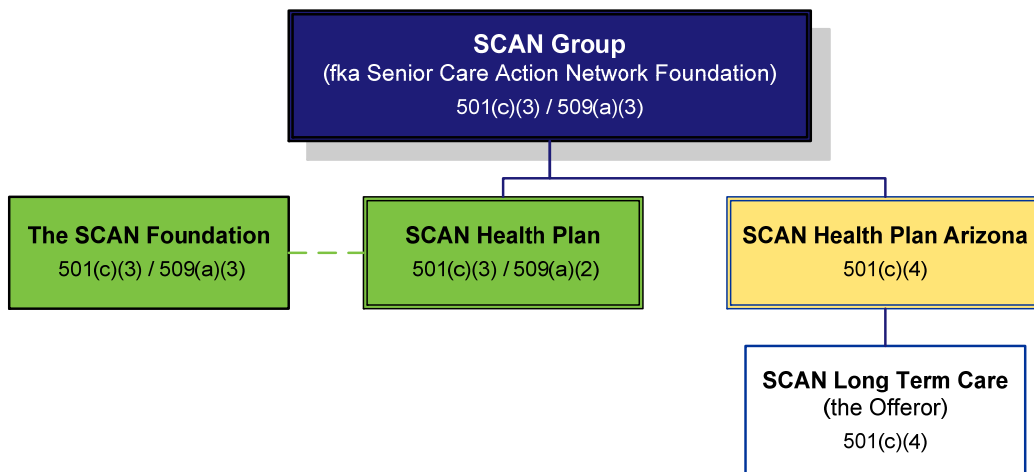
**Exhibit A: Item 6.b License/Certification**

Identified below are the contracts, licenses and certifications for the Offeror and the Offeror’s parent. Additionally, the Offeror will have the benefit of the SCAN Group’s nearly thirty years of experience working with long-term care populations such as Medicare and Medicaid.

<i>Licenses and Certifications</i>		<i>Date Contract (started)</i>	<i>Renewal Date</i>
<b>SCAN Long Term Care</b>			
1	Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care System (ALTCS) program contractor	10/1/2006	Renewed on October 1, 2009 and October 1, 2010
<b>SCAN Health Plan Arizona</b>			
2	Medicare Advantage Organization Contract with Federal Centers for Medicare and Medicaid Services (H9385)	1/1/2007	Annually on January 1
3	State of Arizona Department of Insurance Certificate of Authority, NAIC No. 12279	7/14/2005	NA

**Exhibit B: Item 7.a Ownership**

The corporate relationship between SCAN Long Term Care, its parent and affiliates and the nonprofit status of each entity is presented in the following ownership organizational chart.



page 1 of 10

SECTION G: REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR		Annual Dollar Amount of Transactions				
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		Type of Business Transaction with Provider				
Describe Ownership of Subcontractors	Type of Business Transaction with Provider	2010	2009	2008	2007	2006
A HEAVENLY HOUSE	Program Services	56,535.57				
A TOUCH OF DESERT CLASS	Program Services	70,878.14	88,233.02	96,584.50	55,219.00	
AABS VENTURES LLC	Program Services	27,754.37				
ACCENTCARE AT HOME	Program Services	215,886.57	123,511.82	39,235.71	100,928.00	
ADAMS HOUSE INC	Program Services	40,724.36				
ADVANCED SENIOR CARE AGENCY	Program Services	2,133,437.15	1,617,232.46	326,139.05	109,677.00	
AETNA (AUSHC DENTAL PLN OF CA)	Program Services	119,378.16	114,824.04	107,907.05		
AKDHC LLC	Program Services	2,452,089.46	728,420.46			
ALARYS HOME HEALTH, INC.	Program Services	975,248.18	361,839.01	31,703.15		
ALERT ADULT CARE	Program Services					
ALL VALLEY HOME HEALTH CARE	Program Services				31,321.00	
ALLEGRO ENTERPRISES INC	Program Services				40,509.00	
ALL-MED HEALTH CARE INC	Program Services	301,322.27	330,134.35	180,079.51		
ALL'S WELL HEALTH CARE SOLUTIONS	Program Services	40,304.43				
AMERICAN AMBULANCE	Program Services	63,978.86	52,662.63	62,595.97		
AMERICAN CARE HOMES, INC	Program Services	32,195.23	32,029.92			
AMERICAN PHYSICIANS INC	Program Services	59,372.19	67,980.74	72,246.49	50,852.00	
AMERICAN RETIREMENT CORP	Program Services	766,447.34	957,620.71	588,271.60	219,833.00	26,349.80
AMETHYST ARBOR ASSISTED LIVING	Program Services		95,091.66	33,190.45		
APACHE HEALTH SERVICES, INC	Program Services	97,137.14	31,488.92	185,890.60		
APACHE JUNCTION HOSPITAL	Program Services					
APOGEE MEDICAL GROUP	Program Services					
APRIA HEALTHCARE, INC.	Program Services	82,762.41	31,488.92	34,874.39	84,337.00	
ARBOR ROSE SENIOR CARE, LLC	Program Services	100,249.06	115,814.00	155,207.62		
ARC PARK REGENCY	Program Services	168,593.34	58,086.45			
AREA AGENCY ON AGING REGION	Program Services	922,117.55	56,790.76	35,406.47	36,329.00	
ARIZONA BAPTIST RETIREMENT CEN	Program Services		1,175,093.64	647,091.08		
ARIZONA BRIDGE TO INDEPENDENT LIVING	Program Services		122,059.67	498,444.72	251,769.00	
ARIZONA CONSUMER DIRECT PERSON	Program Services	1,997,283.35	1,859,285.84	1,017,925.41	233,052.00	
ARIZONA ONCOLOGY ASSOCIATES	Program Services	601,154.94	129,382.27			
ARIZONA PULMONARY SPECIALISTS	Program Services	39,985.42		46,338.22		
ARIZONA SPECIALTY PHYSICIANS	Program Services	28,855.05	32,975.47			
ARIZONA STATE PHYSICIANS ASSOC	Program Services	95,913.30				
ASAP HEALTH SOLUTIONS, INC	Program Services	33,736.21				
ASELA'S CARE HOME	Program Services					
ASSIST LIV AT BLOOMFIELD MANOR	Program Services		27,728.62	50,783.65	31,123.00	
ASSIST LIV AT MOUNTAIN VISTA	Program Services		41,702.75	31,606.78		
ASSISTED LIVING AT PHOENICIAN	Program Services	43,577.40		55,564.53	28,967.00	

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR		Annual Dollar Amount of Transactions				
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		2010	2009	2008	2007	2006
<i>Describe Ownership of Subcontractors</i>	<i>Type of Business Transaction with Provider</i>					
ASSISTED LIVING CONCEPTS, INC	Program Services		136,565.83	77,558.42	51,183.00	
ASSURED CARE HEALTHCARE SERVIC	Program Services	2,551,548.62	922,346.69	533,200.15	93,976.00	
AT HOME CARE INC	Program Services	1,228,510.21	1,066,475.76	984,718.60	285,671.00	
AT HOME SOLUTIONS LLC	Program Services	117,118.25	83,880.75	29,735.29		
AT YOUR DOOR ELDERCARE, LLC	Program Services	139,971.38	25,859.64			
AVALON CARE CENTER-CHANDLER	Program Services	611,131.52	512,218.06	375,117.68	182,656.00	
AVALON CARE CENTER-SCOTTSDALE	Program Services	805,194.88	477,853.10	352,262.76	191,362.00	
AVERY INVESTMENTS OF SCOTTSDALE	Program Services	187,632.88	76,288.78	50,682.23		
AZ AHC INC	Program Services	125,927.48	43,411.55	26,677.51		
AZ CAMELBACK BUSINESS LLC	Program Services	62,839.63				
AZHAR R. JAN	Program Services		67,501.08	69,108.49	51,391.00	
AZORE II LLC	Program Services	189,258.69	103,370.63	95,269.17		
BAKORP LLC	Program Services	41,801.49	42,463.23	41,371.31		
BANNER ARIZONA MED CLINIC, LTD	Program Services	48,874.01	35,387.76			
BANNER BAYWOOD HEART HOSPITAL	Program Services	196,950.59	68,327.68	40,436.73		
BANNER BAYWOOD MEDICAL CENTER	Program Services	437,402.75	550,638.85	481,447.44	349,119.00	
BANNER BOSWELL MED CTR	Program Services	611,375.93	392,137.44			
BANNER DEL E WEBB MEDICAL CENT	Program Services	207,903.42	119,398.02			
BANNER DESERT MEDICAL	Program Services	451,539.39	347,195.74	314,936.15	107,393.00	
BANNER ESTRELLA MEDICAL CENTER	Program Services	194,071.22	269,291.19	380,146.64	47,401.00	
BANNER GATEWAY MEDICAL CENTER	Program Services	280,204.56	143,611.57			
BANNER GATEWAY MEDICAL CENTER	Program Services					
BANNER GOOD SAM MED	Program Services	818,533.98	525,451.36	535,185.13	201,388.00	
BANNER HOME CARE ARIZONA	Program Services	215,982.28	365,791.88	97,987.71	67,077.00	
BANNER THUNDERBIRD MEDICAL	Program Services	592,514.67	416,830.87	423,807.23	443,995.00	
BAPTIST VILLAGE SUNRIDGE	Program Services			77,709.96	65,989.00	
BAPTIST VILLAGE THUNDERBIRD	Program Services		41,428.94	98,787.85	47,619.00	
BAREFOOT DOCTORS HEALTHCARE	Program Services		29,597.18	41,499.12		
BEATITUDES CAMPUS OF CARE	Program Services		27,728.76	244,900.26	167,998.00	
BEAUTIFUL BEGINNINGS ALH	Program Services		33,464.17			
BETHESDA GARDENS	Program Services	135,380.03	83,511.43	278,697.39	42,929.00	
BIG SKIES	Program Services		28,488.19	25,520.69		
BIO-MEDICAL APPLICATIONS OF AZ	Program Services	168,058.50	167,638.86	171,724.56	27,224.00	
BLUE LADY INC	Program Services	174,317.57	99,550.11	58,151.68	32,751.00	
BLUE SKY MANOR INC	Program Services	77,837.92	68,223.58	31,619.57		
BOWIE HEALTH GROUP INC	Program Services	131,139.41	53,376.74			
BREA EMERITUS LLC	Program Services	953,843.20	955,466.68	687,800.96	222,178.00	
BROWN ROAD SENIOR HOUSING LLC	Program Services	897,570.45	669,708.21	533,702.13	397,996.00	45,824.28

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR		Annual Dollar Amount of Transactions				
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		2010	2009	2008	2007	2006
<i>Describe Ownership of Subcontractors</i>	<i>Type of Business Transaction with Provider</i>					
C.V.C., LLC	Program Services	198,332.24	277,062.06	233,315.75	170,327.00	
CACTUS GLEN CARE HOME	Program Services		33,644.92			
CAMPERDOWN LLC	Program Services		30,809.95	92,428.09	29,993.00	
CARDIOVASCULAR CONSULT LTD	Program Services	40,556.63	43,957.34			
CARE FOCUS, INC.	Program Services	474,318.19	274,703.84			
CARE INSTITUTE INC. - MESA	Program Services		144,802.55	623,691.33	184,659.00	
CARECO	Program Services		406,883.54	343,641.78	120,463.00	
CARTER CARE HOMES LLC	Program Services	45,102.96				
CASA-DE-CAPRIENTERPRISES, LLC	Program Services	795,527.06	312,597.93	163,484.51	47,591.00	
CATHOLIC HEALTHCARE WEST	Program Services	445,818.14	334,148.34	252,592.95	117,167.00	
CATHOLIC HEALTHCARE WEST	Program Services	120,239.33	79,196.85	45,588.92		
CATHOLIC HEALTHCARE WEST	Program Services	105,168.24	65,647.27	105,366.54		
CENTURY CARE INC	Program Services	26,776.80				
CHANDLER UNITED MEDICAL INVEST	Program Services	1,052,758.63	1,140,012.89	733,106.76	306,349.00	
CHAR-LEE CORP	Program Services	151,406.46	187,586.19	96,272.41	95,593.00	
CHOLLA MEDICAL GROUP, PC	Program Services	25,938.44				
CHRIS RIDGE SENIOR LIVING, LLC	Program Services	101,299.82	74,080.85			
CHRISTIAN CARE MESA INC	Program Services		35,196.45	120,466.55		
CHRISTIAN CARE NURSING CENTER	Program Services		38,091.55	184,141.54	69,019.00	
CHRISTINE PLACE LLC	Program Services		53,675.45			
CHRISTINE PLACE LLC	Program Services	63,748.61		44,421.79		
CITY OF PHOENIX - ETS	Program Services				34,994.00	
CONCENTRIC HEALTHCARE SOLUTION	Program Services		1,339,054.99	1,315,127.36	347,622.00	
CORNERSTONE HOSPICE, INC	Program Services			33,376.55		
CORNWALL HEALTH SYSTEMS, INC	Program Services	46,170.47	76,324.93			
CORONADO DENTAL SERVICES INC	Program Services	309,790.77	44,018.95			
CREATIVE INNERSIONS	Program Services	192,934.49	175,612.82			
CREATIVE NETWORKS LLC	Program Services	61,393.88	166,382.40	144,259.85	57,190.00	
CRIS PREP & RECOVERY	Program Services		73,184.95			
CROSSROAD SENIOR LIVING	Program Services		78,608.68	85,243.54		
CURRY JACKSON AND ASSOC LLC	Program Services	152,687.82	102,170.45	57,891.04	34,462.00	
CYPRESS STAFFING SERVICES, LLC	Program Services	397,378.36	287,885.58	260,024.17	95,258.00	
DANIELA LEKA	Program Services	36,483.25	41,488.28	25,904.84		
DEPENDABLE MEDICAL TRANSPORT	Program Services	2,206,357.03	1,612,335.36	568,856.62		
DESERT AMETHYST RETIREMENT LLC	Program Services	70,782.33	62,325.20			
DESERT FOOTHILLS ADULT CARE HO	Program Services	39,149.18	42,856.45	31,242.18		
DESERT GARDEN ASSISTED LIVING	Program Services	131,714.40	116,184.97	31,375.69		
DESERT HAVEN	Program Services			182,614.34	26,467.00	



page 4 of 10

		Annual Dollar Amount of Transactions				
		Transaction with Provider				
Describe Ownership of Subcontractors		2010	2009	2008	2007	2006
Type of Business						
SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR						
EXHIBIT C: Item 7.d Long-Term Business Transactions; Subcontracted Program Services						
DESERT HAVEN, LLC	Program Services	216,323.53	422,667.21	425,896.41	64,246.00	
DESERT SPRINGS HOSPITAL MEDICAL CENTER	Program Services	34,297.56				
DESERT SPRINGS SENIOR LIVING	Program Services	139,250.46	229,070.82	86,236.90		
DESERT TERRACE NURSING CENTER	Program Services	604,236.99	266,396.04	249,357.52	127,922.00	
DINA POP	Program Services		27,482.25			
DISTRICT MEDICAL GROUP	Program Services	54,728.34				
DJLW HEALTH SERVICES, INC	Program Services	28,395.41	28,753.22			
DREAM CATCHER ASSISTED LIVING	Program Services	111,635.77	99,206.08			
DREAM CATCHER AT PARADISE HEIG	Program Services	115,483.55	58,795.23			
DSI RENAL, INC.	Program Services	29,302.21		26,719.49		
DYNOMETRICS, INC	Program Services	356,500.53	407,437.87	202,606.97		
EAST MESA HEALTHCARE CENTER	Program Services	903,658.95	1,015,599.50	844,002.33		
EDWARD IONESCU	Program Services	27,491.06		44,816.15		
ELDER CARE GERIATRIC SVCS	Program Services		74,515.01			
ELISABETH GRAF-SHAFA, MD	Program Services		27,097.40			
ELLEN B. OLSON MD	Program Services	34,970.05				
EMANUELA BALAI	Program Services	25,429.45				
EMERALD GARDENS INC	Program Services	103,023.11	80,842.72	86,046.41	46,359.00	
EMERGENCY PHYSICIANS SOUTHWEST	Program Services		27,512.82			
EMERGENCY PROFESSIONAL SERVICE	Program Services	25,393.29				
EMERITUS CORPORATION	Program Services	2,215,365.20	1,894,849.58	1,403,957.07	1,262,959.00	200,975.84
ENGERY ENTERPRISE INC	Program Services	616,261.65	432,872.38	255,332.07	48,228.00	
ENROSE ESTATES ASSISTED LIVING	Program Services		40,052.93			
ERSA DYKEMAN	Program Services	41,830.84	58,177.43	87,581.60	48,174.00	
EVANGELICAL LUTHERAN GOOD SAMA	Program Services		115,692.19	539,615.24	395,899.00	
EVERGREEN AT MESA, L.L.C.	Program Services				170,858.00	
EVERGREEN AT SUN CITY	Program Services				124,614.00	
EVERGREEN FOOTHILLS	Program Services				74,424.00	
EVERGREEN MESA CHRISTIAN, LLC	Program Services				249,095.00	
EVERGREEN REALTY ADVISOR INC	Program Services	116,155.88				
EVMARK CORP.	Program Services	167,516.28	126,915.76	35,085.66		
EXPRESS SCRIPTS, INC	Program Services	2,622,290.08		1,442,182.65		
EXTENDED CARE PORTFOLIO TENANT	Program Services	200,348.01				
FAMILY CARE HOMES, INC	Program Services	555,114.84	430,948.04	278,228.27		
FAMILY HEALTHREACH INC	Program Services		60,185.49	123,771.59	36,615.00	
FOOTHILL CARE CENTER, LLC	Program Services	477,071.91	387,918.24	168,954.88	160,489.00	
FOUNDERS HEALTHCARE, LLC	Program Services	272,742.69	270,303.91	202,925.28	46,924.00	
FOUNTAIN OF YOUTH ACH	Program Services		44,281.92	70,845.60		

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR		Annual Dollar Amount of Transactions				
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		2010	2009	2008	2007	2006
Describe Ownership of Subcontractors		Type of Business Transaction with Provider				
FREEDAZ LLC	Program Services	40,012.12				
FRIENDSHIP RETIREMENT CORPORAT	Program Services		114,261.57	403,352.38	153,118.00	
FSL PROGRAMS	Program Services	292,727.05	356,954.44	363,060.22	263,597.00	
GARIBAY'S MEDICAL TRANSPORT	Program Services			28,353.41	28,405.00	
GATEWAY RANCH ASSISTED LIVING	Program Services	26,370.60	43,451.37	49,752.65		
GERIATRIC SOLUTIONS LLC	Program Services	78,001.78	68,379.78	43,454.71	48,446.00	
GLENBO, LLC	Program Services	40,430.31				
GLENDALE HEALTHCARE ASSOCIATES	Program Services	1,745,042.82	1,527,462.35	814,701.10	278,652.00	
GLYNIS INCORPORATED	Program Services	177,364.22	80,061.33			
GOOD NEIGHBOR ASSISTED LIVING	Program Services	1,118,547.22	1,098,938.04	789,500.78	186,204.00	
GRACE ASSISTED LIVING HOME INC	Program Services	25,208.90				
GREENFIELD ASSISTED LIVING	Program Services		384,577.72	162,612.90	77,677.00	
GREGNELL, LTD	Program Services	40,504.56	56,897.80			
HACIENDA SKILLED NURSING FACILITY	Program Services	114,958.32	296,503.88	196,475.16		
HANGER PROSTHETICS & ORTHOTICS WEST, INC	Program Services	68,605.50	57,641.67	43,198.57	45,578.00	
HARRAWAY CORPORATION	Program Services	381,956.03	303,465.34	190,857.30	101,906.00	
HAVEN BEHAVIORAL SERVICES	Program Services	73,918.88	43,831.53			
HEALTH SOUTH SCOTTSDALE REHAB	Program Services				39,293.00	
HEALTHSTAFF INC	Program Services	107,019.27	140,325.41	106,813.96	29,366.00	
HEARTHSTONE HOSP - SUN CITY LLC	Program Services	1,967,485.58	328,323.51			
HEARTHSTONE HOSPITAL - MESA LLC	Program Services	1,086,092.09	228,027.96			
HEARTHSTONE OF MESA LLC	Program Services		193,765.96	118,438.10	143,500.00	
HEARTHSTONE OF SUN CITY, LLC	Program Services	188,931.54	776,987.65	1,417,506.25	1,000,383.00	71,560.14
HELPING HAND	Program Services		44,105.85	44,073.59		
HERITAGE AT CAREFREE	Program Services	142,028.42	60,199.66			
HERITAGE LIFE CENTER LLC	Program Services	214,708.18	33,078.70			
HIGHLAND HEALTHCARE, LLC	Program Services	302,169.45	338,741.52	370,408.83		
HILL-ROM COMPANY, INC.	Program Services	157,871.39	142,026.79	66,445.34	46,198.00	
HOSPICE OF ARIZONA, LCC	Program Services	129,730.50	152,929.54	231,312.79	38,057.00	
HOSPICE OF THE VALLEY	Program Services	346,761.51	547,051.61	367,952.89	165,097.00	
HOSPITAL DEVELOPMENT OF WEST P	Program Services	134,236.67	58,427.34	42,493.07	26,186.00	
HOSPITALIST OF ARIZONA INC	Program Services	85,203.75	67,817.00	26,682.62		
IMMANUEL CARING MINISTRIES INC	Program Services	1,026,480.30	941,392.41	829,454.70	419,868.00	
INN AT THE AMETHYST	Program Services	142,034.76				
INSIGHT HEALTH CORP	Program Services		37,127.27			
INSPIRIS	Program Services	29,046.01				
INSPIRIS, INC	Program Services	626,789.00	572,321.14	491,632.54	379,801.00	
INSTANT CARE OF AZ INC	Program Services	1,384,183.37	1,023,632.06	724,045.03	251,737.00	

page 6 of 10

		Annual Dollar Amount of Transactions				
		Type of Business Transaction with Provider				
Describe Ownership of Subcontractors		2010	2009	2008	2007	2006
SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR						
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services						
INTERNISTS ONCOLOGIST LTD	Program Services	32,057.55				
IRONWOOD CANCER & RESEARCH CENTERS, PC	Program Services	64,423.73	59,473.88	34,000.71		
JACK R. CAVALCANT MD, PC	Program Services	29,030.86	51,135.40			
JAN AZHAR RAFIQ GEN PTR	Program Services	56,368.05				
JANINE ROUMAIN M.D.	Program Services	222,142.50				
JAYLEE INC.	Program Services	118,414.97	197,911.57	141,533.63		
JENNINGS SOUTH INC	Program Services	1,245,405.22	1,039,568.29	835,034.30	410,116.00	36,391.68
JOHN A. DOVER, MD INC.	Program Services	58,960.42	62,000.87	28,124.29		
JOHN C LINCOLN NORTH MOUNTAIN	Program Services	379,408.49	338,643.92	321,730.48	82,449.00	
JOHN FEELEY	Program Services		25,415.80			
JOHN GARVEY	Program Services	29,602.00				
JOLLEY FAMILY ASSISTED LIVING	Program Services	29,251.71	61,278.21	46,690.57		
KCI, USA, INC.	Program Services	105,147.09	105,691.61	46,702.22	80,293.00	
KC'S HOME HEALTH CARE LLC	Program Services	39,393.08	36,948.37			
KINDRED NURSING CENTERS WEST	Program Services			241,456.62	93,831.00	
L AND H, LLC	Program Services	75,952.69				
LAS FUENTES ASSISTED LIVING	Program Services	116,426.79				
LATANYA KING	Program Services	71,610.35				
LEGACY HOME CARE, LLC	Program Services	138,346.33	77,723.92	33,045.98		
LEGACY SENIOR MANAGEMENT . LLC	Program Services	1,868,536.12	1,697,264.51	1,194,899.94	550,857.00	
LEGACY VILLAGE AT MESA, LLC	Program Services	494,797.75	40,846.81			
LEO ARCHER & SUSAN Q ARCHER	Program Services	63,688.11	52,277.25			
LIFE CARE CENTER OF NORTH GLENDALE	Program Services	2,057,096.77	2,379,865.11	2,316,328.27	1,140,197.00	
LIFE CARE CENTERS OF AMERICA	Program Services	8,514,134.89	9,860,558.62	8,771,850.66	4,392,195.00	
LIFECARE SOLUTIONS	Program Services	127,250.42				
LIFELINE SYSTEMS, INC.	Program Services	26,181.48				
LIFESPAN BEHAVIORAL HEALTH LLC	Program Services	85,407.00	74,996.46	26,904.48		
LIFESTAR AMBULETTE INC	Program Services		96,256.06	286,278.13	148,950.00	
LINA BOT	Program Services			25,926.08	28,145.00	
LOS NINOS HOSPITAL	Program Services					
LSREF GOLDEN OPS 26 (AZ), LLC	Program Services	119,204.72				
MADISON CONSULTANTS INC	Program Services					
MARAVILLA CARE CENTER INC	Program Services	671,685.42	508,136.70	260,566.55	31,543.00	
MARC CENTER OF MESA INC	Program Services	37,650.60	50,068.59			
MARCELA MURARIU	Program Services					
MARICOPA COUNTY SPECIAL HEALTH	Program Services	919,073.85	600,884.92	766,605.34	27,932.00	
MARK ALLEN FOUNDATION, INC	Program Services	57,161.91	51,041.54	466,810.00		
MARYLAND GARDENS	Program Services	336,221.72	420,371.99	342,702.04		

page 7 of 10

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		Annual Dollar Amount of Transactions				
Type of Business Transaction with Provider		2010	2009	2008	2007	2006
MARYVALE SPECIALTY	Program Services	28,316.79				
MAXIM HEALTHCARE SERVICES, INC	Program Services	131,962.24	396,215.81	106,998.43		
MAYO CLINIC ARIZONA	Program Services	59,041.35	319,242.52			
MD ROOMSERVICE	Program Services	44,435.83	44,511.66			
MEDICAL DATA EXPRESS (MDE)	Program Services			26,010.00		
MEDIX STAFFING SOLUTIONS	Program Services	68,662.27				
MEDPRO	Program Services		104,901.88	89,422.68	73,221.00	
MESA GENERAL HOSPITAL	Program Services				119,292.00	
MESA I ENTERPRISES, LLC	Program Services	634,219.03				
MESA LUTHERAN HOSPITAL	Program Services				102,623.00	
MESA SENIOR CARE, LLC	Program Services				183,907.00	
MGA HOME HEALTHCARE, LLC	Program Services	33,076.52				
MI CASA NURSING CENTER	Program Services	1,363,057.31	1,628,024.90	1,560,632.31	686,733.00	
MICHAEL B. BAYLESS	Program Services	107,247.70	76,286.28			
MILESTONE OPERATIONS, LLC	Program Services	636,035.41	202,495.17			
MONTEREY CARE	Program Services	438,271.08	500,557.03	210,045.04	66,314.00	
MOUNTAIN VISTA MEDICAL CENTER	Program Services	112,218.40	61,777.39	65,153.12	161,436.00	
MURIEL R. FENTON	Program Services	451,875.80	370,893.70	410,266.49	340,441.00	57,014.46
NABCO ASSOCIATES	Program Services			99,499.19	80,911.00	
NEW ARIZONA FAMILY, INC	Program Services		41,370.88	65,483.01	41,300.00	
NICULAE SPIREA	Program Services	44,947.49		58,098.95		
NIGHTINGALE HOMECARE	Program Services				29,209.00	
NORTH MOUNTAIN HEALTH CARE LLC	Program Services	757,345.50	786,833.43	459,780.50	226,031.00	
NURSING SOLUTIONS	Program Services	145,983.17				
OASIS CARE HOMES, LLC	Program Services	42,841.20	45,214.35	38,509.50	50,355.00	
ONCOLOGY RESEARCH ASSOCIATES	Program Services	79,127.47				
OPTION 1 NUTRITION HOLDINGS LL	Program Services	34,889.18				
PALMS SENIOR LLC	Program Services		123,240.22	409,086.24	49,015.00	
PALO VERDE HEMATOLOGY/ONCOLOGY LTD	Program Services	68,258.89		30,267.57	26,348.00	
PARKWOOD ASSISTED LIVING	Program Services		26,613.23			
PAUL PETRINI	Program Services			57,011.85		
PAUL POPESCU	Program Services	25,197.09	30,771.91			
PAUL S. DRINKWATER, MD	Program Services	29,000.00				
PECOS HEALTHCARE LIMITED PARTE	Program Services	753,095.84	623,010.23	323,570.25	97,205.00	
PHOENIX EI TRANSPORTATION	Program Services	25,814.52	27,694.33	33,447.15		
PHOENIX HEALTHCARE LLC	Program Services	441,196.54	326,659.60	55,369.60		
PHOENIX JEWISH COMMUNITY KIVEL	Program Services	220,731.32	168,151.24	340,766.88	241,867.00	
PHOENIX MEDICAL GROUP PC	Program Services	28,979.74	29,495.33			

page 8 of 10

		Annual Dollar Amount of Transactions				
		Type of Business Transaction with Provider				
Describe Ownership of Subcontractors		2010	2009	2008	2007	2006
SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR						
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services						
PHOENIX MOUNTAIN NURSING CENTE	Program Services	1,027,424.86	845,078.30	599,297.78	352,467.00	25,041.77
PHOENIX MOUNTAIN NURSING CTR	Program Services	295,855.32	246,392.75	71,483.64		
PHOENIX SENIOR LIVING, LLC	Program Services	1,657,046.84	1,359,155.67	1,038,222.43		
PINNACLE HEALTH FACILITIES XXVI	Program Services	189,026.28			285,019.00	
PINNACLE HEALTH FACILITIES XXI	Program Services	253,272.47	222,786.05			
PINNACLE HEALTH FACILITIES XXU	Program Services			36,408.99		
PLAZA HEALTHCARE	Program Services	3,294,780.80	3,781,242.43	2,391,444.88	692,941.00	
PORTABLE XRAY AZ	Program Services				26,946.00	
PREFERRED HOMECARE INFUSION.LL	Program Services	216,322.05	140,297.43	58,516.36	165,340.00	
PREMIER HOSPICE & PALLIATIVE C	Program Services		42,903.75			
PRIMARY FUNDING CORPORATION	Program Services		448,738.86			
PRN MEDICAL SERVICES	Program Services	93,289.90				
PROFESSIONAL HEALTH CONSULTANT	Program Services	165,049.84	37,422.63			
PROFESSIONAL HOME CARE SERVICE	Program Services	125,097.28	51,019.50	53,518.15	34,653.00	
PROFESSIONAL MEDICAL TRANSPORT	Program Services	382,380.23	288,531.06	174,601.21	78,129.00	
PROMISE HOSPITAL OF PHOENIX IN	Program Services			86,471.53		
PUJICA BEBEC	Program Services	61,920.60	32,315.64			
PULMONARY ASSOCIATES PA	Program Services	26,088.58				
PURFOODS LLC	Program Services	92,921.79				
QLP, LLC QUALITY LIFE PRODUCTS	Program Services	126,392.28	95,946.33	48,406.48		
QUALITY LIFE CARE LLC	Program Services	93,561.41	37,632.23			
QUILTED CARE LTD CO	Program Services	81,211.15	131,091.80		60,160.00	
RADIANT HILLS HEALTH ASSOCIATE	Program Services	1,738,852.72	1,210,350.08	92,702.97	339,940.00	25,835.78
RAINBOW CARE CENTER	Program Services	50,991.51	92,716.39	36,582.83		
RED MOUNTAIN REFLECTIONS ALH	Program Services	62,846.73		65,917.06		
RED MOUNTAIN SENIOR HOME	Program Services	34,424.94				
REJOICE ASSISTED LIVING HOME	Program Services	28,988.28	27,246.94	46,600.04		
RENAISSANCE EAST, LLC	Program Services	162,900.73	239,785.86			
RENAISSANCE VILLAGE AL, LLC	Program Services	158,449.17	108,985.89			
RENAISSANCE WEST, LLC	Program Services	1,666,087.58	1,392,834.64			
RENAL CARE GROUP ARIZONA LLC	Program Services	138,120.81	109,948.99	64,355.74		
RENEWCARE OF SCOTTSDALE	Program Services	497,459.43	310,668.70	169,066.60	120,717.00	
RGL DEVELOPMENT	Program Services			34,778.42		
RODICA MERTIC	Program Services	47,441.05				
RUBY GRAHAM	Program Services	113,153.75	118,446.46			
RURAL METRO CORPORATION	Program Services	30,191.63	29,977.80	37,424.25		
SAINT JOSEPH'S HOSPITAL	Program Services			39,932.80		

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR  
EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services

page 9 of 10

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Annual Dollar Amount of Transactions				
		2010	2009	2008	2007	2006
SANDRA REELEY-BAKER	Program Services	95,338.62	117,270.16	123,198.81	228,868.00	39,336.52
SCHWEICHLER ADULT CARE HOMES	Program Services	91,452.29	75,481.33	47,699.56		
SCOTTSDALE ALH	Program Services				90,853.00	
SCOTTSDALE ASSISTED LIVING LLC	Program Services	77,365.90	51,722.14			
SCOTTSDALE HEALTHCARE HOSPITALS	Program Services	613,960.84	263,013.52	527,403.63	174,849.00	
SCOTTSDALE PHYSICIANS GROUP	Program Services	119,739.12	85,289.36			
SCOTTSDALE RESIDENTIAL CARE	Program Services	701,294.21	783,116.56	650,779.91	217,067.00	
SELECT MEDICAL CORP	Program Services	148,922.66	70,951.99	32,816.40		
SELECT SPECIALTY HOSP - AZ INC	Program Services	121,251.54	123,321.89	44,708.80	36,018.00	
SENIOR LIVING OPTIONS, LLC	Program Services	675,607.02	522,601.47	388,984.72	37,259.00	
SHAPC, LLC	Program Services	54,976.02				
SHIV CHASSM K CHANDLER	Program Services		26,428.63			
SIERRA LAND GROUP LNC	Program Services	227,612.14	1,177,674.62	787,869.93	408,692.00	
SILVER STAR ASSISTED LIVING	Program Services	26,199.87				
SIMONMED IMAGING INC	Program Services		34,851.19			
SIRONA INFUSION, LLC	Program Services	57,952.64	41,751.12	25,181.81		
SJHMC PHYSICIAN SERVICES	Program Services		27,736.88			
SLO ENCANTO PALMS LLC	Program Services	236,070.59	116,302.14	42,175.93		
SLO RIDGECREST LLC	Program Services	314,555.92	449,932.31	249,092.87	256,390.00	
SMI IMAGING, LLC	Program Services	29,787.73				
SOLTERRA OF ARIZONA, LLC	Program Services	161,746.42				
SONORA QUEST LABORATORIES, LLC	Program Services	148,723.14	111,555.84	103,285.14	75,385.00	
SONORAN SKY COMMUNITY SERVICES	Program Services		43,197.29			
SOUTHWEST DIAGNOSTIC IMAGING	Program Services	45,005.30	39,675.02	38,734.11	26,404.00	
SOUTHWEST KIDNEY INSTITUTE, PL	Program Services	54,373.47	52,158.45	48,680.94	38,165.00	
SOUTHWEST KIDNEY-DAVITA DIALYS	Program Services	78,847.61	92,902.15			
SOUTHWESTERN EYE CENTER,LTD.	Program Services	29,906.40				
SPECIALIZED ASSISTED LIVING	Program Services	130,875.41	86,426.58	45,419.53	28,446.00	
SPRING VALLEY	Program Services		53,807.11	182,155.00	96,919.00	
ST. LUKE'S BEHAVIORAL HEALTH C	Program Services		37,514.56	78,634.22		
ST. LUKE'S MEDICAL CENTER, LP	Program Services	182,414.28	275,198.53	266,377.38	64,643.00	
STRATFORD ASSISTED LIVING, LLC	Program Services	232,622.55				
SUN CITY DIALYSIS CENTER, LLC	Program Services	28,129.17				
SUN HEALTH PHYSICIANS	Program Services		29,155.33	229,589.76	258,266.00	
SUN WEST HEALTH CARE AND REHAB	Program Services	1,129,881.83	947,186.95	358,004.34	164,849.00	
SUNBRIDGE ESTRELLA CARE & REHAB	Program Services	259,031.78	243,288.78	240,712.34	103,451.00	
SUNCREST HEALTH	Program Services	427,803.37	452,818.74	191,364.32	85,960.00	
SUNFLOWER ADULT DAY CARE CENTE	Program Services	50,176.45	70,983.62	35,370.01		

page 10 of 10

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR EXHIBIT C: Item 7.d Long-Term Business Transactions, Subcontracted Program Services		Annual Dollar Amount of Transactions				
		2010	2009	2008	2007	2006
Describe Ownership of Subcontractors		Type of Business Transaction with Provider				
SUNLAND HEALTH ASSOCIATES, LLC	Program Services	44,028.71	50,272.25		306,510.00	28,590.42
SUNNYHILL ADULT CARE, INC.	Program Services		111,742.25	777,667.91		476,289.00
SUNRISE MESA HEALTH CARE	Program Services	433,852.10	604,966.83	223,980.80		25,449.21
SUNSHINE VILLAGE ALC & MEMORY	Program Services	39,251.87	30,957.63			
SUNWEST REHAB CO, LLC	Program Services	378,717.64	318,110.14	296,904.37		140,259.00
SW GENERAL INC.	Program Services	689,440.20	516,088.58	244,979.15		39,528.00
SYNERGY HOMECARE	Program Services	266,234.10	181,176.08	146,122.08		35,255.00
THE BRIGHT MORNING STAR ALH	Program Services		117,249.99	202,657.49		
THE CEDAR GARDENS ASSISTED LIV	Program Services	469,579.97	403,680.58			
THE CEDAR SANCTUARY LLC.	Program Services	61,055.03	84,650.09			
THE CEDARE GARDENS ASSISTED LIVING	Program Services	27,095.84				
THE CENTER FOR ORTHO RESEARCH	Program Services				261,123.00	
THE ENSIGN GROUP, INC.	Program Services				38,645.00	
THE LODGE AT 14TH ST	Program Services		44,390.72	65,166.91		
THE LOVING KIND CARE HOME	Program Services		26,849.55	25,997.57		
THE PARK AT 7TH AVE	Program Services	158,193.92	140,665.02	113,014.22		42,024.00
TIFFANIE LIEBICH	Program Services	48,852.52	43,462.21			
TNT LIFE ADVENTURE, INC	Program Services	113,038.16				
TUCSON MEDICAL CENTER	Program Services			45,129.89		
UNITED SEATING & MOBILITY	Program Services	141,758.30				
UNIV MEDICAL CENTER SO NV	Program Services		38,348.91			
UNIVERSITY MEDICAL CENTE	Program Services		40,175.90			
URGENT HOME CARE INC	Program Services	1,398,185.37	41,754.70			
VALLEY CARE MANAGEMENT CORP	Program Services	28,603.94	767,914.50	58,742.20		
VENTANA WINDS ASSISTED LIVING	Program Services	105,828.54	28,849.60			
VHS ACAUISION SUBSIDIARY NUMBER 1, INC	Program Services	158,373.12	112,756.24	143,919.55		131,665.00
VHS ACQUISITION CORPORATION	Program Services	137,590.74	41,957.67	27,404.48		
VHS OF ARROWHEAD, INC	Program Services	119,747.22	152,255.28	64,002.78		53,997.00
VHS OF PHOENIX	Program Services	151,184.17	173,530.48	136,674.35		72,141.00
VISTA HOSPICE CARE INC	Program Services	44,374.90				
VOLUNTEERS OF AMERICA	Program Services		94,573.48	220,991.35		98,629.00
WELLSPRING ADULT CARE HOME	Program Services		25,728.67	26,742.02		
WESTON ENTERPRISE GROUP, LLC	Program Services		77,394.74			
YOUNG LIFE AL INC 2	Program Services	378,203.44	359,178.94	261,634.17		155,744.00
YOUNGTOWN HEALTH, INC	Program Services	1,140,359.28				25,637.52
YUKIKO F. COOPER	Program Services		35,608.62	31,246.14		
ZSOLT BIRO DBA TOP QUALITY ALH	Program Services		43,704.90	42,343.57		
		\$ 6,533,549	\$ 4,707,995	\$ 3,155,321	\$ 1,851,809	\$ 79,677

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR  
EXHIBIT D: Item 7.d Long-Term Business Transactions, Subcontracted Administrative (Non-Program) Services

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Annual Dollar Amount of Transactions				
		2010	2009	2008	2007	2006
Advanced Reimbursement Management, LLC	Assisted with reinsurance remediation project during staffing transition		\$25,000			
Arizona Association of Health Plans, Inc.	Membership Organization		\$25,555			\$54,212
Arizona State Physicians Assoc	Credentialing Services	\$74,508	\$49,625	\$26,600	\$65,258	\$31,475
Computer Bay	IT Support					
Crestec	Informational Materials		\$120,606	\$46,634		
Direct Advertising Response	Informational Materials		\$64,263			
Edmund Jung & Associates	Systems Support		\$51,171	\$42,121	\$49,113	\$343,591
Frazer, Ryan Goldberg, Arnold & FSL Programs	Legal Services	\$25,361	\$61,200	\$32,550	\$36,920	
	Monitor and Investigate Assisted Living Facilities	\$60,400				
Janine Roumain M.D.	Consulting Services	\$241,830				
Kutak Rock, LLP	Legal Services	\$48,754				\$48,343
Low & Childers	Legal Services					\$29,876
Mckesson Health Solutions	Consulting Services				\$69,766	
MDE	Computer Services			\$40,500		
Mehrdad Shafa	Consulting Services	\$37,250				
Michael Malkin	Consulting Services	\$134,251	\$44,431			
Milliman, Inc	Actuarial Services					\$42,253
MRG	Consulting Services			\$215,679	\$532,306	\$552,458
Navigant	Legal Services	\$115,399				
Paladin Projects	Systems Support					\$173,580
Phyllis Biedess	Legal Services	\$27,700				
Steptoe & Johnson LLP	Legal Services				\$36,778	
The O'Toole Group	Consulting Services					\$29,986
Thomas Hoehner	Consulting Services	\$108,800	\$192,000	\$109,558		
TNT Consulting, INC.	Computer Services					\$103,644
Veridus, LLC	Legal Services	\$38,082	\$28,160	\$35,850		

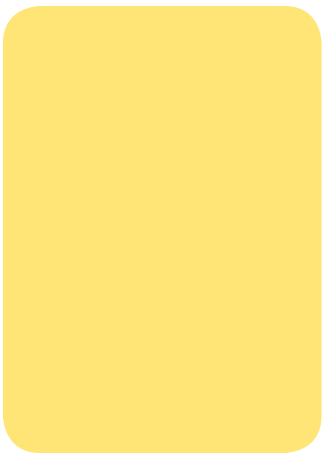


**SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR**

**Exhibit E: Item 8.b.i Related Party Transactions**

Transactions between SCAN Long Term Care, the Offeror, and any related party that have occurred during each of the five years ending December 31, 2010, the relationship of that party to SCAN Long Term Care, and the dollar amount of the transactions for each of the 12-month reporting periods are as follows:

<i>Description of Transaction</i>	<i>Name of Related Party and Relationship</i>	<i>Dollar Amount for Reporting Period</i>				
		2006	2007	2008	2009	2010
Management fee	SCAN Health Plan Arizona Parent	\$135,000	\$1,879,366	\$1,879,366		
Other administrative support charges	SCAN Health Plan Arizona Parent	\$866,197	\$3,985,152	\$5,859,497	\$8,174,760	\$10,738,429
Management fees	SCAN Health Plan Affiliated Entity				\$2,276,322	\$2,714,149
Management fees	SCAN Group Affiliated Entity				\$1,757,694	\$1,959,599



## Our Members are Our Mission

SCAN Long Term Care, a non-profit corporation, directs its financial returns to meeting the needs of its stakeholders, not shareholders.

SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

TABLE OF CONTENTS

SECTION B – CAPITATION

Table of Contents: Section B – Capitation	28
Capitation Bid Submission	
<i>Requirement 1: Capitation Rate Bid</i>	29
Actuarial Certification	30
Capitation Rate Bid Template – GSA 52	32

## *Requirement 1: Capitation Rate Bid*

---

### *Capitation Rate Bid Submission*

SCAN Long Term Care is submitting a response to RFP No. YH12-0001 to be an ALTCS Contractor for GSA #52, Maricopa County.

SCAN Long Term Care's actuarial certification of the rates being submitted and its capitation rate bid for GSA #52, utilizing the AHCCCS prescribed Capitation Bid Template, are included on the following pages.

Concurrent with the delivery of this hard copy of its response to RFP No. YH12-0001, SCAN Long Term Care has submitted to AHCCCS, via the EFT/SFTP server, an electronic copy of its certified capitation rate bid for GSA #52.



15333 N. Pima Road  
Suite 375  
Scottsdale, AZ 85260  
USA

Tel +1 480 348 9020  
Fax +1 480 348 9021

milliman.com

March 24, 2011

**Actuarial Certification**  
**SCAN Long Term Care**  
**ALTCS Elderly & Physically Disabled Capitation Bids: GSA 52**  
**October 1, 2011 – September 30, 2012**

I, Thomas D. Snook, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by SCAN Long Term Care to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 52 under the Arizona Long Term Care System (ALTCS).

The purpose of this certification is to comply with the Instructions to Offerors contained in the Request for Proposal (including amendments through the date of this certification) issued by Arizona Health Care Cost Containment System Administration (AHCCCS). This certification may not be appropriate for other purposes.

The capitation rate to which this certification applies is shown in the table below. The rate applies to the period October 1, 2011 through September 30, 2012. This rate is inclusive of Case Management, Administration, Risk/Contingency and Premium Tax, and net of Reinsurance and Share of Cost. The bid reflects the ALTCS-provided HCBS Mix, Share of Cost, and Reinsurance Offset values.

**SCAN Long Term Care**  
**Proposed Capitation Rate for GSA 52**

**Net Capitation with Premium Tax**

\$3,231.84

It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 52 during the time period for which it are intended.

My determination is based on a review of the claim experience and other information provided by ALTCS, experience data and descriptions of provider contracts provided by SCAN Long Term Care, and my judgment. In performing my analysis, I relied on data and other information provided by ALTCS and by SCAN Long Term Care. I have not audited or verified this data and



other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

The costs which underlie the capitation bid are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are applicable for the purpose of this certification and are reasonably related to the experience of SCAN Long Term Care and/or experience provided by ALTCS and to reasonable expectations. Actual results will differ from the figures indicated in the final offered rates to the extent that future plan experience differs from the assumptions used to develop the figures.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

A handwritten signature in blue ink, appearing to read 'T. Snook', written over a horizontal line.

Thomas D. Snook, FSA, MAAA  
Milliman, Inc.  
15333 N. Pima Road, Suite 375  
Scottsdale, AZ 85260

March 24, 2011

Capitation Rate Bid Template – GSA 52

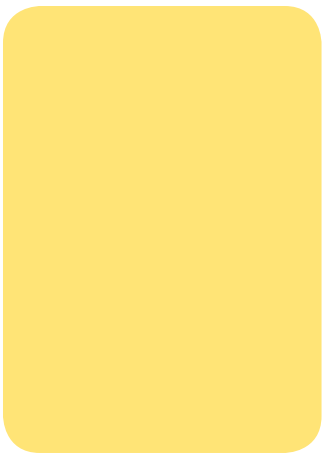
<b>AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission <sup>1</sup></b>			
<b>Service Category</b>	<b>SCAN Long Term Care / GSA 52</b>		
	<b>Gross</b>	<b>MIX</b>	<b>Net</b>
Nursing Facility	\$ 5,347.24	25.82%	\$ 1,380.66
Share of Cost			\$ (223.08)
<b>Net Nursing Facility</b>			<b>\$ 1,157.58</b>
HCBS Home and Community	\$ 1,637.99	74.18%	\$ 1,215.06
<b>Net HCBS</b>			<b>\$ 1,215.06</b>
Acute Care Prior to Reinsurance			\$ 617.41
Reinsurance Offset			\$ (229.85)
<b>Net Acute Care</b>			<b>\$ 387.56</b>
<b>Medical Component <sup>2</sup></b>			<b>\$ 2,760.20</b>
Case Management <sup>3</sup>			\$124.23
Administration <sup>4</sup>		8.00%	\$ 249.14
<b>Sub-Total of Scored Components</b>			<b>\$ 3,133.57</b>
Risk/Contingency at 1%			\$ 33.63
<b>Net Capitation</b>			<b>\$ 3,167.20</b>
Premium Tax (98% of Final Cap)			\$ 64.64
<b>Net Cap w/ Premium Tax</b>			<b>\$ 3,231.84</b>

**Key**

- user input
- user input using AHCCCS provided numbers
- formula

**Notes**

- 1) Numbers are fictional for example purposes and are on a Per Member Per Month (PMPM) basis.
- 2) Scored component, must be within the range provided by AHCCCS or will not be accepted.
- 3) Scored component (no max, no range supplied).
- 4) Scored component. Bidder must enter admin as a %. Admin dollars will be a calculation. Max admin accepted for bid is 8%. If bidders bid admin % above the max will not be accepted. Admin % is calculated as: Admin / (Net NF + Net HCBS + Acute Care Prior to RI + Case Management)
- 5) The above template must be provided for each GSA bid.
- 6) With bid submission bidder must submit an actuarial certification signed by a qualified actuary.
- 7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.



## Our Members are Our Mission

SCAN Long Term Care engages qualified, experienced personnel in the integration of processes and communications across all functional areas and with external stakeholders, ensuring efficient and effective delivery of program services for our members.



SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

## TABLE OF CONTENTS

## SECTION C – ORGANIZATION

Table of Contents: Section C – Organization	33
Moral and Religious Objection Submission	
<i>Requirement 2: Statement of Moral and Religious Objections</i>	34
Organization and Staffing Submissions	
<i>Requirement 3: Resumes of Key Personnel</i>	35
<i>Requirement 4: Justification for Positions Not Full Time</i>	84
<i>Requirement 5: Functional Organizational Chart</i>	88
Sanctions Submission	
<i>Requirement 6: Sanctions since 2008</i>	91
Claims Submissions	
<i>Requirement 7: Claims Adjudication Process</i>	93
<i>Requirement 8: Promoting and Advancing EDI and EFT</i>	105
<i>Requirement 9: Clinical and Data Edits</i>	108
Encounters Submissions	
<i>Requirement 10: Encounter Submissions Process</i>	111
Information Services Submissions	
<i>Requirement 11: Information Services Structure and Support</i>	118
<i>Requirement 12: Information System Changes and Modifications</i>	130
<i>Requirement 13: Software Vendor Information</i>	133
<i>Requirement 14: Support of IT Federal Mandates</i>	136
Grievance System Submission	
<i>Requirement 15: Grievance System</i>	138
Corporate Compliance Submission	
<i>Requirement 16: Corporate Compliance Program</i>	145
Finance and Liability Management Submissions	
<i>Requirement 17: Audited Financial Statements</i>	149
<i>Requirement 18: Performance Bond Requirement</i>	150
<i>Requirement 19: Minimum Capitalization Requirement</i>	151

## *Requirement 2: Statement of Moral and Religious Objections*

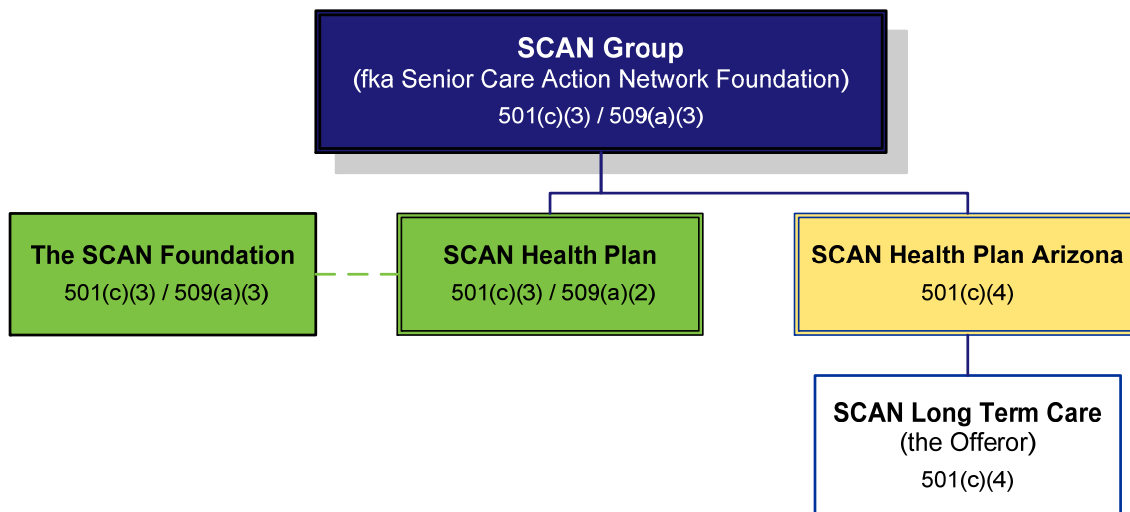
---

### *Moral or Religious Objections*

SCAN Long Term Care, the Offeror, has no moral or religious objections to providing any of the services covered under Section D, Program Requirements of the ALTCS RFP No. YH12-0001.

*Requirement 3: Resumes of Key Personnel*

SCAN Long Term Care is part of SCAN Group, a family of nonprofit companies, which also includes The SCAN Foundation, SCAN Health Plan (a California plan) and SCAN Long Term Care’s parent company, SCAN Health Plan Arizona. The following organizational chart depicts the relationships amongst the entities of SCAN Group.



SCAN Group companies have managed member care in public programs for over 30 years and has provided integrated managed care to frail Medicaid members in the State of California since 1984. Additionally, SCAN Health Plan was one of four original Social Health Maintenance Organizations awarded a contract by Centers for Medicare and Medicaid Services in 1984 to provide home and community based services to members at risk for needing long term care services. SCAN Health Plan of Arizona was incorporated in 2005 and, in 2006, organized SCAN Long Term Care to administer services to the ALTCS elderly and physically disabled population under a contract with AHCCCS.

*SCAN Long Term Care Staffing*

By way of Administrative Services Agreements, reviewed and approved by AHCCCS, SCAN Health Plan Arizona provides executive leadership, management, and personnel to meet all of the staff requirements and support services for serving the ALTCS program. Additionally, SCAN Health Plan provides specific operational and system support to SCAN Health Plan Arizona and SCAN Long Term Care in the areas of member services, finance, actuarial services, accounting and legal counsel, as well as, providing support related to its health information system, including staffing for information systems, enrollment, claims adjudication and encounters processing.

SCAN Health Plan Arizona and SCAN Long Term Care believe employees who are experienced and well-trained for their day-to-day responsibilities, are able to bring enthusiasm and passion to their jobs and provide better focus to meet the needs of our members. This commitment to Mission is evident in every interaction we have with our members. The Phoenix Business Journal, founder of the “Best Places to Work” program, ranked SCAN Health Plan Arizona 12<sup>th</sup> on the 2010 list of top employers. SCAN Health Plan Arizona was acknowledged for creating an enjoyable corporate culture and work environment that fosters personal and professional growth for its employees. SCAN Health Plan Arizona was also named by Modern Healthcare magazine as one of the top 100 “Best Places to Work in Healthcare” in the United States for 2010. Modern Healthcare’s “Best Places to Work in Healthcare” awards recognize innovative healthcare workplaces that engage and inspire employees.

SCAN Long Term Care personnel have the education and experience to fulfill the job requirements of each of the positions required under the ALTCS contract. SCAN Long Term Care also has worked hard to nurture a culture that fosters personal and professional growth and, when appropriate, promotes individuals from within its own organization.

### SCAN Long Term Care Executive Leadership

SCAN Long Term Care executive officers are highly qualified individuals whose educational backgrounds and years of experience in public health care programs provide valuable leadership to the organization. Our chief executive officer, Elizabeth Russell, has over 19 years of experience in healthcare leadership positions, ten of those years in managed care. She has been at SCAN Health Plan since 2005, moving to Arizona operations in December 2010. She brings extensive experience and broad understanding of the plan’s business, technology, claims, regulatory, and systems needs to serve the ALTCS population.

Our chief medical officer, Dr. Mehrdad Shafa’s educational background is in pediatric medicine and managed care. He has worked for health care plans serving the AHCCCS population for eight years, including work with two ALTCS plans. Before coming to SCAN, he served as chief medical officer with three AHCCCS health plans and has been involved in two acute care plans, as well as with AHCCCS plans managing Special Needs Populations, Developmentally Disabled, and Health Care Group lines of business. In addition he has served as the chief medical officer of a health plan with SSI members in Texas and a primary care management plan in Indiana.

Our chief financial officer, Randy Stone, has over 22 years of experience in the health care industry and provides SCAN executive leadership devoted solely to Arizona financial operations and business planning. Mr. Stone most recently served as the chief financial officer for the largest managed Medicaid health plan in the United States. Through prior experience as a financial executive for both physician practice management and healthcare service companies, he also demonstrates his knowledge of provider-based financial issues, including those related to claims management.

### Other Key Staff Positions for SCAN Long Term Care

SCAN Long Term Care recognizes the change in the number of Key Staff positions an individual staff member is allowed to occupy under the ALTCS contract for CYE2012. At this time, only one staff member occupies more than two key staff positions; the Compliance Officer and Contract Compliance Officer are combined and held by a single individual who also currently serves as the Dispute and Appeal manager. SCAN Long Term Care is submitting both a resume for the individual currently fulfilling these positions and a job description for the a new position we propose to create, *Compliance Lead/Appeals and Disputes Management*, in order to be fully compliant with the staff requirements under the CYE2012 contract.

The following table summarizes the resumes and job descriptions for SCAN’s key personnel included in this section.

<i>AHCCCS Required Staff (CYE2012 Contract, Section D, ¶25)</i>	<i>SCAN Long Term Care Job Title</i>	<i>Personnel</i>
<b>Executive Management</b>		
Administrator/Chief Executive Officer (a)	Chief Executive Officer	Elizabeth Russell
Medical Director/Chief Medical Officer (b)	Vice President, Medical Director	Mehrdad Shafa, M.D.
Chief Financial Officer/CFO (c)	Finance Officer (CA)	Randy Stone

<i>AHCCCS Required Staff (CYE2012 Contract, Section D, ¶25)</i>	<i>SCAN Long Term Care Job Title</i>	<i>Personnel</i>
<b>Compliance</b>		
Compliance Officer (f)	Vice President, Compliance	Tina Graham
Contract Compliance Officer (i)	Vice President, Compliance	Tina Graham
Dispute and Appeal Manager (g)	Vice President, Compliance Compliance Lead/Appeals and Disputes Management (CYE2012)	Tina Graham Job Description
<b>Program Services</b>		
Case Management Administrator/Manager (r)	Vice President, Case Management Manager, Case Management Manager, Case Management	Joey Zepeda Laura Holub Carolyn Griffiths
Behavioral Health Coordinator (n)	Behavioral Health Coordinator	Linda Buscemi
Medical Management Coordinator (m)	Manager, Utilization Management	Sheila Reeser, R.N.
Pharmacy Coordinator/Director (d)	Pharmacy Coordinator	Yelena Slavina, PharmD
Dental Director/Coordinator (e)	Dental Coordinator (contractor)	Timothy Lee Lukavsky, D.D.S.
Quality Management Coordinator (j)	Manager, Quality Management	Karen Leonard, MPH, CPHQ
Maternal Health/EPSTD (child health) Coordinator (l)	Manager, Quality Management	Karen Leonard, MPH, CPHQ
Performance/Quality Improvement Coordinator (k)	Quality Initiatives Specialist	Diane Gamble
<b>Provider Network Services</b>		
Provider Services Manager (o)	Vice President, Provider Network Management Manager, Network Management	Thomas Hoehner Sharon Hawn
Provider Claims Educator (q)	Manager, Network Management and Contracting	Tida Garcia
<b>Operations</b>		
Chief Operating Officer (a)	Vice President, Operations	Maureen McGurrin
Claims Administrator (p)	Vice President, Claims Claims Director	Bevann Moreland Joseph Jefferson
Encounter Processing Staff (x)	Encounter Data Manager Encounter Project Analyst	Marc Carren Selva Abeyta
Business Continuity Planning and Recovery Coordinator (h)	Manager, Business Support	Laura Phelps

*Elizabeth S. Russell*  
*Chief Executive Officer*

The Chief Executive Officer oversees the entire operation of SCAN Long Term Care under its ALTCS EP/D contract with AHCCCS to ensure adherence to program requirements. To ensure timely response to AHCCCS, the CEO is located in Arizona and available during working hours.

*Experience*

**Chief Executive Officer** **December 2010 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for providing overall executive direction to all matters and affairs of SCAN Long Term Care; establishing functionally and fiscally sound organizational structures, operations, and strategic initiatives; and developing and maintaining effective relationships with SCAN Long Term Care constituencies. Executive member of the board of directors and leads an executive team responsible for the appropriate stewardship of organizational assets, the financial performance of the organization, and compliance with all applicable laws and regulatory guidelines.

**Senior Vice President Network Management and Claims** **November 2005 – December 2010**  
**SCAN Health Plan, Long Beach, CA**

Responsible for strategies to expand the company's brand and mission by developing and managing provider networks and payment systems consistent with margin requirements, excellent member and provider service. Direct responsibility for all regulatory and operational aspects for contracting, financial modeling, delegated oversight, load, test and claims payment for California and Arizona. Expert in systems redesign including software development and installation. Member of senior management team for SCAN Health Plan and SCAN Group. Reported to the President/CEO and managed a team of approximately 140 through 4 direct reports three vice presidents and an executive assistant. SCAN Health Plan is the fourth-largest Medicare Advantage plan in the United States.

**Chief Operations Officer, Regal Medical Group, Inc.** **April 2004 – November 2005**  
**Heritage Provider Network, Inc., Northridge, CA**

Responsible for setting and accomplishing business and community service goals; achieving operating and financial objectives; maintaining the organization's ongoing financial viability; adapting the organization to clinical, economic, technological and regulatory changes; managing the interface between Regal Medical Group and contracting HMOs; establishing and maintaining relationships with and responding to the needs of the market, employers, enrollees, physicians, hospitals, joint venture partners and contracting providers; and supporting the CMO in achieving quality assurance, utilization management and patient care objectives. Reported to the owner and President and managed a team of 250 through eight direct reports including the CFO, vice presidents of medical management, quality management, network management and IT, and directors of human resources, marketing and facilities. Regal Medical Group, a wholly owned subsidiary of Heritage Provider Network, is a management service organization (MSO) for medical groups and Independent Physician Organizations (IPAs) in Los Angeles, Orange, San Bernardino, Ventura and Riverside counties in California.

**Senior Vice President, Integrated Managed Care Services, Health Care Partners Medical Group** **July 2001 – April 2004**  
**Health Care Partners, LLC, Torrance, CA**

Responsible for strategic oversight, management and optimization responsibilities for the departments of Contracting (Payor, Hospital, Provider and ancillary), Claims, Eligibility and Referrals. Participated on the Board of Directors and senior executive team in strategic and long range planning and the execution of those plans for Health Care Partners Medical Group, managing 650,000 lives in Southern California. Reported to the Chief Operations Officer and managed a team of 400+ employees through 3 direct reports including vice president of integrated managed care services, director of physician contracting

and director of health plan contracting.

**Vice President, Northern California  
PacifiCare of California, Cypress, CA**

**January 2001 –  
July 2001**

Responsible for the development and direction of programs in contracting to negotiate, standardize and coordinate provider contracting activities. Specific responsibilities included profit/loss responsibility for Northern California and direct networks statewide, development of provider relationships, negotiations and strategic network development. Reported to the President of Northern California and managed a team of 35 through five direct reports including three directors and two managers.

**Senior Vice President, Integrated Managed Care Services, Health  
Care Partners Medical Group**

**June 1999 –  
January 2001**

**Health Care Partners, LLC, Torrance, CA**

Responsibilities consistent with those described for the period July 2001 – April 2004.

**Vice President, Contracting  
Health Care Partners, LLC, Torrance, CA**

**June 1995 –  
June 1999**

Responsible for the development and direction of programs in contracting to negotiate, standardize and coordinate payor and provider contracting activities. Specific responsibilities included development of payor relationships, negotiation and monitoring of payor (HMO, PPO and EPO) contracts, strategic network development, implementation and monitoring of hospital, physician, and ancillary provider networks, development of physician contract strategy and incentives. Extensive experience in design and implementation of capitation and risk based incentives. Reported to senior vice president, Integrated Managed Care Services and managed a total of 40 employees through three direct reports including directors of plan contracting, director of physician and ancillary contracting and project manager(s).

**Administrative Director, Business Development  
USC Norris Cancer Center and Hospital, Los Angeles, CA**

**December 1994 –  
June 1995**

As a member of the Senior Management team, responsible for all aspects of business development, marketing, sales and contracting at a University-based tertiary cancer hospital and research center.

**Director Contracting, Huntington Provider Group  
Unihealth Foundation, Los Angeles, CA**

**1992 –  
1994**

Director of Contracting for 320,000 member Independent Physician's Associations.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

MBA, Health Care Administration and Computer Science, University of Southern California; Los Angeles, California; 1992

BA, English Literature; Pitzer College; Claremont, California; 1974

*Mehrdad Shafa, MD, MMM, CMO*  
*Medical Director*

The Medical Director is a board certified pediatric emergency physician licensed to practice in Arizona, and the Quality Management Officer of SCAN. The Medical Director is located in Arizona and is responsible for the overall implementation of the Medical Management and Quality Management Plans and is the chairperson of the Quality Management/Medical Management (QM/MM) Committee.

*Experience*

**Medical Director** **January 2011 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

A member of the executive management team and responsible for oversight and direction of all SCAN Long Term Care quality management (QM) and medical management (MM) activities including but not limited to chairing the QM/MM and Peer Review Committees; hiring experienced key personnel for the QM and MM Departments; medical policy development and implementation; and providing interpretation of medical policy and procedures to guide and support the provision of long term care services. Represents SCAN at AHCCCS and ALTCS meetings and serves as the key clinical liaison to the provider network, hospitals, SNFs, and other vendors rendering medical care and services to members.

**Physician Consultant and Medical Director** **2006 – January 2011**  
**Various Locations**

**Q Mark, Inc., Englewood, CO** – Reporting to Chief Executive Officer, was charged with developing and implementation of a strategic and long term business plan (completed), and ongoing marketing and promotion for Q Mark, an NCQA-certified software vendor dedicated to provision of HEDIS, Hybrid and consulting services to health plans and physician groups.

**Health Care Excel, Indianapolis, IN** – Reporting to Chief Executive Officer, was in charge of strategic development and program developments for the corporation, the Quality Improvement Organization (QIO) for Indiana and Kentucky and provides utilization surveillance for Ohio, Missouri and Iowa.

**Net Education Design, Inc., Kennedale, TX** – Provides consultant services to this pioneer firm specializing in Disease Management and Health Education Programs. Net Education Design develops and publishes high quality healthcare educational products that improve the lives of people and the effectiveness of healthcare processes that serve them.

**Sterling Health Plans, Bellingham, WA** – Reporting to the Chief Medical Officer, provides credentialing, resource management and fraud and abuse review services. Licensed in 50 states and Washington, D.C., Sterling Insurance Plans provides a complete range of Medicare Advantage, Part D and was the nation's first Medicare Advantage Private Fee For Service Plan.

**Health Care Excel QualityQuest, Phoenix, AZ** – Reporting to Chief Executive Officer, charged with providing leadership for all HCE QQ medical activities, initiatives, proposals, and other business developments. Health Care Excel QualityQuest (HCE QQ) is a subsidiary of Health Care Excel, Inc. and commenced operations as the External Quality Review Organization (EQRO) for Arizona Health Care Cost Containment System (AHCCCS) in 2004. HCE QQ is charged with statewide quality oversight of Children's Rehabilitative Services and Behavioral Health Services. HCE QQ has successfully expanded its scope of operations and has been awarded several contracts in multiple states.

**Aetna/Schaller Anderson, Incorporated (SAI), Phoenix, AZ** – Reporting to SAI Vice President for Medical Affairs, has been involved with turnaround operations for health plans in five states and served as Medical Director, Schaller Anderson Healthcare of Arizona (2006 – 2007) and as Chief Medical Officer for Maryland Physicians Care Health Plan (2007); CHOC Health Alliance (2007 – 2009); ADVANTAGE Care Select (2009); and Community Health Plan, Aetna Better Health and ACS Plans (2010). Acquired by Aetna Health, Inc. in 2007, SAI is nationally recognized company specializing Medicaid managed care, Primary Care Case Management, Medicare, SNP and Disease Management.



**Consultant** **2009 – Present**  
**Arizona Medical Board (BOMEX), Scottsdale, AZ**

Serves as the External Consultant Reviewer for Pediatrics and Pediatric Emergency Medicine cases investigated by BOMEX which is committed to serving the public through the honest, fair, and judicious licensing and regulation of allopathic physicians and physician assistants.

**Consultant** **2007 – Present**  
**The TriZetto Group, Inc. (TriZetto), Newport Beach, CA**

Assisted TriZetto’s Marketing, Informatics and Research Divisions with design and creation of specific tools to meet the future needs of the Medicaid Population. TriZetto, whose customers serve more than 150 million health plan members, or approximately 50% of the insured population of the United States, focuses on the business of healthcare and offers a broad portfolio of technology products and services.

**Chief Medical Officer** **2004 – 2005**  
**Maricopa Managed Care Systems (MMCS), Phoenix, AZ**

Reporting to the Chief Executive Officer, was charged with creating and implementing effective turn around measures to provide quality medical care and restore financial health to the organization. MMCS has been providing quality care to residents of Maricopa County since AHCCCS inception in 1982. It provided Acute, Long-term, and Medicare Advantage plans for 72,000 members and operated the largest long-term care plan in the nation.

**Chief Medical Officer** **2003 – 2004**  
**Care1st Health Plan Arizona, Inc., Phoenix, AZ**

**Chief Medical Officer** **2001 – 2002**  
**Schaller Anderson Healthcare (SAH), Phoenix, AZ**

**Associate Medical Director, Quality Management** **1999 – 2001**  
**Blue Care Network, Southfield, MI**

**Regional Director of Pediatrics, Western Wayne Region (1997 – 1999)** **1988 – 2001**  
**Physician In-Charge, Redford Medical Center (1995 – 1999)**  
**Division Head, Pediatrics, Redford Medical Center (1992 – 1995)**  
**Henry Ford Health System, Detroit, MI**

**Physician Advisor for Utilization Review** **1982 – 1983**  
**Pontiac General Hospital, North Oakland Medical Center, Pontiac, MI**

*Licenses, Certifications and Professional Affiliations*

Certified in Medical Quality (CMQ), American Board of Medical Quality, 2007 - 2012  
Certificate in Medical Management, Carnegie Mellon University, Pittsburgh, 1999  
Distinguished Fellow, American College of Medical Quality, 1999  
Diplomate, American Board of Pediatrics, 1989-1996, 1997-2003 , 2004-2010 and 2011-2013  
Fellow, American Academy of Pediatrics, 1990  
Federation Licensure Examination (FLEX), 1985  
Medical License - AZ #29768, 2001; IN #0166776A, 2009; MI #4301048376, 1985 (voluntary expiration, 2003); ECFMG #348-311-2, 1983  
DEA License # AS3110575, 1985  
National Practitioner Identification (NPI) # 1750387171

*Education*

Masters of Medical Management (MMM), H. John Heinz, III School of Public Policy and Management, Carnegie Mellon University, Pittsburgh, PA, June 2000  
Chief Resident, Department of Pediatrics, Pontiac Affiliated Hospitals, Pontiac, MI, 1986–1987  
General Pediatrics Resident, Department of Pediatrics, Pontiac Affiliated Hospitals, Pontiac MI, 1983-86  
Doctor of Medicine, CIFAS University School of Medicine, Dominican Republic, September 1982

*Randy Stone*  
*Chief Financial Officer*

The Chief Financial Officer oversees the SCAN Long Term Care budget, accounting systems, and internal and external financial reporting under the ALTCS/EPD contract.

*Experience*

**Chief Financial Officer** **2011 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for leading the entire finance department with diverse functions such as financial and regulatory reporting, financial planning and analysis, provider finance, accounts payable, premium billing, accounts receivable, payroll, tax, audits and treasury. Works closely with actuaries for all IBNR models in compliance with business structure. Reports directly to the Chief Executive Officer and participates as a member of the SCAN Long Term Care and SCAN Health Plan Arizona executive teams.

**Chief Financial Officer** **2001 – 2010**  
**L.A. Care Health Plan, Los Angeles, CA**

The largest public healthcare agency in the U.S. servicing 850,000 low income members in the Los Angeles area and generating revenues exceeding \$1 billion. Key member of the senior management team responsible for financial leadership of the organization. Oversaw all accounting operations, medical economics, financial reporting, budgeting, risk management, and financial regulatory compliance. Successfully introduced and rolled out a business planning process that contributed approximately \$106 million in net equity over a 9-year period. Developed financial plans for three new product plans that collectively produced more than \$120 million in annual revenue. Established a multi-disciplined senior management team to re-tool internal processes, quantifying service drivers and improving the contribution margin by 10.1%. Led the financial due diligence team to determine economic valuation of two proposed acquisitions of \$18 million and \$22 million, respectively. Designed and implemented a cost accounting and reporting system to support underwriting of the Medi-cal rates, justifying a rate increase of 6.6% in the 2010-11 contract years.

**Senior Vice President/CFO** **1998 – 2001**  
**Unimed Management Company, Burbank, CA**

A \$163 million for-profit physician practice management company consisting of seven separate medical groups servicing nearly 500,000 commercial and senior individuals.

Held responsibility for the Finance Division, including all accounting, finance and treasury functions for the divestiture of the organization. Provided asset valuation and due diligence to achieve the successful sale of 6 separate operating units totaling \$10 million, including liquidating one unit. Reduced cash demands \$7.8 million in a liquidation settlement by effectively negotiating all outstanding claims liability accounts.

**Vice President, Financial Services – Western Operations** **1997 – 1998**  
**MedPartners, Inc., Long Beach, CA**

A physician practice management company with revenues of \$1.4 billion consisting of 11 separate medical groups. Directed all accounting services, including financial forecasting, cash management, purchase / acquisition reconciliation, cost contain reporting, budget compliance and oversight. Implemented financial forecasting reporting, successfully identifying the impact of cost savings initiatives and enhancing analytical measurement of financial performance and cash flow needs. Centralized multiple accounts payable departments into a single unit, effectively reducing delinquent invoice backlogs from 90 days to just 15 days. Successfully restructured the finance division by reallocating labor resources and reducing overhead by \$1 million. Identified and quantified an unrecorded medical claims reserve of \$75 million and implemented an actuarial reserve model to

monitor the reserve. Performed an audit of a \$60 million subsidiary, identifying unrecorded obligations and bringing accounting records and reporting into compliance with GAAP and regulatory statutes.

**Vice President, Finance and Treasurer** **1995 –**  
**Talbert Medical Management, Co., Costa Mesa, CA** **1997**

A \$400 million start up physician practice management company, which separated from FHP with a successful \$60 million IPO. Oversaw all accounting management, financial reporting, financial planning, forecasting, budgeting, treasury / banking, SEC compliance and materials management. Completed a successful \$60 million IPO as Chief Accounting Officer, collaborating in the assessment of asset split from the parent company, and development of financial history. Protected an \$80 million revenue stream by directing the selection and implementation of a new Accounts Receivable and billing system.

**Regional Vice President** **1988 –**  
**FHP International, Inc., Fountain Valley, CA** **1995**

A publicly traded healthcare services company serving more than 1.9 million patients across 11 states and Guam. Held responsibility for staff model; IPA operations, with full bottom line accountability; and finance & administration, including accounting management, medical claims, operations and capital budgeting, purchasing and human resources. Led a cross-functional project team to centralize payroll services for 9,500+ employees across 5 states, reducing processing costs by \$3 million annually. Directed staff model operations consisting of 20 ambulatory medical and 6 dental centers reduced patient wait times more than 30% by realigning physician schedules with patient preferred appointment times. Delivered \$200 million in revenue growth over a 3-year period through the geographic expansion of IPA operations by contracting with 15 to 20 medical groups and hospitals. Saved the organization an estimated \$600,000 in penalties and fees by negotiating the settlement of an alleged breach of contract, avoiding a subsequent loss of \$30 million in revenues.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

MBA in Accounting / Finance, California State University - Long Beach

BS in Management & Accounting, California State University - Long Beach

*Tina Graham*  
*Compliance Officer*  
*Contract Compliance Officer*

The Compliance Officer implements and oversees the SCAN Long Term Care compliance program under its ALTCS EP/D contract with AHCCCS and has designated and recognized authority to access records and independently refer suspected member fraud, provider fraud and member abuse cases to AHCCCS, Office of the Inspector General or other duly authorized enforcement agencies. The Compliance Officer is located in Arizona and available to all employees. SCAN Long Term Care Compliance Officer is also its Contract Compliance Officer, serving as the primary point-of-contact for all SCAN Long Term Care operational issues under its ALTCS EP/D contract with AHCCCS.

*Experience*

**Vice President, Compliance** **January 2007 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for the implementation and oversight of the Compliance Program; investigation and independent referral reporting to Arizona Office of Inspector General; primary point of contact for AHCCCS inquiries of operational issues, tracking of deliverable submissions; coordinate the preparation and execution of contract requirements such as Operational and Financial Reviews and periodic audits; manage and oversee policy development; monitor corrective action completion. Assures regulatory compliance by developing and maintaining processes, policies, procedures and reporting in accordance with applicable Federal and State laws, rules and regulations. Educates departmental leadership on new or revised AHCCCS requirements and trains employees regarding fraud, waste and abuse detection and reporting. Chairs the Cultural Sensitivity Improvement task force to explore and collaborate with cross-functional team on ways to improve cultural competency program; monitors and tracks related initiatives. Chairs the Compliance Committee and reports directly to the Chief Executive Officer.

**Director of Appeals and Compliance** **November 2004 – January 2007**  
**Mercy Care Plan/Mercy Care Advantage, Phoenix, AZ**

Compliance Officer and Director of Appeals for all lines of business including Health Care Group, AHCCCS Acute, AHCCCS ALTCS, DDD and Medicare Advantage SNP. Responsible for directing internal fraud, waste and abuse investigations; conducting compliance reviews with functional areas to confirm compliance with Medicare and Medicaid requirements and identifying areas requiring corrective actions; leading and coordinating state regulatory audits and corrective action development; directing research and investigation of HIPAA privacy and security incidents and developing and presenting compliance reports to the compliance committee. Acted as liaison with AHCCCS and CMS for compliance related inquiries. Chaired ad hoc and ongoing compliance and appeals work groups and other related meetings.

**Director of Grievance & Appeals Department and Privacy Officer** **June 2001 – October 2004**  
**Value Options, Phoenix, AZ**

Responsible for representing the plan at BBA, SMI (Seriously Mentally Ill) and provider appeals administrative hearings and leading a team that conducted investigations involving alleged human rights violations of seriously mentally ill populations. Coordinated with outside counsel on compliance and risk management issues; drafted compliance related manuals and policies; and advised the plan on fraud, waste and abuse investigations and reporting. Acted as project lead for the health plan and direct care clinics on HIPAA privacy implementation. Advised on HIPAA requirements for the development of web-based compliance training for all affiliates; advised IT staff on HIPAA transaction implementation requirements; and provided technical assistance in development of HIPAA tracking software. Facilitated updating various functional areas on new contract or regulatory requirements

**Associate Attorney  
Joseph Indelicator, Jr., P.C., Houston, TX**

**November 1999 –  
August 2000**

Litigation firm with focus on family law-conducted depositions and drafted requests for interrogatories, admissions and production; researched and drafted various pleadings; advised clients during mediations and settlement negotiations; appointed attorney/and/or guardian ad litem by family courts; daily case management and client contact.

**Coordinator for Psychiatric Services  
Saint Margaret Mercy Health Care Centers, Dyer, IN**

**April 1995 –  
June 1996**

Performed service needs evaluations for the psychiatric department's child, adolescent and adult services divisions. Duties included; gathering clinical information and observations; providing reports and recommendations to psychiatrists; processing civil commitments; obtaining prior-authorizations for admissions and crisis intervention for emergency room.

**Research Assistance  
Harvard School of Health, Project on Human Development in  
Chicago Neighborhoods, Chicago, IL**

**October 1994 –  
October 1995**

Gathered data for longitudinal research study. Duties included: obtaining subject consent and "buy-in", administering lengthy, multi-disciplined, psycho-social protocol to parents and their children; and editing submitted protocols for accuracy and completeness.

**Crisis Intervention Specialist and Case Manager  
Southlake Center for Mental Health and Jail Forensic Unit,  
Merrillville, IN**

**June 1990 –  
October 1994**

Crisis specialist for community mental health agency. Duties included: gathering clinical information and observations of patients for reporting to psychiatrists; processing civil commitments; obtaining prior-authorizations for admissions; case management for seriously mentally ill patients and county jail inmates; and crisis intervention.

*Licenses, Certifications and Professional Affiliations*

State Bar Arizona, 2001

State Bar Texas (inactive), 1999

*Education*

South Texas College of Law, Juris Doctorate, May 1999

Purdue University, Bachelor of Arts, 1994



## JOB DESCRIPTION

**POSITION TITLE: Compliance Lead (Appeals and Disputes Management)**  
**DEPARTMENT: AZ Compliance**  
**SUPERVISOR: VP, Compliance (Compliance Officer)**

**GRADE:**  
**FLSA: Exempt**  
**DATE: 02/11/11**

**JOB PURPOSE:**

The Compliance Lead will manage and adjudicate member and provider grievances and requests for hearing and will submit monthly grievance system reports to AHCCCS. Track and trend grievance system data to facilitate performance improvement. Supervise grievance system staff to assure timely resolution of cases. Assists VP, Compliance in compliance related activities to monitor and oversee the Arizona compliance program.

**ESSENTIAL JOB RESULTS:**

Ensures the provision of timely quality health care to members by facilitating the timely movement of grievances and appeals resulting in on-time closure of all cases.

Supports special projects by assigning and overseeing job responsibilities to administrative workflow functions.

Provides updates to management by preparing reports and statistics pertaining to grievances, appeals and claims disputes on a monthly and/or ad hoc basis.

Processes the timeliness of grievances, appeals and claims disputes by assembling cases and/or supervising the assembling of cases and ensuring that deadlines are met. Monitor and facilitate monthly Grievance System reporting to AHCCCS.

Accomplishes organizational objectives by facilitating, tracking and monitoring compliance with requirements.

Achieves compliance by evaluating new, proposed and existing requirements. Monitors and tracks implementation of new requirements.

Communicates expectations; plans, monitors, and appraises compliance audit results; develops, coordinates, and enforces systems, policies, procedures, and desk top standards.

Identifies and evaluates trends and proposes enhancements and/or modifications as necessary to meet requirements.

Maintains quality service by providing accurate and timely reporting; respond and resolve inquiries; initiates audits and ensures compliance and accuracy for related processes.

Audits, tracks, investigates and reports potential fraud waste and abuse.

Monitors corrective actions to completion.

## JOB DESCRIPTION

Assists in activities related to the cultural sensitivity program.

Facilitates compliance related training.

Coordinates regulatory related projects as needed.

Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies.

Contribute to team effort by accomplishing related results as needed.

### **QUALIFICATIONS:**

BA/BS in Health Care, Business or related field or equivalent job experience.

Strong interpersonal skills, including excellent written and verbal communication skills.

Strong commitment to detail.

Demonstrated leadership and management skills.

Ability to work independently, prioritize and manage multiple tasks effectively, organize work flow, adhere to timeliness and function in a fast-paced environment.

Proven ability to exercise independent thought and decision-making skills.

Ability to work effectively and participate in a team environment.

Proven ability to interact effectively with all level of the organization.

### **CONDITIONS OF WORK:**

Proof of current driver's license and automobile insurance.

Primarily sedentary, ability to lift at least 20 pounds.

Frequent telephone and computer use.

**While this job description is intended to be an accurate reflection of the essential job results, management reserves the rights to modify, add, or remove duties from particular jobs and to assign other duties as necessary.**

*Joey Zepeda**Case Management Administrator*

The Case Management Administrator is located in Arizona and responsible for overseeing all case management functions to ensure appropriate and cost effective medical, medically-related social services and behavioral health services are identified, planned, obtained and monitored for members enrolled with SCAN Long Term Care under the ALTCS EP/D contract.

*Experience*

**Vice President, Case Management** **February 2006 –**  
**Director, Case Management (February 2006 – September 2007)** **Present**  
**SCAN Long Term Care, Phoenix, AZ**

Responsible for the oversight and management of the case management department and assuring the timely development and delivery of programs that support the independence of SCAN Long Term Care members. Established and maintains a Member/Provider Council that provides the health plan with input and insight for enhancing the provider network while maintaining a member-centric focus. Develops policies, procedures and desktops for the department and conducts annual reviews to ensure they reflect current AHCCCS policy and practices. Develops training materials and manuals to meet the training objectives of the ALTCS program and responsible for ongoing administrative and medical services training to department staff. Developed an audit tool that enables management to track and trend productivity/performance standards on a monthly, quarterly and annual basis and ensures that monthly case files are audited, in order to maintain documentation in accordance with AHCCCS and health plan guidelines. Responsible for ensuring mandated reports are submitted within timelines. Reviews monthly/quarterly reports to identify strengths and areas for improvement. Participated in the development of tracking and collecting member's share of cost payments to the health plan. Represents SCAN Long Term Care in the community when appropriate to job specifications and/or for interpretation of benefits, programs, and processes. Participated in the development of automated tracking and trending AHCCCS contract requirements and internal SCAN requirements. Successfully passed Operational and Financial Reviews with AHCCCS. Reports directly to the Chief Executive Officer of SCAN Long Term Care and supervises all Case Management Managers.

**Provider Liaison Manager** **April 2004 –**  
**Value Options, Phoenix, AZ** **February 2006**

Provided direction and supervision to Provider Liaisons, in order to ensure provider compliance with state and federal regulations. Educated, trained, and provided oversight to Provider Liaisons responsible for serving as a primary contact and point of communication and problem/issue resolution for the provider. This included working closely with the provider organization's executive management regarding the provider's performance in quality management, data validation, contract performance, grievance and appeals, and the implementation of corrective actions. Worked collaboratively with all other departments to support mission and philosophy of Value Options goals. Participated in negotiating contracts for identified service needs. Participated in the development of an outpatient database which identified each service contracted providers could deliver. Participated in the development of an electronic referral database and a database that tracks communication and interaction with contracted providers. Participated in the development of provider report cards and provider management.

**ALTCS Case Management Supervisor, Mercy Care Plan** **January 2001 –**  
**Schaller Anderson of Arizona, Phoenix, AZ** **April 2004**

Responsible for education, training and providing oversight to ALTCS case managers responsible for the coordination of care and utilization management of long term care recipients and provided direction and supervision to ensure compliance with state and federal regulations. Previously responsible for ongoing administrative and medical service training to department staff and educating provider network in regards



to billing procedures and prior authorization guidelines. Performed audits of medical records for assessing appropriateness of services. Worked closely with Long Term Care (LTC) Director on special projects assigned. Completed staff performance reviews. Worked collaboratively with other departments to support mission and philosophy of Schaller Anderson goals. Coordinated with Finance Director the LTC review process of the quarterly Acute Care Recoupment report which saved approximately \$50,000 on a quarterly basis. Participated in negotiating contracts for identified service needs. Selected to manage the Alternative Residential Setting program. Developed an audit tool that enables management to track and trend productivity/performance standards on a quarterly and annual basis. Participated in the development of training manual and materials used for all LTC staff. Selected as the LTC representative for the weekly Medical Operations and Provider Services strategic planning meetings. Selected as the LTC super user for internal computer systems (Atlantes, QMACS, DOA).

**ALTCS Case Manager**

**October 2000 –**

**Mercy Care Plan, Phoenix, AZ**

**January 2001**

Responsible for identifying and coordinating medically appropriate services in the most cost-effective manner for individuals approved for Arizona Long Term Care Services (ALTCS). Provided coordination across all facets of the service system in order to determine efficient use of resources and minimize any negative impact to the member. Worked in collaboration with members, family members, and providers in order to provide a continuum of service options that support the expectations and agreements established through the care plan process. Maintained documentation in accordance with Arizona Health Care Cost Containment System (AHCCCS) guidelines. Participated in the development of the LTC program which included working closely with Provider Services, Data Services and Information Systems in determining configuration needs.

**Team Leader**

**March 1997 –**

**Value Options, Glendale, AZ**

**October 2000**

Responsible for hiring, training and the supervision of case managers responsible for the care and oversight of Seriously Mentally Ill individuals. Served as liaison between administration and the outpatient clinical team in order to identify and coordinate clinically appropriate services in the least restrictive setting. Monitored utilization of services in collaboration with psychiatrist and team members on a daily basis. Assisted psychiatrist and providers in obtaining prior authorizations for medications and/or outpatient services. Applied knowledge in identifying, planning, and coordinating services for high-risk members in order to decrease inpatient census. Assisted in the planning and coordination in completing petitions for court orders. Conducted daily record reviews to ensure services were being delivered and documented in accordance with established standards/requirements. Coordinated and maintained the accuracy of medical record movements. Developed and implemented an audit tool that was utilized company wide which enabled management to track and trend productivity/performance standards. Contributed to the successful completion of all assignments on time and within budget.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

B.A. in Psychology, Arizona State University West, 2000

A.A in General Studies, Glendale Community College, 1994

*Laura Holub*

*Case Management Manager*

The Case Management Manager ensures implementation, evaluation, and compliance of the SCAN Long Term Care Case Management Plan and initiatives, requirements, and goals identified through AHCCCS Medical Policy Manual administrative and case management requirements. The Case Management Manager is located in Arizona and has responsibility for overseeing the case management department to ensure ALTCS medically-related social services and behavioral health services are identified, planned, obtained, monitored, and provided in a cost-effective manner within the least restrictive setting for the elderly and physically disabled population.

*Experience*

**Manager, Case Management**

**January 2006 –**

**Supervisor, Case Management (July 2006 – January 2008)**

**Present**

**SCAN Long Term Care, Phoenix, AZ**

Responsible for monitoring Case Manager caseloads on a daily basis to ensure compliance with AHCCCS standards. Identify areas of improvement to be incorporated in the Case Management training curriculum as well as the annual comprehensive Case Management Plan. Participates in the annual development of measurable goals for case management program(s) based on data from utilization reports, audits, quality indicators, survey results, regulatory agencies, plan initiatives, and priorities. Gathers data and generates reports, analyzes findings and prepares quarterly and annual written reports that address strengths and/or areas of improvement related to both monthly case file audits and other areas of department operations. Participates in ongoing administrative and medical service training to department staff. Participates in developing, implementing, and annually reviewing ALTCS Case Management desktops and related forms. Oversees revision of training materials and desktops to ensure they are reflective of AHCCCS policy. Participates in monthly and quarterly department reporting that outlines key accomplishments, project status, personnel updates, and other issues. In coordination with the Medical Management department, participates in bi-weekly inter-disciplinary team meetings surrounding clinical care and service delivery options for ALTCS members. In coordination with the Network Management Services and Quality Management departments, participates in meetings to review areas of improvement relating to assisted living facility compliance with regulatory requirements. Supports staff and their performance by communicating job expectations; planning and monitoring, and appraising job results; coaching, counseling, and disciplining employees; initiating, coordinating, and enforcing systems, policies, and procedures. Maintains staffing levels for the department by recruiting, selecting, orienting, and training employees; maintaining a safe and secure work environment; and developing personal growth opportunities. Participated in the Alternative Residential Setting (ARS) workgroup to improve ARS activities for members. Participated in the Self-Directed Attendant Care Case Management Subcommittee to establish guidelines utilized by ALTCS program contractors. Developed and maintain training materials and manuals to meet the training objectives of the ALTCS program. Oversee the ongoing administrative and medical services training to department staff. Developed a metric tool that enables management to track and trend productivity/performance standards for case managers on a monthly, quarterly and annual basis and ensures that monthly case files are audited, in order to maintain documentation in accordance with AHCCCS and health plan guidelines. Represents SCAN Long Term Care in the community when appropriate to job specifications and/or for interpretation of benefits, programs, and processes. Reports directly to the Vice President of Case Management and supervises Case Management Supervisors, Case Management Trainer and Behavioral Health Coordinator.

**Director of Community Services**

**July 2005 –**

**Prehab of Arizona, Mesa, AZ**

**July 2006**

Responsible for guiding provision of behavioral health services to clients enrolled through the Regional Behavioral Health Authority. Lead a team comprised of the Clinical Director, Child and Family Team Coach,

Business Managers and Psychiatric professionals responsible for a staff of approximately 65 people. Decreased the cost of single case agreements by 80% through development of contracted services in our system of care. Improved results of practice improvement reviews conducted by the RBHA by 30%. Reduced staff turnover by 12%. Lead the Family Advisory Council to provide feedback in the development and delivery of services.

**Provider Liaison****July 2004 –****Value Options, Phoenix, AZ****July 2005**

Educated, trained, and provided oversight to Providers responsible for serving RBHA clients. This included working closely with the provider organization's executive management regarding the provider's performance in quality management, data validation, contract performance, grievance and appeals, and the implementation of corrective actions. Worked collaboratively with all other departments to support mission and philosophy of Value Options goals. Participated in negotiating contracts for identified service needs. Participated in the development of an electronic referral database and a database that tracks communication and interaction with contracted providers. Participated in the development of provider report cards and provider management. Participated in the network analysis of needs and securing community providers or developing programs with providers to meet network needs.

**ALTCS Case Management Supervisor, Mercy Care Plan****April 2003 –****Schaller Anderson of Arizona, Phoenix, AZ****July 2004**

Responsible for education, training and providing oversight to ALTCS case managers responsible for the coordination of care and utilization management of long term care recipients and provided direction and supervision to ensure compliance with state and federal regulations. Previously responsible for ongoing administrative and medical service training to department staff and educating provider network in regards to billing procedures and prior authorization guidelines. Performed audits of medical records for assessing appropriateness of services. Worked closely with Long Term Care (LTC) Director on special projects assigned. Completed staff performance reviews. Worked collaboratively with other departments to support mission and philosophy of Schaller Anderson goals. Participated in negotiating contracts for identified service needs. Supervised Pediatric Case Managers and developed assessment enhancements to capture the needs and system coordination necessary for pediatric members. Participated in the development of revisions to training manual and implementation of computer system conversion. Selected as committee member for internal computer systems committee.

**ALTCS Case Manager****July 2001 –****Mercy Care Plan, Phoenix, AZ****April 2003**

Responsible for identifying and coordinating medically appropriate services in the most cost-effective manner for individuals approved for ALTCS. Provided coordination across all facets of the service system to determine efficient use of resources and minimize any negative impact to members. Worked in collaboration with members, family members, and providers in order to provide a continuum of service options that support the expectations and agreements established through the care plan process. Maintained documentation in accordance with AHCCCS guidelines. Participated in the development of the LTC program which included working closely with Provider Services, Data Services and Information Systems in determining configuration needs.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

Master of Counseling, MC/MFT, University of Phoenix, 1999

Advanced Language Studies, Resident Program, University of Arizona, Guadalajara, Mexico 1993

B.A. in Psychology, Summa Cum Laude, Arizona State University, 1992

*Carolyn Griffiths**Case Management Manager*

The Case Management Manager ensures implementation, evaluation, and compliance of the SCAN Long Term Care Case Management Plan and initiatives, requirements, and goals identified through AHCCCS Medical Policy Manual administrative and case management requirements. The Case Management Manager is located in Arizona and has responsibility for overseeing the case management department to ensure ALTCS medically-related social services and behavioral health services are identified, planned, obtained, monitored, and provided in a cost-effective manner within the least restrictive setting for the elderly and physically disabled population.

*Experience***Manager, Case Management****January 2008 –****Supervisor, Case Management (January 2008 – January 2010)****Present****SCAN Long Term Care, Phoenix, AZ**

Responsible for monitoring Case Manager caseloads on a daily basis to ensure compliance with AHCCCS standards. Identifies areas of improvement to be incorporated in the Case Management training curriculum as well as the annual comprehensive Case Management Plan. Participates in the annual development of measurable goals for case management program(s) based on data from utilization reports, quality indicators, survey results, regulatory agencies, plan initiatives, and priorities. Gathers data and generates reports, analyzes findings and prepares quarterly and annual written reports that address strengths and/or areas of improvement related to monthly case file audits. Develops and implements quarterly inter-rater reliability scenario testing to department staff. In addition, gathers data and generates reports, analyzes findings and prepares quarterly and annual written reports that address strengths and/or areas of improvement. Participates in ongoing administrative and medical service training to department staff. Participates in developing, implementing, and annually reviewing ALTCS Case Management policies and procedures. When applicable, revises policies and procedures to ensure they are reflective of AHCCCS policy. Participates in monthly and quarterly department reporting that outlines key accomplishments, project status, personnel updates, and other issues. In coordination with the Medical Management department, participates in bi-weekly inter-disciplinary team meetings surrounding quality of care and service delivery options for ALTCS members. In coordination with the Network Management Services and Quality Management departments, participates in meetings to review areas of improvement relating to assisted living facilities compliance with regulatory requirements. Accomplishes staff results by communicating job expectations; planning and monitoring, and appraising job results; coaching, counseling, and disciplining employees; initiating, coordinating, and enforcing systems, policies, and procedures. Maintains staff by recruiting, selecting, orienting, and training employees; maintaining a safe and secure work environment; and developing personal growth opportunities. Participated in the development of the Home and Community Based Needs Tool with other ALTCS program contractors. Participated in the Self-Directed Attendant Care Committee to establish guidelines utilized by ALTCS program contractors.

**Researcher****July 2005 –****Social Work Research and Development Unit, York, England****May 2007**

Evaluated how two social service programs promoted the needs of children and young people within the community, with a particular emphasis on ascertaining/promoting the wishes of children and young people. Respected the basic human rights of individuals including principles of privacy and confidentiality. Conducted structured interviews with young people with complex needs aged ten to 16 as part of the Evaluation of the Treatment of Foster Care in England project.

**Practice and Dissertation Tutor  
School of Applied Social Sciences, Durham University,  
Durham, England****October 2004 –  
September 2006**

Responsible for reviewing Masters in Social Work (MSW) students' practice placements in the field as well as the outcomes of their social work practice placements. Encouraged an understanding of how social workers need to constantly consider the rights of their clients in combination with creatively considering whether policies and procedures within practice are meeting the needs of clients. Taught MSW students in the areas of Human Development (Practice I) and Social Work Research Methods. While working with MSW students, discussed and challenged the relationship between social work practice, ethics, values, and theory. Participated in the establishment of ensuring ethics and professional accountability within social work practice at Durham University.

**ALTCS Case Manager  
Mercy Care Plan, Phoenix, AZ****November 2001 –  
August 2004**

Responsible for providing health care coverage for members enrolled in Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid program, by coordinating appropriate long-term care services to elderly and physically disabled individuals. Conducted assessment interviews with child, adult and elderly long-term care recipients relating to medical, social, and educational long-term care needs. Evaluated the effectiveness and efficiency of services being provided through identifying member needs and implementing appropriate, cost-effective services. Interacted as a team member both within and outside the department by coordinating care and offering personal expertise regarding resources. Coordinated and implemented in-service trainings for the Long Term Care Department with regard to the disabled youth population as well as newly hired employee trainings. Coordinated and conducted a research project regarding the youth population with the Long-Term Care Department.

**Behavioral Health Case Manager  
Value Options, Glendale, AZ****July 2000 –  
November 2001**

Responsible for monitoring consumer utilization of services and coordinating consumer care in collaboration with a psychiatrist, psychiatric nurse, and other members of the clinical team on a daily basis. Assisted in the planning and coordination in completing petitions for court orders. Managed daily and weekly meetings for a clinical team while tracking progress and needs of adult service users. Assessed service users' capabilities while evaluating behavioral health symptoms through routine assessments, including completion of petitions for court orders when necessary. Coordinated care for medical and psychiatric needs by utilizing available community resources. Conducted clinical teamwork and management of daily case paperwork. Provided crisis intervention within the clinic and community as necessary.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

PhD in Social Work, University of Bristol, England  
Masters of Social Work, Arizona State University West  
B.S. in Psychology, Northern Arizona University

*Linda Buscemi**Behavioral Health Coordinator*

The Behavioral Health Coordinator is located in Arizona and has responsibility for implementing Behavioral Health (BH) Program requirements under AHCCCS policies, rules and the ALTCS EP/D contract and is responsible for coordinating member behavioral care needs with BH providers; developing processes to coordinate behavioral health care between primary care providers and behavioral health providers; participating in the identification of best practices for behavioral health services in a primary care setting; and coordinating behavioral care with medically necessary services.

*Experience***Behavioral Health Coordinator****October 2006 –****SCAN Long Term Care, Phoenix, AZ****Present**

Responsible for ensuring members receive quality behavioral health (BH) services which includes building a strong, diverse and accessible provider network and developing new and innovative ways to provide quality care and promote member independence. Responsible for ensuring compliance with AHCCCS administrative and case management policy for BH services and the development, implementation, and management of all policies and processes related to members receiving and/or needing BH services. Coordinates with case management to ensure a smooth transition and delivery of BH services upon enrollment for members that transition from the Regional Behavioral Health Authority, and/or other health plans; collaborates with case manager, member, member's representative/guardian and BH care provider for initial and quarterly BH consultations. Consults with case management staff regarding BH issues/needs and placement decisions for BH units in nursing facilities, and level II & III 24-hour residential facilities. Coordinates with medical management to track and monitor psychiatric inpatient admissions, discharges, and assists to develop discharge plans. Tracks and monitors persons with court ordered treatment, coordinating court order treatment amendments and change of venue when applicable. Ensures daily claims are authorized and paid appropriately. Reviews, approves, tracks, and monitors all BH reinsurance requests; submits reinsurance requests and supporting documentation to AHCCCS/Division of Health Care Management/ALTCS Unit using appropriate forms; and tracks and monitors service plans for E/PD members who receive specialized services covered under High Cost BH Reinsurance. Generates reports, analyzes findings and prepares written report addressing strengths and areas for improvement regarding BH services. Establishes and maintains working relationships with contracted providers and community health agencies; provides education to contracted providers; and builds, runs, and monitors reports to ensure all timelines are met according to ADHS. Reports to the Case Management Manager and provides consultation to 60 case managers and for all departments.

**Clinical Director- Clinical Supervisor****October 2004-****Prehab of Arizona, Glendale, AZ****September 2006**

Provided Clinical Supervision to all agency therapists, including monitoring client progress and appropriate case documentation and responsible for outpatient Utilization Management or care coordination at CSP level. Determined priority for program components in conjunction with Program Manager and Program Director and implemented Quality Management and submission of required reports. Responsible for supervision of clinical staff, including hiring, performance evaluations and disciplinary actions, as well as ongoing staff development and training activities.

**Stakeholder Liaison****October 2002 –****Access Line Clinician (October 2002 – July 2003)****October 2004****ValueOptions, Phoenix, AZ**

Responsible to ensure consumer services were appropriate, expedited when necessary, and available to all public schools. Maintained daily reports on system trends for all stakeholders. Analyzed customer service complaints and issue resolutions to identify gaps in services and create better flow distribution.

Responsible for providing issue resolutions to nine CPS sites and Juvenile Detention centers in Maricopa county and assisted in protocol development for MCJPD, ADJC, CPS and DDD. Assisted communication between all stakeholders, including CPS, Juvenile Probation and Parole, contracted Mental Health Agencies, Public Schools. Attended weekly Child Resource Staffings at Detention Centers. Promoted and educated community on RBHA services and participated on the Educational Subcommittee, which served as a campaign to educate school administrators and incorporate mental health services in schools. Assisted in developing forms and procedures for court appearances. Conducted monthly training for new hires at CPS and to probation officers.

**Associate Program Director/Clinical Director****May 1999 –****Clinical Director (January 2000 – October 2002)****October 2002****Assistant Clinical Director/Counselor (May 1999 – December 1999)****Community Medical Services, Phoenix, AZ**

Responsible for assisting day-to-day operation of 6 clinics. Acted as the liaison between state funding agencies and state licensing department to ensure contractual performance agreements were met. Clinical lead in CARF accreditation process; oversaw policy and procedure development, counseling activities, and quality management; and corrected any and all deficiencies with regard to external audits. Revised all clinic forms to NARBHA, and state and federal licensing standards. Provided individual, couple and family counseling and case management services; administered psychological assessments; ensured client satisfaction, interventions, and rights. Chairperson for the Quality Management Team.

**Testing Psychologist****July 1998 –****New Oakland Child Adolescent & Family Center, Davisburg, MI****March 1999**

Responsible for administering and assessing psychological evaluations for children in an outpatient program; reported recommendations on how to cope with the diagnostic findings; and presented findings and recommendations at weekly conferences. Performed crisis intervention counseling, as well as family, couple, individual, and group counseling. Assisted in development of an educational program.

**Counselor****July 1998 –****New Beginnings Counseling Center, Clarkston, MI****March 1999**

President of New Beginnings Counseling Center, Inc. Responsible for all administrative duties in running a corporation. Provided individual, couple, and family therapy.

**Therapist and Diagnostician****September 1997 –****Graham Counseling Center, Oakland University, Rochester, MI****July 1998**

Provided Individual, couple, and family counseling. Administered, scored, and interpreted diagnostic evaluations and career assessments.

*Licenses, Certifications and Professional Affiliations*

Licensed Professional Counselor, AZ Board of Behavioral Health Examiners, Sept. 1, 1999

National Certified Counselor, National Board of Certified Counselors, North Carolina, June 1998

Limited Licensed Psychologist, Michigan Board of Psychologists, April 1998 (inactive)

Licensed Professional Counselor, Michigan Board of Counselors, April 1998 (inactive)

*Education*

Masters of Arts Counseling specialization in Advanced Mental Health, Oakland University, Rochester, MI, 1998

Bachelors of Arts Psychology, Oakland University, Rochester MI, 1996

*Sheila R. Reeser, R.N.*

*Medical Management Coordinator*

The Medical Management Coordinator is located in Arizona and has responsibility for all medical management requirements under AHCCCS policies, rules and the ALTCS EP/D contract, including ensuring adoption and consistent application of appropriate medical necessity criteria; ensuring appropriate concurrent review and discharge planning of inpatient stays is conducted; development, implementation and monitoring care coordination, disease management and case management functions; monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services; and monitoring prior authorization functions and assuring decisions are made in a consistent manner based on clinical criteria and within timeliness standards.

*Experience*

**Manager, Medical Management**

**July 2007 –**

**Supervisor, Medical Management**

**Present**

**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for oversight of the day-to-day Medical Management department operations (prior authorization, complex case management, and concurrent, retrospective and prospective review) to ensure cost effective, quality patient care, adhering to regulatory guidelines and internal quality standards. Ensures the provision of timely quality health care to members by collaborating with the Medical Director to formulate, delegate and evaluate quality utilization strategies and programs. Responsible for monitoring the quality and timeliness of prior authorization turnaround times, the quality of Notice of Action letters, and the accuracy of the transplant log. Writes departmental policies and the annual Medical Management Plan and Medical Management Work Plan and assists with the development, implementation, and evaluation of UM/UR/PA processes. Oversees regulatory activities to assure contractual compliance; collects and analyzes utilization data to ensure requirements are met; and prepares all required documents. Reports directly to the Medical Management Director and interfaces with Quality Management to ensure all quality policies and procedures are followed and appropriately applied per program requirements. As a Supervisor for the Department, Ms. Reeser was responsible for oversight and day-to-day operations of the prior authorization, medical claims review, concurrent review, and complex case management teams and acted as clinical liaison for the disease management and medication therapy management programs. Developed, reviewed and revised medical management policies and procedures. Prepared reports for tracking and trending utilization. Developed and analyzed inter-rater reliability studies. Supervised, advised, and facilitated the ongoing development and education of the medical management staff. Identified potential problems and participates in the development and implementation of appropriate corrective actions. Researched and reviewed claims and grievances for medical necessity and appropriateness of claims payment, participated in settling claims and authorization disputes. Interfaced with all departments within SCAN Health Plan to ensure appropriate support for all medical management activities.

**Supervisor, Medical Claims Review**

**March 2006 –**

**TriWest Healthcare Alliance, Phoenix, AZ**

**July 2007**

Interpreted and implemented contract requirements for Medical Claims Review. Monitored the claims process, identifying and implementing process improvements. Provided staff guidance and managed all challenging and complicated claim cases. Conducted monthly performance audits. Developed, reviewed and revised Medical Claims Review Policies and Procedures. Prepared reports for tracking and trending. Identified need for changes in rules for clinical software and claims programs.



**Supervisor, Clinical Support Unit** **October 2004 –**  
**Arizona Physicians IPA, Phoenix, AZ** **March 2006**

Responsible for overseeing a centralized Prior Notification call center and acted as clinical liaison for providers and the call center. Performed inter-rater reliability reviews on Clinical Support Unit staff and silent monitoring of Prior Notification staff. Reviewed and analyzed complex medical records and determined appropriateness of care and claims payment. Performed second level review of complex Prior Notification cases. Developed, reviewed and revised Prior Notification Policies and Procedures. Monitored and reported daily Prior Notification statistics to the health plan and regulators.

**Supervisor, Current Review, Mercy Care Plan** **January 2002 –**  
**Onsite Concurrent Review Nurse, Mercy Care Plan (Jan - July 2002)** **October 2004**  
**Schaller Anderson Incorporated, Phoenix, AZ**

Responsible for day-to-day supervision and monitoring of concurrent review department activities, including supervising, advising and facilitating ongoing development and education of concurrent review staff. Identified problem areas and participated in the development and implementation of appropriate corrective actions. Researched and reviewed claims and grievances for medical necessity and appropriateness of claims payment; participated in settling claims and authorization disputes. Interfaced with all Mercy Care Plan departments to ensure appropriate support for inpatient authorization and concurrent review activities. As an on-site concurrent review nurse, reviewed and analyzed complex medical records and determined appropriateness of care, need for services and intervention and facilitated safe and cost effective discharge plans.

**Complex Case Manager;** **1987 –**  
**Training and Quality Review Director (July 1994 – October 1998)** **2002**  
**Training Manager (October 1989 – July 1994)**  
**Utilization Review Analyst (1987 – 1989)**  
**The Principal Financial Group, Phoenix, AZ**

Responsible for performing Quality Assurance reviews on complex case management documentation, compliance, and processes; providing complex case management services, working as a team with patient, family, physician, hospitals and service agencies; evaluating medical services and care and suggesting methods of treatment to promote recovery in the most cost effective manner; and performing complex medical claims reviews. Developed and implemented training and reference manuals; facilitated training programs and coordinated the Total Quality Improvement team and processes. Conducted telephonic medical necessity reviews of inpatient hospital confinements, surgical procedures and outpatient services.

**Staff RN, Medical Intensive Care Unit** **1984 –**  
**Mercy Hospital Medical Center, Des Moines, IA** **1987**

Member of Student Nurse Mentoring Program; Provided unit orientation training to new employees; and ACLS certified member of hospital cardiopulmonary resuscitation team.

*Licenses, Certifications and Professional Affiliations*

Registered Nurse license, State of Arizona, 1987- present

*Education*

Masters Degree in Organizational Management, University of Phoenix, Phoenix, Arizona

Bachelors Degree in Business Management, University of Phoenix, Phoenix, Arizona

Nursing Degree, Mercy Hospital Medical School of Nursing, Des Moines, Iowa

*Yelena Slavina, Pharm-D*  
*Pharmacy Coordinator*

The Pharmacy Coordinator, an Arizona licensed pharmacist or physician, oversees and administers the prescription drug and pharmacy benefits of SCAN Long Term Care under its ALTCS EP/D contract with AHCCCS.

*Experience*

**Pharmacy Coordinator** **November 2006 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Provide oversight and coordinate the implementation of SCAN Long Term Care (SCAN) Formulary, Utilization Management Requirements (such as Prior Authorization edits, Step Therapy edits, Quantity Limits) and SCAN Pharmacy Benefits by the contracted pharmacy benefits manager (PBM) in collaboration with the Pharmacy Department and SCAN Medical Director. Participate in meetings and discussions with the PBM during which Pharmacy Benefits decisions are made. Provide oversight or feedback for the production of member and provider communication materials: e.g., SCAN's Formulary Book. Review and update the pharmacy-related sections of the SCAN Provider Manual. Ensure Web site maintenance for SCAN's formulary and utilization management tools updates. Develop select internal Policies and Procedures related to SCAN.

**Clinical Pharmacist** **November 2006 – Present**  
**SCAN Health Plan, Long Beach, CA**

Other responsibilities include, but are not limited to: Medicare Part D Formulary development, management, submission to CMS and implementation for the Medicare Advantage Prescription Drug (MAPD) Plans and Special Needs Plans (SNP); development and implementation of Utilization Management requirements, such as Prior Authorization criteria, Step Therapy criteria and Quantity Limits for MAPD and SNP; development and implementation of pharmacy benefits; production of pharmacy-related marketing materials for MAPD and SNP (e.g., Medicare Part D comprehensive and abridged print formularies, Annual Notice of Change, Evidence of Coverage, Low Income Subsidy Rider); quality assurance of other marketing materials, such as Explanation of Benefits and transition letters; quality assurance of the pharmacy-related sections of the BID submission to CMS; maintenance of the Medicare Part D Formulary for Web site placement; annual Transition Policy submission to CMS and provision of implementation oversight for MAPD and SNP; preparation of the pharmacy-related training materials for different SCAN Health Plan departments: Sales, GHM, etc.; evaluation of new drug therapies; development and implementation of clinical initiatives, such as a generic incentive program; serving as a clinical and a Medicare Part D resource to the Pharmacy Department and other departments at SCAN Health Plan.

Previous Responsibilities at SCAN Health Plan included, but were not limited to: conducting P&T Subcommittee/Committee meetings; performing Medication Therapy Management reviews; development and implementation of a Fraud, Waste and Abuse Program based on CMS requirements; Performing reviews of the coverage determination requests, appeals and grievances.

**Ambulatory Care Pharmacist** **June 2006 – October 2006**  
**Kaiser Permanente Valley Service Area, Los Angeles, CA**

Performed all functions consistent with the day-to-day operations of the Ambulatory Care Pharmacist in the Medication Therapy Management, Oncology, Anticoagulation and Hypertension Ambulatory Care Clinics, including provision of direct patient care activities; initiating, adjusting, and discontinuing pharmacological therapy per existing protocols; reviewing all medications for appropriateness, therapeutic duplications, potential adverse reactions, drug interactions; monitoring for complications and therapeutic outcomes; providing preventative therapy, such as assessing for immunizations, mammography, bone mass density, depression and colorectal screening; educating patients on disease

states, medications, the importance of adherence and lifestyle modifications; conducting patient specific conversions to ensure evidence-based, formulary and cost-effective therapy; performing physical assessments; ordering and monitoring appropriate laboratory tests; documenting patients progress.

**Community Pharmacist**

**October 2004 –**

**Retail Pharmacy (Kroger, Inc), Los Angeles, CA**

**November 2006**

Performed all functions consistent with the day-to-day operations of the Community Pharmacist in the retail pharmacy, including receiving, processing, filling, verifying, and dispensing prescriptions; screening for the drug interactions; counseling patients on prescriptions and OTC products; answering phone calls from physicians offices and patients; calling for the new prescriptions, refills and prescription transfers; answering drug information questions; providing emergency contraception services.

**Graduate Intern**

**June 2004 –**

**Retail Pharmacy (Sav-On, Inc), Los Angeles, CA**

**October 2004**

Performed all functions consistent with the day-to-day operations of the Graduate Intern under the pharmacist's supervision in the retail pharmacy, including receiving, processing, filling, and dispensing prescriptions, counseling patients on prescriptions and OTC products, answering phone calls from physicians offices and patients, calling for refills and prescription transfers, answering drug information questions, assisting in inventory control.

*Licenses, Certifications and Professional Affiliations*

Registered Pharmacist (RPh) license, State of California, 2004 – Present

Registered Pharmacist (RPh) license, State of Arizona, 2007 – Present

Member, Academy of Managed Care Pharmacy (AMCP), 2008 – Present

Cambridge Who's Who Registry of Executives and Professionals – Honored Member (2007)

America's Top Pharmacists (Listing in the Guide to America's Top Pharmacists, 2006; First Edition)

Minnie Levens Award for Excellence in Patient Care, 2004

Rho Chi Pharmacy Honor Society – Lifetime Member, 2003

Golden Key National Honor Society – Lifetime Member, 1999

National Dean's List (biography published in the 22nd Annual Edition; 1999)

*Education*

Pharmacy Practice Residency, Kaiser Permanente, Los Angeles, California: 2005-2006

University of California, San Francisco (UCSF) School of Pharmacy (Doctor of Pharmacy); San Francisco, CA: 2000-2004

University of California, Los Angeles (UCLA) (Molecular, Cell and Developmental Biology), Los Angeles, CA: 1996-2000

**Timothy Lee Lukavsky, D.D.S.**  
**Dental Coordinator**

The Dental Coordinator, an Arizona Licensed dentist, oversees and administers dental benefits of SCAN Long Term Care under its ALTCS EP/D contract with AHCCCS and assists the Medical Director in coordinating communications between SCAN Long Term Care and AHCCCS.

**Experience**

**Dental Consultant** **2007 – Present**  
**SCAN Long Term Care, Phoenix, AZ**

Provide expertise and support of SCAN Long Term Care (SCAN) dental benefits, including utilization management requirements (such as Prior Authorization edits) and in collaboration with the Medical Management Department and SCAN Medical Director. Utilize clinical expertise in reviewing and managing member dental benefit utilization requests. Participate in meetings and discussions with the SCAN Medical Director during which dental benefits decisions are made. Provide oversight or feedback as needed for the production of member and provider communication materials, including review and update of the SCAN Long Term Care Provider Manual.

**Special Care Dentist - Faculty** **2006 – Present**  
**A.T. Still University, Mesa, AZ**

Active Practice of Dentistry which consists of best quality of care considered with education and mentoring of Dental students.

Clinical Supervisor of pre-Doctorate student dentists.

Provide special needs care treatment.

**Senior Consultant** **2006 – Present**  
**New Century Partners, Phoenix, AZ**

Serves as the Dental Consultant dedicated to review of service requests for appropriateness, effectiveness and timely delivery of care to members.

Oversees the professional review and utilization management of claims.

Provide professional opinion and clinical oversight.

**Dental Director and Partner in L.L.C.** **1997 – Present**  
**Dental Management Network, LLC, Phoenix, AZ**

Active Practice of Dentistry with focus on individuals requesting care, diagnoses their dental/oral conditions, prescribes and carries out, or directs others in carrying out, appropriate dental/oral treatment, or refers individuals for specialty consultation or treatment in conformance with approved clinical protocols and guidelines.

Educates individuals in the nature of oral health related conditions and in the general promotion of oral health related disease prevention.

Designs, develops, and implements appropriate Dental Department policies, protocols and procedures which are in compliance with the most current accepted professional standards.

**Associate Dental Director** **1995 – 1997**  
**Dental-Net, Inc./Employers Dental Services, Phoenix, AZ**

Active Practice of Dentistry with focus on requesting care, diagnoses their dental/oral conditions, prescribes and carries out, or directs others in carrying out, appropriate dental/oral treatment, or refers individuals for specialty consultation or treatment in conformance with approved clinical protocols and guidelines.

Educates individuals in the nature of oral health related conditions and in the general promotion of oral

health related disease prevention.

Designs, develops, and implements appropriate Dental Department policies, protocols and procedures which are in compliance with the most current accepted professional standards.

**Associate Dentist** **1991 –**  
**Family Dental Group, Phoenix, AZ** **1993**

Provided general dental services in a dental practice. Instructed patients on preventive dental care and causes and treatment of dental problems; diagnosed and treated oral-related diseases; and provided preventive and general corrective services.

**Associate Dentist** **1990 –**  
**Apache Family Dentistry, Apache Junction, AZ** **1993**

Provided general dental services in a dental practice. Instructed patients on preventive dental care and causes and treatment of dental problems; diagnosed and treated oral-related diseases; and provided preventive and general corrective services.

**Associate Dentist** **1988 –**  
**Conrad Tang, D.D.S., Phoenix, AZ** **1990**

Provided general dental services in a dental practice. Instructed patients on preventive dental care and causes and treatment of dental problems; diagnosed and treated oral-related diseases; and provided preventive and general corrective services.

### **Licenses, Certifications and Professional Affiliations**

Member, American State Dental Association

Central Arizona Dental Society

Western Regional Board

Central Regional Board

Member, Academy of General Dentistry

Member, Hispanic Dental Association

Member, American Association of Dental Consultants

Arizona State Board of Dental Examiners License Number D03956 Issued September 28, 1988

Mexico and Honduras Ministries – Volunteer annually to rural towns (performing dentistry to the poor).

### **Education**

Doctor Dental Surgery, Creighton University School of Dentistry, Omaha, NE, 1988

Bachelor of Arts Degree with Post Graduate in Cancer Research, Henry Lynch, M.D. , Creighton University, Omaha, NE, 1975 - 1980

*Karen E. Leonard, MPH, CPHQ*  
*Quality Management Coordinator*  
*Maternal Health EPSDT Coordinator*

The Quality Management Coordinator is located in Arizona and responsible for ensuring individual and systemic quality of care; integrating quality throughout the organization; implementing process improvement; resolving, tracking and trending quality of care grievances; and ensuring a credentialed provider network. The Maternal Health/EPSDT Coordinator is responsible for ensuring receipt of EPSDT services and maternal and post partum care; promoting family planning services; promoting preventive health strategies; identifying and coordinating assistance for identified member needs; and interfacing with community partners.

*Experience*

**Director, Quality Management** **May 2009 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for day-to-day oversight of the Quality Management Department and all quality-related functions required by state and federal regulations; development of department policies and procedures; development, implementation and monitoring of the Quality Management Program; and development and implementing quality initiatives that directly improve the care and services delivered to members. Ensures processes are in place to monitor the quality of care received by members and appropriate actions are taken when quality issues are identified. Ensures quality improvement initiatives are carried out and analyzed for success. Develops strategies to achieve improvements in state mandated performance measures and Performance Improvement Projects. Responsible for the credentialing of practitioners and organizational providers within the network. Oversees all oversight monitoring functions for delegated entities, contracted facilities, and medical record review. Responsible for the oversight of the Maternal Child Health/EPSDT functions including the development and implementation of the Maternity and EPSDT Programs and annual work plans. Reports directly to the Chief Medical Director.

**Director of Quality Improvement/Maternal Child Health** **October 2006 – May 2009**  
**Manager, Quality Improvement Department (through April 2007)**  
**Department University Physicians Healthcare, Phoenix/Tucson, AZ**

Quality Improvement – Responsible for oversight of the Quality of Care (QOC) Review process including documentation of issues, review of pertinent information. Collaborated with the QOC Steering Committee and the Medical Director in the resolution of issues as well as the development and implementation of interventions. Responsible for the development, implementation and outcome measures for the AHCCCS required Performance Improvement Projects as well as the required Performance Measures. Coordinated the reporting process to the Quality Management/Performance Improvement Committee and prepared and submitted all AHCCCS required reports. Oversaw the process for site and medical record audits, reporting of findings, data tracking and trending.

Maternal Child Health/EPSDT – Responsible for the implementation of the Maternal Child Health (MCH)/EPSDT Program as defined by AHCCCS, including the development of a Maternity Care and EPSDT Work Plan. Oversaw the development and implementation of community and provider education programs that support the MCH program. Responsible for ensuring that regulatory requirements related to the MCH/EPSDT Programs are followed by employees.

**Manager, Network Development/Provider Services** **October 2005 –**  
**University Physicians Healthcare, Phoenix/Tucson, AZ** **October 2006**

Provided management in the day-to-day operations of the Network Development Department. Provided guidance and direction for network contracting strategies, provider recruitment, contract negotiations, provider retention, education and problem resolution. Directly supervised Network Development staff through goal setting, defining department priorities. Directed network development and contracting strategy through network analysis, contractual rate analysis, AHCCCS guidelines, and Plan needs.

**Director, Member Services/Grievance & Appeals** **January 2004 –**  
**Manager, Grievance & Appeals (May 2004 – March 2005)** **October 2005**  
**Quality Management Analyst (January 2004 – May 2004)**  
**Maricopa Managed Care Systems (formerly MIHS), Phoenix, AZ**

Directed and managed day-to-day operations of the Member Services Department, including monitoring operational service levels in the call center to AHCCCS performance standards and call center staff for performance in call handling, providing coaching and feedback to staff as necessary. Managed day-to-day operations in the Grievance & Appeals Department, including the processing of member appeals and provider claim disputes for Maricopa Health Plan and Maricopa Long Term Care Plan and representing the health plans at AHCCCS hearings through the Office of Administrative Hearing. Chaired the Member Appeals Committee. Interfaced with providers on claim dispute resolution. Reviewed all Notice of Appeal Resolution letters to ensure that applicable Arizona Statutes supported the decision. Ensured that Health Plan effectuated Director's Decision expeditiously. Maintained department policies and procedures. As QM Analyst, responsible for the design, statistical analysis and implementation of Quality Improvement Studies conducted by the Health Plan per AHCCCS requirements and for Medical Management Department.

**Performance Improvement Analyst** **October 2002 –**  
**VHA West Coast, El Segundo, CA** **May 2003**

Conducted data analysis on a variety of hospital operations report cards, clinical studies and workforce strategy surveys. Assisted in study design, and literature search for new studies. Designed and developed data collection tools for various studies. Performed data analysis using SPSS.

**Quality Management Coordinator** **January 2002-**  
**Harriman Jones Medical Group, Long Beach, CA** **October 2003**

Prepared all documentation related to appeals and grievances. Notified contracted Health Plans and or patient of the disposition of the submitted complaints as directed by company policy. Maintained aggregate report of complaints, grievances and appeals and provided quarterly reporting to each contracted Health Plan as well as the Quality Management Committee. Developed and maintained all Quality Management Department Policies and Procedures. Conducted provider medical record audits and prepared result summaries and aggregate reports

*Licenses, Certifications and Professional Affiliations*

CPHQ (Certified Professional Healthcare Quality)

*Education*

Masters in Public Health, California State University, Long Beach, California, 2001

Paralegal Certificate Program, University of California, Irvine, California, 1996

Bachelors of Science, Nutrition, California State Polytechnic University, Pomona, California, 1980

*Diane Gamble**Performance/Quality Improvement Coordinator*

The Performance/Quality Improvement Coordinator is located in Arizona and responsible for focusing organizational efforts on improving clinical quality performance measures; the development and implementation of performance improvement projects; utilizing data to develop intervention strategies to improve outcomes; and reporting quality improvement/performance outcomes.

*Experience***Quality Initiatives Specialist****SCAN Long Term Care and SCAN Health Plan, Phoenix, AZ****February 2010 –****Present**

Responsible for managing all aspects of Performance Improvement Projects under the ALTCS EP/D contract, including the development and implementation of interventions and outreach programs that will produce demonstrable improvement in outcomes associated with the project; conducting outcome measurements; and reporting improvements as required by AHCCCS. Responsible for the development and implementation of interventions and strategies to improve rates on required long term care Performance Measures, including monitoring progress on all implemented interventions, assessing effectiveness through data analysis and reporting performance improvements and outcomes. Responsible for the development of behavioral health goals utilized to better manage members with behavioral health conditions and improve communication between primary care and behavioral health providers, including monitoring the generation of reports, assessment and evaluation, and reporting improvements and outcomes. Coordinates the analysis and reporting on all quality improvement activities including the preparation of reports required by AHCCCS. Assists the Director of Quality Management with the development and revision of Quality Management policies and desktop procedures.

Also acts as project lead for the annual HEDIS audit including Roadmap completion, vendor selection and coordination, supervision and training of support staff, medical record data collection and abstraction oversight, board certification tracking, trending and reporting. Assists with coordination and document identification for the SNP Structure and Process Measures including annual submission to NCQA through the Interactive Survey System (ISS). Assists with development and management of the Medicare Quality Improvement Projects and Chronic Condition Improvement Program. Coordinates the analysis and reporting on all quality improvement activities including the preparation of reports required by Centers for Medicare & Medicaid Services (CMS).

**Performance/Quality Improvement Supervisor****University Physicians Healthcare, Tucson, AZ****March 2009 –****January 2010**

Acted as project lead for the annual HEDIS audit, which included Roadmap preparation, supervision of medical record auditing processes, 100% over-read and submission to NCQA through the Interactive Data Survey System (IDSS). Acted as the project lead for the Special Needs Population (SNP) Structure and Process Measures. Responsibilities included training, coordination of management efforts, document preparation, facilitation of executive level review, and submission to NCQA through the Interactive Survey System (ISS). Supervised performance/quality improvement coordinators monitoring individual and team performance through training, workflow evaluation, and prioritization of tasks. Assisted with the development and evaluation of Performance Improvement Projects and Corrective Action Plans, which included the implementation of valid data sources, intervention development, monitoring, and outcomes measurements in accordance with NCQA, HEDIS, AHCCCS and CMS standards. Developed and prepared clinical and administrative reports required by government agencies for the purpose of meeting NCQA, HEDIS, AHCCCS and CMS standards. Assisted with the development and revision of Quality Management (QM) policies and desktop procedures. Served as a front line liaison with physicians, staff, patients, contracted entities, and the public concerning requests for information regarding University Physicians Health Plans and the QM Department. Presenter at national conferences hosted by the World Research Group and the Association for Community Affiliated Plans.



**Performance/Quality Improvement Coordinator  
University Physicians Healthcare, Tucson, AZ**

**March 1994 –  
February 2009**

Assisted with the development and evaluation of Performance Improvement Projects and Corrective Action Plans, which included the implementation of valid data sources, intervention development, monitoring, and outcomes measurements in accordance with NCQA, HEDIS, AHCCCS and CMS standards. Developed and prepared clinical and administrative reports required by government agencies for the purpose of meeting NCQA, HEDIS, AHCCCS and CMS standards. Assisted with the development and revision of Quality Management (QM) policies and desktop procedures. Served as a front line liaison with physicians, staff, patients, contracted entities, and the public concerning requests for information regarding University Physicians Health Plans and the QM Department. Performed site reviews and medical record audits for new and existing providers.

**Quality Improvement Administrative Assistant  
University Physicians, Inc., Tucson, AZ**

**March 1993 –  
February 1994**

Prepared and distributed correspondence, review tools, quarterly reports, studies, quality improvement plans and other data. Participated in the compilation of quality improvement reports which required ordering, sorting and preparing medical records for review, and extracting pertinent data from computer print-outs. Entered information and updated the database monitoring system for the department. Served as a liaison with physicians, staff, patients and the public concerning requests for information regarding the department. Delegated and monitored appropriate assignments for the secretary.

**Quality Improvement Secretary  
University Physicians, Inc., Tucson, AZ**

**June 1988 –  
May 1990**

Provided secretarial support including the recording and transcription of minutes, data entry, and the preparation of letters, labels, quality improvements plans, review tools, reports and documents. Ordered supplies and prepared accounts payable vouchers for incurred expenses. Answered telephones and scheduled multidisciplinary appointments

**Medical Receptionist  
Diagnostic Images, Salt Lake City, UT**

**September 1984 –  
June 1987**

Registered patients and facilitated the collection of payments. Transcribed the radiologists' progress notes for each procedure. Handled multiple phone lines and requests in a professional manner.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

Language, Pima Community College, Arizona, 1993-1995

Medical Terminology, Utah Technical College, 1985

*Thomas J. Hoehner, MBA, JD*  
*Provider Services Manager*

The Provider Services Manager is located in Arizona and responsible for overseeing provider services staff to coordinate communications between SCAN Long Term Care and its subcontractors under the AHCCCS EP/D contact; enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program; and maintain a sufficient provider network.

*Experience*

**Vice President, Provider Network Management** **2010 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for overseeing all activities related to development and maintenance of network contracting and provider relations, as well as regulatory reporting and requirements regarding network operations. Implemented a new contract management system for contract development, rate tracking and reporting requirements. Directs activities to coordinate communications between SCAN and its subcontractors and hiring a sufficient number of provider services staff to enable providers to receive prompt resolution to their problems/inquiries and appropriate education about participation in the AHCCCS program. Manages and directs staff to educate contracted and non-contracted providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available resources such as provider manuals, Web site, fee schedules, etc. Identifies trends and guides the development and implementation of strategies to improve provider satisfaction; communicates with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices; and identifies trends and guides the development and implementation of strategies to improve provider satisfaction.

**Chief Executive Officer** **2003 – 2010**  
**Titan Health Management Solutions, Inc., Phoenix, AZ** *(concurrent)*

Developed business plan, legal structure, hired associates, developed policies and procedures, secured clients, and secured initial financing for start up organization. Developed and implemented all policies and procedures, including operational and financial reporting requirements, to ensure accurate and thorough claim review, billing consultation, appeal services, and collections for multi-facility organizations, specialty physician groups, and ancillary surgical centers.

**Chief Executive Officer** **2007 – 2010**  
**TXNPlus Global, Inc., Phoenix, AZ** *(concurrent)*

Developed business plan, legal structure, and financial requirements and raised capital for start up international organization with operations in the United States, SE Asia, China, and Australia. Developed marketing materials and business partnerships with on-line digital content providers, financial institutions, education and wellness providers. Coordinated development of all IT and transaction specifications for integration into e-commerce and financial institution systems.

**Owner** **2007 – 2010**  
**Pinnacle Management Group, LLC, Phoenix, AZ** *(concurrent)*

Worked directly with Corporate Street Management to develop all aspects of new market operations and finance for new Medicaid and Medicare lines of business. Designed and developed operations and financial workflow and process, including EDI submissions, claims processing, medical management review, concurrent review, and financial planning, reporting and analysis. Ensured regulatory and state compliance of operations and reporting functions.

<b>Vice President, Operations</b>	<b>2001 –</b>
<b>HealthNet of Arizona, Inc., Phoenix, AZ</b>	<b>2003</b>
Responsible for claims processing and call center, and coordinated successful conversion of claims system platform. Participated in Operations Quality Initiatives Committee, Provider Relations Committee, Product Development Committee, Contracting Committee, CIT Committee (Community Outreach) and National Best Practices Committee. Developed Provider Outreach programs to work with providers on claims and payment issues, in conjunction with Provider Network department. Generated improvements including: a 81% reduction in claims on hand; reduced average answer time; 75% reduction in Department of Insurance complaints; increased quality results from 90% to 98%.	
<b>Chief of Staff, Western Region</b>	<b>1999 –</b>
<b>Aetna US Healthcare, Los Angeles, CA</b>	<b>2001</b>
Served seven months as interim Site Executive for 1,400 FTE Service Center bringing and maintaining all service levels within standards for fourth quarter 1999 while meeting budget objectives. Developed business alignment and operations integration strategy and workflow through 2001 for all western region service centers. Developed national initiatives for report standardization, balanced scorecard reporting, and E-health. Served as West Region Operations Legislative and Regulatory lead, ensuring regulatory compliance in all operations areas.	
<b>Director of Operations</b>	<b>1996 –</b>
<b>Senior Manager of Finance (1996-1997)</b>	<b>1999</b>
<b>Prudential Health Care, Inc., Los Angeles, CA</b>	
Responsible for management of over 1,400 associates involved with data entry, claims, billing & eligibility, customer service/call center operations, finance and internal consulting. Led <i>Project Service</i> project, reducing suspended claims on-hand by 50% and recalculations on-hand by 60%, and exceeding all customer service performance objectives with an increased call volume. Increased auto-adjudication and EDI submission rates for Los Angeles by over 25%. Successfully led DOC compliance team, correcting over 27 deficiencies within a year, leading to full compliance with all DOC regulations and a favorable audit by the DOC. Assisted with financial turnaround and restructuring of Prudential Healthcare Plan of California. Led healthcare plan initiatives on MLR reduction, re-contracting, and administration cost reductions.	
<b>Financial Systems Analyst</b>	<b>1993 –</b>
<b>Daniel Freeman Medical Center, Inc., Inglewood, CA</b>	<b>1994</b>
<b>Financial Analyst II</b>	<b>1990 –</b>
<b>Centinela Hospital Medical Center, Inglewood, CA</b>	<b>1993</b>
<b>Operations Planning Administrator</b>	<b>1989 –</b>
<b>Toyota Motor Sales, Torrance, CA</b>	<b>1990</b>

*Licenses, Certifications and Professional Affiliations*

Active Member, The State Bar of California (#194348), February 1998  
 Member, California Bar Association, American Bar Association  
 American Bar Association, John Marshall Bar Association

*Education*

University of Florida College of Law, Gainesville FL, 1996  
 Teaching Assistant Fellowship, Appellate Advocacy, Spring, Fall 1996  
 High Honors, Appellate Advocacy, Spring 1995  
 MBA, Financial Administration, Michigan State University, East Lansing MI, 1989  
 Bachelor of Science, Biochemistry, Michigan State University, East Lansing MI, 1987

*Sharon L. Hawn*

*Provider Services Manager*

The Provider Services Manager is located in Arizona and responsible for overseeing provider services staff to coordinate communications between SCAN Long Term Care and its subcontractors under the AHCCCS EP/D contact; enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program; and maintain a sufficient provider network.

*Experience*

**Manager, Network Management**

**June 2006 -**

**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

**Current**

Develops the provider network, which includes physicians, hospitals, nursing homes, ancillary providers, and home and community based organizations, in accordance with applicable regulatory requirements and the SCAN Long Term Care Network Development and Management Plan and SCAN Health Plan Arizona Network Management Plan. Maintains a viable, stable provider network through positive interactions with providers, on an individual and group basis by use of open communications, rapid problem resolution, training and education. Monitors the provider network to ensure adequacy, accessibility and availability in accordance contractual and regulatory compliance and the SCAN Long Term Care Network Development and Management Plan and SCAN Health Plan Arizona Network Management Plan. Assesses the provider network on a regular basis to determine adequacy relative to membership growth trends in respect to both geographical area and medical specialties needs. Ensures that the provider network complies with the SCAN Health Plan Arizona Cultural Competency Plan. Develops and disseminates provider education material and policies and procedures in relation to SCAN Long Term Care and SCAN Health Plan Arizona and conducts provider training and education as required. Manages Network Management Services staff. Develops, monitors, and evaluates provider Corrective Action Plans in conjunction with other health plan departments. Assist in the development and coordination of policies and procedures related to provider contracting and network management. Contributes to development and achievement of company goals and objectives that align with the organizational vision. Monitoring and development of department report deliverables to the regulator. Coordinates and facilitates the Network Operations Committee meetings advising committee members as to the status of contracts and to seek feed back from committee members as to ensure network adequacy.

**Network Service Representative**

**November 2005 –**

**Mercy Care Plan, Phoenix, AZ**

**June 2006**

Recruitment, negotiation, and maintenance of contracts with long term care providers (Skilled Nursing Facilities, Assisted Living Homes/Centers, and Home & Community Based Services). Conducted regular site visits with contracted providers to train on health plan policies and procedures and regulatory requirements. Provider claim issues research and resolution. Coordination with other health plan departments to ensure membership needs are being met by the network.

**Network Service Representative**

**June 2004 –**

**Health Choice Arizona, Tempe, AZ**

**November 2005**

Recruitment, negotiation, and maintenance of Primary care and Specialist provider contracts. Conducts regular site visits with contracted providers. Initiation of process for provider credentialing. Education of providers on health plan policies and procedures and regulatory requirements. Assisted in provider claims issue resolution. Network review to ensure adequacy. Coordination with other health plan departments to ensure membership needs were being met by the network. Assisted in bid process for Medicare line of business under health plan.

**Provider Service Representative/Contracts Specialist** **November 2000 –**  
**Maricopa Integrated Health Systems (MIHS), Phoenix, AZ** **June 2004**

Education and maintenance of contracts with ancillary and physician providers. Pre-contract site visit audit. Conduct regular site visits to education contracted providers on health plan policies and procedures and regulatory requirements. Conduct JOC meetings with transportation providers. Assisted in group provider training for physician, assisted living, and skilled nursing facilities. Provider claim issue research and resolution. Coordination with other health plan departments to ensure membership needs were being met by the network.

Recruitment and contract negotiation for physicians wishing to participate in the MIHS network. Coordinated with credentialing to ensure providers completion of credentialing prior to network addition.

**Service Representative** **January 2000 –**  
**Garry L Johnson & Associates, Mesa, AZ** **November 2000**

Application processing for both group and individual insurance policies. Process group and individual policy terminations. Knowledge of multiple plan requirements and benefits offered by the agency. Assisted policy holders with problem resolution.

**Patient Advocate/Case Aide Data Entry** **May 1990 –**  
**Maricopa Integrated Health Systems (MIHS)/Maricopa Managed** **January 2000**  
**Care, Mesa, AZ**

Triage, assess, and problem solve member calls. Communication with providers to ensure member services are being provided effectively. Schedule site visits for case managers. Make referrals for services for health plan members based on case manager direction. Liaison between primary care physician and the case managers. Assign and maintain appropriate case manager case load assignments based on regulatory requirements.

Enter all data elements into data system for case manager from initial member visit and reviews.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

Mesa Community College, general studies

Northern Illinois University, general studies, January – May 2006

Arizona State University, general studies, August – December 2005

*Tida Garcia**Provider Claims Educator*

The Provider Claims Educator facilitates the exchange of information between grievance, claims processing and provider relations and SCAN Long Terms Care's network providers to include: educating contracted and non-contracted providers; interfacing with the call center to compile, analyze and disseminate information from provider calls; identifying trends and guide the development and implementation of strategies to improved provider satisfaction; and communicating frequently with providers to ensure the effective exchange of information and gain feedback.

*Experience***Manager, Network Management and Contracting** **2009 – Present**  
**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

Responsible for supervising network management representatives who service contracted providers and ensuring Network Management staffing is sufficient to support providers receiving prompt resolution to their problems or inquires and appropriate education about participation in the AHCCCS program. Manages the negotiation of provider, hospital and ancillary contracts that are financially sound and meet regulatory requirements. Responsible for the implementation of a paperless contract management system and the execution of restructuring department functions and responsibilities, including all policies/procedures and desktops. Manages and directs staff to educate contracted and non-contracted providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and available resources such as provider manual, Web site, fee schedules etc. Remediate encounters related to provider edits. Constantly monitors communication with providers to ensure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices. Identifies trends and guide the development and implementation of strategies to improve provider satisfaction

**Operations Director** **July 2008 – June 2009**  
**Dental-One, INC, Glendale, AZ**

Managed a multi-dentist office servicing over 2,500 patients, overseeing accounts receivables, collections, claim billing procedures, and insurance benefits. Introduced efficient process to enhance revenue within the facility and accounts receivable reduction. Responsible for the office budget and efforts to exceed monthly production goal. Promoted an environment in which patients enjoyed high levels of service and employees were motivated to deliver top performance.

**Director of Medicare Program Operations** **September 2005 – March 2008**  
**Care1st Health Plan Arizona, Phoenix, AZ**

Provided leadership and oversight of all projects/activities related to Medicare business, including both business and system initiatives to include project definition and project planning management and reporting. Assisted parent plan in California in the implementation of Medicare business; prepared and conducted on-site Medicare reviews/audits. Responsible for maintaining compliance with Medicare regulations policies and procedures. Directly supervised the Medicare claims adjudication and Enrollment departments. Managed the Risk Adjustment vendor to ensure maximum financial return from CMS. Coordinated Prescription Drug Events (PDE) functions, resolving errors and reducing encounter issues. Liaison with CMS plan manager and plan resource for all departments with any Medicare program questions/issues.

**Director of Claims** **October 2004 – September 2005**  
**Care1st Health Plan Arizona, Phoenix, AZ**

Responsible for all claims and encounter department functions. Ensured all adjudication of claims and encounters adhered to state, federal agencies and health plans policies. Collaborated with the parent company in California to streamline claims adjudication and enhance processes for better accuracy.

Developed policies and procedures. Provided oversight to coordination of claims recovery for providers and ensured completion was within standard deadlines. Developed strategies to decrease/avoid encounter pends to avoid state sanctions.

**Encounter/Reinsurance Manager** **January 2004 –**  
**Maricopa Integrated Health System, Phoenix, AZ** **October 2004**

Managed health plan claims processing and recovery functions in a high volume production environment. Lead team to resolve activities of claims technical challenges. Implemented various performance and production enhancing programs. Worked with state agencies to streamline the encounters and recovery process. Served as Interim Assistant Director of Claims.

**Testing Research Supervisor, Mercy Care Plan** **August 2000 –**  
**Recovery Supervisor, Mercy Care Plan** **January 2004**  
**Claims Supervisor, Mercy Care Plan**  
**Schaller Anderson of Arizona, Phoenix, AZ**

Responsible for various claims department functions.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

University of Phoenix/Business Management, 2004-2006

*Maureen McGurrin**Vice President, Operations*

The Vice President, Operations is located in Arizona and provides leadership and direction in the development, maintenance and oversight of effective and efficient operational systems, processes, policies and procedures designed to achieve business objectives and regulatory compliance in a manner consistent with the SCAN mission and services provided under the ALTCS EP/D contract with AHCCCS.

*Experience***Vice President, Operations****July 2006 –****SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ****Present**

Responsible for the oversight and management of day-to-day operations through performance monitoring and reporting, operational reviews and assessments and continual quality improvement processes. Manages the performance of delegated operational functions, including services rendered by SCAN Health Plan in Long Beach and outside professional consultants, to ensure performance standards and expectations are achieved. Achieved operational and financial readiness review processes for implementation of SCAN Long Term Care at start-up in 2006 and 2007 and assures ongoing regulatory compliance by developing and maintaining policies, procedures, processes and reporting in accordance with applicable Federal and State laws, rules and regulations. Facilitated development of fiscal reporting for alignment with regulatory reporting requirements. Manages and monitors the annual budget to maintain fiscal discipline to remain within budget. Responsible for managing strategic planning for all SCAN Health Plan Arizona lines of business, including SCAN Long Term Care. Reports directly to the SCAN Health Plan Arizona Chief Executive Officer.

**Clinical Operations Consultant- Government Programs****August 2000 –****Director, Special Populations****June 2006****Schaller Anderson Incorporated, Phoenix, AZ**

Developed and implemented strategic plans for programs, assessed effectiveness and appropriateness of efforts internally and externally, and provided leadership in the planning, development and management of new initiatives. Established and implemented short-term and long range organizational goals, objectives and operating procedures; monitored and evaluated operational effectiveness; and effected changes required for improvement. Ensured continual optimal health plan performance and reporting outcomes. During this time, Schaller Anderson and its affiliates, provide management of physical and behavioral health care for Medicaid, Medicare, commercial, and employer self-funded plans, servicing 1.3 + million people in seven states. Consulting Projects included:

- Project Manager for selection of an integrated case management software system for physical health, behavioral health and long term care to be used for health plan operations in six states, including design/development and implementation; came in under budget and ahead of schedule.
- Project Manager for the coordination of start up operations for administering medical and behavioral health services for a self-funded health plan covering 8,000 employees.
- Participated as part of the on-site corporate project team responsible for developing and implementing full scope operations for a newly-formed at-risk Medicaid health plan which successfully accomplished regulatory readiness and transitioning 90,000 members in 45 days.
- Served as Acting Director, Long Term Care, for Mercy Care Health Plan (Phoenix AZ), managing performance improvement activities including outcome reporting to identify early warning trends which resulted in increased compliance ratings under the annual operational and financial audit by 35% from the previous year. As a Corporate Consultant to Mercy Care Health Plan, analyzed targeted operational areas for cost improvement, implemented strategies and expanded provider contracts to improve delivery of health care to a long term care population which resulted in



increased HEDIS scores, surpassing targeted scores established by regulatory contract.

- Consulted on and coordinated the implementation of medical management workflow processes to successfully enroll, transition and initiate case management outreach to membership of a Medicaid health plan providing services to 38,000 children, adults and special populations. Revised contracts and aligned personnel resources to accommodate growth and increased operational compliance with regulatory requirements.
- Project Manger for implementation of a state operated health plan serving 8,000 foster care children throughout Arizona. Evaluated and facilitated the development of policies and procedures, committee structures, assessment tools, outcome reporting, and workflow processes to improve service delivery for medical management, member and network services, resulting in increased compliance with regulatory operational reviews. Provided training on health information system to improve efficiencies and track data, which had not been recognized under the current administration.
- Conducted gap analysis and implemented strategies to secure provider contracts, expand medical management and behavioral health operations for a 81,000 member Maryland Medicaid health plan; developed tracking tools and enhanced workflow processes to maximize successful back-to-back transitions for 52,000 members throughout the state and meet regulatory compliance.
- Collaborated in developing and implementing strategies for cost containment and improved service delivery to the aged, blind and disabled membership specific to ancillary providers for a 93,000 member university-owned Medicaid health plan in Oklahoma. Assisted in identifying specialty services, developing audit processes, and revised/developed procedures for tracking and trending.

**Healthcare Consultant  
Louisville, KY**

**October 1996 –  
August 2000**

Collaborated in preparing responses to state RFPs for Medicaid contracts that were successfully awarded to health plans in three states. Provided on-site technical expertise/assistance and coordinated all phases of operational start-up for the full scope of Medicaid services at a newly- formed private health plan in Maryland, which ranked third out of six participating health plans in membership enrollment at start-up. Prepared recommendations to improve service delivery for special populations, based upon analysis of operations and consumer issues, for a Medicaid plan operating in Orange County, California.

**Manager, Long Term Care  
Arizona Physicians, IPA, Phoenix, AZ**

**September 1990 –  
July 1996**

Responsible for the long-term care service delivery component for elderly, and physically and developmentally disabled members in a NCQA-accredited private health plan. Accountable for the oversight of daily corporate operations, fiscal and personnel management, contract compliance, strategic planning, quality improvement/ benchmarks, cost containment, and customer satisfaction/service. Prepared and coordinated health plan assessments, including identifying, designing and implementing quality and performance indicators to improve the delivery of health care services, resulting in improved patient outcomes, higher satisfaction ratings and consistently high annual audit compliance ratings by regulators. Developed and implemented strategies for complying with HEDIS measures. Designed, identified, implemented, and analyzed survey tools and data collection; collaborated with providers to effectively increase and enhance the delivery of preventive services.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

BA, Sociology, University of South Florida

*Bevann Kathryn Moreland*  
*Claims Administrator*

The Claims Administrator is responsible for the development, implementation and administration of a claims processing system capable of paying claims in accordance with state and federal requirements. The Claims Administrator oversees the entire claims department for SCAN Long Term Care under the ALTCS EP/D contract to ensure adherence to program requirements.

*Experience*

**Vice President, Claims** **September 2008 – Present**  
**SCAN Health Plan, Long Beach, CA**

Responsible for the Claim Departments serving both Arizona and California Medicare /Medicaid business including but not limited to day-to-day operations for all aspects of compliance, quality and financial outcomes, developing and maintaining policy and procedures related to all aspects of compliance, quality and financial outcomes for all claim transactions. Oversees multiple functional areas, including Claims production mailroom through adjudication, Audit and Quality, Claims Customer Service, and System configuration units. Executive Sponsor and Owner of Claims Service Initiative Project focusing on reduction of administrative costs and increase in compliance and quality outcomes. Direct reports to this position are the Director of Claims, 2 Project Managers and 1 Executive Assistant. The Arizona and California Claims Departments consist of over 110 FTE's including the staff dedicated to the ALTCS line of business.

**Vice President, Integrated Managed Care Services (IMCS)** **March 2002 – September 2008**  
**HealthCare Partners Medical Group, Torrance, CA**

Responsible for IMCS departments which include Claims Production (automation, professional and hospital units) and Quality Assurance (audit, appeals and customer service), Eligibility (enrollment for all HMO and FFS lives), Retro Review and Referral coordinators. Major projects include MSO Redesign, Self Funded Initiative, Multi-state Acquisition Transitions, New Product Line Development, Benefit Redesign, Provider Set up, Patient Support Center, HIPAA EDI Claims, Provider and Patient Portals. Developed, implemented, evaluated and monitored annual multi-million dollar budget activity for all IMCS departments. Managed successful multi-year, multi-million dollar redesign of MSO systems and processes to achieve decreased costs per claim, increased quality, implement web based customer facing functions and a platform for membership growth. Re-organized duty aligned departments within claims into customer focused departments with higher level of accountability and control of outcomes.

**Director, HealthCare Advisory Services** **October 2000 – December 2002**  
**BDO Seidman, LLP, Costa Mesa, CA**

Developed relationships with potential clients to promote HealthCare Advisory Consulting Services; acquired and managed contracts with health plans, IPA's and medical groups for a variety of consulting services including:

- Diagnostic assessment of IPA operations, information systems, health plan and provider contracts
- Contract compliance with providers, IPA's/MSO's, and health plans
- Revenue recovery in the areas of capitation, contract incentives, reconciliation of membership and member months trending and other sources of missed revenue
- Audits on information system set-ups, contract implementation and key providers

Summarized project findings; reported and presented to client Senior Management involved with project

**Vice President, Information Systems** **March 1999 – October 2000**  
**Prospect Medical, Santa Ana, CA**

Responsible for oversight of MIS department structure and personnel including the Eligibility

Department and Capitation Department. Implemented upgrades in 5/99 to become 100% Y2K compliant. Designed and implemented Helpdesk to organize the department and deliver support and reports in a timely manner. Assisted in negotiating Full Risk contracts with PacifiCare and Secure Horizons. Operationalized full risk structure for IDX system and implemented procedures in each department. Developed and implemented security provisions to allow employees' confidentiality if they chose Prospect as their IPA. Initiated and completed system conversion from EZ-Cap to IDX for the Prospect, Cal Optima and Santa Ana/Tustin networks. Instrumental liaison between outside consultant groups and internal staff to design and develop reports and system changes both with MAS90 and IDX

**Director, Business Development** **July 1998 –**  
**St. Joseph Hospital, Orange, CA** **March 1999**

Reorganized and integrated the acquired Orange County FPA IPA and Medical Group into the Heritage Health Foundation within legal boundaries. Integrated entire IPA operations from ISG to IDX information systems over four month period. Established 42 new physician practices on an independent basis or within existing medical group operations from FPA employed physician group practices. Renegotiated contracts for new IPA and new Provider PSA's for St Joseph Hospital Affiliated Physicians IPA. Oversaw FPA bankruptcy issues for St Joseph Hospital and Physician network including step by step involvement with bankruptcy court, FPA and legal counsel to ensure maximum protection both from a financial and a patient care standpoint. Closed the FPA Operations in Orange including the IPA and all Physician offices.

**Director, IPA Operations (June 1992 – July 1998)** **July 1998 –**  
**Positions preceding Director: Manager, IPA Operations;** **December 1991**  
**Eligibility/Capitation Supervisor; Eligibility and Benefits**  
**Coordinator; Claims Coordinator/Night Shift Supervisor; Lead**  
**Claims Examiner**

**FPA/OCMCS/St. Joseph IPA, Orange, CA**

Responsible for Customer Service Teams: Utilization Management, Claims and Customer Service, including oversight for Support Teams: Eligibility, Capitation, Revenue Recovery, Stop loss, Provider Relations, Auditing, Training, and Scanning. Team development resulted in increased Customer Satisfaction to 98%. Cost per Claim down to \$1.62 with Team implementation, EDI and Scanning encounter data. Referral turn around time decreased to 48 hours for routine authorization.

**Health Plan Coordinator** **March 1991 –**  
**Health Plan of America, Orange, CA** **December 1991**

**Functional Claims Examiner & Customer Service Representative** **September 1987 –**  
**Blue Cross of California, Anaheim Hills, CA** **June 1991**

**Claims/Premium Billing Technician** **March 1986 –**  
**American Medical International (AMI, Inc.) Costa Mesa, CA** **September 1987**

*Licenses, Certifications and Professional Affiliations*

Member, WEDI (Workgroup for Electronic Data Interchange) SNIP, 1998 - Current

- White paper contributor; Y2K, EDI Various Transactions and HIPAA Security and Privacy

Developing Partner (Managed Care Master Software Product), South Huntington Associates, Huntington Beach, CA, 1996 - 2008

*Education*

Business Law and General Education, University of LaVerne, LaVerne, CA, 1988

Associate Arts Classes, Business Education, Orange Coast College, Costa Mesa, CA, 1984

*Joseph Jefferson*  
*Claims Director*

The Claims Director is responsible for managing the day-to-day operations of the claims adjudication and EDI processes for SCAN Long Term Care provider claims submitted for services rendered to members under the ALTCS EP/D contract.

*Experience*

**Claims Director** **January 2010 – Present**  
**SCAN Health Plan, Long Beach, CA**

Responsible for Medicare and Medicaid claims operations for northern California, Southern California, and Arizona, including managing the claims adjudication process, provider services, training and audit, system configuration, and EDI. Accomplishments include review and restructure of claims operations, infrastructure build including policy and procedure review and modification/creation, workflow restructure, and software implementation including MACESS, ICES, and reviewing new enterprise operating system. Reports directly to the Vice President for Claims and actively manages five managers, four supervisors, and one trainer.

**Independent Consultant** **January 2009-December 2010**  
**Self Employed, Gilbert, AZ**

Consulted for the Government of Peru to build the framework for a specialized Medicaid-like program for rural communities. Performed functional analysis, claims training and auditing, system and benefit design review, workflow re-design, policy and procedure documentation, and CMS audit readiness review for health plans across the United States.

**Claims Director** **December 2006 – December 2008**  
**Schaller Anderson/Aetna, Phoenix, AZ**

Responsible for claims operations for a 540,000 member Medicaid/Medicare health plan, including ensuring adherence to state and federal compliance for Medicaid, Medicare, Sarbanes-Oxley, and HIPAA. Responsible for management and processing of 500,000+ claims per month while managing 110 employees including three Managers, seven Supervisors and an Administrative Assistant. Accomplishments included reducing claims inventories to record low levels, implementation of Sarbanes-Oxley compliance, and implementation of Trizetto, QNXT® operating system. Managed joint operating committee meetings with hospitals throughout the State of Arizona. Instrumental in working across the provider network to facilitate claims disputes and resolutions. Led a cross-functional team to overcome internal roadblocks to automated processing and corrected configuration deficiencies. Reviewed and participated in provider contract negotiations. Negotiated settlement agreements as needed. Negotiated contracts with external vendors and network providers. Worked as liaison between Schaller Anderson, the Arizona Hospital Association, and Arizona State Legislators to craft legislation.

**Director, Claims Administration** **November 2002 – December 2006**  
**Kaiser Permanente Mid-Atlantic, Silver Spring, MD**

Responsible for claims operations for a thriving 520,000 member Commercial and Medicare staff model HMO. Responsible for adherence to state and federal compliance for Maryland, Virginia, District of Columbia, Medicare, as well as Sarbanes-Oxley and HIPAA. Responsible for management and processing 105,000+ claims per month. Accomplishments included implementation of Sarbanes-Oxley compliance, HIPAA reporting and compliance, managing and implementing Medicare Part D benefits program for the region, bringing all medical center encounter data into the Diamond System, release management and implementation of a new Diamond version and MACESS EXP. Instrumental in implementing individual accountability within Claims Administration by introducing a time accounting system which reduced the time on system variance from 30%+ to 5%. Negotiated with Labor to produce and implement performance standards for Union staff. Produced the first staff reviews within Claims

Administration in over 2 years and re-engineered the departments within Claims administration for optimum efficiency. Mentored and coached Management staff to increase oversight within Claims Administration, which ultimately increased overall performance and accountability.

**Director of Claims (Subcontractor)  
Network Health, Cambridge, MA**

**March 2002 –  
November 2002**

Responsible for claims operations for a growing Medicaid managed care health plan and payment of 60,000+ claims per month, reducing a backlog of fifty days receipts to fourteen days on average. Established and implemented medical operational policies for the organization. Developed and documented workflow process as well as developing and conducting claims and systems training for other departments. Accomplishments include: implementation of ClaimCheck™ software and establishing an Appeals and Grievance process, as well as establishing a training program and stabilizing numerous EDI issues within the health plan. Created and managed departmental budget.

**Contract Consultant/Senior Consultant  
Scheur Management Group, Newton, MA**

**May 1998 –  
October 2001**

Participated on team to perform a claims audit and functional analysis of the Claims Division for a 250,000+ member HMO and a functional analysis of a 125,000+ member HMO. Furnished reports detailing the results and an action plan to correct deficiencies within both HMO Claims Divisions and interrelated departments including redesigned workflows and reporting structure. Temporarily managed a Commercial and Medicare plan; responsible for managing operations for claims, customer service, appeals and grievances, enrollment, and training and auditing. Performed various consultative services for clients and within company owned health plans including auditing, establishing productivity standards and the re-design of workflows and functions within Operations.

**Product Support Analyst  
McKesson HBOC, Rockville, MD**

**August 1998 –  
November 2000**

Responsible for assisting clients with defect reporting, software testing and configuration management. Test software and configuration both at the client site and within AMISYS. Report defects and work with programmers to affect modifications to AMISYS software.

**Claims Manager/Field Services Manager  
United Healthcare, Baltimore, MD**

**September 1991 –  
February 1998**

Responsible for overseeing claims operations for four companies, maintaining ten days average inventory. Established and implemented medical operational policies for the organization. Developed and conducted claims and systems training for other departments. As part of turnaround management team, contributed to reversal of three-year financial loss trend to profitable status. Conducted functional analysis of claims department and, with approval of Executive Director, redefined workflow, developed and implemented policies and procedures and specified computer enhancements. Reduced claims adjustment inventories from 60+ days to 7 days. Assumed responsibility for provider appeals and increased productivity by 1300% by adjusting workflows.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

Business Administration, University of Maryland University College, Ongoing Course Study

*Marc Carren*

*Encounter Data Manager*

Responsible for day-to-day operations of encounter data analysis, processing, submission, remediation and reporting related to SCAN Long Term Care's ALTCS EP/D contract with AHCCCS. Participates in department level policies and procedures development, strategic planning, and resource and system management.

*Experience*

**Encounter Data Manager**

**SCAN Health Plan, Long Beach, CA**

**Feb 2008 –**

**Present**

Leads team responsible for the processing of transactions for 130,000 members enrolled with Arizona and California Medicare Advantage/Medicaid plans, including SCAN Long Term Care's participation in the ALTCS Program.

- Within two years, increased data accuracy and quality by identifying and implementing business and system controls and process procedures.
- Created previously unavailable access to encounter data through state-of-the-art transaction portal.
- Lowered transaction costs by negotiating relationship with a new clearinghouse vendor.
- Created policies and procedures for all encounter data processing for Medicare and Medicaid submissions.
- Team leader responsible for the budget, system, and staff charged with ensuring the accuracy and completeness of delegated risk-adjustment data composing over \$1 billion in revenue.

**Director of Operations**

**System Flux, Inc, Irvine, CA**

**Dec 2005 –**

**Jan 2008**

Managed entire company operations for small, start-up software consulting firm specializing in the healthcare industry.

- Led a staff of 8 – 11, including software developers, technical analysts, sales representatives, and support representatives.
- Represented firm to clients; developed and recommended software solutions; developed new accounts; reactivated dormant client relations, deepened and broadened C-level and long term relationships.
- Managed advertising, project, and custom solution campaigns from cradle to grave.
- Successfully negotiated relationships with vendors and business partners at rates in-line with start-up company expectations.

**Sr. Project Analyst**

**SmileCare Dental, Santa Ana, CA**

**March 2005 –**

**Dec 2005**

Senior IT resource for 50+ office dental group based in Southern California.

- Successfully negotiated relationship with electronic imaging vendor and implemented electronic attachment solution for claim processing which reduced DSO by over 25%.
- Lead innovator and designer of automated electronic claim workflow designed to reduce FTE hours by 50%.

**Business Analyst  
InSight Health, Lake Forest, CA**

**July 2003 –  
March 2005**

Specialized in integration, EDI, and Revenue Cycle solutions for this national diagnostic radiology services vendor.

- Successfully introduced business automation and EDI solutions to increase electronic claim submission from 35% to 85% thereby reducing DSO of claims by over 50%.
- Led team of analysts in all EDI and integration related projects for IT department.
- Created relationship with alternative clearinghouse vendor and renegotiated existing clearinghouse vendor contract to reduce transactional costs by 25%.

**EDI Operations Manager  
Quality Systems, Inc, Irvine, CA**

**June 1998 –  
July 2003**

Built from ground-up and managed team of 10 individuals providing EDI services to all clients of this leading national practice management and EMR vendor for dental and medical solutions.

- Created custom-built EDI system including claims, statements, reminders, eligibility, and remittance advice before HIPAA regulations standardized these transaction sets.
- Grew EDI services revenue from under \$1 million to over \$8 million within 5 years.
- Represented company to clients; developed and built software solutions; developed new clients; reactivated dormant client relations.
- Successfully negotiated relationships with vendors and business partners at rates below the competition.
- Provided innovative solutions to dental and medical groups that were unique to their time helping these companies lower their costs and focus on their core competency of caring for patients.

*Licenses, Certifications and Professional Affiliations*

Workgroup for Electronic Data Interchange (WEDI), 2009

*Education*

Master of Business Administration, University of Phoenix, Long Beach CA, 2009-2010

Bachelors of Computer Science, California State University Fullerton, Fullerton CA, 1993-1998

*Selva Abeyta**Encounter Project Analyst*

The Encounter Project Analyst is a subject matter expert in AHCCCS claims and encounters processing who defines, develops and coordinates inter-departmental projects related to the analysis and remediation of SCAN Long Term Care encounter processing and submissions.

*Experience***Senior Project Manager** **March 2008 – Present**  
**SCAN Health Plan, Long Beach, CA**

Supports SCAN Long Term Care in meeting regulatory and ALTCS program requirements for encounter processing. Works on ALTCS-specific projects to identify and assist in areas where SCAN Long Term Care may need to enhance or remediate processes to comply with AHCCCS contracted requirements. Coordinates designated projects ensuring timely team involvement and successful conclusion, including performing ongoing evaluation of impact on workflow processes within departments to ensure maximum efficiencies. Analyzes data for trending outcomes and identification of opportunities for process improvement measures. Collaborates with team members to develop and execute quality measures for selected projects.

**Senior Business Configuration Consultant** **September 2004 – April 2006**  
**The Trizetto Group, Inc., Phoenix AZ**

Made business assessments for implementation of the QNXT software product, developed written configuration documentation base on client's feedback. Supported and guided client during the installation and transition process. Assisted with the testing and set up of the software at client site.

Assisted clients on development of new process and policies due to software changes. Worked with private insurance and government programs for both managed care and full-insurance products.

**Director Business Services** **February 2000 – June 2004**  
**Vista Care, Phoenix AZ**

Responsible for the management of several IT areas such as PMO, Project Implementation unit for planning and coordination of large projects involving multiple divisions and geographical areas, Training Division for the Carenation product (proprietary software developed by Vista Care for the management of hospice services), IT QA unit- support to software product development by testing new products. Triaging user/software problems and verifying anomalies of the software. Responsible for requirement gathering for the development of new software for Business Analyst unit. Supported all Vista Care users with hardware and software related issues as part of the IT Help Desk, including equipment tracking, equipment configuration and hardware needs. Assessor of software packages for the company and advisor to Senior Management about purchasing options. Conducted JAD sessions and was participant of the Technical Design Team also responsible for strategic planning and finding long – term growth opportunities.

**Account Executive** **May 1994 – November 1999**  
**GTE Data Services, Managed Care Division, Phoenix AZ**

**Account Executive** (1997- 1999) Oversaw all work performed for assigned customer relating to use of Q/Care (proprietary managed care software product). Ensured highest level of customer satisfaction from all aspects of services and product provided. Protected existing revenue streams; “up-sold” into account, bringing new revenue streams. Interpreted contracts; managed contracts, service level agreements and account deliverables.

**Implementation Manager** (1994- 1997) Managed training, testing and documentation units for Q/Care product. Liaison between application development staff and client. Served as business advisor to Technical Design Team. Performed project management functions at clients' locations for software



implementation teams. Acted as business consultant throughout implementation process, business set-up or business requirement gatherings. Attended healthcare related conferences and seminars.

**Director of Health Care Plan Operations** **February 1992 –**  
**Arizona Physicians IPA (a Division of United Health Plan), Phoenix AZ** **May 1994**

Directed Claims and Customer Service Divisions with 158 employees and an operational budget of over \$3.5 M in third largest HMO in Arizona; membership of 150,000, processing an average 200,000 claims per month. Developed strategic planning and long term growth opportunities for division. Responsible for departmental organization; established production goals, processing guidelines and quality standards. Planned and implemented policies and procedures applicable to operation of Encounter Division; brought into compliance with U.S. Government and State of Arizona Medicaid agency mandated guidelines. Responsible for creation and definition of system modifications as well as final approval to software changes and test results. CQI lead on several projects. Transition company to new computer. Created and train a testing team for new software implementation. Through development of new encounter system, policies and procedures avoided payment of \$675,000 penalty assessed against HMO by the State of Arizona. Drove design of processes that allowed division to decrease turn around time on claims from 15 days to 3 days.

**Administrator** **February 1985 –**  
**Arizona Health Care Cost Containment System, Phoenix AZ** **May 1992**

Managed claims, encounters, reinsurance, deferred liability processing in innovative state Medicaid program utilizing prepaid, capitated service delivery mechanism, carried out by contracted health maintenance organizations. Responsible for claims processing support functions e.g. provider registration, reference file maintenance, and provider assistance unit. Managed Long-Term Care unit with case management services and claims processing. Project manager on design of Managed Information System upgrade that transitioned all processing functions from batch to on-line processing. As PMMIS Project Manager managed testing teams and define requirements for Claims, Encounters, Reinsurance, Provider files, Reference files, Prior Authorization, Long Term Care requirements for the process of claims. Developed, reviewed and evaluated high level and detail system design. Developed training material and trained users.

Oversaw documentation development and presentation of system for certification to Health Care Federal Administration. Developed and supervised system testing and files conversion of first software designed to manage a prepaid Medicaid program in the nation. Maintained and analyzed system problems after implementation. Reviewed new policies for design and continuous upgrades to original programs.

*Licenses, Certifications and Professional Affiliations*

HIAA full certification program for Health and Life Insurance Administration.

Certified Public Services Management.

Certified as a Health Care Professional by the Academy of Health Care Management.

*Education*

Bachelors of Arts, French and Music, University of Nevada, 1971

*Laura K. Phelps*

*Business Continuity Planning & Recovery Coordinator*

The Business Continuity Planning & Recovery Coordinator is designated to coordinate SCAN Long Term Care's Business Continuity and Recovery Plan, in accordance with AHCCCS Policy 104 *Business Continuity and Recovery Plan* and under its ALTCS EP/D contract with AHCCCS.

*Experience*

**Manager, Business Support**

**2005 –**

**SCAN Long Term Care and SCAN Health Plan Arizona, Phoenix, AZ**

**Present**

Reports to the Chief Executive Officer and responsible for managing all facility functions, related vendor contracts, and fulfilling the customary business needs of company offices to include:

- Responsible for development and compliance with a preventative maintenance schedule for the office facility and functions as liaison between landlord, vendors and employees. Manages building repair and maintenance functions, including scheduling, supervising and overseeing staff and vendor personnel involved in the provision of repair service.
- Specifies, recommends purchases and maintains company stock of common office equipment in support of the organization's needs, including coordinating the design and specified maintenance for the audio visual equipment system.
- Provides day-to-day oversight of purchasing, printing and the mail service center, including mailing member fulfillments and member literature requests.
- Secures facility records are kept within compliance and the implementation of all personal health information (PHI) records are stored in a secured, access controlled environment and in fire proof cabinets. Acts as the Record Retention Coordinator. Manages Arizona off-site record retention and coordinates appropriate record destruction processes through the Corporate Legal department's Record Retention Manager in Long Beach.
- Responsible for the development, annual review and updating of a written Business Continuity Plan which addresses specific provisions for recovery of key customer priorities in conjunction with the Director of Workplace Services in Long Beach, CA. Along with assuring processes for eligibility and enrollment; scheduling; clinic visits; prior authorization; surgeries; utilization review/concurrent review; claims/provider payments; grievance and appeals; and quality of care concerns are in place and processes have been addressed within the Business Continuity Plan. Manages the SCAN Business Continuity contractor in preparing an annual summary of the Business Continuity Plan for submission to AHCCCS, Division of Health Care Management. Plans and coordinates with the Director of Workplace Services the Arizona specific annual drill and responsible for the training for departmental personnel to ensure familiarity with the plan. Responsible for reviewing and implementation of any change due to periodic testing and documenting results.
- Key member in the Threat Assessment Team and represents functions within security. Conducts Risk Management evaluations, including assessing security processes and the building access system.

**Corporate Purchasing Manager**

**2002 –**

**Schaller Anderson Incorporated, Phoenix, AZ**

**2004**

Responsible for centralized purchasing and facility agreements for multiple sites nation-wide. Incorporated "best practice" policies and procedures as a result of Schaller Anderson Incorporated merging Mercy Care Plan operations into its corporate organization and other opportunities for improvement from expanding business operations.

- Purchasing/Facilities Manager** **2000 –**  
**Southwest Catholic Healthcare Network d.b.a. Mercy Care Plan,**  
**Phoenix, AZ** **2002**  
 Responsible for managing all purchasing, facilities, security, off-site storage and the mail services center. Effectively coordinated design, planning & the implementation for a complete reconfiguration of the 80,000 sq. ft. facility, including the build out of a “state of the art” computer room, print and mail center operations.
- Office Services Manager** **1999 –**  
**Premier Healthcare of Arizona, Phoenix, AZ** **2000**  
 Responsible for multiple facilities, purchasing, and mail/copy operations. Assisted the State-assigned receivership organization in the closure of the company.
- System Contracting Supplies, Shared Business Services** **1998 –**  
**Catholic Healthcare West, Phoenix, AZ** **1999**  
 Responsible for supplies contracting for a multi-hospital system environment. Participated as the Member and Contracting Lead for the Ergonomic Focus Group for the hospital system.
- Purchasing/Facilities Manager** **1995 –**  
**Southwest Catholic Health Network d.b.a. Mercy Care Plan and**  
**Mercy Healthcare Group, Phoenix, AZ** **1998**  
 Managed all purchasing, facility, security and mail services center. Achieved significant cost reductions and productivity initiatives through facility reconfigurations & new equipment.
- Purchasing Manager** **1992 –**  
**Airline Training Center Arizona, INC., Goodyear, AZ** **1994**  
 Responsible for centralizing and managing all purchasing, facility services and materials management functions for an airline pilot training school. Implemented an integrated SBT accounting/inventory system.
- Subcontractor Coordinator** **1989 –**  
**Paint Equipment Manufacturers (DBI), Phoenix, AZ** **1992**  
 As Liaison for 3M Contractor Product Division and subcontractor, responsible for production scheduling, inventory control, and billing reporting.

*Licenses, Certifications and Professional Affiliations*

None

*Education*

Various technical training courses related to contract law, facilities management, materials management and purchasing

---

#### *Requirement 4: Justification for Key Positions Not Full Time*

---

SCAN Long Term Care (SCAN) fulfills the key personnel requirements set by AHCCCS for ALTCS Contractors by engaging qualified, seasoned professionals with expertise in serving elderly and physically disabled members enrolled in the ALTCS program and other publicly funded programs. These dedicated SCAN staff and management have successful careers serving the health and independence needs of our most frail citizens.

##### *Full-time Employed Personnel*

By way of administrative services agreements with its affiliated companies, SCAN Health Plan Arizona and SCAN Health Plan, all but one of the key positions identified in Section D, Paragraph 25 of AHCCCS' Request for Proposal (YH12-0001) are full-time employees. The one exception is the Dental Coordinator who is a contractor. Many of SCAN's key personnel allocate a portion of their time among three lines of business in Arizona; however, the functional responsibilities assigned to each of these individuals are consistent with the description of the key position assigned to them under the ALTCS contract.

##### *Time Devoted to ALTCS Functions*

The Vice President Case Management, his leadership team, and all non-clinical case managers, as well as our Behavioral Health Coordinator, devote 100 percent of their time to our ALTCS members. Typically, the allocation of time for other personnel is divided approximately 50 percent to SCAN ALTCS-specific functional responsibilities and 50 percent to the other two lines of business.

##### *Justification for Key Positions Not Full-time*

There are six key positions for which SCAN has either combined two positions under one person or the position is filled by someone who has other assigned functional responsibilities that are outside of those defined for the key position under the ALTCS program. There is only one position which is not filled at this time. SCAN's justification for these six and the one part-time position, identified above, is provided in the following paragraphs.

Compliance Officer and Contract Compliance Officer – These two key positions are combined and held by a single individual, Tina Graham. Ms. Graham is focused on contract compliance, AHCCCS deliverables, and Compliance Program activities, including fraud, waste and abuse prevention, reporting and training. Both positions are supported by three full time equivalent personnel dedicated to compliance related activities. This individual also serves as the Dispute and Appeal Manager under SCAN's current AHCCCS contract and will be transitioned as indicated in the next paragraph. The Compliance Officer also periodically supports Medicare related activities, including support of the Special Needs Plan, such as grievance, appeals and compliance related matters. These Medicare duties occupy approximately 15 percent of her time.

Dispute and Appeal Manager – This position is currently being fulfilled by the Compliance Officer, Tina Graham. Given the new requirement for CYE2012 that no single individual can fulfill more than two key personnel roles, a Compliance Lead position will be created and filled prior to the beginning of the contracting period on October 1, 2011. The Compliance Lead will manage two full time equivalents dedicated to member grievance and appeals and provider claims disputes. Given the low volume of appeals, grievances and disputes, the Compliance Lead will also support compliance related activities. The grievance system staff also support Medicare member grievance and appeals. The job description for this position is included at the end of the response to this requirement.

Dental Director - Tim Lee Lukavsky, DDS, is an outside consultant, engaged in ALTCS program related activities approximately 2-3 hours per month (approximately 2 percent of his time). The limited time Dr.

Lukavsky spends with SCAN Long Term Care is based on low membership utilization of limited adult dental benefits and a small population of EPSDT members.

Business Continuity Coordinator – SCAN’s Facilities Manager, Laura Phelps, serves as its Business Continuity Coordinator. Ms. Phelps facilitates day-to-day business support functions that lend itself to hands on support of SCAN’s Business Continuity Plan (BCP). Because the Business Continuity Coordinator role is only utilized in the event that the BCP is activated, it is not necessary to have a full-time dedicated individual solely devoted to that role.

Quality Management Coordinator and EPSDT/Maternal Health Coordinator – Karen Leonard, Quality Management Director, fulfills these two roles. SCAN’s EPSDT population continues to be small and SCAN has not had a pregnant member since first becoming an ALTCS program contractor in 2006. Ms. Leonard devotes approximately 60 percent of her time to the ALTCS program and less than ten percent of that time is devoted to the EPSDT/MCH programs. Ms. Leonard also supports quality management related activities for Medicare lines of business, including the Special Needs Plan Model of Care, and structure and process requirements. Ms. Leonard is supported in both roles by nine experienced quality management staff.

Provider Claims Educator – SCAN’s Provider Claims Educator, Tida Garcia, also serves as a provider liaison for claims and contracting issues for all lines of business as most of SCAN’s network also contracts to provide Medicare services (with the exception of certain HCBS providers). Ms. Garcia allocates approximately 50 percent of her time to the ALTCS program and 50 percent to SCAN’s Medicare plans. These roles compliment each other by fostering provider relationships through collaboration on issues that impact providers and identifying provider training and coaching opportunities.

#### *SCAN Health Plan Arizona’s Related Lines of Business*

Consistent with AHCCCS requirements, SCAN’s parent company, SCAN Health Plan Arizona, has a contract with the Centers for Medicare and Medicaid Services to serve the dual eligible population in Maricopa County. In the spirit of the underpinnings of coordinated care for dual eligibles and to better serve members dually enrolled in SCAN’s ALTCS and SNP membership, SCAN has integrated the SNP and ALTCS functional business areas, including leveraging key staff expertise, to foster collaborative management of our members’ services across lines of business. SCAN also has Medicare Advantage plans in Maricopa and Pima Counties that also share similarly aligned processes.



## JOB DESCRIPTION

**POSITION TITLE: Compliance Lead (Appeals and Disputes Management)**  
**DEPARTMENT: AZ Compliance**  
**SUPERVISOR: VP, Compliance (Compliance Officer)**

**GRADE:**  
**FLSA: Exempt**  
**DATE: 02/11/11**

**JOB PURPOSE:**

The Compliance Lead will manage and adjudicate member and provider grievances and requests for hearing and will submit monthly grievance system reports to AHCCCS. Track and trend grievance system data to facilitate performance improvement. Supervise grievance system staff to assure timely resolution of cases. Assists VP, Compliance in compliance related activities to monitor and oversee the Arizona compliance program.

**ESSENTIAL JOB RESULTS:**

Ensures the provision of timely quality health care to members by facilitating the timely movement of grievances and appeals resulting in on-time closure of all cases.

Supports special projects by assigning and overseeing job responsibilities to administrative workflow functions.

Provides updates to management by preparing reports and statistics pertaining to grievances, appeals and claims disputes on a monthly and/or ad hoc basis.

Processes the timeliness of grievances, appeals and claims disputes by assembling cases and/or supervising the assembling of cases and ensuring that deadlines are met. Monitor and facilitate monthly Grievance System reporting to AHCCCS.

Accomplishes organizational objectives by facilitating, tracking and monitoring compliance with requirements.

Achieves compliance by evaluating new, proposed and existing requirements. Monitors and tracks implementation of new requirements.

Communicates expectations; plans, monitors, and appraises compliance audit results; develops, coordinates, and enforces systems, policies, procedures, and desk top standards.

Identifies and evaluates trends and proposes enhancements and/or modifications as necessary to meet requirements.

Maintains quality service by providing accurate and timely reporting; respond and resolve inquiries; initiates audits and ensures compliance and accuracy for related processes.

Audits, tracks, investigates and reports potential fraud waste and abuse.

Monitors corrective actions to completion.

## JOB DESCRIPTION

Assists in activities related to the cultural sensitivity program.

Facilitates compliance related training.

Coordinates regulatory related projects as needed.

Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies.

Contribute to team effort by accomplishing related results as needed.

### **QUALIFICATIONS:**

BA/BS in Health Care, Business or related field or equivalent job experience.

Strong interpersonal skills, including excellent written and verbal communication skills.

Strong commitment to detail.

Demonstrated leadership and management skills.

Ability to work independently, prioritize and manage multiple tasks effectively, organize work flow, adhere to timeliness and function in a fast-paced environment.

Proven ability to exercise independent thought and decision-making skills.

Ability to work effectively and participate in a team environment.

Proven ability to interact effectively with all level of the organization.

### **CONDITIONS OF WORK:**

Proof of current driver's license and automobile insurance.

Primarily sedentary, ability to lift at least 20 pounds.

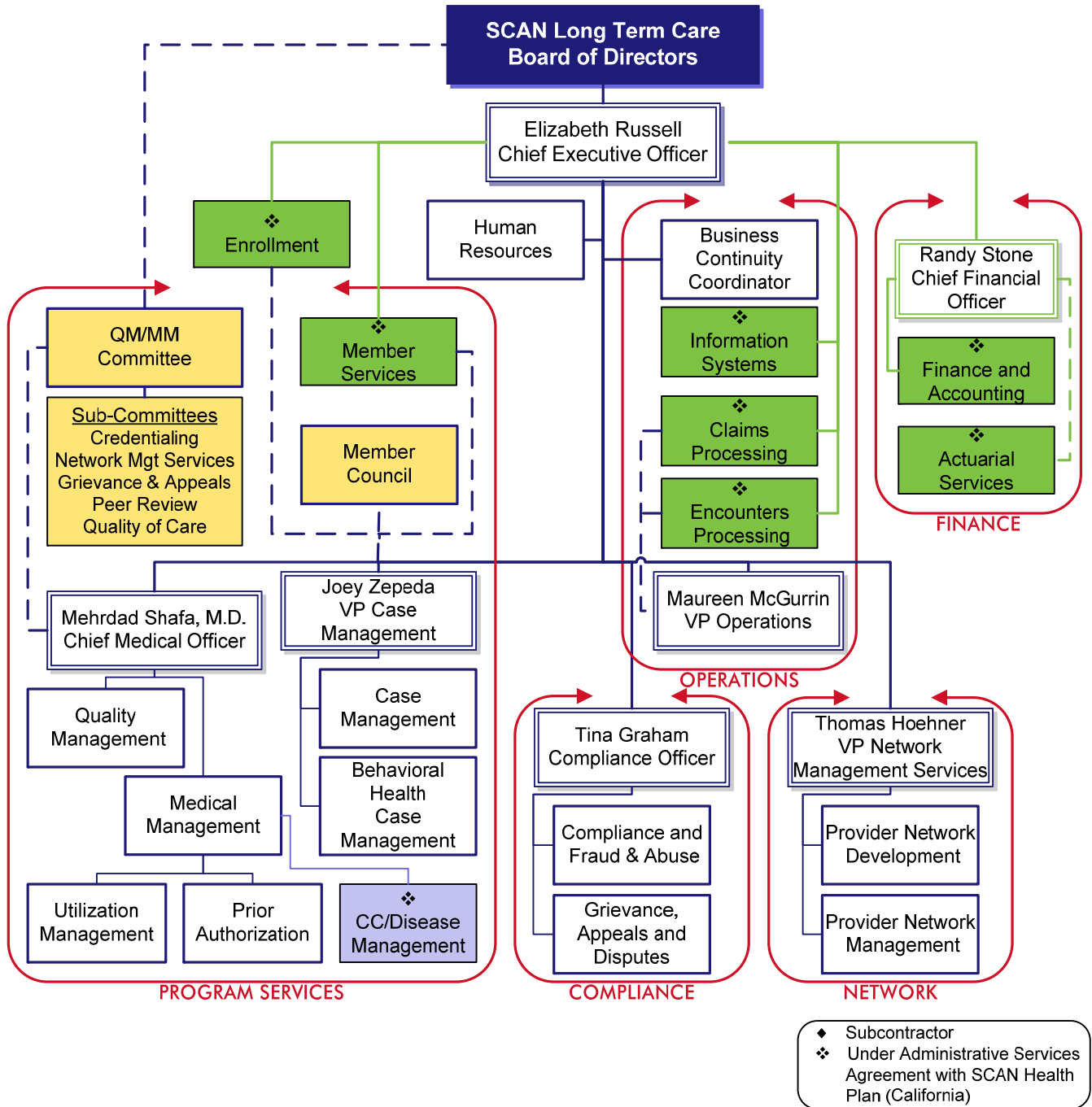
Frequent telephone and computer use.

**While this job description is intended to be an accurate reflection of the essential job results, management reserves the rights to modify, add, or remove duties from particular jobs and to assign other duties as necessary.**

**Requirement 5: Functional Organizational Chart**

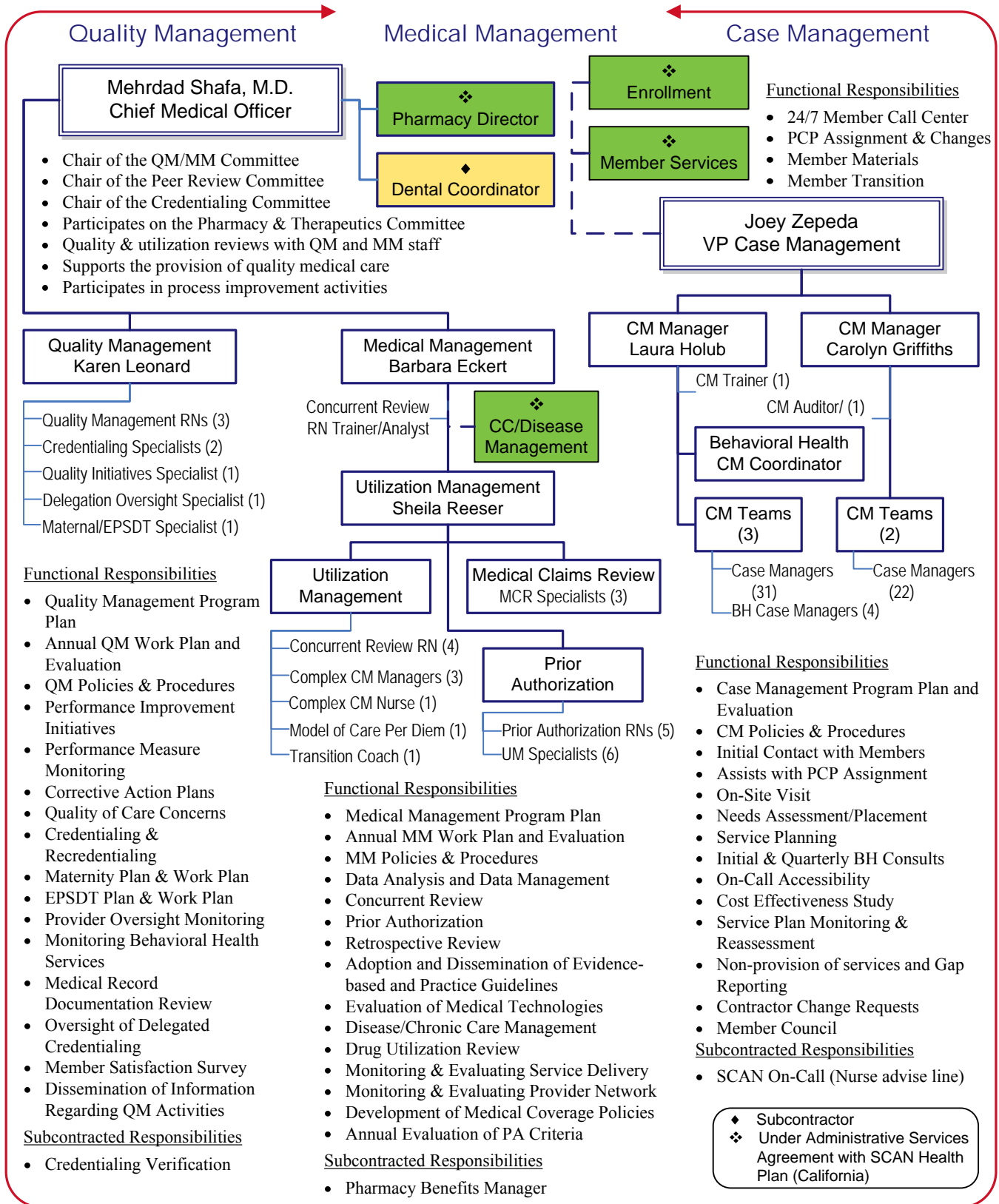
SCAN Long Term Care’s functional organizational chart (below) identifies the functional areas of each key program area. SCAN Health Plan Arizona provides staffing for SCAN Long Term Care positions and subcontracts through an administrative services agreement with SCAN Health Plan, an affiliate, for certain support functions. The following two pages further outline the functional responsibilities of each program area.

SCAN Long Term Care Functional Organizational Chart



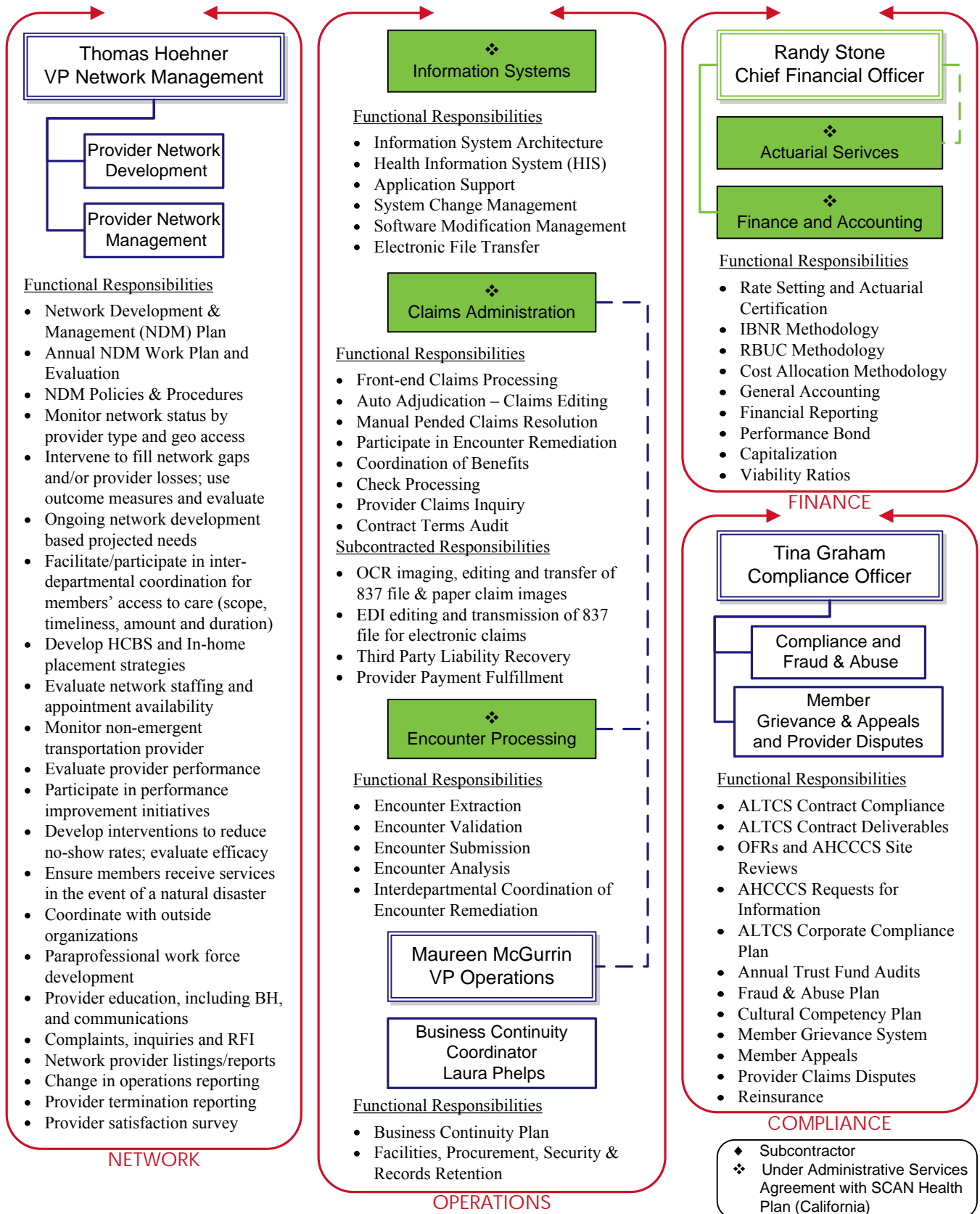


Functional Organizational Chart – Program Service Areas



PROGRAM SERVICES

Functional Organizational Chart – Areas of Network, Operations, Finance and Compliance



### Requirement 6: Sanctions since January 1, 2008

#### Sanctions

The table below identifies all of the sanctions levied against SCAN Long Term Care, the Offeror; SCAN Health Plan Arizona, its parent organization; or any legally related corporate entity since January 1, 2008 that have been imposed by AHCCCS, Medicaid programs in other states, Medicare or any state insurance regulatory body.

<i>Sanction Description and Date</i>	<i>Sanction Reason</i>	<i>Timeline to Correct/Resolve</i>
<b>SCAN Long Term Care</b>		
Aged Pended Encounter Sanction – Quarter ending September 2007 \$7,390	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending December 2007 \$7,345	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending March 2008 \$30,750	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending June 2008 \$29,670	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending September 2008 \$6,350	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending December 2008 \$8,190	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending March 2009 \$16,445	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending June 2009 \$28,560	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending September 2009 \$26,870	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending December 2009 \$29,300	Aging of pended encounters	Suspended

<i>Sanction Description and Date</i>	<i>Sanction Reason</i>	<i>Timeline to Correct/Resolve</i>
Sanction for failure to reduce individual rates with each HCBS provider by five percent March 1, 2010 \$40,000	Failure to reduce individual rates with each HCBS provider by five percent	Correspondence mandating corrected rates sent to impacted providers on December 28, 2009
Sanction for equity distribution without AHCCCS approval March 4, 2010 \$60,000	Equity distribution without AHCCCS approval	Finance department education completed on May 14, 2010
Aged Pended Encounter Sanction Quarter ending March 2010 \$88,275	Aging of pended encounters	Suspended
Enrollment suspension April 16, 2010	Encounter accuracy and prior authorization turn around data accuracy	Suspension lifted August 27, 2010; ongoing encounter accuracy monitoring continues
Aged Pended Encounter Sanction Quarter ending June 2010 \$122,785	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending September 2010 \$226,460	Aging of pended encounters	Suspended
Aged Pended Encounter Sanction Quarter ending December 2010 \$239,360	Aging of pended encounters	Suspended
<b>SCAN Health Plan Arizona</b>		
NONE		
<b>SCAN Health Plan (California)</b>		
NONE		

## *Requirement 7: Claims Adjudication Process*

---

SCAN Long Term Care (SCAN) recognizes timely, accurate claims payment is fundamental to meeting our promise to providers who deliver care and services for our members. At the same time, complete, accurate and timely claims data is critical so utilization and cost data is readily available to SCAN's Medical and Case Management departments for making effective clinical and service decisions. This same data, provided to AHCCCS through encounter reporting, is also essential for supporting assessment of and budgeting for the ALTCS Program.

To meet the needs of its providers, members and AHCCCS, SCAN requires an efficient claims adjudication process that not only incorporates data validation and editing, but also clearly minimizes manual intervention, ensuring both operating and cost efficiencies. In light of this, SCAN has just completed a major quality improvement project we call the Claims Service Initiative (CSI) during the first quarter of 2011 which not only encompassed changes to the claims module of its healthcare information system, but also included procedural process improvements and staff training. SCAN is confident the results of the CSI Project will result in significantly higher levels of automation resulting in greater efficiency and lower administrative costs.

### *Claims Acquisition and Loading*

#### Paper Claims

Providers are directed to send paper claims to SCAN's post office box in Phoenix, AZ. Paper claims are couriered overnight to the SCAN Claims Department in Long Beach, CA, where the claims are date stamped with the date of receipt and batched in counts of 100 by form type. Batches are picked up daily by FutureVision Technologies, Inc. (FVTech) a domestic imaging vendor that specializes in converting paper CMS 1500 and UB04 claims to HIPAA-compliant ANSI 837I and 837P formats.

In addition to preparing, inventorying, and then imaging claims by optical character recognition (OCR), FVTech systematically matches claim data elements assigning the correct member and provider identifiers. Clean claim edits are applied to each claim to prevent claims from being incorrectly rejected by SCAN for OCR errors. FVTech separates claims that score below 99 percent accuracy in the OCR process, and returns them to SCAN for manual entry. FVTech translates claims to the ANSI 837I and 837P formats, and loads the files and images, each business day, to the SCAN secure file transfer protocol (SFTP) server. Claims are then ready for front-end claims processing.

#### Electronic Claims / Electronic Data Interchange

SCAN offers all providers the option to submit claims via EDI, and works with its contracted provider network to increase EDI submission rates. SCAN has contracted with Office Ally™, a full service domestic clearing house, to accept EDI submissions from providers at no charge to the provider, including claims that are submitted to other clearinghouses with whom providers have trading partner agreements (e.g. Emdeon.) Office Ally applies ANSI X12 Level 1-5 edits, rejecting claims back to providers as appropriate, and systematically assigning the appropriate member and provider identifiers. Each business day, Office Ally loads the HIPAA-compliant 837I and 837P files to SCAN's SFTP. Claims are then ready for the front-end claims processing. SCAN's average EDI rate for the three months ended February 2011 was over 62 percent.

#### Front-End Claims Processing

Each business day between 12 and 3 p.m., SCAN's information technology (IT) department loads all 837 files from the SFTP server, and moves them into SCAN's front-end claims processing system, the Transaction Portal ( TP.) In the Transaction Portal, member and provider matching is validated ensuring FVTech and Office Ally assigned the correct member and provider identifiers. Next, clean claim edits are applied. If an EDI claim does not pass these initial edits, an unsolicited claim status message (u277) is

sent, notifying the provider of the claim rejection and rejection reason(s); for a paper claim, a claim reject letter is systematically generated and mailed to the provider explaining the rejection reason(s.) Claims failing validation remain in the TP with a “pend” status and are resolved daily. If the Claims Examiner can resolve the pend, the claim is loaded into MC400. If the claim pend is due to provider error, the Claims Examiner rejects the claim with a reject letter or claim status message back to the provider. Claims that pass all validations are systematically loaded into the claims processing module of SCAN’s healthcare information system, MC400.

TP files are managed using the TP EDI Front-End Processing Report. Management monitors the report daily for timeliness consideration, and assigns pending claims to claims examiners for correction or rejection.

### *Claims Processing and Payment*

#### Claims Adjudication

SCAN processes claims by batch from the TP into the MC400 with the intent to maximize automated adjudication. Claims are processed against comprehensive edits and benefit adjudication rules that can be individually configured based on contractual and regulatory requirements. Applied edits include, but are not limited to: member eligibility, benefit limitations, provider demographics, prior authorization, duplicative services, and diagnosis and procedure codes. SCAN utilizes Ingenix Clinical Claims Editing System® (iCES) software which edits both professional and facility claims against CMS, CCI and industry standard billing guidelines to ensure accuracy of a provider’s coding practices. Based on these edits and other system logic, claims are processed to pay, deny, or pend for further review.

#### Pended Claims Resolution

Claims may be pended for a variety of reasons, including but not limited to, retrospective medical review, potential coordination of benefits (COB), clinical and reference table edits. Pended claims are monitored daily for timeliness, and manually adjudicated by claims examiners. Claims requiring retrospective review are systematically loaded daily into the Medical Review database. Medical Claim Review Specialists in Arizona check the database daily and prepare cases for review by the appropriate clinical staff. Determinations to approve or deny are entered into the Medical Review database and MC400. The claims are finalized in MC400 on a daily basis and cases are closed in the database by Claims staff. Claims examiners also work with the SCAN Enrollment Department to investigate pended claims with other insurance indicators. Claim examiners review claims pended by the iCES editing software and complete adjudication. Claims examiners are trained to resolve pended claims using documented procedures based on AHCCCS contract guidelines.

#### Claims Payment

When a claim is finalized (post audit), the claim is queued in MC400 to await the accounts payable (AP) process. The AP process runs nightly to generate and transmit files to Emdeon®, SCAN’s provider payment fulfillment vendor. Within 48 hours of file receipt, Emdeon prints and mails payments and remittance advices (RA) to providers. The RA contains the required notification comments regarding final claim disposition, including reasons for partial payment or denial. The provider’s rights and instructions to file a dispute are included on every RA. (A sample RA is included with this response.)

### *Claims Cost Avoidance*

AHCCCS and its program contractors are the payers of last resort. Cost avoidance is critical to assuring the financial viability of the AHCCCS program as well as solidifying confidence of stakeholders by assuring responsible stewardship of state and federal funding. SCAN shares in this philosophy by engaging in robust cost avoidance activities that are in compliance with AHCCCS requirements. SCAN

reports to AHCCCS quarterly on cost avoidance activities, which includes coordination of benefits, third party liability, clinical editing software.

#### Coordination of Benefits (COB)

In support of ongoing cost avoidance efforts in partnership with AHCCCS, SCAN avoids payment of a claim where another payer has primary responsibility. Using AHCCCS enrollment data, the MC400 flags primary coverage and SCAN monitors fields like “Related Causes Code” and “Other Payer Organization Name.” If a member has other insurance, or if an explanation of benefits (EOB) is attached to a claim, SCAN recognizes COB and assumes secondary payer responsibility. When a claim without an EOB is received for a member with other insurance, SCAN will deny the claim and request the primary EOB.

#### Third Party Liability (TPL)

SCAN outsources TPL services to Recovery Management Systems (RMS). SCAN typically issues claim payments, then RMS pursues recovery from potential third parties. SCAN IT provides RMS with year-to-date claims data via monthly FTP uploads. RMS reviews the payment data to target potential TPL related claims using Diagnosis Code Reports that generate member questionnaires and statutory liens. RMS coordinates correspondence efforts needed for its pursuit of potential TPL recoveries. RMS also coordinates with AHCCCS’s contracted vendor, Health Management Systems (HMS), to obtain total/dual plan referrals and verify reinsurance that may apply. In compliance with requirements, no TPL claims are pursued or settled without AHCCCS approval. RMS reports TPL recoveries to SCAN monthly. In compliance with AHCCCS requirements, SCAN provides monthly TPL reporting to AHCCCS.

#### *Provider Claims Inquiries*

SCAN’s claim Customer Service Representatives (CSRs) are available from 8:00 a.m. to 5:00 p.m. (PST) each business day to respond to provider questions, status inquiries, and informal complaints regarding claims payment. Additionally provider SCAN network management service representatives are available by telephone and in person to work collaborative with the provider and the Claims Department for inquiry resolution. Claims inquiries may be faxed to CSRs or providers may access SCAN’s Web site to research claim status. Each inquiry is entered into a tracking database. Most inquiries are resolved while the provider is on the telephone. Inquiries not immediately resolved are routed to a Claims Examiner. The provider is contacted via phone and informed once the issue is resolved. Each process step is documented in the tracking database supporting all AHCCCS performance requirements, including acknowledgement of calls within three business days; resolving and/or stating the result to the provider within 30 business days; and if not resolved in 30 days, documenting why the issue was unresolved, and then resolving within 90 days. Provider inquiries are trended to determine any system or payment related issues that lead to inquiries so any deficiencies are tracked to the root cause and corrected.

#### *Claim Monitoring Process and Reports / Identification and Resolution of Deficiencies*

SCAN uses a variety of scheduled and ad hoc reports to monitor claims receipts, production, quality, and call statistics on a daily, weekly, and monthly basis. Reports include mail and FV Tech inventory reports, EDI receipt reconciliation reports, transaction portal reports, productivity reports, to error reports and processed and denied claims reports. SCAN’s Claims Management team meets daily to discuss issues and review data from the previous day’s activity. The meeting focuses on effective and efficient ways to proactively manage timeliness and accuracy to meet or exceed AHCCCS targets. Claims workflow processes and outcomes are audited by SCAN’s Compliance and Internal Audit Departments.

#### Timeliness

To measure timeliness, SCAN compares the original date of claim receipt to the processed date. In line with AHCCCS requirements, SCAN’s goal for claims is 90 percent adjudicated in 30 calendar days, and 99 percent adjudicated in 60 days. Our rolling 12-month average exceeds AHCCCS targets, with 97

percent claims adjudicated within 30 days and 99 percent within 60 days. To prevent deficiencies, timeliness is tracked daily via the Claims Pend report. If timeliness standards are at risk, resources are reallocated or overtime hours scheduled to meet the goal.

### Accuracy

SCAN's goals for both procedural and financial accuracy are 97 percent. To ensure these targets are met, SCAN completes daily pre-payment and monthly post-payment audits. SCAN recently completed a system and process enhancement that allows additional time for finalized claims to be available for pre-payment audit. Claims are systematically loaded nightly to the pre-payment audit tool. Claims Auditors review selected claims using the extensive filtering capabilities within the tool; the filters are based on error trending, and specific claim types such as high dollar, denials and coordination of benefits. Errors identified are loaded into the SCAN intranet, where they are retrieved by Examiners who correct the error prior to final AP posting. Claims Auditors audit 100 percent of new Examiners' work until they meet accuracy standards.

A post-payment random claims audit of three percent is completed each month. Auditors utilize a separate version of the audit tool to review those claims selected for audit, but follow the same process as described above for identification and correction of errors. The audit department abides by documented procedures and AHCCCS standards to guide their audit activities. All audit data is stored in the online claims audit tool, and reported to Claims management each month, as well as on the AHCCCS Dashboard Report. Robust reporting is available from both databases that allow claims management to regularly review and resolve issues.

If deficiencies are identified on a claim, additional training is scheduled and performance is tracked. Root cause tracking and trending analysis is performed on claims errors that are corrected to prevent ongoing issues. This Continuous Quality Improvement process is used for examiner, provider, and system set up issues, with goals of increased accuracy, decreased cost, and improved customer satisfaction. This approach has had a very positive impact on our accuracy outcomes.

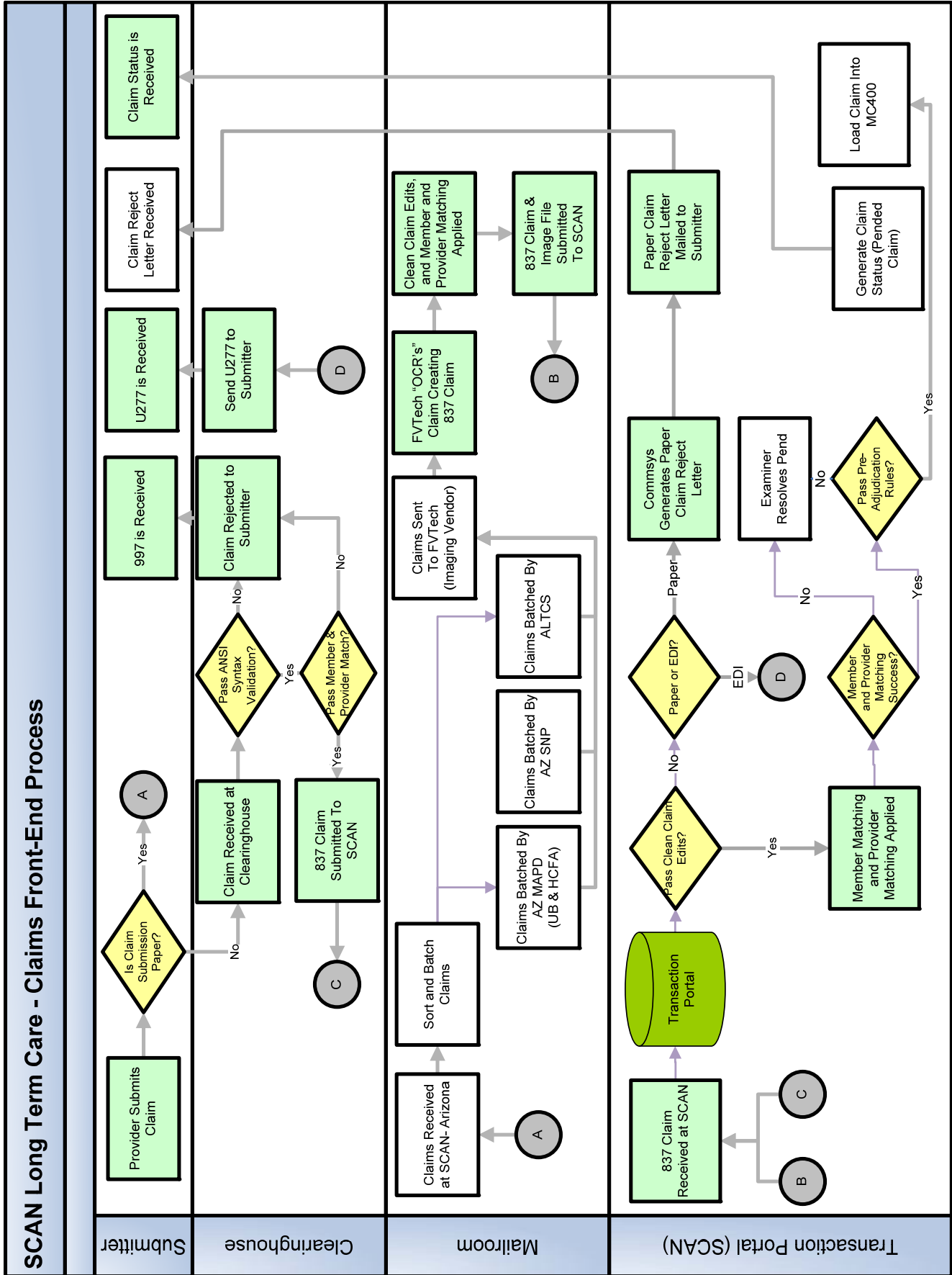
### Continuous Process Improvements

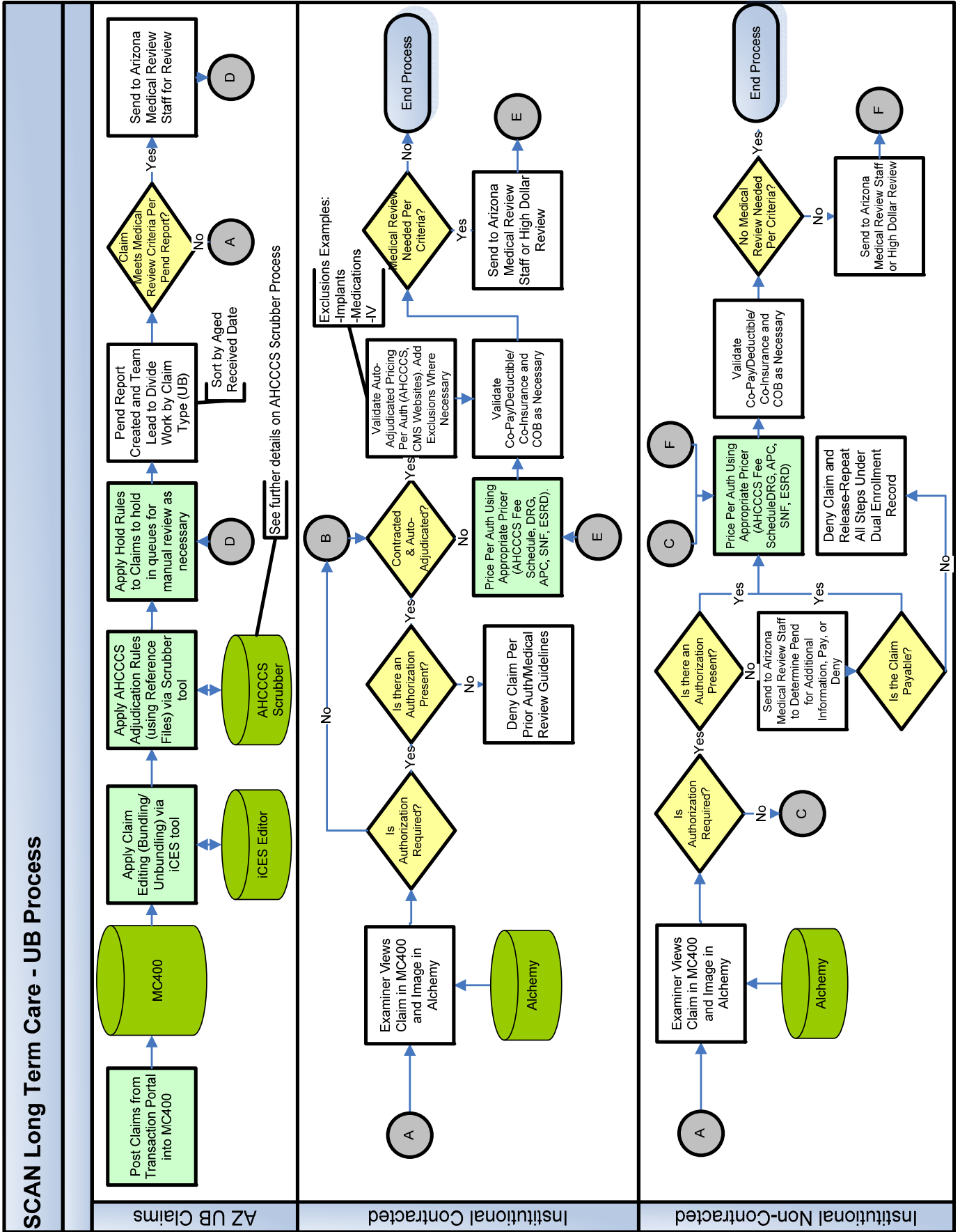
SCAN embarked on the CSI Project in 2008 to improve claims efficiency, accuracy and compliance. This two-year comprehensive initiative has introduced more than forty improvements to the claims, medical management and customer service modules of our healthcare information systems and inter-related departmental processes. Many of the resulting process improvements have been weaved throughout this narrative as established processes and are reflected in the flowcharts included with this response.

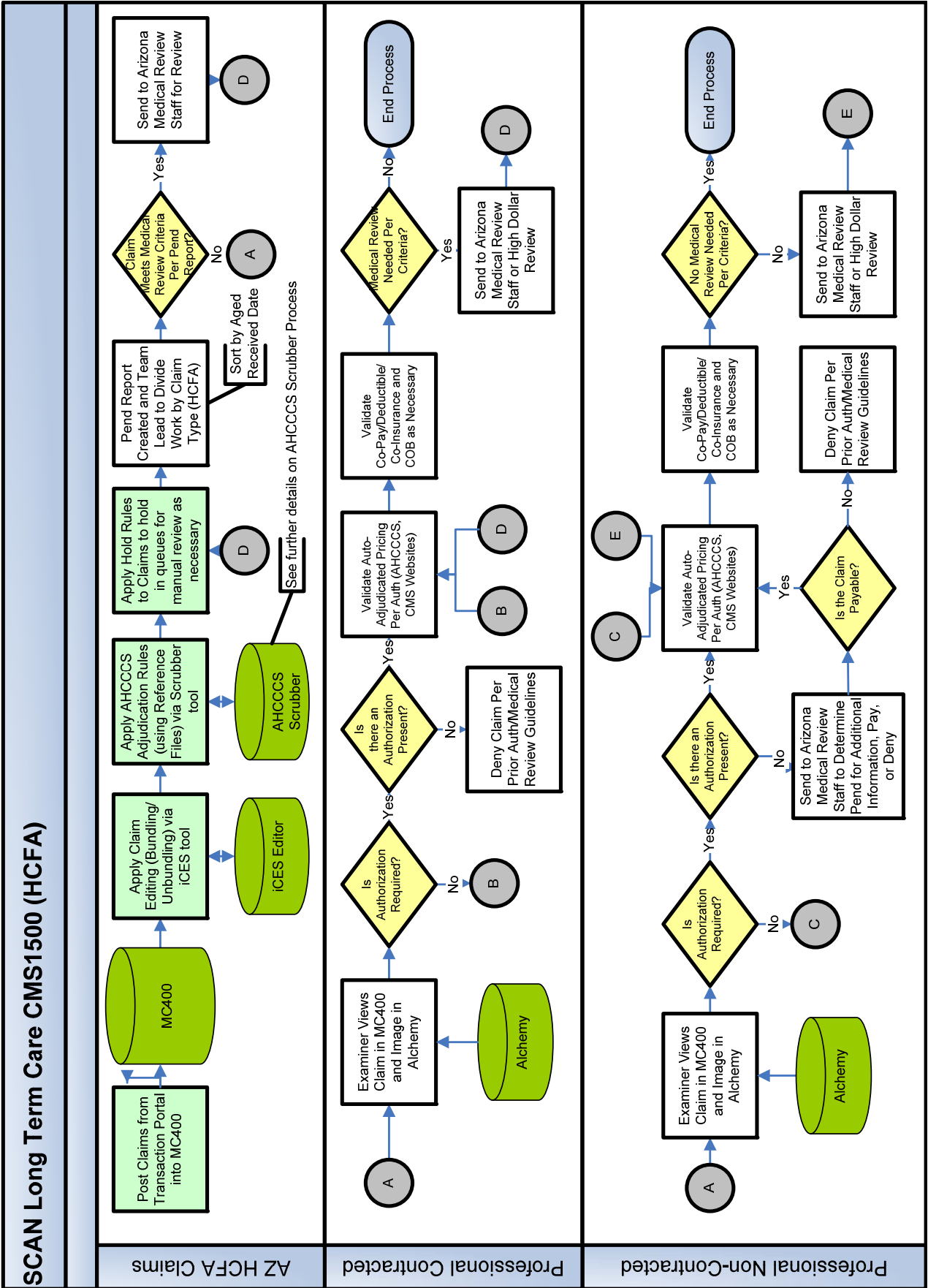
SCAN has exerted significant man hours and expense to remediate its healthcare information systems and related processes to evolve SCAN's claims adjudication/payment system and more fully automate AHCCCS requirements. CSI Project implementation has been completed over the course of the last two years, with the final project phase improvements being in production as of March 27, 2011. Some enhancements include: increased EDI submission rate; COB automation for dual member claims; AHCCCS reference file edits; reporting improvements; automated code set loading and improved OCR quality and read rate. Additionally, our process improvement teams are currently active on an implementation of an upgrade to V5010 and ICD10 planning and design.

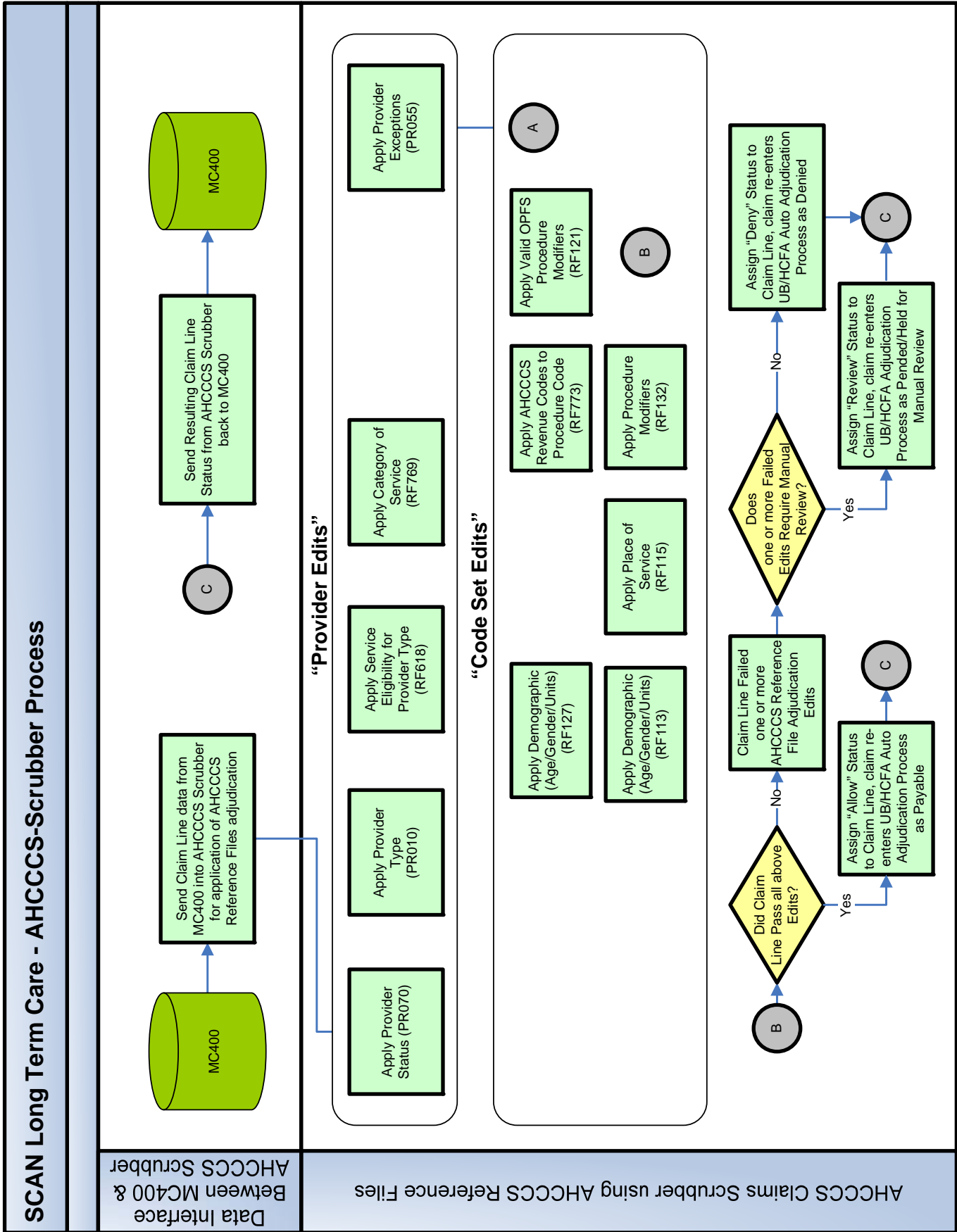
While SCAN is confident this CSI Project has resulted in significantly improved efficiency, accuracy and compliance, it will continue to seek additional process improvements that reduce healthcare and administrative costs.

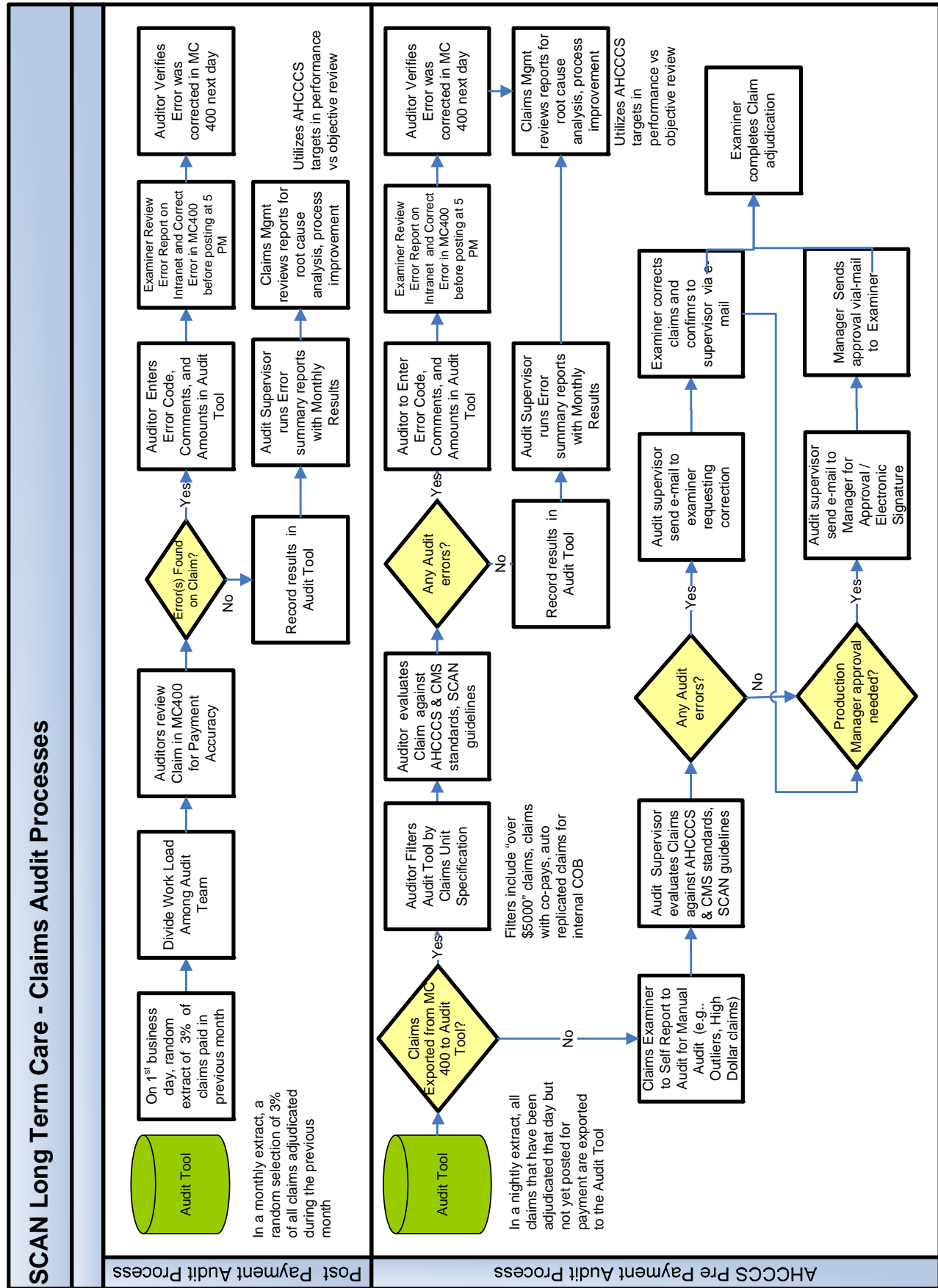





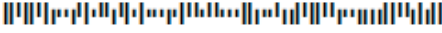










Remittance Advice (page 1 of 3)

<p>3800 KILROY AIRPORT WAY    <b>SCAN Health Plan</b>          3800 Kilroy Airport Way, Ste 100          Long Beach, CA 90806</p>	<p><b>Forwarding Service Requested</b></p> <p>511 1.8970 AT 0.479      3-DIGIT 850</p>  <p>MGA HOME HEALTHCARE, LLC      5          2800 N 44TH ST          SUITE 600          PHOENIX, AZ 85008-1552</p>	<p><b>Company:</b> 3  <b>Vendor No.:</b> 0000000007  <b>Vendor Name:</b> MGA HOME HEALTHCARE, LLC  <b>Tax ID No.:</b> [REDACTED]  <b>Check Number:</b> 919305  <b>Check Date:</b> 03/14/2011</p>
--	--	--

If you have any questions regarding claim payments, please contact a Claims Customer Service representative at (877) 235-7226 (toll-free).

 3800 KILROY AIRPORT WAY SUITE 100, PO BOX 22616 LONG BEACH, CA 90806	<p><small>U.S. BANK 633 WEST FIFTH STREET, LOS ANGELES, CA</small></p> <p>96-3582 1222</p>	<p><b>CHECK DATE: 03/14/2011</b>  <b>CHECK NO.: 919305</b></p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;"><b>AMOUNT</b></td> </tr> <tr> <td style="text-align: center;"><b>\$** 1,330.00</b></td> </tr> </table> <p><b>VOID AFTER 90 DAYS</b></p>	<b>AMOUNT</b>	<b>\$** 1,330.00</b>
<b>AMOUNT</b>				
<b>\$** 1,330.00</b>				


<p><b>PAY One Thousand Three Hundred Thirty Dollars</b></p> <p><b>TO THE ORDER OF</b>      <b>MGA HOME HEALTHCARE, LLC</b>          2800 N 44TH ST          SUITE 600          PHOENIX, AZ 85008</p>	
--	---

Remittance Advice (page 2 of 3)

20130115190

Retain for your records.

**Company:** 3  
**Vendor No.:** 0000000007  
**Vendor Name:** MGA HOME HEALTHCARE, LLC  
**Tax ID No.:** [REDACTED]  
**Check Number:** 919305  
**Check Date:** 03/14/2011


  
**HEALTH PLAN**

**Medical Claim Detail**

Procedure/ HCFCS/ REV Code	Modifier	Billed Units	Billed Amount	Final Billed Amount	Allowed Amount	COB Paid Amount	Covered Amount	Deductible/Coinsurance/ Co-payment	Write-off Amount	Paid Amount	Remark Code
2800N 44TH ST, PHOENIX, AZ 85008											
<b>Provider: MGA HOME HEALTHCARE LLC    Provider ID: 092315</b>											
<b>Member:</b> [REDACTED]			<b>Member #:</b> [REDACTED]	<b>Claim #:</b> 17686796			<b>Patient Account #:</b> [REDACTED]		<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>	
01/30/2011	G0154	004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A
			<b>Claim Totals:</b>	109.93	109.93	95.00	0.00	0.00	14.93	95.00	
<b>Member:</b> [REDACTED]			<b>Member #:</b> [REDACTED]	<b>Claim #:</b> 17686709			<b>Patient Account #:</b> [REDACTED]		<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>	
02/01/2011	G0154	004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A
02/02/2011	G0154	004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A
02/03/2011	G0154	004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A
02/04/2011	G0154	004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A
02/05/2011	G0154	004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A
			<b>Claim Totals:</b>	531.65	475.00	0.00	0.00	0.00	56.65	475.00	
<b>Member:</b> [REDACTED]			<b>Member #:</b> [REDACTED]	<b>Claim #:</b> 17686787			<b>Patient Account #:</b> [REDACTED]		<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>	
01/30/2011	G0154	004	109.93	109.93	95.00	0.00	95.00	0.00	14.93	0.00	0A,DA
01/31/2011	G0154	004	100.93	100.93	95.00	0.00	95.00	0.00	5.93	0.00	0A,DA
			<b>Claim Totals:</b>	210.86	190.00	0.00	190.00	0.00	20.86	0.00	
<b>Member:</b> [REDACTED]			<b>Member #:</b> [REDACTED]	<b>Claim #:</b> 17686790			<b>Patient Account #:</b> [REDACTED]		<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>	
02/01/2011	G0154	004	100.93	100.93	95.00	0.00	95.00	0.00	5.93	0.00	0A,DA
02/02/2011	G0154	004	100.93	100.93	95.00	0.00	95.00	0.00	5.93	0.00	0A,DA
			<b>Claim Totals:</b>	201.86	190.00	0.00	190.00	0.00	11.86	0.00	
<b>Member:</b> [REDACTED]			<b>Member #:</b> [REDACTED]	<b>Claim #:</b> 17686793			<b>Patient Account #:</b> [REDACTED]		<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>	

Remittance Advice (page 3 of 3)

Procedure/ Date	HPCS/ REV Code	Modifier	Billed Units	Billed Amount	Final Billed Amount	Allowed Amount	COB Paid Amount	Non Covered Amount	Deductible/Coinsurance/ Co-payment	Write-off Amount	Paid Amount	Remark Code	
02/03/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
02/04/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
02/05/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
<b>Claim Totals:</b>				302.79	302.79	285.00	0.00	0.00	0.00	17.79	285.00		
<b>Member:</b> [REDACTED]				<b>Member #:</b> [REDACTED]		<b>Claim #:</b> 17686706	<b>Patient Account #:</b> [REDACTED]	<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>				
02/01/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
<b>Claim Totals:</b>				100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00		
<b>Member:</b> [REDACTED]				<b>Member #:</b> [REDACTED]		<b>Claim #:</b> 17686799	<b>Patient Account #:</b> [REDACTED]	<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>				
01/30/2011	G0154		004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A	
<b>Claim Totals:</b>				109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00		
<b>Member:</b> [REDACTED]				<b>Member #:</b> [REDACTED]		<b>Claim #:</b> 17686712	<b>Patient Account #:</b> [REDACTED]	<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>				
02/01/2011	G0154		004	109.93	109.93	95.00	0.00	0.00	0.00	14.93	95.00	0A	
02/05/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
<b>Claim Totals:</b>				210.86	210.86	190.00	0.00	0.00	0.00	20.86	190.00		
<b>Member:</b> [REDACTED]				<b>Member #:</b> [REDACTED]		<b>Claim #:</b> 17686703	<b>Patient Account #:</b> [REDACTED]	<b>Received Date:</b> 02/16/2011	<b>Bill Type:</b>				
02/04/2011	G0154		004	100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00	0A	
<b>Claim Totals:</b>				100.93	100.93	95.00	0.00	0.00	0.00	5.93	95.00		
<b>Provider Totals:</b>				1,879.74	1,879.74	1,710.00	0.00	380.00	0.00	169.74	1,330.00		
<b>Location Totals:</b>				1,879.74	1,879.74	1,710.00	0.00	380.00	0.00	169.74	1,330.00		
<b>Vendor Totals:</b>				1,879.74	1,879.74	1,710.00	0.00	380.00	0.00	169.74	1,330.00		
<b>Remark Codes</b>				<b>Description</b>									
0A				Charges exceed contracted/Legislated fee agreement and/or payment reflects COB w/primary carrier									
DA				Denied - Service Not Authorized									

**Right for Claims Dispute:**  
If you believe the determination on any claim is incorrect, you have the right to dispute the claim. The dispute will be reviewed by parties not involved in the initial determination. All claim disputes must be filed in writing with an explanation of the legal and factual basis for the dispute 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. Once completed the claim disputes may be mailed or hand delivered.  
SCAN Long Term Care  
1313 E. Osborn Rd., #150  
Phoenix, AZ 85014



### Requirement 8: Promoting and Advancing EDI and EFT

SCAN Long Term Care (SCAN) continually looks for ways to improve efficiency improvements in its healthcare information system and the electronic exchange of information that will add value to our providers, reduce operating costs and ensure the integrity and security of data. Maintaining a system that leverages technology to eliminate paper transactions and minimize manual intervention in claims submission and payment also reduces errors and rework. Promoting electronic data interchange (EDI) for claims submissions and electronic funds transfer (EFT) for claims payment takes more than having an existing relationship with providers. SCAN must also interface with vendors who have strong, reliable and secure systems and support user friendly options for both practitioner and facility providers.

#### *Promoting Electronic Data Interchange (EDI)*

SCAN currently contracts with Office Ally for all Electronic Data Interchange (EDI) transactions. This arrangement has allowed SCAN to:

- Offer a free EDI option to providers regardless of size (providers can either submit an 837I or 837P directly to Office Ally or use the Office Ally online claim screens to submit their claims and manage their receivables)
- Work with Office Ally to apply clean claim edits consistently to all providers submitting electronically and establish member selection rules and procedures to streamline the adjudication of dually enrolled members
- Provide an electronic claim status solution and offer an attachment solution to give providers an electronic mechanism to submit medical records

In addition to the above, SCAN established regular data exchange and updated procedures with Office Ally and now provides Office Ally with the entire provider database so that:

- Providers submitting to Office Ally or any clearinghouse that redirects their claims to Office Ally would not have to first obtain SCAN approval for EDI transmissions
- Office Ally is able to utilize the most current AHCCCS-rendering provider requirements for claims that require a rendering provider

SCAN has an established presence on the SCAN Health Plan Web portal home page that links providers directly to Office Ally. This Web site promotes the benefits of submitting claims electronically, including reduction of payment errors and data entry errors; early access to claims status (not available for paper claims); lower administrative handling and postage costs; and free EDI submission through Office Ally.

*SCAN Insights*, our Arizona provider newsletter has regularly published articles on how to submit claims using EDI. We will continue to use this avenue to market our EDI solution to our providers.

Furthermore, since October 2010, whenever a paper claim is rejected as a result of clean claim edits the first paragraph in the reject letter states:

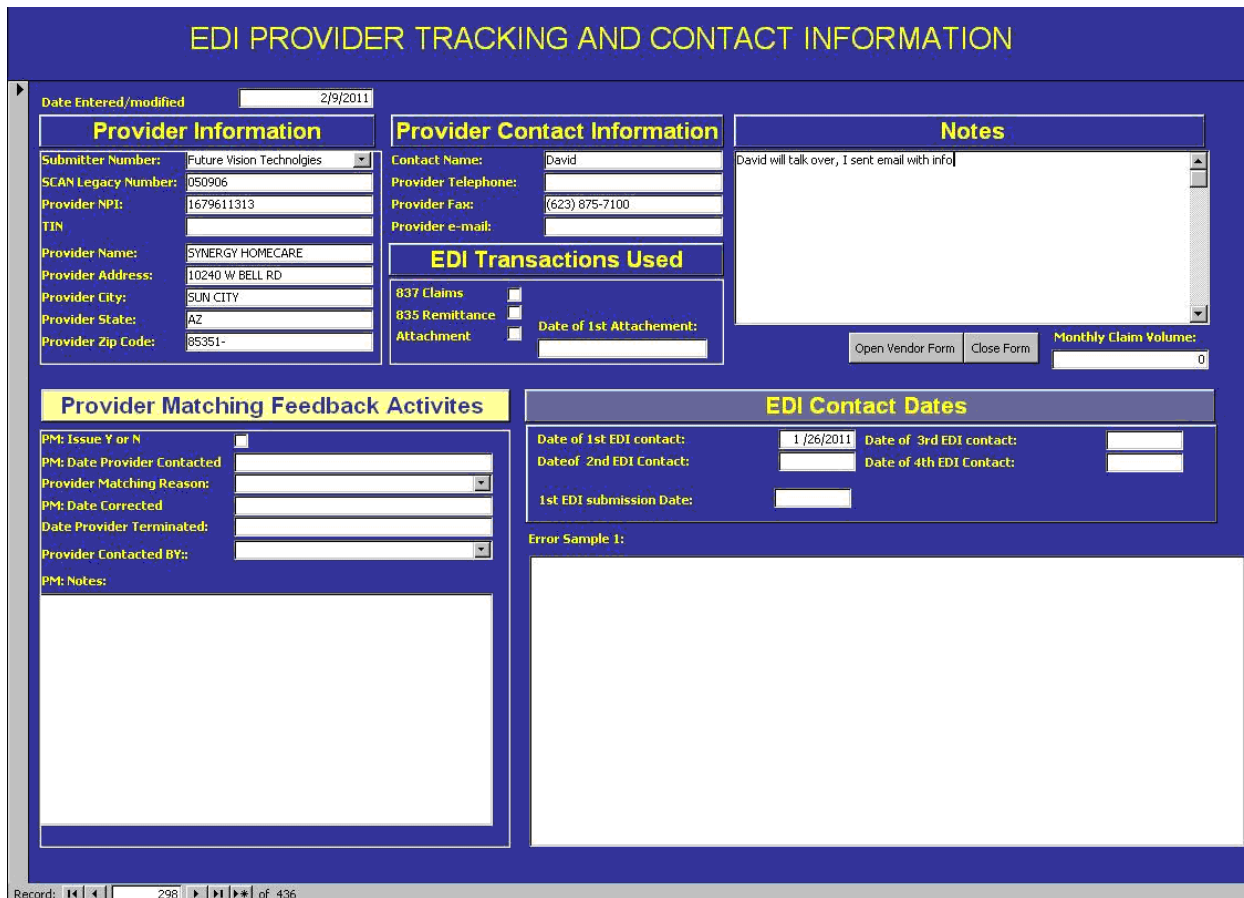
“We encourage you to submit your claims electronically through our preferred clearinghouse - Office Ally. Electronic claims are processed faster and more accurately than paper claims. If you need to submit paper claims, you MUST use the standard UB-04 or 1500 claim form.”

Response to these promotions is captured from claims data in the MC 400, reported each month in the ALTCS Claims Dashboard, and reviewed regularly by Claims Management in order to ensure progress is being made.

SCAN also has an initiative to place an EDI message encouraging providers to submit electronically on all remittance advices beginning April 1, 2011.

## Tracking EDI

SCAN has developed a database to track all outreach activities, along with call scripts, and has assigned staff to the effort works to convert paper submitters to electronic submission. The following page shows a snapshot of the database used.



**EDI PROVIDER TRACKING AND CONTACT INFORMATION**

Date Entered/modified: 2/9/2011

Provider Information	Provider Contact Information	Notes
<b>Submitter Number:</b> Future Vision Technologies <b>SCAN Legacy Number:</b> 050906 <b>Provider NPI:</b> 1679611313 <b>TIN:</b> <b>Provider Name:</b> SYNERGY HOMECARE <b>Provider Address:</b> 10240 W BELL RD <b>Provider City:</b> SUN CITY <b>Provider State:</b> AZ <b>Provider Zip Code:</b> 85351-	<b>Contact Name:</b> David <b>Provider Telephone:</b> <b>Provider Fax:</b> (623) 875-7100 <b>Provider e-mail:</b> <b>EDI Transactions Used</b> 837 Claims <input type="checkbox"/> 835 Remittance <input type="checkbox"/> Attachment <input type="checkbox"/> <b>Date of 1st Attachment:</b>	David will talk over, I sent email with info

Open Vendor Form Close Form Monthly Claim Volume: 0

Provider Matching Feedback Activities	EDI Contact Dates
<b>PM: Issue Y or N</b> <input type="checkbox"/> <b>PM: Date Provider Contacted</b> <b>Provider Matching Reason:</b> <b>PM: Date Corrected</b> <b>Date Provider Terminated:</b> <b>Provider Contacted BY:</b> <b>PM: Notes:</b>	<b>Date of 1st EDI contact:</b> 1/26/2011 <b>Date of 3rd EDI contact:</b> <b>Date of 2nd EDI Contact:</b> <b>Date of 4th EDI Contact:</b> <b>1st EDI submission Date:</b> <b>Error Sample 1:</b>

Record: 298 of 436

With the coordinated effort described above, SCAN will continue to build awareness of the benefits of EDI claim submissions to providers and make every effort to convert providers to submitting claims this way.

### *Promoting Electronic Funds Transfers (EFT)*

SCAN will use strategies similar to those used for promoting EDI transactions to promote EFT. Provider outreach and education materials will be developed that explain the benefits of EFT, including faster access to funds, improved provider staff efficiencies and less processing time than mailed paper checks. We will also highlight the ease with which a provider can be enrolled in the EFT process.

SCAN is committed to and has taken positive steps to promote the use of EFT throughout the provider network. In May of 2010, Network Management conducted a survey of 342 assisted living homes and centers, asking if they had interest in obtaining payment through EFT. Approximately 109 providers responded. Of these, 77 percent stated that they would be interested in EFT. Since that time, Network Management has identified SCAN network providers currently on EFT with other plans and has further identified a small population of “partner providers” willing to enroll on EFT quickly, for testing purposes.

SCAN Network Management Services has developed training and materials that highlight the ease with which a provider may enroll in the EFT payment process. These provider outreach and education materials have been developed to explain the benefits and value of using the EFT process, including faster

access to funds, improved provider staff efficiencies and increased security. *SCAN Insights*, our provider newsletter, and provider visits by Network Management representatives will also be used to directly encourage participation in the EFT process. EFT enrollment forms and additional educational materials will be posted on the SCAN Provider Web site. Providers will also receive a similar messaging posted on the claims remittance advice.

### *Advancing EDI and EFT*

SCAN supports AHCCCS' commitment to increasing electronic claims submission and is taking several steps to increase participation. SCAN Network Management Services conducts outreach to providers who are submitting paper claims exclusively to determine what, if any, are the barriers to their electronic submission. Providers who are eligible for participation in the Electronic Health Record (EHR) Incentive Program, and whose needs meet the definition of "meaningful use", are directed to contact AHCCCS regarding registration for the program.

Additionally, SCAN is also coordinating a provider outreach opportunity with Office Ally by targeting providers that either submit paper claims or a combination of paper and electronic claims to SCAN. This effort is designed to identify those providers who already submit electronically through Office Ally to other health plans, but not to SCAN. SCAN and Office Ally will initiate an outreach effort to each of the identified providers and encourage them to also submit their claims to SCAN electronically.

### E-SCAN Work Group

SCAN recognizes the priority AHCCCS has given to implementing efficiencies that streamline administrative processes for itself and contractors in its Five Year Strategic Plan for 2012-2016 (Strategy 3.4). SCAN has initiated a cross-functional work group, E-SCAN, to explore the advancement of EDI and EFT, as well as opportunities to increase both utilization and process improvement. Participants of the work group include Network Management Services, Claims and Healthcare Informatics. In addition, we will engage network providers, as primary stakeholders, in identifying advancement opportunities and evaluation criteria.

The objectives of this work group are to

- Identify barriers to provider participation
- Analyze alternative solutions to address these barriers
- Support the implementation of cost-effective processes, tools and training
- Monitor and report the results of the activities to senior management and the provider network

For example, SCAN recognizes that barriers exist to being able to participate in electronic exchange due to lack of technology and training. There may also be reservations regarding the disclosure of financial account information to third-party vendors. As solutions are identified, SCAN will seek input from our EDI and EFT vendors, as appropriate, for the efficacy of implementing interfaces with their processes.

SCAN has already begun to identify some alternative solutions that will be studied by the work group. For example, SCAN will look at the cost-effectiveness of placing computer equipment and billing software in facilities that currently are submitting claims manually. Additionally, SCAN will examine ways to incentivize providers to participate in both EDI and EFT. For example, SCAN would like to share administrative cost savings with providers who fully participate in both EDI claims submission and EFT claims payment if they meet defined performance measures for completeness, timeliness, and accuracy.

SCAN will disclose to AHCCCS the information on any incentive plan upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or the Centers for Medicare and Medicaid, and will seek AHCCCS approval of any provider performance incentive plan prior to implementation.

## *Requirement 9: Clinical and Data Edits*

---

### *Clearinghouse Edits*

Prior to SCAN Long Term Care (SCAN) receiving an EDI claim, SCAN's preferred clearinghouse partners perform standard EDI ANSI level 1-5 validation which includes file syntax validation, balancing, and code set validations. These edits support the AHCCCS required edits for data accuracy. Any claims that fail to pass these validations are rejected back to the provider by the clearinghouse for correction and resubmission.

### *Transaction Portal (TP)*

SCAN applies front-end edits to ensure only "clean claims" are accepted and has the ability to accept, edit, and reject HIPAA mandated ANSI v4010A1 837 professional and institutional claim transactions based on configurable electronic data interchange (EDI) business rules. These business rules include edits implemented at SCAN's preferred clearinghouse partners and front-end clean claim edits that are applied in SCAN's EDI front-end application, Transaction Portal (TP) to ensure that submitters correctly complete the required claims fields for a payer to process a professional and institutional claim transaction. The following front-end edits are applied for or by SCAN.

#### Clean Claim Edits

These edits are based on the HCFA and UB paper claim box fields. These edits validate that the required fields of an EDI 837 claim are populated in addition to the minimum required fields to process a claim in the core processing system, MC400. Some fields, e.g. national provider identifier (NPI), are only required for certain bill types or types of claims. Additionally, the clean claim edits validate the HCPCS, diagnosis, POS, type of bill, and condition codes.

There is currently one set of clean claim edits in TP consisting of approximately 50 HCFA and 65 UB edits. The edits are highly configurable, with each individual edit having the ability to be configured to be turned on/off as well as having the ability to turn on/off the entire set of clean claim edits based on claim submitter or line of business. Claims that fail the clean claim edits will be rejected back to the submitter via an electronic claims status or claim reject letter depending on whether the original claim was submitted via EDI or paper. Clean claim edits support the AHCCCS requirement for edits for data accuracy.

#### Member Validation

The member data listed on an inbound claim is validated against the MC400 member database to ensure the member is a valid SCAN member. This validation contains a "waterfall" of validations, where if a member fails the first edit based on certain criteria, the member will be validated against the next edit until all scenarios are evaluated. A claim can be rejected for member not eligible on date of service or member not found. Member validation edits support the AHCCCS requirement for edits for member eligibility and enrollment.

#### Provider Validation

The provider listed on an inbound claim is validated against MC400 provider database, using robust criteria to correctly identify the provider. The matching criteria includes common identifiers such as NPI, provider name, provider address, provider state, and Medicaid identification number, which are applied in a "waterfall" of validations, including secondary validations to ensure the correct provider is selected. Provider validation edits support the AHCCCS requirement for edits for provider qualification.

### *Code Bundler Software*

The Ingenix Claims Editing System® (iCES) clinical claims editing software is used to identify claims that are submitted to SCAN with incorrect information, supporting the AHCCCS requirements for edits for data accuracy and adherence to AHCCCS policy. Both professional and facility claims are edited against CMS, CCI, and industry standard billing guidelines to ensure the accuracy of the provider's coding practices. SCAN's AHCCCS claims are subject to a subset of edits separate from other lines of business to enable the claims to be considered by only AHCCCS compliant edits.

The edits applied by iCES span a range of coding categories: AHCCCS claims billed by providers with invalid or incorrect procedure codes, diagnosis codes, and/or modifiers, and invalid service frequencies/combinations, among other incorrect billing practices, are not paid. Claims with multiple or bilateral procedures performed may have their payment appropriately reduced according to industry standard guidelines, enabling SCAN to support AHCCCS' cost avoidance initiatives. A few examples of these edits are listed below:

- Non-specific diagnosis code: This edit identifies claim line that contains a diagnosis code that requires a 4th or 5th digit for appropriate specificity.
- Modifier 26 required: This edit identifies claim lines that do not contain modifier 26 (professional component) for a procedure with a professional component / technical component split that was performed in an inpatient hospital, emergency room or other outpatient place of service.
- Procedure not typical with patient gender: This edit identifies claim lines with procedures that are considered not typical for the patient's gender.
- Multiple procedure reductions: This edit identifies claim lines where there are two or more procedures subject to a multiple reductions for the same date of service and by the same physician. These claims will be reviewed to determine if one of the procedures is subject to a payment reduction.
- Inappropriate bilateral procedure: This edit identifies the situation where an exclusively conditional bilateral code is reported more than once for the same date of service and all or some of these codes have a modifier of 50. This edit also identifies inherently bilateral procedures that are billed on more than one line. This edit does not apply to independently bilateral or non-bilateral services. This is an example of an edit that supports the AHCCCS requirement for edits in the area of overutilization standards.

### *AHCCCS Adjudication Rules Project*

The AHCCCS adjudication rules application applies a series of data related edits driven off of the provider and reference files provided directly from AHCCCS. This editing is specific to AHCCCS, and improves SCAN's performance against service level agreements for claim processing and encounter submission accuracy. The AHCCCS adjudication rules fall into one of three categories and are applied in sequence according to the rule category.

#### *Provider*

The Provider edit rules represent the first series of edits that an ALTCS claim passes through during adjudication and is driven off of the provider files produced weekly by AHCCCS. These edit rules validate provider information such as AHCCCS enrollment status, and that any services submitted are eligible for reimbursement based on the specific provider and provider type.

#### *Code Set*

The code set rules represent the second series of edits that are applied and are based on the reference files provided by AHCCCS at the beginning and middle of the month. These edits validate that the procedure codes on the claim have been submitted in conjunction with the appropriate information such as bill type, place of service, and modifiers. These edits also determine if the services submitted on the claim are

eligible for reimbursement based on the member's demographic information such as age and gender. These code set edits support the AHCCCS requirement for edits for data accuracy and adherence to AHCCCS policy.

#### Other Encounter

These edits are the final series of edits to be applied. The AHCCCS provider and reference files do not drive these rules; instead, these rules are developed based on other forms of AHCCCS guidance and compare data elements on the claim itself to determine reimbursement eligibility. For example, one of these rules validates that the admit source submitted on the claim is relative to the admit type.

## *Requirement 10: Encounters Submissions Process*

---

In support of the AHCCCS initiatives for error free efficient processing, SCAN Long Term Care (SCAN) has developed a tested and documented infrastructure to meet the needs of the AHCCCS encounters submission process. SCAN has exceeded the pend rate requirements from AHCCCS five of the past ten months and, importantly, has demonstrated an improving rate of success month after month. Further, SCAN has exceeded all AHCCCS encounter submission requirements as of March 2011. As a result of the tested and documented process improvement and infrastructure, SCAN expects to consistently exceed these targets moving forward. SCAN's strategy is to continue strengthening our processes and workflow to sustain this performance.

### *Encounter Submissions*

#### Overview

SCAN's encounter data submission process begins with claims being processed and finalized in the MC400 claim processing module of the healthcare information system (MC400). The data from the MC400 is replicated real-time into a data warehouse (Claims DW). This data is utilized for many purposes including AHCCCS encounter submission. Additionally, Pharmacy claim data is also received weekly from SCAN's Pharmacy Benefit Manager, Express Scripps, Inc (ESI) and stored into the Claims DW. SCAN's Vice President of Healthcare Informatics (HCI) is responsible for the encounter submission process. The SCAN Arizona Encounter Extraction (SAEE) process extracts data from the Claims DW and transforms it into encounter data in the appropriate EDI file formats. To support this process, SCAN utilizes Medical Data Express (MDE) software for encounter file generation and AHCCCS encounter pend and denial management.

#### Extraction

The SAEE process currently runs the week before the first AHCCCS monthly adjudication cycle. Ad-hoc resubmits of remediated encounters are also run in the middle of the month for submission into the second AHCCCS encounter adjudication cycle. This process extracts all claims from the Claims DW that have been finalized since the last time the SAEE was run. The data is loaded into the encounter tracking database (ETD), thus ensuring there is a permanent link between the claim and the encounter data from which all billed, allowed, paid, coordination of benefits, co-pay charges and adjustments can be directly retrieved. Claims eligible for extraction as encounter data include all original, adjusted and prior-period claims for fee-for-service and case-rate contracts. Understanding AHCCCS requirements, SCAN takes care to only include adjustments to claims resulting from SCAN's internal review processes, an identified error from AHCCCS, or information from a provider. Finally, SCAN will only include finalized claims meeting the following criteria (1) claim is in a final payment status, (2) claim has a positive paid amount or other insurance paid amount, and (3) claim has been denied for other than administrative reasons or has an adjustment reason code. These many edits ensure accurate submission of valid encounters.

#### File Generation

Once the encounter data has been extracted, SCAN utilizes MDE's Xpress Pro software to generate the required ANSI X12 837 and NCPDP files. This process delivers the files to SCAN's FTP server, SCAN's Information Technology (IT) department then transfers the files to the AHCCCS' SFTP server. All file transfers are closely tracked by the Healthcare Informatics Encounter Data Team (HCI Encounter Team) in a File Submission Tracking Spreadsheet (Submission Tracking Sheet). Each batch, filename, submission date and reason are noted, and as response files are generated by AHCCCS, the HCI Encounter Team updates the Submission Tracking Sheet confirming 997 receipt, 824 receipt, and PMMIS file loading. Any anomalies, such as files not receiving an 824 receipt or a file not displaying as loaded in PMMIS are immediately escalated to the Manager of the HCI Encounter Team. The issue is entered in

the Submission Tracking Sheet, the issue is researched and resolved, or escalated to AHCCCS Technical Support for assistance in resolution.

### Monitoring

As soon as they are made available, all AHCCCS encounter submission reports from TI Portal and PMMIS are pulled by SCAN IT via SFTP, deposited on an internal file system for processing by the HCI Encounter Team. The HCI Encounter Team runs the SAEE to extract, transform, and log the data from the AHCCCS encounter submission reports to the ETD. All report responses from AHCCCS, including 824 and 277U files, are used to status and track each encounter on its journey from the MC400 through final approval in PMMIS.

### *Timeliness*

SCAN tracks encounter submission to ensure all finalized claims are sent to AHCCCS within 240 days after the end of the month in which the services on the claim were rendered. Starting in March 2011, SCAN began an encounter/claim reconciliation process that includes actionable discrepancy reporting for Encounter Analysts in the HCI, Claims, Pharmacy, and Network Management departments (Encounter Analysts). This process, initiated after each submission cycle, ensures SCAN is aware of any claims that may have not been appropriately extracted for encounter submission so action can be taken before the 240 day window elapses. Over time, SCAN has worked diligently to improve the PMMIS approved encounter rate within this 240 day window. As such, SCAN has improved from 61.3 percent of encounters approved within the 240 day window in contract year 2007, to 88.4 percent in contract year 2009, and most recently, SCAN has reported 96.5 percent encounters approved within the 240 day window in contract year 2011.

### *Accuracy and Completeness*

In addition to editing the process for newly finalized claims that are extracted as encounters by the SAEE, SCAN also proactively monitors existing pended and denied encounters and analyzes for remediation. This effort results in: (1) adjustments being made to the claim data in the MC400 and sent to AHCCCS as replacement encounters, or (2) voiding of encounters in PMMIS as a result of incorrect encounter extraction. As per AHCCCS requirements, when SCAN voids an existing encounter in PMMIS, the original encounter CRN, date of the void transaction, identification of the user performing the void, and the specific reason for the void transaction is stored in the ETD. SCAN has substantially remediated pend and denial backlog cleanup within the last two years. In December of 2008, SCAN had a 50 percent pend rate in PMMIS and, as of March 2011, SCAN had an 8.0 percent pend rate in PMMIS. SCAN has diligently worked to improve the PMMIS first-pass pend rate for all encounters. As such, SCAN's tracking of this first-pass pend rate for 2010 data revealed a decline from 7.6 percent in March of 2010 to just 3.4 percent in December 2010.

Over the last two years SCAN has been implementing a Claim Service Initiative (CSI) Project which included several technical and process improvement related releases focusing on data integrity, automation, and accuracy. This includes an AHCCCS Adjudication Rules engine, Ingenix Claims Editing System® (iCES) and Web.Strat™ software, provider file reconciliation with AHCCCS Provider reference files, automated claim split for dual members, and improved claim file EDI validation. Releases already implemented confirm the improvement in SCAN's encounters submissions.

### *Remediation Process*

SCAN strives to ensure that all pended and denied encounters are resolved within 120 days of the original AHCCCS processing date. When the PMMIS cycle adjudication reports are made available by AHCCCS and loaded into the ETD by SCAN's Arizona Encounter Extract process, an internal workflow is initiated. Automated reports are generated by the HCI Encounter Team in SCAN's Encounter Reporting Portal (ERP) and the Encounter Analysts are notified to review and analyze the reports. The ERP includes



detailed reports of pended and denied encounters which provide information for immediate identification and potential remediation of any new encounter issues. Additionally, pend detail files (CL & DTLAGNG) are loaded into MDE's Pend Analyzer tool (Pend Analyzer) to allow for routine and ad-hoc pend remediation by the Encounter Analysts.

When AHCCCS standards are not met due to pend or denied encounters, the Encounter Analysts quickly sort, filter and group pends and denials. Using filtered and sorted data along with Pend Analyzer, PMMIS, and the MC400 claim system, an Encounter Analyst investigates common trends, identifies root causes and/or launches focused remediation efforts. Using these tools, SCAN's analysts focus on pends and denials with the highest impact and oldest age. Once common solutions are found, a team of encounter analysts performs the corrections directly within PMMIS or by adjusting the claim in the MC400. In addition, root cause analysis is performed and remediation occurs as needed in the applicable systems. Data is then reviewed in subsequent months to ensure remediation was successful or if additional remediation is required.

To ensure the highest prioritization for remediation, reinsurance claims are given special attention through detail reporting and dedicated claim examiners within the Claims Department. Each day, members are flagged as potential reinsurance cases within the Claim Audit tool. These members are then compared against the monthly AHCCCS reinsurance case reports, providing the most accurate list of potential reinsurance claims and encounters for follow-up.

All activities for pend and denial remediation are monitored by SCAN management on a continual basis. Summary reports are reviewed, remediation reasons are noted, and trends are examined for process improvement. SCAN's management team often takes opportunities to drive focus on specific remediation efforts, which often includes a priority to aged encounter pends and denials.

### *Trending and Reporting*

The HCI Encounter Team produces several weekly and monthly reports to ensure all activity around AHCCCS encounter processing is reviewable by various levels of SCAN staff including the Arizona CEO, Finance, Compliance, and Operations. These reports are automatically or manually refreshed according to AHCCCS report receipt timeframes and are either available in the ERP or by email from the Manager of the HCI Encounter Team. Additionally, in accordance with the AHCCCS' Encounter Manual for 2011, SCAN has updated the ERP to produce the additional four encounters submission and revision tracking reports for AHCCCS. These reports utilize data contained within the ETD and AHCCCS produced reports (such as the EC9AM report).

An example of SCAN's reporting includes the Weekly Executive Summary Report which is manually produced each Friday by the Manager of the HCI Encounter Team. This report utilizes data from the AHCCCS EC9AM, 277U, CL/DTLAGNG, and TI Portal reports to track monthly statistics of encounter submission and their associated TI Portal success rates, as well as existing pend and denial remediation rates. Thus, SCAN can track on a weekly basis each month's approved, pended, and denied encounter rates. Additionally, this summary report contains a tracking grid of each Pend/Denial and TI Portal rejection reason SCAN has received since the contract year 2007. This tracking grid allows for current problem assessment and prioritization, accurate trending and tracking of remediation efforts. This report is distributed to multiple recipients including SCAN's executive management, claims, encounters and network management teams.

To ensure AHCCCS has complete encounter data from SCAN, as of March 2011, the HCI Encounter Team updated the Encounter Reporting Portal to produce a specialized report that reconciles the MC400 claim data to the encounters approved in PMMIS. This detailed report includes all claim information and applicable encounter statuses. The report can be grouped by contract year, pend/denial reason, provider, or encounter age, among other sorting and filtering bases. The Encounter Analysts, as directed by SCAN management, then analyze various slices of the reconciliation results to focus effort on specific areas of

concern. If there are any discrepancies in this comparison, analysis leads to action similar to the pend and denial remediation process, which will result a root cause analysis, process adjustment if needed and correction to the encounter data.

If, as a result of this reconciliation report and analysis, encounters require resubmission then SCAN first submits the data through AHCCCS' Test environment to preview results and ensure appropriate resolution to the reconciliation issue. Once the test results are approved by SCAN management the data is submitted to AHCCCS for the next production adjudication cycle.

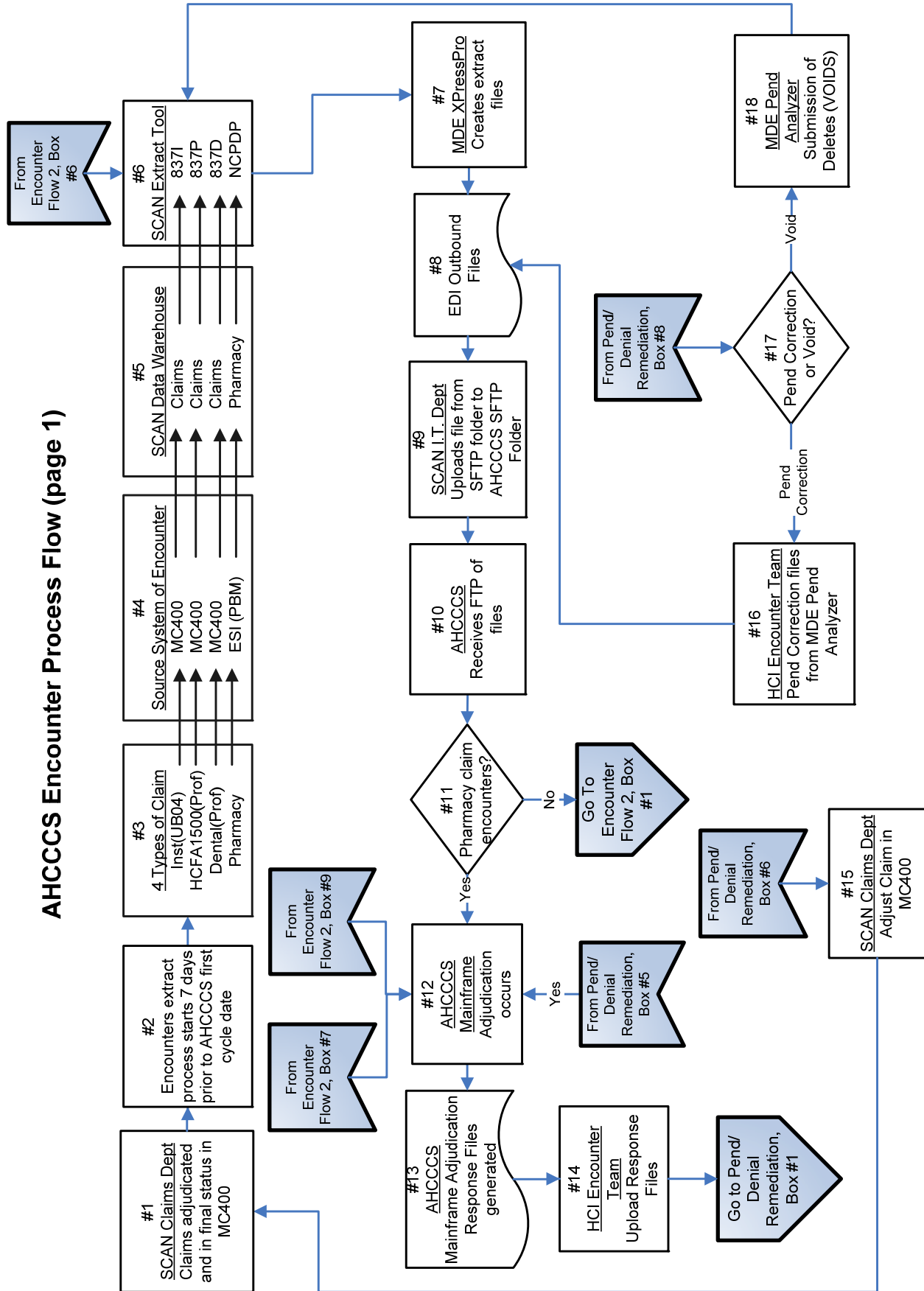
### *Continuous Process Improvement and Feedback Mechanisms*

SCAN was placed on a Notice of Enrollment Sanction on March 31, 2010 by AHCCCS. Encounter performance was cited in the sanction. SCANS' Executive Team responded quickly to this notice and assigned a senior project director to oversee an organizational effort to remedy this situation. The AHCCCS Response Project brought several positives to the relationship between SCAN and AHCCCS, including more frequent technical assist meetings including detailed root cause resolution and system changes. The meetings also gave AHCCCS an opportunity to provide feedback to SCAN about our systems and remediation efforts. Internally, SCAN developed and adhered to a project plan that included weekly executive review and update sessions with the SCAN CEO, Finance, and Compliance. This project not only helped develop operational and structural improvements in relation to AHCCCS claim and encounter processing, but also established a structure for future process improvement projects.

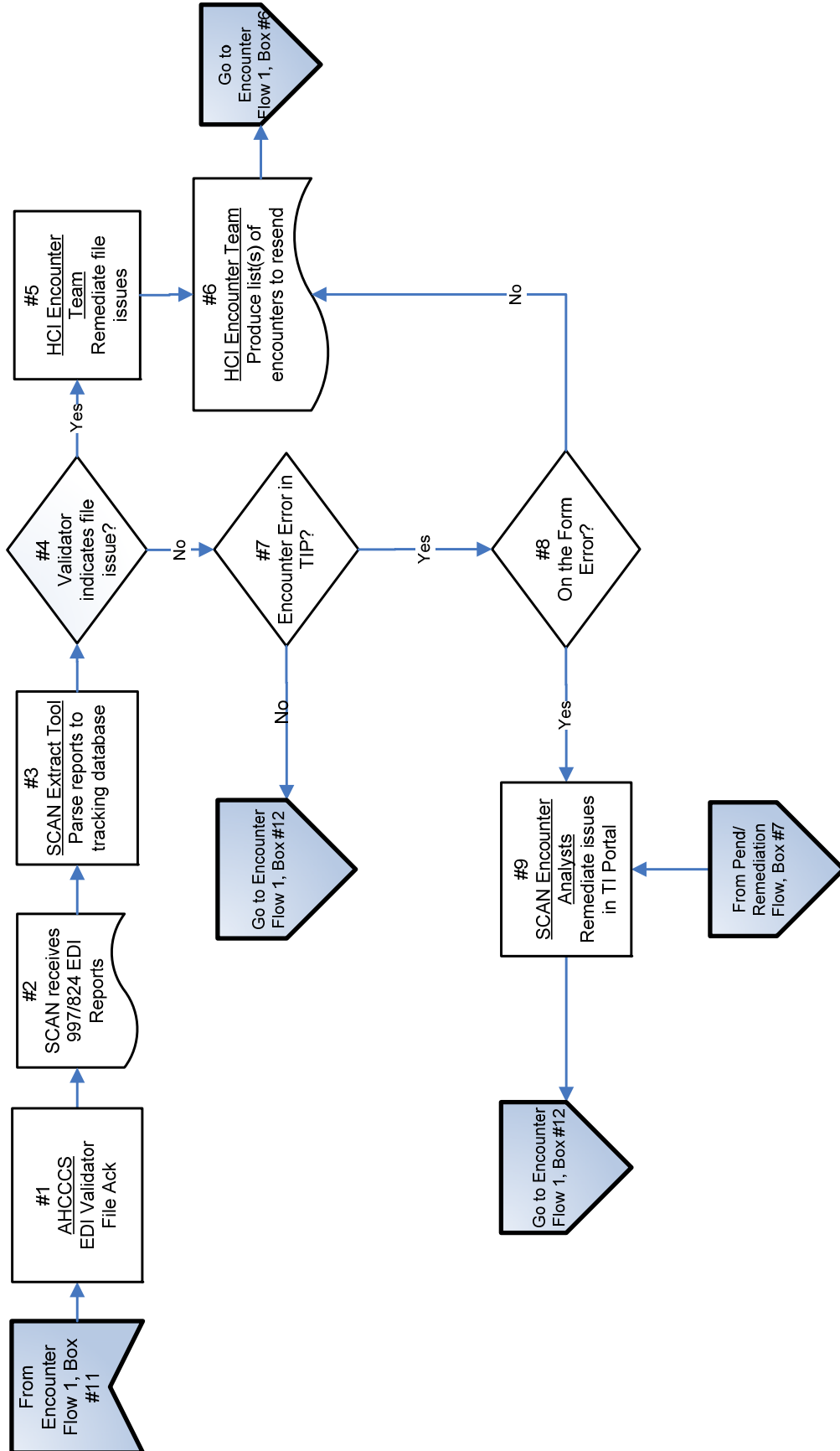
During the AHCCCS Response Project, SCAN developed quality checks providing feedback mechanisms for the encounter and claim adjudication processes. These monthly quality checks include claim audits, validation of provider information against the AHCCCS Reference Files, claim data reconciliation between the MC400 and PMMIS, and encounter pend and denial reason analytics. Results from the quality checks are reviewed for process improvements by SCAN management and then prioritized and implemented by Claims, Network Management, Pharmacy, or Healthcare Informatics staff. In addition, AHCCCS notifications, monthly or quarterly meetings with AHCCCS, and other regulatory compliance guidance, provide information about upcoming changes. The HCI Encounter Team works with SCAN management to prioritize encounter and claim process changes based on these feedback mechanisms. The quality checks, new requirement identification and feed back to management ensures the encounter and reporting systems receive focus and priority.

SCAN's results have proven the merits of these feedback mechanisms with its improved encounter adjudication rates which, as of March 2011, achieved all processing rate requirements, including all TI Portal acceptance rates over 95 percent, a PMMIS approval rate of 76 percent, and a pend rate below eight percent. SCAN's focus remains on submitting complete, accurate, and timely encounter data in accordance with all AHCCCS requirements. SCAN would like to acknowledge the AHCCCS Encounter Unit for their valuable time and technical expertise in assisting SCAN achieve this result.

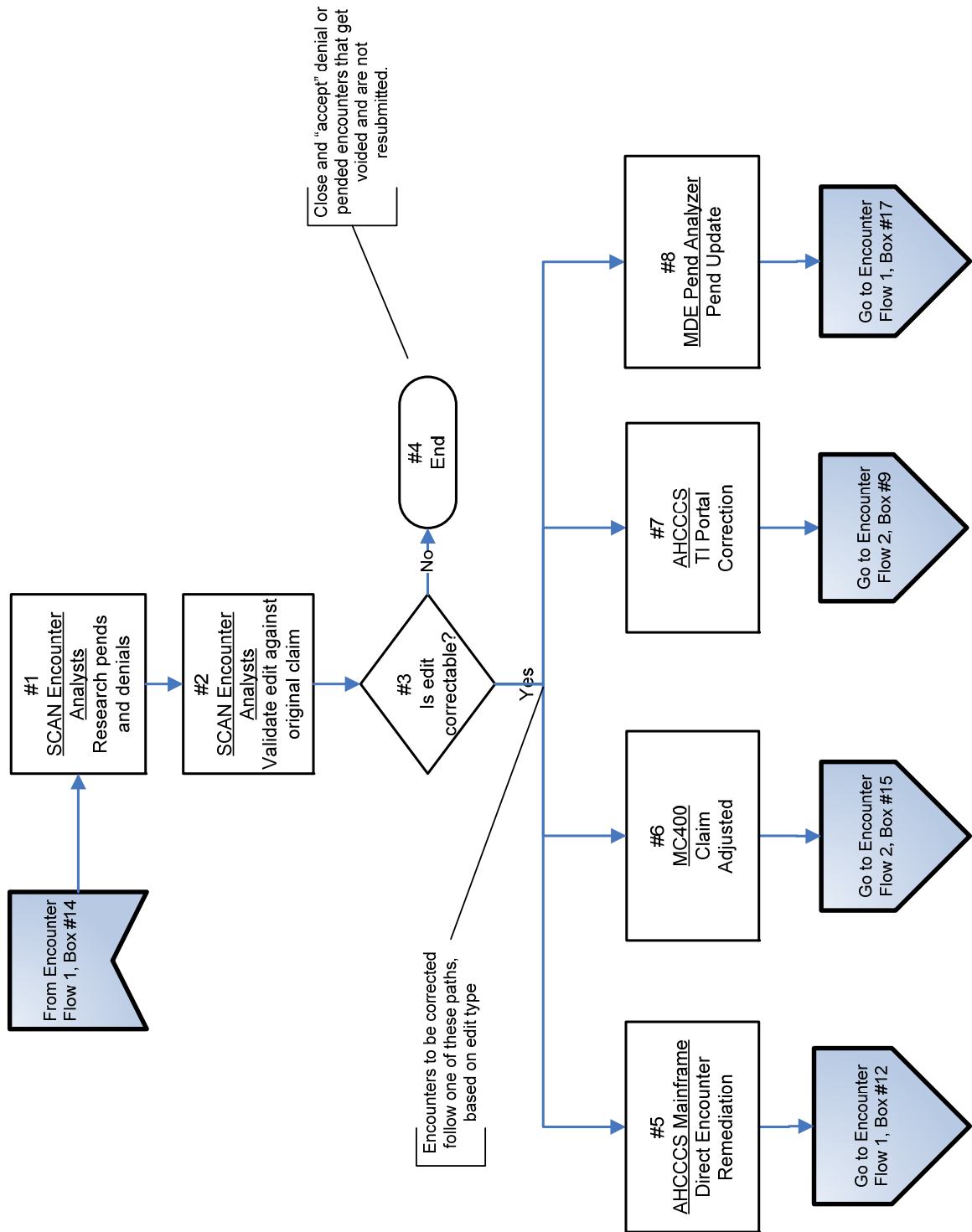
### AHCCCS Encounter Process Flow (page 1)



**AHCCCS Encounter Process Flow (page 2)**



### Pend/Denial Remediation Process Flow



## Requirement 11: Information Services Structure and Support

The Information Technology (IT) vision for SCAN Health Plan and its affiliates, including SCAN Long Term Care (SCAN), is *“to use Information Technology and our subject matter expertise to support business solutions that improves our ability to deliver value to members, caregivers, providers, employees and business partners.”*

### *SCAN IT Organizational Structure*

The IT organization is composed of four (4) primary entities:

- Infrastructure Support
- Systems Administration
- Project Management Office
- Programming Support

The above entities report to the Chief Information Officer at SCAN Health Plan, who reports to the Chief Executive Officer. At SCAN, day-to-day IT functions are managed by a Senior Helpdesk Technician, a full time employee located in Arizona, with access to the IT infrastructure and resources located within SCAN Health Plan. This full time employee coordinates IT activities for SCAN within the IT department and with all other relevant departments.

### Software and Hardware Overview

SCAN is supported by best practices and standardized technologies. Specific systems for SCAN reside in Long Beach, California and are supported by provisions for fail-over recovery and business continuity services. No portion of SCAN Health Plan’s business processes or information technology systems and support is supplied by organizations outside of the United States. All SCAN processing and support is provided by domestic entities.

MC400 forms the “core” of SCAN’s Healthcare Information System (HIS). MC400 has been in use at SCAN Health Plan for nearly nine years, since July 2002. MC400, along with SCAN’s other core systems were in use when AHCCCS awarded SCAN our original ALTCS contract in 2005. These systems were expanded and upgraded to support our new ALTCS line of business.

MC400 processes Provider and Member set-up and maintenance, Provider Capitation (currently SCAN Arizona does not have any capitated contracts in effect) and Claims information – as well as all other data related to the management of these areas (i.e., Provider Contracts, Member Benefits, Claim Payments, etc.). MC400 runs on an IBM AS/400 platform. Healthcare Electronic Data Interchange (EDI) features are supported by way of a separate application, Transaction Portal (a Windows based application) that interfaces to the AS400 for processing of ANSI EDI and other file types. SCAN currently processes AHCCCS ANSI 5010 820 (Premium) and 834 (Enrollment) EDI transactions, as well as, accepting ANSI 4010 837 Electronic Claim Submissions. SCAN implemented the 5010 version transactions with AHCCCS in October 2010.

McKesson CareEnhance® Clinical Management Software (CCMS®) is the source for Medical Management, Case Management, Disease Management, Utilization Management and Prior Authorization information and is managed on a separate Windows server. CCMS® receives MC400 related data via the SCAN Data Warehouse (a central data repository). Similarly, Medical Management data needed by MC400 (i.e., authorizations) is interfaced through the SCAN Data Warehouse to MC400. The SCAN Data Warehouse acts as a central source for reporting, analysis, and other processes.

The SCAN Data Warehouse is a custom built central repository that supports real-time interfaces between systems and is a focal point for other data collection and activity (analysis, reporting, etc.). Data

utilization throughout the company is managed using the Data Warehouse. The Data Warehouse is a grouping of Microsoft (MS) SQL databases where data replicated from core applications and external data resides. Through this Data Warehouse, business users and analysts are provided discrete levels of capability to use the data to suit their business function. Further, this Data Warehouse becomes a repository for other EDI-type functions to SCAN vendors. Data collection from external sources is also maintained in the Data Warehouse, such as pharmacy and encounter data.

SCAN business units also have the ability to create Microsoft® (MS) Access databases for use in reporting, monitoring and tracking various business data and processes. These data bases are stored on the SCAN share drive with security and business continuity oversight.

Security support for local and remote expansion needs is accommodated by way of a template-style approach to ensure standardization. Service areas use local authentication that synchronize with Active Directory at SCAN Health Plan headquarters location in Long Beach, California. Local servers handle unique application needs along with the typical logon authentication, file, and print server tasks. Centralized application needs are handled by way of secure communications across the wide area network (WAN) to the SCAN headquarters location.

At SCAN, Business Continuity, including a Disaster Recovery Plan is an ongoing process to plan, develop, test, and implement changes to processes and procedures that support the recovery of critical information technology functions within the organization in the event of a disaster. A Disaster Recovery Plan (DRP) is used to recover a facility rendered inoperable, including relocating information technology operations into a new location. In 2004 SCAN and First Consulting Group, Inc., collaborated to develop the initial SCAN DRP, which forms a subset of SCAN’s comprehensive Business Continuity Plan. The plan is a living document that evolves as the SCAN systems advance. The testing and validation of the recovery plan is facilitated by the SCAN Internal Audit Team and full scale testing is performed at least once every three years with companywide tabletop tests occurring annually. Iron Mountain and SunGard© are the two vendors which provide backup services and recovery facilities to SCAN respectively. In compliance with our contract with AHCCCS, SCAN submits an annual summary of its Business Continuity and Recovery Plan to AHCCCS.

An information system diagram and data flow diagrams have been included as exhibits at the conclusion of this section.

*Primary Applications*

MC400

MC400		
1	Installed version	2.1
2	Latest version	2.1
3	Healthcare Functions	Provider, Enrollment, Member, Claims
4	Vendor	SCAN owned and managed system
5	Vendor Address	3800 Kilroy Airport Way Long Beach, California 90806
6	Contact Person	Earlene Boyd
7	Hardware	IBM AS/400 iSeries 525
8	Software:	OS/400
9	MC400 support	Edmund Jung & Associates, Inc. 10815 Canoga Avenue Chatsworth, California 91311 Account Manager: Eddie Tang

The MC400 system is a GUI application that has integrated processing and is used for primary back-end application functions for SCAN's ALTCS members. MC400 has been implemented at SCAN since 2002.

MC400 consists of a collection of integrated modules (including, but not limited to, Membership, Enrollment, Group Management, Providers, Claims, Authorization Matching, Benefits, Plans, Coordination of Benefits (COB), Capitation, Premium, Accounts Payable (AP), and Accounts Receivable (AR)). All of these modules are tightly integrated within one Health Information System (MC400) and all reference and cross-reference the same database files and the same business rules within the system. As a result of this integrated systems architecture, the MC400 Health Information System does not need to interface with many disparate systems for data relating to membership, claims, providers, AP, etc.

SCAN Health Plan has developed a custom central repository, the SCAN Data Warehouse, which serves as an intermediary in the exchange of data between systems. Real-time data replication of Member, Provider and Claims data flows from MC400 to the SCAN Data Warehouse. On a scheduled basis other systems such as CCMS® receive data from the Data Warehouse. Likewise, CCMS® data flows through the SCAN Data Warehouse and is scheduled to be picked up daily by MC400.

SCAN Data Warehouse is also a central source for performing data collection from external partners and utilized as the source for data reporting and analysis. Encounters and pharmacy data are collected and managed separately in a MS SQL Server Databases within the Data Warehouse.

In addition to the interfaces described above, the MC400 system is capable of receiving the HIPAA compliant transactions outlined in the AHCCCS Technical Interface Guidelines. Since October 2010, SCAN receives and processes the AHCCCS Enrollment (834) and Premium (820) files in the ANSI 5010 version. Claims are received via an 837 ANSI 4010 file format from Emdeon®, a vendor contracted to image paper claim forms, while SCAN also receives electronic 837 ANSI 4010 files directly from select clearinghouses such as Office Ally™ and Emdeon. SCAN utilizes Medical Data Express (MDE) to map outbound encounter data into an 837 ANSI 4010 format for submission to AHCCCS. Claims payment checks are transferred through the clearinghouse Emdeon.

MC400 allows for real-time updates for:

- Enrollments, maintaining member demographic information, and eligibility
- Maintaining history of demographic changes related to a member's eligibility
- Maintaining and displaying benefit and plan information including service limits, co-payments and primary coverage responsibility, including incremental tracking of benefit usage
- Provider demographics including provider types, physician specialties, languages spoken and contact information
- Maintaining history of changes to provider contracts and fee schedules
- Logging functions for member service calls and activities, including automated routing of activity codes to specific work queues of other functional area staff
- Applying "clean claim edits" and other claim edits applied to ensure the accurate processing of claims, including the real-time editing of AHCCCS claims against the AHCCCS reference files
- Applying National Correct Coding Initiative (NCCI) edits to claims in real-time mode for both interactive and batch transactions for electronic claim submissions status
- Claims processing including automated routing of claims to work queues, the assignment of status codes, pending a claim or claim line, automated adjudication and notes capability
- Viewing of member claims history
- Accounts receivable and accounts payable processing

MC400 outputs include:

- Member eligibility reporting



- Group, plan and provider information
- Claims payments
- Electronic transfer of funds for Claims payments
- Capitation payments
- Premium billing
- Provider directory
- Remittance Advice
- Real-time data replication

### *Claims*

SCAN recently completed a two-year claims remediation project to improve efficiency, accuracy and compliance while reducing healthcare and administrative costs. The final phase of these enhancements was completed during the first quarter of 2011. Through this project SCAN implemented changes to the claims module of its healthcare information system to improve automated claims processing, and also imbedded procedural process improvements and staff training. Newly introduced bundler software and data edits assist in reducing healthcare costs while increasing automation. SCAN expects the new system to achieve significantly higher levels of automation resulting in lower administrative costs.

SCAN accepts both paper and electronic claims. After acquisition, paper and electronic claims are integrated in the SCAN claims processing module. Paper claims are sent to a designated Arizona post office box and are then transported by courier to SCAN in Long Beach, California. The ANSI 837 claims files from our clearinghouses are received by SCAN Health Plan between 8AM-2PM each business day and are systematically loaded into MC400 for processing via the EDI application, Transaction Portal. During the past several years, there have been significant improvement efforts resulting in upgrades to claims processing by streamlining steps, implementing enhanced toolsets, such as a code bundler, a pricing tool, and AHCCCS Claims Scrubber, improving claims accuracy.

Remediation of claims not able to adjudicate on the first pass is accomplished by re-staging those claims for SCAN staff who apply claims adjudication rules and regulations. Claims are rejected with notification sent to original submitters, claim data is adjusted or claim payments are manually applied as each situation requires.

SCAN offers all providers the option to submit claims electronically using EDI, at no cost to the provider. SCAN works with our provider network and our claims clearinghouses to increase rates of EDI claims submission, including proactively reaching out to providers who submit a high volume of paper claims and educating them on EDI claims submission. These clearinghouses are: Future Vision Technologies, Office Ally™ and Emdeon© for inbound claims; Express Scripts, Inc. (ESI), our contracted pharmacy benefits manager, for electronically submitted inbound pharmacy claims; and Emdeon for claim payment by check.

### *Encounters*

SCAN's encounter data submission process begins with claims being processed and finalized in SCAN's claim processing system (MC400). This claim data is replicated real-time into an internally developed custom Data Warehouse where it is used by multiple systems for multiple purposes, including AHCCCS encounter submission. A process extracts the claim data and transforms it into encounter data in appropriate EDI file formats. Medical Data Express (MDE) is used to enable the encounters extract and submission to AHCCCS. AHCCCS encounter data reporting, including proprietary reports, are outputs of this process.

The SCAN Encounter Extractions (SAEE) process currently runs monthly the week before each first monthly adjudication cycle. Claims eligible for extraction as encounter data include all original, adjusted,

and prior-period claims for fee-for-service for contracted providers. All billed, allowed, paid, coordination of benefits and co-pay charges and adjustments are taken from the direct interface to the finalized claim data, tying the accuracy of this data to the claims adjudication and audit processes. Anomalies causing encounter data not to be reported back to AHCCCS are immediately brought to the attention of the Healthcare Informatics Encounter Data Team (HCI Encounter Team) for research and resolution.

SCAN Health Plan tracks encounter submissions to ensue all finalized claims are sent to AHCCCS within 240 days after the end of the month in which the services were rendered. SCAN has worked diligently to lower the encounter first-pass pend rate. During 2010 that rate has declined from 7.6 percent early in the year to 3.1 percent in November 2010.

### *MC400 Application Support*

SCAN Health Plan has full rights to the source code for MC400. Edmund Jung & Associates (EJA) supplies service for enhancement, maintenance and 24/7 on-call support of SCAN’s MC400 system.

EJA has over 20 years of application design, development and maintenance expertise with MC400-based variants of the health information system (HIS), and continues a long-standing partnership with, among many others, one of the top five health plans in California. Within that particular partnership, EJA supports an entire division’s requirements for MC400-based HIS, including:

- On-line transaction processing for a number of different plan products
  - Commercial (Large, Mid-Size, Small Group, and Point of Service),
  - Individual
  - Medicare
  - Medicaid
  - Administrative Services Only (ASO)

EJA is also contracted with other notable health care institutions, including: Johns Hopkins Health Care and the University of Pittsburgh Medical Center Health Plan, along with Phoenix Health Plan in Arizona.

MC400 system software version information is contained within the “MC400 System” table (presented earlier in this section).

### CareEnhance® Clinical Management Software (CCMS®)

CCMS®		
1	Installed Version	5.3
2	Latest Version	5.3
3	Healthcare Functions	Medical Management and Case Management
4	Vendor	McKesson Health Solutions
5	Vendor Address	275 Grove Street, Suite 1-110 Newton, MA 02466-2273
6	Contact Person	Kathy Sutton
7	Hardware	HP Intel Architecture
8	Software	MS-Windows OS, MS SQL Server
9	Scheduled Upgrades	Annually – 2011 install date to be determined

CCMS® is the electronic home of member medical data and is used to support Case Management, Medical Management, Disease Management, Prior Authorization, and Concurrent Review information requirements. CCMS is updated daily with:

- ALTCS member demographic and eligibility information, including prior plan data if member is transferring to SCAN from another AHCCCS contracted health plan

- Provider information
- Benefit plans and coverage
- Paid claims information

CCMS® is updated weekly with paid pharmacy claims information.

CCMS® core application functionality is supported by our vendor, McKesson, however, SCAN Health Plan runs the software on SCAN Health Plan servers in Long Beach, California and makes programming changes to back-end CCMS® processes.

Authorizations created in CCMS® are interfaced daily to the SCAN claims system (MC400) to support claims adjudication.

Case Management, Medical Management, Disease Management, Concurrent Review, Prior Authorization and Quality Management information in CCMS® is captured daily to a reporting database or repository.

Using CCMS®, SCAN Case Management and Medical Management staff:

- View cases, authorizations, referrals, reviews, case notes, and attached documents for individual members
- Manage caseloads via case manager's member log or reminder/task log
- Complete SCAN designed assessments, level and manage cases according to SCAN customized care strategies
- Access online guidelines
- Create, categorize, assign, and monitor member cases
- Create and document Service Plans
- Create and follow-up on member interventions
- Create and follow-up on member goals
- Create and manage recurring authorizations for HBCS and long-term care placements
- Create and manage authorizations and referrals for professional services and acute admissions
- Conduct concurrent reviews
  - Track and document acute admission discharge plans
  - Document a case using a notes module that includes a user customized glossary function
  - Set automatic reminders and task lists
  - Manage members remotely, unconnected to the network
  - Access InterQual (McKesson) Criteria and attach the review
  - Access Care Guidelines (Milliman), as needed
  - Request and receive Medical Director review
  - Refer and track members, cases, and events (authorizations and quality events)

CCMS® is highly configurable and customized by the end-user. The following CCMS® capabilities are maintained by SCAN clinical and IT support staff:

- Design and implementation of assessments
- Design and implementation of care strategies including case stratification, milestones, educational pathways, auto-generated problems, interventions, goals, and notes
- Clinical Guidelines
- Auto creation of notes, reminders, cases
- Interfaces to/from the SCAN Data Warehouse

The CCMS® system software version information is contained within the “CCMS®” table (presented earlier in this section).

### Grievance and Appeals Database

SCAN utilizes a Grievance and Appeals Database in Arizona to track and trend member grievances, appeals, cases or events. The Grievance and Appeals Coordinator (GAC) is responsible for data input. The GAC inputs member demographics and critical case file information. This MS Access database is the single source for all member complaints, grievances and appeals information.

SCAN Grievance and Appeals Database utilizes a case structure that allows SCAN to document all activities involved with tracking, trending and resolving a specific case/event, including, but not limited to: grievance and appeal type (dispute categories), timeliness (aging), claims disputes, authorization (effectuation) tracking, standard and expedited hearings, provider specific tracking and trending, access to care and contract service levels.

### Data Warehouse

<i>Data Warehouse</i>		
1	Installed Version	MS SQL 2008 (10.0.2531)
2	Latest Version	MS SQL 2008 R2
3	Healthcare Functions	Central SQL Database Server
4	Vendor	SCAN owned and managed system
5	Vendor Address	3800 Kilroy Airport Way Long Beach, California 90806
6	Contact Person	Sajid M. Chaudhary
7	Hardware	HP Intel Architecture
8	Software	MS-Windows OS, MS SQL Server
9	Scheduled Upgrades	Continually upgraded, as needed

The SCAN Data Warehouse is a custom built central repository that supports interfaces between systems and is a focal point for other data collection and activity (analysis, reporting, etc.). The SCAN Data Warehouse is a grouping of MS SQL databases where data replicated from core applications and external data resides. Through this Data Warehouse, business users and analysts are provided HIPPA compliant role-based discrete levels of capability to use the data to suit their business function. Further, the SCAN Data Warehouse becomes a repository for other EDI-type functions to SCAN vendors. Data collection from external sources is also maintained in the Data Warehouse, such as pharmacy and encounter data.

The Data Warehouse system software version information is contained within the “Data Warehouse” table (presented earlier in this section).

Exhibit 1  
SCAN Information System

# SCAN Information System

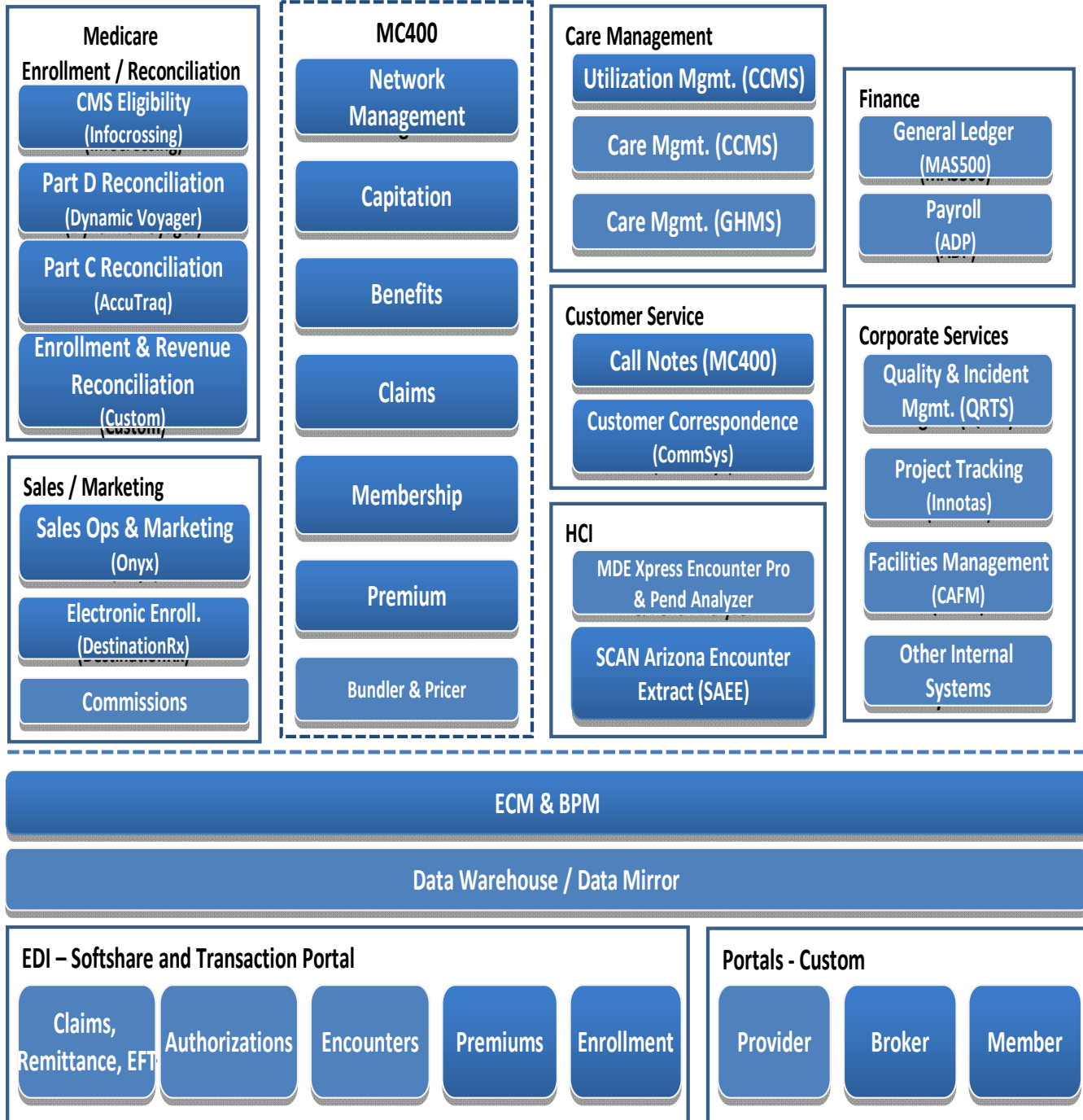
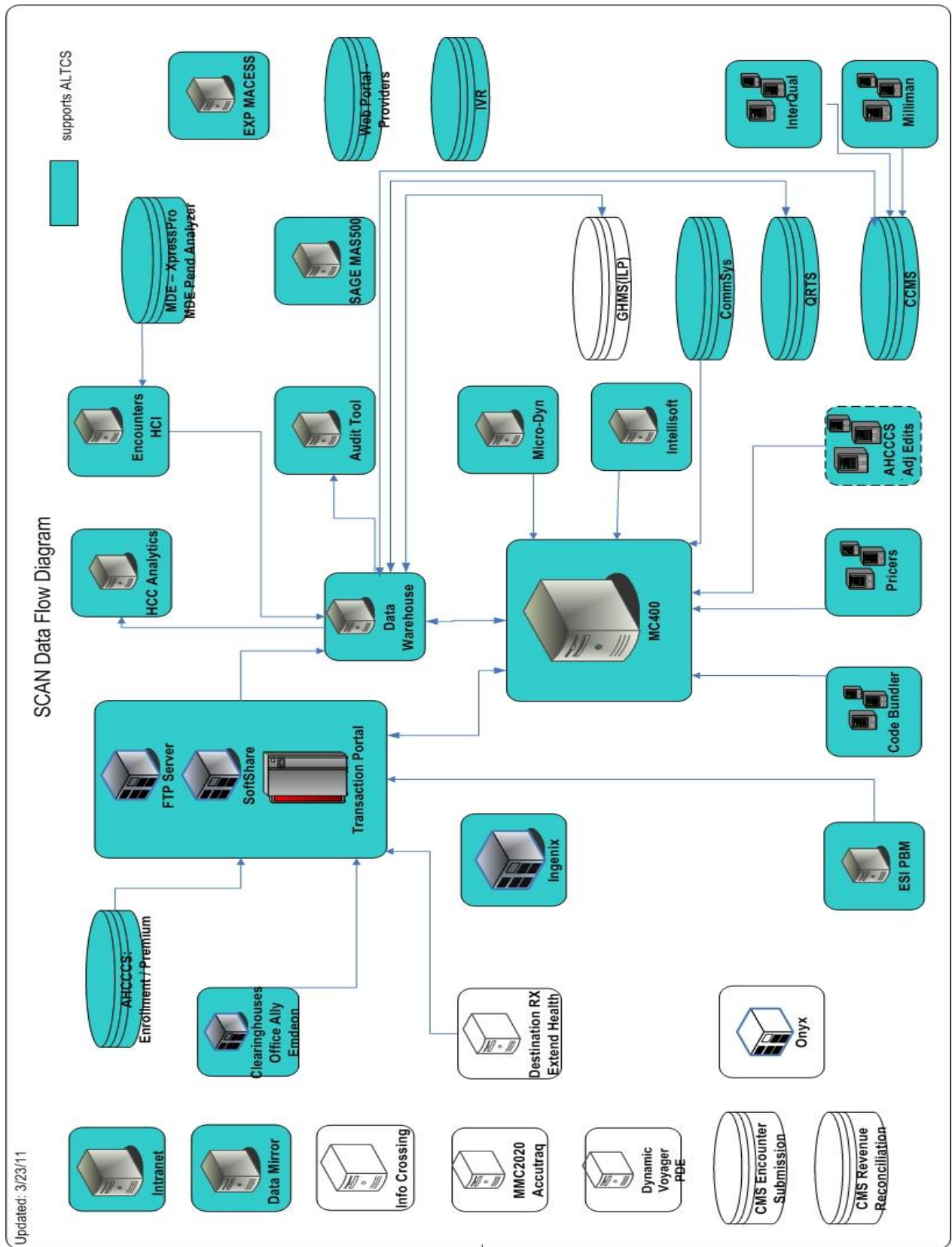
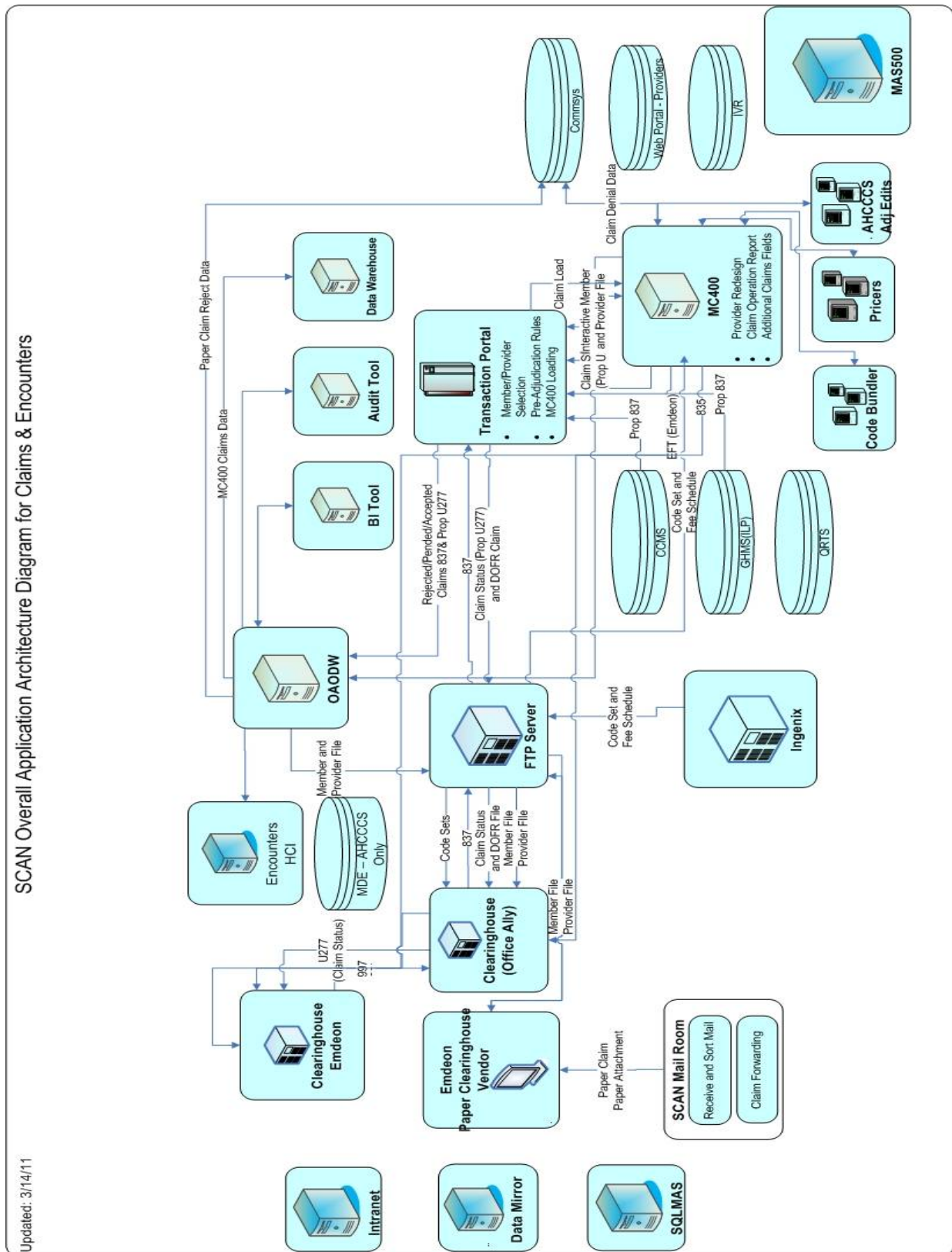


Exhibit 2  
Systems Data Flow Diagram



*Exhibit 3  
Claims and Encounters Application Diagram*



*Exhibit 4*  
*SCAN Complete Systems Inventory*

<i>Application</i>	<i>Description</i>	<i>Platform</i>	<i>Internal/ External</i>
MC400 (formerly OAO)	Core Health Plan: Membership, Claims, Premium, Capitation v. 2.1	IBM i5	I
McKesson CCMS®	Care Management/ Utilization Management v. 5.3	Wintel	I
Transaction Portal	EDI Interface - Custom	Wintel	I
Softshare ECS v. 6.0/Delta v. 5.0	EDI Translation	Wintel	I
Softshare Delta	EDI Mapper v 5.0	Wintel	I
EXP MACESS	Workflow v. 3.2	Wintel	I
EXP MACESS	Automated Enrollment Error Management v. 3.2	Wintel	I
Alchemy	Scanning and Imaging v. 7.6	Wintel	E
Global 360	Scanning and Imaging v. 9.3	Wintel	I
Audit Tool	Custom SQLServer Application	Wintel	I
Aldon	Source code manager v.7.5A	Wintel	I
Ingenix Web.Strat	Pricer v. 1009	Wintel	E
Ingenix iCES	Bundler/Code Editor v. 4.4	Wintel	E
AHCCCS Claims Scrubber	Custom	Wintel	I
Ingenix GeoAccess	Geographical mapping tool	Wintel	E
CommSys	Letter Generation v. 3.5	Wintel	I
Portal	Custom	Wintel	I
Onyx	Lead Tracking	Wintel	I
SAGE MAS500	General Ledger	Wintel	I
IntelliSoft IntelliCred	Provider Credentialing	Web	E
IntelliSoft IntelliContract	Contract Management	Web	E
Destination Rx	Medicare Electronic Enrollment	Web	E
Extend Health	Medicare Electronic Enrollment	Web	E
Infocrossing	CMS Eligibility Interface	ASP	E
MMC2020 Accutraq	CMS Enrollment Reconciliation	ASP	E
Dynamic Voyager PDE	CMS Part D Reconciliation	ASP	E
Custom	CMS Encounter Submission	Wintel	I
Custom	CMS Revenue Reconciliation	Wintel	I
Custom	HCC Analytics	Wintel	I
Data Warehouse	SQL - Custom	Wintel	I
Data Mirror	Real-time data replication v. 6.3	Wintel	I
Express Scripts	Pharmacy Data	Wintel	E
MDE Pend Analyzer	Encounter Data Management v. 1.0.2951.23306	Wintel	E
MDE XPressPro	Encounter Data Management v. 1.0.0.0	Wintel	E
Encounter Extraction	SAEE	Wintel	I
Micro-Dyn Encoder-Plus with	Diagnosis Related Grouping v. 14.1.1	Wintel	I



<i>Application</i>	<i>Description</i>	<i>Platform</i>	<i>Internal/ External</i>
PRICERActive			
SSRS	Custom reporting tool	Wintel	I
Office Ally™	Clearinghouse	n/a	E
Emdeon©	Clearinghouse	n/a	E
<p>Note:</p> <p>The CMS (Centers for Medicare and Medicaid Services) processes/systems noted in this table enable Arizona’s ability to identify and process related data and apply benefits for their Special Needs Plan (SNP) population.</p>			

---

## *Requirement 12: Information Systems Changes and Modifications*

---

### *SCAN's IT System Change Order Process for Software Modifications*

SCAN's IT systems change management process for software modifications is governed by the IT Governance Committee (ITGC), which includes SCAN California and Arizona representation and participation. This committee assists all SCAN organizations in matters relating to the definition and alignment of information technology strategy and resources, providing alignment with overall corporate plans.

Once a project has been approved by the ITGC, it follows the standard IT Systems Development Life Cycle (SDLC). Requests for modifications that are above a specific resource usage threshold for software modifications are managed using a System Modification Request form. These forms are submitted by business units with detailed information about the requested changes. These requests are researched, estimated, prioritized and approved by the ITGC, prior to work being started. Changes are planned and reviewed with the requestor and the development staff before being programmed. Changes are tested and require approval/sign off in several environments by developers, IT staff and the requesting business unit prior to being implemented in our Production environment. All software modifications must follow SCAN's formal change management process.

Requests that are under minimum project size thresholds and deliver small enhancements or maintenance-type deliverables are managed locally, but are developed, tested and delivered using our standard SDLC. These projects are not required to go to the ITGC for approval. Sign off is required from requesting department personnel for any size project prior to implementation.

Application source code changes are managed through a commercial source control tool, Aldon Change Management System (ACMS). Changes are unit tested in isolation. User acceptance and regression testing are performed in an integrated TEST environment. This testing procedure requires the SCAN Health Plan business unit to formally accept the delivered changes before the changes are scheduled to be promoted into the MC400 Production environment. When user acceptance is received, the MC400 system changes go through the IT Department's formal Change Control process, which is invoked online and managed by a workflow process which promotes requests to various levels of approvers for their sign off.

Change control is not completed and scheduled for implementation until all required approvals are obtained. Application source code changes are implemented on a standard weekly cycle that takes place on Thursday after business hours. Business unit personnel perform a validation immediately in Production to certify that the changes implemented work as intended. IT provides post-implementation support for the changes by monitoring system performance and working with the business to verify that processes function as signed off.

### *Major Version Upgrades and Change Management*

#### **Online Change Management**

During 2010 a new online Change Control application used for managing system changes was rolled out to SCAN Health Plan employees. This application is used to document change requests, their timing and specific instructions or any other necessary details for all SCAN Health Plan internally supported systems. This application also automatically routes requests for ascending levels of approval prior to authorization being granted for this request to be implemented. As a part of SDLC, this standard change management process is always used for in-house and vendor supported application modifications.

## MC400 Healthcare Information System

There have been no major system version upgrades to SCAN's MC400 application system in the last five years. SCAN IT owns and manages major system upgrades when they do occur. SCAN Health Plan owns the MC400 source code and makes regular modifications where application changes are needed to support regulatory updates and business process improvements.

### *MC400 Change Management*

For MC400, requests for software modifications, as opposed to system upgrades, are initiated by a business unit using a System Modification Request form. The business unit submits their request form with detailed information about the requested changes. SCAN's standard change management process is always used. Requests are begun, researched, estimated, prioritized and approved by ITGC, prior to design and then development work being started. Changes are planned, reviewed with requestor and development staff before design and programming are begun. As the standard process requires, changes are tested and require approval/sign off in several environments by developers, IT staff and the requesting business unit prior to being implemented in SCAN's Production environment. Business validation of the changes and IT post-implementation support of the functionality are incorporated into all updates to ensure changes function as signed off.

## CareEnhance® Clinical Management Software (CCMS®)

A major upgrade to CCMS® core functionality was completed and implemented at SCAN Long Term Care (SCAN) in 2010, which made major enhancements to the user interface. SCAN is now on CCMS® Version 5.3. SCAN installs an annual upgrade to CCMS® application code, which is made available each year by our vendor, McKesson.

### *CCMS Change Management*

Changes to the CCMS® configuration are initiated by submission of a CCMS® Change Request form by a manager or supervisor. Program changes such as new or enhanced interfaces are also subject to the ITGC process and the IT Department's formal Change Control process.

In the CCMS® change process, the requestor must include identifying the need for change, documenting change reason, proposed change and impacted programs, draft of new workflow, policy and business design and obtain business approval, submit change request and supporting data to the Clinical Systems Administrator (CSA), sponsor the change, test the change as needed, sign off to accept change, prepare notification of changes to user manual and training materials, sign off on revisions and train staff. Changes are coordinated through the CSA and governed by the change process documented in the CCMS® Supervisor Guide. The guide includes a matrix of reviewers and approvers by type of change.

The CSA's responsibilities in the CCMS® change process includes coordinating change from request to implementation, document changes, maintain change log, research issues, impacts and solutions and make recommendations, provide needed expertise on data base/data relationships/look-up tables/clinical system impacts/assessment design, build assessment change into training environment, coordinate with Healthcare Informatics to include new data in Data Warehouse, ensure change in all other training environments, coordinate and support change testing, ensure approved changes are made to user manuals and training materials, coordinate with IT to implement change in the Production environment using IT formal Change Control process and validate changes in Production and notify system users of implemented change.

## Grievance and Appeals Database

SCAN utilizes a Grievance and Appeals Database in Arizona to track and trend member grievances, appeals, cases or events. The Grievance and Appeals Coordinator (GAC) is responsible for data input. The GAC inputs member demographics and critical case file information. This Microsoft® Access database is the single source for all member complaints, grievances and appeals information. SCAN Grievance and Appeals Database utilizes a case structure that allows SCAN to document all activities involved with tracking, trending and resolving a specific case/event, including, but not limited to: grievance and appeal type (dispute categories), timeliness (aging), claims disputes, authorization (effectuation) tracking, standard and expedited hearings, provider specific tracking and trending, access to care and contract service levels. Changes to the Grievance and Appeals Database are made, as necessary, to accommodate AHCCCS regulatory and operating policy requirements. Change Control, including definition, testing and implementation, is the responsibility of SCAN's Compliance Officer.

## Medical Data Express (MDE)

SCAN uses customized versions of MDE's Xpress Encounter Pro and Pend Analyzer that were originally purchased in January 2007. In June 2010, SCAN and MDE collaborated to redesign SCAN's version of Xpress Encounter Pro so that SCAN's Healthcare Informatics Encounter Data Team managed the software responsible for extracting claim data from MC400. MDE's Xpress Encounter Pro became solely responsible for generating encounter EDI files for submission to AHCCCS. Subsequent to that date there have been two Xpress Encounter Pro releases from MDE to remediate minor issues. During this time, MDE's Pend Analyzer has been used for AHCCCS pend tracking and remediation with only minor releases to issues as they arose.

### *MDE Change Management*

With the highly customized MDE software in place at SCAN, all changes to the software are driven by SCAN. SCAN's Healthcare Informatics Encounter Data Team is responsible for managing all software changes to Xpress Encounter Pro and Pend Analyzer. This team is responsible for all business analysis and technical specifications to provide to MDE for any software changes. SCAN then collaborates closely with MDE on any changes by thoroughly testing (following black box and regression testing methodologies) the software in a test environment before coordinating with management and executive approval of release of the software into Production. The Encounter Data Team saves all documentation for the software change in a well-identified network folder for reference, communication, and support purposes. While there are no planned major upgrades to the existing software, SCAN stays current with all regulatory and AHCCCS defined requirements, and as change needs arise, they will be fed into the previously described change management process for MDE's software in order to maintain integrity and efficiency. Examples of changes SCAN Health Plan is currently considering and analyzing for software changes are ANSI v5010 and ICD-10.

### *Planned System Conversion in Next Five Years; Subsystems Affected*

Currently there is no plan for a major system conversion at SCAN Health Plan. However, SCAN does continually monitor the marketplace to evaluate products which would provide improved technology, improved data processing and/or more robust support for implementing regulatory changes with each line of business in mind. To date, no application has been identified for conversion. If a replacement or major upgrade is identified and a project is approved, SCAN will notify AHCCCS at once and provide our plan for the project. At least six months prior to the planned conversion, SCAN will inform AHCCCS of the status of the change and provide SCAN's action plan for implementing or upgrading to the identified application which will outline a timeline, milestones, and adequate testing before implementation. SCAN will request AHCCCS review and comment on the system conversion timeline as submitted.

*Requirement 13: Software Vendor Information*

*MC400 Healthcare Information System*

MC400 has been in use at SCAN Health Plan since July 2002. MC400, along with SCAN Health Plan’s other core systems were in use when AHCCCS awarded SCAN Long Term Care our original ALTCS contract in 2006. These systems were expanded and upgraded then to support the new ALTCS line of business. These expanded systems continue to support our ALTCS line of business today.

Programming modifications for MC400 Healthcare Information System are outsourced to Edmund Jung and Associates (EJA). EJA has over 20 years of expertise with MC400-based HIS. EJA has been under contract with SCAN since September 2004. EJA is tasked with delivery of enhancements only at the request of SCAN IT for those projects that have been approved for implementation. SCAN’s change order process is followed in all instances and is governed by the SCAN IT Governance Committee.

SCAN IT personnel oversee SCAN’s MC400 production and test environments. Day-to-day production support is provided by SCAN IT personnel with EJA available to SCAN 24/7 to assist in the support tasks. EJA is also contracted with other notable health care institutions including, Johns Hopkins Health Care and the University of Pittsburgh Medical Center Health Plan, along with Phoenix Health Plan in Arizona.

Application source code changes are managed through a commercial source control tool, Aldon Change Management System (ACMS). Changes are unit tested in isolation. User acceptance and regression testing are performed in an integrated TEST environment. This testing procedure requires the SCAN business unit to formally accept the delivered changes before the changes are scheduled to be promoted into the MC400 Production environment. When user acceptance is received, the MC400 system changes go through the IT Department’s formal Change Control process, which is invoked online and managed by a workflow process which promotes requests to various levels of approvers for their sign off. Change Control is not completed and scheduled for implementation until all required approvals are obtained. Application source code changes are implemented on a standard weekly cycle that takes place on Thursday after business hours. Business unit personnel perform a validation immediately in Production to certify that the changes implemented work as intended. IT provides post-implementation support for the changes by monitoring system performance and working with the business to verify that processes function as signed off.

MC400 System Software Version Information

MC400		
1	Installed version	2.1
2	Latest version	2.1
3	Healthcare Functions	Provider, Enrollment, Member, Benefits, Claims
4	Vendor	SCAN owned and managed system
5	Vendor Address	3800 Kilroy Airport Way Long Beach, California 90806
6	Contact Person	Earlene Boyd
7	Hardware	IBM AS400 iSeries 525
8	Software:	OS/400
9	MC400 support	Edmund Jung & Associates, Inc. 10815 Canoga Avenue Chatsworth, California 91311 Account Manager: Eddie Tang

CareEnhance® Clinical Management Software (CCMS®)

CCMS® has been in use at SCAN Health Plan since October 2004. The CCMS® application is supported by the vendor, McKesson. SCAN Long Term Care runs the application on local servers in Long Beach, California and makes configuration and back-end programming changes to the system.

*CCMS® System Software Version Information*

CCMS®		
1	Installed Version	5.3
2	Latest Version	5.3
3	Healthcare Functions	Medical Management and Case Management
4	Vendor	McKesson Health Solutions
5	Vendor Address	275 Grove Street, Suite 1-110 Newton, MA 02466-2273
6	Contact Person	Kathy Sutton
7	Hardware	HP Intel Architecture
8	Software	MS-Windows OS, MS SQL Server
9	Scheduled Upgrades	Annually – 2011 install date to be determined

*Data Warehouse*

The SCAN Data Warehouse has been in use since April 2003. The SCAN Data Warehouse is a custom built central repository that supports interfaces between systems and is a focal point for other data collection and activity (analysis, reporting, etc.). The Data Warehouse is a grouping of MS SQL databases where data replicated from core applications and external data resides, such as pharmacy and encounter data. Through this Data Warehouse, business users and analysts are provided HIPAA compliant role-based discrete levels of capability to use the data to suit their business function. Further, this Data Warehouse becomes a repository for other EDI-type functions to SCAN external vendors. Data collection from external sources is also maintained in the Data Warehouse. Example: pharmacy data.

Data Warehouse Version Information

Data Warehouse		
1	Installed Version	MS SQL 2008 (10.0.2531)
2	Latest Version	MS SQL 2008 R2
3	Healthcare Functions	Central SQL Database Server
4	Vendor	SCAN owned and managed system
5	Vendor Address	3800 Kilroy Airport Way Long Beach, California 90806
6	Contact Person	Sajid M. Chaudhary
7	Hardware	HP Intel Architecture
8	Software	MS-Windows OS, MS SQL Server
9	Scheduled Upgrades	

*Grievance and Appeals Database*

SCAN has utilized a Grievance and Appeals Database in Arizona since 2006 to track and trend member grievances, appeals, cases or events. The Grievance and Appeals Coordinator (GAC) is responsible for

data input. The GAC inputs member demographics and critical case file information. This Microsoft Access database is the single source for all member complaints, grievances and appeals information.

SCAN Grievance and Appeals Database utilizes a case structure that allows SCAN to document all activities involved with tracking, trending and resolving a specific case/event, including, but not limited to: grievance and appeal type (dispute categories), timeliness (aging), claims disputes, authorization (effectuation) tracking, standard and expedited hearings, provider specific tracking and trending, access to care and contract service levels.

## *Requirement 14: Support of IT Federal Mandates*

---

### *Current support and future IT Federal mandates.*

SCAN Health Plan (SCAN) has been in business for more than three decades and is a successful non-profit health plan dedicated to providing a unique combination of comprehensive medical coverage, prescription benefits and in-home personal care services, primarily to the elderly. The aim of the plan is to enable older adults and the physically disabled to remain independent and in their own homes.

SCAN Health Plan understands the important link between technology and servicing its Arizona Long Term Care membership. To maintain current and future support for Federal mandates, and to remain HIPAA compliant, SCAN continues to closely monitor Federal mandate changes. Key SCAN business executives and process owners are regularly updated on Federal mandates by the Centers for Medicare and Medicaid Services announcements and calls. SCAN IT will assess our system capabilities, identify updated IT mandates which apply to SCAN's Arizona Long Term Care line of business, plan for and implement them on time. All Federal mandate projects must follow SCAN's System Development Life Cycle (SDLC) and the IT Department's formal Change Control process.

SCAN Health Plan has been successful in implementing Federal mandates by their due dates and has in fact previously been an early mandate adopter. In 2010, SCAN was one of six or fewer plans to meet the early implementation deadline for processing of AHCCCS Electronic Data Interchange transactions for Premium (820) and Enrollment (834) files in ANSI 5010 format, almost 16 months earlier than the Federal mandate required. Since that date, SCAN Health Plan has also implemented the ANSI NCPDP D.0 Claims transaction functionality required under the ANSI 5010 regulation with our Pharmacy Benefit Manager (PBM).

For the remaining 5010 transactions including claims, referrals, and authorizations:

- SCAN Health Plan 5010 remediation project efforts are in progress
  - Milestones
    - Technical gap analysis completed May 2011
    - Business rules rewrite April 2011
    - Publish final project plan May 2011
    - Begin testing transactions August 2011
    - Implement transactions by January 1, 2012

SCAN has embarked on an organizational ANSI X12 v5010 project. As such, SCAN is on track to comply with mandated dates for submission of encounter data in the 837 v5010 and NCPDP Post Adjudication File standards to AHCCCS, as well as receive, extract, transform, and load all AHCCCS supplied reports. The HCI Encounter Data Team is slated to complete gap analysis between the existing and new standards by May 2011, which will quickly transition into system and EDI implementation. SCAN will be prepared to test with AHCCCS by the end of summer in order to achieve compliance by AHCCCS' mandated date. These system and EDI implementations will involve changes to SCAN's Arizona Encounter Extract process, EDI file generation, report receipt, and internal reporting engines.

For ICD-10 implementation:

- SCAN has begun the process of system assessment and planning
- SCAN has an initiative underway to perform organizational assessment and develop coordinated implementation plans that begin in 2011 to ensure compliance for mandated implementation date
- SCAN is allocating appropriate resources to ensure significant business and technical expertise resides within the internal team and is secured from external vendors



- This company-wide project will include performing assessment, analysis and requirement gathering to properly scope the implementation across the organization, working in tandem with our provider partners, vendors, and regulatory agency partners
- From our initial fact-finding, various projects will be initiated within the guidance and oversight of the ICD-10 initiative
- Each project will be scoped and undertaken, targeting a solution for that specifically identified set of objectives, thus SCAN will apply individualized care and attention to each business need and workflow

SCAN intends to continue to focus on and devote resources to implementing all current and future Federal mandates to ensure that our membership population receives the best and most thorough care, which enables our members to remain independent and in their homes, and out of care facilities, for as long as possible.

## *Requirement 15: Grievance System*

---

SCAN Long Term Care (SCAN) grievance system provides a mechanism for members and contracted and non-contracted providers to submit grievances, appeals and claims disputes in accordance with AHCCCS and federal requirements. SCAN has policies in place that meet AHCCCS requirements and processes to train all new and current personnel. SCAN tracks and trends issues identified by the grievance system database to determine root cause and facilitate cross-functional system improvement. SCAN continually develops improvement initiatives from trending grievance system data to improve service quality.

The Compliance Officer (CO) oversees the SCAN grievance system. Reporting to the CO is the newly developed position is the Compliance Lead, which will serve as the Appeal and Dispute Manager under the AHCCCS CYE2012 contract. Under the direction of the Compliance Lead is the Grievance and Appeal Coordinator (GAC), who processes member grievance and appeals according to AHCCCS and federal requirements, as well as the Claims Dispute Coordinator (CDC), who resolves provider claims disputes according to state requirements. Grievance system staff are trained to distinguish between member grievances, appeals and provider claims dispute so as to properly triage and categorize cases that are received to assure assignment to the appropriate process and staff member. All grievance system case files are maintained in accordance with state and federal record retention requirements. SCAN takes member and provider complaints seriously and strives to assure issues are addressed.

### *Member Grievances and Appeals*

All SCAN members receive a Member Handbook that describes the grievance and appeal processes available to them. The handbook is provided directly to the member during the initial case management meeting in which the grievance and appeals process is specifically discussed. The Member Handbook, as well as other written documents (Notice of Action, Notice of Appeal Resolution, Notice of Extension of Resolution and Notice of Extension of Notice of Action), are translated into the member's primary language (if the plan has received information that the member has limited English proficiency). In addition, these documents are available in alternative formats upon request and include an explanation of how members may obtain this information. The member may call the Member Services Department or the Grievance and Dispute Department for assistance in filing a grievance or appeal.

### *Member Grievances*

Members or their designated representative may initiate grievances either orally or in writing directly to their Case Manager, the Member Services Department, the Grievance and Dispute Department, or any other functional area that receives grievance information from a member.

Grievances that are filed in writing are acknowledged in writing within five business days of receipt. A written acknowledgment letter is not required for grievances received orally. SCAN's goal is to investigate and close all grievances within ten business days but no later than 90 business days of receipt via a written response. Grievances involving quality of care issues are referred to the Quality Management (QM) department for investigation within 2 business days based upon SCAN internal policies and procedures.

When a grievance is received, the GAC logs the case information into the Grievance Database for tracking purposes. The GAC monitors the Grievance Database daily to track the status of cases and to ensure that grievances are resolved within the required timeframes. The GAC also monitors Quality of Care investigations to ensure timely resolution of quality of care issues.

The grievance is investigated using methods tailored to the complaint. Facts are gathered from internal and external sources as necessary to gain full understanding of the issues. The investigation could include

gathering medical records or interviewing the member and other witnesses. The GAC will consider all information provided by the member when developing investigative findings and recommendations.

Upon completion of the investigation, the member is provided a written resolution letter that explains the outcomes of the grievance investigation and contact information if the member has any questions. The GAC sends the resolution letter within the required 90-day timeframe.

### Standard and Expedited Member Appeals

A SCAN member receives a Notice of Action when a service has been denied, terminated, reduced or modified. The notice explains to the member in easily understood language when the action took place, including the factual and legal basis, and explains how the member may file a standard or expedited appeal. The notice also explains when and how the member may request that the benefits continue until a hearing decision is made.

The member or the member's designated representative may request an appeal of an adverse action within 60 days after the date of the adverse action. The member's representative may be a provider that the member has designated in writing to be their representative. SCAN does not take punitive action against a provider that requests a standard or expedited resolution or supports a member's appeal. The appeal may be submitted either orally or in writing directly to the member's Case Manager, the Member Services Department, the Grievance and Dispute Department, or any other functional area receiving the request. All Departments are instructed to route all appeals directly to the Grievance and Dispute Department. The member or member's representative may submit facts and/or legal and policy information in person or in writing and may request to review SCAN's case file, including medical and other records used to make the initial decision and in reviewing the appeal. All appeals are handled by the GAC and are logged in the Grievance Database.

If the member feels that the standard appeals timeframe could seriously jeopardize their health they can request an expedited appeal. Only a qualified clinical staff who was not involved in the initial review and who are healthcare professionals that have appropriate clinical expertise, may determine if the request meets expedited appeals criteria, which is based upon whether the standard appeals timeline could jeopardize the member's life, health or could impact the member's ability to attain, maintain or regain maximum function. The GAC notifies the member in writing that the appeal will be processed as either a standard or expedited appeal. The GAC acknowledges in writing the receipt of standard appeals within five business days and within one business day for expedited appeals.

Only qualified clinical staff who were not involved in the initial review and who are healthcare professionals that have appropriate clinical expertise, may be involved in the review of an appeal. The GAC forwards all documentation relevant to the initial review plus any additional documentation supplied by the member, member's representative or healthcare provider to the Medical Management Department. The Medical Management Department can request additional information if needed. The Medical Management Department will either uphold or overturn the initial decision. The GAC monitors the Grievance Database daily to track the status of cases and to ensure that appeals are resolved within the required timeframes.

The GAC ensures that all standard appeals are closed within 30 business days and, expedited appeals, within three business days or expeditiously as the member's health condition requires for expedited appeals via a written response to the member. The written resolution includes the content required by AHCCCS contract and is written in easily understood language. If SCAN requires additional time to obtain information, the member receives a written notice explaining the reason for the delay and an explanation of how the delay is in their best interest. This written notice is sent within 14 days from the original receipt date of the Notice of Extension Letter.

The GAC sends the member a closure letter that explains the decision, including decisions not wholly in favor of the member and the reason for the decision. If the decision is in the member's favor, the GAC

assures the Medical Management Department issues the appropriate authorization and effectuates the decision. If no decision is rendered within the required timeframe, the appeal is considered denied. If the decision was not in the member's favor, the member has the right to request a State Fair Hearing. Detailed information about how to request a State Fair Hearing is provided in the closure letter.

### *Provider Claims Disputes*

SCAN's contracted and non-contracted providers are notified of their right to file a claims dispute challenging claims payments, denials or recoupment's in the SCAN Provider Operations Manual and the written notice accompanying each remittance advice for claim payment. Providers may file a claims dispute within 12 months from the date of service or 60 days from an adverse action to a timely submitted claim. Providers are encouraged to use the informal mechanisms SCAN offers prior to filing a formal claims dispute, such as the claims service telephone line or by contacting their Network Management Services representative.

Claims disputes are handled by the Claims Dispute Coordinator (CDC). When a claims dispute is received, the CDC applies a date stamp to all associated documents and logs the dispute into the Claims Dispute Database. An acknowledgment letter is sent to the provider within five business days. The CDC researches the claims dispute by reviewing the claim history, the provider contract as applicable and state and federal claims adjudication rules. Cases that require medical necessity review, such as prior-authorization issues, are referred to the Medical Management Department for clinical review. Cases for reconsideration of an outlier calculation are reviewed by a Medical Claims Analyst for review and resolution. A Notice of Decision is sent to the provider within 30 days of the receipt of the claims dispute. The Notice of Decision contains the AHCCCS contractually mandated provisions, including the legal basis for the decision and the provider's right to request a hearing if the provider disagrees with the Notice of Decision. If the claims dispute is found in favor of the provider, the CDC directs the claims department to reprocess the claim, with accrued interest, according to the Notice of Decision and monitors the progress to assure reprocessing occurs no later than fifteenth business days from the date of decision.

### *Requests for State Fair Hearing*

Member and Provider written requests for State Fair hearing are documented in the Hearing Log. Grievance system staff copies the file, including the request for hearing, and includes a cover letter with the AHCCCS required information concerning the case. The request for hearing packet is sent to the AHCCCS Office of Administrative Legal Services (OALS) no later than five business days from the date of receipt. If cases are resolved prior to the hearing date, grievance staff notifies the OALS of the withdrawal immediately in order to assist in the management of the state fair hearing calendar.

### *Grievance System Data Used to Improve Performance*

SCAN continuously tracks and trends grievance data in order to improve services to members and providers. Several sources are used to identify opportunities for performance improvement. The Grievance and Appeals Database assigns each case an issue category and contains a field for provider name. These fields allow for trending of issue categories as well as tracking of individual providers to determine patterns leading to complaints. The Claims Dispute Database also tracks and trends dispute reasons, dispositions and resolutions. All tracking and trending reports are shared and discussed with SCAN's Grievance Committee.

The Grievance and Appeal Database captures: member name, AHCCCS ID number, receipt date, acknowledgement date, appeal description/type (e.g. reducing physical therapy hours, discharge from facility), provider name, date when appeal was routed to QM, response date back from QM, staff member assigned to case, disposition, final disposition letter date to member, overturn/uphold date, State Fair Hearing date and disposition (if applicable), etc.

SCAN submits monthly AHCCCS Grievance System reports as mandated by contract. A cover letter accompanies the report that points out trends, analyzes root cause and speaks to corrective measures being taken. The data from that report is incorporated into an internal month-to-month volume report by category (grievance, appeal, prior-authorization and claims disputes). This internal report is distributed to the SCAN Management Team and discussed in the Grievance Committee to review month to month volume fluctuations, cross-functional trends to monitor compliance and potential areas for improvement.

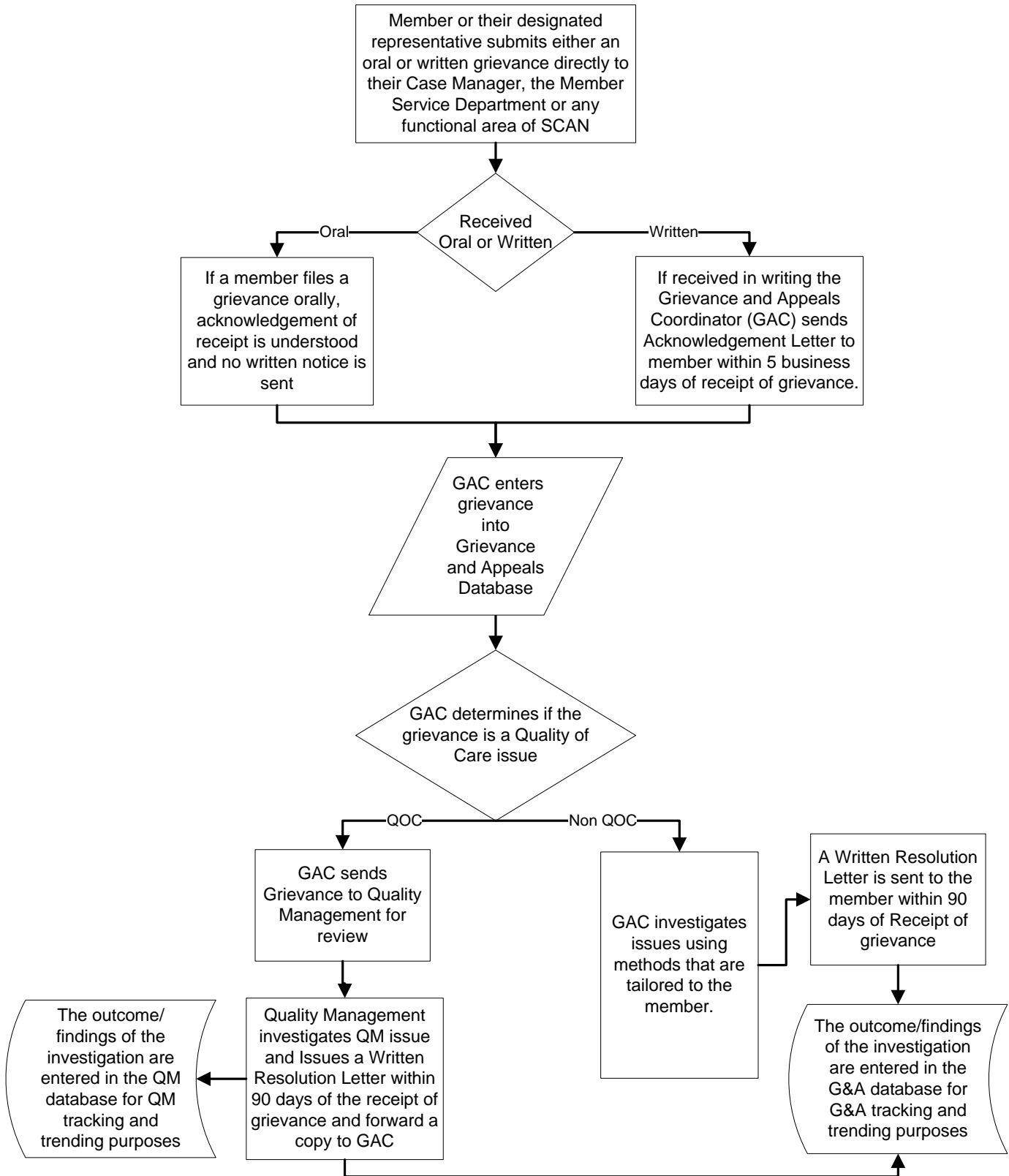
SCAN's Grievance Committee is a workgroup that uses cross-functional collaboration to address performance improvement opportunities stemming from grievance system data trending. Committee participants include: the Compliance Department, Case Management Department, Quality Management Department, Medical Management Department and the Network Management Department. Standing agenda items include: review of previous minute entries, reviewing trending reports; updates on quality management performance improvement initiatives; and updates on immediate jeopardy cases (specifically reviewing assisted living facilities corrective action progress). The agenda also includes issues that have arisen since the last committee meeting so as to assure follow-up.

SCAN's weekly claims meeting made up of department representatives from Grievance and Dispute, Network Management, Claims, Operations, Case Management, Medical Management and Compliance provides opportunity for multiple functional areas to review issues and projects so as to improve claims processing service levels. Claims Dispute trending is included in the weekly meeting dashboard and is discussed as an agenda item. Root cause of issues is explored as well as options for improvement. Progress is tracked until remedial activities are completed.

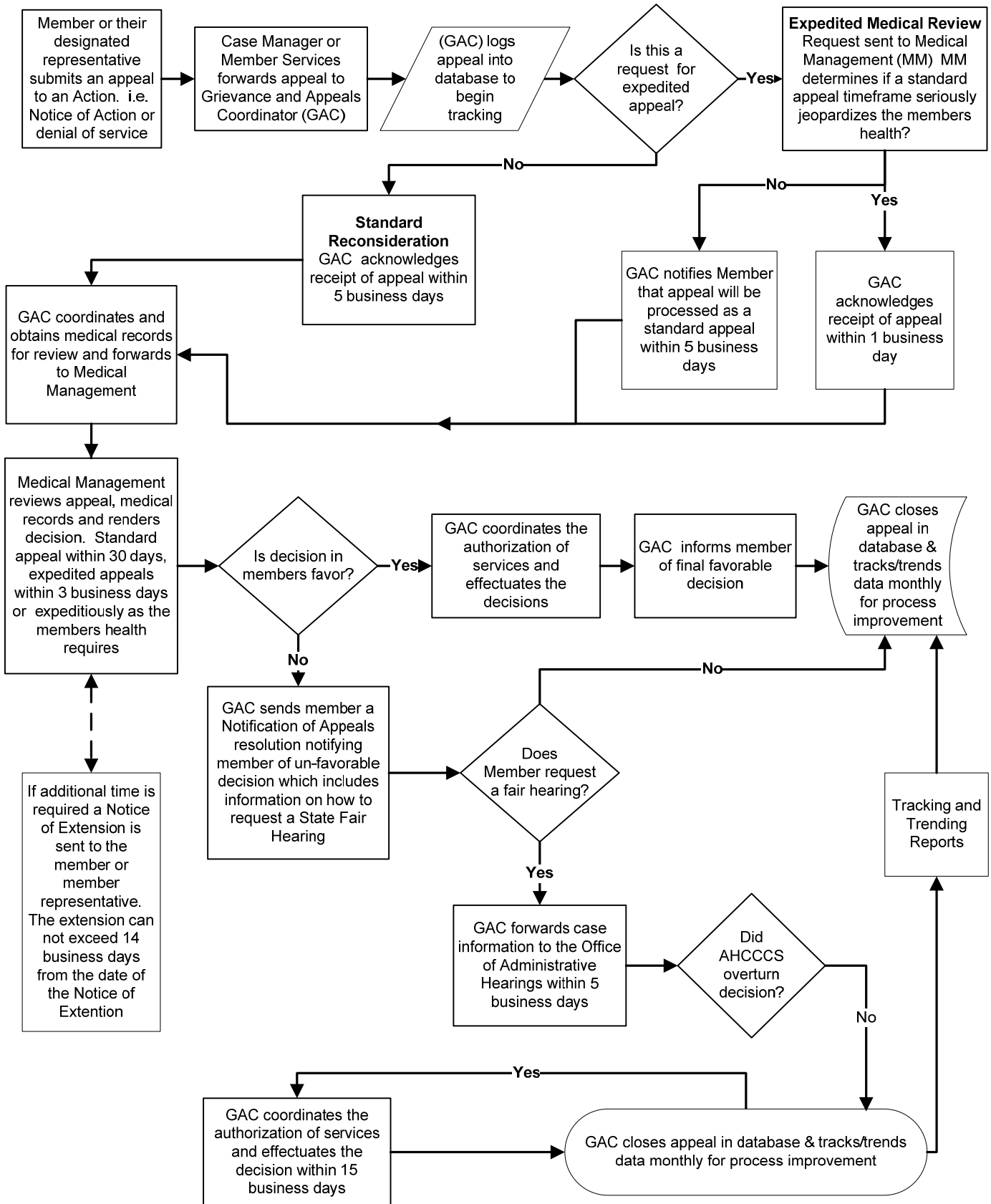
Trending grievance system issues and provider claims dispute has resulted in system improvements for SCAN. For example, SCAN has made network adjustments resulting in better services to members thereby reducing non-emergent transportation related grievances from the most prominent trend to a rare occurrence. Transportation grievance have trended downward from 61 Grievances in 2007 to nine Grievances in 2010. SCAN has also used grievance trends to identify areas for provider and staff education, explore ways to improve activities and diets provided in Assisted Living Homes and Centers and enhance member education in fall prevention. Provider dispute trends have been used to develop claims staff training opportunities.

Member service excellence is a core value at SCAN Long Term Care. Assuring our provider partners claims disputes are quickly addressed and prevented helps foster better member service levels by allowing providers to focus on care. SCAN is committed to timely and fair resolutions of member and provider grievances, disputes and appeals. SCAN Long Tern Care's culture is an environment of constant improvement in the areas of compliance and dispute resolution that furthers our mission of quality care for our members.

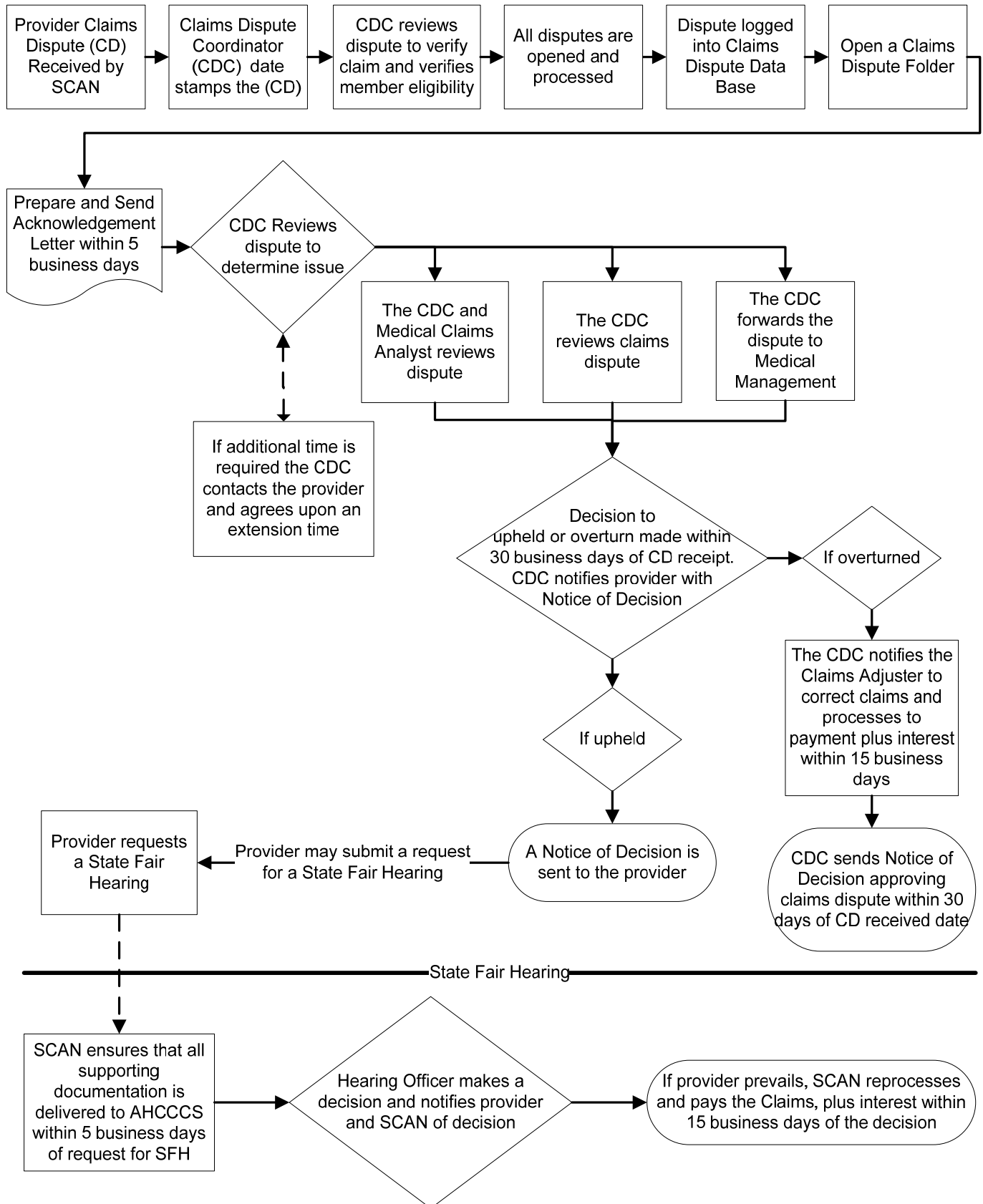
**Member Grievance Flowchart**



### Member Appeal Process Flowchart



**Provider Dispute Flowchart**





---

## *Requirement 16: Corporate Compliance Program*

---

SCAN Long Term Care (SCAN) Compliance Program is designed to meet and exceed state and Federal requirements for Corporate Compliance. SCAN's culture of accountability for employees and management includes policies and processes designed to promote self monitoring of individual departmental activities to assure compliance. The Compliance Program consists of the program integrity requirements mandated under federal managed care regulations, including:

- A designated Compliance Officer and Compliance Committee that is accountable to the SCAN Chief Executive Officer
- Written policies and procedures that articulate SCAN's commitment to compliance
- SCAN policy and state and federal requirement enforcement
- Effective SCAN employee training
- Open lines of communication between the Compliance Officer and SCAN employees
- Internal monitoring of SCAN functional areas
- Prompt disclosure, response and correction of compliance issues

### **Compliance Officer, Compliance Committee and Compliance Staffing**

The SCAN Board of Directors appointed the Compliance Officer for the organization. The position reports directly to the SCAN CEO and is a member of the Arizona Executive Team. The Compliance Officer also coordinates with related SCAN Parent corporate counterparts, including the Vice President, Internal Audit, the Senior Vice President of Compliance and General Counsel. The Compliance Officer manages and oversees a department of support staff that facilitates Compliance Program activities. The Compliance Officer is accessible to all employees, members and contractors.

The SCAN Compliance Officer is an on-site, Arizona-based official who provides daily oversight to the Arizona Compliance and Grievance and Dispute Departments and is responsible for all compliance oversight within SCAN. The SCAN Compliance Officer is a senior level position that has the authority to review all documents and other information that are relevant to compliance activities, and to make independent referrals to the AHCCCS Office of Inspector General.

The Compliance Officer is responsible for interfacing and collaborating with AHCCCS personnel regularly to coordinate compliance related activities, including AHCCCS audits and reviews. As the AHCCCS liaison for SCAN, the Compliance Officer is the point of contact for SCAN management and employees concerning requirement related questions and determining when regulatory guidance from AHCCCS is warranted. The Compliance Officer monitors and facilitates regular AHCCCS deliverable submissions as well as ad hoc AHCCCS requests. The Compliance Officer attends regular ad hoc AHCCCS meetings, including the Compliance Officer Network Group (CONG), held by the AHCCCS Officer of Inspector General, and the AHCCCS CEO meetings.

The SCAN Compliance Committee consists of management from local and corporate functional areas in order to allow for cross-functional collaboration and accountability. The committee is chaired by the Compliance Officer. The membership includes leadership with the authority to commit budgetary resources as necessary. The Committee agenda includes "Early Warning Signs," allowing for self disclosure of potential compliance issues or future areas of risk that require more robust intervention and monitoring. The agenda also provides corrective action updates and progress as well as reports on any suspected fraud, waste or abuse that has been reported.

The Compliance Officer oversees SCAN privacy program in compliance with the Health Insurance Portability and Accountability Act by implementing local policies and procedures and serving as the local representative in collaborating with SCAN Group Corporate Risk Management in meeting new Health Information Technology for Economic and Clinical Health (HITECH) Act requirements.

The Compliance Officer provides direct management and oversight of the Compliance Department. The department consists of a Compliance Administrative Assistant, Compliance Lead, Compliance Specialist, grievance system staff and a financial analyst devoted half-time to compliance activities. The financial analyst is responsible for annual member trust fund audits. Compliance Department staff are authorized to interface with management and employees regularly, including ongoing internal meetings and in compliance related inquiries and audits.

The Compliance Lead will be a newly established position under the CYE2012 contract to serve as leadership support for the Compliance Officer and management to grievance system staff. The position serves in a dual capacity due to the low grievance and appeal volume not supporting a full-time dedicated management position. The Compliance Lead will also supervise the Compliance Specialist, who is responsible for Policy Committee meeting preparation, annual policy review and compliance auditing. The Lead will assure tracking, investigating and reporting of suspected fraud, waste and abuse to the AHCCCS Office of Inspector General as well as monitoring compliance with AHCCCS requirements and Compliance policy requirements.

### **Program Documents, Policies, Procedures and Enforcement**

The SCAN Compliance Program consists of the SCAN Code of Conduct, the Compliance Program Description and Work Plan that outlines corporate compliance expectations as well as compliance activities. SCAN has policies and procedures in place to meet state and federal requirements for the ALTCS program for all SCAN functional areas. Through a collaborative cross-functional Policy Committee chaired by the Compliance Officer, SCAN reviews, updates and creates policies based on the most current AHCCCS contract and other state requirements using SCAN policy writing guidelines. Policies include provisions for fraud, waste and abuse detection and reporting as well as SCAN's whistleblower anti-retaliation provisions and Compliance Hotline information.

Compliance program expectations are also outlined in the SCAN Provider Operations Manual that includes state and federal False Claims Act information and the state's hotline for reporting potential fraud, waste and abuse. The SCAN's Member Handbook explains fraud, waste and abuse to members and provides the SCAN Member Services customer service line as a mechanism to report suspected issues.

SCAN policies and procedures are enforced by the Compliance Officer with the support of the SCAN Chief Executive Officer. As issues arise, risk analysis is completed to determine enforcement strategies. If an issue is detected of significant severity, individual employee disciplinary action, including employee termination could be warranted.

### **SCAN Employee Training and Open Lines of Communication**

Compliance training is conducted for new hires and refresher training for current staff on multiple components of the Compliance Program. The training includes a review of the Compliance Program Policy, Fraud, Waste and Abuse Policy, Cultural Sensitivity requirements and related SCAN tools, as well as a corresponding explanatory presentation that includes orientation to AHCCCS policy manuals located on the AHCCCS Web site. Employees are informed of the availability of the Compliance Hotline and the ability to report suspected compliance issues anonymously. Additionally, employees are informed of the availability of the Compliance Officer for open discussion of potential compliance concerns. The presentation and policy review include provisions of the False Claims Act and explanation of SCAN's policy of non-retaliation against employees who report potential compliance issues, such as suspected fraud, waste or abuse. SCAN Group has also developed mandatory HIPAA employee training that all new SCAN Long Term Care employees must complete.

It is SCAN's policy that management conduct annual departmental policy training to all employees with corresponding sign-in sheets copied to the Compliance Department for verification. The Compliance Department disseminates and requires management sign-off for AHCCCS requirement changes pertaining to their functional areas.

---

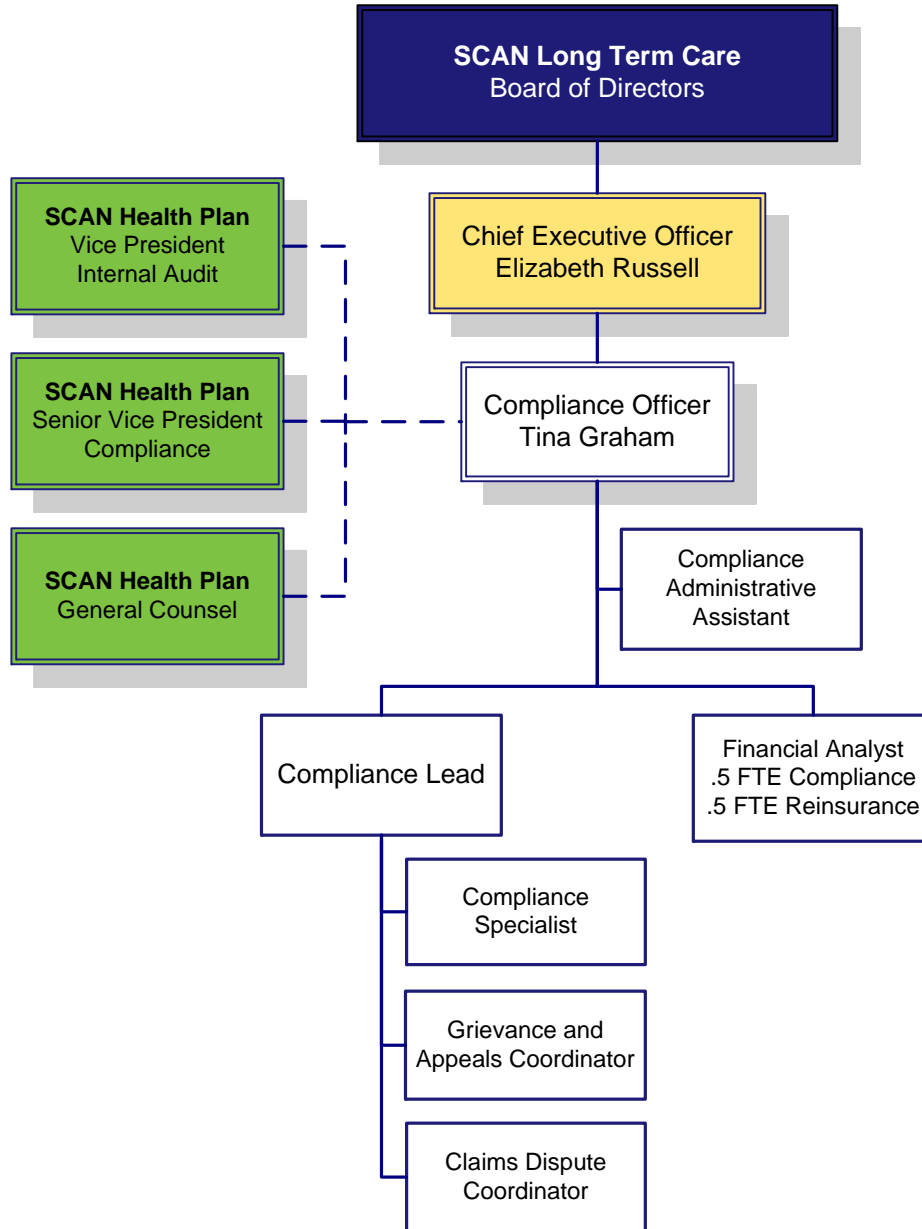
## **Internal Monitoring and Corrective Action**

With the support of the Compliance Department, SCAN's management is responsible for self monitoring and identification of potential compliance concern. Newly enacted SCAN policies require departmental management to conduct internal reviews and audits, including confirmation of data accuracy used to track compliance and regulatory agency partners' deliverables. AHCCCS deliverables are closely reviewed and tracked for consistency with AHCCCS reporting requirements and to monitor functional area performance. The Compliance Department also identifies an area to be audited on an annual basis as well as conducts targeted audits if compliance issues are suspected. Audit results are fully disclosed to the audited department and the Compliance Committee so that any necessary corrective measures can be taken. If a compliance issue is identified, the Compliance Officer coordinates with related SCAN departments and AHCCCS to assure an appropriate self disclosure, enforcement and corrective action strategy is developed that meets AHCCCS' expectations.

SCAN considers regulatory compliance a company wide responsibility and immerses compliance into all aspects of day-to-day management and operations. The Compliance Officer and SCAN management have enacted the structure necessary to support a robust Compliance Program, while creating an open environment in which compliance issues are readily identified and remedial action is taken to correct problems.

### SCAN Long Term Care

#### Organizational Chart for Compliance



---

*Requirement 17: Audited Financial Statements*

---

SCAN Long Term Care, the Offeror, is an existing ALTCS Contractor that has been operating since CYE2007. The three most recent audited financial statements for calendar year ended December 31, 2007, 2008 and 2009 for SCAN Long Term Care and SCAN Group, the related ultimate parent company, have been filed with, and accepted by, AHCCCS in accordance with contract reporting requirements. The audited financial statements for the calendar year ended December 31, 2010 will be submitted to AHCCCS on or before April 30, 2011.

Having met the submission requirement through current contract requirements, resubmission of audited financials with this bid response is not required.

---

*Requirement 18: Performance Bond Requirement*

---

As requested by AHCCCS, SCAN Long Term Care has an irrevocable standby Letter of Credit issued by U.S. Bank, a Federal Deposit Insurance Corporation, in the amount of \$8,163,445. This amount has been pledged to AHCCCS to guarantee SCAN Long Term Care's performance bond requirement for CYE2011. The irrevocable standby Letter of Credit was approved and accepted by AHCCCS on October 26, 2010, as meeting the Bond Substitute requirement.

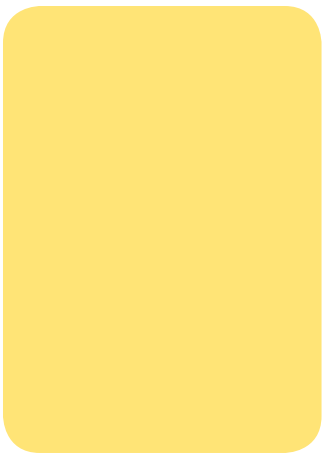
*Requirement 19: Minimum Capitalization Requirement*

---

SCAN Long Term Care, the Offeror, is an existing ALTCS Contractor that has been operating since CYE2007 and is currently serving geographic service area (GSA) 52 Maricopa County.

At December 31, 2010, SCAN Long Term Care's equity, based on unaudited financial statements, equaled \$3,440 per member and met financial viability criteria requirement of at least \$2,000.

Additionally, based on unaudited financial statements at December 31, 2010, SCAN Long Term Care's unrestricted capital balance was \$10,009,825, which is more than double the required minimum capitalization of \$5,000,000.



## Our Members are Our Mission

SCAN Long Term Care focuses on each member's individual medical, functional, social, cultural and behavioral health needs, promoting their total wellness through integration of consistent quality health care and services in the least restrictive setting.



SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

## TABLE OF CONTENTS

## SECTION D – PROGRAM

Table of Contents: Section D – Program	152
Case Management Submissions	
<i>Requirement 20: Inter-departmental Coordination</i>	153
<i>Requirement 21: Level of Consistency among Case Managers</i>	156
<i>Requirement 22: Assessing and Meeting Needs of Complex Care Members</i>	159
<i>Requirement 23: Assessing and Care Planning for Home-Based Services</i>	162
<i>Requirement 24A: Case Management Scenarios – Case A: Oscar</i>	165
<i>Requirement 24B: Case Management Scenarios – Case B: Magda</i>	168
<i>Requirement 24C: Case Management Scenarios – Case C: Wanda</i>	171
<i>Requirement 24D: Case Management Scenarios – Case D: Roger</i>	174
Medical Management Submissions	
<i>Requirement 25: Utilization Data Management</i>	177
<i>Requirement 26: Successful Interventions in Over-/Under-Utilization</i>	183
<i>Requirement 27: Chronic Care/Disease Management Programs</i>	186
<i>Requirement 28: Consistent Application of Clinical Criteria</i>	189
Quality Management Submissions	
<i>Requirement 29: Quality Improvement Opportunities</i>	192
<i>Requirement 30: Peer Review</i>	195
<i>Requirement 31A: Quality of Care Scenarios – Case A: Licensure Risk</i>	198
<i>Requirement 31B: Quality of Care Scenarios – Case B: Environmental Risk</i>	201
<i>Requirement 32: Improving Quality of Care and Performance</i>	204
<i>Requirement 33: Member and Provider Feedback</i>	207
<i>Requirement 34: Monitoring Home Services</i>	210
<i>Requirement 35: Oral Presentation</i>	213

## *Requirement 20: Inter-departmental Coordination*

---

SCAN Long Term Care (SCAN) recognizes the value created by inter-departmental coordination to ensure all members' health and service needs are met with optimal outcomes. The shared belief in this value begins with the orientation and training of new case managers. SCAN focuses on assuring all case managers appreciate and understand the processes for coordination with other departments on medical needs, fraud and abuse, grievance issues, quality of care reporting, the inter-disciplinary team (IDT) process, behavioral health needs, notice of action requirements, non-provision of services, disease management referrals, member services coordination, risk management and best clinical practice guidelines. Case managers are a crucial link in the chain of providing information to and receiving information from a variety of sources and departments to effectively collaborate on meeting the needs of an individual member, as well as achieving organization-wide improvement.

### *Inter-departmental Coordination on Individual Members*

For an individual member, inter-departmental coordination begins when the member first enrolls with SCAN. The Administrative Assistant receives and reviews the Pre-Admission Screening (PAS) information to determine the appropriate assignment of a case manager (CM) based on member age, placement, location, Regional Behavioral Health Authority (RBHA) status and ventilator dependent status. For members who transition from another program contractor, the Transition Coordinator reviews the Enrollment Transition Information (ETI) received from the sending program contractor. If the PAS or ETI indicates the member has medical equipment, procedures or therapies, a copy of the document is given to the Prior Authorization Department to coordinate care and authorize services as appropriate. Additionally, if the PAS or ETI indicates the member receives behavioral health services through the RBHA, a copy of the document is given to the behavioral health (BH) Supervisor to ensure that information is received from the RBHA and services are transitioned appropriately. If the member is under age 21, the Maternal Child Health Coordinator designee is scheduled to attend the initial assessment along with the CM.

An IDT is a cross-functional team comprised of members from different disciplines convened for the purpose of examining the status of a case and developing continued care management strategies around the clinical issues of the case. Representatives from case management, medical management and behavioral health are core participants. The IDT may involve a quality management department representative, compliance representative, psychiatric consultant, a medical director, the member, the member's primary care provider (PCP) or other consultant as appropriate to the case. An IDT staffing occurs when internal reports or CM assessment of the member indicates one of the following criteria:

- Qualifying age for EPSDT services
- Frequent emergency department visits or hospitalizations including psychiatric stays
- High volume medications or poly-pharmacy
- A current plan of care that is not being followed
- Placement changes more than three times in the past six months for reasons other than clinical need
- Service needs that are at or temporarily exceed 100 percent of cost-effectiveness
- A court-ordered evaluation and treatment or complex behavioral needs
- One-to-one coverage in existing placement
- Receipt of a 30-day notice to discharge
- Medical needs that require complex case management or disease management
- Grievance or quality of care issues
- A barrier to moving to a less restrictive setting
- Other needs identified by the CM or other party who may request an IDT

An example of how SCAN improved member health and service outcomes for an individual member through interdepartmental collaboration can be seen in the case of a 48 year old male who enrolled with

SCAN on March 1, 2007 at the age of 45. He had multiple diagnoses, including uncontrolled diabetes, hypertension, schizoaffective disorder, bipolar disorder, psychosis and personality disorder. A brief history showed that before July 2006 the member was in several group home placements. These placements were unsuccessful due to the member's noncompliance with medical and diabetic care, resulting in multiple ED visits and serious medication overdosing. He was then admitted to a nursing facility behavioral unit where he was assaultive, and the police were called out several times. He was petitioned at the hospital and placed on court ordered treatment. On November 22, 2006 the member was placed in a nursing facility behavioral unit. He continued to reside there upon enrollment with SCAN.

Upon review of his ETI, the Transition Coordinator made the BH Coordinator aware of the member's placement, and the case was assigned to a CM with behavioral health experience. From the point of his initial assessment, the member expressed interest in living more independently. A staffing was conducted with the facility clinical director, unit manager, SCAN's BH Coordinator and the CM. Despite the Clinical Director's assessment that the member would "never leave the facility", SCAN serves all members from the perspective of its mission and philosophy to respect the member's desires regarding placement and keep them as independent as possible. Over the next 15 months, a series of interdisciplinary meetings were held involving the ombudsman, nursing facility staff, SCAN's BH Coordinator, the member's counselor, Network Management representatives, the CM and the Medical Director. These meetings identified the type of providers and services the member would need to be successful. By August 2008, SCAN introduced the member to a behavioral day program with a provider who also runs a rehabilitative group home. The member moved into the home in November 2008 and continues to reside in this setting. His court order was dismissed in February 2011 and he is currently exploring an independent living option.

#### *Inter-departmental Coordination for Process Improvement and Service Outcomes*

On an organization wide scale, SCAN accumulates data through case manager reports filed as grievances or quality of care reports, a variety of data mining activities, survey processes, and provider monitoring activities. The data gathered through these various resources results in reports that are tracked, trended and analyzed to identify opportunities for improvement throughout the organization. The analysis is reviewed at multidepartment meetings and a process for improvement is identified. These meetings include:

- Network Management
- Clinical Management Team
- Assisted Living Facility Sub Committee
- Quarterly grievance management and executive team review
- Monthly Least Restrictive Setting reviews
- Disease Management IDT staffings
- Case Management and Network Management Non-Provision of Service/Gap reviews
- Quality Management/Medical Management Meetings

CMs are trained in all aspects of the process improvement that involve their role and member or provider coordination. The activities and their results are measured through the QM process and the results are presented to the Case Management Department to complete the feedback loop. The Case Management Department also hosts quarterly focus groups for CMs to elicit ideas for improvement in member services, provider performance or SCAN operations. The focus groups are comprised of CMs, supervisors, department managers and the department vice president. The outcomes of these meetings and recommendations are taken by the management team to other departments wherever collaboration is needed.

Inter-departmental collaboration and data on an organizational level have resulted in improved member health and service outcomes in several areas. Two examples can be seen in the preventive health

screenings for members with diabetes and improved initiation of services for members in their own homes.

### Diabetes Screenings

Review of diabetic screening data for 2007 and 2008 showed that SCAN’s performance needed improvement. Quality Management, Case Management and Network Management met to identify barriers to meeting performance targets. Identified barriers included the lack of a way to gather data on members who had other primary insurance, testing members who could not easily leave their residence, collecting information from residential placements and educating members on where to get services. Case managers assisted in collecting data from placements including assisted living centers and skilled nursing facilities. Case managers also played a role in educating members about where to go to complete testing and assisting with the coordination of those services. Providers were identified to go into member homes and placements to complete lab draws and eye exams for those members unable to visit external clinical sites. These process changes resulted in improved performance on all three measures and improved member health outcomes. For measurement period CY2009 SCAN exceeded MPS on A1c and Lipid testing and had statistically significant improvement on eye exam rates. We continue to evaluate our interventions and identify process improvements.

<i>Measure</i>	<i>SCAN Rate CYE2007</i>	<i>SCAN Rate CYE2008</i>	<i>SCAN Rate CYE2009</i>	<i>MPS</i>
A1c	56.5%	63.6%	85.6%	80.0%
LDL-C	47.8%	56.1%	75.2%	72.0%
Eye Exam	26.1%	31.8%	45.1%	60.0%

### Initiation of Home and Community Based Services

Analysis of the data related to the initiation of services for 2007 showed that SCAN achieved an 85 percent performance rating. Meetings with Case Management and Quality Management resulted in the development of a modified Provision of Service (POS) Assessment reflecting the performance criteria and exclusions measured by AHCCCS. The assessment is completed by case managers when services are initiated and member satisfaction is confirmed. For members who have not yet received a service, the data is extracted into a POS report sent out weekly to the CMs for follow-up on the services. Review of the documentation indicated consistency in the documentation of the services reviewed and the member’s refusal or acceptance of services could be improved. A refusal of services form was created to enhance consistency. Case managers were re-trained on qualifying services, the criteria for documentation of a refusal or exclusion criteria such as hospice. One barrier identified by case managers was that family caregivers had challenges leaving the home to complete training, even when an alternative caregiver was offered. Agencies were identified that would come into the home to train family caregivers in a timely manner. Lastly, the Case Management department began scheduling home based assessments within seven business days whenever possible for members residing in their own home. This allowed more time for the family and case manager to get services established in the home or follow-through on training and still meet the 30 day guideline.

<i>Measure</i>	<i>SCAN Rate CYE2007</i>	<i>SCAN Rate CYE2008</i>	<i>SCAN Rate CYE2009</i>	<i>MPS</i>
Initiation of HCBS Services with 30 days of member enrollment	85%	86.4%	94.2%	92%

SCAN values the importance of inter-departmental coordination beginning with orientation and training of all SCAN employees. Collaborating and partnering with the member, internal departments and external providers validates SCAN’s mission to be member focused. Internal data and reports allow for a broader view in tracking and trending to improve and develop new and innovative ways to serve our members. SCAN’s inter-departmental coordination with all departments has proven successful for improving health and service outcomes on an individual and organizational basis.

## Requirement 21: Level of Consistency among Case Managers

### *Monitoring and Improving Consistency*

SCAN Long Term Care (SCAN) is a non-profit organization whose mission and expertise is in developing partnerships that deliver the right health care in the right setting while maximizing the members' ability to remain independent. Accurate and reliable assessment of the member's needs and services is vital to achieving this goal. SCAN recognizes the importance of monitoring and improving consistency with case management processes. SCAN utilizes a multi-prong approach to ensure Case Managers (CM) are assessing member needs consistently, timely, appropriately and cost-effectively. A successful case management program requires initial and ongoing monitoring of CMs. This is accomplished through several key program components within SCAN: new-hire training, quarterly inter-rater reliability (IRR) sessions; audit practices; monitoring reports and ongoing department trainings. In addition, supervisors shadow CMs in the field on a semi-annual basis to evaluate their application of interviewing techniques, use of standardized tools and knowledge of required processes. CMs may also request a field visit with a supervisor on an as-needed basis to trouble shoot barriers or provide feedback in complex situations.

### *New-Hire Training*

SCAN CMs receive ALTCS specific orientation and training performed by the SCAN Case Management Department Trainer. The ten day training includes comprehensive instruction on the ALTCS program requirements and shadowing of experienced CMs. Training includes, but is not limited to, an overview of AHCCCS, member rights and responsibilities, program contractor responsibilities, components of ALTCS case management including: service planning and coordination; brokering of services; facilitation and advocacy; monitoring and reassessment; gate keeping; case management visit standards; needs assessment and care planning; behavioral health (BH) services and standards; placement and service planning. As part of their training, CMs learn it is their responsibility to collaborate with the member and their representative to assess needs and develop a mutually agreed upon care plan and authorize appropriate covered services based on each member's individual needs. CMs learn processes for referring members to available and appropriate community-based services. CMs receive detailed training on the Home and Community Based Services (HCBS) Needs Tool and the accompanying Instruction Guide.

Each new CM has a mentor who is a senior CM experienced with SCAN and ALTCS requirements. This mentor serves as a point of contact for questions, demonstrates assessment and interview techniques in the field and shadows the new CM on assessments. During this shadowing process, the mentor ensures appropriate use of the HCBS Needs Tool and Level of Care determinations until the new CM has reached an understanding and comfort level to operate independently. Through training and working with their mentor, new CMs learn the skills necessary to consistently utilize the Assessment Tool, interview members, and develop an individualized service plan to best meet the member's needs. In addition to partnering with new case managers, SCAN mentors meet quarterly with management and the department trainer to address improvement to new hire training, changes to field practice and suggestions for enhancing the mentor program.

### *Inter-rater Reliability*

SCAN develops case scenarios and conducts quarterly IRR sessions with case management staff to measure and evaluate reliability in assessing level of care, recording needs, authorizing services, and completing forms for members in nursing facilities, assisted living centers, and home and community based settings. The case management teams rotate IRR participation on a quarterly basis. New CMs participate in an IRR scenario at the end of their 90-day probationary period. The IRR sessions for both new and existing CMs include role-playing a member interview related to a member's Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The CMs are asked to individually complete the necessary forms for the member regardless of setting. CMs are asked to complete forms

required if the member lived in a nursing home, assisted living center and home setting. Forms included are the HCBS Needs Tool, Uniform Assessment Tool (UAT), Service Plan, Contingency Plan, Residency Agreement and Single Occupancy Agreement. The results are analyzed and compared to guidelines provided by AHCCCS for use of the Needs Assessment Tool and appropriate service combinations.

The results are analyzed and compared to guidelines provided by AHCCCS for use of the needs assessment tool and appropriate service combinations. The CM participants are brought back together to discuss the overall results of their IRR session. This allows for dialogue about how the CMs understood the member’s needs leading to their assessment of needs and recommended service authorization. The Vice President and Managers of Case Management meet on a quarterly basis to review the results of each IRR session. Trends and training needs identified through this analysis are discussed during the Case Management Department meetings as well as with SCAN’s Executive Management Team. Training is conducted on an individual or group basis to improve consistency, reliability, and adherence to guidelines. For example, in February 2010 the CM department was trained on the UAT instructions. Following this training, the CMs achieved 100 percent agreement on the UAT level of care in IRR sessions. The results of IRR sessions were discussed following each quarterly IRR session, including 4/28/2010, 7/13/2010, 10/12/2010, 12/7/2010, and 3/15/2011. Topics which required training were discussed in these feedback sessions, such as how laundry time is determined for members residing in an apartment with laundry on the premises, but outside of the member’s apartment. The below chart outlines how the CMs have achieved increased consistency amongst their overall selections of UAT level of care and tightened the range of attendant care hours authorized in IRR sessions.

<i>Measure</i>	<i>December 2009</i>	<i>April 2010</i>	<i>June 2010</i>	<i>September 2010</i>	<i>December 2010</i>
Level of Care	72%	100%	100%	100%	100%
Range in Number of Attendant Care Hours	12 hours	14 hours	15 hours	7 hours	5 hours

Given the range of attendant care hours selected by case managers in IRR sessions, the management team identified alternative methods for conducting future IRR sessions with the goal of increasing understanding regarding the amount of time needed for completion of ADL and IADL tasks. For instance, future sessions will be conducted at the Foundation for Senior Living’s Caregiver House. To conceptualize how long a task may take, CMs will act as the member and caregiver in completing ADL and IADL tasks. These timed activities include CMs being given specific caregiver task instructions and completing them within the time allotted. The objective of the exercise is to give CMs a better understanding of reasonable timeframes for each task based on the member’s needs. CMs will complete a mock assessment while at the Caregiver House. An experienced CM will complete a side-by-side assessment with a less seasoned CM to review the consistency between service authorizations and need determinations. Future IRR sessions will be completed with the supervisor and management team to reinforce consistency between the first and second level review of changes in member services or approval of the member HCBS Needs Tool and service authorizations. An additional element in future IRR sessions will be CMs completion of the Patient Health Questionnaire (PHQ-9), the mini-cog/mental status exam, and behavioral health history to evaluate the consistency of CM assessments of a member’s behavioral health needs.

### Audits

The SCAN Case Management Department Auditor completes three case file audits for all CMs each quarter to review consistent use of department processes and tools. The Auditor reviews authorization consistency and accuracy. The case files are randomly selected to include samples from various setting types and behavioral health services. Focused audits provide feedback on specific areas throughout the department, such as service determination and authorization patterns. The focused audits are analyzed by the CM Managers allowing for the identification of over/under-utilization or specific interval of service or Level of Care (LOC) trends by individual CMs. SCAN is automating the process of gathering this

information. Other focused audits for each CM include quarterly review of the HCBS Needs Tools and Level of Care Authorizations for residential settings. Analyzing CM patterns allows for individualized instruction, improvement and remediation where necessary. In January 2011, SCAN began developing an Assisted Living Facility UAT to ensure consistent application of ALF LOC authorizations.

## Reports

SCAN generates and reviews reports to monitor consistent assessment of needs, service delivery patterns and follow up on service determinations. These reports include:

- **Level of Care and Service Authorization Comparison:** Compares the UAT LOC entered by the CM to the amount of services and LOC within service authorizations.
- **Utilization by CM:** Lists services authorized by each CM for their members. It is used to capture any duplication of services and ensure a range of service types and frequency appropriate to the caseload.
- **Milestones:** Lists the due date for member assessments and timeliness of completion.
- **Provision of Services:** Identifies members who are within the first 30 days of enrollment but have not begun services and assesses the satisfaction of new members receiving services.
- **Total Services Authorized:** Identifies critical care services authorized as well as specialty subgroups, such as Spouse Attendant Care and Self-Directed Attendant Care
- **Behavioral Health Request or Need:** Utilized to audit referral and follow up of behavioral health services. Generated off assessment data indicating the member requested a behavioral health service or scored in a range that would point to a need.
- **Level of Care Change Report.** Lists members who have changed LOC settings to ensure follow up is completed within a ten day timeframe and needs are reassessed as appropriate.

## Ongoing Department Trainings

During the monthly management meetings, trends are reviewed and opportunities for improvement are identified. SCAN has a CM focus group that suggests training topics and reviews process changes prior to department trainings. A portion of each bi-weekly meeting is dedicated to training. Ongoing trainings are conducted to improve consistency in the following areas: HCBS Needs Tool Instructions; UAT Instructions and consistent practices; wound care/skilled nursing; clinical documentation; preventive health screenings including diabetes care; assessing for home modifications; assessing behavioral health needs; Spouse Attendant Care; Self-Directed Attendant Care; Employment Education and Housing; community resources and support groups; and cultural awareness.

SCAN's mission is to enhance the ability of the elderly and physically disabled to manage their health and control where and how they live. Through on-going training and development, the Case Management Department routinely monitors and seeks improvement in Department programs and processes.

## Requirement 22: Assessing and Meeting Needs of Complex Care Members

Since its inception, SCAN Long Term Care (SCAN) has embraced the idea that elderly and physically disabled individuals have medical needs that are complex and often have accompanying emotional and social effects. These vary in degree from normal depression, anxiety and grief to complex behaviors. SCAN's belief is that member needs can best be met through an integrated case management approach addressing the medical, functional, social, cultural and behavioral health (BH) needs of each member. The organization understands that a range of social, environmental and age-related conditions, if left unaddressed, may have a negative impact on overall health and functioning and lead to more costly medical utilization.

Assessing member needs begins upon enrollment. The Administrative Assistant (AA) reviews the Pre-Admission Screening (PAS) or Enrollment Transition Information (ETI), if applicable, and assigns members with behavioral needs to a BH Case Manager (CM). Members through age 21 are assigned to a CM experienced with pediatric cases and medically complex or ventilator dependent members are assigned to a CM with a nursing degree. Beginning with the initial contact, the AAs answer questions for members and/or their representatives and have access to the CM of the Day (CMOD) and the Supervisor or Manager if a complex or urgent need arises. SCAN's Initial Visit Report indicates the AHCCCS standard of 12 business days has been met with 99.74 percent accuracy this contract year. SCAN's internal goal is to assess members residing in their home within seven business days to meet member needs as quickly as possible.

The CM reviews the PAS and/or ETI prior to visiting the member. During the initial onsite assessment and reassessments, the member's current medical, functional and behavioral health status, including strengths and needs is evaluated. In addition to the assessment, there are several ways a member's needs identified as behaviorally or medically complex are coordinated. Members who are complex in one or both areas are reviewed through the inter-disciplinary team (IDT) process. An IDT is comprised of cross-functional SCAN and contracted staff convened for the purpose of examining the status of a case and developing continued care management strategies around clinical issues. Case management, medical management and behavioral health representatives are core participants. Quality Management representative, Compliance representative, psychiatric consultant, a medical director, the member, the member's primary care provider (PCP) or other consultant as appropriate to the case may also attend.

### *Behavioral Management*

Behavioral needs assessment and care planning begins at enrollment and is monitored on an ongoing basis. Whenever there is a change in needs or care plan, coordination between all parties is essential. SCAN accomplishes this through:

Review of the ETI and PAS – Facilitates appropriate assignment of the case, transition of existing services and identification of all parties involved such as the Regional Behavioral Health Authority (RBHA), previous BH providers or current service providers involved in the member's care. Members transitioning from the RBHA, on court ordered treatment (COT) or placed in a behavioral unit are assigned to the BH Team. The BH Supervisor ensures services from the RBHA are transitioned within 30 days and coordination occurs with the RBHA Transition Coordinator and any BH provider involved.

Assessment Process – The Patient Health Questionnaire (PHQ-9) depression scale is used along with a mini-cog or mental status exam and behavioral health history to assess the need for behavioral health services. For members whose PHQ-9 score is greater than five, a letter is sent to the member's PCP to evaluate a course of treatment and make recommendations. The need for behavioral health services may be identified by the assessment process or requested by the member.

IDT Process – Member's needs assessed as complex due to a behavioral diagnosis or uncontrolled behaviors are reviewed in an inter-disciplinary team (IDT) staffing to evaluate appropriate case assignment and interventions. The CM, BH CMs, BH CM Supervisor, BH Coordinator, and Supervisor



attend the staffing. It is determined if the BH CM will assist the CM or if the case will be assigned to a BH CM. Communication occurs with the member, representative, PCP, specialists and servicing providers as appropriate.

BH Service Review and Consults – The CM reviews requests for behavioral health services with the BH Coordinator within three business days of the request and completes the referral for services within one day following the review. Case Managers complete quarterly behavioral health consultations with the BH Coordinator for members receiving ongoing services. Consultations include the CM, member, member's primary support system, BH provider, BH Coordinator and physician or any health care provider as needed. The BH consultation includes, but is not limited to, ensuring that services are appropriate, assessing progress and documenting changes. The member is actively involved in the goals of their treatment plan and discharge planning. The CM faxes the consultations to the member's PCP, member guardian and BH Provider within one business day of the consult to coordinate care. At the request of the BH Coordinator, additional consultation may occur between the SCAN Medical Director and/or the psychiatric consultant. Each consultation is audited by the BH Coordinator to monitor coordination with the member's PCP, guardian and BH provider.

Ongoing monitoring, assessment of member's needs and changes to care plans occurs throughout the Case Management Department. They include:

BH CM Team meetings – The team completes monthly case staffings to review current care plans, assess member needs and modify services to optimize care. If there are changes in the member's care plan, communication is sent to the PCP, BH Provider and other servicing providers as appropriate to the member's case.

Inpatient Psychiatric Review – The BH Coordinator, BH Supervisor, SCAN psychiatric consultant and Medical Management concurrent review nurses review all SCAN members admitted to a psychiatric inpatient hospital on a weekly basis. Admissions are reviewed to evaluate if it is an acute episode for the member that is potentially resolved or there is a need for a change in the member's ongoing plan of care. The current progress of the member is assessed and discharge planning is coordinated between departments. Member's representatives and servicing providers are engaged as appropriate, and the plan of care is updated. Appropriate placement is discussed, and behavioral health services are in place before the member is discharged.

Crisis Report and Assessment – In Crisis situations may be an indicator that current behavioral health services are not sufficient or a member not receiving services is now in need of ongoing support. Mobile crisis contracted providers fax a report to the CM indicating any crisis services received. A claims report is generated monthly to retrospectively review services provided and ensure CMs were notified of all crisis services. An assessment of the crisis is completed to determine if it was an environmental trigger, an acute medical or emotional episode or a change to the care plan is needed. High risk members receive a crisis plan shared with any support system, service provider and saved internally. Environmental assessments or behavior plans may be completed for members who do not need ongoing counseling or psychiatric services but need adjustments in their environment to prevent triggers for behaviors.

Court Ordered Treatment – Members on COT are seen on a monthly basis by a SCAN contracted psychiatrist contracted. The BH CM meets with these members on a monthly basis and completes a staffing with the Medical Director, BH Coordinator, BH CM Supervisor, BH CM and treating psychiatrist. For members in need of BH services but not consenting to treatment, the CM consults with their Supervisor and the BH Coordinator to explore alternative choices. If the member is determined to meet the criteria for a petition, SCAN staff initiates and follows-through with the process. The BH Coordinator, psychiatric consultant and/or Medical Director is consulted as needed. If a petition is filed and member is under Court Ordered Treatment (COT), SCAN attorneys are contacted. A case is developed including timelines for renewal and status updates. The CM coordinates any changes to the care plan with the member's PCP, member representatives and behavioral health providers.

### *Medically Complex*

Medical needs assessment and care planning begins with enrollment and is monitored on an ongoing basis. SCAN manages members with specialty needs through the following methods:

Specialty needs – Members on a ventilator are assigned to a CM with a nursing degree due to the medical complexity. Pediatric Members are assigned to a CM with experience in pediatrics who understands Children’s Rehabilitative Services (CRS) coordination, school systems and Early and Periodic Screening Diagnosis Treatment (EPSDT) requirements. Although not all pediatric members are medically complex, the majority of pediatric members have multi-systemic involvement.

Risk Statistic Report – Provides a risk score for members based on age, gender, NHC status, institutional status, race, county, base non-IP cost, Rx cost, number of office visits, number of ER visits, number of inpatient admissions, oxygen use, COPD, hypertension, medication, use of anticoagulants, phosphate binders, renal dialysis cost and a number of other factors. Members scoring over 95 percent risk score are screened for complex case management. The IDT reviews these members to allow for comprehensive feedback on a member’s needs, care plan, and the appropriateness of a referral for either disease management or complex care management. Members not identified through the report but possibly requiring complex case management can be referred by internal staff via the referral process in CareEnhance® Care Management Software (CCMS®). If the member has an external primary insurance, the CM will coordinate to secure services for the member.

Skilled Needs Report – Identifies members receiving or meeting the criteria to receive skilled services. It is utilized to complete reviews of members needs via IDT. Members at risk of compromising skin integrity due to being bed bound, quadriplegic, unstable medically, have pressure ulcers, surgical wounds, etc. are referred for home health evaluations and ongoing monitoring as determined necessary by the assessment. This care is coordinated through the member’s PCP and/or specialists involved.

Disease Management – A recruitment report is run indicating members whose diagnoses are appropriate for disease management programs. Members may be referred to internal disease management programs or the CM coordinates with the member’s primary insurance to ensure the member is appropriately enrolled in such a program. CMs assess preventive screenings for members with chronic conditions, such as diabetes. They provide educational material and make referrals where appropriate through SCAN contracted providers or providers available through the member’s primary insurance. The member’s care plan is updated and shared with the member, representative, PCP and appropriate parties.

Pharmacy Reviews – Reports identifying members on high risk medications, taking drugs with a potential drug to drug interaction, utilizing multiple prescribers or pharmacies and having specific disease states and classes of medications are used to enroll members in our Medication Therapy Management Program.

Hospice Coordination – SCAN identifies members enrolled with hospice and the hospice provider in order to coordinate care.

When considering behavioral or medical needs, CMs assist members in identifying their goals and give supplemental information about community resources and support groups. CMs partner with families, members and providers in the development of the care plan, whether behavioral or medical in nature. For all members receiving behavioral and medical services, SCAN takes steps to ensure the medical and behavioral providers exchange necessary information to coordinate care on the member’s behalf. Members whose needs cross multiple domains and are involved with multiple providers are reviewed through the IDT process. CMs participate in this process to receive input on how to best meet member needs and provide services to the member in the most appropriate manner. The CM serves as a coordination point between the providers, the IDT and the member.

### Requirement 23: Assessing and Care Planning for Home-Based Services

SCAN Long Term Care (SCAN) believes that most members can be placed and/or maintained in the least restrictive environment. As long as quality and cost effectiveness standards can be met in the home and community based setting (HCBS), this is the primary placement goal for SCAN members. The percent of SCAN members residing in their own home has increased from 33 percent in January 2010 to 37 percent in December 2010. The percent of SCAN members residing in an Alternative Residential setting decreased from 41 percent to 40 percent. In the same time period, the percentage of members residing in a Skilled Nursing Facility also decreased from 25 percent to 23 percent.

#### *Needs Assessment*

Assessment of needs begins upon enrollment with SCAN. When the Administrative Assistant identifies that a member is transitioning from the Regional Behavioral Health Authority (RBHA) or has diagnosed mental health issues, the case is assigned to the Behavioral Health (BH) Team. Members through age 21 are assigned to a pediatric Case Manager (CM), and members on a ventilator or with complex medical needs are assigned to a nurse. The CM begins assessing the case upon receiving the Preadmission Screening (PAS) or Enrollment Transition Information (ETI). This review assists the CM in establishing a functional, emotional, cognitive and medical baseline. The ETI also contains previously agreed upon care plan and service information.

The CM completes assessments for new members within 12 days of enrollment and every 90 days for reassessments on existing members in a home based setting. SCAN's internal goal for home based members is to complete initial assessments within seven business days. The assessment is completed by conducting an informal conversation style interview with the member and/or representative to determine what strengths the member has to draw upon. These strengths may include past successes in health management, problem solving, family or informal support systems, and immediate and future life goals including the desire to self-direct his or her care. In a reassessment, the CM measures member satisfaction, the quality of services being delivered, goals that have been met and any adjustments to services.

The CM uses the SCAN Comprehensive Assessment Tool, the Uniform Assessment Tool (UAT), and the HCBS Member Needs Tool in completing their assessment. The SCAN Comprehensive Assessment Tool is utilized to assess the member's strengths and needs in the areas of functional ability, medical conditions, behavioral health, social, environmental and existing formal/informal support systems. CMs also review cultural and spiritual beliefs including limitations to treatment, dietary preferences and language needs with the member. Gender preference for a caregiver and other special requests are taken into account. All of these tools, combined with professional judgment, input from the member, their representative and providers contribute to the comprehensive needs assessment.

The Patient Health Questionnaire (PHQ-9) depression scale is used in conjunction with a mini-cognitive assessment or mental status exam to assess the need for behavioral health services. If this need is identified by the assessment or the member, the CM and BH Coordinator review the case within three business days, and the CM refers the member to a contracted provider within one business day of the meeting. Consultations for members receiving ongoing behavioral health services take place with the BH Coordinator on a quarterly basis. Consultations include the CM, member, member's primary support system, BH provider, BH Coordinator and physician or other health care provider as needed. The behavioral health consultation includes, but is not limited to, ensuring that services are appropriate and that the member is actively involved in the goals of their treatment plan and discharge planning. The primary care provider (PCP) is also informed of the services for appropriate coordination. The CM faxes the consultations to the member's PCP, member representative and BH provider within one business day of the consult. At the request of the BH Coordinator, additional consultation may occur between the

SCAN Medical Director and/or the psychiatric consultant. All behavioral services are documented on the Service Plan.

### *Care Planning*

The CMs take ALTCS covered services, community based services, cultural values and member preferences into consideration as appropriate for meeting member needs. CMs are expected to ensure the member is placed in the least restrictive setting, and assist the member and the member's representative in making informed decisions and understanding potential risks. The CM respects the member's rights and wishes and provides educational material where appropriate utilizing Healthwise and the Schering-Plough Database health resources. The CM explains the array of services available and works with the member and representative to provide innovative, flexible, and creative service options, including both covered services and community based services. All members are educated regarding their option to choose Self-Directed Attendant Care (SDAC) or Spouse Attendant Care. Members are informed of their responsibilities if they choose the SDAC model related to fiscal employer agency, timekeeping, training and other duties. If a member has elected to use SDAC, a referral is made to the Fiscal Employer Agent (FEA) to begin the process of obtaining a Tax Identification Number, recruiting a caregiver and completing the necessary steps to successfully participate in the program. Members selecting Spouse Attendant Care are encouraged to investigate how this choice may impact their eligibility for other publicly funded programs.

The care planning process for members includes coordination of behavioral health services. When it is determined that a member has a history of behavioral health services or is currently in need of a referral, the CM ensures referrals are made to the BH network. For new members that previously received services, the CM notes this in the Assessment Tool and re-authorizes services or transitions services to a SCAN provider. Members who are experiencing instability in their current setting or have significant behavioral health challenges, such as frequent use of the crisis system or current problematic symptoms (i.e. psychosis), are staffed with the BH Supervisor, BH Coordinator and other team members to determine if the member will be managed by the BH Team. CMs coordinate with the BH providers that are currently treating SCAN ALTCS members. CMs receive updates in monthly and quarterly reports from the BH care providers documenting the member's ongoing progress and needs. Additionally, the CM schedules and coordinates initial and quarterly consultations with the SCAN BH Coordinator. To the extent possible, these reviews incorporate input from everyone on the member's support system and address the member's current status, functions, strengths, signs of improvement and the design of ongoing services including exit from services. The member's diagnosis is recorded in CareEnhance<sup>®</sup> Care Management Software (CCMS<sup>®</sup>). All corresponding services are documented in the member's Service Plan.

Upon completion of the member needs assessment, the CM discusses with the member and/or the member's representative the availability of needed services and the appropriateness of the member's placement choice. The CM completes the member's Service Plan in collaboration with the member and their representative at the time of the assessment. The CM discusses the member's needs identified in the Service Plan with the PCP and the HCBS provider if appropriate. The Service Plan addresses medical, behavioral health, activities of daily living (ADL) and independent activities of daily living (IADL) needs as well as community referral agencies. CMs advocate and coordinate across all facets of the service system to maximize resources and minimize negative impact to the member. When selecting these providers, the CM takes into account language, cultural needs and gender preference for a caregiver along with other requests of the member or their representative. The Service Plan identifies services being authorized and retroactively approved for prior period coverage. The member or the member's representative is required to sign the Service Plan indicating agreement or disagreement with the developed care plan. This occurs at the initial assessment and anytime the Service Plan is revised. If there is disagreement in frequency or service type, the member receives notification of their right to file an appeal via the Notice of Action (NOA) process. Service Plans are mailed to member representatives

not in attendance at the assessment. A cover letter is included stating the need for the Service Plan to be returned indicating agreement or disagreement with the documented services. CMs follow up with representatives within two weeks of mailing the Service Plan.

Goals and objectives are developed with direct involvement from the member and their representative as well as providers. Goals are member specific, attainable, measurable, able to clearly identify the action or intervention and include timeframes for attaining desired outcomes. Goals and objectives are reviewed at each reassessment to identify progress and barriers. Services are adjusted based on changes in the member's condition or a request from the member based on medical necessity, appropriateness and cost-effectiveness.

The CM reviews the Member Rights Notice form pursuant to the Ball vs. Betlach order with the member or their representative and confirms understanding of the Notice. CMs develop a written Contingency Plan for those members receiving critical care services in their home. Critical care services include attendant care, personal care, homemaker care and respite. The Contingency Plan includes documentation of the actions the member and/or the member's representative take to report any non-provision in service and the resources available to the member. Servicing providers and the member's informal support system are considered resources in resolving unforeseeable non-provisions within the member's service preference level. The CM explains the member and family's right to use an agency caregiver as backup if the primary caregiver is unable to report to work. Unless it is the member and/or the member's representative's choice, the member's informal support system will not be considered as the primary source of assistance for any service gap. The Contingency Plan states that if a caregiver does not arrive at the scheduled time, the AHCCCS 800 number is the primary contact. Members participating in the SDAC Program are encouraged to locate a backup caregiver and have this person complete the process for payment by the FEA. The CM follows SCAN guidelines to ensure compliance with AHCCCS timeframes when an unforeseeable non-provision in critical services occurs.

Members have access to the CM of the Day (CMOD) during business hours and the CM on Call (CMOC) after hours to resolve any non-provision of service situations seven days per week. Both the CMOD and CMOC have the authority to authorize services to meet the member's immediate needs. SCAN has a contracted agency that will provide a back up caregiver within two hours of the reported non-provision of services. The CMOD and CMOC coordinate with the assigned CM regarding these acute incidents, allowing the CM to evaluate the member's immediate needs and determine whether the member requires an on-going change in services. If necessary, the CM may conduct a reassessment earlier than the 90-day period to manage changes in member needs and to develop an updated Service Plan.

Within seven days of the assessment, the CM completes the placement maintenance screen and cost-effectiveness study and authorizes agreed upon services. The CM calls the member or representative within seven days after authorizing the service to make certain services have begun and the member's needs are met. Services are provided to the member within 30 calendar days of the member's enrollment.

SCAN's goal is to help members remain in the least restrictive environment and sustain their quality of services. This requires continual needs assessments and the development of a detailed care plan that outlines each party's responsibilities and desired outcomes. SCAN continues to identify processes and programs to improve CMs' skills in assessing needs and creating comprehensive care plans coordinated with the member, family, internal and external providers.

---

### *Requirement 24: Case Management Scenarios – Case A: Oscar*

---

Within seven days of enrollment, the Administrative Assistant (AA) contacts Oscar, April (wife) and the nursing facility to notify them Oscar is enrolled with SCAN. At the time of the initial call, the AA welcomes Oscar to the health plan and provides Oscar with the name and contact information of his Case Manager (CM). The on-site assessment is scheduled with Oscar and April to occur within 12 business days of enrollment. During this call, the primary care provider (PCP) for managing Oscar's health care needs is selected. The AA confirms with April that Oscar has an advance directive in place and asks April to have a copy of the document available for the CM at the initial on-site assessment. A welcome letter is sent to Oscar summarizing the telephone discussion and confirming the appointment date and time for the initial on-site assessment.

As part of the care planning process, the CM received Oscar's Preadmission Screening (PAS) prior to the initial on-site assessment. From a review of the PAS, the CM establishes Oscar's functional, emotional, cognitive and medical status prior to enrollment. The nursing home chart provides Oscar's current status, diagnosis, medications and physician treatment orders. To obtain further information regarding Oscar's current treatment plan and successes, the CM interviews the charge nurse, nurse aids, physical therapist, facility social worker and the assigned Nurse Practitioner (NP) for the facility. The CM talks to the NP to assess if medical conditions such as a Urinary Tract Infection (UTI) have been ruled out as the cause of Oscar's recent confusion. The CM requests a pharmacy review in CareEnhance® Clinical Management Software (CCMS®) through SCAN's Pharmacy Department to eliminate medications or side effects as a cause of Oscar's recent confusion.

The CM introduces self to Oscar and April and presents them with the New Member Welcome Packet. The CM explains the ALTCS program and reviews each document in the New Member Welcome Packet including a review of the Member Handbook. The CM answers any questions regarding the packet before obtaining Oscar's signature on the Member Packet Contents form. Oscar and April receive a 3"x 4" magnet that contains the assigned CM's picture, direct phone number, SCAN's toll-free number with CM's extension, transportation telephone number and the CM's email address for future reference.

#### **Needs Assessment**

The CM completes the initial assessment by conducting a conversational style interview with Oscar and April. The assessment is entered real-time into the CCMS®. During this interview, the CM obtains information on Oscar's strengths, past successes in health management and problem solving, family or informal support system, and immediate and future goals. The CM gathers information on Oscar's medical equipment, therapy needs and his current medications. The CM reviews satisfaction with the current placement. It is determined that Oscar and April would like Oscar to return home if possible and would like therapeutic home visits to determine the feasibility of this plan. The CM discusses all placement and home and community based service options available with an emphasis on the array of Attendant Care services, including Self-Directed Attendant Care and Spouse Attendant Care. April and Oscar indicate they may want to utilize Spouse Attendant Care. A Home and Community Based Services (HCBS) Member Needs Tool is completed with information obtained from the chart review, interviews with nursing facility staff, and Oscar and April. The CM uses the Needs Tool to determine the level of assistance Oscar requires to complete his activities of daily living (ADL), independent activities of daily living (IADL), and any needs to be met through informal supports. Oscar, April and the CM discuss the other needs identified during the assessment, including the PCP order requirements for physical therapy, occupational therapy, home modifications, bladder/bowel care and seating evaluation for the existing custom wheelchair.

Oscar's responses to the behavioral health (BH) portion of the baseline assessment, which includes the Patient Health Questionnaire (PHQ-9), is scored and reviewed to determine if depression is indicated. This information, combined with the mental status exam and behavioral history, is gathered by the CM.

At the conclusion of the behavioral health portion of the assessment, the CM discusses behavioral health services with Oscar and April and inquires if Oscar is interested in services.

At completion of the initial assessment, the CM completes and prints a Service Plan with April and Oscar indicating he is receiving nursing facility services and will continue to receive them while the transition plan is put in place. The Service Plan also indicates a home modification evaluation will be completed due to potential discharge home. To reside at home, Oscar will need a safe entry and exit from the house. The CM explains important elements of a home safety plan such as smoke detectors, evacuation route, lights, etc. and clarifies the plan will be completed at his home assessment after discharge. April and Oscar are informed that an inter-disciplinary team (IDT) will be scheduled to discuss all of Oscar's needs and transition plan with timeframes. Oscar and April are informed a new CM will be assigned once he moves home, and an IDT will be scheduled prior to the move to ensure a smooth transition. The CM, Oscar, and April review and sign the Service Plan. A copy is left with Oscar and April.

If Oscar requests behavioral health services, the CM meets with the BH Coordinator for consultation regarding the appropriateness of Oscar's request within three business days of the initial assessment. Within one business day of the discussion with the BH Coordinator, the CM makes a referral for the psychological evaluation, if appropriate. Within one business day of the initial assessment, the CM makes a referral for a home modification evaluation. The CM coordinates with Oscar, April and the nursing facility to have the member at home the day of the evaluation. Within 14 days of identifying the need for home modifications, the CM and CM Supervisor reviews the evaluation and approvals, denials or requests for extension are sent as appropriate. Any denial will comply with Notice of Action requirements.

An IDT staffing is scheduled with the Medical Management Nurse, BH Coordinator, Case Management Supervisor, Nursing Facility Representative, Oscar, April, the CM who assessed Oscar in the facility and the CM to receive the case in the community. The Medical Director, Case Management Manager, psychiatrist, and Housing, Education and Employment Coordinator are available to consult as needed. The IDT reviews whether Oscar has a need for any items covered under the Community Transition Service through AHCCCS. The CM explains the program and limitations to Oscar and April advising them to contact the CM regarding previously unidentified needs as quickly as possible after Oscar's return home. It is explained that there is a 90 day period in which these needs may be met under the Community Transition Service. The results of the pharmacy review are discussed and communication with the PCP occurs if necessary. Within three business days of the IDT, the CM completes a preliminary cost-effectiveness study to ensure that the agreed upon services meet cost-effectiveness standards. The care plan that was begun during the assessment is completed with input from the IDT.

### **Care Plan and Outcomes**

Need – Oscar needs help completing his ADLs and IADLs while residing at home.

Intervention – An Attendant Caregiver will assist Oscar in completing these tasks. Spouse Attendant Care was discussed with Oscar and April. They have elected to use this service. The CM completes appropriate forms for this service and advises Oscar and April to evaluate how this may affect other benefits. Names of agencies for training are provided to April. Nursing facility staff will train April on transferring techniques. The HCB agency will also work with April when Oscar returns home.

Outcome – Oscar will live at home. His ADLs and IADLs will be completed on a daily basis.

Need – Oscar needs bladder and bowel care, monitoring of his skin condition and medical needs.

Intervention – The nursing facility staff will work with April on education related to bladder/bowel care needs of her husband. Oscar's PCP writes orders for Home Health Nurse evaluation and ongoing services of bladder/bowel care and monitoring of skin condition. The nurse will also educate April on what to watch for in skin integrity and appropriate positioning to prevent skin breakdown.

Outcome – Prior to moving home, Oscar and April will have completed training on bladder/bowel care needs and how to monitor and maintain Oscar's skin integrity. Upon discharge, Oscar will receive Home

Health visits for bladder/bowel care at minimum two times per week. Oscar and April will coordinate with the Home Health Nurse to obtain necessary knowledge and skills to follow proper hygiene and maintain skin integrity. Over the next 12 months Oscar will have no incidents of decubitus ulcers or bladder infections.

Need – Oscar needs wheelchair accessibility into his home and the master bathroom.

Intervention – The CM makes a referral for a home modification and ensures that accessibility modifications are completed prior to Oscar’s discharge

Outcome – Oscar will be able to safely enter and exit his home. He will also have access to necessary areas within the home. This will be measured by a follow-up visit to the home by the CM upon completion of the home modifications. Oscar will demonstrate his ability to use the modifications and his satisfaction will be documented by the CM.

Need – Oscar needs to increase independence and improve use of his wheelchair, use adaptive equipment, and maintain his range of motion to the extent possible.

Intervention – Oscar’s PCP writes orders for Physical Therapy and Occupational Therapy evaluations and potential ongoing therapy. The evaluations will include any special cushions or positioning devices. Oscar will learn the skills necessary to better operate his wheelchair and determine his baseline abilities. April and Oscar will receive instruction on range of motion exercises to maintain Oscar’s abilities. The CM will give community resources for utensils and other items that may not be covered by ALTCS.

Outcome – Oscar will be able to demonstrate an understanding of how to safely operate his wheelchair, utilize adaptive equipment, and maintain skin integrity. Oscar will demonstrate the appropriate use of his wheelchair, both in the home and to enter an exit the home, as documented by PT/OT notes and spouse report. Oscar will have no contractures over the next 12 months as documented by Home Health notes, PCP notes and member/spouse report.

Need – Oscar needs a means of being transported to medically necessary appointments. April needs a means of transporting Oscar in the community for non-covered services.

Intervention – The CM gives contact information for scheduling transportation for medically necessary services as well as community resources for options of securing their own wheelchair accessible van.

Outcome – Oscar will have transportation for medically necessary appointments and can explore options for securing his own means of transportation.

Need – Oscar needs to develop a social network in the community. Oscar needs support in his adjustment to his recent injury and reintegration into the community. Oscar may need employment in the future.

Intervention – Oscar and April will be given information on a spinal cord injury support group. If Oscar indicates a desire for behavioral health support services, a referral will be sent to a BH Provider. When Oscar is able, he will be referred to the Work Incentive Planning and Assistance (WIPA) office.

Outcome – Oscar will have the contact information for the Spinal Cord Injury Association as a means to create a social support group. Oscar will have information on the WIPA and work incentive programs to utilize when he is ready. Oscar will attend a minimum of one Spinal Cord Injury Association meeting over the next 90 days.

The CM will coordinate with any third party insurance or community agency on Oscar’s needs. Prior to Oscar’s discharge, the community CM reviews the transition plan and ensures all services are in place, including a supply of medications with prescriptions for refill, physical therapy, occupational therapy, home modifications instrumental to returning home are completed, Home Health referral, BH services and Attendant Care services. The CM schedules an assessment to occur within ten days of Oscar’s discharge. The CM submits an electronic Member Change Report to notify AHCCCS that Oscar moved from an institutional to an HCBS setting, does a final review of the cost-effectiveness study (CA160), and updates the placement screen (CA161). At the time of the assessment, the CM completes a Safety Plan with Oscar and April. The CM continues to monitor Oscar’s health condition by receiving and reviewing monthly Home Health reports as well as communicating with Oscar and April as appropriate. The CM will work with Oscar and the WIPA office on his long term goal of employment.



---

### *Requirement 24: Case Management Scenarios – Case B: Magda*

---

The Administrative Assistant (AA) receives the Enrollment Transition Information (ETI) packet before the member is enrolled with SCAN Long Term Care (SCAN). A copy of the ETI packet is shared with Medical Management to ensure a smooth transition of any durable medical equipment (DME), supplies, or skilled services to SCAN. Upon enrollment, the AA verifies Magda's coverage and the initial call takes place within three business days. During the call, the AA welcomes Magda to the health plan, provides Raquel with the name and contact information of Magda's Case Manager (CM), assigns the selected primary care provider (PCP) for managing Magda's health care needs from within the SCAN network and explains the purpose of the on-site assessment. The on-site assessment is scheduled with Magda and Raquel to occur within 12 working days of enrollment. The AA confirms with Raquel that Magda has an advance directive already in place and asks Raquel to have a copy of the document available at the initial on-site assessment. Upon completion of the initial contact, a welcome letter is sent to Magda in care of Raquel summarizing the telephone discussion and confirming the appointment date and time for the initial on-site assessment.

As part of the care planning process, the CM received Magda's ETI prior to the initial on-site assessment. Reviewing the ETI allows the CM to establish Magda's functional, emotional, cognitive and medical status prior to enrollment. The CM contacts all providers currently involved in Magda's care to inform them of the recent transition to SCAN and sends an authorization to continue established services for 30 days.

Prior to completion of the baseline assessment and Service Plan, the CM introduces self to Magda and Raquel and presents them with the New Member Welcome Packet. The CM explains the ALTCS program and reviews each document in the New Member Welcome Packet, including a review of the Member Handbook. The CM answers any questions regarding the Packet before obtaining Magda's signature. Magda and Raquel receive a 3"x 4" magnet that contains the assigned CM's picture, direct phone number, SCAN's toll-free number with CM's extension, transportation telephone number and the CM's email address for future reference.

#### **Needs Assessment**

The CM completes the initial assessment by conducting a conversational style interview with Magda and Raquel. The assessment is entered real-time into the CareEnhance® Clinical Management Software (CCMS®). During the initial visit, the CM becomes aware that the caregiver has been late causing Raquel to be late for work. The CM educates the family on calling the AHCCCS 800 number and the CM when there is a delay in Attendant Care services being provided as scheduled, and that SCAN has an agency able to provide a caregiver within two hours in these situations. The CM discusses alternative caregiver options with Magda and Raquel.

Questions regarding Magda's change in cognitive and physical status cannot be adequately answered because of the family's difficulty making appointments with the PCP. It is undetermined if there is a change to her medical status since her last visit. There has not been an assessment or evaluation relating to Magda's recent falls. The CM explores the underlying issues with getting an appointment. The CM calls Member Services with Raquel, and she selects a Romanian speaking doctor. Raquel calls the doctor while the CM is present and schedules an appointment for the following week. The CM completes a Release of Information form with Raquel and sends the completed Release to the previous PCP to have Magda's historical medical records sent to the new PCP. During the assessment, the CM views Magda's bathroom and observes that she could benefit from grab-bars in the shower and DME, such as a shower bench or chair. The CM completes the My Doctor Visit form with Raquel to be taken to the upcoming doctor's appointment. Questions on the form include bathroom medical equipment to reduce falls in the shower, reported changes to Magda's cognitive status, her agitation and recent falls. Raquel is encouraged to discuss the changes in Magda's mental status and details regarding falls. She is also coached to take all of Magda's medication to the doctor visit. The CM gives Raquel some information on home safety relating to area rugs, electrical cords and general fall prevention.

The CM gives Raquel the option of Magda attending Adult Day Health on Tuesdays and Thursdays to get socialization with her peers. The CM explains there is an Adult Day Health center available where staff and members speak several different languages, including Romanian. This might be an option for Magda to get out of the house and interact with peers. The CM discusses with the family whether the church has a quiet room available to prevent disruption or a companion that can sit with Magda during church. Adult day health may augment socialization received through church or offer a replacement of socialization activity if Magda is not able to resume attending church. Raquel and Magda will think about whether Magda would like to attend Adult Day Health. They are informed they can schedule a visit before making a decision and contact information for Adult Day Health is left with them.

The need for Power of Attorney, Mental Health Power of Attorney, and advanced directives is discussed with Raquel and Magda given the recent diagnosis of early stage dementia. The CM emphasizes the importance of completing these documents while the person is able to actively participate and make wishes known. The CM reviews the advance directive information included in the New Member Packet and shows Raquel and Magda where agencies are listed that can help in completing the forms. During the behavioral health section of the baseline assessment, the CM completes the Patient Health Questionnaire (PHQ-9), the mini-cognitive assessment, and a behavioral history. Behavioral health services would be offered at this time as appropriate.

At the conclusion of the initial visit, Magda and Raquel agree to leave current attendant care services in place for the first 30 days of enrollment. The CM explains that the HCBS Needs Tool, requested increase in attendant care hours, and request for respite care will be staffed with the Supervisor. They will be informed of a decision as soon as possible, at maximum of 14 days. The CM completes and prints a Service Plan with Magda and Raquel indicating she is receiving Attendant Care. Magda signs the ALTCS Member Service Plan indicating that she disagrees that this will be her ongoing service plan and would like it modified. She agrees to continue receiving the current services until a decision can be made. The CM notes in the comments section of the Service Plan that Magda and Raquel are requesting an increase in Attendant Care hours, initiating respite care, and considering adult day health services.

Upon identifying the concerns regarding assessed versus requested caregiver hours, the CM staffs the case with their Supervisor within three business days of completing the assessment to determine whether a Notice of Action letter is necessary or if Attendant Care hours need to be increased. The Supervisor compares the HCBS Needs Tool from the previous Program Contractor with the current HCBS Needs Tool to determine the change in need for Attendant Care hours. Based on review of the HCBS Needs tool, the Supervisor sees that the 16 year old grandchild is acting as the caregiver on Tuesdays and Thursdays after arriving home from school and on Monday, Wednesday and Friday after Magda returns from dialysis. This time has been allotted as Informal Support (IFS) on the HCBS needs tool. The Supervisor and CM discuss the case and agree the 16-year-old grandchild should not provide unassisted care to the member each afternoon because it appears this is when most of the falls have occurred. The member is attempting to utilize her walker and do things on her own rather than relying on the grandchild. They also discuss that the member does not have appropriate DME. The CM will follow-up with the PCP about a shower chair/bench and grab bars. The CM advises the Supervisor that a referral will be made for the installation of the grab bars.

The Supervisor and CM discuss Raquel's request for respite care on Sundays while Raquel is at church. Magda's informal support system will be away every Sunday morning. She needs formal care during this time. Therefore the CM will authorize this time as Attendant Care. The CM recognizes that the time allotted as informal support will now be Attendant Care, but also recommends that Magda attend adult day health. The CM completes a cost-effectiveness study (CA160) to ensure that the agreed upon services meet cost-effectiveness standards. The CM contacts Raquel to discuss the updated Attendant Care hours and Adult Day Health, explaining that an updated Service Plan will be mailed for signature. The cost-effectiveness study (CA160) and placement screen (CA161) are both updated and printed for the member chart.

## Care Plan and Outcomes

Need – Magda needs assistance completing activities of daily living and independent activities of daily living. Magda needs supervision prior to her adult daughter arriving home. Magda needs to eliminate the risk of falls and increase home safety.

Intervention – Magda will receive Attendant Care prior to and after dialysis. The CM will provide information to the family on a bed and chair alarm for Magda that notify her caregivers if she gets up without supervision. The CM will talk with the PCP to see if Magda has been evaluated related to possible progression of neuropathy and orders for DME and grab bars for the rest room. Magda's PCP will write an order for physical therapy if medically appropriate. The CM will give information on home exercises, fall prevention (Matter of Balance) and home safety.

Outcome – Magda will complete her activities of daily living and independent activities of daily living with assistance on a daily basis. She will remain safe in the home with supervision. Magda and Raquel will eliminate hazards within the home over the next 30 days. Magda will have no falls over the next 90 days as a result of increased supervision, reduced hazards and alerts to caregivers.

Need – Magda needs the opportunity to socialize with people of her age who speak the same language.

Intervention – Magda will be referred to Adult Day Health, a day program which has staff and attendees who speak the same language as Magda. The CM also suggests Raquel contact her church and discuss options for Magda to continue attending church. They may have a variety of options such as a companion program or a quiet room.

Outcome – Magda will have the opportunity for social activities with her peer group in her primary language two days per week. She will continue attending church.

Need – Raquel needs support for herself and education on Magda's condition.

Intervention – The CM provides information to Raquel on the Alzheimer's Association and caregiver support groups, including the SCAN Connections Resource Center. The CM also reviews the appropriate use of respite and explains how Raquel can utilize this service by contacting the CM.

Outcome – Raquel will maintain her emotional and physical health. She will know how to utilize informal supports in the community as well as accessing the CM. Raquel will attend one caregiver support group over the next 90 days. She will have an increased understanding of dementia and how to best communicate with Magda measured by her self-report to the CM.

Need – Determine the cause of Magda's agitation and confusion.

Intervention – The CM will request information from Magda's PCP related to her care plan. The CM will ask the PCP for an opinion on evaluation of increased confusion to determine if this is a progression of her chronic condition of dementia or if there is an acute medical issue to be addressed.

Outcome – Magda will have an evaluation from her PCP completed and recommendations on a plan of care will be followed to reduce her agitation and confusion. Magda and Raquel will have a better understanding of the progression of Magda's condition. Appropriate behavioral health referrals to manage mood changes will be made if recommended.

Raquel is encouraged to contact the CM if there are any barriers to care or if she notices any changes in her mother's condition. The CM will utilize reminders in the CCMS® system to trigger follow-up with DME referrals and to ensure installation and satisfaction with grab bars. The CM will continue to monitor Magda's condition on an ongoing basis and complete face to face assessments each 90 days, unless a change in condition warrants a shortened interval.

## Requirement 24: Case Management Scenarios – Case C: Wanda

### *Interaction of the Case Manager*

Upon learning of Wanda's move into the assisted living facility, the Case Manager (CM) schedules an appointment to meet with the facility, Wanda and her family to complete a reassessment. The appointment is scheduled to take place within ten business days of the date of notification. During the call to make the appointment, the CM discusses the recent hospitalization and information received from the Medical Management Department with the new diagnosis. The CM reviews the SCAN Long Term Care (SCAN) directory that is maintained by Network Management to ensure the facility is contracted and licensed at the appropriate level to manage the member's care needs. The CM informs the son of the Room and Board Responsibilities and explains a Residency Agreement will be completed during the scheduled appointment. The CM end dates the authorization for Attendant Care and sends a closure letter to the Attendant Care provider. The Attendant Care provider is educated that any change to a member's service, including the discharge of services should be communicated to the CM. The CM reviews Wanda's room and board responsibilities prior to conducting the assessment. The Client Assessment and Tracking System (CATS) CA 160 is updated to ensure cost-effectiveness, and Wanda has the required income to meet the minimum room and board requirements. The CM revises the CA161 screen to reflect the current placement and completes an electronic Member Change Request (MCR) notifying AHCCCS of Wanda's new address and living situation. The CM notifies the facility of Wanda's room and board responsibility. The provider is educated that member moves are to be authorized by the CM and reviewed for appropriateness prior to admission to the facility. The CM lets the facility know that the Residency Agreement and Financial Change Agreement will be completed during the member assessment. Network Management Department is notified of the assisted living facility's activities so that the SCAN Provider Representative can complete follow-up activities with the provider.

The CM contacts Medical Management regarding the recent hospitalization and requests medical records and discharge orders be obtained. Notes from the hospitalization are reviewed. Records are requested from the member's primary care provider (PCP) and the PCP is advised of the hospitalization. Records are also requested from the oncologist. The CM and the Care Transition Coordinator, a nurse who coaches members after hospital discharge, work closely together to ensure that the PCP has received discharge orders and information from the hospital. The member, their representative and facility are provided with the Personal Health Record (PHR) and coached on medication management, PHR, PCP and specialist follow-up, and educated on red flags, signs and symptoms. Any new specialist name and contact information is entered in the CareEnhance<sup>®</sup> Clinical Management Software (CCMS<sup>®</sup>) for coordination of care.

### **Needs Assessment**

Upon beginning the assessment, the CM obtains verbal permission from the member for her son and facility representative to be present and participate in the assessment. The CM completes the assessment by conducting a conversational style interview with Wanda and her son. The assessment is entered into CCMS<sup>®</sup>. The CM explains the goal of keeping all members in the least restrictive setting while balancing health and safety needs and informs the family of services available in each setting. The CM speaks with Wanda to assess her preferred setting and explains all placement options. The CM discusses advanced directives, Power of Attorney, Mental Health Power of Attorney and encourages the family and member to evaluate if any updates are appropriate due to the recent changes in her medical condition. The CM reviews the facility chart to ensure orders are in place and discharge orders from the hospital are on file. The Medication Administration Record (MAR) is reviewed to ensure medications have been reconciled and are being administered correctly, including any changes due to recent hospitalization. The CM ensures that any Home Health, Durable Medical Equipment (DME), specialist appointments or any other needs have been met and schedules follow-up on any outstanding items. The CM ensures that the facility has a current care plan in place that reflects the member's needs.

The CM discusses with the family and facility health changes and needed service changes going forward should be coordinated with the CM. This ensures a decision is made accounting for all service options available as well as a safe plan. The CM assesses that Wanda is not able to get to the doctor as she was before and discusses transition to an in-home doctor who can see her at the facility and coordinate care.

At the conclusion of the assessment, the CM completes and prints a Service Plan with Wanda and her son indicating she is receiving assisted living home services. The CM informs Wanda and her son that an inter-disciplinary team (IDT) will be scheduled to discuss all of Wanda's needs. The CM, Wanda, and her son review and sign the Service Plan. The CM, Wanda's son and the facility representative complete the Residency Agreement and Member Financial Change Agreement. Copies of the Service Plan and Residency Agreement are left with Wanda and her son. The facility representative receives a copy of the Residency Agreement and the Member Financial Change Agreement.

Within three business days of the assessment, an IDT staffing is held to review Wanda's care plan. The team reviews the medical records from the hospital, PCP and oncologist. They discuss the member's specific cancer diagnosis/type, cancer staging, disease progression, prognosis, cancer treatment plan whether it is curative or palliative, risk factors associated with her treatment, co-morbidities and her current status as assessed by the CM. The facility care plan is reviewed along with the doctor orders. Outstanding facility quality issues and current monitoring activities are discussed. Wanda is currently non-ambulatory and is at risk for skin breakdown. She will need to be evaluated by a Home Health Nurse to monitor her condition and coordinate any skilled needs.

The team reviews if the member has previously been enrolled in a disease management program through her primary insurance. Her goals are evaluated in consideration of her new condition. The CM coordinates with Wanda's primary insurance to determine the type of complex care management available and exchange updated information on member's condition.

### *Care Plan and Outcomes*

Need – Wanda needs assistance in following her treatment plan for pelvic cancer as well as managing her co-morbidities. Clinical assessments may demonstrate a need for additional goals or changing of goals depending on her condition and advance directives.

Intervention – A Home Health Nurse evaluation will be completed with follow-up to monitor member's condition. The Home Health Nurse will coordinate with Wanda's PCP, oncologist, Wanda, family, and CM as appropriate. Wanda will be transitioned to an in-home doctor who can manage her care closely with the facility, family, CM and clinical team.

Outcome – Wanda will reside in chosen setting with coordination of Home Health to monitor her skilled needs and coordinate with the assisted living facility, family and CM.

Need – Wanda needs to complete activities of daily living (ADL), independent activities of daily living (IADL) and maintain skin integrity with assistance due to immobility.

Intervention – Wanda will continue to reside in the assisted living facility to receive assistance with her ADLs and IADLs. Home Health will assist in monitoring skin integrity, medication monitoring and diabetes management.

Outcome – Wanda will continue to reside in chosen setting and receive assistance managing her conditions. Wanda will have no incident of decubitus as documented by the facility and home health visits.

Need – Determine how to best treat Wanda's confusion and combativeness so she can receive appropriate assistance.

Intervention – The CM will contact the PCP and determine if records indicate the cancer has metastasized and could be causing her confusion, if there are other potential medical origins and if the PCP will be treating the confusion. If needed, a referral will be made to a psychiatric provider to evaluate and recommend treatment for her confusion and combativeness.

Outcome – Wanda will have decreased confusion and combativeness as reported by family, facility staff, and Home Health providers. This will be documented on a behavior log provided to the facility.

Need – Wanda needs a PCP who can come into the facility to monitor her care and coordinate care.

Intervention – The CM will make a referral to a PCP who is contracted with Wanda’s primary insurance and can visit Wanda at the facility. This will include a palliative approach to care if warranted, respecting her wishes and needs for symptom management, including pain management, and her emotional, psychosocial and spiritual needs. This may include a referral and coordination with hospice when appropriate. Wanda’s records will be transferred to this PCP, and an initial visit is scheduled.

Outcome – Wanda’s condition will be monitored and coordinated within the assisted living setting.

The CM will continue to receive and review home health reports on a monthly basis and coordinate care with Wanda’s PCP and oncologist. If a complex care management program is available through her primary insurance, the CM will coordinate as needed. The CM will monitor any change in condition and ensure the care plan and Service Plan are updated as appropriate. IDT staffings will be held as needed.

---

## *Requirement 24: Case Management Scenarios – Case D: Roger*

---

### *Interaction of the Case Manager*

Within seven days of enrollment, the Administrative Assistant (AA) contacts Joyce, Roger's guardian, to notify her about Roger's enrollment with SCAN Long Term Care (SCAN). At the time of the initial call, the AA welcomes Roger to the health plan and provides Joyce with the name and contact information of his Case Manager (CM). The on-site assessment is scheduled with Joyce and Roger within seven business days of enrollment if possible but will not exceed 12 business days from enrollment. The AA discusses Roger's current primary care provider (PCP) with Joyce. If the PCP is in SCAN's network, the AA inquires if they would like to keep the same PCP. If the PCP is not in the network, one will be selected with the member or representative. The AA discusses with Joyce whether Roger has an advance directive and guardianship papers already in place. The AA asks Joyce to have a copy of any advance directive and guardianship papers available at the initial on-site assessment. Upon completion of the initial contact, a welcome letter is sent to Joyce confirming the appointment date and time, the CM's name, and phone number and selected PCP contact information.

The CM receives Roger's Preadmission Screening (PAS) prior to the initial on-site assessment. From a review of the PAS, the CM establishes Roger's functional, emotional, cognitive and medical status prior to enrollment. Prior to completion of the baseline assessment and Service Plan, the CM introduces self to Roger and Joyce and presents them with the New Member Welcome Packet. The CM explains the ALTCS program and reviews each document in the New Member Welcome Packet, including a review of the Member Handbook. The CM answers any questions regarding the Packet content before obtaining Joyce's signature on the Member Packet Contents form. Roger and Joyce receive a 3"x 4" magnet that contains the assigned CM's picture, direct phone number, SCAN's toll-free telephone number with CM's extension, transportation telephone number and the CM's email address for future reference.

After reviewing the legal guardianship documents, Joyce is entered into the CareEnhance® Clinical Management Software (CCMS®) as a legal guardian contact for Roger. Her information is forwarded to the AA to enter into the system that tracks member enrollment, contacts, and coverage utilized by Member Services and non-clinical staff at SCAN.

### *Needs Assessment*

The CM completes the initial on-site assessment by conducting a conversational style interview with Roger and Joyce. The assessment is entered into CCMS®. The CM explains the objective of the assessment is to determine Roger's needs, determine the cost-effectiveness of those services, and document a mutually agreed upon care plan. During this interview, the CM discusses with Roger and Joyce the strengths Roger has to draw upon, such as past successes in terms of health management and problem solving, family or informal support system and Roger's immediate and future goals. The assessment tool is completed along with a Uniform Assessment Tool (UAT) and HCBS Member Needs Tool to gain an understanding of the level of assistance Roger needs in his home environment to complete his activities of daily living (ADL) and independent activities of living (IADL). The tool is completed indicating the level of assistance needed and any informal supports (IFS) to be provided. During the face to face interview, a behavioral assessment is completed including the Patient Health Questionnaire (PHQ-9), the mini-cognitive assessment and a history of behaviors and services. Additionally, Roger's medical history, current medications and status of managing his conditions is gathered. The CM discusses the role of the PCP related to Roger's respiratory infections, seizures and the type of services a PCP would coordinate such as DME or therapies. The CM determines if Roger and Joyce are experiencing any barriers to care and intervenes as appropriate.

The CM discusses all services available and explains the goal of keeping members in the most independent setting possible. Joyce indicates she would like to keep Roger with her. The CM explains the most appropriate services in meeting this goal emphasizing Attendant Care, day programs, behavioral health (BH) services, and supports for Joyce.

The CM completes and prints a Service Plan with Roger and Joyce indicating Roger will receive Attendant Care, a day program, and a behavioral health services referral. The CM explains that an Interdisciplinary Team (IDT) is appropriate to provide input regarding Roger's behavioral, psychiatric, and medical needs. Joyce signs the plan indicating she is in agreement with the Attendant Care, day program and a behavioral health referral. She is advised that the specific type of day program and behavioral health services may be adjusted after input from the IDT. Joyce and the CM complete a Contingency Plan. Joyce is advised of the process to follow should the caregiver be late or not show up as scheduled. Copies of both forms are left with Joyce. Joyce is provided with the crisis numbers to contact if Roger's behaviors escalate. The CM completes a Release of Information with Joyce for Roger's medical records and sends the request to Roger's previous PCP and any other providers of which Joyce is aware. The history of Roger's traumatic brain injuries (TBI) and any neuropsychological evaluations previously completed are integral to appropriately planning his care.

The CM consults with the BH Coordinator within three days of meeting with Joyce and Roger. During the discussion it is suggested that a BH CM be assigned to the case and invited to the IDT. A referral for behavioral health services is sent to a contracted agency within one day of the consultation. The CM also requests an IDT to occur five days from the date of assessment and includes the CM Supervisor, BH Coordinator, BH Supervisor, BH CM, Medical Director or designee and Joyce to participate via telephone. The CM completes a preliminary Cost Effectiveness Study indicating the Attendant Care services and day program to ensure cost effectiveness. In addition to the psychiatric evaluation referral that has been completed, the team also recommends a referral for a functional assessment, a specialist referral to a neurologist and a therapeutic day program versus a routine adult day health program. The team discusses comprehensive resources for Joyce and Roger available in the community and completes the care plan. The team reinforces with Joyce this is the initial plan and the BH CM will work closely with her during ongoing evaluations and the monitoring of Roger's needs as information is received and Roger's needs change.

### *Care Plan and Outcomes*

Need – Roger needs prompting and supervision to complete bathing, changing clothes, and taking medications. Roger needs to have supervision when outside of the house.

Intervention – Roger will be referred to an Attendant Care agency that has caregivers experienced in working with the behavioral health population. Self-Directed Attendant Care was explained to Joyce but she does not want to be present at all times to direct the care as the guardian. She is also struggling and does not want to provide the care herself as a family caregiver. The CM will provide Joyce with information on low cost door chimes and alert systems. This would give an indication that Roger may be leaving the home.

Outcome – Roger will get prepared for the day with assistance 50 percent of the time over the next 45 days without episodes of refusing care, being verbally aggressive or physically striking out per report of Joyce and caregiver. Roger will increase from 50 to 100 percent within 90 days. The risk of Roger leaving the home unsupervised will be decreased due to the sound activation of the door chime or alert system. Roger will have no incidents of leaving the home unsupervised as documented by the attendant and reported by Joyce.

Need – Roger needs daily activity that is stimulating and meaningful to him.

Intervention – Roger will be referred to a therapeutic day program experienced in handling members who are younger in age and may have disruptive behaviors.

Outcome – Roger will reduce his boredom and learn to manage his conditions through the therapeutic day program. The long term outcome for Roger may be learning a skill and contributing to the community.

Need – Roger needs an evaluation of the origin of his seizures and treatment recommendations that may decrease or eliminate the seizures.

Intervention – The CM requests a Pharmacy review be completed. The medications will be reviewed for potential side effects that may affect his seizures or any of the other symptoms and behaviors. The PCP



will be requested to order a blood test to determine if Roger is maintaining a therapeutic level of seizure medication in his system. His PCP will also be requested to make a referral to a neurologist to complete an evaluation and treatment recommendations. At the request of the CM, the PCP will complete a referral for a Home Health evaluation by a Nurse due to his frequent seizures. The CM will provide Roger and Joyce with educational material on seizure safety.

Outcome – Joyce will have educational materials and training to handle seizures to increase Roger’s safety. Roger will receive appropriate treatment for his seizure disorder as evaluated by the Home Health nurse in coordination with the PCP or specialist. Roger will be adherent to his medications as prescribed. Over the next six weeks he will reach a therapeutic level of medication in his system which will result in decreased seizures. Roger will have no seizures after an eight-week period resulting in no falls.

Need – Roger needs treatment and support to help with his behaviors and symptoms related to his schizoaffective disorder.

Intervention – Roger will be referred to a psychiatric provider for evaluation and ongoing monitoring as determined appropriate. A functional assessment will be requested to assist in developing a behavioral plan that is tailored to the member’s abilities and level of functioning.

Outcome – Roger will adhere to taking his medication as prescribed and completing his activities of daily living without resistance at a minimum of 90 percent of the time. This will be reported by Joyce, the day program and Roger’s caregiver. There will be decreased incidents of fabrication and leaving the house without supervision.

Need – Joyce needs support for herself and education on Roger’s conditions.

Intervention – The CM provides information to Joyce on the Brain Injury Association of Arizona, the Arizona Governor’s Council on Spinal and Head Injuries, caregiver support groups and mental health associations. The CM also reviews the appropriate use of respite and explains how Joyce can utilize this service by contacting the CM.

Outcome – Joyce will reduce her stress based on self-report. Joyce will know how to utilize informal supports in the community as well as accessing the CM. She will have an increased understanding of Traumatic Brain Injuries and the TBI Community. Joyce will attend one TBI support group over the next 60 days.

Need – Roger and Joyce need a way to reinforce his positive behaviors without cigarettes that could compromise his respiratory condition and contribute to occasional upper respiratory infections.

Intervention – The CM will provide information to Roger and Joyce about available smoking cessation programs and the impact of smoking on Roger’s respiratory infections. The CM coordinates with the BH provider to provide Joyce alternative strategies that may increase Roger’s positive behaviors in a healthy manner.

Outcome – Joyce will use positive rewards for Roger’s behavior over the next 90 days that do not include cigarettes. Joyce and Roger will have resources to decrease or quit smoking if he chooses to do so as a long term goal. The CM will re-assess Roger’s goals in this area at each visit.

After the care plan is completed, the BH CM will make an appointment to review with Joyce and Roger. Joyce and Roger will sign the updated Service Plan. The CM confirms that Joyce is aware of crisis numbers to contact if needed. The CM will follow-up on referrals and ensure the providers have shared appropriate information such as evaluations, changes to medical conditions and current medications for coordination of care. The CM will complete the cost-effectiveness study in the Client Assessment and Tracking System CA160 and CA161 to reflect the member’s services and placement. A letter will be sent to Roger and Joyce confirming the change to a BH CM. The BH CM will follow up to ensure the services referred begin within 30 days of Roger’s enrollment, and he and Joyce are satisfied.

## Requirement 25: Utilization Data Management

### *Overview – Medical Management Data Utilization*

The SCAN Long Term Care (SCAN) Medical Management program and processes generate a rich store of information and data that, when integrated with that from other SCAN sources like claims, provider services, member services and pharmacy, are used to evaluate member and/or provider utilization patterns. Variances from standard utilization patterns in a particular area or by an individual will trigger analyses of root causes, which guide the department’s efforts to improve Medical Management activities and promote improved member outcomes.

### *Data Collection and Data Warehousing*

Data are gathered and documented by multiple departments throughout the company, including Prior Authorization, Concurrent Review, Case Management, Claims, Member Services and Provider Services, and from SCAN’s pharmacy benefit manager (PBM). SCAN uses two major information systems to collect and house member and provider information: McKesson’s CareEnhance® Clinical Management Software (CCMS®), used for collecting prior authorization, concurrent review and case management activities, and MC400, SCAN’s core healthcare information system, for housing member and provider setup and claims information. Data from the two systems are linked through a SQL-based data warehouse (DSBI), which is refreshed from the MC400 on a real-time basis and from CCMS® every night. The DSBI also receives data feeds from the PBM’s database. The systems have been upgraded and expanded to support the ALTCS line of business.

Reports can be generated from either the CCMS® or MC400 system. The DSBI is capable of generating specialized reports that integrate data elements drawn from both CCMS® and MC400 or the PBM’s database. Medical Management is supported by a robust Healthcare Informatics Department, which develops, generates and analyzes data that are specific to the ALTCS population. Reports are run based on regulatory specifications and the needs of the clinical departments.

Individual departments have the capability to generate reports from the systems and DSBI that meet specific departmental needs. In addition, Healthcare Informatics can generate standard reports, as well as customized reports, that incorporate complex data elements from multiple sources (e.g., pharmacy, case management and claims). The reports are used by the Medical Management Department to monitor and track the effectiveness of resource utilization by members and providers. (See the table that follows.)

<i>Report Name</i>	<i>Reviewed</i>	<i>Identifies</i>
Inpatient Census	Daily	Number of admissions, facility, length of stay, readmissions, behavioral health
Inpatient Utilization	Monthly	Admissions/1000, days/1000, average length of stay, readmissions
Skilled Nursing Facility Census	Monthly	Days/1000, average length of stay
Readmission	Monthly	Members readmitted to a hospital within 30 days
Prior Authorization Utilization	Monthly	Service authorization requests by provider name/service type
ED Usage by Member	Monthly	Members with frequent emergency department usage
PCP Utilization by Member	Monthly	Under utilization of primary care provider services
Inpatient Cost	Quarterly	Identifies facilities by claim type, total days, average length of stay and billed charges
Risk Statistics Report	Monthly	Members at risk for future use of services
Pharmacy Utilization	Quarterly	Members at risk for polypharmacy issues

### *Monitoring and Analysis*

SCAN's Chief Medical Officer is responsible for overseeing the collection, reporting and utilization of medical information. The Medical Management manager is responsible for generating reports in a timely manner. The reports are reviewed jointly by the director and manager of Medical Management and the medical director to identify patterns of over- and under-utilization of services by members and providers.

Utilization data are trended, tracked and compared with data from the previous month, quarter or year as applicable. For specific data, statistical analyses are applied to identify members and providers whose use of resources falls above or below two standard deviations from the mean. Members identified as under- or over-utilizers are assigned to a complex case manager (CCM), who reviews the member's records and gathers other relevant information for evaluation. The case manager's review may include communications with the member and his/her primary care provider (PCP) to determine possible cause(s) for the variance. Based on the findings, the case manager develops an intervention plan aimed at resolving the issue(s) and improving the member's health status. Interventions may include referral to complex case management or disease management or behavioral health for continued management of the issues.

For providers identified as under- or over-utilizers, the medical director requests reports from Healthcare Informatics to obtain further information about the provider, such as panel size, specialty, location, etc. The medical director reviews the additional information to assess potential causes of the aberrant utilization pattern and may communicate with the provider to determine whether the pattern actually signals an issue. If the provider's resource utilization reveals a sustained pattern of overuse or underuse, the SCAN Chief Medical Officer will contact or meet with the provider to jointly review the available information. The Chief Medical Officer collaborates with the provider to identify solutions and remedies as appropriate. SCAN will assist providers by means of multiple interventions such as academic detailing, dissemination of best practices and, when appropriate, implementation of a corrective action plan. Monitoring of resource utilization will continue until the issues are resolved. Noncompliant providers will be referred to the Quality Management/Medical Management (QM/MM) Committee for further discussion and possible action.

### *Examples of Utilization Variances Identified by Medical Management*

#### Member Under-utilization of PCP and Specialist

The *Risk Statistics Report* (see sample at Attachment A) was used to identify Member A for under-utilization of PCP and specialists. The CCM's review identified that the member had been diagnosed with stiff-man syndrome, a rare neurologic disorder of unknown etiology characterized by progressive rigidity. The CCM contacted the long term care case manager (CM) who had just completed the member's baseline assessment through a face-to-face visit. At that meeting the member expressed frustration with her neurologist and PCP. She was having difficulty communicating with her neurologist and was reluctant to access care from her PCP. She requested assistance with finding another neurologist. The member had significant pain management issues that prevented her from accessing care or being transported to her PCP. As a result, the CCM arranged for an in-home visit by a nurse practitioner (NP). The member was very satisfied with the care provided by the NP and requested to have the NP become her assigned PCP. Since the interventions were implemented, the member has not been admitted to the hospital.

#### Member Over-utilization of Emergency Department

Medical Management's *ED Usage by Member* report (see sample at Attachment B) was used to identify Member B. The member and/or his caregivers frequently called 911, which resulted in multiple hospitalizations for "altered mental state." The member was referred to a CCM, who reviewed the member's information and, after consulting with the CM, convened an Inter-disciplinary Team (IDT) meeting to conduct a root cause analysis and implement interventions. The IDT included the CM, the Behavioral Health supervisor and coordinator, and the medical director. During the process, the CM

reported that the PCP had informed her that the member was noncompliant with his medication regimen because he did not appear to understand its importance and that had caused the member's confusion which could be safely treated in an ambulatory setting. The CCM arranged for an in-home visit by the NP for medication management and education. After consulting with the PCP, the NP ordered skilled nursing visits and a nutritional consult. The member continues to be monitored and ongoing education is provided to the member and his caregiver to help him to better manage his healthcare needs. Since these interventions were implemented the member's ED use has been significantly reduced.

#### Over-utilization by a Provider

SCAN Medical Management analyzed drug utilization reports (see sample at Attachment C) to identify frail and elderly members at risk for drug interactions caused by polypharmacy, particularly for those taking 15 or more medications. The analysis identified several members who had been taking 15 or more medications regularly for three continuous months. A communication was sent to each member's PCP with the entire list of the member's prescribed medications. The letter asked the PCP to review the list for therapeutic duplication, high risk medications (drugs that are poorly tolerated by frail elderly members), selection of cost-effective alternatives and to evaluate appropriate use of psychotropic medications.

For confirmed cases of over prescription of medications by specialists, PCPs were asked to contact the specialists, inform them of their findings, and assist the specialists with obtaining a complete list of the member's prescriptions before dispensing a new medication.

#### Under-utilization by a Provider

Each quarter Healthcare Informatics analyzes claims data for the preceding four quarters and identifies the members 1) who have been assigned to the same PCP for more than one year; and 2) for whom SCAN has received claims for acute care visit(s) but none for a preventive health maintenance exam within the past 12 months. A communication is sent to the providers with a list of the identified members. Providers are asked to verify the accuracy of the information and, if appropriate, arrange for a preventive health maintenance visit for those members within 30 days. Claims data are trended and tracked to verify whether the member remains assigned to the same PCP and whether the services were delivered.

#### *Program Effectiveness Evaluation and Oversight*

Utilization data and reports are reviewed jointly by the Medical Management director and manager and the medical director on a monthly basis. Utilization reports are presented quarterly to the QM/MM Committee, which is responsible for oversight of Medical Management initiatives and activities. The QM/MM Committee reviews and discusses the information and reports and may make further recommendations. The committee is accountable to the Board of Directors for all MM and QM related matters.

Attachment A – Risk Statistics Report

Mbr ID	Name	Gender	Age	Predicted cost percentile	Baseline				Hypertension	CHF	Ischemic Heart Disease	Depression	Vascular Disease	CVA	Ortho Injury	Specified Heart Arrhythmia	Selected Cancers	Cardio Respiratory Failure	Renal Failure	Count of comorbidities	PCP Name	PCP visits in the past 12 mos
					IP admits	IP days	ER visits	Enrollment month														
		F	95	57	0	0	0	12	0	1	0	0	0	0	0	0	0	0	1	3 MCCARTY, FOSTER T	Y	
		F	46	92	2	7	16	12	1	1	0	0	1	0	0	0	0	1	0	4 TALLURI, MURALI	N	
		M	75	60	0	0	0	12	1	0	1	0	0	1	0	0	0	0	0	4 ABDEL-RAHMAN, ANWAR I	N	
		M	88	62	0	0	0	12	0	1	0	0	1	1	0	0	0	0	0	3 PARKER, JEFFREY B	N	
		M	57	71	1	11	2	12	0	0	0	0	0	1	1	0	0	0	0	3 WEEKLY, THOMAS C	N	
		M	77	73	0	0	1	12	1	0	0	0	0	1	0	1	0	0	0	4 KACZAR, PHILIP C	N	
		F	52	86	1	4	1	12	1	0	1	0	0	0	0	0	0	1	3 WOODS, ALEXIS A	N		
		F	67	3	0	0	0	12	1	0	0	0	0	0	0	0	0	0	1 BLAU, ELIOT	N		
		F	74	23	0	0	0	12	1	0	1	0	0	0	0	0	0	0	2 ESTES, APRIL L	N		
		F	96	50	0	0	0	12	0	0	1	0	0	0	0	0	0	0	3 LEVINE, DOV	N		
		M	52	59	0	0	0	12	0	1	0	0	0	0	0	0	0	0	2 SY, RACHEL K	N		
		M	54	60	0	0	0	12	0	1	0	0	0	0	0	0	0	0	2 TALLURI, MURALI	N		
		M	45	80	1	7	5	12	1	0	1	0	0	0	0	0	1	1	5 PHAM, PHUC H	N		
		F	84	30	0	0	0	12	0	1	1	0	0	0	0	0	0	0	2 GREGORY, JOE K	N		
		M	77	89	0	0	4	12	1	1	1	0	0	1	1	0	0	1	8 KORYAKOS, JOHN	Y		
		F	70	38	0	0	0	12	0	0	1	0	0	0	0	0	0	0	3 TAKAHASHI, BRUCE A	N		
		M	68	94	1	9	2	12	1	0	1	0	0	0	0	0	0	1	3 HERNANDEZ, MARTIN J	N		
		F	37	44	0	0	1	12	1	0	1	0	0	0	0	0	0	0	2 RAKKAR, NAVJOT	Y		
		F	92	59	1	3	1	12	0	0	1	0	0	0	1	0	0	0	3 PACE, LEE W	N		
		F	38	18	0	0	0	12	0	0	0	0	0	0	0	0	0	0	1 TALLURI, MURALI	N		
		F	98	10	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0 JACKSON, KEVIN G	N		
		M	54	71	0	0	2	12	0	1	1	0	0	1	1	0	0	0	4 TALLURI, MURALI	N		
		F	85	7	0	0	0	12	0	0	1	0	0	0	0	0	0	0	1 MURPHY, C DANIEL	N		
		F	86	70	0	0	1	12	1	0	1	0	0	1	0	0	0	0	4 CLARK, RANDOLPHA	N		
		F	84	26	0	0	0	12	0	0	0	0	0	0	0	0	0	0	0 RUDBERG, THEODORE L	N		
		F	93	34	0	0	0	12	0	0	1	0	0	0	0	0	0	0	1 MACLEOD, DANIEL T	N		
		F	89	62	0	0	0	12	0	1	1	0	0	0	0	0	0	0	3 BRUCE, DAVID I	N		
		F	87	52	0	0	1	12	0	0	1	0	0	0	0	0	0	0	3 RAUSCHER, ROBERT J	N		
		F	87	61	1	5	4	12	0	1	1	0	0	0	0	0	0	1	3 PATEL, KIRIT	N		

Attachment B - Emergency Department (ED) Usage by Member Report

Last Name	First Name	Mbr ID	Medicaid	Line Of Business	Claim Nbr	Prov ID	Provider Name	Admit Date	Discharge Date	Admit DX	Admit Dx Desc	Primary Diagnosis	Primary Diagnosis Desc	Discharge Status
1947 - ED Usage by Member Admit Date 10/1/10-10/31/10														
				ALTCS NON-VENT	16998 197	095617	BANNER BOSWELL MED CTR	10/12/2010	10/13/2010	786.50	CHEST PAIN UNSPECIF IED	787.01	NAUSEA WITH VOMITING	01
				ALTCS NON-VENT	16257 425	095617	BANNER BOSWELL MED CTR	10/7/2010	10/7/2010	850.0	CONCUSSION WITH NO LOC	850.0	CONCUSSION WITH NO LOC	01
				ALTCS NON-VENT	16445 648	049884	BANNER ESTRELLA MEDICAL CENTER	10/25/2010	10/25/2010	723.5	TORTICOL LIS, UNSPECIF IED	723.5	TORTICOL LIS, UNSPECIF IED	01
				ALTCS NON-VENT	16739 441	037024	BANNER THUNDERBIRD MEDICAL CTR	10/16/2010	10/17/2010	530.12	ACUTE ESOPHAG ITIS	530.12	ACUTE ESOPHAGI TIS	01
				AZ CONNECTI ONS	16345 928	012589	SCOTTSDALE HEALTHCARE OSBORN	10/1/2010	10/1/2010	682.2	CELLULITI S AND ABSCESS OF TRUNK	682.2	CELLULITI S AND ABSCESS OF TRUNK	01
				AZ CONNECTI ONS	16359 521	012589	SCOTTSDALE HEALTHCARE OSBORN	10/12/2010	10/12/2010	787.02	NAUSEA ALONE	276.51	NAUSEA ALONE	01

Attachment C – Prescribed Drug Usage by Member Report

Pharmacy NCPDP	Date Filled	Rx Number	Drug NDC	Drug Name	Drug Type	Claim Source	Prescriber ID	Prescriber Name	Ingredient Cost	Member Contrib	Plan Cost	Days Sup	Qty
0354934	01/03/2011	000000052531	005910349	HYDROCODON-ACETAMINOPHEN 5-500	GEN	Retail	MW0012803	WILLIAMS, CAROL E RN FNP	\$7.83	\$0.00	\$9.38	15	60.0
0327711	01/13/2011	000000564668	584680130	RENVELA 800 MG TABLET	SSB	Retail	BT8265084	TING, STEVEN C MD	\$195.14	\$0.00	\$196.69	30	90.0
0318940	01/24/2011	000008819737	001691834	NOVOLIN N 100 UNITS/ML VIAL	SSB	Retail	MP1470664	PREVETTE, ELIZABETH R., NP	\$55.70	\$0.00	\$56.45	30	10.0
0354643	01/24/2011	000000485448	593100579	PROAIR HFA 90 MCG INHALER	SSB	Retail	MW0012803	WILLIAMS, CAROL E RN FNP	\$37.15	\$0.00	\$38.70	25	8.5
0354643	01/27/2011	000000487715	001431240	DIGOXIN 125 MCG TABLET	GEN	Retail	AP7137955	POST, JOHN MARK MD	\$2.08	\$0.00	\$3.63	28	12.0
0354643	01/28/2011	000000548644	000710156	LIPITOR 20 MG TABLET	SSB	Retail	BC8281230	CHATHA, MANINDER P MD	\$148.25	\$0.00	\$149.80	30	30.0
0354643	01/28/2011	000000463372	000743080	NIASPAN ER 1,000 MG TABLET	SSB	Retail	BS9100253	SARIRIAN, MEHRDAD, MD	\$129.55	\$0.00	\$131.10	30	30.0
0354643	01/28/2011	000000475345	001730470	EPIVIR 150 MG TABLET	SSB	Retail	AP7137955	POST, JOHN MARK MD	\$196.33	\$0.00	\$197.88	30	30.0
0354643	01/28/2011	000000548643	001850820	BENAZEPRIL HCL 20 MG TABLET	GEN	Retail	BC8281230	CHATHA, MANINDER P MD	\$6.00	\$0.00	\$7.55	30	30.0
0354643	01/28/2011	000000426389	005970046	VIRAMUNE 200 MG TABLET	SSB	Retail	AP7137955	POST, JOHN MARK MD	\$526.64	\$0.00	\$528.19	30	60.0
0354643	01/28/2011	000000489130	007815077	LORATADINE 10 MG TABLET	GEN	Retail	MW0012803	WILLIAMS, CAROL E RN FNP	\$7.20	\$0.00	\$8.75	30	30.0
0354643	01/29/2011	000000607553	082903284	BD INSULIN SYR 0.5ML 31GX5/16"	SSB	Retail	AP7137955	POST, JOHN MARK MD	\$24.11	\$0.00	\$25.66	25	100.0
0354643	01/28/2011	000000571804	537460253	RANITIDINE 150 MG TABLET	GEN	Retail	AP7137955	POST, JOHN MARK MD	\$20.43	\$0.00	\$21.98	30	60.0
0354643	01/28/2011	000000499948	602580162	RENAL CAPS SOFTGEL	GEN	Retail	BC8281230	CHATHA, MANINDER P MD	\$5.10	\$0.00	\$6.65	30	30.0
0354643	01/28/2011	000000465619	619580401	VIREAD 300 MG TABLET	SSB	Retail	MW0012803	WILLIAMS, CAROL E RN FNP	\$713.77	\$0.00	\$715.32	30	30.0
0354643	01/28/2011	000000426400	636531171	PLAYIX 75 MG TABLET	SSB	Retail	AP7137955	POST, JOHN MARK MD	\$167.69	\$0.00	\$169.24	30	30.0
									<b>Member Total</b>	<b>\$2,242.97</b>	<b>\$0.00</b>	<b>\$2,266.97</b>	
										<b>16</b>	<b>Script(s)</b>		

---

## *Requirement 26: Successful Interventions in Over-/Under-Utilization*

---

SCAN Long Term Care (SCAN) generates utilization reports and analyzes them to assess the rates at which members and providers use resources such as emergency department (ED), hospitals, and pharmacy. These reports are valuable in directing attention to areas in which members' or providers' over- or under-utilization of a service may signal opportunities for SCAN to intervene and promote positive changes in member's health status and wellbeing.

### *Successful Intervention – Reduction of Readmission Rates*

Among the reports regularly reviewed by Medical Management, review of the following triggered an in-depth analysis of hospital readmissions and resulted in lower readmission rates and improved member outcomes:

- Hospital bed days per thousand members
- Skilled Nursing Facility (SNF) bed days per thousand members
- Hospital admissions per thousand members
- Hospital readmissions per thousand members

The tracking and analysis of readmission rates from 2007-2009 revealed that the rate of readmissions within 30 days of hospital discharge was between 27 and 28 percent, higher than the industry standard for this population base. To assess the high readmission rate, SCAN's associate medical director completed a root-cause analysis of all readmissions within 30 days occurring during a three-month period. The investigation identified the following factors that contributed to potential preventable readmissions:

- Insufficient medication reconciliation by the member or caregiver
- Lack of post-discharge follow-up with the primary care provider (PCP)
- Failure of the member or facility to successfully initiate planned outpatient services
- Inadequate support of member by family or caregiver
- Insufficient or unclear information given to member or caregiver by the discharging facility

As a result of the associate medical director's study, SCAN Medical Management developed the following initiatives to address the causes with the goal of preventing avoidable readmissions within 30 days of hospital discharge:

- Establishment of a care transition process
- Initiation of internal and external referrals to Chronic Care/Disease Management or complex case management and/or the behavioral health team
- Formation of the Readmission Committee
- Initiation of in-home visits by a nurse practitioner/physician

### Care Transition Process

SCAN developed and implemented a care transition program in the fourth quarter of 2009 based on a program successfully introduced by SCAN Health Plan in California and modified to meet the needs of SCAN's Arizona membership. The program is conducted by telephone by a transition coordinator, who is a licensed nurse or social worker. The transition coordinator interacts with members and their caregivers to provide education about self management, medication management, and care options in order to promote continuity of the member's care during the transition from hospital to home. The primary role of a transition coordinator is to encourage the members and/or caregivers to take an active role in managing all aspects of care by:

- Discussing and advocating for the member's care preferences
- Identifying and achieving a member's personal goals
- Encouraging and promoting of greater self-management



SCAN concurrent review nurses start the care transition process by identifying all members who are hospitalized in an acute or skilled nursing facility. The nurse obtains discharge planning information from the facility case manager and relays the information to the care transition coordinator. The transition coordinator then contacts the member/caregiver during the hospital stay or within two days post discharge to complete a Transition Assessment to address the following:

- Medication self management – to address medication reconciliation, member’s knowledge and means of managing
- Personal health record (PHR) – to encourage the member to maintain a PHR to support communication and ensure continuity of care
- Primary care and specialist follow-up – to inform the member/caregiver/advocate a about when and whom to visit for follow-up care
- Knowledge of warning signs and symptoms – to educate the member/caregiver/advocate about indicators that suggest his or her condition is worsening and how to respond
- Advance directives – to encourage the member/caregiver/advocate to complete an Advance Health Care Directive stating the member’s wishes regarding medical care/treatment in the event they become unable to direct their care or treatment

In addition, Inter-disciplinary Team (IDT) meetings are held as needed to present and discuss selected cases of members who are at risk for poor transition and/or readmission. The IDT includes the medical director, Medical Management manager, concurrent review nurses, the transition coordinator and assigned case manager, attending physicians and/or nurse practitioners.

#### Internal and External Referrals to Disease Management Programs

A second approach was to use the quarterly reviews of the *Risk Statistics Report (RSR)* to prospectively identify members at risk for hospital readmission and frequent emergency department utilization. Members identified through analysis of the *RSR* or during inpatient concurrent review, are referred to the Chronic Care/Disease Management or Complex Case Management programs as appropriate. The Disease Management nurse/case manager and/or complex case manager completes a comprehensive assessment to identify the member’s issues and formulates a care plan to achieve the member’s short- and long-term goals. The care plan is shared with the IDT.

#### Readmission Committee

In November 2010 SCAN established a weekly Readmission Committee that includes the medical director, the care transition coordinator, experienced nurses from concurrent review, complex case management, quality management, long term care case managers, and staff from other disciplines as needed. The committee reviews members who have been readmitted twice within a 30-day period or three times within a six-month period. The inter-disciplinary makeup of the committee allows for a holistic review and multiple approaches to interventions that will successfully reduce the member’s utilization, and optimally, improve his or her outcomes. Interventions may include on-site visits by concurrent review and complex case management, education by complex case management, assistance in accessing community resources, and on-site nurse practitioner/physician visits. Interventions will be tracked and analyzed monthly and the success of intervention outcomes will be measured by reviewing the following data sets:

- Member readmission following intervention within 30 and 90 days
- Admitting diagnoses
- Number of preventable readmissions

Results of outcomes analyses will be reported back to the Readmission Committee quarterly to discuss and develop additional interventions for the member.

### In-Home Nurse Practitioner/Physician Visits

In 2010 SCAN began partnering with several in-home physician and nurse practitioner groups to clinically assess members who are identified through the analyses of the *RSR* and referred for an in-home assessment. During these visits, the practitioner assesses the member’s environment and medical conditions and develops a comprehensive plan of care. The member’s PCP is then informed of the plan of care and any changes in the member’s treatment or health status.

#### *Results*

Since implementation of the initiatives described, SCAN has dramatically reduced the readmission rate over the past three contract years.

<i>Contract Year</i>	<i>Goal</i>	<i>Readmission Rate</i>
2007-2008	20%	28%
2008-2009	20%	27%
2009-2010	20%	19%

#### Example: Avoidable Readmission

The case below describes how SCAN intervened after a member was identified with frequent readmissions caused by insufficient or unclear communication about her condition.

A 51-year-old member was identified as having recurrent hospital admissions related to her diagnosis of metastatic ovarian cancer. The member and her family were struggling with all the medical complications and decision-making related to this grave prognosis. The member had been given the treatment options of additional surgery or continuing chemotherapy for her end-stage ovarian cancer. The Case Management Department referred the member for complex case management intervention. The complex case manager contacted the member and provided education related to her diagnosis, symptom management and pain control. She encouraged the member to discuss her end-of-life wishes with her family. As a result, the member elected to enroll in a home hospice program. Her symptoms and pain issues were successfully managed by the hospice providers and her family received the emotional support they needed to accept the member’s decision to stop aggressive treatment. The member remained in her home surrounded by her family without further hospital admissions because of the support and services provided by hospice and SCAN until she succumbed to her disease.

#### *Process Evaluation and Reporting*

SCAN continues to monitor quarterly readmission rates, identify members with recurring hospitalizations, and identify facility and provider utilization trends. The readmission data are reported to the Quality Management/Medical Management Committee on a quarterly basis. The committee recommendations will guide further program modifications or refinements.

---

## *Requirement 27: Chronic Care/Disease Management Programs*

---

### *Disease Management Programs*

The SCAN Long Term Care (SCAN) disease management/chronic care programs assist members with chronic diseases or complex conditions in managing their conditions more effectively, preventing exacerbations and complications and improving outcomes, while allowing them to live at the most independent level possible and improve care outcomes. SCAN's established disease management/chronic care programs are particularly suited to the needs of the ALTCS population.

SCAN currently has established disease management (DM) programs for congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). SCAN selected these diagnoses based on data analyses showing that CHF and COPD occurred respectively among 15.1 percent and 16.8 percent of its members.

### *Program Description*

SCAN uses eligibility criteria developed by the National Committee for Quality Assurance to identify members for participation in these DM programs. A SCAN registered nurse provides telephonic education following evidence-based guidelines. The nurse informs the member about how to identify symptoms and develops a plan of care that includes interventions that may help prevent exacerbations and unnecessary emergency department (ED) visits and hospitalizations. Program participation requires that the member or caregiver has access to a telephone, lives in a private home or in an assisted living home or facility, is not enrolled in hospice, is not on dialysis, is not on a ventilator and has the ability to weigh safely for the CHF program.

The DM programs include the following components:

- Identification of eligible members
- Provision of member outreach
- Intervention, including education, medication reconciliation, coaching in self-management strategies, goal setting and discussion of co-morbid conditions
- Identification of community resources
- Education of providers about COPD and CHF guidelines through the SCAN Web site and newsletters

The Medical Management and Case Management departments have well-established processes that are well-coordinated with DM nurses. An Inter-disciplinary Team (IDT), which includes the case manager, the Case Management Department manager or supervisor, the complex case manager and the medical director, meets bimonthly and on an ad hoc basis to review all members enrolled in the DM programs. The member's physician or specialist, Behavioral Health staff, nurse practitioners and a clinical pharmacist are included as needed. The IDT particularly focuses on challenging cases for which the standard interventions have not been effective and develops recommendations for further interventions.

### *Identifying Members for Chronic Care/Disease Management (CC/DM) Programs*

For members who have been diagnosed with multiple chronic conditions or whose chronic condition is poorly managed, SCAN utilizes an enhanced CC/DM model that integrates the major components of DM into the intensive case management process. These members are identified using the *Risk Statistics Report (RSR)*, a predictive modeling system that is not only able to identify members' historical utilization data, but is also able to prospectively identify those with high potential for future use of resources such as ED and inpatient (IP) hospitalizations. The *RSR* uses detailed formulas to combine claims data with certain diagnoses in order to create a ranking score that categorizes members according to their utilization history. This tool is extremely flexible and allows queries to selectively focus on high-risk members in

order to maximize system efficiencies and achieve best outcomes. Another excellent feature of this tool is that specialized reports can be generated for each primary care provider (PCP).

Using the *RSR*, members are stratified into three categories for appropriate interventions. Initial stratification identifies the members with scores in the highest 20<sup>th</sup> percentile. These members are screened for inclusion in complex case management or disease specific and/or episodic case management programs. The most recent baseline assessment by the case manager is reviewed by the complex case manager. Members are screened to determine whether they live in a home or community based setting and are willing to participate in the program. The following reports are produced and analyzed by the Healthcare Informatics Department to determine whether the member has been assigned to the appropriate care management level:

- Outliers (Inpatient claims >\$25,000)
- Most common chronic conditions
- ED usage by member
- Members with HIV diagnosis
- DM recruitment/referral report (CHF/COPD)

As a result of the review activities, members may be placed in one of three care management categories:

**Level 1 – Supported Self-Care** – Provides multidisciplinary support to a member, the family or the caregiver to develop skills and confidence to provide self care in the home, assisted living or nursing home and to maintain the member’s current state of wellness for their age or disease states.

**Level 2 – Disease Specific and Episodic Case Management** – Includes members with a single disease state or multiple disease states that require a higher level of case management, and further surveillance and evaluation in addition to Level-1 activities.

**Level 3 – Complex Care Management** – Includes high risk members that require involvement of an Inter-disciplinary Care Team and ongoing evaluation and updating of the member’s care plan.

After the initial stratification and care management placement, members will be assessed on an ongoing basis and their placement into a level may be modified as indicated.

#### Disease Management Reporting and Evaluation

SCAN monitors and reviews reports to evaluate the effectiveness of the DM and CC/DM programs in terms of the program’s goals and individual members’ outcomes, including members’ satisfaction with the program.

Monthly and quarterly reports identify the number of enrolled members with the diagnosis of COPD or CHF. In addition, SCAN tracks and trends the effectiveness of outreach, recruitment and retention in the programs, as well as the reasons for nonparticipation or opting out.

Using the *RSR*, SCAN will begin monitoring the longitudinal progress of each CC/DM member. Second quarter and third quarter data from contract year 2010-2011 will be compared to evaluate the effectiveness of the CC/DM interventions. SCAN also intends to follow this review of member progress with longitudinal evaluation of PCP member panel risk scores.

The director and manager of Medical Management will review the reports to determine whether the desired goals have been obtained. The results will be reported to the Quality Management/Medical Management (QM/MM) Committee. These goals include reducing hospital admissions and readmissions related to COPD and CHF diagnoses, reducing ED utilization related to COPD and CHF diagnoses and increasing internal referrals to DM to increase the number of enrolled members.

Disease Management Program Statistics

	<i>July-Sept 2010</i>	<i>Oct-Dec 2010</i>	<i>Percent Change</i>
Participation	14	16	Increased 14.3%
ED visits/1000	0.21	0.19	Decreased 9.5%
Admissions	4	3	Decreased 25%

Satisfaction surveys of both programs conducted in 2010 indicated high levels of satisfaction among participants. Ratings were consistently at or above the 90<sup>th</sup> percentile on such outcomes as having more control over their health, knowing who to call to get needed care, enhanced enjoyment of life and help in talking to their provider.

The Medical Management manager reports the outcomes of the DM and DM/CC programs quarterly to the QM/MM Committee. Feedback provided by the committee is evaluated to enhance the current programs and to research other disease DM/CM programs for future implementation based on the most prevalent disease states.

Consideration of Future Programs

SCAN is presently evaluating implementation of a chronic disease self-management program for its chronic care members. SCAN Connections Resource Center staff have been trained and certified as master trainers for the program. Based on the Stanford University Chronic Disease Self Management Program, the program was developed as a collaborative research project between Stanford and Northern California Kaiser Permanente, and has been shown to improve the healthful behaviors (exercising, coping, symptom management), the health status (self-reported health, fatigue, disability, etc.) and to reduce days in hospital for program participants. Rather than treat specific chronic conditions such as diabetes with disease specific interventions, this evidence-based program follows the underlying assumptions, among others, that people with chronic conditions have similar concerns and problems; people with chronic conditions must deal not only with their disease, but also with the impact of their condition on their lives and their families; and that the process, or way the program is taught, is as important as the subject matter, if not more so.

Data analysis has revealed that 13.7 percent of SCAN members have a diagnosis of diabetes. Based on this information, SCAN intends to begin a diabetes DM program by July 2011. Data analyses will be used as a basis for implementing other programs to address other chronic diseases or conditions prevalent in SCAN’s membership.

## *Requirement 28: Consistent Application of Clinical Criteria*

---

### *Medical Review Criteria*

SCAN Long Term Care (SCAN) uses nationally recognized evidence-based clinical criteria to evaluate the appropriateness of medical services requested for or provided to our members. SCAN uses established processes to monitor the consistent use and application of criteria by clinical staff.

The SCAN Quality Management/Medical Management (QM/MM) Committee is responsible for reviewing and approving the criteria, which are updated at least every two years or with the development of new medical evidence, guideline revisions or introduction of new technologies. The QM/MM Committee considers input from practicing network practitioners and/or leading experts in their field.

SCAN uses the definition of medical necessity as described in the AHCCCS Medical Policy Manual. SCAN clinical staff use the following published review criteria, which are consulted in the order listed:

- AHCCCS Medical Policy Manual
- Milliman Care Guidelines®
- InterQual® Criteria
- Medicare national and local coverage guidelines
- National Institute of Health (NIH) Consensus Statements
- National Guidelines Clearinghouse (NGC)
- American Medical Association-Medical Literature
- Agency for Healthcare Research and Quality (AHRQ) publications and newsletters
- American Association of Health Plans guidelines ([www.health.gov](http://www.health.gov)) as approved by the Medical Practice Committee and the Quality Council.

For review of behavioral health services SCAN utilizes the following criteria, which are consulted in the order listed:

- Milliman Care Guidelines®
- InterQual® Criteria
- American Academy of Child and Adolescent Psychiatry, American Psychiatric Association (a Joint Publication) Criteria for Short-Term Treatment of Acute Psychiatric Illness
- American Society for Addictive Medicine Patient Placement Criteria-Revised, 2nd Edition

The above criteria and guidelines are used to review and evaluate prior authorization requests for medical services, assess appropriateness of level of care, and make determinations of medical necessity. SCAN Medical Management is cognizant that these criteria are a powerful, but not the only tool for making such determinations. SCAN physician reviewers incorporate other relevant information, such as the presence of co-morbidities, member language and cultural preferences, environment and circumstances, provider experience and other pertinent information to make well grounded decisions. Specifically, the reviewer takes into account whether the member is considered frail, disabled and/or geriatric. If there are no established criteria for a given request, the physician reviewer conducts a literature search and may consult with an expert in the field to make such determinations. In addition, providers are able to submit published peer-reviewed medical literature in support of their requests.

### *Dissemination of Medical Management Criteria*

The key to successful dissemination of criteria is the thorough education of staff in its use and application. The process starts with hiring knowledgeable staff, followed by frequent and continual staff education

and monitoring by audits and inter-rater reliability studies. The medical criteria are embedded within the CareEnhance® Clinical Management Software (CCMS®). The criteria are available to and are shared with providers when requested.

*Application of Medical Management Criteria*

SCAN uses medical management criteria for three basic functions: concurrent reviews, retrospective reviews and prior authorizations. Physician reviewers use all the available sources of information, including submitted documentation, verbal information and information from internal and external sources, information obtained during discussions with the provider or other experts and gathered information about member’s personal circumstances and cultural preferences.

Service requests are reviewed against appropriate review criteria prior to a determination by the Medical Management licensed reviewer and/or a physician reviewer. The Medical Management reviewer documents in the member case file the criteria used to make the review determination. Service requests that meet the criteria are approved and processed according to SCAN’s established authorization procedures. Requests reviewed by the Medical Management staff that fail to meet the established criteria are referred to the physician reviewer, who reviews the criteria and guidelines available and who considers other member-specific circumstances in order to render a determination. Only a physician reviewer can issue an adverse determination. Criteria used as the basis of a decision to modify, delay or deny services in a specified case are disclosed to the provider if requested. The member is informed of the criteria used to make the determination. SCAN Medical Management completes and communicates the results of medical necessity determinations to prevent potential delay of care and to remain compliant with timeframes established by AHCCCS.

Certain procedures that require prior authorization may be delivered in emergent and life threatening situations. SCAN will not withhold approval of care that may jeopardize a member’s health status due to lack of information and the review will be completed after the member’s health status is stabilized.

*Performance Monitoring and Evaluation*

SCAN continually monitors and evaluates Medical Management department and staff productivity to meet members’ care needs and to ensure compliance with established standards. These include data entry accuracy and timeliness, appropriateness and completeness of documentation, work load, number of cases referred to physician reviewers, percentage and number of approved requests, number of appeals and number of upheld appeals.

SCAN’s Medical Management trainer conducts annual inter-rater reliability studies and random audits to ensure consistency of the reviews performed by Medical Management staff and provides education when errors or inconsistent decision making trends are identified.

**Audits**

SCAN’s Medical Management trainer or designee randomly selects at least five files from each prior authorization and concurrent review staff at least quarterly. The files are audited for accuracy, completeness, appropriateness and timeliness of the documentation. Audit results are shared with staff and the performance results will be shared in the department’s quarterly meeting.

The audit results shown below involved the completeness of data entry for ten Prior Authorization Department staff. For each individual, 15 to 20 files were randomly selected each month.

<i>Benchmark</i>	<i>October 2010</i>	<i>November 2010</i>	<i>December 2010</i>
90%	99%	98%	98%

The results demonstrate that the Medical Management's performance has continually exceeded the department's internal minimum performance requirement of 90 percent.

#### Inter-rater Reliability Review

To assess the extent to which two or more Medical Management clinical staff agree and consistently apply decision-making criteria, the department annually conducts inter-rater reliability reviews (IRR) of all clinical staff involved in making decisions about medical necessity, identification of quality issues and application of criteria to approve or deny a service.

The Medical Management manager, who has been trained in the use of Milliman Care Guidelines® and InterQual® criteria and an understanding of the SCAN's guidelines, sets up the case studies and scoring standards.

The IRR consists of six different case studies for each unit within the department—prior authorization, concurrent review, retrospective review and physician reviewers—and two case studies for the transplant coordinator's review. Each case study includes an overview of the member's medical history with presenting symptoms, physical examination, lab studies, test results, findings and physician's orders.

Individuals whose IRR scores are lower than the department's minimum performance requirement of 85 percent are required to attend additional training on the criteria involved and retake the IRR. The department's IRR scores are reported to the QM/MM Committee annually. The department's aggregate IRR results for contract year 2009-2010 ranged from 85 to 99 percent.



## *Requirement 29: Quality Improvement Opportunities*

---

SCAN Long Term Care (SCAN) has an established Quality Management (QM) Program which is the foundation for all quality activities conducted throughout the health plan. The QM Program monitors the quality and appropriateness of care and services delivered to our members based on community, regulatory, internal and national standards. The QM Program consists of established policies, procedures and activities that support the vision and mission of the organization, as well as meet contractual requirements. A component of the QM Program is the work plan which includes specific objectives designed to demonstrate how SCAN will monitor the care and services delivered to our members. SCAN utilizes specific measurable indicators, benchmarks and methodologies to determine if improvements in the delivery of care and service have been achieved. The Board of Directors (BOD) has ultimate authority and responsibility for the quality and integrity of the QM Program. Oversight of the program is delegated to the Chief Medical Officer (CMO) by the BOD through the Chief Executive Officer (CEO). The CMO, with input from all functional areas, is responsible for ensuring all QM Program components are relevant to SCAN membership and carried out in accordance with SCAN policies and procedures.

### *Identification of Improvement Opportunities*

A key component of the QM program is the process to identify quality improvement opportunities. SCAN utilizes an inter-departmental approach to ensure that all issues relevant to the care and service received by members are considered for a quality improvement project. SCAN places a high priority on proactively identifying improvement opportunities through data analysis. Both clinical and non-clinical areas are reviewed and considered. SCAN utilizes information gleaned from monitoring and evaluating data which demonstrates a trend or opportunity for improvement. These data are considered in defining a project for the annual QM work plan. Improvement opportunities are identified through various internal and external sources. Sources for potential quality improvement projects include but are not limited to:

- Occurrence reporting of potential quality of care concerns
- Tracking and trending quality of care issues
- Reviewing past performance on Performance Improvement Projects
- Annual Provider Survey
- Provider complaints
- Tracking and trending member grievances
- Reviewing past and current performance on established performance measures and relevant HEDIS measures
- Annual Member Survey
- Utilization monitoring
- On-going services and service site monitoring and delegation monitoring

Data from these sources are compiled and analyzed to determine if there are identifiable trends that potentially may impact the quality of care and services delivered to members or produce adverse outcomes. The data analysis utilizes an integrated approach, including review and input from clinical and operational areas. The QM Department reports identified trends to the Quality Management/Medical Management (QM/MM) Committee and assesses these trends for potential quality improvement projects.

### *Selecting Quality Improvement Projects*

Once areas for improvement have been identified, SCAN selects projects for inclusion in the QM work plan based on several factors, including but not limited to, the significance of the issue in relation to members' health, the prevalence of a condition among the membership, the health risk status of members, contractual requirements and potential impact on target populations. Other considerations may include current performance measured against goals, benchmarks and/or national trends. The QM department will present the improvement opportunities to the QM/MM Committee through the annual QM work plan. The QM/MM Committee has the responsibility to review and approve the work plan and ensure the goals and objectives are relevant to the membership and are based on sound scientific evidence or community practice standards. SCAN's CMO chairs the QM/MM Committee which includes membership from community providers who can offer input and feedback on the QM Program and work plan components.

The committee also includes representation from SCAN's key functional departments. With approval from the committee, the QM Department implements the quality improvement projects. In addition to the projects submitted through the annual QM work plan, SCAN may also initiate a quality improvement project on an ad hoc basis if data trends indicate action should be taken quickly to improve a particular area of concern. QM Department presents ad hoc to the QM/MM Committee for input and approval. A project plan is then developed and implemented through an inter-departmental approach.

### *Quality Improvement Project Design and Implementation*

Each project has defined objectives that support its goal. The work plan drives the project by identifying the measurable objectives, improvement strategies, interventions, the department responsible for executing the interventions, and the method by which the interventions will be analyzed for effectiveness. Chosen interventions are evidence based or those proven successful through the SCAN's past experience. Newly designed interventions must be logical and must be linked to the root cause analysis associated with the improvement opportunity. The QM Department tracks and monitors each project and updates the work plan quarterly. Any necessary changes to the work plan are reported to the QM/MM Committee and reported to AHCCCS. This may occur if barriers are identified as the project is in progress.

### *Measuring Effectiveness*

The SCAN utilizes the "Plan – Do – Study – Act" (PDSA) process improvement methodology for evaluating the effectiveness of an intervention. Through the PDSA process, interventions can be evaluated for effectiveness fairly quickly. The components of the PDSA process are as follows:

- Plan** Determine what variables will be measured to determine effectiveness and what predictions can be made about the intervention
- Do** Test the intervention or change on a small scale to determine if it is going to produce the desired outcome, assess for unintended consequences and adjust the intervention as needed
- Study** Complete an analysis of the measurement, compare the outcome to the predictions and summarize what was learned
- Act** Take action by implementing the interventions with modification if needed

To improve quality and performance, SCAN uses rapid cycle change by setting objectives, systematic monitoring over time, integrating quality across the organization and involving inter-disciplinary teams. Instead of a lengthy project, staff brainstorm to identify changes that will lead to improvement and test these changes. Through rapid cycle change, staff to try a potential change and test its effectiveness over a relatively short period of time. Each indicator measured has an identified benchmark that must be achieved in order for a particular intervention to be deemed successful. Benchmarks are determined based on past performance and/or local and national mean scores if available.

### *Example of Identified Improvement Opportunity*

The AHCCCS Minimum Performance Standards (MPS) for diabetic members receiving eye exams is 60.0 percent; however, for CYE2007 and 2008 SCAN's measurements were 26.1 percent and 31.8 percent, respectively. Considering the long term complications associated with diabetic retinopathy and the prevalence of diabetes among the membership (approximately 20 percent) improvement on diabetic eye exams was selected for a quality improvement project. The goal was to achieve a statistically significant improvement in eye exam rates from the previous measurement.

Through a root cause analysis of data and current interventions, several barriers to achieving the MPS or a statistically significant improvement were identified. We attributed the low performance rate for eye exams partially to members having other primary insurance and partially to members not receiving service as needed. The findings of the analysis are presented in the following table.

<i>Measure</i>	<i>Count CYE2008</i>	<i>Missing service</i>	<i># of those with other Primary Insurance</i>	<i>Percent of those missing services with other Primary Insurance</i>
eye exam	107	73	27	37.5%

### Multi-Departmental Intervention (Eye Exams)

To address the low performance rate on eye exams, SCAN established partnerships with several eye vendors that now provide eye exams in assisted living centers and nursing facilities. Each eye vendor reports quarterly on the number of members who have received this service. The Case Management (CM) Department assisted in identifying members who could not access care in an ambulatory setting or had an alternate primary payer. The QM Department provided training to case managers on the importance of diabetic testing and the associated complications of diabetes if not managed. The QM Department also met regularly with the CM Department to ensure that all case managers were aware of the diabetic members on their case load and they had the necessary tools to help the member access the care needed. Ongoing analysis of the data and the development of the diabetic database allow for real time status of our diabetic members in relation to their annual required tests. This information is provided to case managers on a quarterly basis. Members and primary care providers received regular mailings to remind members missing services of how and where to access care. The Member Services (MS) Department assisted members with scheduling appointments if needed.

### Measuring Effectiveness

Through the use of the PDSA cycle, SCAN has been able to identify successful interventions that have led to improvement in various quality improvement projects. The successful interventions have become standard operating procedure, while undergoing continuous review to ensure they continue to produce the desired outcomes. The following table demonstrates the effectiveness of the PDSA cycle on testing process changes and interventions related to diabetic eye exams.

<b>PDSA Cycle</b>		<b>PDSA Action</b>		
<i>Plan</i>	Intervention	Partner with eye vendors to conduct on-site retinal eye exams Increase contact with members through case management and member mailings		
	QM Department	Run reports to determine members needing services Set up quarterly reports from vendor on completed tests Conduct member and provider mailings		
<i>Do</i>	MS Department	Receive calls from members needing help in scheduling services		
	CM Department	Assist in determining members who cannot receive care in ambulatory setting Provide assistance to members in accessing care as needed		
	Network Management	Work with vendor on agreement and scope of work to be completed		
<i>Study</i>	Measured by	Improvement in eye exam rates		
<i>Act</i>	Outcome	<u>CYE2008 rates</u> 31.8%	<u>CYE2009 rates</u> 45.1%	<u>CYE2010 rate (preliminary data)</u> 63%

The success of these multi-departmental interventions was realized in a relatively short period of time. They were implemented in the fall of 2009; improvement was noted beginning with the first quarter of CYE2010 (Oct – Dec 2009). The improvement was statistically significant for the CYE2009 measurement period, but fell short of the MPS of 60 percent. These successful interventions have continued and have become standard practice in the organization. We continue to collaborate with our eye care vendors and routinely meet to ensure continued success. QM and CM continue to meet and review current practice and new processes to ensure continued improvement in our diabetic eye exam rates. SCAN’s goal for 2010 is to achieve a rate of 60 percent for diabetic eye exams. A preliminary review of data for CYE2010 indicates that our eye exam rate is expected to exceed this goal.

---

### *Requirement 30: Peer Review*

---

SCAN Long Term Care (SCAN) utilizes a formal Peer Review (PR) process to establish whether the care and services provided to members is consistent with current professional standards of medical practice. The safety and delivery of quality medical care to our members is the focus of all peer review activities. The PR process is designed to provide an independent examination of a set of facts by an impartial group of professional peers using evidence based clinical guidelines and standards and/or regulatory requirements to determine whether acceptable medical care or service has been rendered. The scope of the PR process includes cases where there is evidence of quality deficiency in the delivery of care or services to members, including the omission of needed care. Peer review is conducted on the care and services rendered by contracted and non contracted practitioners and/or providers. All PR activities are confidential and protected from discovery.

#### *Peer Review Committee Structure and Role*

The SCAN Peer Review Committee (PRC) is chaired by SCAN's Chief Medical Officer (CMO) or plan Medical Director. SCAN does not delegate PR responsibilities. The PRC meets quarterly as an executive session of the Quality Management/Medical Management (QM/MM) Committee. The committee members include contracted providers practicing in the community. SCAN ensures that providers from the same or similar specialty participate in the review and recommendation process of individual PR cases. External consultation is utilized if the needed specialty is not represented on the PRC. If a case involves a behavioral health provider, SCAN ensures that a behavioral health practitioner participates in the PR for that case. Every member of the PRC signs a confidentiality statement and must excuse themselves from any case review where there is the possibility of a conflict of interest. The Quality Management (QM) Department oversees the PR process and ensures that all PR documents such as minutes, reports, practitioner documents and committee recommendations are kept confidential. SCAN ensures that provider and member information is kept confidential during the review process by:

- Requiring all PRC committee members to sign a confidentiality and conflict of interest statement at each PRC meeting
- Restricting access to documents solely to the committee members and QM staff as indicated
- Identifying documents as peer protected by referencing applicable statutes as indicated
- Documents provided to the committee for review are retrieved at the close of each meeting and confidentially disposed of as necessary

#### *Provider Education on Peer Review Process*

Providers are educated about the PR process through SCAN's *Provider Operations Manual*. Information about the PR process is also available on SCAN's Website via the Provider Tools link. The information included covers SCAN's PR process, including how cases are selected for peer review, the scope and responsibility of the PRC and how a provider can appeal an action of the PRC. The QM Department will provide a copy of SCAN's Peer Review policy to any provider upon request.

#### *Case Identification, Review and Decisions*

The PR process begins with a referral of a potential quality of care issue to the QM Department. Referrals come from a number of sources, including but not limited to, an occurrence reported directly to the Grievance Unit or through Case Management, Medical Management, Member Services, Network Management, a provider or AHCCCS. The QM Department accepts referrals and assigns a nurse reviewer to initiate the investigation and review process. The QM nurse abides by internal policies and regulatory time frames for investigating and resolving the issue. The investigation includes gathering medical records, reviewing claims, requesting provider responses, reviewing publically reported information and consulting with others who may have pertinent information about the issue. Once the

information has been gathered, the nurse will review the case and recommend an initial determination, including the substantiation status of the allegations as well as the severity level of the case. The determination is made using the following severity level ratings.

**Level 0** – No quality of care issue identified

**Level 1** – Minor quality of care or service issue(s)

**Level 2** – Moderate quality of care issue(s)

**Level 3** – Severe quality of care issue(s)

The QM nurse also recommends any interventions necessary to resolve the issue and presents the case to a medical director for review and signature. The medical director may take one of the following actions:

- Concur with the findings of the QM nurse and sign off on the case
- Request additional information before signing off on a case
- Change the initial findings of the QM nurse and sign off on the case
- Request additional interventions and actions
- Recommend the case be reviewed by the Peer Review Committee

Cases that are assessed at a level 3 are recommended for peer review. Other cases may also be referred at the discretion of the medical director. The PRC is responsible for conducting a second level review and making recommendations for action to SCAN's CMO based on their findings. The recommendations may include but are not limited to:

- Peer education
- Written corrective action plans
- Cap on enrollment
- Sanctions
- Suspension, restriction or termination of contract

The PRC may also recommend that SCAN make referrals to Child or Adult Protective Services, AHCCCS or other regulatory agencies for further investigation and action. The QM Department is responsible for ensuring that corrective action plans are implemented and completed and reporting reports all substantiated quality of care cases to the appropriate regulatory agency.

#### *Due Process and Practitioner Appeal Rights*

If the PRC recommends action to limit/suspend or terminate a practitioner's ability to practice within SCAN, they are notified in writing and their appeal rights to the PRC's recommendations are included in the notice. The practitioner may file an appeal with the SCAN CMO who will convene an appeals committee comprised of peer physicians to provide a review of the PRC's recommendation. The CMO presides over the appeal hearing. All recommendations made by the appeals committee are reviewed by Executive Management before final action is taken. Providers also are notified of these appeal rights through the Provider Manual and the information included on SCAN's Web site. SCAN reports all adverse actions taken against a practitioner in accordance with 45CFR §60.9 as indicated.

In the event the PRC makes a recommendation to terminate non-physician provider, the QM Department coordinates with Network Management to ensure that all regulatory and internal requirements are followed. If the termination involves a nursing facility or alternate residential setting, SCAN complies with AHCCCS Contractor's Operations Manual Policy 421 – *Contract Termination: Nursing Facility and Alternative Residential Settings*. The QM Department coordinates with Case Management and Medical Management to transition members to new placements. SCAN takes all necessary actions to ensure the safety and continuity of care and services to members affected by a contract termination.

### *Incorporating Peer Review Activities into the Quality Management Process*

PR activities are fully integrated into QM processes through various methods, including but not limited to:

- Recommending provider corrective actions
- Tracking and trending peer review data
- Incorporating peer review findings and recommendations into the credentialing process
- Assessing peer review findings for potential quality improvement projects and systemic improvement recommendations

### *PRC Recommendation for Corrective Action*

PRC recommendations are a vital component of the QM process. PRC recommendations are communicated to providers in writing and may include a corrective action, required continuing medical education or a letter of education. Corrective actions and PRC recommendations are coordinated through the QM Department, including communicating with the provider and conducting follow-up to ensure corrective action has been implemented and improvement has been sustained. For example, the outcome of a recent PRC case included recommending the provider under review receive an educational letter about the importance of abiding by the attending psychiatrist's medication orders. The QM Department continues to monitor this provider's compliance with the PRC recommendations and reports the outcomes back to the PRC as necessary.

### **Tracking and Trending**

PRC findings are maintained in the QM Quality of Care database. The database is secure, allowing only QM staff to access the information. Peer review information is tracked on an aggregate basis and is reported to the QM/MM Committee as part of the Quality of Care Tracking and Trending reports. Identified trends are reviewed and considered for quality improvement projects. The QM/MM Committee is responsible for reviewing and approving the proposed quality improvement projects and ensures that the goals and objectives are relevant to SCAN's membership. After QM/MM committee approval, the QM Department moves forward with implementing the quality improvement projects.

### **Recredentialing Process**

Peer review recommendations become part of the practitioner's credentialing file and are reviewed by the Credentialing Committee at the time of recredentialing. At that time, the committee conducts a quality review of each provider, including the following information:

- Grievance and Appeals data
- Quality of care issues including Peer Review recommendations
- Performance Measure rates as applicable
- Appointment availability
- Utilization rates on identified indicators
- Medical record audit results if applicable

If the committee recommends limiting, suspending or terminating a provider's participation in the network, the provider would receive written notice, which would include information on the appeals process.

### Requirement 31: Quality of Care Scenario – Case A: Licensure Risk

SCAN Long Term Care's (SCAN) mission is to continue to find innovative ways to enhance our members' ability to manage their health and control where and how they live. To that end, SCAN continually focuses on assisting members in finding the least restrictive, most appropriate living arrangement that is safe, meets the members' care needs and respects their rights and choices. In the given scenario, SCAN has been working with the facility owner, the Arizona Department of Health Services (ADHS) and the other program contractor to seek a favorable outcome for the residents given the geographic limitations on acceptable alternative facilities. Quality Management (QM) has worked with colleagues in Network Management (NM), Medical Management, (MM) and Case Management (CM) to protect the interests of our members and facilitate the facility's licensure. Because we have been intimately involved in our members' cases, SCAN is prepared to initiate action at the point license remediation is not possible and our members are potentially subject to an immediate jeopardy situation.

#### *Ongoing Monitoring*

SCAN routinely monitors contracted facilities through several different cross-departmental methods to ensure that quality and service issues are identified and addressed proactively. These methods include but are not limited to:

- The Quality of Care (QOC) review process
- Tracking and trending QOC and grievance data
- Case Management reports
- Recredentialing reviews
- Network Management reports
- Oversight monitoring
- Review of publically reported data

Through these sources and others, SCAN will become active with a contracted facility as soon as we learn of a potential licensing or compliance issue. In the scenario presented, the NM Department had already begun the process of working with the facility owner and ADHS to assist and support efforts to secure a license. NM will have initiated an internal notification process to QM, CM and other departments about the licensure issue and alerted the facility in writing that it will be placed on bed hold until this issue is resolved. All SCAN departments receive regular communications from NM relative to the status of the facility's license.

Given the limited options in the service area, SCAN would consider the potential closure of this facility in the rural area as the "loss of a key provider." SCAN considers the loss of a key provider to include the loss of any care or service provider availability that would create a severe lack of access to needed care for members. Because of the potential loss of this provider, the NM Department will have already initiated several important processes with other SCAN departments by identifying any special needs the member(s) may have and assessing the adjoining Geographical Service Areas (GSA) for existing facility contracts or potential contracting opportunities. In addition, SCAN, in collaboration with the other program contractor, will notify the AHCCCS Division of Health Care Management about the potential loss of this provider and their relicensing issue. The notification will be made in writing and include how this network change will affect the delivery of service and the plan for maintaining quality care to affected members. SCAN will also notify in writing the AHCCCS Clinical Quality Management (CQM) unit in writing as expeditiously as the situation demands.

Throughout this license remediation process, the case manager will work with the members and families, as appropriate, to determine the immediate and long-term needs of the members. The NM, CM and MM departments will also work together to identify an appropriate alternate placement for each of the affected members in a facility that best meets that member's needs. The CM Department will communicate to the

members the current status of the facility, including the potential need to initiate a Member Change Request to place the members in acute status until the licensing issues are resolved or the members are relocated to an alternate licensed facility. If it is determined that the facility will remain unlicensed, the NM Department will begin the contract termination process and notify the facility that SCAN will be relocating our members using a member communication plan developed in collaboration with the facility and AHCCCS. SCAN will review and abide by the requirements stipulated in AHCCCS Contractor Operations Manual Policy 421- *Contract Termination: Nursing Facilities and Alternate Residential Settings* as applicable to this scenario.

### *Timeline*

#### Notification of an Immediate Jeopardy (IJ) Triggering Event

Notification of an IJ triggering event can be received anywhere in the organization. In this scenario, SCAN believes the triggering event will be a decision by ADHS to close the facility. Regardless of who receives the notification, SCAN has an established procedure to initiate the IJ process. The Vice President of CM is immediately notified by the department receiving the IJ report. The Vice President of CM or designee will notify the Executive Team and department managers including the QM Department, of the reported situation. The QM Department is organizationally responsible for coordinating the IJ meeting. The QM Department calls an internal IJ meeting for key personnel from the following departments: CM, NM, MM, QM, Compliance and Executive Management. During this meeting the situation will be presented to the IJ team, with a focus on key issues, actions already taken and decisions needing to be made to protect our members and ensure that they are safely transitioned to a new placement.

The CM Department identifies each member in the facility and reports to the team member needs, including diagnosis, level of care and decision making status/power of attorney. The MM Department provides input on any members who may be receiving skilled services or who are medically fragile and require immediate intervention. The gravity of the reported IJ situation is analyzed by the team and a determination is made as to whether a certified caregiver should be placed in the facility while the situation is under investigation and throughout the transition process if needed. In the case of a quality of care issue, the QM Department may send a nurse to the facility to assess the allegations and determine and/or confirm the level of risk to our members. The QM Department also notifies the appropriate regulatory agencies, including but not limited to, AHCCCS, ADHS, Adult Protective Services and/or law enforcement if necessary.

#### 24 Hours Post Notification

The CM Department schedules face-to-face meetings with the members and/or their families to inform them of the triggering event and discuss relocation and new placement options. Heavy emphasis will be placed on ensuring that any special needs of the members, including but not limited to, behavioral health services, language preferences, ongoing therapies and treatments, have been fully considered when determining an appropriate new placement. In addition, the case managers acknowledge the member's right to choose and make decisions based on their cognitive ability. In this situation, there is no assisted living home in the area to place the members. The case manager suggests and discusses the following options with each member and family:

- Relocate member home with family and initiate services to meet member's care needs through HCBS and home health services.
- Determine if nursing home placement may be appropriate for the member until a less restrictive setting can be identified.
- Identify if there are any assisted living facilities pending licensure in this GSA.
- Assess the availability of facilities in adjacent GSA's that can provide the level of care needed by the members.



The case manager logs all interactions and communications with each member regarding new placement on the member tracking log located on an internal SCAN shared drive and accessible to all inter-departmental staff participating in the resolution of the IJ situation. The IJ team reconvenes as necessary to update each other, assess progress and ensure members are safe and all members' care needs continue to be met. In the event a member refuses to leave the facility, SCAN will present the member with a Managed Risk Agreement and notify them that remaining in an unlicensed facility may result in losing his or her ALTCS status.

#### 24 – 48 Hours Post Notification

Once SCAN has identified a new placement for each of our members in the facility, the case manager, with the assistance of MM and QM, initiates the member relocation process. Member moves are prioritized based on the immediate needs of the member. Relocations are completed as swiftly as possible while taking into consideration the stress and disruption a move may cause the member. In preparation for the move, a SCAN IJ team member is on-site to manage the move ensuring the member's chart, medications, TB/chest x-ray record, DME and personal belongings are transferred with the member. SCAN also ensures that important medical record information is forwarded to the new facility, including but not limited to, Face Sheet, Current Physician Orders, Medication Sheets, Treatment Sheets and Care Plan. The SCAN CM will complete the member transition checklist and document all actions in the member's case file. The CM will also determine, with input from the member, if the member's primary care provider (PCP) assignment needs to be modified based on the new placement location. If so, the CM will notify the department administrative assistant and a PCP change will be initiated. As the member moves take place and are completed, SCAN will keep AHCCCS apprised of the status of each member. Due to the decision of ADHS to close the facility, the NM Department will begin the process of terminating the facility's contract per ACOM Policy 421, as applicable, and send a contract change notice by e-mail to all appropriate SCAN departments.

#### Post Member Relocation

Once the members are relocated, the case manager contacts each member and their families and conducts a face-to-face meeting within seven business days of relocation to ensure that the member is satisfied with the new placement and all ordered services are being received. The case manager updates the member log indicating that the moves have been completed, all services are being provided as ordered and the member/family is satisfied with the new placement. The QM Department notifies the AHCCCS CQM when all members have been safely transferred.

#### **After Action Assessment**

As part of SCAN's commitment to ensuring continuous quality improvement, the QM Department schedules a brief follow-up meeting within ten business days following the conclusion of the IJ action process and member relocations. The purpose of the meeting is to conduct an after action assessment to assess the details of this particular situation, discuss unanticipated barriers, review current processes and make recommendations for improvement as necessary. Members are then transitioned to the Inter-disciplinary Team (IDT) process for continued monitoring as needed. The IDT is a cross-functional team comprised of staff from different departments who convene for the purpose of examining the status of a member and to ensure that appropriate care and services are in place to meet their clinical and psychosocial needs. In this scenario, the IDT would meet as needed to ensure that the members have adjusted to their new placement, identify any care or service needs that have not been addressed and ensure the continued coordination and delivery of care. NM will continue to monitor this service area for gap issues to ensure any new members needing services in this GSA will be adequately served.

### Requirement 31: Quality of Care Scenario – Case B: Environment Risk

SCAN Long Term Care's (SCAN) mission is to continue to find innovative ways to enhance our members' ability to manage their health and to control where and how they live. To that end, SCAN continually focuses on assisting members in finding the least restrictive, most appropriate living arrangement that is safe, meets the members' care needs and respects their rights and choices. In the event that a member is subject to an Immediate Jeopardy (IJ) situation in any setting, SCAN executes its established internal process for managing IJ situations to correct the situation and place the member in a safe environment. This scenario involves the possibility of having to potentially evacuate a nursing home, which can be a serious undertaking given the inherent risks associated with the acuity and frailty of its residents. Such a decision must be made with consideration of the potential risk and benefit to the members. No emergency situation is straightforward; the decisions made throughout the event will occur as details unfold and will involve many changing factors.

#### *Timeline*

##### Notification of an Immediate Jeopardy (IJ) Triggering Event

Notification of an IJ triggering event can be received anywhere in the organization. In this scenario, the triggering event may be reported to SCAN through a number of facility contacts. Regardless of who receives notice, SCAN has an established procedure to initiate the IJ process. The Vice President of Case Management (CM) is immediately notified by the department receiving the IJ report. The Vice President of CM or designee will notify the Executive Team and the department managers, including the Quality Management (QM) Department, of the reported situation. The QM Department is organizationally responsible for coordinating the IJ meeting. The QM Department calls an internal IJ meeting with key personnel from the following departments: CM, Network Management (NM), Medical Management (MM), QM, Compliance and Executive Management. During this meeting the situation will be presented to the IJ team with a focus on key issues, actions already taken and decisions needed to protect the members and ensure that they are safely transitioned to a new placement. Due to the proximity of a holiday, key staff may participate in the IJ meeting by phone or may identify alternate staff to attend the meeting. SCAN ensures that adequate staffs are available to meet the needs of members after hours and during holidays. Each department is responsible for ensuring that adequate staff are on duty and back up coverage is available. The purpose of this IJ meeting is to develop an action plan to ensure that all members are safe and not at risk for any consequences due to the adverse environmental conditions. The IJ team will agree to department assignments and establish a timeline for contacting the facility, other program contractors and AHCCCS and reporting back to the IJ team. Information gathered will be used to develop an action plan to facilitate the management of the members through the situation.

The CM and MM departments will present a review of all SCAN members in the facility, including specific information on the member's diagnosis, level of care, ability to make health care decisions, presence of an advance directives and access to family for possible home placement during this event. The goals of the action plan are to keep members safe throughout this event, expedite the transfer of the members to an appropriate care setting in the event they are required to move and to ensure that all needed care and services are received with the least amount of disruption to the member. The QM Department is responsible for notifying the Clinical Quality Management (CQM) unit and the ALTCS Operations unit at AHCCCS. Notification is made by telephone and followed in writing as expeditiously as the situation demands. In the scenario presented, SCAN will notify AHCCCS within 30 minutes of the conclusion of the internal IJ meeting. The notification will include all the most current facts known about the situation, including reports that the press are on the way to the scene. The Vice President of CM, or designee, will be the point person for SCAN's IJ team at this facility. SCAN immediately sends representation from the IJ team to conduct a comprehensive on-site assessment of the severity of the situation, including a determination of the reason for the air conditioning outage, possibility for correction and options for temporary cooling sources to avoid member relocation. Working collaboratively with the

other program contractors, nearby nursing facilities, local hospitals and emergency services, the IJ team will work to find a comprehensive solution for all nursing facility residents. Key SCAN staff identified for this emergency situation will be available over the holiday weekend to assure continuity of care. SCAN would also activate its Business Continuity Plan's Crisis Communications Team to manage press releases and triage reporters as necessary.

Under Arizona Administrative Code (AAC) R-9-10-916, every nursing facility in the State of Arizona is to have a Facility Disaster Plan. The Plan must outline how the facility assigns responsibilities to staff during a disaster and how they prepare to evacuate the building if necessary, including potential use of sister facilities for alternate placement during disasters. Based on the facts in this scenario, in addition to assessing the severity of the situation, the IJ team would also focus their efforts on assessing the facility's compliance with the activation and implementation of their Disaster Plan and providing additional support and resources as needed.

In addition, the QM Department, along with the CM and MM departments, will identify other program contractors with members in this facility and jointly start discussions with the facility about sister or neighboring facilities, including hospitals or other emergency facilities, that may be able to accommodate the needs of affected members. Several of the actions that may be coordinated across contractors and with the facility include, but are not limited to, determining the availability and viability of utilizing portable air conditioning units and the installation timeframe, setting up hydration stations, procuring dry ice, identifying clinicians who could triage residents for medical needs and possible immediate relocation and coordinating the transportation of residents to other facilities if necessary. At all times SCAN will work in concert with all stakeholders to ensure that the needs of residents are being addressed.

#### Decision point – Alternate Air Conditioning

If it is determined the facility can provide temporary air conditioning that is sufficient to cool the building to the regulatory standard set forth in AAC R-9-10- 915 (no less than 71° F or more than 84°), members will not be relocated, but will be monitored on-site for signs of dehydration and associated complications. SCAN will have appropriate clinical and staff resources on-site during the duration of the use of the portable units to monitor whether they continue to operate appropriately and maintain an acceptable living environment for the members. SCAN will continue to provide AHCCCS with regular updates as needed on the status of the situation, the coordination of activities with other stakeholders and key decisions. SCAN will also identify dual eligible members and ensure that all payers are notified and the coordination of care and services is not interrupted during this situation. If the facility is not able to provide adequate cooling to meet the regulatory requirement, SCAN will work with the facility and other program contractors and proceed with moving the members to temporary placements.

#### Coordinated Evacuation Plan

SCAN will coordinate with the other program contractors and the facility to ensure the members are moved safely and timely if indicated. Members are prioritized for relocation based on medical needs and the degree of risk for each member. SCAN will identify any members who could potentially move home for the long weekend with family and receive skilled and HCBS services in the home during this period. If such home transfer is possible, the CM and MM departments will identify, authorize and secure the services to meet the member's needs. SCAN will coordinate and assist the facility with all aspects of moving the members, including but not limited to:

- Coordinating with the facility Medical Director
- Assisting with notifications to PCPs about the temporary relocation
- Arranging for the delivery of skilled and/or needed HCBS services
- Assisting families with relocations and ensuring they have medications and orders
- Addressing any special needs the member may have including behavioral health and ensuring the availability of these services

In preparation for the move, SCAN's on-site IJ team will ensure that all appropriate medical record documentation, DME, medications and personal belongings are transferred with the member. This may vary depending on the location of the temporary placement. SCAN utilizes an internal communication process to track all activities associated with relocating member moves due to a facility closure. This process would be initiated in this scenario to ensure that all SCAN staff has access to information about the relocation plans for any given member. Case managers log all interactions and communications with members regarding new placement on the member tracking log located on a SCAN shared drive and accessible to all staff involved in the evacuation process. As member moves take place and are completed, SCAN will continue to provide AHCCCS with regular updates on member relocations.

#### Post Relocation

Although this is a temporary move for the members, SCAN will conduct an assessment on each member after they have been relocated. Within 24 hours of the transition, the CM Department will contact family/representatives to confirm each member is established in the new placement, and ensure the members are safe and their needs are being met. The CM Manager notifies all SCAN departments of the status of the members once the moves and the follow-up contacts have been completed. The CM and MM departments review all members to ensure that the temporary placement is adequate to meet their needs during the temporary relocation. Additional services may be put in place if needed. The CM and QM departments notify the AHCCCS CQM and ALTCS Operations units of the outcome of the moves, the placement of each member and any barriers identified and what is being done to address them.

#### Transition Back to Facility

Prior to moving any member back to the facility, SCAN will meet with the facility's administration to ensure the air conditioning unit is fully functional and the environment is safe for residents. Depending on the nature of the problem, SCAN may request an independent inspection to ensure the unit is working properly and is expected to continue working without further interruption. Once confirmed, SCAN will begin working with the facility, members and their families and other program contractors to coordinate the members' move back to the facility.

If appropriate, members will be given the option to move back to the facility or remain in the alternate setting. If a member chooses to remain in the alternate setting, SCAN will ensure that all documentation, information and personal belongings are properly transferred to the new location. SCAN will utilize the Inter-disciplinary Team (IDT) to assess all other members to determine a safe and effective process to transition them back to the facility. The IDT is a cross-functional team comprised of staff from different SCAN departments who convene for the purpose of examining the status of a member and to ensure that appropriate services and care are in place to address the member's clinical and psychosocial needs. Those members who wish to return back to the facility will be reviewed by the IDT to confirm their needed level of care. The IDT and case manager will work with the member and family to ensure a safe transfer back to the facility. Because of this disruption and the potential stress that some members may experience, SCAN will make available all appropriate services, including behavioral health support, home health, attendant and personal care. Members would continue to be monitored by the IDT as needed.

#### After-Action Assessment

As part of SCAN's commitment to ensuring continuous quality improvement, the QM Department schedules a follow-up meeting of the IJ team within ten business days following the conclusion of the IJ triggering event. The purpose of the meeting is to conduct an after-action assessment to review the details of this particular situation, discuss unanticipated barriers, review current processes and make recommendations for improvement. Any recommendations or opportunities for improvement are reviewed for process improvement. SCAN is committed to continuously reviewing its processes to ensure that the members continue to receive the delivery of seamless high quality care and service.

*Requirement 32: Improving Quality of Care and Performance*

SCAN Long Term Care (SCAN) is part of The SCAN Group whose mission is to provide quality care to meet the needs of the elderly and physically disabled. To that end, SCAN has aligned its mission and principles with AHCCCS to ensure our approach to quality care includes member-centered care and innovations for integrating the delivery of care across multiple settings through a comprehensive network of providers. SCAN is committed to continuously working toward delivery of high quality care and service to our members and proactively working toward continuous quality improvement.

*Organizational Commitment to Improving Quality*

SCAN’s commitment to quality begins with the executive leadership and is dispersed throughout the organization by department directors and managers. The Board of Directors (BOD) has the ultimate authority and responsibility for the quality and integrity of the Quality Management (QM) Program. The BOD responsibilities for the QM Program include:

- Annually reviewing and approving the QM Program, including the program description, Annual Work Plan and Annual Work Plan Evaluation from the previous year.
- Regularly reviewing reports from the Quality Management/Medical Management (QM/MM) Committee, including actions and findings related to identifying issues that present a significant or chronic quality of care issue.

The BOD has given the Chief Medical Officer (CMO) through the Chief Executive Officer (CEO) the responsibility for ensuring adoption of the QM Program throughout SCAN. As chair of the QM/MM Committee, the CMO has direct responsibility to the CEO for execution of the Program. SCAN’s CEO and CMO understand, support and take all necessary steps to advance initiatives that drive quality improvement. Senior management takes an active role in quality initiatives, as well as participates in the QM/MM Committee. Participation on the committee includes the CEO, the Vice President of Operations, the Vice President of Case Management, and the Vice President of Network Services. Their input on quality initiatives are a vital component to the overall success of the QM Program. In addition, SCAN utilizes a QM/MM Committee calendar which includes reports from key functional areas in the plan, including but not limited to, Grievance and Appeals, Case Management, Network Management and Member Services. This ensures that quality monitoring conducted throughout the organization is communicated to the QM/MM committee for review, feedback and potential recommendation for a formal quality improvement project.

*Improvement in the Delivery of Health Services*

Through commitment, appropriate resource allocation and cross-departmental collaboration on implementation of intervention strategies, SCAN has realized statistically significant improvement in several key clinical and non-clinical areas. These areas have an impact on our members’ health and ability to remain independent. Through these key measurements SCAN has demonstrated its ability to examine performance issues, identify barriers and develop successful interventions that have shown statistically significant improvement. Examples of improvements realized over the past three years are shown in the following tables.

Diabetes Performance Measures

Measure	SCAN Rate CYE2007	SCAN Rate CYE2008	SCAN Rate CYE2009	MPS
A1c	56.5%	63.6%	85.6%	80.0%
LDL-C	47.8%	56.1%	75.2%	72.0%
Eye Exam	26.1%	31.8%	45.1%	60.0%

SCAN achieved the AHCCCS Minimum Performance Standard (MPS) for A1c and lipid testing and a statistically significant improvement on eye exam rates.

**Initiation of Home and Community Based Services**

<i>Measure</i>	<i>SCAN Rate CYE2007</i>	<i>SCAN Rate CYE2008</i>	<i>SCAN Rate CYE2009</i>	<i>MPS</i>
Initiation of HCBS Services	85%	86.4%	94.2%	92%

SCAN achieved the MPS for the initiation of home and community based services.

**Advance Directive Performance Improvement Project**

<i>Measure</i>	<i>Baseline CYE2007</i>	<i>1<sup>st</sup> Re-measurement CYE2009</i>	<i>Improvement</i>
Evidence of Advance Directive	52.6%	63.6%	20.4% p = .025

SCAN achieved a statistically significant improvement on the Advance Directive performance improvement project

*Integration of Quality throughout the Organization*

Quality is very important to the mission and values of SCAN; part of the 2011 strategic focus for SCAN is on Quality and Compliance. This message is communicated throughout the organization by senior leadership through written communications, as well as through employee meetings. Quality improvement is integrated through the organization through various other methods, including but not limited to, providing training to staff on the identification and reporting of potential quality of care concerns, ongoing departmental self-monitoring processes to ensure compliance with contractual obligations and through the integration of process improvement through the Clinical Management (CM) team meetings. The QM/MM Committee is an additional forum for the communication of quality improvement outcomes. The make up of the committee is cross-departmental and also includes outside provider representation; all QM projects are communicated with and reviewed by the committee before implementation.

**Quality of Care Employee Trainings**

SCAN conducts a comprehensive training for employees on how to identify and refer suspected quality of care issues to the QM Department. The training includes information on the grievance process, the quality of care referral process, the identification and reporting of member abuse and neglect and member-to-member altercations. Training is provided to all new SCAN employees who have direct contact with members within the first 60 days of hire and annually thereafter. The CM Department receives the training within the first two weeks of hire. As the result of effective employee training, SCAN continues to identify concerns and opportunities for improvement through organization wide observation and reporting. A revised training was implemented in the fall of 2009. Since that time, the QM Department has seen an increase in potential quality of care referrals in relation to the change ( $\Delta$ ) in membership over the past three years as follows:

**Quality of Care Referral Volume**

<i>CYE</i>	<i>Membership</i>	<i><math>\Delta</math> Membership</i>	<i>QOC Referrals</i>	<i><math>\Delta</math> QOC</i>
2008	2,151	n/a	112	n/a
2009	2,807	30%	308	175%
2010	2,919	4%	472	55%

The increase in the number of referrals has allowed SCAN to improve its oversight of all the care and services members receive, as well as, track and trend and identify providers who may require corrective action or more frequent on-site reviews.

### Departmental Self-Monitoring

In 2010, SCAN introduced a self-monitoring program requiring all health plan departments to conduct internal monitoring activities to ensure employee understanding of ALTCS contract requirements and department contractual responsibilities. The components of the self monitoring program include:

Validating Data Accuracy – All departments are responsible for verifying the accuracy of data utilized in reports used for decision making, as well as those in outgoing correspondence and used to compile reports and documents submitted to AHCCCS and the Centers for Medicare and Medicaid Services, in accordance with regulatory requirements.

Policy and Procedure Training and Annual Review – SCAN employees must complete annual training in regard to current departmental policies and procedures specific to their position. New employees must complete a policy and procedure training no later than 30 days after their date of hire. All employees must sign a form to indicate they have completed the training. Employees are encouraged to follow up with their direct supervisor or above to ensure their understanding of the policies they have received.

Employee Performance Planning – Through the development of an employee performance plan linked to Organization/Department goals and objectives, as well as regulatory requirements, SCAN ensures that its commitment to quality is dispersed throughout the organization. Each employee meets with their direct supervisor or manager to determine the specific measurable performance objectives for which they are responsible. Measurements of compliance are also incorporated into the objectives. Quarterly, each manager/supervisor meets with their staff to review the individual's success in completing their objectives. Modifications to the objectives are made as necessary. This process lends itself to ensuring that department managers are aware of employee issues that may affect the overall quality of work which, in turn, may impact plan performance and the delivery of care to our members.

### Clinical Management Team (CMT)

In 2010, SCAN implemented a new subcommittee of the QM/MM Committee known as the CMT. The goals of the CMT include, but are not limited to:

- Providing clinical oversight and leadership for all clinical areas (MM, including Clinical Pharmacology, QM and CM, including Behavioral Health) and coordinating with other areas
- Identifying areas of clinical service improvements and opportunities for growth and innovations
- Reviewing and overseeing best practice models for clinical services, with a focus on the highest concentration of member diagnoses
- Organizing clinical service processes and improving clinical administrative services
- Monitoring and assessing clinical metrics/outcomes and providing feedback to stakeholders
- Implementing interventions that will result in improved outcomes for members and the organization
- Transforming manual clinical processes to automated processes, when feasible
- Monitoring corrective actions and/or newly implemented processes that impact the delivery of care and service to our members

The CMT reports up through the QM/MM Committee and is chaired by the SCAN CMO or designee. The committee meets at least quarterly and includes representation and input from MM, CM and QM departments. The CMT provides and/or assists in the oversight of SCAN clinical services, including those provided to frail elderly and disabled members enrolled in ALTCS.

Requirement 33: Member and Provider Feedback

Utilizing feedback is an invaluable tool that can assist organizations in identifying critical areas for improvement. SCAN Long Term Care (SCAN) utilizes several methods to gain feedback from members and providers. These include but are not limited to:

Tracking Member Complaints and Grievances

Member complaints and grievances are processed and tracked through the Grievance and Appeals Unit of SCAN’s Compliance Department. Grievances can be received anywhere in SCAN, but are primarily received through the Member Services and Case Management departments. Action is taken to address each grievance situation. Grievance data is tracked in a secure database and reported in aggregate to identify trends by program area, as well as by provider. A cross-departmental Grievance and Appeals Committee reviews data internally and recommends system or process changes. Semiannually, Grievance data is reported up to the Quality Management (QM) and Medical Management (MM) departments. Trends are reviewed and analyzed and recommendations for actions and interventions are made.

Tracking Provider Complaints

The Network Management Department is responsible for managing and monitoring provider complaints. SCAN uses an inquiry and complaint call tracking system to measure provider calls by line of business and call type. This data is reported to the Network Management Committee (NMC) on a monthly basis. The NMC is cross-departmental and responsible for addressing network needs, as well as provider relation issues identified through provider complaint tracking.

Conducting Targeted Surveys and Reviewing Survey Data

SCAN places a high value on feedback obtained through the member and provider survey process. SCAN has conducted three member and provider surveys in the past four years. Comprehensive in nature, both surveys addressed a variety of issues pertinent to the ALTCS population being surveyed. The validated surveys were administered by North American Testing Organization (NATO). Each year SCAN reviewed and analyzed the results to identify areas for improvement and has implemented relevant interventions to achieve improvement in the following areas:

<i>Member</i>	<i>Provider</i>
Transportation	Case manager assistance in coordination of care
Satisfaction w/ personal doctor	Prior authorization forms clear and user friendly
Communication with doctor about end of life decisions	Improved access to ancillary services
Case manager call backs to members	

Results of member and provider surveys are communicated throughout SCAN including, but not limited to, Member/Provider Council, Senior Management, NMC, and the Quality Management/Medical Management (QM/MM) Committee. The results and analysis are also reviewed to identify improvement trends, and opportunities for continued improvement.

Reviewing AHCCCS Member Survey Data

SCAN members are included in the Member Satisfaction Surveys conducted by AHCCCS. SCAN reviews and analyzes the data to assist in identifying opportunities for improvement, and compares like questions to data gathered internally to ensure member issues are addressed. In 2008, AHCCCS administered a long term care Member Satisfaction survey to 3,217 members, including 421 SCAN members in assisted living facilities, nursing facilities and homes. Based on the findings of this survey, SCAN’s Case Management department has initiated a committee to work with other program contractors to improve the number and types of resident activities conducted in assisted living facilities.



*Example of Member Driven improvement*

Improved Transportation

Initially, SCAN contracted with several vendors to provide transportation services to members. It was during this time that the members gave feedback through the member survey as well as the grievance process about the difficulty they were having with transportation. In addition, SCAN was receiving notification of transportation issues from case managers, and contracted facilities. A member survey SCAN conducted in 2007 included questions about transportation services. Members were asked to respond to the following question: ***“Did you have any problems in getting transportation to or from a medical visit?”*** Nearly 45 percent of respondents indicated they had experienced a problem in getting to or from a medical appointment. During 2007, SCAN had also received 61 grievances related to transportation.

In late 2007, SCAN contracted with Dependable Medical Transportation Services (DMTS) to provide transportation services. SCAN worked extensively with DMTS to reduce transportation issues through ongoing communication and reporting. The 2008 AHCCCS member survey indicated that 17 percent of SCAN members were experiencing difficulty with transportation but only 43 percent received assistance with their transportation problem.

Using the Plan – Do – Study – Act process for improvement, SCAN was able to demonstrate sustained improvement over time. In September 2008, SCAN entered into an agreement with DMTS to function as the transportation call center, as well as our primary transportation vendor. Over the past four years, SCAN has seen a dramatic improvement in member satisfaction with transportation services and a decrease in the number of transportation grievances received.

Process Improvement for Transportation

<i>PDSA Cycle</i>	<i>PDSA Action</i>
<i>Plan</i>	Improve transportation services to members ( identified through member survey data)
<i>Do</i>	Enter partnership with new key vendor to provide majority of transportation services and function as transportation call center
<i>Study</i>	Measurement of improvement tracked through grievance data as well as member survey re-measurement
<i>Act</i>	Improvement noted – continue with new process, implemented continuous monitoring processes to ensure continued improvement

DMTS is a key provider for SCAN and is routinely engaged with multiple departments to address any member issues that arise. DMTS participates on our Member/Provider Council and is always seeking ways to improve the service it provides to our members. The table below represents the results from the past three member surveys conducted by SCAN.

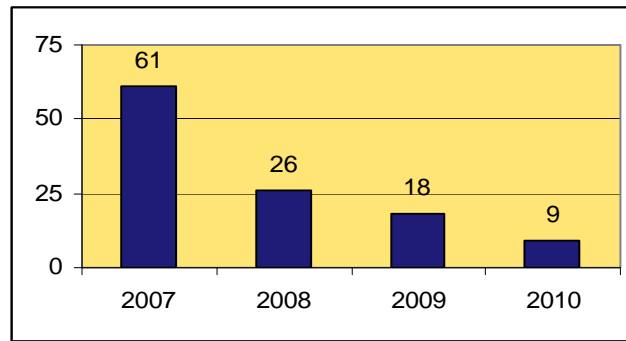
Comparative Results of Member Surveys (Question #11)

*In the last 12 months did you have any problems in getting transportation to/from the medical visit?*

	2007	2008	2009
<i>Respondents</i>	83	346	293
<i>Yes response</i>	44.6%	12.7%	11.9%
<i>No response</i>	55.4%	87.3%	88.1%

SCAN continues to work with DMTS to improve satisfaction with the transportation services provided. These efforts are reflected in the reduction of member grievances related to transportation, as follows:

Trend in Number of Transportation Grievances



*Example of Provider Driven Improvement*

The Annual Provider Survey is reviewed and analyzed to identify areas for improvement that impact our provider network. The provider survey includes questions in several areas of plan operations, including but not limited to, Network Management, claims processing, referrals and authorizations, case management and formulary issues. In 2009, providers were questioned about SCAN’s prior authorization form and the clarity of the information they received back when a service was denied. Seventy-two percent of providers indicated the form was user friendly and 69 percent indicated the denial reasons were clearly stated. The MM Department identified this as an opportunity for improvement. To that end, MM redesigned the authorization form to clearly identify the criteria for an expedited, urgent and standard request, and developed a section on the form that is exclusively used to communicate the approval status of the request and, if denied, the specific reasons for the denial.

<i>PDSA Cycle</i>	<i>PDSA Action</i>
<i>Plan</i>	Redesign the authorization request form to improve provider satisfaction improve operational efficiency in the Medical Management Department
<i>Do</i>	Modify form to include: clearer options for the type of request (expedited, urgent, routine) and a separate section to communicate the detailed reason if a request is denied.
<i>Study</i>	Monitor provider feedback through antidotal information, as well as through the Provider Satisfaction Survey.
<i>Act</i>	Institutionalize new form or continue modifications as necessary

In 2009 a total of 1,021 providers were mailed a satisfaction survey. A total of 179 providers responded to the survey. For the questions related to the authorization form, respondents reported an improvement in both of the following areas.

<i>Respondents Who Strongly Agree or Agree</i>				
<i>Question</i>	<i>2010</i>		<i>2009</i>	
	<i>Count</i>	<i>Percent</i>	<i>Count</i>	<i>Percent</i>
Authorization forms are user friendly?	162	72%	158	84%
Reasons for prior authorization denials are clearly stated?	158	69%	140	74%

This improvement complements the process improvements conducted throughout the MM Department in 2009 focused on improving prior authorization turn around times and the content of the required notice of actions. These efforts have resulted in better performance throughout MM Department, consistent compliance with prior authorization turn around times and notice of action language.

### Requirement 34: Monitoring Home Services

As part of the Quality Management Program, SCAN Long Term Care (SCAN) conducts ongoing monitoring of the services and services sites which provide care to our members. For those members residing in their own home, SCAN conducts an ongoing review of agencies that provide Home and Community Based Services (HCBS) including but not limited to Direct Care Services, Home Health Nursing, Adult Day Health and Home Delivered Meals.

Service monitoring activities include:

- Credentialing Review
- Network Management Oversight
- Case Management Oversight
- Quality Management Oversight
- Annual On-site Auditing

#### *Credentialing Review*

During the process of contracting new providers, the Quality Management (QM) department conducts an initial review of the organization's credentials. This review includes ensuring the provider is licensed to operate in Arizona, is compliant with all state or federal requirements, and that the provider is reviewed by an appropriate accrediting body or by SCAN prior to contracting. The provider is also reviewed to ensure they have liability insurance that meets SCAN requirements. SCAN recredentials organizational providers every three years. At the time of recredentialing, SCAN verifies that the provider remains in good standing with state requirements and continues to have appropriate licensure and insurance coverage. In addition, SCAN reviews the quality of care and services the provider has rendered during the previous three years. This is done through a review of member grievances, on-site audit results, internal review results, utilization data, as applicable, and Quality of Care issues and trends.

#### *Network Management Services Oversight*

SCAN has developed an innovative and interactive Web-based Provider Portal to capture non-provision of service (NPS) data submitted by its contracted provider network. NPS occurs any time that the number of hours for critical services are not provided as scheduled. Timely reporting of correct NPS information is a requirement for all contracted providers for these critical care services: Attendant Care, Personal Care, Respite Care and Homemaker. The Network Management and Case Management departments partner to collect data required to report gaps in service to AHCCCS. A gap in service is the difference between the number of hours scheduled and the hours that are actually provided to the member. SCAN determines if the NPS reported is an actual gap in service based on the AHCCCS definition, and reports that information to AHCCCS on a monthly basis. To further monitor service sites, Network Management Services (NMS) schedules site visits to all HCBS provider types for orientation and training. Thereafter, site visits can be routine, requested by the provider or initiated to address an issue. Site visits are an opportunity for NMS to monitor the provider's contractual compliance and service delivery.

#### *Case Management Oversight*

Case managers are responsible for ongoing Service Plan monitoring and reassessment to confirm the continued suitability and cost-effectiveness in meeting individual member's service and placement needs. The member's Service Plan outlines their HCBS needs. When a case manager authorizes services from a HCBS provider for members within their first 30 days of enrollment, they contact the member within seven days of the service date to verify the services were received. If the services were not rendered, the case manager contacts the servicing provider to find out the reasons why and determine when services will be initiated. The case manager will then contact the member to verify the services were initiated on the new date the provider committed them to begin. If the services were again not rendered, the case manager will inform his or her supervisor. The supervisor will inform NMS and the QM Department of the issue to determine the appropriate action. At the initial assessment and each reassessment, the case manager educates the member to contact the provider agency, the case manager and/or AHCCCS if their

caregiver does not show up to provide services as scheduled. The case manager assists the member in finding a replacement caregiver to provide services when the member reports that the caregiver is unavailable and the member requests assistance.

### *Quality Management Oversight*

The Quality of Care review process monitors HCBS services and service sites. When quality of care issues are received, a QM nurse reviews all reported information and conducts an investigation to determine the validity of the concern. After completion of the investigation, a summary of the case, along with the initial assigned severity level, is provided to the Chief Medical Officer for review. If applicable, the Peer Review Committee may review the case. Substantiated cases are referred to appropriate regulatory agencies and may also require a Corrective Action Plan (CAP). The QM nurse sends a Provider Response Letter/CAP request with a response due date. Upon response from the provider, the QM nurse reviews the provider's interventions, evaluations and resolutions, and presents these findings to a medical director for final review. SCAN tracks all reported quality of care concerns to ensure trends across the network are identified for potential quality improvement opportunities.

### *Annual On-site Auditing*

Contracted HCBS agencies providing services to members residing in their own home are audited to ensure they are compliant with AHCCCS requirements. Agencies that receive an Annual On-site Audit (audit) are Direct Care Services, Home Health Nursing, Adult Day Health and Home Delivered Meals. SCAN conducts oversight monitoring of HCBS providers that are reviewed by a delegated entity.

### *SCAN Audit Process*

SCAN utilizes a comprehensive audit tool approved by the QM/MM Committee to evaluate the agencies' compliance with regulatory requirements. At the conclusion of each audit, SCAN conducts an exit interview with the agencies to discuss audit findings and share any noted opportunities for improvement or need for a CAP. SCAN formally notifies the agencies of their results in writing within ten days of completing the audit. Recommendations for improvement are conveyed and adequate information is given to develop and implement a CAP if necessary. Concerns discovered during the audit are communicated to the appropriate SCAN departments for tracking and follow-up. Agencies are required to adhere to CAP requirements and correct all deficiencies. Agencies issued a CAP are re-evaluated within six months of the original audit to determine the effectiveness of the CAP measures. Agencies that fail to comply with corrective action requirements are reviewed internally and additional actions may be taken, such as placing a hold on new referrals or possible contract termination.

### *Direct Care Services*

Direct Care Services include Attendant Care, Personal Care, Respite Care and Homemaker services. The on-site audit tool is inclusive of, but not limited to, the following components to ensure the Direct Care Worker (DCW) has 1) verified personal references, 2) skills that match the member needs and preferences, 3) training through an approved training program, 4) competency with abilities to provide attendant care, personal care and homemaker services, and 5) training on member rights, time management, cultural diversity/sensitivity, following Service Plans, types of disabilities, reporting changes in condition and verbal and written communication. Each DCW must also be cleared before rendering care to members through evidence of an initial/annual proof of freedom from pulmonary tuberculosis and must have current certifications in cardiopulmonary resuscitation (CPR) and first aid training. The Direct Care Service agency is responsible for conducting periodic supervisory visits to ensure that the member and their family are satisfied with services provided. The purposes of the supervisory visits are to assess and document the DCW's competency in performing the assigned duties in a safe manner as ordered and according to the training they have received, to speak with the member about the quality of care provided by the DCW and to educate the member about how to contact the agency should a concern develop between supervisory or case management visits. From the date of initial

service provision, and for the next 90 days, supervisory visits are required after five days, 30 days, and 60 days (if an issue is identified at the 30 day supervisory visit), and 90 days. After the initial 90-day visit, all other visits occur at least every 90 days from the previous visit. Findings of the audit, including opportunities for improvement or need for a CAP, are discussed with the agency. Results of all Direct Care Service audits are compiled in an aggregate report and analyzed across the network. Opportunities for improvement are evaluated from an aggregate perspective. For example, in 2010, SCAN identified a trend across the network with their compliance with the timeliness of 5-day supervisory visits. The QM Department has incorporated improvement in this area as a goal on the 2011 QM Work Plan.

### *Home Health Nursing*

Home Health Nursing agencies receive an audit to ensure they are compliant with AHCCCS requirements. The on-site audit tool is inclusive of, but not limited to, the following components:

Patient file – patient demographics, emergency contacts, physician, patient rights, advance directives, medical history, diagnosis, plan of care, patient assessment, reports of patient summaries to physicians, supervisory reports, patient transfer or discharge summary

Home Health Nurse file – education and work experience, verification of professional credentials and education, initial/annual proof of freedom from pulmonary tuberculosis, orientation and in-service training, competence and performance of home health nurse

Findings of the audit and noted opportunities for improvement and/or need for corrective action are discussed with the agency. The results of all Home Health Nursing agency audits are compiled in an aggregate report and analyzed across the network. Opportunities for improvement are evaluated from an aggregate perspective.

### *Adult Day Health*

Area Agency on Aging (AAA) is a delegated entity that conducts monitoring activities for Adult Day Health facility providers on behalf of SCAN. AAA submits quarterly reports with findings for reviewed providers to the QM Department. The QM Department conducts oversight monitoring by analyzing the reports to identify trends or quality of care concerns. Quality of care concerns are submitted to the QM nurse for review. The QM nurse discusses the findings with AAA and shares any noted opportunities for improvement or need for corrective action. Adult Day Health care facility providers that are not affiliated with AAA are audited by the QM Department. An audit is conducted to ensure the providers are compliant with AHCCCS policy, Arizona Administrative Code (AAC) and Arizona Department of Health Services (ADHS) requirements. SCAN utilizes a comprehensive audit tool that is based on the criteria from the AAC Title 9, Chapter 10, to assess the performance of the provider. The audit also includes the review of the latest inspection survey found on the ADHS Division of Licensing Services online database.

### *Home Delivered Meals*

A delegated provider, AAA conducts monitoring activities for home delivered meal services. AAA submits quarterly reports with findings for providers that have been reviewed. The QM Department conducts oversight monitoring by analyzing reports to identify trends or quality of care concerns. Quality of care concerns are submitted to the QM nurse for review. In addition, policies and procedures regarding delegated monitoring are reviewed annually. QM personnel schedule ride-along monitoring activities with the home delivered meals division of AAA in order to review their process and ensure adherence to quality practices. The QM representative discusses the findings with AAA and shares any noted opportunities for improvement or need for corrective action.

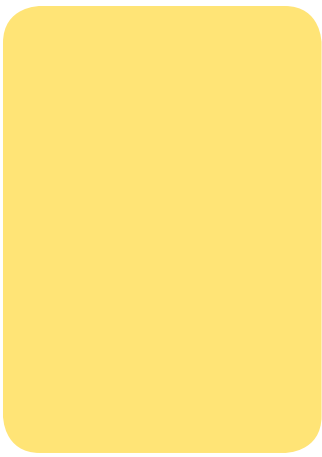
SCAN is committed to providing high quality HCBS services to our members. With our multi-departmental, comprehensive approach, we are able to continuously evaluate and monitor the delivery of services and implement interventions timely that ensure quality of care.

### *Requirement 35: Oral Presentation*

---

SCAN Long Term Care is pleased to have the opportunity to present its solutions to two case scenarios and answer questions during an oral presentation to AHCCCS. We understand the presentations will be audio-taped solely for the Agency's use in the evaluation process.

SCAN Long Term Care will submit the names and resumes of participating individuals as prescribed by AHCCCS, indicating whether any one is a contractor/consultant, and what role each individual plays under the health plan's current and CYE2012 ALTCS contract.



## Our Members are Our Mission

SCAN Long Term Care is committed to developing and maintaining an accessible network of providers experienced in providing quality care and services appropriate to the needs of our elderly and physically disabled members.

SCAN LONG TERM CARE  
Response to Contract/RFP No. YH12-0001

## TABLE OF CONTENTS

## SECTION E – PROVIDER NETWORK

Table of Contents: Section E – Provider Network	214
Provider Network Submissions	
<i>Requirement 36:</i> Network Development and Management Plan	215
<i>Requirement 37:</i> Network Launch	245
<i>Requirement 38:</i> Provider Communications	246
<i>Requirement 39:</i> Communicating Information about Providers	248
<i>Requirement 40:</i> Inquiries, Complaints and Requests for Information	251
<i>Requirement 41:</i> Provider Services Staff Training	254
<i>Requirement 42:</i> Provider Services Staffing Levels	257
<i>Requirement 43:</i> Handling the Loss of Network Facilities	259
<i>Requirement 44:</i> Provider Performance Issues	262
<i>Requirement 45:</i> Network Summary and Attestation Statement	265
Network Attestation Statement (copy)	266



*Requirement 36: Network Development and Management Plan*

---

*SCAN Long Term Care  
Network Development  
and  
Management Plan  
CYE 2012*

*Submitted April 1, 2011*

*SCAN LONG TERM CARE (SCAN)  
NETWORK DEVELOPMENT and MANAGEMENT PLAN CYE2012*

The following CYE 2012 Network Development and Management Plan (the Plan) is being submitted as part of the SCAN Long Term Care (SCAN) 2012 bid response, and is built on the CYE 2011 plan approved by the Arizona Health Care Cost Containment System (AHCCCS) in December 2010. SCAN will continue to work on the initiatives described below, and has included an interim evaluation of 2011 objectives in this Plan. The 2011 plan will be fully evaluated at the end of CYE 2011 and once those evaluations are complete, updates will be made to this CYE 2012 Plan consistent with findings. The purpose of the Plan is to provide a framework to guide SCAN's provider network development and maintenance according to AHCCCS contractual standards. SCAN is pleased to present this Plan to AHCCCS as a demonstration of its ability to engage in the multi-faceted process of building, evaluating and maintaining a diverse and flexible network able to quickly adapt to and accommodate changing fiscal and provider circumstances and member needs.

*SCAN'S COMMITMENT*

SCAN continues to approach, meet with and listen to the Maricopa County provider community as a firm expression of our commitment to building collaborative business and provider relationships in order to provide the best and most comprehensive services to SCAN Arizona Long Term Care (ALTCS) members. SCAN continues to contract with providers for all lines of business to facilitate ease of transition when any ALTCS member chooses to join our Medicare Special Needs Plan.

SCAN is also committed to the principle of placing each member in the least restrictive residential setting, preferably in their own home if possible. In support of these guiding principles SCAN will, through a comprehensive provider network, deliver the necessary services consistent with these principles.

Finally, SCAN made a commitment to the provider network to pay claims timely and accurately, and to be responsive to their needs. During the past twelve months, the average for claims paid within thirty (30) days was 96.43 percent. Also, the plan has offered the expedited facility payment (EFP) process for residential facilities, where these providers are consistently paid at the same time of the month throughout the year. SCAN will discontinue this process due to the new requirement for submission of standardized claims for services as outlined in R9-22-710.

Provider calls are responded to and issues addressed expeditiously. Calls to Network Management Services, Claims, Member Services and Grievance and Appeals are documented, tracked and trended, as required by AHCCCS. Tracking and trending documents have been customized in some cases to allow the receiving department to capture all the information needed to effectively deal with the callers' concern.

SCAN will continue to honor all of its service commitments in 2011.

*NETWORK STRATEGY*

SCAN maintains and monitors a diverse, adaptable and culturally sensitive provider network, including home and community based (HCBS) providers, alternative residential facilities (ARFs) and behavioral health (BH) practitioners, which are supported by contracts and sufficient in number to provide all covered services to ALTCS members in accordance with AHCCCS requirements.

SCAN continues to track membership by zip code using GeoAccess® reports to trend growth, as well as to analyze network adequacy based on the special needs of members. Internal meetings with Medical Management, Compliance, Grievance and Appeals and Case Management are conducted on an on-going basis to assess membership needs.

SCAN utilizes membership data to determine future network needs, as well as ensure that the capacity of the network meets the medical, social and special needs of ALTCS members.

Network Management Services will continuously assess the network development strategy for additional opportunities to ensure that the on-going needs of the membership are being met.

### *NETWORK MANAGEMENT PLAN*

The Plan outlines the current status of the SCAN provider network to demonstrate the efficiency and adequacy of its network in the delivery of ALTCS covered services, and to illustrate the process for projecting future needs based upon established criteria that, at a minimum, include the following:

- Program services
- Membership growth
- Number and type of providers within Maricopa County
- Number of physicians with hospital privileges
- Projected service utilization
- Number of providers with closed panels
- Specialty service accessibility in comparison with medical community norms
- Membership demographics
- Member medical needs
- Contracted provider and vendor performance
- HCBS, skilled nursing facility (SNF) and ALF capacity levels

### *NETWORK DEVELOPMENT*

SCAN has a comprehensive provider network to meet the needs of our ALTCS membership. The network was constructed to ensure that all ALTCS covered services are available and accessible to our ALTCS members in an effective, efficient and compliant manner, in the same way that services are provided to non-AHCCCS members. The network, consisting of primary care providers (PCPs), specialist physicians, dentists, alternative care providers, hospitals, SNFs, ancillary providers, BH professionals, ALFs, and HCBS organizations, was developed utilizing the following standards, guidelines and principles:

- Providers are properly credentialed, licensed, AHCCCS registered and participate in Medicare.
- Numbers of providers are sufficient to provide all ALTCS covered services, including special medical needs.
- Covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.
- Covered services are provided within required time and distance limits. For example, 95 percent of the health plan's members residing in Maricopa County are able to access a PCP and retail pharmacy within five miles of their primary residence.
- Covered services are provided by sufficient personnel, including emergency medical personnel, on a 24 hour a day, 7 day a week basis, including requiring PCPs to have appropriate backup coverage for absences.
- Ensure that PCPs and specialists who provide inpatient services have admitting and treatment privileges at a minimum of one general acute care hospital within a geographic service area (GSA) or that they use the health plan's contracted hospitalist network.
- Ensure an adequate number of hospitals geographically located throughout Maricopa County that meets or exceeds AHCCCS hospital network requirements.
- Ensure that membership has access at least equal to, or better than, community norms.

- Provides out-of-network coverage for medically necessary services in the event the contracted network is unable to provide covered services.
- Promotes member- centric care in a manner consistent with ALTCS Guiding Principles.
- Supports the member’s informal support system through provision of Respite Care, Adult Day Health programs and other services.
- HCBS services and settings are available for members with cognitive impairments, behavioral health and other special medical needs.
- Delivers services and settings in a culturally competent manner.
- Ensures the availability of HCBS services to allow members, when appropriate, to reside in or return to a home setting.

Additionally, SCAN does not and will never discriminate with respect to participation in the ALTCS program, reimbursement or indemnification against any provider based solely on the provider’s type of licensure or certification.

SCAN will never discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment. This provision, however, does not prohibit the health plan from limiting provider participation to the extent necessary to meet the needs of its members. This provision also does not interfere with the measures established by the health plan to control costs consistent with its responsibilities under the ALTCS program.

If the health plan declines to include an individual or group of providers in its network, it informs the health care provider(s) of the reason for its decision in writing. The health plan may not include providers excluded from participation in federal health care programs.

#### *INTERIM EVALUATION OF CYE2011 OBJECTIVES*

##### *OBJECTIVE 1: Finalize an Electronic Fund Transfer (EFT) Process*

**EVALUATION:** SCAN acknowledges the requirement for Electronic Funds Transfer (EFT) capability under the current AHCCCS CYE 2012 contract, as well as the priority given EFT in AHCCCS’ Five Year Strategic Plan for 2012 – 2016.

Network Management is dedicated to and has taken steps to promote and advance the use of EFT throughout the provider network. In May of 2010, Network Management conducted a survey of three hundred forty-two (342) Assisted Living Homes (ALHs) and Centers (ALCs), to determine whether they had interest in receiving payment through EFT. Approximately one hundred nine (109) providers responded. Of those, seventy-seven percent stated that they would be interested in EFT. Since that time, Network Management has identified those providers currently on EFT with other plans and has further identified a small population of “partner providers” willing to enroll on EFT quickly for testing purposes.

Provider outreach and education materials have been developed that explain the benefits of the EFT process, including faster access to funds, provider staff efficiencies and less processing than mailed paper checks. Network Management training and materials also highlight the ease with which a provider may enroll in the EFT process. Providers will receive similar messaging in the claim remittance advice. SCAN Insights, the provider newsletter, and visits by Network Management representatives will also focus on the EFT process and the benefits to the provider. Enrollment forms and further educational material will be posted on the SCAN Provider Web site.

Network Management is continually educating the provider community and promoting the use of the EFT process.

*OBJECTIVE 2: Increase Zone Compliance for SNFs*

**EVALUATION:** In the Network Development and Management Plan submitted in November 2010, SCAN reported forty-eight (48) SNFs in the network. As of March 2011, SCAN has contracts for fifty-two (52) SNFs. In the previous plan submission, it was reported that SCAN met the requirements in four out of the ten Zones. With the addition of several facilities and the restructuring of the Zones, SCAN is able to report an increase in Zone compliance, currently meeting or exceeding the AHCCCS required levels in eight (8) out of nine (9) Zones. Network Management continues to work toward full compliance within all Zones.

*OBJECTIVE 3: Implementation of IntelliContract™ (IC) Software to Improve the Contracting Process*

**EVALUATION:** In its efforts to enhance the contracting process, Network Management is in the implementation phase of the IC software. Provider demographic information is being loaded and audited in the software database, and standardized contract templates are being drafted and prepared for legal and compliance review. Network Management anticipates full implementation in June 2011. Once implemented, procedures and desktops will be developed or evaluated to ensure consistent and complete documentation of workflow. This will lead to a more streamlined contracting process and will standardize the workflow within the department, allowing for better contract monitoring and reporting of the provider network.

*OBJECTIVE 4: Increase the Number of In-Home Providers in HCBS Settings*

**EVALUATION:** Network Management continues to work collaboratively with Case Management on the initiative to increase the number of members appropriately residing in an HCBS setting. The work group meets regularly to review and brainstorm ideas for ways to identify and educate members about transitioning to a lesser restrictive setting when appropriate. SCAN continues to work with Foundation for Senior Living (FSL) and Valle Del Sol for low- income housing opportunities, as well as with the AZ Furniture Bank to offer furniture packages to members able to move back into a home setting. Network Management will outreach to the provider network as member needs are identified to assist with successfully transitioning willing members to a lesser restrictive setting

The 2011 plan will be fully evaluated at the end of CYE 2011 and once those evaluations are complete, updates will be made to this CYE 2012 Plan consistent with findings.

*PROVIDER FEEDBACK*

SCAN Executive Management continues to meet with community health care leaders representing hospital systems, physician groups, HCBS organizations, ancillary service providers, ALFs and SNFs. SCAN also meets with a multitude of community health and human services organizations, as well as government officials and individual senior and disability advocates, on a regular basis. The purpose of these meetings is to provide an ongoing overview of SCAN, to better understand local medical community norms and to determine any changes in those norms that SCAN may have overlooked. SCAN will continue to listen to provider concerns and assess the receptivity to our health plan in the Maricopa County market. These open dialogues supply SCAN with an abundance of information instrumental to the decisions made by our Executive Management as SCAN continues its growth. The most relevant findings from these meetings continue to be:

- Strong synergy with the SCAN mission, its member- centric focus and our not- for- profit status
- Strong support for and interest in working collaboratively with SCAN in the development of new and innovative service delivery approaches
- Strong interest in participating in a Continuing Medical Education (CME) accredited geriatric education program

- Positive response to SCAN's taking the time and initiative to meet and listen to their needs and concerns
- Appreciation for SCAN's expressed commitment to the provider community as evidenced by our focus on excellent member and provider service
- Confidence that current provider concerns and needs are of the type that can be adequately addressed by SCAN
- SCAN's commitment to giving back to the community.

### *NETWORK ACCESS*

SCAN provides members with the necessary tools to access the network. These tools include (1) a Provider Directory available in hard copy or electronically; (2) a Member Handbook containing basic network and service accessibility information; (3) the Member Services Department with bi-lingual and interpretation capabilities; and (4) a Nurse Line available twenty four (24) hours per day, seven days per week. All member materials are available in Spanish. In addition, members are encouraged to contact their respective case manager (CM) for network assistance.

#### Primary Care Provider (PCP)

PCPs are responsible for providing or coordinating all necessary medical care for assigned SCAN members. For specialty care, PCPs refer members to contracted specialists. PCPs and/or SCAN CMs assist members with referral options and specialist access.

#### PCP Selection

SCAN has developed a comprehensive panel of primary care providers consisting of family practitioners, internal medicine, general practitioners, OB/GYN and pediatricians. Members are allowed to select a contracted PCP upon plan enrollment. If a new member does not select a PCP, the plan will assign one based on their identified needs and geographic proximity. If a member requires a specialist as a PCP, Case Management, in concert with Medical Management and Network Management Services, will assist the member with the selection process. A member may elect to change their PCP up to two (2) times per year. If the member is unable to establish a relationship with either provider (the reason for change is not due to location), the third change will require approval by a medical director so that the member can be educated about continuity of care, and a CM will assist in helping the member choose an appropriate PCP. If a new enrollee has an established relationship with a non-contracted PCP and desires to remain on that physician's panel, SCAN will make every effort to enlist the physician into the SCAN network.

#### Specialty and Ancillary Referrals

Members are able to self-refer for gynecological and obstetrical services, annual mammograms, and outpatient behavioral health services. Members under 21 may also self-refer to dental services. A PCP referral is required for certain specialty services, including referrals to certain types of ancillary providers. However, referrals for consultation and follow-up visits to most specialists do not require health plan prior authorization (PA) unless the specialist is a non-contracted provider or one of a few specialty types such as plastic surgery. PCPs will be responsible for obtaining plan PA for facility admissions and some ancillary services. SCAN will provide PCP's with online links to locate contracted specialists and request PAs.

#### Emergent and Urgent Services

Emergent and urgent care are provided through contracted hospitals and urgent care centers sufficient in number and geographic location to meet the needs of current and future membership.

## Transportation

Emergent and non-emergent ground transportation, including ambulances, vans and taxicabs, are available to members throughout Maricopa County. For non-emergent ground transportation, a member need only call the SCAN Transportation Call center to schedule their transportation. SCAN has contracted with several providers, offering our membership a choice for this benefit.

## Hospitals and Nursing Home Facilities

Specialists are responsible for obtaining PA from SCAN for non-emergent hospital admissions. Prior authorizations are also required by SNFs.

## Alternative Assisted Living and Home and Community Based Services

SCAN CMs are instrumental in assisting members and their families with identifying and authorizing a continuum of service options that will support their needs and agreements made during the care planning process for maintaining the member in the least restrictive setting. Case Management will continue to make a concerted effort to assist members in returning to a home (the member's home if possible) or *least restrictive setting*. SCAN will focus on helping those members residing in their own homes to remain in that setting through the use HCBS services. It should be noted that once a member has been relocated to a residential setting, that member's home may be sold by their family, or, if the member's home was a rental, that home may not be available.

SCAN employs the following strategies to decrease the percentage of members residing in ARS:

- Adjust a member's room and board costs to allow a limited amount to be saved each month toward a deposit on an apartment or independent housing setting. Members will be required to maintain at least the minimum room and board payment.
- Partner with the Maricopa County Regional Behavioral Health Authority (RBHA) to keep those members that are in low-income housing through the RBHA to continue with the low-income housing as they transition to ALTCS. This allows the low-income housing to continue through the RBHA, while SCAN covers the costs of in-home services and supports equal to or exceeding the cost of housing.
- For members in SNFs, where there is agreement from the PCP, encourage the use of the therapeutic bed hold benefit to try a placement in an HCBS setting. This would include discharge to an ARS or the member's own home with services in place. This will allow all parties to assess whether the member and/or their support system can manage the member's needs outside of a SNF placement.
- Low-income housing: SCAN has developed a relationship with FSL and Valle del Sol to provide housing at a cost members can afford, even if they are living at the minimum social security insurance (SSI) income levels. The homes through Valle Del Sol are 85 percent complete and two (2) of the homes will be ready for move-in this month.
- Furnishings: For members transitioning from an ARS or SNF setting, SCAN will pursue providing furnishings from a furniture bank to provide essential items for daily living to members.
- Senior Centers: SCAN's Behavioral Health Coordinator visited a majority of the senior centers in the Valley and has a list of activities and other programs that the CMs can use to refer members to. Members who may not want Adult Day Health services may find the more active group of seniors at centers to be more compatible with their needs and may establish a community connection.
- Explore the possibility of contracted pharmacies delivering pre-packaged medications to members in their own home, similar to the program used for assisted living settings.

- A monthly review of barriers identified by CMs will be completed and any network needs forwarded to the Network Management Department for follow-up as appropriate.
- Consider collaborating with an entity or organization that provides screening and potential house-mate matches between those who have a home and those who need a home.
- SCAN will attempt to collaborate with apartment complexes to offer housing at a cost members can afford, even if they are living at the minimum SSI income levels.

### *CURRENT PROVIDER NETWORK STATUS*

The following is a status update on the SCAN provider network in Maricopa County by provider type.

#### Primary Care

As of March 1, 2011, SCAN has over 1,000 primary care providers and “physician extenders,” such as nurse practitioners and physician assistants, under contract for ALTCS services. SCAN uses GeoAccess® reports to monitor the PCP network to ensure that it meets the AHCCCS five mile radius requirement between the member’s primary residence and a contracted PCP.

#### Specialty

SCAN has approximately 2,500 physician specialists in our provider network. The number and type of specialists meet or exceed the routine and special medical needs of the ALTCS population, local medical community norms and AHCCCS requirements.

#### Specialists as Primary Care Providers

There are medical conditions when it may be advantageous for a member to be assigned to a specialist as their PCP. For example, a member with cancer may be assigned to an oncologist for primary and specialty care. These assignments require authorization by the Medical Director. As of March 2011, SCAN has not had any member who requested assignment to a specialist as their PCP.

#### Specialty Network

The specialty network does not currently have any service gaps. Network Management will continue to monitor the specialty network and address any needs as they arise.

#### Hospital Network

The SCAN acute hospital network consists of thirty-four (34) facilities, including two (2) tertiary hospitals, and meets the AHCCCS geographical location requirement. The hospital network includes the following facilities:

- Arizona Regional Medical Center
- Arrowhead Hospital
- Banner Baywood Medical Center
- Banner Boswell Medical Center
- Banner Children's Hospital at Banner Desert Medical Center
- Banner Del E. Webb Medical Center
- Banner Desert Medical Center
- Banner Estrella Medical Center
- Banner Gateway
- Banner Good Samaritan Medical Center
- Banner Good Samaritan Rehabilitation Institute



- Banner Heart Hospital
- Banner Thunderbird Medical Center
- Chandler Regional Medical Center
- Generations Behavioral Facility
- Gilbert Emergency Hospital
- John C. Lincoln Hospital Deer Valley
- John C. Lincoln Hospital North Mountain
- Maricopa Medical Center
- Maryvale Hospital
- Mercy Gilbert Medical Center
- Mountain Vista Medical Center
- Paradise Valley Hospital
- Phoenix Baptist Hospital
- Select Specialty Hospital - Phoenix
- Select Specialty Hospital - Phoenix Downtown
- Select Specialty Hospital - Scottsdale
- St. Luke's Behavioral Health Center
- St. Luke's Medical Center
- Tempe St. Luke's Hospital
- Trillium Specialty Hospital - East Valley
- Trillium Specialty Hospital - West Valley
- West Valley Hospital
- Wickenburg Community Hospital

The tertiary hospitals, Banner Good Samaritan Medical Center and Maricopa Medical Center, are centrally located and therefore, are geographically accessible to ALTCS members. The SCAN specialty network has physicians with admitting privileges at both facilities.

For those PCPs that do not have admitting privileges, SCAN has contracts for hospitalist services with District Medical Group (DMG), Banner PHO, Inpatient Physician Network of Arizona, Maricopa Integrated Health Systems, American Physicians Inc., Integrated Medical Services and John C. Lincoln.

#### Skilled Nursing Facilities

SCAN has contracts with fifty-two (52) SNFs. The chart below demonstrates that the SNF network currently meets the AHCCCS required levels in eight (8) out of nine (9) zones. The service gap in Zone 3 has been identified and assigned for outreach efforts. Potential providers in these zones are being reviewed for possible recruitment; however, we are not experiencing placement difficulties in the deficient zone.

Network Management Services has reviewed the areas surrounding the deficient zone and has identified other placement options for members.

<i>Skilled Nursing Facilities</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
1	4	4	100%
2	8	8	100%
3	2	1	50%

<i>Skilled Nursing Facilities</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
4	5	6	120%
5	3	3	100%
6	8	9	113%
7	4	7	175%
8	8	10	125%
9	4	4	100%
<b>Total</b>	<b>46</b>	<b>52</b>	<b>113%</b>

### Assisted Living Homes

SCAN has contracts with 309 Assisted Living Homes (ALHs) in Maricopa County. The chart below demonstrates that the ALH network meets or exceeds the AHCCCS requirements in all nine (9) zones.

<i>Assisted Living Homes</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
1	20	72	360%
2	14	23	164%
3	10	12	120%
4	7	14	200%
5	20	41	205%
6	16	25	156%
7	10	13	130%
8	20	54	270%
9	20	55	275%
<b>Total</b>	<b>137</b>	<b>309</b>	<b>226%</b>

### Assisted Living Centers

SCAN has contracts with forty-five (45) Assisted Living Centers (ALCs) in Maricopa County. Network Management has made multiple attempts to contract directly with the individual Covenant facilities. However, these attempts continue to be unsuccessful. Network Management will continue to outreach to these facilities to discuss contracting with SCAN. The chart below demonstrates that the ALC network currently meets or exceeds AHCCCS requirements in five of the nine zones. The service gaps are noted in this Plan under the Network Gaps or Limitations section..

<i>Assisted Living Centers</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
1	4	3	75%
2	6	9	150%
3	0	0	100%
4	2	2	100%
5	4	2	50%
6	10	9	90%
7	4	3	75%

<i>Assisted Living Centers</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
8	8	13	163%
9	4	4	100%
<b>Total</b>	<b>42</b>	<b>45</b>	<b>107%</b>

#### Adult Foster Care

SCAN has a contract with FSL for Adult Foster Care (AFC) services at seventy-five (75) locations throughout the GSA. The AFC network meets AHCCCS network requirements in eight (8) out of the nine (9) zones. This service gap has been noted in this Plan in the Network Gaps or Limitations section.

<i>Adult Foster Care</i>			
<i>Zone</i>	<i>AHCCCS Requirement</i>	<i>2011 Contracts</i>	<i>Percent</i>
1	20	22	110%
2	10	10	100%
3	2	2	100%
4	0	1	100%
5	24	27	113%
6	4	4	100%
7	1	2	200%
8	5	7	140%
9	2	0	0%
<b>Total</b>	<b>68</b>	<b>75</b>	<b>110%</b>

#### Home and Community Based Network

SCAN has contracts with seventy-three (73) primary HCBS organizations for the provision of Adult Day Health Care, Attendant Care, Home Delivered Meals, Home Health, Home Maker, Personal Care, Respite Care and Home Modification services.

SCAN underwent a comprehensive selection process to identify and contract with a fiscal intermediary for the Self Directed Care program. *Consumer Direct Personal Care* was selected as the intermediary. A contract was executed and numerous implementation meetings were conducted to ensure the program was implemented efficiently and integrated into the day- to- day operational structure of SCAN. As of February 2011, CMs reported that SCAN has thirty one (31) members participating in this program.

SCAN members continue to utilize the benefit of allowing their spouse to act as their paid attendant. As of February 2011, CMs reported that SCAN has sixty seven (67) members participating. SCAN will continue to monitor, review and analyze the utilization of both programs.

#### Behavioral Health Network

As of January 2011, sixty-three (63) percent of SCAN members receive behavioral health services in some form. SCAN, recognizing the critical need for behavioral health services for the ALTCS population, spends considerable time and effort identifying those organizations with the most knowledge, experience and success in providing inpatient and outpatient treatment to this population. The behavioral health network is specifically designed to deliver ALTCS covered behavioral services to the elderly and physically disabled. Recently, Network Management assigned a liaison to work between Network and Case Management to collaborate on identifying providers to outreach to for contracting with SCAN. The

network has not been limited to mental health, but also includes behavioral problems related to dementia, Alzheimer's disease, traumatic brain injury and other organic diagnoses. The network has been intentionally developed with considerable breadth and depth due to limited capacity issues in Maricopa County. SCAN prefers to over-size the behavioral health network rather than expose itself to the possibility of not being able to meet the needs of its members due to capacity constraints. The SCAN inpatient mental health network includes hospitals, nursing homes, behavioral residential facilities and group homes.

#### Inpatient Mental Health Hospitals

SCAN continues to contract with Banner Behavioral Health Hospital, St. Luke's Generations Hospital, Senior Horizons, an Abrazo Health Systems facility and Maricopa Medical Center to provide inpatient mental health hospital care.

#### Inpatient Mental Health Nursing Facility

SCAN continues to contract with the Youth Development Institute to provide inpatient mental health nursing home services for adolescents as the need arises. In addition, the plan contracts with Ridgecrest, Maryland Gardens, Palm Valley, East Mesa Care Center, Desert Sky, Desert Haven and Scottsdale Village Square, each of which provides some level of nursing home behavioral health services.

#### Residential Facilities

SCAN contracts with two (2) mental health providers that will serve children and adolescents with substance abuse and mental health issues. These residential facilities are Devereux and Youth Development Institute.

#### Alzheimer's Facilities

Several network ALCs and many SNFs provide care for members with advanced dementia and/or Alzheimer's disease. SCAN has contracted with eighteen (18) facilities for Alzheimer's treatment in an ALC and twenty-one (21) facilities for this type of treatment in a SNF setting.

#### Adult Therapeutic Foster Home

SCAN has contracted with FSL to provide Adult Therapeutic Foster Home services.

#### Behavioral Health Group Homes

SCAN contracts with seven (7) providers that offer Level II and III Adult Behavioral Health group homes. The providers are Sonoran Sky, Creative Innervations, FSL, Arizona Mentor and Marc Center. Additional providers will be added as needs are identified.

#### Outpatient Mental Health

SCAN contracts with ten (10) mental health providers that are able to deliver an array of outpatient covered services, either in-office or in-home, for adults, children and adolescents. Each mental health provider has staff that is bi-lingual in Spanish and English to ensure that culturally sensitive and competent services are delivered to SCAN members. The mental health providers are:

- Chicanos Por La Causa
- Individual and Family Psychological Services
- Devereux Arizona
- Empact – SPC (crisis only)
- Jewish Family and Children's Services
- Marc Center

- Mentus Group
- Michael Bayless and Associates
- Valle Del Sol
- Southwest Behavioral Health

### Behavioral Health Utilization

As of January 2011, 1829 members, or 63 percent of the SCAN membership, were receiving some form of behavioral health services. Of the total membership, 1430, or 49 percent, were on psychotropic medication only. Ten percent, or 297 members, were receiving behavioral health services, counseling and medication, and twenty-eight members (<1%) were receiving counseling with no medications. There are seventy-three (73) members currently in behavioral health placements. The plan experienced monthly incremental growth in CYE2010, and projects that the total percentage of members receiving behavioral health services will continue to grow in CYE2011.

### Behavioral Health Network

Currently, there are no unmet needs in the behavioral health network. In anticipation of continual growth in CYE2011, the plan will continue to monitor the needs of the membership and recruit providers accordingly.

### Pharmacy

Express Scripts Inc. serves as the SCAN Pharmacy Benefit Manager (PBM), and SCAN utilizes the PBM retail pharmacy network. The network consists of over 650 retail pharmacies, which meets the AHCCCS distance requirement of five miles from a member’s primary residence. As a means of monitoring compliance with AHCCCS requirements, SCAN utilizes GeoAccess analysis of contracted retail pharmacies. Through the Express Scripts agreement, and multiple long-term care pharmacies, SCAN provides pharmacy services to members residing in SNFs. Express Scripts continuously monitors the pharmacy network to ensure compliance.

### Ancillary Provider Network

SCAN has developed a comprehensive ancillary provider service network designed to provide ALTCS covered services on a county-wide basis. The network includes, but is not limited to, the following organizations:

<i>Provider</i>	<i>Covered Services</i>
Nationwide Vision	Vision Services
Preferred Homecare	DME and IV Therapy
Med-One Healthcare	DME
ALL-MED	DME
Apria	DME, Home Health (IV Therapy and Home Health Nursing)
Professional HomeCare Services	Home Health and Enteral
Sonora Quest Laboratories	Laboratory Services
Dependable Medical Transport Services	Non-Emergent Ground Transportation
NextCare	Urgent Care
Hanger	Prosthetics and Orthotics
DaVita	Dialysis
Banner Good Samaritan Rehabilitation Institute	Rehabilitation Services (PT, ST, OT)
Covenant Alliance Rehabilitation	Rehabilitation Services (PT, ST, OT)

<i>Provider</i>	<i>Covered Services</i>
Foundation for Senior Living	Rehabilitation Services (PT, ST, OT)
Odyssey Hospice	Hospice
Hospice of Arizona	Hospice
Desert Oasis Hospice	Hospice
Hospice of the Valley	Hospice

### Networks for Special Populations

The SCAN network includes providers to meet special medical needs, such as ventilator dependent, traumatic brain injury and behavioral health. SCAN continues to expand its special needs network as members with special medical needs are identified. Members with special health care needs are assigned to specialty care for primary care needs, as determined appropriate by the Medical Director.

Providers for the behavioral health and traumatic brain injury network have been previously listed. Ventilator providers are listed on the chart below.

<i>Ventilator Providers</i>	<i>Provider Type</i>
Baker, Sandra	AFC Home
Fenton, Muriel (AKA Sweetwater Haven)	AFC Home
Graham, Ruby	AFC Home
Trillium Specialty Hospital	Long Term Care Hospital
Select Specialty Hospital	Long Term Care Hospital
Coronado Care Center	Skilled Nursing Facility
East Mesa Healthcare Center	Skilled Nursing Facility
Grace Health Care	Skilled Nursing Facility
Highland Manor Health and Rehab	Skilled Nursing Facility
North Mountain Medical and Rehab	Skilled Nursing Facility
Palm Valley Rehab and Care Center	Skilled Nursing Facility
Plaza Healthcare	Skilled Nursing Facility
Springdale West	Skilled Nursing Facility
Sun West Choice Health Care	Skilled Nursing Facility

### Children and Young Adults

As of March 2011, SCAN has 19 members under the age of 21. SCAN recognizes this population presents unique medical and service challenges. As such, the network includes pediatricians, pediatric specialists and other providers offering pediatric care, such as La Hacienda.

### Other Key Network Providers

Based upon provider and community feedback, SCAN will contract with organizations that address specific needs of the ALTCS population.

### Residency Programs

SCAN remains contracted with Banner Good Samaritan Academic Medical Services to access their medical residency program, and the Arizona School of Dentistry and Oral Health to access their dental residency program.

### Federally Qualified Health Centers

SCAN remains contracted with Mountain Park Medical Center and Maricopa Family Health Center. Both are Federally Qualified Community Health Care Centers. SCAN will continue its contracting efforts with Clinica Adelante, a west Maricopa County Federally Qualified Health Care Center.

### Home Care Medicine

SCAN provides a variety of specialty services to our membership in the home environment. Contracts with multiple in-home physician groups and individuals allow our members the choice of primary care in a conventional setting or in their home. Current data appears to indicate that the in-home choice is gaining in popularity and may soon be the standard rather than the exception.

### Emergency Alert

SCAN has contracts with two (2) providers for emergency alert services.

### Maricopa Medical Clinics

SCAN has contracted with the Maricopa Integrated Health System to access their twelve (12) medical clinics. Our market research shows that there are a number of ALTCS members who prefer these clinics.

### Residential and Skilled Nursing Home Care Management

SCAN contracts with INSPIRIS and Scottsdale Physician Group to provide care management services to SCAN members residing in ARS and SNFs. SCAN also has a number of in-home physicians who currently serve over 400 members, and will continue to explore the expansion of these provider types.

### Interpretation Services

SCAN currently contracts with Language Line Services to provide telephonic translation services. SCAN is also contracted with Language Connections for telephonic, on-site translation and sign language interpretation services for both members and providers. The plan also contracts with AT&T as a backup vendor.

### *NETWORK GAPS AND LIMITATIONS*

SCAN recognizes the volatility of provider networks and the need to respond expeditiously to meet unanticipated network services gaps or limitations through both short and long term interventions. SCAN has specific protocols to address network gaps based upon such unanticipated events as licensure revocation, facility closure, bankruptcies, contract terminations for cause, special medical needs and natural disasters. These protocols are based on the single guiding principle of doing whatever is appropriate to care for the member as promptly as possible.

SCAN understands that all material changes to the network must be approved by AHCCCS in advance, with "material" defined as any change that affects five percent or more of the SCAN membership. Additionally, SCAN will notify AHCCCS within one (1) business day of any unexpected changes that would impair its provider network.

Network Management has established the Network Management Committee (NMC) which meets monthly to review and monitor the following:

- Development of the SCAN provider network
- Identification of special health care needs by the Case Management or Medical Management departments
- Network Development Plan objectives
- Provider availability and accessibility

- Network zone compliance
- Network staffing (reviewed quarterly)
- New or revised policies and procedures impacting providers
- Terms, conditions and/or restrictions relative to new or amended contracts
- Network gaps and limitations, including behavioral health or any special needs
- Provider issues and trends

The NMC Chair is responsible for reporting committee findings, actions and recommendations to the Executive Management team on a regular basis.

SCAN continues to monitor and expand the network, when appropriate, to ensure that capacity levels meet or exceed current and projected demand. This enables SCAN to accommodate any foreseen or unforeseen network crises, as well as prepare for future growth. The plan monitors and assesses the medical community and approaches new providers about joining the network, when and where appropriate.

In preparation for an unanticipated event, SCAN developed a backup plan by provider type, including a secondary line of contracted providers. SCAN contracts with Preferred Homecare, Med-One Healthcare and three other durable medical equipment (DME) providers to ensure sufficient availability of this service under all circumstances. SCAN was able to accomplish this without sacrificing negotiated pricing advantages. Infusion services are equally covered by organizations like Option Care, Apria, LifeCare Solutions and Preferred Home Care. In the event that any one contracted provider cannot meet the needs of a particular member, SCAN has only to refer the case to an alternative provider of the same service, thereby ensuring the member's access to timely care and services. The plan has contracts with a sufficient number of ARFs and SNFs in the ALTCS zones to ensure adequate coverage by these or similar facility types in a geographical area. SCAN also contracts with a sufficient number of primary care and specialist physicians. If the health plan discovers that its contracted provider network is unable or inadequate to deliver any type of medically necessary care required under ALTCS, SCAN will cover these services in a timely manner through an out-of-network provider until a provider is contracted. The plan will coordinate PA and payment with the non-contracted provider. Network Management will provide the non-contracted provider information on plan and regulatory requirements.

A network analysis will be performed immediately in order to assess the situation, including determining the type (SNF, hospital, ancillary, ambulance, practitioner, etc.), and number of services required by the member, as well as review a list of available providers in the community who can meet those needs. Once the assessment is completed, recruiting efforts will occur in order to contract with the needed provider(s) to ensure that the needs of the members are met in the most appropriate setting. Temporary or provisional credentialing of providers in areas of need may occur. The assigned CM will coordinate the provider change with the member and their family, and the Network Management and Medical Management departments.

#### Gaps in Critical Services

SCAN recognizes that the plan is responsible for establishing a network of contracted providers adequate enough to ensure that critical services are provided without gaps, pursuant to the Ball v. Betlach case settlement. SCAN will resolve gaps in critical services within two (2) hours of an issue being reported.

Network Management meets with Case Management staff on a monthly basis to review any gaps in services that have or that may occur. These manager-level meetings have proven valuable in identifying and preventing gaps in services.



SCAN submits a semi-annual report to AHCCCS outlining trends and corrective actions regarding gaps in services, grievances related to service gaps and other reports as deemed necessary to fulfill the settlement agreement.

*Ongoing Network Development Activities*

While SCAN acknowledges the following deficiencies, through previous communications with AHCCCS, SCAN has demonstrated that it is able to accommodate the needs of the membership through contracts with alternate facility placement types in surrounding regions should a member request placement in a deficient zone. SCAN remains confident that the provider network is adequate and sufficient to deliver ALTCS covered services to our members.

*GAP #1*

<i>Current network gap:</i>	Skilled Nursing Facilities/Zone 3 The SNF requirement for Zone three is two and the plan is currently contracted with one.
<i>Short-term interventions:</i>	We are currently in the contract process with Sunbridge Estrella. Once the provider completes credentialing, the contract will be finalized and SCAN will meet the gap in Zone 3.  In the interim, the current SNF network continues to meet the needs of the members residing in the zone. In the adjacent Zone 4, there are an additional six (6) contracted SNFs which may be used as a safety net if the need should arise.
<i>Long-term interventions:</i>	SCAN is in the final stages of contract process with Sunbridge Estrella. Once this is finalized, SCAN will be compliant in this zone.
<i>Outcome measures:</i>	Compliance with zone requirement.

*GAP #2*

<i>Current network gap:</i>	Assisted Living Centers (ALC)/ZONES 1, 5, 6, and 7 The requirements for the deficient zones are as follows: Zone 1: Required 4; SCAN has 3 Zone 5: Required 4; SCAN has 2 Zone 6: Required 10; SCAN has 9 Zone 7: Required 4; SCAN has 3
-----------------------------	---

*Short-term interventions:* SCAN is currently in the contracting process with Sunshine Village, which is awaiting our final contract signature. Once this contract is completed, SCAN will meet the requirement in Zone 1.

For the remaining zones, SCAN will identify non-contracted ALCs in the deficient zones and outreach to discuss contracting.

At this time, SCAN has determined that our contracted ALCs have the capacity to accommodate members requiring this service type. Should that change for any reason, SCAN will place the members in a contracted ALC located closest to the requested zone. SCAN may explore the possibility, when appropriate, to offer additional services and support to the member, allowing him or her to remain in their home.

*Long-term interventions:* SCAN continues to outreach to the Covenant Health Network facilities to encourage individual facilities in these zones to reconsider their non-participation with SCAN.

*Outcome measures:* Compliance with zone requirements

*GAP #3*

*Current network gap:* Adult Foster Care Homes/Zone 9

The requirement for Zone nine is two AFC homes. Currently, SCAN does not any homes in the network in this zone.

*Short-term interventions:* Two AFC homes which fall within Zone nine have been identified on the Arizona Department of Health Services (ADHS) licensing Web site. One home is in Gilbert and another is in Queen Creek. Outreach efforts are currently underway to verify that these homes are in the FSL network and can be added to the SCAN network through the FSL contract. If these homes are current and added to the network, SCAN will be fully compliant in this zone.

*Long-term interventions:* SCAN continues to work with FSL to enhance public awareness of the need for additional AFC homes in these areas, and to assist in recruitment efforts.

*Outcome measures:* The development and maintenance of an AFC network to adequately serve the needs of the ALTCS population in Maricopa County, as measured by zone compliance.

**NETWORK MAINTENANCE**

Provider network stability, coupled with flexibility and adaptability, is essential to meeting the needs of the ALTCS population. SCAN maintains its provider network through communication, education, training, monitoring, assessing and evaluating to ensure adequacy and sufficiency in the delivery of ALTCS covered services to SCAN members.

SCAN recognizes the critical importance of continuing to maintain effective, meaningful provider communication and education channels to ensure mutually satisfactory partnerships for the benefit of our members.

## Communications

SCAN maintains a dynamic, integrated provider communication process that involves all SCAN departments in a manner designed to consistently respond to provider concerns and needs. SCAN established a formal provider communication, training and support program. This program uses a variety of methods to communicate with the provider network. SCAN employs both oral and written communication to convey applicable federal and state laws and AHCCCS requirements, as well as health plan policies and procedures to our provider network. Components of this communication process are described below.

### Health Plan Accessibility to Providers

Effective provider partnerships are based upon mutual respect, trust and open communication. Providers have a direct link to SCAN through their Network Management Services Representative to express their concerns and needs, and SCAN assures that this communication link remains open and responsive. Providers know that any problem can be elevated and responded to and they view that as a valuable commitment to service. SCAN forms active partnerships with its providers through the ability to develop a personal and familiar contact source to enhance this process. Network representatives are available during normal business hours. For after-hours and weekend coverage, SCAN has an answering service which will triage these calls. Network calls that cannot wait until the next business day will be forward to the Vice President of Network Management Services. Additionally, SCAN attempts to acknowledge provider telephone calls within one (1) business day.

### Provider Notifications and Contract Amendments

SCAN notifies providers of any change to applicable laws and regulations prior to implementation. A formal contract amendment process is used to incorporate these changes into the contract. Contract amendments require the signatures of authorized representatives of each party.

### Provider Web Site Link

To facilitate provider communications about administrative functions, SCAN offers interactive Web site links that enable providers to determine member eligibility electronically, and ascertain claims status. In 2011, the plan will continue efforts to enhance its Web site to allow providers access to an automated PA system.

### Provider Newsletter

Contracted providers receive a SCAN newsletter twice a year. The newsletter includes plan updates, information regarding policy and procedure changes, information about changes that will affect claims and encounters and articles on health topics of importance to ALTCS members. In CYE 2010, the provider newsletters included topics such as: Healthy Nutrition for Seniors, EPSDT Reminders, the Medication Administration and Documentation (MAD) project, ALTCS benefit changes, Direct Workforce updates, Flu Prevention, Diabetes Screenings, Reporting Fraud and Abuse, Disease Management, Advance Directives, Multi-Cultural Competency Tools and Electronic Billing.

### Provider Surveys

SCAN generally conducts an annual provider satisfaction survey which allows the plan to receive feedback from providers on its performance, including the adequacy of the network. Providers are encouraged to recommend other providers as part of the plan's efforts to expand the network, where and when appropriate. In CYE 2010, the provider survey was conducted in September. The survey instrument was prepared by the plan in consultation with an external market research vendor. One thousand twenty one (1021) providers were mailed surveys. One hundred seventy nine (179) surveys were returned for a response rate of 18 percent. The vendor, North American Testing Organization, was responsible for administration and tabulation of the results. The survey findings were presented to the

SCAN Executive Management team, the Member/Provider Council and the Quality Management/Utilization Management (QM/UM) Committee.

#### Provider Complaints/Claims Disputes

SCAN considers provider complaints as a valuable communication channel to identify operational deficiencies, make necessary changes and maintain positive relationships with network providers. SCAN understands the importance of addressing provider issues and concerns in a prompt and responsive manner and makes every effort to resolve provider issues in an informal manner first. If unsuccessful, SCAN has a formal provider claim dispute resolution process in accordance with AHCCCS requirements. The Compliance Officer is responsible for monitoring formal claim dispute reports and implementing any necessary corrective actions.

#### Provider Association Memberships

SCAN has been, and will continue to be, actively involved in health care and community based associations and advocacy groups in Arizona to better understand the needs of various health providers and community advocates. SCAN is a Business Associate member of the Arizona Health Care Association (AHCA), the Arizona Assisted Living Federation of America and the Arizona Assisted Living Home Association. These memberships allow SCAN to better understand the concerns of the ALC and ALH industries.

#### Member/Provider Council

Network Management continues to leverage our association with the Member/Provider Council in order to effectively communicate with members and providers, and to allow our providers to communicate directly with our members or their representatives. The SCAN Member/Provider Council provides the plan with input and insight on policy and programs and promotes a collaborative effort in enhancing the provider network, while still maintaining a member- centrist focus. The Council, chaired by the Vice President of Case Management, meets at least quarterly, and Council membership is representative of the population and community served. SCAN promotes active involvement and open dialogue with the Council to ensure that the needs of members are met.

#### Training and Education

All contracted providers receive a SCAN orientation. Network Management staff meet with the provider and/or their office staff within sixty days (60) of the effective date of the provider's contract or letter of agreement. As part of the orientation, SCAN staff provides an overview of the SCAN Provider Operations Manual (POM).

The POM contains the subject matter required by AHCCCS and serves as the basis for initial provider training. It is intended to be used as a reference guide by provider offices. The POM is updated annually, or more frequently if required, to include SCAN and AHCCCS updates and changes. The POM is available to all providers on the SCAN Web site at [www.scanhealthplan.com/article/arizona/physicians.html](http://www.scanhealthplan.com/article/arizona/physicians.html).

During the orientation, providers are informed about the availability of Language Line and Language Connections to ensure that members with limited- English- proficiency receive medical care in a culturally sensitive and competent manner in a language they understand. Providers also receive ongoing education regarding cultural diversity through the SCAN Web site.

#### Training

The Network Management staff, at the convenience of the provider, will schedule regular meetings on an individual and group basis. In CYE 2011, Network Management Services will continue our successful provider outreach program to enhance SCAN's name recognition, and to ensure that members have

minimal difficulties in accessing care. When problems arise, staff will immediately work to resolve the situation through provider education and training.

#### Inter-departmental Collaboration

The SCAN Medical Management Department serves as a rich source of education for network providers. Medical Management reviews data regarding the care that SCAN members receive on a regular basis. Data from a wide variety of monitoring activities identify areas where provider(s) education would benefit both the provider and the member. Trends that indicate potentially inappropriate over/under utilization of specialty referrals, diagnostic services or pharmaceuticals are noted. The Medical Director may contact these providers to discuss these trends and possible options. In addition, the Medical Director will make site visits to an office when SCAN determines that direct peer intervention is warranted and education and training is needed.

Network Management staff, in cooperation with the Case Management and Medical Management departments, train providers about programs such as Children's Rehabilitative Services (CRS), behavioral health services and cultural competency. SCAN assists provider offices with referrals to these programs and helps them overcome barriers.

Case Management staff also assists providers with the management of members with special needs. As specific situations arise, the CMs educate the providers about community programs and resources or other health care providers that are available to help with the management of special needs. They will assist the provider with the referral process to save them time and resources. Case managers develop collaborative relations with providers to assure that they are fully aware of the member's health care needs and challenges.

In CYE 2010, Network Management provided group training to ALHs on Healthy Nutrition for Seniors, Cultural Awareness, Fall Prevention, the diabetes initiative, reminders on the admission process when admitting member into the ALH and Customer Service. Documentation of these trainings is maintained by Network Management. These trainings have been well-received and will continue in CYE 2011.

#### Education

SCAN Health Plan initiated a CME accredited Geriatric Symposium for providers a number of years ago. The symposium has been extremely well received by the physician community in California and SCAN is now seeking certification for the same educational program in Arizona because the local medical community has expressed a strong desire for geriatric training. SCAN's Medical Director frequently consults with local geriatric residency programs for assistance and guidance in the development of the local symposium and for guidance with the day-to-day management of our diverse geriatric membership.

In October 2010, SCAN sponsored a CME presentation for clinicians on "Diet and Healthy Living" and "Evidence for Nutrition and Brain Fitness" at the geriatric symposium "Promoting Optimal Outcomes in Aging." In CYE 2011, the plan, under the guidance of the SCAN Medical Director, will continue to work collaboratively with the Arizona Geriatric Society in an effort to bring useful educational presentations to our providers.

Additionally, in 2011 SCAN will continue to enlist the support of its Geriatric Advisory Board to identify national best practices in geriatric care and to share this information with providers in an effort to improve medical outcomes for members.

#### Monitoring

Network accessibility, availability and quality are continually monitored. Network Management is responsible for conducting on-site provider visits in accordance with the following schedule:

- Semi-annual visits to PCPs

- Annual visits to ARFs, HCBS organizations, behavior health providers and SNFs with assigned members
- Semi-annual visits to major ancillary providers
- Annual visits to all other providers with encounters in each representative's assigned area.

The purpose of the site visits is to determine contractual compliance, including but not limited to, appointment availability/wait times, physical environment of physician's office or residential facility and service delivery documentation.

If a provider's office needs immediate attention, the Network Management staff makes themselves readily available for assistance to that office. In addition, Network Management staff is available for ad hoc visits or group meetings whenever needed to clarify policies, address provider concerns and provide training as necessary.

Staff from other departments may accompany Network Management representatives on site visits in order to provide specific information and education to providers. An example would be Medical Management staff offering information on clinical guidelines.

#### Availability

The health plan routinely performs an analysis of provider availability utilizing GeoAccess®. Information obtained through the availability analysis is used by the health plan to manage and monitor the network throughout the year, and to focus recruiting efforts. The results of the availability analysis are reported to the NMC for review and action as necessary.

If deficiencies are identified, the cause and any opportunities for improvement are determined, and responsibility for interventions assigned. Effectiveness of the interventions is the basis for determining success. The health plan analyzes plan-wide member and provider data to measure availability standards through the following:

- The annual availability analysis includes a radius analysis of PCPs, pharmacies, hospitals and high volume specialties, and a review of the percentage of open/closed PCP panels. Key cities and zip codes without the desired access will be identified by specialty so that focused recruiting efforts may be made.
- SCAN has available a summary of the network that can be sorted by zip code, grouped by specialty and sorted by language(s) spoken. This information is available to all internal staff, including but not limited to, Medical Services and Case Management.

#### Review of Provider Geographic Distribution

Comparison of the provider network to community norms is performed periodically by reviewing HMO commercial provider networks. This effort will coincide with ongoing recruiting.

#### Review of PCP to Member Assignment

Open panels are monitored on a quarterly basis to ensure adequate availability to members. The health-plan established standard is to have 80 percent or more of its PCP panels open at any given time. A report is generated monthly to monitor this standard.

#### Accessibility

Appointment scheduling and wait time are monitored during the scheduled site visits. The Network Management representative interviews appropriate staff regarding appointment availability and wait times using the AHCCCS standards below.

Primary Care

Emergency PCP appointments – same day of request or within 24 hours of the member’s phone call or other notification, or as medically appropriate  
 Urgent care PCP appointments – within 2 days of request  
 Routine care PCP appointments – within 21 days of request  
 Scheduled appointment wait time –within 45 minutes

Specialty Referrals

Emergency appointments – within 24 hours of referral  
 Urgent care appointments – within 3 days of referral  
 Routine care appointments – within 45 days of referral  
 Scheduled appointment wait time –within 45 minutes

Behavioral Health Services

Emergency appointments – within 24 hours of referral  
 Routine appointments – within 30 days of referral

Dental Appointments for member under age 21

Emergency appointments – within 24 hours of request  
 Urgent appointments – within 3 days of request  
 Routine care appointments – within 45 days of request

Maternity Care

First trimester – within 14 days of request  
 Second trimester – within 7 days of request  
 Third trimester – within 3 days of request  
 High risk pregnancies – within 3 days of identification of high risk by SCAN or maternity care provider, or immediately if an emergency exists

In addition to the on-site monitoring at provider visits, SCAN may periodically conduct “secret shopper” surveys to ascertain compliance with appointment scheduling. This process involves calling contracted providers with SCAN encounters anonymously and asking about appointment availability. Network Management provides written communication to the providers with the results following the survey. If the provider is found to be non-compliant, they are educated on the appointment availability requirements and re-surveyed within ninety (90) days.

SCAN conducted a “secret shopper” survey during the last two weeks in December 2010 and the first two weeks in January 2011. Providers were randomly selected based on submitted encounters. Overall, 93 percent of providers surveyed were found to be compliant.

Providers are educated about appointment standards through the SCAN provider newsletter and regular network mailings. Language regarding Appointment Availability and Accessibility has also been added to the PA letters sent to all providers, both contracted and non-contracted, when a PA is given by SCAN.

<i>Provider Type</i>	<i>Number Surveyed</i>	<i>Standard Met</i>	<i>Standard Not Met</i>	<i>% Compliance</i>
Primary Care Provider	98	90	8	92%
Specialist	76	73	3	96%
Dental	5	5	0	100%
Behavioral Health	5	4	1	80%
TOTAL	184	172	12	93%

### *Medically Necessary Non-Emergent Transportation*

SCAN requires its non-emergent ground transportation providers to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment, and does not have to wait more than one hour after making the call to be picked up for transportation home.

In the recent Member Satisfaction Survey conducted during the third quarter of 2010, 83 percent of SCAN members who responded stated that they were never late to an appointment due to transportation.

### *Members Who Do Not Keep Scheduled Appointments (No Shows)*

A major barrier to recruiting providers is convincing them that SCAN has a solution to the patient “no show” problem. This problem has been prevalent in the AHCCCS and ALTCS populations for many years and providers have grown very weary of it. SCAN recognizes this problem and has taken a number of proactive steps to resolve the issue:

- SCAN arranges for more in-home physician and service visits to support our frail, elderly and disabled populations. To date, these home visits include primary care, behavioral care and HCBS services.
- SCAN CMs work closely with their members to educate them about the importance of keeping all appointments to their continued well being. Members are instructed to contact the provider at least 24 hours in advance if they cannot make an appointment.
- SCAN has significantly upgraded its transportation services by adding Dependable Medical Transport, Phoenix EI Transportation, Garaby’s Transportation Services and Sunflower Transportation. This has resulted in more members being transported on time to their appointments, resulting in fewer no shows.

These improvements and our continued vigilance will continue to result in fewer no shows.

### *Additional Monitoring Measures*

The health plan assesses performance against standards in a variety of ways including:

#### Member Grievances

Health plan staff document, research and follow-up as appropriate on member issues that relate to dissatisfaction with care and services, such as wait times and appointment standards. The QM Department tracks quality of care complaints against providers on a quarterly basis. A QM representative sits on the Grievance Committee and keeps abreast of grievances. When individual provider trends are noted, the provider is referred to the QM/UM Committee and Network Management Department for additional follow-up and referral to the Credentialing and Peer Review Committees at the discretion of the Medical Director. Aggregate information is presented to health plan quality committees on a quarterly basis for review and action as necessary.

#### Member Satisfaction Surveys

SCAN strives to complete an annual mail-in survey of our membership that references their satisfaction with any number of health plan functions, including the adequacy of the provider network. SCAN conducted a member survey in the third quarter of 2010. The survey results were received and presented to Executive Management and submitted to AHCCCS for approval.

#### Case Management

Case Management has been, and will continue to be, actively involved in assisting providers with coordination and continuity of care for members. Case managers report providers who are unwilling to assist in coordination and continuity of care to Network Management Services. Network Management



reviews the contractual and AHCCCS requirements for both coordination and continuity with the provider involved in order to provide appropriate education and/or training..

#### Prior Authorization Unit

The Prior Authorization Unit, in conjunction with the Medical Director, regularly reviews the use of non-contracted providers and submits a listing of network needs to Network Management based on this report. In addition, the Hospital Concurrent Review nurses, working in conjunction with the hospitalist program, provide feedback to Network Management regarding specialty services needs. For services unavailable within the network, the health plan allows non-network providers to provide services to members through the current episode of care.

HCBS, institutional and behavioral health provider network capacity is monitored on a regular basis. SCAN continues to focus on the enhancement of our behavioral health network to ensure members have access to these services. There are no current access barriers to behavioral care providers.

#### Quality

While availability and accessibility are critical components to an effective service delivery system, timely review of quality of care is equally as important. Medical Management continuously monitors and profiles physician utilization to assure quality of care. Medical Management collects and analyzes the following clinical data:

- medication formulary prescribing patterns
- Patient emergency visitations
- Specialty referral patterns
- Inpatient hospital admissions and re-admissions
- Lab and radiology referrals

This data is compared to the utilization patterns of peers within the GSA. The QM/UM Committee and the Medical Director evaluate this data to facilitate proper resolution and address outliers.

#### *Department Coordination*

The overall goals of Network Management are to offer a provider network of the highest quality, and to ensure that ALTCS and health plan standards are met through regular communication, education and ongoing monitoring of the network. This occurs internally through health plan departments working in conjunction with Network Management to guarantee customer satisfaction for both members and providers.

Network Management has primary responsibility for the development and management of the provider network through contracting and monitoring, and for ensuring network adequacy through evaluation of network capacity, availability and accessibility. Network Management maintains a staff of sufficient size to oversee the development, contracting, maintenance and monitoring of the SCAN provider network.

SCAN recognizes the critical need for the collection, integration and coordination of provider related information from other departments. Network Management participates on numerous committees in order to secure the information and data necessary to compliment the work processes of these departments.

In addition to internal sources, SCAN also relies on external sources to monitor the adequacy of the network.

To effectively coordinate the flow of provider information, SCAN established a Network Development and Management (ND and M) Committee. The committee is comprised of representatives from Network Management, QM, MM, Prior Authorization, Claims, Appeals and Grievances, Compliance, Executive Management and Case Management. The committee, chaired by the Vice President of Network

Management Services, meets monthly to assess the network's adequacy. Meeting agendas generally encompass the following:

- Review and development of the SCAN provider network
- Identification of special health care needs by the Case Management or Medical Management departments
- Review of the Network Development and Management Plan objectives
- Provider availability and accessibility
- Review of network zone compliance
- Review of Network staffing
- Review of new or revised policies and procedures impacting providers
- Review of terms, conditions and/or restrictions relative to new or amended contracts
- Review of network gaps and limitations, including behavioral health or any special needs populations
- Review of provider issues and trends

The Committee Chair is responsible for reporting committee findings, actions and recommendations to Executive Management and the Board of Directors on a regular basis.

#### *Coordination with Outside Organizations*

SCAN understands the importance of, and is committed to, active and collaborative involvement with community organizations and public entities in fostering improved care and services for the elderly frail, physically disabled and socio-economically disadvantaged. SCAN has established relationships with FSL and the Area Agency on Aging, Region One. The plan has joined the Arizona Health Care Association (AHCA) as a Business Associate member to better understand the needs and concerns of the nursing home industry in Arizona. SCAN will continue to enhance our existing partnerships with the following organizations and entities:

- Arizona Bridge to Independent Living (ABIL)
- Arizona Health Care Cost Containment System
- Arizona Department of Health Services
- Children's Rehabilitative Services
- Maricopa Special Health District
- State Health Insurance Assistance programs (SHIP)
- Magellan – the Maricopa County Regional Behavioral Health Authority
- Various religious organizations with specialized senior programs such as Beatitudes.

In addition to developing and maintaining collaborative relationships with the aforementioned organizations, SCAN believes that a managed care organization like SCAN has a responsibility to serve as a community information and referral resource for members and non-members alike. Accordingly, SCAN has developed a comprehensive Community Resource Directory and has established the SCAN Connections Resource Center within its office to educate and direct members, non-members and their families to community organizations, programs and activities that will enhance their health, independence and well being.

#### *Direct Workforce Initiatives*

SCAN recognizes the critical role that the direct care workforce plays in a long term care system, and the myriad challenges associated with recruitment and maintenance of qualified and trained para-professionals in this field. SCAN believes that long term care plans have an obligation to actively support this initiative to ensure ongoing quality of care for its members.

SCAN continues our efforts to assist in relieving the financial burden for direct care workforce caregivers by offering quarterly First Aid/CPR training classes at no cost to them. SCAN partnered with Gateway Community College for the “Arizona Caregivers Night: Together we Care” event held August 6, 2010, at the US Airways Arena. The Expo/Job Fair was held to increase awareness of and appreciation for Arizona caregivers. SCAN sponsored a presentation on providing excellent customer service and a second session on Trading Ages™, educating people on the effects aging has on the person. Additional workshops/demonstrations were held on managing stress, what makes a good caregiver, First Aid/CPR and other important topics. Approximately 600 people attended. SCAN will continue to work with community partners in supporting and educating the community.

### *Emergency Department Use Reduction Strategy*

SCAN recognizes the critical need for members to receive medical care in the right setting, and believes routine care should be provided at PCP offices and not at emergency departments (EDs). To reduce unnecessary ED utilization, SCAN has developed and will continue to implement the following protocols, practices and programs.

### *Membership Education*

The SCAN Member Handbook contains a definition of emergency services and information about proper usage, requesting emergent/urgent PCP appointments and urgent care availability. SCAN CMs are responsible for ensuring that members receive a member handbook and understand the information. Member Services is available to respond to any member inquiry, and all member collateral materials and correspondence include the Member Services contact information.

### *Provider Contracts*

SCAN provider contracts require PCPs to provide coverage on a twenty-four (24) hour per day, seven (7) day per week basis. In addition, emergency PCP appointments will be on the same day or within twenty-four (24) hours of the member’s notification, or as medically appropriate.

### *Provider Education*

The SCAN Web site, which is available to PCPs, has information on coverage requirements and the names and locations of Urgent Care centers. Network Management representatives also highlight proper ED usage during the provider orientation session and subsequent training. Primary care providers assist members in understanding the different levels of care and the proper setting for receiving each level of care (routine, urgent and emergent).

### *Utilization Monitoring*

Hospitals are required to notify SCAN within ten (10) days of a SCAN member receiving ED services. SCAN currently collects and analyzes this data on a routine basis to detect any physician trending patterns. Physicians whose patients frequent the ED may be contacted to ascertain the cause (i.e. patient education, panel capacity, etc.) and to request corrective action. Physicians electing to not cooperate with SCAN in the reduction of inappropriate ED usage may be terminated from the network.

### *SCAN On-Call*

This program provides access to registered nurses twenty-four (24) hours per day to assist members in making the right decisions about their health. SCAN members can speak to a registered nurse to ask about a medical condition, learn about a medication or determine whether they should contact a medical professional. The nurses use the Utilization Review Accreditation Commission’s (URAC’S) accredited, symptom-based algorithms. The nurses neither dictate nor act as a barrier to accessing care. The nurse assists members in receiving the right service at the right time from the right location through informed decision-making. SCAN On-Call is not intended to replace the advice of the member’s physicians.

However, the service provides SCAN members quick access to health information any time of the day or night.

The collective effect of this multi-faceted approach will be to minimize unnecessary ED usage.

### *Significant Barriers to Efficient Network Deployment within the Service Area*

AHCCCS budgetary constraints may cause a hardship for HCBS providers within the community due to reduced pricing while at the same time they are experiencing increased costs of care. Potentially this could cause a work force shortage for certain provider types and could become a potential barrier to our zone compliance. Secondly, there is a shortage of certain physician specialists in Maricopa County. These specialists include gastroenterology, urology, dermatology, oral surgery, infectious disease, neurosurgery, rheumatology and pain management. While AHCCCS may not be in a position to rectify this situation through recruitment efforts, it could assist in increasing provider awareness of this network issue.

### Preventing the Loss of a Facility

Preventing the closure of a contracted facility is a primary goal for Network Management. Network Management reviews various tools in efforts to be proactive in identifying homes that may have a potential for closing or termination. Arizona Department of Health Services licensure information, and/or sanction notices, as well as internal feedback from Case Management and Quality Management, are reviewed on a regular basis. In addition, Network Management staff visits these facilities on a regular basis and documents these visits on the Provider Visit form. Part of each visit is dedicated to making observations that could alert the plan to a potential quality of care issue or closure. SCAN also benefits from the observations of its CMs who routinely visit SCAN members in these facilities as part of the care management process.

When alerted of a potential closure or termination,, SCAN staff may take a number of steps to attempt to avoid the termination. Initial steps may include:

Outreach by Network Management and/or Quality Management staff to the provider to educate and assist in process improvement efforts, issue resolution and/or requests for a Corrective Action Plan (CAP) when appropriate. Network Management may also place a hold on new admissions to the facility until areas of concern are addressed and resolved.

When possible, SCAN's goal is to preserve the facility relationship and avoid closure to eliminate any disruption to the member's services.

### Managing the Loss of a Facility

However, there are times when a facility closure is imminent or occurs. For those times, SCAN has implemented both a policy and desktop procedure for handling these situations in order to minimize disruption for the member, ensure a smooth transition and assure that their needs and wishes are appropriately met. SCAN understands that this can be a very traumatic event for the member and will utilize this process to communicate to all parties involved and will work with the member and their family to minimize the impact and to identify another contracted facility which best meets the members' needs.

SCAN achieves this by following the steps outlined below:

- Any SCAN employee receiving notification of an imminent or voluntary closure of a facility must immediately notify the Vice President of Case Management or designee.
- At this point, the use of the Closure Tracking Log is implemented. The log was created as a means of collecting all pertinent information in one centralized location for staff to document steps and updates throughout the transition process. The tracking log contains pertinent information regarding the

facility closure, notifications, members affected, member move checklist and communication log. The log allows other individuals to obtain current and up-to-date information on the members involved, communications received from all parties and steps taken by SCAN staff during the process.

- Next, the Vice President of Case Management will notify Executive Management and the managers of Case Management, Network Management, QM, MM, and Member Services of the facility closure. On the date of notification, the group may convene to discuss the closure and begin to strategize the next steps.

The Network Management Services Vice President will verbally contact the provider within one (1) business day to review closure notification and will also review the impact the closure will have to the SCAN network to determine whether the closure results in a material change. If it is determined that it will, and there is no other contracted provider available, SCAN will cover these services in a timely manner through an out-of-network provider until a suitable network provider is located.

In addition to notifying AHCCCS of the facility closure immediately, SCAN will also notify ADHS and other program contractors, if they have not already been notified, immediately or within one (1) business day of notification of any unexpected changes that could impair its provider network. Alerting all parties involved is critical to the success of this process

SCAN Case Management and MM staff coordinate their efforts in identifying members in the facility, any high risk member needing special placement or transportation and any member who may be an inpatient during this time. If a member is inpatient, CM or MM staff will contact the hospital discharge planners to advise of the closure and to coordinate discharge plans.

SCAN CMs, the Medical Director and MM staff will ensure that every possible medical and psychological need of the member is anticipated. These needs will be determined through a meeting with the member and their family as far in advance of the transfer as possible. The team will determine the best possible transfer location for the member, taking into consideration the following:

- member's health care requirements
- the travel capacity of the member
- convenience of the location to the family.

SCAN staff evaluates and determines if the PCP assignment needs to be modified and whether there are potential risks to the member. If so, on-site support services such as Home Health or Attendant Care are used.

CM staff determines if there are potential risks to members and provides additional on-site support services, such as home health, attendant care, etc.

Case managers also provide on-site supervision of the move to ensure that medications, chart materials, member belongings, medical records and any DME are transferred with the member. The CMs complete the Member Transition Checklist to track all member belongings and information so that it is accounted for in the transition to the new facility.

A master list of members and their new location will be compiled by QM and made available to AHCCCS.

Within seven (7) business days of the move, SCAN CMs will follow up with the members for an on-site review to discuss any outstanding issues and determine if the member is satisfied with the placement.

Network Management completes the formal termination notification to the provider and sends appropriate communications system-wide to alert all SCAN staff of the facility termination.

Finally, all SCAN staff involved in the facility closure process will reconvene after the move to evaluate the process and identify success and opportunities for improvement.

SCAN's primary goal is to prevent a Nursing or Assisted Living facility closure whenever possible. However, there are times when this cannot be achieved. When SCAN is notified of a facility closure, we have an identified procedure in place to handle the process from beginning to end..

#### *Natural Disasters*

In the event of a natural disaster, SCAN's Business Continuity Plan will be executed. Staff will immediately perform a detailed network analysis in order to assess the situation, including determining the type and the number of services immediately needed by the members, and will review available providers in the community who can meet these needs. Protocols will be enacted using the coordinated efforts of all involved departments. In preparation for an unanticipated event, SCAN will develop a Contingency Plan for each nursing home and alternative residential home provider, including a secondary line of contracted providers.

#### *CONCLUSION*

SCAN Network Management Services is committed to providing an adequate, accessible, and quality network to our members. We will continue to be an advocate for our members and the community at large. Member and provider education will continue to ensure compliance and quality of all delivered services. We welcome all input from members, providers and AHCCCS in order to continually improve our services, our quality of network and the satisfaction of our members.

*Requirement 37: Network Launch*

---

SCAN Long Term Care is an Incumbent Contractor and, therefore, is exempt from this requirement.

### *Requirement 38: Provider Communications*

---

SCAN Long Term Care (SCAN) recognizes the critical importance of maintaining effective, meaningful provider communication channels to ensure mutually satisfactory partnerships for the benefit of our ALTCS members. SCAN maintains a dynamic, integrated communication process that involves all departments and includes a formal provider communication, training, and support program that includes oral and written communications to inform providers of program standards, applicable federal and state laws, and health plan policies and procedures.

SCAN assigns each contracted provider to a Network Management Services representative, who is available to explain program standards, changes in laws and regulations, and changes in subcontractor requirements. If a provider's office needs immediate attention, staff are available during regular business hours to assist. For after-hours issues related to members' care, the department maintains an on-call answering service and returns such calls within 30 minutes.

Plan requirements, updates, and changes that affect the provider community are communicated to the network through one or more of the following: provider orientation visit, the SCAN Provider Operations Manual; the SCAN provider contract; provider maintenance visits, SCAN Insights (provider newsletter), the SCAN Web site Provider Tools page, direct mailings or "blastfax" communications to providers, Joint Operations Committee meetings with providers; provider group training, and continuous medical education (CME) training for physicians.

#### *Provider Orientation*

A Network Management Services representative conducts a new provider's orientation within 60 days of the provider's contract effective date. During the orientation the representative provides a comprehensive review of SCAN operations, the ALTCS program standards and requirements, including but not limited to reviewing the Provider Operations Manual, and educates the provider on the prior authorization process, claims and billing, coordination of benefits for dual members, the role of case managers, fraud and abuse, cultural competency and key contact information.

The representative continues to support the provider with updates on program and subcontractor changes through ongoing provider visits that are scheduled throughout the year. In addition, the representative will continue to be available to respond to questions or concerns the provider may have as they come up.

#### *Provider Operations Manual*

The SCAN Provider Operations Manual offers contracted providers a comprehensive description of the SCAN long term care program and requirements as well as AHCCCS-required subjects, including applicable laws and regulations. The manual provides the basis for initial provider training and is intended to be used as a reference guide by provider offices. The manual is updated annually or more frequently if required to incorporate updates and changes to SCAN long term care and AHCCCS programs. The manual is available to providers through the SCAN Web-site and in hard copy if requested.

#### *SCAN Provider Contract*

SCAN notifies providers of any changes to applicable laws and regulations prior to their enactment. A formal contract amendment process will be employed to incorporate such changes into the legal document. Likewise, any changes in contract terms and conditions will follow the same process. Contracts and contract amendments require the signature of the authorized representative of each party.



### *Maintenance, Education, and Training Visits*

Network Management Services staff schedule regular meetings on an individual and/or group basis to provide outreach and share educational materials with providers. Provider visits and the information reviewed are documented on the Provider Visit form. The department has established benchmarks for the minimum number of on-site visits, as follows:

- Semi-annual visits to primary care providers (PCPs)
- Annual visits to assisted living centers, homes, home and community based service (HCBS) organizations, behavior health providers, and nursing homes with assigned members
- Semi-annual visits to major ancillary providers
- Annual visits to all other providers with encounters in a representative's assigned area.

### *Additional Communication with Providers*

#### SCAN Insights Provider Newsletter

Another method of communicating with the provider network is through SCAN Insights, the provider newsletter. SCAN mails the newsletter to contracted providers semi-annually. The newsletter includes plan regulatory requirements and updates, information regarding policy and procedure changes, and information about topics of importance for providing services to SCAN members.

Past newsletters have addressed such topics as healthy nutrition for seniors, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) reminders, the Medication Administration and Documentation (MAD) project, ALTCS benefit changes, direct workforce updates, flu prevention information, diabetic screenings, reporting fraud and abuse, disease management, advance directives, multi-cultural competency tools, correct coding and encounter validation studies, Claims Corner, and information on electronic billing

#### SCAN Web Site Provider Tools

Requirements, updates and changes to the provider network are also posted on the SCAN Web site Provider Tools page ([www.scanhealthplan.com/article/arizona/physicians.html](http://www.scanhealthplan.com/article/arizona/physicians.html)). The Provider Tools page is an effective means of communicating with the provider network and is available 24 hours a day, seven days a week. SCAN offers free Web-based continuing medical education (CME) activities designed for the specific needs of frail and elderly persons, including the physically disabled, such as those who are enrolled with ALTCS. The CME programs are available to contracted and non-contracted providers and may be found through the Provider Tools page.

#### Provider Mailings and "Blast fax" Communications

While SCAN continues to look for innovative ways to communicate with providers, we may also use standard provider mailings or "blast faxes" to broadcast information to the provider network.

#### Provider Group Trainings

Provider group trainings are also an effective way to convey information to the provider network. SCAN has used such trainings to educate the provider network on assisted living requirements and expectations, HCBS providers about non-provision of service requirements, and physicians regarding correct coding.

### *Summary*

One of the main responsibilities of Network Management Services is to ensure that the SCAN network of providers are trained on the standards of the program, changes in laws and regulations, and changes in contractual requirements. The department will continue to educate the network through provider orientation and regular visits, provider tools; such as the Provider Operations Manual and the SCAN Web site, as well as through continuing open communications between SCAN and the provider network.

### *Requirement 39: Communicating Information about Providers*

SCAN Long Term Care (SCAN) Network Management Services oversees the development, maintenance and monitoring of the provider network. Network Services is responsible for managing the provider network relative to contracting and ensuring network adequacy with respect to capacity, availability and accessibility in accordance with AHCCCS network standards. This is achieved by building relationships with contracted providers to educate them on SCAN's requirements and responsibilities and improve operational efficiencies. This, along with fostering open lines of communication among the various internal SCAN departments, such as Case Management, Quality Management, Member Services, Medical Management, Claims, and Grievance and Appeals, promotes a strong environment in which to gather information and share it with appropriate staff when issues or concerns are identified.

#### **Network Development and Management Committee**

SCAN recognizes the need to integrate and coordinate information relative to provider performance and to effectuate the necessary corrective action to ensure quality care for ALTCS members. To effectively coordinate provider information, SCAN has established a Network Management Committee. The committee is comprised of representatives from Network Management Services, Quality Management, Medical Management, Compliance, Operations, Grievance and Appeals, and Case Management, as well as the medical director. The committee, chaired by the vice president of Network Services, meets monthly to assess the network's adequacy in providing ALTCS covered services in accordance with AHCCCS requirements and SCAN standards. The meeting agenda includes, but is not limited to, the following:

- Review and development of the SCAN provider network
- Identification of special health care needs by Case Management or Medical Management
- Review of the Network Development Plan objectives
- Provider availability and accessibility
- Review of network zone compliance
- Review of network staffing
- Review of new or revised policies and procedures impacting providers
- Review of terms, conditions and/or restrictions relative to new or amended contracts.
- Review of network gaps and limitations, including behavioral health and special needs populations
- Review of provider issues and trends

The committee chairperson is responsible for reporting committee findings, actions and recommendations to the executive team on a regular basis.

In addition, interdepartmental meetings are held weekly to review provider claims issues, trends, provider call tracking data, and system updates.

#### **Gathering Information Needed to Manage the Network**

SCAN utilizes several approaches to gather information needed to manage the network and ensure that the network has the capacity to provider services to the ALTCS population. SCAN routinely analyzes the network through the use of GeoAccess® reporting. This tool allows the Network Department to plot out the providers against the membership and assists in identifying network gaps. This tool is also utilized to make sure that dual eligible members have access to both Medicare and Medicaid benefits which ensure the seamless delivery and coordination of care and benefits. Because approximately 80 percent of our ALTCS members are enrolled in our Special Needs Plan, SCAN continually monitors to see that the needs of these members are met.

Making sure providers are available and accessible to our members is another critical function of network management. To this end, SCAN uses several methods to routinely monitor network access and availability, including a secret shopper survey and again during routine office visits conducted by the provider services representatives. Providers who are noncompliant with the established appointment requirements are educated and re-measured to ensure they meet standards. Aggregate data related to provider availability is reported to the QM Committee semiannually. If areas of the network consistently perform below the appointment standard, SCAN will take action to augment the network as needed.

A key area of focus is the alternate residential setting component of our network. SCAN works to make sure the network includes an adequate number of quality assisted living facilities for members who prefer the least restrictive setting. SCAN has formed a work group to monitor contract compliance, quality issues, and oversight reviews of our contracted assisted living homes. A collaborative effort between Network Management, Case Management and Quality Management, the work group proactively shares information and jointly identifies homes to be considered for contract termination based on their performance. Based on the analysis of this data, the work group will forward recommendations for contract termination to executive management as indicated.

In addition, SCAN's Quality Management Department participates in the Nursing Facility Review Collaborative (NFRC). This group shares responsibility for reviewing skilled nursing facilities across contractors and sharing information about the findings as well as any quality of care issues. The QM Department reports the results of this review in aggregate to the QM Committee. Individual facilities with concerns that require corrective action may be contacted by the Network Management Department as indicated. The NFRC is currently working to expand the process to assisted living centers shared across contractors. It is scheduled to roll-out in 2012. Through the collaborative, SCAN is better able to proactively address provider issues and make network management decisions appropriately.

#### *Inter-departmental Coordination*

To effectively monitor and manage the provider network, SCAN recognizes the critical need for the collection, integration, dissemination and coordination of provider related information from other departments within the organization. Provider issues are identified throughout the organization including but not limited to: occurrence reporting through the Quality Management Department, member grievances, provider complaints, medical management interactions and network management operations. Communication of issues varies depending on the complexity and nature of the issue.

Case Management (CM) staff report provider related issues to either Network Management Services representatives or to Quality Management staff, depending on the nature of the issue. When appropriate, Case Management staff assist in filing grievances on behalf of a member.

#### Example of Interdepartmental Communication

A SCAN LTC member was unable to schedule an appointment within the AHCCCS-required time frame. The member's case manager notified the Network Management Services representative who contacted the provider to educate him/her on the appointment availability and accessibility standards. The Network Management Services representative re-surveyed the provider in 30-60 days and the provider was found to be compliant. If the provider had continued to be noncompliant with the appointment standards, a corrective action plan (CAP) would have been requested from the provider.

The Members Services Department assists with the network monitoring process by identifying and processing member-requested primary care provider (PCP) changes and addressing member complaints on a provider specific basis. Member Service representatives and CM staff assist members with filing grievances and forwarding them to the Grievance and Appeals specialist and/or Network Management Service representatives. The Grievance and Appeals specialist reports member complaints about providers to a Network Management Services representative and forwards a copy of any quality related complaints to QM staff. These departments work closely together to resolve member complaints.

Quarterly Grievance and Appeals Committee meetings address issues, track outcomes, and monitor provider issues in addition to monthly Network Management Committee meetings, which also meets to review and address network identified issues.

The SCAN compliance officer reports any provider fraud and abuse cases that have been filed with AHCCCS to Network Management Services Vice President or designee.

Quality Management staff report on provider concerns and information gathered during site visits.

SCAN also reviews the quarterly letter from the AHCCCS Division of Health Care Management identifying PCPs with member panels (for all plans in aggregate) exceeding the AHCCCS member panel capacity standard of 1,800. The QM Committee, which oversees credentialing activities, evaluates these providers in terms of quality and accessibility, and determines if a corrective action is necessary. If deficiencies are noted, SCAN addresses a possible reduction in panel size. If corrective action is warranted, QM staff notifies the Member Services and Network Management Services representative of the action. Examples of corrective actions may include moving members from a provider's panel or closing/reducing a provider's panel.

The Claims department staff reports any abnormal or aberrant claim submissions on an individual and collective basis (e.g. hospital outliers) to Network Management Services Claims Coordinator for investigation. Trends are also communicated at the weekly interdepartmental claims meeting.

Network Management Services staff reviews Provider and Member Satisfaction Surveys to identify any network adequacy issues. These findings are shared with the Executive Team and the survey results may serve as a tool to identify process improvements for administering the provider network, potential quality of care complaints that require investigation and validation of processes in place are providing the information needed to comply with the contract requirements.

### *Summary*

Understanding the importance of interdepartmental communication Network Management Services works closely with other SCAN departments maintain open communications and cultivate an integrated information structure related to provider compliance, performance and service to SCAN LTC members

### Requirement 40: Inquiries, Complaints and Requests for Information

SCAN Long Term Care (SCAN) considers provider network stability the cornerstone of a viable managed care organization. As such, SCAN understands the need to formulate and maintain mutually beneficial business partnerships with all network providers. SCAN clearly articulates the respective roles, responsibilities and performance expectations of both parties and provides leadership to align plan and provider interests for the benefit of members. This continues to be achieved through contractual terms and conditions, operating manuals, policies and procedures, collaboration, and training. Most importantly, the plan must consistently perform its responsibilities and meet or exceed the providers' expectations to ensure satisfaction and retention.

Substantial turnover is generally indicative of a provider's dissatisfaction with the plan's ability to meet anticipated expectations (e.g., inaccurate or untimely payments, non-responsiveness to service related issues, etc.). Constant provider network changes are disruptive to health plan operations, and more importantly, they interfere with the continuity of members' overall care.

SCAN employs three primary mechanisms to assess provider satisfaction. These methods include: 1) the tracking and trending of provider inquiries, requests for information and complaints via the provider call tracking database; 2) contract termination reasons; and 3) an annual provider satisfaction survey.

#### *Tracking and Trending Provider Inquiries, Requests for Information and Complaints*

SCAN Network Management Services has developed a policy and procedure which specifically addresses the process of tracking providers' calls to Network Management and Claims staff, to ensure that provider inquiries, requests for information and/or complaints are handled effectively within the time standards set forth by AHCCCS.

SCAN tracks provider calls to ensure that providers receive timely responses to their inquiries, requests for information and complaints.

- If a provider is unable to reach a live person, their call is acknowledged within three business days of receipt.
- Providers' issues are resolved within 30 business days of receipt.
- If unresolved within 30 business days, SCAN notifies the provider and documents why the issue goes unresolved.
- Finally, steps are taken to ensure full resolution within 90 days of receipt.

When a provider call is received by SCAN Network Management or Claims staff, either via an incoming call or a voice message, the employee receiving the call logs it in the AZ Provider Call Tracking Database. The call type, category, and reason for call are captured for each call received. Provider call reports are reviewed weekly by the Network Management Services manager or designee to monitor resolution time-frames.

Call trends are reviewed to identify areas of provider education opportunities, internal system enhancements; and process improvements. Identified claim trends are then reviewed at the Claims meetings and Network/provider issues are reviewed at the Network Management Services Committee meeting.

Provider calls received by other departments, such as Member Services, or Medical Management, pertaining to a Network Management Service issue, request for information or complaint are forwarded to the appropriate Network Management Service representative for follow-up and resolution.

Tracking provider complaints and grievances can provide an early warning sign of dissatisfaction and must be addressed promptly and responsibly to the satisfaction of the provider. SCAN recognizes that

there will be instances where the plan will uphold its position, but the plan has an obligation to substantiate, document, or defend the reasoning behind the decision to the provider in a professional, reasonable, and appropriate manner. SCAN has implemented operational protocols to systematically and routinely monitor verbal and written provider complaints and grievances and establish procedures to promptly resolve the issues. SCAN tracks provider inquiries, requests for information, and complaints to detect trends that may indicate a systemic operational deficiency that would require immediate attention. SCAN considers the provider call tracking procedure a means to resolve problem and as a continuous quality improvement initiative.

### *Monitoring of Contract Termination Reason*

SCAN also monitors the reasons for contract terminations, as they may indicate failures in the provider problem resolution process. Typically, health plans simply accept the reasoning offered by the provider to the Network Services Representative. A SCAN Network Management Service representative will review the reasons for contract terminations to determine the impact on the provider network and, if appropriate, will outreach to those providers to attempt to reverse the decision to withdraw from the network. This intervention may also include an interdepartmental review to incorporate input from the plan medical director, vice president of Case Management, compliance officer or the Grievance and Appeals specialist, and vice president of Network Management Services, to allow for an independent assessment of the event.

### *Provider Satisfaction Survey*

SCAN conducts an annual Provider Satisfaction survey to elicit feedback from the provider network and evaluate the level of satisfaction with the organization's services in several areas. SCAN has offered providers the opportunity to respond to the survey either by mail or electronically.

The Provider Satisfaction Survey tool was developed by an inter-disciplinary team of key management personnel to assess providers' satisfaction in the following areas:

- Network management and customer service satisfaction
- Provider training
- Information offered to providers
- Accuracy of claims and process
- Referral and authorization process
- Case management satisfaction
- Available information on SCAN Web site and provider tools page
- Knowledge of translation services available to SCAN members
- Member issues
- Health plan issues
- Pharmacy and formulary
- Adequacy of the specialty/ancillary provider network

The questions included in the Provider Satisfaction Survey were written to gather feedback from the network regarding overall plan performance. The questions were similar to the previous year's survey in efforts to establish baselines for each targeted area. Specific questions applicable to the areas noted above will be incorporated in the survey. Service ratings are measured based on following categories of response:

- Strongly agree
- Agree

- Neutral
- Disagree
- Strongly disagree
- Not applicable

Once the survey is completed, the results of the survey are compiled and communicated to SCAN's Executive Team, Member and Provider Council, Quality Management Committee, and Board of Directors for the identification of improvement opportunities, development of appropriate actions and establishment of future performance measurements. These improvements, actions, and measurements are documented and incorporated into the annual Network Development and Management Plan in accordance with AHCCCS requirements.

### *Summary*

SCAN is committed to the development and maintenance of a stable, viable provider network. Through the aforementioned mechanisms of tracking provider inquiries, requests for information, and complaints; monitoring provider termination reasons; and through the Provider Satisfaction Survey SCAN is dedicated to enhance provider satisfaction, streamline operational efficiencies, and minimize provider turnover, ultimately providing a more stable provider network to SCAN members.

## *Requirement 41: Provider Services Staff Training*

---

SCAN Long Term Care's (SCAN) Network Management Services Department is responsible for developing and maintaining a contracted network that provides all covered services. The network consists of primary care providers (PCPs), specialists, skilled nursing, assisted living and other group home facilities, hospitals, home and community based services providers, behavioral health providers, and ancillary providers. Each contracted provider is assigned a Network Management Services representative who will serve as a vital link to SCAN's operations. Network Management Services also conducts training activities and keeps providers informed of their contractual responsibilities.

Just as important as educating our SCAN network of providers with the most accurate and up-to-date information, it is equally important to ensure that the SCAN Network Management Service staff have the proper tools needed to do their job to the highest level of service. When new staff members are added to Network Management Services, the network management training described below is completed within thirty days of the hire date in addition to the the required SCAN New Employee Orientation Training. The training information is reviewed with Network Management Service staff annually to be use as a refresher course on educational information available to them. Staff training is also reviewed at the annual performance evaluation with Network Management staff.

### *Network Management Services New Employee Training*

Objectives for the overview and training of Network Management Services staff are to establish a clear understanding of the following:

- Regulatory programs
- Resources and tools available on the AHCCCS Web site
- Network Management Services Department policies and procedures
- Network Management Services objectives and requirements
- Plan benefits, member/provider responsibilities
- Resources and provider tools available on the SCAN Web site
- Provider call tracking requirement
- Network Management Services Department operations
- Other local department responsibilities and those delegated to corporate

The following items are reviewed with Network Management Services new hires and annually for existing Network Management Service staff:

- Overview of AHCCCS
- Overview of ALTCS
- Overview of Medicare program
- Review of the AHCCCS Web site to include, but not limited to:
  - Fee schedules
  - Provider registration
  - National provider identifier (NPI)
  - Guides and manuals
    - Claims clues
    - AHCCCS Contractor's Operations Manual (ACOM)
    - Fee For Service Billing Manual
    - AHCCCS Medical Policy Manual (AMPM)
- Review of the AHCCCS contract
- Review of Network policies and procedures



- Review of the Network Development and Management Plan
- Review of the SCAN Provider Operations Manual, which included but not limited to:
  - Appeals and State Fair Hearings
  - Case Management
  - Claims and Billing
  - Cultural Competency
  - Fraud and Abuse
  - Members Rights and Responsibilities
  - Prior Authorization Requirements
  - Providers Roles and Responsibilities
  - Review of ALTCS covered services
- Review of the SCAN Web site and Provider Tools page ([www.scanhealthplan.com](http://www.scanhealthplan.com))
- Review of the Provider Call Tracking database and call tracking procedure
- Review of Network Management Service Department operations
- Overview of other SCAN department responsibilities
- Overview of department responsibilities which are delegated to the corporate office

#### *Shadowing Staff*

Another aspect of training for Network Management Services staff is that new staff members will shadow other Network staff to understand the various roles within the department and how all of the pieces fit together. Each Network Management Services staff member plays a critical role in the department's responsibility of recruiting, maintaining and educating the SCAN provider network.

#### *Ride-Alongs with Case Management Staff*

Network Management Services staff are encouraged to participate in ride-alongs with several of the staff from Case Management. This allows them the opportunity to go into the "field" and not only understand their role with the providers, but also how their role ultimately fits into the bigger picture of SCAN's mission of finding innovative ways to enhance seniors' ability to manage their health, provide choice, and to continue to control where and how they live.

#### *Summary*

SCAN Network Management Services will continue to provide comprehensive training to department staff to ensure adequate understanding of the regulatory requirements, plan policy and procedures, providers' responsibilities and tools available to effectively educate the provider network.



**NETWORK MANAGEMENT SERVICES (NMS)  
NEW EMPLOYEE TRAINING CHECKLIST**  
(All Training to be completed within 30 days of hire date)

Employee: \_\_\_\_\_

Hire Date: \_\_\_\_\_

Training Item	Objective	Employee Signature	Date
Overview of AHCCCS/ALTCS/Medicare Programs Review of the AHCCCS Web site to include but not limited to: Fee schedules Provider Registration NPI Guides and Manuals <ul style="list-style-type: none"> <li>• Claims Clues</li> <li>• ACOM</li> <li>• FFS billing Manual</li> <li>• AMPM</li> </ul>	Understanding of the regulatory programs Understanding of the resources and tools which can be found on the AHCCCS Web site		
Review of the AHCCCS Contract	Understanding of the regulatory requirements		
Review NMS Policies & Procedures	Understanding of department policies and procedures		
Review of Network Development and Management Plan	Understanding of department objectives and regulatory requirements which fall under NMS's responsibility		
Review of the SCAN Provider Operations Manual (which includes but not limited to the following): <i>Review of ALTCS Covered Services</i> <i>Claims and Billing</i> <i>Member Rights and Responsibilities</i> <i>Providers Roles and Responsibilities</i> <i>Case Management</i> <i>Prior Authorization Requirements</i> <i>Cultural Competency</i> <i>Appeals &amp; State Fair Hearings</i> <i>Fraud and Abuse</i>	Understanding of the plan benefits, member/provider responsibilities, process, procedures, and requirements which the providers must follow		
Review of SCAN Web site and Provider Tools page	Understanding of available providers tools and resource information on the Web site		
Review of Provider Call Tracking process	Understanding of AHCCCS requirement of tracking and trending of providers inquiry calls, requests for information and complaints and resolution timeframes		
Overview of NMS department operations	Understanding of department operations		
Overview of other SCAN AZ department responsibilities	Understanding of SCAN AZ department roles		
Overview of department responsibilities managed in Long Beach/Corporate office	Understanding of departments located in CA		
Shadow other NMS staff	Understand roles and responsibilities of team members		
Ride-A-Longs with SCAN Case Management	Understand roles and responsibilities of other SCAN team members and relationship between providers and members.		

## Requirement 42: Provider Services Staffing Levels

Part of SCAN Long Term Care's (SCAN) mission is to find innovative ways to enhance members' ability to manage their health care and continue to control where and how they live. SCAN must continue to develop partnerships that allow us to deliver the right health care, in the right setting, and at the right cost while maximizing the member's ability to remain independent.

Network Management Services is responsible for developing and maintaining these partnerships. The SCAN network consists of primary care providers (PCPs), specialists, skilled nursing, assisted living and other group home facilities, hospitals, home and community based services providers, behavioral health providers, and ancillary providers. Each contracted provider is assigned a Network Management Services representative who will serve as a vital link to SCAN's operations. Network representatives are available during normal business hours. For afterhours and weekend coverage SCAN has an answering service to triage these calls. Network calls that cannot wait until the next business day will be forwarded to the vice president of Network Management Services.

In order to develop, maintain, and educate our comprehensive network of providers, Network Management Services ensures that it has adequate staffing levels to meet the needs of the network. As of February 2011, Network Management Services consists of the following staff members: vice president of Network Management Services, Network/Contract Services managers (2 positions), Network Management Services administrative assistant, project manager, Network Management Services specialist (6 positions), claims analyst (claims educator), and claims analyst (2 positions).

### *Process for Evaluating Network Management Service Staffing Levels*

Workloads are evaluated based on provider call volume and resolution timeliness, provider complaint reports, provider visit compliance reports, the review and evaluation of the Provider Satisfaction Survey results, and provider education commitments. Staffing levels are evaluated against these workloads on a monthly, quarterly, and annual basis to ensure that all performance measurements are achieved. Additionally, staff may be reassigned duties to assist with any areas that may need temporary additional assistance due to increased or variable workloads.

Workload reviews include the following to meet AHCCCS requirements to support contract activities. These are evaluated, measured, and monitored by the following activities:

**Review of Provider Call Tracking Database Call Reports** – Provider call reports are reviewed weekly and information is shared monthly at Network Management Service Committee meetings. Reports are evaluated to ensure that provider inquiries, requests for information and complaints are addressed timely with proper resolution within the AHCCCS mandated timeframes.

**Review of detailed Provider Complaint Report** – due to inability of providers to receive information and/or resolution from Network Service representative. Provider complaint reports are reviewed quarterly to identify trends relating to provider dissatisfaction. The information will be presented quarterly to the Network Management Services Committee.

**Review of provider visit compliance** – SCAN Network Management Services conducts provider visits in accordance with the following standards.

- Semi-annual visits to primary care providers (PCPs)
- Annual visits to assisted living centers and homes, home and community based organizations, behavior health providers and nursing homes with assigned members
- Semi-annual visits to major ancillary providers
- Annual visits to all other providers with encounters in each representative's assigned area.

**Review and evaluation of SCAN provider Satisfaction Survey responses** – Annually SCAN conducts a provider satisfaction survey to the providers in the SCAN network. The primary focus is to target those providers who have provided services to SCAN members to elicit feedback on how the plan in meeting their needs. Providers were surveyed on the following areas:

- NMS staff returns calls promptly
- NMS staff resolves your issues
- NMS has provided adequate training

SCAN conducted a Provider Satisfaction Survey over a three week period during the 3rd and 4th quarter of 2010 for which it recorded the following results:

<i>Strongly Agree or Agree</i>	<i>2010</i>	<i>Base</i>
Network Management Services staff returns your phone calls promptly.	77%	159
Network Management Services staff answers your questions and/or resolves your issues to your satisfaction.	77%	164
Network Management Services has provided adequate training on SCAN policies and procedures.	69%	157

Based upon provider visit compliance and feedback from the provider community, Network Management Services restructured department responsibilities. Responsibilities were combined and two additional Network Management Services specialists were assigned to support the needs of the provider network.

*Summary*

Provider network stability, coupled with flexibility and adaptability, are essential to meet the needs of the ALTCS population. SCAN maintains its provider network through communication, education, training, monitoring, assessing and evaluating to ensure adequacy and sufficiency in the delivery of ALTCS covered services to SCAN members.

SCAN recognizes the critical importance of continuing to maintain effective, meaningful provider communications and education channels to ensure mutually satisfactory partnerships for the benefit of our members. To support these efforts, SCAN Network Management Services will continue to evaluate staffing ratios based on the criteria included in this response.

### *Requirement 43: Handling the Loss of Network Facilities*

---

Knowing the changeable nature of Arizona's long term care provider community and recognizing that nursing and assisted living facility transitions occur frequently, the SCAN Long Term Care (SCAN) Network Management Services Department monitors network facilities for viability and quality of care directly through annual on-site visits and indirectly through referrals of issues by other SCAN departments. SCAN believes that it is important to work with providers to *prevent* contract termination or closure if at all possible. However, if closure/termination cannot be prevented, SCAN follows established processes to immediately assess the effect of the closure or termination on members residing in the facility and other providers in the community. Whether working to prevent closure/termination of a facility managing safe transitions for members during an unavoidable closure/termination, Network Management Services works jointly with other SCAN departments, including Case Management, Quality Management, and Medical Management to assess the conditions and members' needs and carry out the recommended actions.

#### *Preventing the Loss of a Facility*

SCAN's goal is to identify facilities at risk for closure/termination in advance in order to be able to work with the facility to prevent the closure/termination. To monitor for potential closure/contract termination issues, Network Management Services uses the following resources.

Network Management Services' annual on-site visits to facilities are structured to maintain the provider relationship as well as to identify concerns that indicate noncompliance with contract requirements or state and federal regulations and which could lead to closure or contract termination. The department is also linked to the Case Management, Medical Management, Quality Management, and Grievances and Appeals departments through processes and procedures for reporting issues identified during their staff members' encounters with the facility or internal department reviews of facility issues. These internal reports may reveal a facility's licensing or insurance issues as well as quality of care issues. Network Management Services also regularly reviews publically reported data such as Arizona Department of Health Services (ADHS) reports to identify licensure information and/or sanction notices.

When alerted to a facility's potential for closure or termination, Network Management will collaborate with key representatives from Case Management, Quality Management, and Medical Management to discuss the potential closure and determine whether to initiate steps to try to prevent the termination. The team may decide upon interventions such as the following:

- Network Management and/or Quality Management staff may offer assistance to the provider, such as education or assistance in improving processes and resolving issues. They also may request a corrective action plan (CAP) when applicable.
- Network Management may be directed to place a hold on any new admissions to the facility until the areas of concern are addressed and resolved.

Network Management is responsible for notifying the provider of the actions to be taken and may facilitate other department's actions as well.

#### *Managing the Loss of a Facility*

If closure or termination of a nursing or assisted living facility cannot be prevented, however, SCAN focuses on the need to transition its members safely and without disruption to the member's care. SCAN immediately activates its facility closing process, which provides an integrated approach to support the members through the transition. The process requires that SCAN makes sure members' wishes and needs are known and attempts to meet them in the most appropriate manner. Because of the inter-disciplinary approach to facility transitions, SCAN maintains a Closure Tracking Log, a database into which involved

staff document information pertinent to the transition on an ongoing basis to allow all departments to stay current.

#### Notification of Facility Closure or Termination

Any SCAN employee may receive notification of an imminent or voluntary facility closure or termination. The notice may be received from the facility's management, the Arizona Department of Health Services (ADHS), AHCCCS, other program contractor, or another SCAN department.

The employee receiving the notification of closure immediately begins the formal internal notification process by relaying the notification to the vice president of Case Management or designee, who immediately sends an e-mail to notify the SCAN Executive Team, and the managers of Case Management, Network Management Services, Quality Management, Medical Management, and Member Services of the facility closure. On the date of notification, the group may convene to discuss the closure timeframe and determine the next steps.

Upon receiving notification of the closure the Network Management Services vice president or designee will verbally notify the provider of the action within one business day to review the closure notification. The Network Management Services vice president/designee also assesses whether the closure will result in a material change to the network (i.e., will affect five percent or more of SCAN's membership). If the change will constitute a material effect, Network Management Services is required to report the closure/termination to AHCCCS, which must approve members' transitions in advance.

SCAN also notifies other parties who may not have been notified from other sources, such as the ALTCS and Clinical Quality Management units of the Division of Health Care Management (DHCM), ADHS, as well as other program contractors to alert them to the unexpected changes and their potential impact on their health plan, members, and network.

#### Assessment of Members' Needs and Transition Support

SCAN Case Management and Medical Management staff coordinate efforts to identify the members residing in the facility, including high-risk members needing special placement or transportation, and members who may be in an acute inpatient facility at the time. For members in acute inpatient facilities at the time, Case Management or Medical Management staff contact the hospital discharge planners to advise them of the closure and coordinate discharge plans.

SCAN case managers, the medical director and Medical Management staff will meet with the member and his/her family as far in advance of the transfer as possible to see that the medical and psychological needs of the member are anticipated. The team will determine the best possible transfer location for the member, taking into consideration the member's health care requirements, ability to travel, and the new location's convenience to the family. The CM staff evaluates and determines whether the member's primary care provider (PCP) assignment may need to be modified. If the transition will pose potential risks to the member, the CM will authorize additional on-site support services, such as home health, attendant care, etc.

SCAN Case Management staff also provide on-site supervision of the move to make sure that medications, chart materials, member's belongings and medical records, and any DME are transferred with the member. The Case Management staff will complete the Member Transition Checklist to see that all member belongings and information are accounted for in the transition to the new facility.

The Quality Management Department compiles a master list of the members being moved with their new locations and makes the list available to AHCCCS.

### Facility Transition Follow-up

Within seven business days of the move, SCAN Case Management staff follows up with the members for an on-site review to discuss any outstanding issues and whether the member is satisfied with the placement. When the transition is completed, Network Management Services staff will complete the formal termination notification to the terminated provider and send a companywide communication to inform SCAN departments of the facility's termination, including the SCAN Health Plan Provider Services Department, which is responsible for updating SCAN systems information with the effective date of the contract termination. All SCAN staff involved in the facility closure process will reconvene after the move to evaluate the process and identify areas of success and those that need improvement.

#### *Summary*

SCAN understands that a transition to a new facility can be very traumatic for members. For this reason, throughout the process SCAN staff make a point of communicating with all parties involved, working with the member and family to minimize the potential disruptions, and to identify another contracted facility which best meets the member's needs.

If it is discovered during the closure transition process that any component of SCAN's provider network, specifically a nursing home or alternative residential home, is unable or inadequate to deliver any kind of medically necessary care required under ALTCS, SCAN will cover these services in a timely manner through an out-of-network provider until a suitable network provider is located.

## *Requirement 44: Provider Performance Issues*

---

SCAN's goal is to offer a comprehensive provider network of the highest quality and to ensure that ALTCS and health plan standards are met through regular communication, education and ongoing monitoring of the network. Network Management Services regularly monitors provider performance directly through Network Management's scheduled or unscheduled on-site visits and indirectly through integrated internal procedures that involve Network Management Services in issues identified by other SCAN departments, such as Grievances and Appeals, Quality Management, Case Management, Medical Management, and Member Services. SCAN's primary interest is in working with providers to preserve the relationship by offering education on contract requirements and regulatory standards whenever possible. However, if providers do not conform to contractual and regulatory performance requirements, Network Management will pursue contract termination.

### *Ways of Assessing Provider Performance*

#### Network Management Services On-site Visits

Network Management Service's annual or semi-annual on-site visits are structured to maintain the provider relationship as well as to identify issues that could alert the plan to potential quality of care issues that could lead to contract termination (e.g., signs of changes or indications that the facility is not complying with contract specifications). Network Management will first attempt to work with the provider through education, further review of AHCCCS, ALTCS, and SCAN regulations and requirements. The department may conduct unscheduled visits if necessary in cases where providers are unresponsive.

#### Member Grievances

The SCAN grievance system allows members and contracted and noncontracted providers to submit grievances, appeals, and provider claims disputes in accordance with SCAN policies, which reflect AHCCCS and federal requirements. SCAN tracks and trends grievance issues to determine root cause and facilitate cross-functional system improvement to improve service quality. An example of the process occurred with a network assisted living facility. An escalating number of grievances received by the Grievance and Appeals specialist about this provider between the final quarter of 2008 and the second quarter of 2010, trends were identified regarding housekeeping, food, facility conditions, and staff responsiveness.

When the facility did not respond to Appeals and Grievances and Quality Management's attempts to contact them, Network Management Services became tried to schedule a site visit. When the facility administrator did not return Network Management's calls, the department conducted an unscheduled on-site visit. The findings from the visit, along with the concerns expressed by Appeals and Grievance and Case Management were evaluated and discussed by the Grievance Committee. The committee recommended that SCAN work with the provider on a corrective action plan (CAP). Network Management Services held meetings with the provider to develop the CAP. No further grievances were filed about this provider during the remainder of 2010. The results were reported to the Grievance and Appeals Committee.

#### Quality Management Tracking

Provider performance issues are also monitored by the Quality Management Department, which investigates and resolves referrals of quality of care issues on a case-by-case basis. A provider involved in a quality of care case may be subject to a corrective action, including but not limited to continuing education, additional staff training, and bed hold. In addition, the QM department reports quality of care data in aggregate in order to identify trends by provider or provider type. As trends are identified, the Quality Management assesses them further to identify opportunities for improvement that may be



considered for inclusion in the QM work plan. The decision to include a project in the QM work plan is based on several factors including but not limited to:

- The significance of the issue in relation to the members' health
- The prevalence of a condition among the membership
- The health risk status of the members
- Contractual requirement
- Impact potential on target population

The QM/MM Committee is responsible for reviewing the final QM Work Plan to ensure that the goals and objectives are relevant to the membership and based on sound scientific evidence or community practice standards. The work plan must be approved by the QM/MM Committee. With the approval from the committee, the QM Department moves forward with implementing the quality improvement projects. Network Management Services becomes involved in interventions that occur as a result of the quality tracking process, which may take the form of facilitating meetings with a provider, placing bed holds, assisting with provider education (either singly or collectively) about regulations and contract requirements and changes in policy as well as in stronger interventions such as placement of bed holds or contract termination.

#### Member Satisfaction Surveys

SCAN's annual Member Surveys evaluate members' satisfaction with health plan functions, including the adequacy of the provider network, access to care, and transportation. Responses to survey questions addressing network performance are reviewed by Network Management and reported to the Network Services Committee for discussion and recommendations. If potential issues or trends are identified, they are investigated further to assess causes and determine interventions. Results are reported back to the Network Management Committee and to the QM/MM Committee. Member Surveys conducted in 2009 and 2010 indicated that SCAN members overall appear to be satisfied with their personal doctor or nurse practitioner, access and availability and ancillary services. The 2010 responses showed a significant increase in the number of members reporting that they have one person they think of as their personal doctor or nurse (88 percent in 2010, compared to 84 percent in 2009).

#### Case Management and Medical Management

Case Management (CM) is actively involved in assisting providers with coordination and continuity of care for members. Case managers send reports to Network Management of providers who do not comply with AHCCCS requirements for the coordination and continuity of care. Upon receipt of a report, Network Management reviews with the provider the contractual and AHCCCS requirements for coordination and continuity. Case managers may also report service accessibility issues to Network Management for follow-up.

Timely review of quality of care is as important as review of accessibility and availability. Medical Management continually monitors and provider utilization through analysis of:

- Medication formulary prescribing patterns
- Member emergency department visits
- Specialty referral patterns
- Inpatient hospital admissions and readmissions
- Lab and radiology referrals

Data are compared to the utilization patterns of peers in the general service area (GSA) and evaluated by the QM/MM Committee and the medical director to address variances. Identified trends are reported to the Network Management Committee and interventions will be determined in collaboration with other relevant departments.

### *Process for Addressing Provider Performance Issues*

While Network Management Services relies on interdepartmental communication to provide information about providers' performance or contract issues, ultimately it is the department's responsibility to see that providers conform to AHCCCS regulations and requirements and the standards set forth in the provider's contract agreement with SCAN. SCAN will work to preserve the provider relationship, and when possible, will provide education on contract requirements or regulatory standards and facilitate other efforts as needed.

When it is determined that an intervention is necessary, the Network Management Services representative communicates with the provider about the issue. The form of communication depends on the issue's level of severity and/or nature and may be by telephone, written communication, a personal visit, or combination. The communication provides education on the identified issue and may review contract language or cite the regulatory requirement to be addressed. For certain issues, a "hold" may be placed on the provider to stop further admissions or referrals until the issue is resolved. The hold may be internal to SCAN (i.e., without notifying the provider) if there is concern that the provider's awareness may jeopardize the member. The provider is expected to rectify the issue within a given timeframe, during which the Network Management Services representative conducts follow-up with the provider to verify compliance. If compliance is not reached within the stated timeframe, SCAN may request a corrective action plan (CAP).

A provider's repeated noncompliance or unwillingness to resolve a performance/contract issue, may be considered grounds for terminating the provider's contract. A cross-functional review and evaluation is completed by the integrated committee that includes key staff from Case Management, Medical Management, Quality Management, Network Management, and the medical director to determine how loss of the provider will affect SCAN's membership and the network. If the termination would cause a material change to the network (i.e., affect five percent or more of SCAN's membership), Network Management will obtain AHCCCS approval prior to the termination. Additionally, SCAN notifies AHCCCS within one business day of any unexpected changes that would impair its provider network. Once a provider termination decision is made, Network Management notifies the provider in writing, case managers contact affected members and help them identify other network providers who would be able to meet the members' needs. If no network provider is available to provide the same type of service, SCAN will authorize a non-contracted provider until a contract agreement can be executed. When a provider is terminated due to quality issues, QM staff will notify AHCCCS. Network Management Services will notify SCAN internal departments of the termination and its effective date, including the SCAN Health Plan Provider Services Department, which will update the provider information in the information system which governs claims payments to the provider.

*Requirement 45: Network Summary and Attestation Statement*

---

There is no hard copy response for this submission requirement.

Concurrent with submitting the hard copy of its Response to Contract/RFP No. YH12-0001, SCAN Long Term Care has submitted its Network Summary and Network Attestation Statement to AHCCCS via the EFT/SFTP server. A copy of the Network Attestation Statement is included following this page for reference.

**NETWORK ATTESTATION STATEMENT**

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement from  
**SCAN Long Term Care**  
To The  
**Arizona Health Care Cost Containment System**  
**Division of Health Care Management, Operations**

I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

GSA #52: Maricopa County

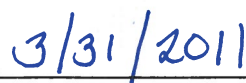
		<u>Requirement</u>	<u>Contracted</u>
Skilled Nursing Facilities	Zone 3	2	1
Assisted Living Centers	Zone 1	4	3
	Zone 5	1	2
	Zone 6	10	9
	Zone 7	4	3
	Zone 9	2	0
Adult Foster Care Homes	Zone 9	2	0

I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

GSA #52: Maricopa County



(Network Administrator Signature)



Date