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March 31, 2011

VIA HAND DELIVERY

Jamey Schultz
Contract and Purchasing Section
701 E. Jefferson, MD5700
Phoenix, AZ 85034

Dear Ms Schultz:

Evercare Select is pleased to submit our response to Arizona Health Care Cost Containment System's (AHCCCS) Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled (E/PD) request for proposal (RFP) for all Geographic Service Areas (GSA).

As an existing local program contractor, Evercare Select has been privileged to serve the ALTCS E/PD program and its members since the programs inception in 1989. We have enjoyed a collaborative relationship with AHCCCS and ALTCS program administrators working side by side to provide innovative solutions to the unique challenges facing the ALTCS E/PD population.

As a result of this collaboration we believe we are a much stronger and effective organization than in the past. As evidenced by our fully and substantially compliant Operational and Financial Review (OFR) results over the past several years—increasing from 88% in 2008 to 93% in 2010—we have focused diligently on:

- ALTCS Guiding Principles of Choice, Dignity, Independence, Individuality, Privacy and Self-Determination
- Exceeding all aspects of contract compliance while providing outstanding service to our members, providers, AHCCCS and the local communities we serve
- Collaboration and innovation with AHCCCS and other ALTCS Program Contractors

Our experienced leadership team and staff have collectively over 600+ years of experience with the ALTCS program. We have invested time and effort meeting with stakeholders where they live and work, in their local community with the goal of better understanding how we can meet their needs while improving outcomes for ALTCS members. We have built trusted relationships in rural communities that have been traditionally underserved and continue to develop and maintain strong collaborative relationships in Maricopa County where our growth was limited. While there is still work to do, we believe together with AHCCCS, we can leverage our diverse geographic experience to better serve the ALTCS program throughout Arizona.

Evercare Select is supported by our parent company, UnitedHealthcare (UHC), a recognized clinical leader in the Arizona health care community. UHC has invested in several innovative clinical programs such as:

- the medical home model with 10 sites underway
- creation of a clinic dedicated to the management of chronic care for seniors in Maricopa County
- leaders in the national ACO demonstration project in Tucson with Tucson Medical Center

In addition, UHC has been a thought leader in the eMR discussion, working with and leading the Arizona Health-e Connection (AzHeC) since its inception, helping to guide electronic medical record (EMR) and health information exchange (HIE) policy and deployment in Arizona. Benton Davis, CEO of UnitedHealthcare-Western States has served on the AzHeC Executive Committee since 2009 and is currently Chairman of the Board of Directors for AzHeC. Our company's commitment to Arizona is further evidenced by the grant funding we've provided for several projects such as Mobile Clinics.

Through our 22 years of experience serving ALTCS members we have demonstrated our commitment and ability to deliver fully integrated, high quality, cost effective health care services to ALTCS and its membership. Evercare Select has the capacity, infrastructure, necessary resources and flexibility to expand our services and accommodate any potential membership growth upon contract award. Our history, our local team and our dedication to innovation will make Evercare Select the right choice for ALTCS and its members.

Should you have any questions or require clarification of any of our responses, please feel free to contact me at 602-745-7998 or karen_brach@uhc.com or Jacquie Smith, Proposal Manager at 412-221-2583 or jacquie.smith@uhc.com.

We look forward to the opportunity to continue serving ALTCS and its members.

Sincerely,

Karen Brach, RN

Karen Brach, RN
Executive Director
Evercare Select

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

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 24th day of February, 2011, in Phoenix, Arizona.
Signature Karen Brach	Date 2/28/11	
Karen Brach, Chief Executive Officer		
Typed Name and Title		Michael Veit
Evercare Select		Contracts and Purchasing Administrator
Name of Company		

ALTCS RFP YH12-0001 QUESTIONS AND RESPONSES DATE: February 24, 2011

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
1	Capitation Template – Document F			Please confirm that the case management fee and risk/contingency are separate from the administrative portion of the capitation bid and not included in the 8 percent maximum.	The case management component and the risk/contingency component are not included in the 8 percent administrative maximum.
2				Is inclusion of the questions being addressed required as part of the narrative responses?	The number of pages that may be submitted for submission requirement 7 is four pages of narrative description of the claims adjudication process, five pages of flowcharts and up to four pages for the remittance advice.
3	Data Supplement	Utilization Data	ftp site	Can we assume that the Nursing home cost, and the assisted living cost is presented in the utilization data net of the share of cost? Can AHCCCS provide clearer direction to bidders on the distribution of the share of cost by placement within a county?	Yes, the Offeror can assume that the Nursing home cost and assisted living cost is presented net of share of cost. It is not necessary to know the distribution of share of cost by placement for rate development or the bid submission. AHCCCS estimates that more than 95% of share of cost is for members residing in nursing facilities.
4	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			Please confirm the paid through date for the encounters that are represented within the databook.	The Databook is based on encounter dates of service (DOS). The Databook includes information through the first December encounter cycle. Any encounters that were approved and adjudicated by the first December encounter cycle with DOS between 10/01/07 – 06/30/10 would be included in the databook.

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5	Policies and Manuals 419 ALTCS Network Standards	General Requirements		The requirement states "The standard (either an "X" or a number of facilities/providers required in the tables below) will indicate the number of providers by a specific city, zone, facility location or countywide coverage." Will this requirement be adjusted if the specific location does not currently have the required number of facilities in it?	This requirement will not be adjusted. Offerors should address any gaps or network deviations in the Network Development and Management Plan.
6	Reference Materials – Case Management Training	Bidders Library	N/A	In review of the references materials we noted some discrepancies in the document name and the uploaded file. Could you please review the materials under Case Management Training and confirm that the items posted reflect what we should use during the current procurement?	The links have been changed and this issue has been resolved.
7	ALTCS Bidders Library/ Policies and Manuals	Provider Affiliation Transmission User Manual		The Bidders' Library links to a Provider Affiliation Transmission User Manual dated October 1, 2009, which appears to be the manual used by Acute Care health plans as there are no distinguishing criteria (e.g., Definitions, AHCCCS question/contact person) for ALTCS. To what extent, if any, does AHCCCS expect an ALTCS-only plan to comply with the Provider Affiliation Transmission User Manual dated October 1, 2009 for the CYE2012?	The Provider Affiliation Transmission User Manual is intended for use by Acute Care contractors only, not ALTCS contractors. This link will be removed from the Bidders' Library.
8	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS	Overview	1	General Trend and Rate Setting Assumptions states that "For any GSA where the historical encounters varied significantly from financials AHCCCS may use a true-up factor to account for possible missing encounters. Please provide additional support to identify the impact of this true-up factor either separately or within the databook information. For example, what time periods and GSA's were impacted	After further review of the data AHCCCS will not be using a true-up factor for the base data.

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				by this factor? Were only specific services impacted? What is the magnitude of the impact to the base data?	
9	I. Instructions to Offerors	Q1	1	Is an actuarial certification required if Offeror submits a rate within the published rate range?	Yes. An actuarial certification is required for all Offerors.
10	Section A- Data Supplement Instructions and Overview	**None**	1	When will AHCCCS notify proposers when individuals have been approved to access data and reports on the EFT/SFTP?	On average it is taking two days for notification once all paperwork is submitted. All Offerors that have completed and submitted the appropriate paperwork have been approved and notified as of February 25, 2011.
11	Program Requirements	3/Member Identification Cards	18	Beginning October 1, 2011 the Contractor is responsible for paying the costs of producing AHCCCS member identification cards. The Contractor will receive an invoice the month following the issue date of the identification card. What is the anticipated form and format of this invoice? An example will be helpful. How will the Contractor's capitation rate be adjusted to account for this additional expense? What is the anticipated form of payment that will be acceptable to ALTCS?	A process is currently in place for the AHCCCS Acute Care Contractors where the contracted vendor receives a file from AHCCCS and invoices each Contractor for identification cards produced and sent out to enrolled members. Contractors will pay the vendor directly, using a form of payment acceptable to the vendor. This is the same process that would be utilized during CYE12. The cost of cards is estimated to be immaterial thus capitation rates will not be adjusted.
12	Program Requirements	3/Member Identification Cards	18	During CYE 2012 AHCCCS will meet with Contractors to develop a process for Contractors to also produce and issue member identification cards. Contractors will have complete responsibility for the production, distribution and cost of member identification cards by no later than October 1, 2012. Please define the testing process regarding the transfer of the data necessary to produce ID cards? Please describe the minimum requirements regarding the material used for ID cards? Will ALTCS have minimum specifications for the placement of critical telephone numbers and web site addresses? Will the process mentioned above give the Contractor adequate time for design and testing? How will the Contractor's	A workgroup will be formed comprised of Contractors receiving awards for CYE12 and AHCCCS staff to implement this requirement. Policies and procedures as well as specifications for testing and data transfers will be developed by the group. The cost of cards is estimated to be immaterial thus capitation rates will not be adjusted.

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				capitation rate be adjusted to account for this additional expense (including design and testing)?	
13	Program Requirements	4/Open/Annual Enrollment - Open Enrollment Subsection	18	Should AHCCCS add choice of Contractors to a Geographic Service Area (GSA) other than Maricopa County, all existing members in that GSA will be given the opportunity to choose the Contractor with whom they will be enrolled [42 CFR 438.56(c)(2)(ii)]. Please clarify the intent of this requirement since the maximum number of contracts ALTCS intends to award is limited to "1" in all other GSAs?	The language allows AHCCCS flexibility; however, at this time AHCCCS does not intend to add choice of Contractors to any GSA other than Maricopa County.
14	Program Requirements	3/Enrollment and Disenrollment	18	What is the process Contractors will need to use to report members' acute care health plan choice to AHCCCS?	We believe you are referring to when a member becomes ineligible for ALTCS but remains eligible for the acute care program. This is a very rare occurrence, however, in the event it does occur, the Contractor shall obtain the member's health plan choice and submit that choice to the Communication Center in the Division of Member Services (DMS).
15	Program Requirements	3/Enrollment and Disenrollment	18	Can AHCCCS confirm that the Contractor is only responsible for Member Identification Cards for the ALTCS members in each contracted GSA?	Contractors will only be responsible for Member Identification cards for their own assigned members in each GSA.
16	Program Requirements	3/Enrollment and Disenrollment	18	Will AHCCCS send selected vendors 5010 formatted files for testing and operations? If not, can AHCCCS provide the date it intends to begin transmitting 5010 file formats?	Yes. All testing with selected vendors (outbound and inbound) will be conducted in applicable HIPAA 5010 file formats. All 5010 formats will be in place for October 1, 2011.
17	Program Requirements	3/Enrollment and Disenrollment	18	Where on the 834 or other file will AHCCCS communicate the member's selected PCP to Contractors?	PCP data is assigned and maintained by the Contractor. At this time AHCCCS does not receive or maintain this information.
18	Program Requirements	4/Open/Annual Enrollment - Annual Enrollment Choice Subsection	19	For counties with more than one Contractor, AHCCCS may require a monthly submission of network information (PCPs, nursing facilities, Assisted Living Facilities etc.) to support initial enrollment, annual enrollment choice and open enrollment. Details will be provided at a later date.	If AHCCCS decides to require this information, details and formatting requirements will be provided with adequate time for design and testing. If AHCCCS deems the expense to be material, capitation may be adjusted.

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				Will the process mentioned above give the Contractor adequate time for design and testing? How will the Contractor's capitation rate be adjusted to account for this additional expense (including design and testing)?	
19	Program Requirements	5/Enrollment Hierarchy - Auto-Assignment Algorithm	19	The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. So the Offeror may determine the impact of this subsection on its enrollment projections and process for establishing competitive capitation rates please define "AHCCCS goals" as used in this context. Will a timeframe be established and shared with Offerors?	Based on historical data, an estimated 5% of new members in Maricopa County are auto-assigned. In order to ensure that new Contractors reach an enrollment level that allows for efficiencies and improved viability, AHCCCS may auto-assign a higher percentage of new members to the new Contractor for a period of time. Decisions will be made based on the outcome of the awards and member assignment and will be shared with all Contractors prior to October 1, 2011.
20	Program Requirements	5/Enrollment Hierarchy - Auto-Assignment Algorithm	19	AHCCCS may change the algorithm at any time during the term of this contract. AHCCCS is not obligated to adjust the algorithm for any financial impact this may have on a Contractor. Will ALTCS give the Contractor at least 90 days notice prior to any adjustment? It will be helpful if ALTCS provides all impacted Contractors with a timeframe and projected impact the algorithm change will have on the Contractors to allow for personnel and network adjustments. Will ALTCS analyze personnel and network adequacy of the Contractors to make sure there will be adequate supports and network to serve the members? Please also provide an example or rationale as to under what circumstances and when AHCCCS may make changes to this algorithm.	Given that on average approximately 5% of new enrollment is auto-assigned in Maricopa county, AHCCCS does not anticipate that algorithm changes will result in significant personnel or network adjustments. Contractors will be given adequate notice of planned algorithm changes. Any pertinent data will be shared at that time. No example will be given.
21	Program Requirements	5/Enrollment Hierarchy	19	What is the mathematical formula AHCCCS will use to auto-assign members?	AHCCCS will assign a percentage to each Contractor for auto-assignment based on estimated final Contractor enrollment in Maricopa county. AHCCCS may initially favor Contractors new to a GSA in determining the algorithm. The auto-assignment

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					percentages will be shared prior to October 1, 2011. The mathematical formula programmed into the system allows assignment to the Contractor that is farthest away from their assigned target percentage.
22	Program Requirements	5/Enrollment Hierarchy	19	Based on AHCCCS' experience, what is the expected percentage of members who will choose vs. those who will be auto-assigned for each GSA?	Information regarding historical auto-assignment and choice is provided in the Data Supplement section of the Bidders' Library.
23	D- Program Requirements	8 - Contract Termination, first paragraph	21	The RFP states: "…AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members." Please add language to the effect that rates will remain actuarially sound, assignment algorithm will remain the same, and the program will remain stable.	AHCCCS will not add this language.
24	D- Program Requirements	8 - Contract Termination, subsection a	22	The RFP states that Contractor shall be responsible for "Payment of all outstanding obligations for medical care rendered to members, until AHCCCS is satisfied that the Contractor has paid all such obligations." Please revise as follows: "Payment of all outstanding obligations for covered medical care rendered to members, until Contractor reasonably demonstrates that Contractor has paid all such obligations, or until AHCCCS is otherwise satisfied that the Contractor has paid all such obligations."	Change will be considered for possible future amendment.
25	D- Program Requirements	8 - Contract Termination, subsections c, d, e and f	22	Please insert the phrase "which release shall not be unreasonably withheld or delayed" at the end of subsections c, d, e and f.	Change will be considered for possible future amendment.
26	Program Requirements	10/Covered Services	22	Please provide a list of DME codes for reimbursement on provider fee schedules when providers bill with the following modifiers: LL, NR, RA and RB. Please provide the provider reimbursement amounts when the previously mentioned modifiers are indicated.	Current AHCCCS Fee Schedules are available on the AHCCCS Website.
27	Program Requirements	17/ Member Handbook and	41	When there are program changes, notification shall be provided to the affected members at least 30 days	AHCCCS will provide direction in the event notification to members of a program change is

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		Member Communications		before implementation. Under what circumstances does a "program change" require 30 day prior notification? We understand the importance of keeping our member's informed regarding program changes that have an impact on the member. In our experience there are multiple program changes each year that may not impact the member, the member's access to care or member's covered services. It would be helpful if ALTCS could provide direction.	necessary.
28	Program Requirements	17/ Member Handbook and Member Communications	41	The Contractor shall produce and provide the following printed information to each member or family within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)] Can the Contractor reasonably expect that we will also be allowed 12 business days after receipt of enrollment notification to produce the member's ID card as specified in Section D 3, Member Identification Cards?	A process is currently in place for the AHCCCS Acute Care Contractors where the contracted vendor receives a file from AHCCCS and invoices each Contractor for identification cards produced and sent out to enrolled members. A workgroup will be formed comprised of Contractors receiving awards for CYE12 and AHCCCS staff to implement this requirement. Policies and procedures (which will address timing) as well as specifications for testing and data transfers will be developed by the group.
29	Program Requirements	17/ Member Handbook and Member Communications, Subsection I.	41	The handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution. In the event that AHCCCS, Division of Health Care Management hasn't provided comment on a Contractor's submitted handbook, can the Contractor then assume that it is approved?	No. Member handbooks must be approved by AHCCCS prior to distribution.
30	Program Requirements	20. Quality Management	43	Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO). Please describe any anticipated, expected or planned community initiatives that ALTCS and the QIO may	AHCCCS does not have any information related to any specific community initiatives at this time that the ALTCS Contractor would be required to participate in. AHCCCS can not estimate anticipated personnel needs or costs, without a project being specified.

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				implement during the contract period that will require mandatory Contractor participation. Please describe the expected personnel needs or other cost of these anticipated, expected or planned community initiatives. Please describe how much advanced notice the Contractor will receive prior to a mandatory participation. Is the QIO aware of these anticipated, expected or planned community initiatives?	Contractors would be made aware of an activity/initiative when AHCCCS is made aware. This requirement was added to a previous ALTCS contract at the request of the QIO and other community agencies.
31	Prog. Reqs	D.20	43	States "The Contractor must ensure that the Quality Management/Quality Improvement Unit within the organization is separate and distinct from any other units or departments such as Medical Management or Case Management.? Does this require separate and distinct staff?	Section D, Paragraph 25 (Staff Requirements and Support Services) states that an individual staff member is limited to occupying a maximum of two of the Key Staff positions. The Contractor must be able to demonstrate, however, how it will maintain a separate and distinct Quality Management/Quality Improvement Unit and the steps that it will take to ensure that the Unit is able to successfully carry out the functions of a Quality Management Program, as outlined in Section D, Paragraph 20(A).
32	Program Requirements	20. Quality Management, Subsection B.I	44	The current AHCCCS established performance measures may be subject to change when these core measures are finalized and implemented. The Contractor must have a process in place for internal monitoring of performance measures rates, using the standard methodology established or adopted by AHCCCS, for each required performance measure. Will the Contractor receive advanced notification of at least 90 days prior to implementation of these changes? Will the Contractor have at least 90 days to implement any changes? Will ALTCS adjust capitation rates if these changes result in additional program or administrative costs?	If the core measures are mandated by the Centers for Medicare and Medicaid Services (CMS), AHCCCS will add the specific requirements to the Contractors contract. As AHCCCS is made aware of performance measure requirements, it will communicate the changes to Contractors in a timely manner and costs will be analyzed to determine if a capitation rate adjustment is necessary. It is anticipated that there would be at least 90 days notice prior to any mandated changes to performance measures.
33	Section D, Program	25. STAFF REQUIREMENTS	48	When should a proposer notify AHCCCS of a possible request for an exception to the contract requirement -	While AHCCCS does not encourage exceptions to Key Staff Position requirements, as part of the

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	Requirements, a subsection of A. General	and SUPPORT SERVICES		"An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below unless prior approval is obtained by AHCCCS, Division of Health Care Management"? As part of the proposal? Upon contract award?	proposal, the Offeror should indicate if an individual will be occupying more than two of the Key Staff positions and that the Offeror will be requesting an exception if awarded a contract.
34	D. Program Requirements	25/Staff Requirements and Support Services	51	The CYE2012 requirement for Case Management Supervisor requires "3 years of management/ supervisory experience in the healthcare field". How does an organization factor in an individual's promotion from within their organization? Example: Case Manager with experience who has shown leadership skills and would be promoted from within.	In a future amendment for October 1, 2011, AHCCCS will modify Paragraph 25, Staff Requirements and Support Services, subsection Additional Required Staff, bullet y - Case Management Supervisor(s) to read: "To oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of three years of management/supervisory experience in the health care field or a minimum of three years of case management experience."
35	Program Requirements	28/Network Development	54	The Contractor shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems. Please define "community based primary care and specialty care" as used in this section. Please be specific as to "AHCCCS Provider Types".	This term refers to primary and specialty care providers who, whenever possible, practice in the community in which the member resides. A list of AHCCCS provider types for primary care and specialty care is available in the Bidders' Library.
36	Program Requirements	28/Network Development	54	The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. Please provide a definition of "geographically convenient flow" as used in this section. Especially in consideration of the requirement in this section: The Contractor shall develop and maintain a provider	Contractors are expected to develop a network that affords providers with a reasonable opportunity for sufficient members who may utilize their services. The Contractor is expected to establish and maintain a network that is responsive to the needs of each individual as well as the membership in general. As such, providers must be geographically positioned to

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				Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. Would ALTCS consider there to be a difference in "geographically convenient flow" in urban or rural GSAs? Would ALTCS consider there to be a difference in "geographically convenient flow" for specific "zones" within Maricopa and Pima GSAs based on availability of providers and concentration of members? If yes, please define. How would the Offeror demonstrate a "geographically convenient flow" in its Network Development Plan?	ensure that members are able to fully access needed services in a timely manner. This requirement applies to rural and urban areas or zones. It is up to the Offeror to determine how to demonstrate that its network will meet this requirement.
37	Program Requirements	28/Network Development	54	Please define "community norms"	Community norms refer to services and settings generally available to the general public.
38	Program Requirements	28/Network Development	57	What are the numbers of members who are dual eligible versus non-dual eligible?	Information regarding dual and non-dual placement and member months by county is available in the Data Supplement portion of the Bidders' Library.
	Program Requirements	28/Network Development	57	Does the January 1, 2013 deadline imposed for Maricopa and Pima Counties also apply to all other counties where AHCCCS requires Contractors to be a MA Plan and/or MA SNP or attempt to develop a formal relationship with a MA Plan and/or MA SNP? If the expectation is that a Contractor in a rural county establish a MA/SNP plan or relationship with such earlier than January 1, 2013, is this expected to be in place by October 1, 2011; January 1, 2012; or at the time of bid submission?	The January 1, 2013 deadline does apply to other non-Maricopa/Pima counties. The RFP / Contract will be amended to include this deadline.
39	Program Requirements	28/Network Development	57	Can AHCCCS elaborate on the goals and objectives, and expected collaboration with Contractors to develop E-prescribing during the contract period?	AHCCCS expects to develop goals and objectives in the future. Contractors will be informed at that time.
40	Program Requirements	28/Network Development	57	In relation to dual eligibles, what are the acceptable qualifications for attempting to develop a formal relationship with a MA Plan and/or MA SNP? What constitutes a formal relationship, e.g., LOI, contract? Can multiple Contractors have a formal relationship	A formal relationship includes a contractual arrangement between the Contractor and the MA/MA SNP to work together and share information for the purpose of coordinating care for the member. Multiple Contractors can have a formal relationship

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				with the same MA/MA SNP vendor?	with the same MA/MA SNP vendor.
41	Program Requirements	31/Provider Registration	59	The National Provider Identifier (NPI) is required on all claim submissions and subsequent encounters (from providers that are eligible for a NPI). Please provide detailed instructions for submitting claims and encounters for providers that are ineligible for obtaining an NPI.	AHCCCS policies and processes define and recognize types of providers who are Atypical (not eligible) for National Provider Identifier purposes. Detailed instructions for the submission of claims and encounters are included in the AHCCCS Fee For Service Provider Manual and the AHCCCS 837 Companion Documents available in the Bidders' Library.
42	Program Requirements	32/Network Summary	59	In addition to the above, for counties with more than one Contractor AHCCCS may require a monthly submission of network information (PCPs, nursing facilities, Assisted Living Facilities etc.) to support initial enrollment, annual enrollment choice and open enrollment. If needed, details will be provided at a later date. Please provide additional information about this requirement. Under what circumstances will AHCCCS need this network information? Will there be specific file formatting requirements? Depending on the specifications the Contractor will need adequate time to program and test to meet these specifications.	The Division of Member Services may require additional information to assist members when they are choosing Contractors. If AHCCCS decides to require this information, details and formatting requirements will be provided with adequate time for design and testing.
43	Program Requirements	31/Provider Registration	59	Will AHCCCS provide a database or other resource to look up provider AHCCCS ID numbers? If so, when can Contractors expect to receive this information?	Contractors receive a weekly provider extract file with identification numbers which details additions, terminations and changes to AHCCCS registered providers.
44	D- Program Requirements	33 - Subcontracts	60	The RFP states: "A merger, reorganization, or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS." To confirm, is this intended to require AHCCCS approval of assigning a subcontract to a new owner or effecting the amendment, rather than approval of the subcontract merger, reorganization or change in	If a Contractor has an approved subcontract with a third party for Administrative Services, and the entity providing the Administrative Services merges, reorganizes, or changes ownership, then the Contractor is obligated to provide notice to AHCCCS of the change, and AHCCCS reserves the right to withdraw its approval of the subcontract for Administrative Services upon any such change. If the

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				ownership itself? (Similar to the requirement on page 75, Section 49, which states: "If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner.")	approval is withdrawn, the Contractor must resume direct performance of the administrative services. The Contractor may request continued approval of the subcontractor for Administrative Service in advance of any merger, reorganization, or change of ownership by the Administrative Services subcontractor.
45	Program Requirements	44/Claims Payment/Health Information System	70	In the General Claims Processing Requirements subsection there is a paragraph that reads: "Standardized claims for services must be submitted pre R9-22-719, therefore: • Roster billing is not permitted for nursing facilities for dates of service on or after October 1, 2011; • Contracts shall work with all other providers to eliminate roster billing and submit standardized claims with dates of service on or after October 1, 2012." To make sure the Offeror is clear please define "roster billing". A representative example would be very helpful for the Offeror and a useful communication tool with providers. To be clear, is it the intent of this provision that the nursing home (for October 1, 2011) and other providers (after October 1, 2012) must prepare and submit a valid and accurate claim in the appropriate format? Would AHCCCS consider it to be acceptable if the Offeror/Contractor prepared the claim for the nursing home/provider and then adjudicated the claim to identify under/over billing or fraud? What is the penalty for failure to perform relative to these requirements? Will the Contractor be subject to sanctions in accordance with Section D, Paragraph 80, Sanctions?	Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing. Effective October 1, 2011 all nursing facilities must prepare and submit a claim in the standardized format – UB04 or 837 Institutional. Effective October 1, 2012 all other providers must prepare and submit a claim in the appropriate standardized format. It would not be appropriate for the Contractor to prepare the claim for the nursing facility/provider and then adjudicate the claim as this does not meet R9-22-719. Failure to comply with Contract requirements may result in sanctions in accordance with Section D, Paragraph 80, Sanctions.

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46	D. Program Requirements	44. Claims Payment/ Health Information System	70	As this is a significant change in contract language as addressed by AHCCCS at the Bidders' Conference, please provide AHCCCS's definition of "Roster Billing" and examples of what methodologies may and may not be used by the health plans for CY2012.	Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing.
47	D. Program Requirements	44. Claims Payment/ Health Information System	70	Is "Roster Billing" also disallowed for adult immunization billing?	Currently roster billing for adult immunization is not allowed. Additionally, Contractors must work with all other providers (other than nursing facilities) to eliminate roster billing and submit standardized claims with date dates of service on or after October 1, 2012. Nursing facilities shall be in compliance by October 1, 2011.
48	D. Program Requirements	44. Claims Payment/ Health Information System	70	Please provide a sample or cross-reference for the "standardized claim" form (if other than the UB-04), or otherwise describe the process, AHCCCS expects all nursing facilities to use when submitting claims to ALTCS Contractors on or after October 1, 2011.	AHCCCS expects nursing facilities to use a UB-04 standardized claim form or an 837 Institutional electronic format.
49	Program Requirements	45/Minimum Capitalization Requirements	73	In this section (Minimum Capitalization Requirements) the New Offerors subsection includes the following sentence: "The capitalization requirement is subject to a $5,000,000 ceiling regardless of the number of GSAs awarded." However, in the Continuing Offerors subsection includes the following sentence: "Continuing Offerors that are bidding a new GSA must provide the additional capitalization for the new GSA they are bidding." Please reconcile the differences between these statements – is the capitalization requirement of a continuing offeror capped at a ceiling of $5,000,000 or does the continuing offeror have a competitive disadvantage of providing the additional capitalization of any new GSA they way want to bid? Is the intent to reduce competitive proposals for new GSAs?	The sentence following the one you quoted in the Continuing Offeror's section states "Continuing Offerors will not be required to provide additional capitalization if they currently meet the equity per member standard with their existing membership and their excess equity is sufficient to cover the proposed additional members, or they have at least $5,000,000 in equity." Thus, there is a level playing field for both new and continuing Offerors and no intent to reduce competitive proposals for new GSAs.
50	Program Requirements	52/Financial Viability Standards	75	If, in the course of fulfilling the administrative requirements set forth by the contract, a Contractor	AHCCCS will consider new Contractor start-up costs and lower membership when monitoring compliance

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				incurs administrative costs that result in a ratio of greater than 8%, will AHCCCS consider alternatives to enforcement of the administrative ratio until such time that the Contractor's membership grows to a level supporting the stated ratio?	with the administrative cost ratio.
51	Program Requirements	52/Financial Viability Standards	75	How is the medical expense ratio calculated, e.g., on a cash or accrual basis? In accordance with NAIC requirements?	Contractors are required to prepare and present financial statements on the accrual basis of accounting in accordance with GAAP. The calculation for medical expense ratio is provided in this section of the RFP, Section D, Paragraph 52, Financial Viability Standards.
52	D- Program Requirements	53 – Separate Incorporation	76	The RFP states: "Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." The Contractor understands that using a separate "doing business as" entity name, for use solely for the performance of the requirements of this or another AHCCCS contract, will meet this requirement. Under what circumstances would this scenario not be acceptable?	It is incorrect to assume that use of a d/b/a meets the requirement. The RFP requires the establishment of a corporate entity whose only authorized business is to provide services and coverage under the contract with AHCCCS. It is acceptable to have a single corporate entity that is authorized to provide services under multiple contracts with AHCCCS (e.g., one corporate entity that holds separate contracts with AHCCCS for both the acute and long term care programs).
53	Program Requirements	56 Compensation	77	The RFP lists 7 data sources (a – g) utilized by its actuaries as their basis for rate setting. What assumptions did AHCCCS make in regards to the completeness of the encounter data utilized in the databook, by county?	See Section C - ALTCS General Trend and Rate Setting Assumption for completion factors by GSA.
54	Program Requirements	56/Compensation	77	How will Medicare risk adjustment payments impact capitation payments?	Medicare risk adjustment payments have no impact on AHCCCS' capitation payments to the Contractor.
55	Program Requirements	56/Compensation	77	Which data elements in which files will be used to indicate Prior Period Coverage (PPC) capitation, prospective capitation, reinsurance and payments from liable first and third parties?	Please clarify the question. What files are being referenced?
56	SECTION D. PROGRAM REQUIREMENT	56. COMPENSATION	78	Section states that "AHCCCS adjusts its rates to best match payment to risk" and in renewal years AHCCCS may look at reinsurance, Medicare	The mix of dual and non-duals are reflected in the data used for capitation rate setting, and rarely is there a significant shift that affects the rates. AHCCCS

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	S			enrollment, HCBS member mix and member share of cost values to determine if adjustment are necessary. The RFP also identifies how AHCCCS analyzes or reconciles differences in reinsurance experience, HCBS member mix experience and member share of cost experience. Please provide additional information related to how AHCCCS reviews, analyzes or reconciles deviations in the rate development driven by Medicare enrollment.	monitors dual enrollment for consistency from year to year to determine if changes to capitation rates are necessary. AHCCCS will pay particular attention to Contractors in Maricopa county that may differ from the county average mix of dual and non/dual members to determine if a capitation rate adjustment is necessary.
57	Program Requirements	58. Reinsurance	79	A change in the reinsurance program is the requirement that an inpatient stay occur before a 'regular reinsurance case' can be created. AHCCCS has provided an overall estimate of the impact of this change, but what is AHCCCS's actuarial estimate (percentage) of the reduction in reinsurance which will result from this change by county?	AHCCCS will provide this information by GSA with the reinsurance offset information in the Bidders' Library prior to 3/1/11.
58	Program Requirements	58/Reinsurance	79	Can AHCCCS describe how the reinsurance recoveries are reconciled and flow through the capitation calculation?	Reinsurance is a per member per month offset, by GSA, to the Acute component of the capitation rates. Reinsurance recoveries are not reconciled.
59	Program Requirements	58/Reinsurance-Regular Reinsurance subsection	80	Regular reinsurance coverage applies to prospective enrollment periods and is only available for members who have had an inpatient stay during the contract year. Once an inpatient stay has occurred, all reinsurance covered services for the entire contract year may be applied to meet the deductible. Please define an "inpatient stay"? Is there a limit on the length of stay (must the member have a minimum length of stay)? Will ALTCS accept notice of prior authorization? What protection does the Contractor have if the inpatient claim is not received until 11 months after the end of the contract year?	There is no minimum or maximum limit to the length of stay. Once the inpatient encounter is adjudicated and approved through both the encounter and reinsurance edits, the system will automatically assign to the reinsurance case all reinsurable encounters for that member. Encounters are reviewed individually for timeliness and reinsurance edits. The reinsurance time limit is 15 months from end date of service. AHCCCS will not accept notice of prior authorization.
60	D- Program Requirements	59 – Capitation Adjustments	83	The RFP states: "In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates." Please insert the	Regarding: (i) Contractor is always given the contract amendment for signature. Contractor

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				following sentence at the end of this section: Notwithstanding any other provision of this Agreement: (i) any modification materially, adversely affecting Contractor's compensation, reimbursement, or scope of services provided hereunder shall not be effective without Contractor's prior written consent; and (ii) if the Contractor and AHCCCS cannot reach agreement on the terms of such written modification within sixty (60) days after Contractor delivers a notice of termination to the AHCCCS, the Contractor may terminate this Agreement without penalty upon the expiration of such sixty (60) day period.	has the option not to sign. (ii) Contract language already stipulates the terms for notification to AHCCCS of intent not to renew or continue as an AHCCCS Contractor. See Section E, Paragraph 25, Term of Contract and Option to Renew for further information.
61	Program Requirements	60/Member Share of Cost	84	How is the Share of Cost calculated, and how does it apply to the capitation calculation?	The AHCCCS Division of Member Services (DMS) calculates a member's SOC based on many factors such as a member's income and spousal deductions. Members are notified by letter of their SOC. For more specifics see the ALTCS Eligibility Policy Manual on the AHCCCS Website. For capitation rate development, Share of Cost is calculated using most recent historical actual share of cost information for ALTCS members by GSA. Share of Cost is an offset to the capitation rate. See the Capitation Bid Template in the Bidders' Library for further information regarding how SOC applies to the capitation calculation.
62	Program Requirements	60/Member Share of Cost	84	How is the Share of Cost information shared with Contractors? Is it located within the 834 enrollment files?	SOC information is transmitted on the 834 roster files to the Contractor. In addition, Contractors may log on to the AHCCCS Online website and/or PMMIS to obtain individual member's SOC information.
63	Program Requirements	73/Data Exchange Requirements	93	Where can Contractors find Companion Guides or instructions for proprietary file formats and reports?	All data exchange related documentation including HIPAA Companion Guides, and technical guidelines for proprietary file formats are available in the Bidders' Library.

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64	Program Requirements	78/Operational and Financial Readiness Reviews	96	Please describe the Operational and Financial Readiness Review process, including specific milestones for system testing, on-site visits, AHCCCS departments that will be involved and their roles, and subcontracted entities with whom Contractors will interact. Please provide an explicit list of all file formats and reports that will be required to test during Readiness Review.	Readiness Reviews typically begin in mid-summer and assess a new Contractor's ability to implement the contract October 1st. In general, areas assessed are: the hiring of staff, physical plant operations, claims processing, case management, quality management, medical management, encounter reporting, grievance system; development of policies and procedures etc. Explicit information regarding milestones, participants, file formats and reports is not available at this time.
65	Program Requirements	78/Operational and Financial Readiness Reviews	96	Will AHCCCS provide additional information or guidance for new MCOs to begin implementation procedures prior to contract award?	Information will not be provided prior to contract award. Prior to contract implementation AHCCCS will schedule a series of meetings with new Contractors to provide guidance and assistance. Meetings will be scheduled as soon as feasibly possible (late May or early June).
66	D- Program Requirements	80 – Sanctions; Care Notice Process	98	The RFP provides that AHCCCS may provide a notice and opportunity to cure. Please change the word "may" to "shall."	Contract language will not be changed.
67	Program Requirements	85/Enrollment and Capitation Transaction Updates	101	Will AHCCCS provide a list of Rate Codes, a description of their values and their impact on the capitation received by the Contractor?	EPD capitation rates are paid by contract type, not rate code. Contract types J and 2 are tied to full EPD capitation rates. Contract types L and 4 are tied to Acute Care Only capitation rates. Contract types M and O are tied to PPC rates. A list of rate codes is located in the Bidders' Library in the Rates section, bullet point Enrollment Rate Codes and Eligibility Categories. Rate code descriptions are located at: http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/codes/RF401rate.aspx. Contract type descriptions are located at: http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/HealthPlan/codes/ContractTypes.aspx.

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68	E – Contract Terms and Conditions	4 – Contract Interpretation and Amendment; Written Contract Amendments	103	The RFP states: "The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State." Please add to the end of this sentence the phrase "and signed by a duly authorized representative of Contractor."	Change will be considered for possible future amendment
69	E – Contract Terms and Conditions	4 – Indemnification	104	The RFP states: "The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor." Would it be accurate to revise this sentence to clarify it only refers to actions arising out of litigation against AHCCCS "as a result of Contractor's performance or nonperformance of this Agreement"?	Change will be considered for possible future amendment.
70	E – Contract Terms and Conditions	19 – Temporary Management / Operation of a Contractor and Termination	107	The RFP states: "AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract…." Please insert the word "material" before "term or condition."	Change will be considered for possible future amendment.
71	E – Contract Terms and Conditions	19 – Temporary Management / Operation of a Contractor and Termination	107	The RFP states: "The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services." Please insert the word "commercially reasonable" before "excess."	Change will be considered for possible future amendment.
72	E – Contract Terms and Conditions	25 – Term of Contract and Option to Renew	108	The RFP states: "If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor." What does the phrase "certain costs" refer to?	Certain costs include any costs incurred related to transitioning members due to the Contractor's choice to not renew during a five year contract cycle.
73	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "In the event of a conflict in language between the two documents referenced, the provisions and requirements set forth and/or	If there is a conflict between the AHCCCS RFP and the Offeror's proposal, what is in the AHCCCS RFP will govern. This language will be clarified in a

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				referenced in the RFP shall govern." Which two documents are referenced here? If this refers to all documents identified in this paragraph, what is the order of precedence?	future amendment to Section E.
74	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal." Would such written clarification require a contract amendment to be effective?	Not all clarifications will require an amendment to the contract.
75	E – Contract Terms and Conditions	38 – Cooperation with Other Contractors	111	The RFP states: "AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents, and carefully fit its own work to such other contractors' work. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees." What does the phrase "and carefully fit its own work to such other contractors' work" mean? Also, is it accurate to change the phrase "shall not commit" to "shall not knowingly commit"?	AHCCCS will consider clarification and change in a future amendment.
76	G. Representations I. Instructions to Offerors	Section G. I. General Matters	137-141 151	The editable form for General Matters that is posted on the web is in 10.5 font and so our response is automatically formatted as 10.5 font. Will AHCCCS accept this section in a 10.5 font?	Yes
77	G. Representations I. Instructions to Offerors	Section G. I. General Matters	137-141 151	The editable form for General Matters that is posted on the web is already paginated and has a footer. Will AHCCCS post a revised template? If not, please provide direction regarding how to comply with pagination requirements.	Offerors can save the word document as their own file and then change the footer to exclude the AHCCCS pagination.

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78	G Representations I. Instructions to Offerors	Section G, I. General Matters	137-141, 151	Does AHCCCS plan to release an editable form for General Matters? The form currently on the website cannot be edited and loses its formatting when converted from Adobe.	Yes. This is now available in the Bidders' Library.
79	G. Representations	#7 and #8	139-141	As to information required in Section G and, under Contract No. YH07-0001, reportable within 120 days after year end, does AHCCCS want incumbent contractors to complete this information for the bid submission, within 120 days of year end, and/or both?	Both. Offerors should complete Section G as part of the bid process; Contractors should complete within 120 days of year end.
80	Section G-General Matters	8. Related Party Transactions (b)	140-141	The RFP asks offerors to "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:" Should the offeror place the list before or after subsections (i) and ii)?	The Offeror can place the list before subsections (i) and (ii).
81	G Representations I. Instructions to Offerors	Section G, I. General Matters	137-141, 151	Does AHCCCS plan to release an editable form for General Matters? The form currently on the website cannot be edited and loses its formatting when converted from Adobe.	Yes. This is now available in the Bidders' Library.
82	H	Introduction	142	Please provide the specific weighting by factor (A – D).	AHCCCS is not providing weighting.
83	Section H. Evaluation Factors and Selection Process	A. Capitation	143	AHCCCS has provided three years (one partial) of data as part of the databook. How much weight did AHCCCS give to each year (if any) in the development of it's published rate ranges? Will AHCCCS give direction on how mush weight was given to unaudited financial data, relative to accepted encounters?	For all GSAs except GSA 42, the base period is 100% CYE10 encounters from the databook with completion factors. The base for GSA 42 was set using 50% CYE09 and 50% CYE10. See Section C - ALTCS General Trend and Rate Setting Assumptions for additional information on trends. Unaudited financial data was used as a check on trends, base and final ranges
84	Section H. Evaluation Factors and	A. Capitation	143	Will AHCCCS aggregate or group specific counties base data to develop the capitation rate ranges? For example, will high cost counties be identified and	AHCCCS is not setting rates by county, but by GSA. No GSAs will be grouped for the base. Trends will be smoothed and depending on the credibility (by

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	Selection Process			aggregated to form the basis of the rate range development. If so, please provide the groupings methodology.	membership) will be a blend of the GSA trends and the statewide trends.
85	Instructions to Offerors	2. Prospective Offerors' Conferences and Technical Interface Meeting	145	The text in this paragraph indicates that the Offeror's Conference will be held on February 9, 2011, from 8:30a.m. until 4:30p.m. Are you able to provide any clarification as to what hours the general portion of the conference will take place versus the PMMIS System portion of the conference? This information is being requested so that we may make necessary arrangements to have the appropriate staff in attendance at the correct times.	Please see the Bidders' Library for further information on the Offerors' Conference.
86	I	9	146	"If an Offeror had an ALTCS contract in a GSA that was terminated by AHCCCS, and that same GSA is in the Offeror's proposal, AHCCCS ***may reject*** the proposal with respect to that GSA." Under what conditions would an award be made to a terminated bidder?	It is unknown at this time what circumstances may exist that would cause AHCCCS to award a contract to a previously terminated Contractor.
87	Instructions to Offerors	9/Award of Contract	147	Does AHCCCS intend to equalize membership among all Contractors in GSA 52?	Enrollment after contract award is addressed in Section I, Instructions to Offerors, Paragraph 9, Award of Contract.
88	Instructions to Offerors	9/Award of Contract	147	If AHCCCS chooses to expand the number of Contractors in a GSA, what mechanism will AHCCCS use to determine the maximum number of health plans awarded contracts for each region, particularly in GSA 52?	The mechanism will be based upon the circumstances that would lead AHCCCS to make such a decision. Those circumstances are unknown at this time.
89	Instructions to Offerors	9/Award of Contract	148	Based on information released at the Bidder's Conference, it is our understanding that selective assignments will be performed by AHCCCS for Unsuccessful Incumbents in GSAs in which multiple contracts are awarded. For members who did not exercise choice, AHCCCS will selectively assign the Unsuccessful Incumbent's membership to the Contractor with the lowest capitation rate. Before selective assignment occurs, AHCCCS will contact	The description in the question posed is not accurate. Please see Section I, Instructions to Offerors for information regarding the assignment of members in the event that there is an Unsuccessful Incumbent. The methodology described is only intended for use with this RFP process. New members that do not exercise choice in Maricopa County after contract award will be assigned as described in Section D, Paragraph 5, Enrollment Hierarchy.

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				Contractors with higher capitation rates and allow them to lower their capitation rate to a value equal to the lowest capitation rate. If multiple Contractors have equally low capitation rates, then selective assignments will be made to the Contractor with the lowest membership. Will the hierarchy described above survive the initial reassignment and become the methodology used on an ongoing basis?	
90	14. Contents of Offeror's Proposal	Parag. 2 (no title)	150	The RFP requires that responses be in 11 point font or larger. Is it acceptable to use 9 or 10 point font in tables, charts, and diagrams – for example, 11 point font in organizational charts and various types of flowcharts and diagrams is fairly uncommon. In addition, tables that include numbers or that are structured to compare or group certain types of information in text are often more readable in 9 or 10 point font.	For tables, charts and diagrams the font may be no less than 9 point font. All other responses must be 11 point font or larger.
91	Offeror's Check List & I	14	150	What defines permitted attachments?	See each submission requirement for applicable attachments.
92	I. Instructions to Offerors	14. Contents of Offeror's Proposal	150	Does a hard copy of the Network Summary Template need to be included in the scanned PDF version of the proposal?	No. The hard copy does not need to be included in the PDF version of the proposal.
93	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	151	In Section B. Capitation, the following sentence is included: "AHCCCS will only evaluate the Offeror's full long term capitation rates." However, in Capitation Bid Submission there is the following: 1. All GSAs in which an Offeror bids will require a capitation rate bid submission. Each bid will encompass three components: a medical component, a case management component, and an administrative component. **Each component will be scored separately.**"	Each component of the capitation bid submission will be scored separately for the full long term capitation rate only. The sentence was meant to clarify that bidders would only be submitting a bid for full long-term capitation rates and AHCCCS would only be scoring the full long term care rate. The Acute Care Only and Prior Period Coverage rates will be set by AHCCCS.

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				Please clarify these two statements – will AHCCCS only evaluate the Offeror's full long term capitation rates or will each component of the capitation bid submission be scored separately?	
94	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	151	Capitation states that "AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011." Please clarify if only the lower bound and midpoint PMPM's for each GSA will be provided, or if additional detail will be shared as it relates to the development of these rate ranges. For example, will the specific assumptions for trend or adjustments for programmatic changes be provided which are utilized in the development of the GSA specific rate ranges?	Information regarding rate setting assumptions and trend are currently available in the Data Supplement section of the Bidders'Library.
95	Section I Instructions to Offerors	Paragraph 14, Contents of Offeror's Proposal, B, Capitation	152	Regarding subsequent capitation rate amendments, for the administrative component specifically, will AHCCCS apply the bid Administration percentage to the adjusted rates or will AHCCCS leave the pmpm amount calculated in the original bid?	For awarded rates and any subsequent capitation rate amendments, AHCCCS will use the bid Administration percentage to calculate the dollar amount of the administration component of the capitation rate.
96	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	152	"AHCCCS is also providing Offerors with a case management model. This model is designed to assist Offerors in establishing the case management component of the capitation rates." Please clarify this statement and provide instructions to locate the referenced case management model.	The Case Management Model is one tool the Offeror might use to assist in the development of the case management component of the capitation rate. The Case Management Model is available in the Data Supplement section of the Bidders' Library.
97	Instructions to Offerors	14/Capitation & Capitation Bid Submission Subsection	152	"AHCCCS will adjust the awarded capitation rates via contract amendment prior to October 1, 2011 for Contractor specific capitation factors (e.g., Nursing Facility/HCBS mix adjustments) and reserves the right to adjust awarded capitation rates for program changes, legislative requirements, Contractor experience, and/or actuarial assumptions that were not previously included in the RFP capitation rate ranges	1. Yes, the Contractor may choose not to sign the amendment and provide notice of termination. 2. Any rate changes must be actuarially sound and subject to CMS approval. 3. Sufficient explanation will be provided regarding the basis for any rate changes.

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				published or the awarded capitation rates." There are several questions regarding this statement: 1. Will the Contractor have the right to reject this contract amendment and terminate the contract? 2. Will AHCCCS provide the Contractor with detailed information to determine if the rates offered meet the requirements of the Social Security Act § 1903(m)(2)(A); 42 CFR §438.6(c)(1)(i)(2009); Pub. L. No 111-3, 123 Stat.8, 103; and the American Academy of Actuaries practice note on guidance for certifying Medicaid managed care rates? 3. Will AHCCCS fully disclose its actuarial assumptions, including justification for why these assumptions were not included in the RFP capitation rate ranges published?	
98	I	B.1	152	Will AHCCCS provide Offeror the opportunity to submit test documents to the SFTP to assure accessibility?	Yes, the Offeror may submit test files. Upon submission, notify Celia Rodriguez via e-mail at Celia.Rodriguez@azahcccs.gov for confirmation of receipt.
99	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	152	AHCCCS is requesting an actuarial certification to accompany the proposals. Is there a standard template or specific language that AHCCCS is requesting offerors to include in the actuarial certification? Is there a specific level of detail required as a part of the certification?	AHCCCS is not requiring a specific level of detail and no template will be provided for the actuarial certification.
100	Section I	C. Organization, Question 5	153	In regards to the functional organizational chart of the key program areas and responsibilities requested for question 5, is there a page limit restriction associated with this requirement?	Yes, the standard three page limit applies.
101	C. Organization	6, Sanctions	153	This question requires (1) a description of and specific reason for a sanction, and timeline for resolving any deficiencies, (2) for the bidder and any legally related entities, (3) imposed by a Medicaid program, Medicare, or state insurance regulator, (4) over three	The three page limit requirement stands.

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				years, (5) within the three-page limit in 11 point font size. To permit a comparable level of specificity in responses from both regional, single-plan bidders and multi-state, multi-plan bidders, please consider removing or raising the page limit on this question. We believe that even well run and largely compliant multi-plan entities may need additional space to provide the level of detail and scope of information required. Although a three-page limit can be followed, a likely result is that AHCCCS may receive more summarized or aggregated responses from multi-state, multi-plan bidders, compared to smaller bidders.	
102	I	C.7	153	The instructions state: "Include an actual sample of the remittance advice (front and back)." Are the related page(s) included in the page limitation of the narrative or flow charts?	No. Remittance advice sample (front and back) or a written narrative of the remittance advice may be up to an additional four pages.
103	I. Instructions to Offerors	14.C. Organization	153	Please clarify. Question 7 directs the Offeror to include an actual sample of the remittance advice used. Will AHCCCS count the 2-page (front and back) sample as part of the page limitation for this submission requirement and, if so, within in which (narrative or flowcharts) should the Offeror account for the sample?	The number of pages that may be submitted for submission requirement 7 is four pages of narrative description of the claims adjudication process, five pages of flowcharts and up to four pages for the remittance advice.
104	I. Instructions to Offerors	Sanctions C6	153	Should encounter sanctions that were suspended by AHCCCS be included?	Yes. All sanctions received by an Offeror should be listed. The status of the sanction “suspended” should also be listed.
105	I. Instructions to Offerors	Q5	153	Can you define” Information Systems” as it is a required component of the organizational chart?	The component of the Offeror’s organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
106	I. Instructions to Offerors	Q5	153	Can the organizational chart have separate pages/charts for each functional area? Should it include job functions or staff names?	The submission response is limited to three pages and should include job functions.

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107	Organization	Information Systems/Question 14	154	Question 14 reads as follows: Describe the Offeror's plans and ability to support current and future IT Federal mandates. Please specify which future IT Federal mandates are being referenced in the above question.	Future IT Federal mandates may include, but are not limited to, areas such as, compliance with HIPAA version migrations, implementation of additional HIPAA format requirements, Legislative related requirements; etc...
108	I. Instructions to Offerors	14.D. Program, Case Management Submissions	155	Question 21 The question asks about "HCBS Member needs and service authorizations". Does HCBS refer specifically to members in their own home or to all members in HCB settings including ALFs?	HCBS in this context refers to members in both their own home and community residential settings.
109	Section I	D. Program/Quality Management Submissions, 31 (A)	158	In regard to Scenario A, please specify which type of facility the immediate jeopardy is taking place in.	Licensing requirements specify the number of residents that can reside in each type of facility. In Scenario A, it states that there are six Medicaid members in the facility. This indicates the facility is likely an Assisted Living Facility.
110	I. Instructions to Offerors	14.D. Program, Quality Management Submissions	158	Please clarify. Question 31 provides two quality of care scenarios which inherently include some unknowns that would be discovered during the investigation and handling of the issues. For purposes of describing the process and timeframes it will utilize within the page limit specifications of the bid submission requirement, what parameters (one or more alternative sets of facts/data) does AHCCCS expect the Offeror to use in completing the scenario? That is, does AHCCCS expect, as an outcome of describing each of their processes, to have each Offeror design a single set, albeit different, of complete facts/data for the case and, for the particular case scenario the Offeror describes, how the Offeror will handle the situation?	Please refer back to the first paragraph in Submission #31 for information regarding what should be included in the submission response.
111	I. Instructions to Offerors	Q 34	158	Can you define "service sites of members that reside in their own home"? Does this refer to in-home services only?	The service site for members that reside in their own home would include their home and any community based service sites that a member residing in their

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
					own home may access for services.
112	I	D.35	159	The actual Oral Presentations are to last approximately two hours. Is that one hour per scenario? New information is provided for the selected scenario (D.24, A – D) and an entirely new scenario is provided. "Offerors will be allotted time to privately discuss each scenario and to prepare a timed oral presentation." 1. Is the new information for scenario A – D given to offeror separately from the totally new scenario? 2. If yes, home much "…time to privately discuss and prepare…" is available prior to presentation? 3. If yes to #1, is the new scenario then provided immediately following the first presentation? How much time is allocated to preparing that presentation? 4. If both sets of new information are handed to Offeror at the same time: How much private discussion and preparation time is allotted? Does AHCCCS expect both scenarios to be presented consecutively after one private discussion and preparation period? 5. What equipment is permissible? What equipment does AHCCCS provide for the preparation - flip charts, white boards, overheads, etc.? 6. Will there be an opportunity to provide Offeror date/time requirements to assure availability of participating presenters? 7. Is it permissible to have a different team of 5 presenters for each of the 4 Member Scenarios?	Amount of time will be specified during the Oral Presentation. 1. Yes. New information will be provided for the selected Case Management scenario. A new Quality Management scenario will be provided. 2. Amount of time will be specified during the Oral Presentation. Both scenarios will be completed within the two hour time allotment. 3. See response to #2. 4. See response to #2. 5. A white board will be provided. Offerors should bring whatever tools that they may need to conduct an oral presentation. 6. Please see submission #35 for details of dates the oral presentations will be scheduled and when Offerers will be notified of their specific date and time. 7. Offerors are limited to a five team members total as specified in submission #35.
113	I	E.36	159	Does the Network Management plan (unlimited	No.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				pages) have to follow the format prescribed in the AHCCCS Policy for development of a "Network Management and Development Plan"?	
114	I	E.45	160	Is it true that ALL network LOI and Contract information ***must only*** be provided electronically by 3 PM on April 1, 2011 (Due date and time)? Can AHCCCS guarantee availability to the EFT/SFTP for all bidders on that day? Will EFT/SFTP be available prior to April 1 for uploading?	The information must only be submitted electronically. The EFT/SFTP server is available prior to April 1 for testing and /or early submission. AHCCCS cannot guarantee that unforeseen circumstances (power outage, fire) may not adversely affect server availability. The Offeror may submit test files. Upon submission, notify Celia Rodriguez via e-mail at Celia.Rodriguez@azahcccs.gov for confirmation of receipt. AHCCCS will notify Offerors in the event of EFT/SFTP unavailability.
115	I	E.45	160	How does AHCCCS evaluate and score the adequacy and accessibility of the Network Summary Report?	AHCCCS does not reveal its scoring methodologies.
116	I. Instructions to Offerors	14.E.Provider Network Submissions	160	Question 45 directs the Offeror to use the Network Summary template described in ACOM 420 *Network Summary Policy*. The Bidders' Library provides a Network Summary Template under the subsection "Forms". Should the Offeror use the template provided in the current policy, the Draft Policy for CYE2012 or the Network Summary Template provided in the Bidders' Library?	Offerors should use the Network Summary Template provided in the Bidders' Library (updated on 2/16/2011).

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

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 11th day of March, 2011, in Phoenix, Arizona.
Signature Karen Brach	Date 3/11/11	
Karen Brach, Chief Executive Officer		
Typed Name and Title		Michael Veit
Evercare Select		Contracts and Purchasing Administrator
Name of Company		

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
1	General Question			In restating the question from AHCCCS that we are responding to in our proposal, can this be in 9pt font as opposed to 11pt font? We understand that our response must be in 11pt font.	Yes
2	Program Requirements	12/Behavioral Health		Does the psychiatric inpatient bed days benefit extend to payment for bed days once a member is transitioned to the state psychiatric hospital?	Yes, however, payment is determined by the unique factual circumstances specific to the AzSH placement.
3	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			General Trend and Rate Setting Assumptions of the ALTCS RFP contains historical enrollment for the Acute Care Only members for the time periods that are in the databook. It is noted in the databook supplement that the Other population includes these Acute Care Only members. Does the Acute Care expenditures associated with the Other population include expenditures that are associated with these Acute Care Only members? If so, please provide either the actual dollar amounts, or the percentage of the total acute care expenditures for the Other population that are attributable to Acute Care Only members.	Yes. The expenditures of the Other population include expenditures for Acute Care Only. Historically, the acute component in the full EPD capitation rate is used to set the acute component in the Acute Care Only population. This is done due to the small population size of the Acute Care Only members. AHCCCS plans to follow this methodology for CYE12. Thus assume the dollar amount associated with Acute Care Only members is equal to the PMPM of acute component expenses divided by all prospective member months multiplied by Acute Care Only members.
4	Data Supplement Section C Utilization and Costs			Are the databook expenditures net or gross of reinsurance amounts?	Databook expenditures are actual expenditures and have not been adjusted for reinsurance amounts.
5	Data Supplement Section C TREND AND RATE SETTING ASSUMPTIONS			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Provider Fee Increase (PFI) for Behavioral Health, does the 9.1% PFI effective 10/1/2007 and the 3.8% PFI effective 10/1/2008 apply to all Behavioral Health expenditures or just to Behavioral Health Inpatient expenditures?	The 10/01/07, 10/01/08 and 10/01/10 provider fee schedule changes relate to all behavioral health expenditures. The 2/1/09 provider fee schedule changes relates to all behavioral health service rates set by ADHS so they exclude the tier per diem at an acute hospital, which remained flat. The 4/1/11 provider fee schedule changes exclude behavioral health inpatient service rates set by ADHS.
6	Data Supplement Section C TREND AND RATE SETTING			Section C - General Trend and Rate Setting Assumptions contains a matrix that represents historical and prospective Fee Schedule Changes. With regard to the Free-Standing Dialysis PFI,	COS 37, Outpatient Facility Visits. Data is not available regarding the portion of expenditures of that COS impacted by the fee schedule change.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
	ASSUMPTIONS			what COS does this PFI impact? And what portion of expenditures of that COS is impacted by this PFI?	
7	Forms- Network Summary Form			The second column of the Network Summary form (PC ID#) requires a Contractor Identification Number. How do new bidders obtain this number?	New Offerors are not required to fill out the second column.
8	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.		AHCCCS will publish actuarially sound rate ranges by GSA for the medical component of the capitation rates prior to March 1, 2011. Where are these rates published?	These rates are available in the Data Supplement portion of the Bidders' Library in the Data Supplement, under Section F, Bid Submission Tools.
9	Section C - General Trend and Rate Setting Assumptions, "Table I: Fee Schedule Changes"			This section lists the historical and prospective fee schedule changes for HCBS (home only) providers as 5% and 2.5% rate decreases on 10/1/2009 and 10/1/2010, respectively, and a 2.5% reduction on 4/1/2011. In the databook, there are 14 categories of service that are listed as HCBS home services. Do these fee schedule changes for HCBS (home only) apply to all 14 categories of services associated with HCBS home services? If not, could you please indicate which categories of service that these rate decreases apply to?	The changes for HCBS apply to all 14 categories of service.
10	Capitation			Please provide the actuarial memorandum for the development of the rate ranges for this RFP.	No actuarial memorandum will be provided for the rate ranges. AHCCCS will provide an actuarial certification to CMS at the time the final rates are submitted for approval, no later than September 1, 2011.
11	Capitation			If actuarial memorandum is not available, which factors were adjusted to determine the endpoints of the rate ranges? Examples might be improvements in medical management of acute services, improvements in the HCBS mix, etc. Can you provide those adjustments?	All of the assumptions for developing each mid-point of the range are provided in the Data Supplement, including a discussion of the HCBS mix. The ranges were then developed by computing appropriate deviations from the means.
12	Data Supplement			Pima County claims totals as found in the data supplement files are significantly lower than costs found in the unaudited financials. Were the ranges based on the supplemental files alone, or were adjustments made to account for the differences	The base data used for Pima GSA was the CYE10 encounters which, when adjusted by a completion factor, fall within a reasonable range when compared to the financials. Trends for Pima GSA were based on statewide trends without Pima GSA

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				between the supplemental files and the financials?	data due to the encounter issues for Pima in CYE08 and CYE09.
13	Data Supplement			GSA 44 and GSA 50 consistently show much smaller historical reinsurance offsets than the other GSAs. This differential is not consistent with acute costs in those GSAs relative to other GSAs. Are these reinsurance costs representative of the catastrophic acute costs experienced in these GSAs, or were there extenuating circumstances that led to unusually low reinsurance offsets?	GSA 50 has had historical encounter issues. AHCCCS attributes the low reinsurance payments in CYE08 to the fact that the Contractor did not adjudicate encounters on time and thus missed reinsurance timely filing deadlines. GSA 44 has lower TBI/BEH cases as well as lower regular RI cases. No extenuating circumstances that AHCCCS knows about led to the low reinsurance payments in that GSA.
14	RFP Amendment Number 1	Q&A #2	1	Please clarify- The response to this question also appears as the response to Q#103 regarding the Instructions to Offerors section 14.C.7. Is this the same answer to the question posed by the Offeror: "Is inclusion of the questions being addressed required as part of the narrative responses?" If the Offeror repeats the RFP Bid Requirement, will AHCCCS consider only the space utilized by the response to the requirement?	Inclusion of the question being addressed is not required. The total response (including any restatement) must be within the page limit specified.
15	RFP Amendment Number 1	Q&A #80	20	When the Offeror is required to provide a list as a part of its response to a disclosure requirement in Schedule G (e.g., items 7d and 8), may the Offeror include this as an exhibit/attachment to Schedule G within the General Matters section of the bid response, providing all disclosure information is included in the exhibit and the two parts are fully cross-referenced?	Yes
16	RFP Amendment Number 1	Question 90	22	When using Visio (standard flow charting software), the template shapes generally do not provide adequate spacing for 9 point font in certain shapes. Would a smaller font be acceptable if it can be clearly read within the lines of the template shape or will AHCCCS consider allowing more pages for flow charts given the font size limitation?	A minimum of 8 point font is acceptable for flowcharts only.
17	Program Requirements	19/Pre-Admission Screening and Resident	42	What is the difference between the Preadmission Screening and Resident Review (PASRR) mentioned on page 42 and the Pre-admission Screening (PAS) tool referenced in Sections 2	In order to qualify for ALTCS all applicants must meet both financial and medical eligibility. The PAS is conducted to determine if the person meets medical eligibility for ALTCS. The PASRR is

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
		Review (PASRR)		(Introduction / ALTCS Eligibility: Medical Eligibility section on page 17) and 3 (Enrollment Disenrollment / Disenrollment to Acute Care Program section on page 18)?	conducted prior to a member's admission to a nursing facility and is used to determine whether a member has any diagnosis or other presenting evidence that suggests the potential of mental illness or mental retardation and whether a member requires the level of care provided in a nursing facility and/or needs specialized services.
18	Program Requirements	31/Provider Registration	59	Will AHCCCS provide new offerors a database or other resource to look up provider AHCCCS ID numbers prior to bid submission? If so, when can new offerors expect to receive this information?	No database will be provided to new Offerors prior to bid submission.
19	Program Requirements	32/Network Summary	59	Do non-emergency Transportation Providers (i.e. ITM) require AHCCCS Numbers?	Yes, all providers require AHCCCS Provider Identification numbers.
20	GENERAL QUESTION: D. Program Requirements	44. Claims Payment/ Health Information System	70	In Amendment 1 issued by AHCCCS on 2/25/11, AHCCCS' response to Question 46 indicated that "Any claim that does not meet the standardized claim requirements of R9-22-719 is considered roster billing." Please verify the reference to R9-22-719 is correct, as we believe the correct reference may be R9-22-705.	This reference should be corrected to reflect R9-22-710 as stated in RFP Section D, Paragraph 44, Claims Payment/Health Information System.
21	D- Program Requirements	53 – Separate Incorporation	76	The RFP states: "Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract." AHCCCS previously clarified that it is acceptable to have a single corporate entity that is authorized to provide services under multiple contracts with AHCCCS (e.g., one corporate entity that holds separate contracts with AHCCCS for both the acute and long term care programs). Contractor also administers benefits for AHCCCS dual eligible Medicaid/Medicare members, and maintains a Medicare Advantage contract with	It is acceptable for the Contractor to use the same corporate entity for Medicaid and Medicare contracts.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				CMS. Contractor understands that it will continue to be acceptable to use the corporate entity that is authorized to provide services under the multiple AHCCCS contracts for the Medicare Advantage program. Please advise if this is not correct.	
22	D- Program Requirements	59 – Capitation Adjustments	83	The RFP states: "In these instances the adjustment and assumptions will be discussed with the Contractor prior to modifying capitation rates." AHCCCS previously responded that Contractor is always given a contract amendment for signature, and has the option not to sign. Will the contract be revised to incorporate language establishing that: 1. Modification of the capitation rates will not be effective without a contract amendment? and 2. Contractor is not obligated to sign any contract amendment?	No capitation rate change can be made without a contract amendment. Per response to Question #60 in Amendment #1: (i) Contractor is always given the contract amendment for signature. Contractor has the option not to sign. (ii) Contract language already stipulates the terms for notification to AHCCCS of intent not to renew or continue as an AHCCCS Contractor. See Section E, Paragraph 25, Term of Contract and Option to Renew for further information..
23	E – Contract Terms and Conditions	29 -- Contract	110	The RFP states: "AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal." AHCCCS previously responded that not all clarifications will require an amendment to the contract. Will the contract be revised to incorporate language establishing that any such clarification that materially, adversely affects Contractor's compensation, reimbursement, or scope of services will not be effective without being adopted pursuant to a contract amendment?	Change will be considered for possible future amendment.
24	Provider Network	Section H	142	The second paragraph describes that **"network development portion of Provider Network"** will be scored by GSA. The remaining submission	The "network development portion" refers to the Network Summary, Submission #45. The "network management portion" refers to all other

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				areas: the **network management portion of Provider network…."** are anticipated to be scored statewide, not specific to any GSA". Please clarify your definition of "network development" versus "network management" and where would the **network summary** fall between these two categories?	network submission requirements, #36 through 44.
25	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Each capitation bid will encompass three components; a medical component, a case management component, and an administrative component. Each component will be scored separately. Please provide additional details on how these components will be scored. Will each component have a maximum point level? Will the weighting for the three components be different than 33.3% each?	No further information will be provided regarding the scoring of the capitation bid.
26	Instructions to Offerors B. Capitation	Capitation Bid Submission	151	Will the rate bid for case management remain static, regardless of changes in the underlying case mix over the term of the contract, or will it be adjusted in the annual rate setting meeting to reflect the change in mix for a contractor?	The case management component is reviewed each year for necessary adjustments due to mix change or other factors.
27	RFP Section I; Instructions to Offerors	B. Capitation	152	Please clarify the name of the folder located on the FTP/SFTP server to be used for offeror's bid submissions. Specifically, should bid materials be submitted directly to "/EFPRFP12" or will a subfolder be created for offeror bid submissions (such as an "IN" folder)?	Each Offeror has an available folder listed by the Offeror's name that can be used for the bid submission. The folders can be located when logged on to the AHCCCS sftp. https://sftp.statemedicaid.us/ EPDRFP12 >Data SupplementFiles > (offeror folder name) use tab UPLOAD
28	Section I. Instruction to Offerors	14. CONTENTS OF OFFEROR'S PROPOSAL SECTION B.	152	Is the actuarial certification of the rates for the overall rate (the sum of the three components), a separate certification for each component of the rate that is being bid or only the medical component of the rate?	The actuarial certification is for the total rate bid.
29	Section I	C. Organization, Question 5	153	Regarding the requirement to provide functional organizational charts of the key program areas and responsibilities are Offerors allotted the three page limit per functional area?	The standard page limit of 3 applies to the total submission.
30	I (Instructions to Offerors)	Information Services	154	Regarding the sentence underneath Question 14 (which states: *Reference: Section D, Paragraphs*	The sentence is in reference to Questions 11 through 14.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				44, Claims Payment/Health Information System; 73, Data Exchange Requirements. Question: is this sentence in reference to Question 14 - or is it in reference to Questions 11 through 14?	
31	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	35	159	The reference for the submission requirement cites Paragraph 26 for Quality Management and Attachment H(1) for Enrollee Grievance System Standards and Policy. Are these correct?	The correct references for Submission Requirement #35 is: *Section D, Paragraphs 20, Quality Management, 22, Grievance System; Section F, Attachments, B(1), Enrollee Grievance System; ACOM, 406 Enrollee Grievance Policy; AMPM Chapter 900; 42 CFR 438.240; 42 CFR 438.408; 42 CFR 438.414*
32	I. Instructions to Offerors; #14, Contents of Offeror's Proposal	45	160	What GSAs have Zone requirements?	Two GSAs have Zone requirements – GSA 50, Pima County and GSA 52 – Maricopa. See ACOM Policy 419 Network Standards.
33	Section I	E.45	160	The RFP states: LOIs and contracts should NOT be included with the Offeror's proposal. Please confirm that this statement also indicates that LOIs and Contracts need not be provided electronically via the EFT site.	LOIs and contracts should not be provided via the EFT, however, they must be available for review if requested by AHCCCS.
34	Instructions to Offerors	14. E. Provider Network Submissions	160	Specifically to the provider network, are DD Group Homes a requirement of the ALTCS network? Previously they have been included in the DES program at AHCCCS, but the current requirements for each GSA include "DD Group Home" in the "HCBS Community" provider section. Is this correct for each GSA's requirements?	DD Group Homes are a covered service (see Section D, paragraph 10) and must be available when appropriate.
35	Provider Network		160	On the network summary - will you make a distinction between contracted providers and providers solicited through a Letter of Intent(LOI)? Furthermore, will you consider adopting a similar methodology utilized by Medicare Advantage whereby a random sample of providers is selected to determine if they truly are contracted or if providers actually agreed to contract (via LOI)? If not, what alternative methodology might you consider employing to ensure that providers listed in a network disk, in fact agreed to enter into a contract with a health plan or are currently	There will be no distinction between contracts and Letters of Intent. AHCCCS will not reveal its scoring or verification methodologies.

Question #	Section Name	Paragraph #/Title	Page #	Question	Response
				contracted?	
36	Provider Network	Question 45	160	How will the network summary be scored beyond meeting the minimum network standards?	AHCCCS will not reveal its scoring or verification methodologies.
37	ALTCS Bidders Library/ACOM	Chapter 300 – Financial	310-1	In the Bidder's Library link to the ACOM, the delivery supplemental policy indicates that it applies to all Acute contractors. Under the ALTCS program, is this policy also applicable? If so, what is the method of transmitting delivery information to AHCCCS for the delivery supplemental payments?	There is no delivery supplemental payment for the ALTCS program. This payment only applies to Acute contracts as the policy describes.

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A. General Matters

AHCCCS	Notice of Request for Proposal		AHCCCS Arizona Health Care Cost Containment System
	SOLICITATION NO.: **YH12-0001**	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.:
N/A

Federal Employer Identification No.:
86-0618309

E-Mail Address: karen_brach@uhc.com

Evercare Select
Company Name

3141 North 3rd Ave
Address

Phoenix | AZ | 85013
City | State | Zip

For clarification of this offer, contact:

Name: Karen Brach

Phone: 602.745.7998

Fax: 602.674.3891

Karen Brach
Signature of Person Authorized to Sign Offer

Karen Brach
Printed Name

Executive Director/CEO
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/ X 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

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

Subject	**Reference**	**Offeror's Page #**
Offeror's signature page	**(Front Page)**	**3**
Offeror's Checklist (this attachment)	**N/A**	**4**
Completion of all items in Section G of the RFP	**Section G**	**7**

B. CAPITATION

Subject	**Reqmt. #**	**Offeror's Page #**
Capitation Rate Bid (via EFT/SFTP and hard copy)	1	**16**

C. ORGANIZATION

Subject	**Reqmt. #**	**Offeror's Page #**
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C. ORGANIZATION - CONTINUED

Finance and Liability Management	17	**139**
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	19	**141**

D. PROGRAM

Subject	**Reqmt. #**	**Offeror's Page #**
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	21	**146**
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Quality Management	29	**182**
	30	**185**
	31-A	**188**
	31-B	**191**
	32	**194**
	33	**197**
	34	**200**
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

Subject	**Reqmt. #**	**Offeror's Page #**
Provider Network	36	**205**
	37	**266**
	38	**268**
	39	**271**
	40	**274**
	41	**277**
	42	**280**
	43	**283**

	44	**286**
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 there-from. If the Offeror provides laboratory testing, it certifies that it has complied with and has sent to AHCCCS simultaneous copies of the information required to be sent to the Centers for Medicare and Medicaid Services. (See 42 USC §1320a-7b, PL 101-239, PL 101-432, and 42 CFR §411.361.)

4. AUTHORIZED SIGNATORY

Authorized Signatory for Evercare of Arizona, Inc.
(referred to herein as "Evercare" or "Evercare Select")
[OFFEROR'S Name]

Karen Brach, RN — Executive Director
[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:

Karen Brach, RN		Executive Director, Evercare Select
Name		Title
3141 North 3rd Avenue		602-745-7998
Address		Telephone Number
Phoenix	AZ	85013
City	State	ZIP

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? 09/15/1988

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.
Evercare of Arizona, Inc. was incorporated in the State of Arizona in 1988 and remains an Arizona corporation

in good standing. As a result, it is qualified to operate as a ALTCS Contractor for the purpose of providing services and coverage under a contract with AHCCCS consistent with its present status as a ALTCS Contractor. A copy of the articles of incorporation is attached.

Have any licenses been denied, revoked or suspended within the past 10 years? Yes _☐_ No _☒_

If yes, please explain.

Evercare of Arizona has not had any licenses denied, revoked or suspended within the past 10 years.

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.

No federal or state agency has ever made a finding of noncompliance with any civil rights requirements with respect to our program.

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.

Evercare Select facilities are compliant with federal, state, and local rules regarding accessibility to and usability by persons with disabilities. We comply with applicable laws regarding non-discrimination and abide by Title VII of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and other federal and state laws, regulations or orders (including Executive Orders 11246 and 113756), "Equal Employment Opportunity" and requirements imposed by the regulations implementing these acts and amendments to the laws and regulations. The regulations provide, in part, that no person in the United States shall be excluded from participation in, or denied, any aid, care service or other benefits, or be subject to any discrimination under any program or activity receiving federal funds for any reason, including without limitation, race, color, religion, sex, national origin, ancestry, age, political beliefs, martial status sexual orientation, disability, health status and physical or mental handicap, utilization of covered services, source of payment and the filing of complaints, grievances or legal actions. In addition, Evercare Select requires all persons and entities with which it contracts to comply with such aforesaid laws. Contractors' compliance with these requirements is monitored through quality management and credentialing activities. While members do not visit our facilities for the provision of services, we do audit provider offices regularly and one of the items addressed is accessibility for persons with disabilities. Members are notified in the Member Handbook and other materials of their rights to obtain benefits and services through Evercare Select healthcare providers regardless of disability.

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.

No Evercare Select key personnel have had any felony convictions within the past 15 years.

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.

Evercare Select has never been suspended or excluded from any federal government programs for any reason.

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.

Erika Holmes, F.S.A., M.A.A.A. (Ingenix)

Name

12125 Technology Drive	Minnetonka	MN
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 or reviewing published capitation rates)? Yes_☒_ No _☐_ If yes, what is the name of this firm or organization?

Mary Temm, Mary Temm & Associates
Name

306 W. Virginia Avenue	Phoenix	AZ
Address	City	State

Tom Lescault, MRG Group
Name

4400 N. Scottsdale Road	Scottsdale	AZ
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.

All of Evercare Select's major systems are proprietary.

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.

Evercare of Arizona (Evercare), Offeror, is a continuing program contractor. Evercare timely filed its most recent 2009 Financial Disclosure Statement, i.e., within the last 12 months. There have been no significant changes. Therefore, in accordance with the instructions in RFP YH12-0001, Evercare of Arizona is not completing and submitting this Section G question 7, inclusive of it subparts a-g. Evercare shall timely file its 2010 Financial Disclosure Statement within the appropriate forthcoming filing period.

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:

Name	Address	Percent of Ownership or Control
Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.		

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
Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.		

Names of above persons who are related to one another as spouse, parent, child or sibling:

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is 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:

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.

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:

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

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.

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

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.

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

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.

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.

Evercare Select is a continuing program contractor and there have been no significant changes since our most recent Financial Disclosure Statement; therefore, this item is not applicable.

8. RELATED PARTY TRANSACTIONS

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

Name/Title	Address
Rodney C. Armstead, Director	77 Water St 14th/15th Floors, New York, NY 10005
William A. Hagan, Director and Chief Executive Officer	3141 North 3rd Avenue, Phoenix, AZ, 85013
Kara J. Rios, Director	9701 Data Park Drive, Minnetonka, MN 55343
Kent W. Monical, President	3141 North 3rd Avenue, Phoenix, AZ, 85013
David R. Hoffmeister, Chief Financial Officer	3141 North 3rd Avenue, Phoenix, AZ, 85013
Christina R. Palme-Krizak, Secretary	PO Box 9472, Minneapolis, MN 55440-9472
Robert W. Oberrender, Treasurer	9900 Bren Rd East, Minnetonka, MN 55343
Michelle M. Huntley Dill, Assistant Secretary	9900 Bren Rd East, Minnetonka, MN 55343
Eric J. Wexler, Assistant Secretary	26957 Northwestern Highway, Suite 400, Southfield, MI 48033
Paul T. Runice, Assistant Treasurer	9900 Bren Rd East, Minnetonka, MN 55343
Thomas S. McGlinch, Assistant Treasurer	9900 Bren Rd East, Minnetonka, MN 55343
Garell E. Jordan, Vice President Finance	3141 North 3rd Avenue, Phoenix AZ, 85013
John W. Kelly, Vice President, Tax Services	9900 Bren Rd East, Minnetonka, MN 55343
Karen E. Brach, Executive Director	3141 North 3rd Avenue, Phoenix AZ, 85013

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:

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
General, including providing employees and administrative, financial and managerial services.	United HealthCare Services, Inc. (UHS)	$16,663,261 for the 12 months ended 12/31/2009 per the 2009 annual disclosure statement

Justification:

Evercare of Arizona (Evercare) maintains an AHCCCS-approved management agreement with UHS to perform substantially all of the administration of Evercare. Evercare maintains market competitive rates with these transactions. At this time, no potential adverse impact to Evercare can be identified arising from these transactions. In addition, these transactions were executed in the normal course of Evercare business; therefore, there is no indication of any conflicts of interest between Evercare and these related

parties.

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
Ovations, Inc.	9900 Bren Road Minnetonka, MN 55343	Owner	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.**

Evercare Select's direct services as an ALTCS Contractor, for the purpose of directly serving the State of Arizona or its clients, will be performed within the borders of the United States.

JAN-18-2002 12:5

AMENDED AND RESTATED ARTICLES OF INCORPORATION OF VENTANA HEALTH SYSTEMS, INC.

DATE 1-17-2002

1. Name. The name of the Corporation is Evercare of Arizona, Inc,

2. Purpose. The purpose for which this Corporation is organized is the transaction of any or all lawful business for which corporations may be incorporated under the laws of Arizona, as they may be amended from time to time.

3. Authorized Capital. The Corporation shall have authority to issue 2,000,000 shares of common stock, no par value.

4. Known Place of Business. The street address of the known place of business of the Corporation is 7600 North 16th Street, Suite 150, Phoenix, Arizona 85020.

5. Statutory Agent. The name and address of the statutory agent of the Corporation is CT Corporation System, 3225 North Central Avenue, Phoenix, Arizona 85012 or any other agent as the Board of Directors may designate from time to time.

6. Board of Directors. The minimum number of directors shall be one (1). Directors need not be residents of the State of Arizona nor shareholders of the corporation. The directors, other than the first board of directors, shall be elected at the annual meeting of the shareholders, and each director elected shall serve until the next succeeding annual meeting and until his successor shall have been elected and qualified. The first board of directors shall hold office until the first annual meeting of shareholders. The number of directors may be increased or decreased by the shareholder.

EXECUTED this 17th day of January , 2002.

Maria C. Christu, Secretary

STATE OF ARIZONA
Department of State

TRADE NAME CERTIFICATION

EVERCARE SELECT

I, Ken Bennett, Secretary of State, do hereby certify that in accordance with the Trade Name Certification filed in this Office, the Trade Name herein certified has been duly registered pursuant to Section 44-1460, Arizona Revised Statutes, in behalf of:

EVERCARE OF ARIZONA, INC.
3141 N 3RD AVE
PHOENIX AZ 85013-

2/25/2011 Application

Registration Date: 02/25/2011

Expiration Date: 2/25/2016

Date First Used: 10/1/1996

Trade Name No.: 513438

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Arizona. Done at Phoenix, the capitol, this 1 day of March, 2011.

KEN BENNETT

TABLE OF CONTENTS

B. Capitation

B. CAPITATION

1. All GSAs in which an Offeror bids will require a capitation rate bid submission…...

Evercare Select's capitation rate bids for GSA's 40, 42, 44, 46, 48, 50 and 52 follow.

Section F - Capitation Bid Template

GSA40 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 40		
	Gross	MIX	Net
Nursing Facility	$ 5,463.72	24.86%	$ 1,358.28
Share of Cost			$ (212.17)
Net Nursing Facility			**$ 1,146.11**
HCBS Home and Community	$ 1,655.31	75.14%	$ 1,243.80
Net HCBS			**$ 1,243.80**
Acute Care Prior to Reinsurance			$ 723.05
Reinsurance Offset			$ (196.76)
Net Acute Care			**$ 526.29**
Medical Component [2]			**$ 2,916.20**
Case Management [3]			$ 125.88
Administration [4]		7.82%	$ 253.20
Sub-Total of Scored Components			**$ 3,295.28**
Risk/Contingency at 1%			$ 34.92
Net Capitation			**$ 3,330.20**
Premium Tax (98% of Final Cap)			$ 67.96
Net Cap w/ Premium Tax			**$ 3,398.16**

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.

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Section F - Capitation Bid Template

GSA42 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 42		
	Gross	MIX	Net
Nursing Facility	$ 4,959.24	41.20%	$ 2,043.21
Share of Cost			$ (290.22)
Net Nursing Facility			**$ 1,752.99**
HCBS Home and Community	$ 1,098.00	58.80%	$ 645.62
Net HCBS			**$ 645.62**
Acute Care Prior to Reinsurance			$ 508.10
Reinsurance Offset			$ (186.69)
Net Acute Care			**$ 321.41**
Medical Component [2]			**$ 2,720.02**
Case Management [3]			$ 102.51
Administration [4]		5.23%	$ 157.35
Sub-Total of Scored Components			**$ 2,979.88**
Risk/Contingency at 1%			$ 31.67
Net Capitation			**$ 3,011.55**
Premium Tax (98% of Final Cap)			$ 61.46
Net Cap w/ Premium Tax			**$ 3,073.01**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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)
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7) Bidder must use AHCCCS provided numbers for SOC, HCBS Mix % and Reinsurance Offsets when submitting their bid.

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Section F - Capitation Bid Template

GSA44 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 44		
	Gross	MIX	Net
Nursing Facility	$ 5,078.84	32.13%	$ 1,631.83
Share of Cost			$ (304.75)
Net Nursing Facility			**$ 1,327.08**
HCBS Home and Community	$ 943.66	67.87%	$ 640.46
Net HCBS			**$ 640.46**
Acute Care Prior to Reinsurance			$ 505.15
Reinsurance Offset			$ (106.81)
Net Acute Care			**$ 398.34**
Medical Component [2]			**$ 2,365.88**
Case Management [3]			$ 107.13
Administration [4]		5.48%	$ 141.45
Sub-Total of Scored Components			**$ 2,614.46**
Risk/Contingency at 1%			$ 27.21
Net Capitation			**$ 2,641.67**
Premium Tax (98% of Final Cap)			$ 53.91
Net Cap w/ Premium Tax			**$ 2,695.58**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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.

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Section F - Capitation Bid Template

GSA46 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 46		
	Gross	MIX	Net
Nursing Facility	$ 4,773.57	39.05%	$ 1,864.08
Share of Cost			$ (343.32)
Net Nursing Facility			**$ 1,520.76**
HCBS Home and Community	$ 1,033.17	60.95%	$ 629.72
Net HCBS			**$ 629.72**
Acute Care Prior to Reinsurance			$ 523.72
Reinsurance Offset			$ (120.27)
Net Acute Care			**$ 403.45**
Medical Component [2]			**$ 2,553.93**
Case Management [3]			$ 120.59
Administration [4]		7.79%	$ 217.63
Sub-Total of Scored Components			**$ 2,892.15**
Risk/Contingency at 1%			$ 30.12
Net Capitation			**$ 2,922.27**
Premium Tax (98% of Final Cap)			$ 59.64
Net Cap w/ Premium Tax			**$ 2,981.91**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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.

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Section F - Capitation Bid Template

GSA48 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 48		
	Gross	MIX	Net
Nursing Facility	$ 5,094.51	37.04%	$ 1,887.01
Share of Cost			$ (379.10)
Net Nursing Facility			**$ 1,507.91**
HCBS Home and Community	$ 1,525.82	62.96%	$ 960.66
Net HCBS			**$ 960.66**
Acute Care Prior to Reinsurance			$ 517.50
Reinsurance Offset			$ (124.59)
Net Acute Care			**$ 392.91**
Medical Component [2]			**$ 2,861.48**
Case Management [3]			$ 96.03
Administration [4]		5.67%	$ 174.90
Sub-Total of Scored Components			**$ 3,132.41**
Risk/Contingency at 1%			$ 32.57
Net Capitation			**$ 3,164.98**
Premium Tax (98% of Final Cap)			$ 64.59
Net Cap w/ Premium Tax			**$ 3,229.57**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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.

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Section F - Capitation Bid Template

GSA50 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 50		
	Gross	MIX	Net
Nursing Facility	$ 5,560.53	33.24%	$ 1,848.32
Share of Cost			$ (265.64)
Net Nursing Facility			**$ 1,582.68**
HCBS Home and Community	$ 1,507.46	66.76%	$ 1,006.38
Net HCBS			**$ 1,006.38**
Acute Care Prior to Reinsurance			$ 591.69
Reinsurance Offset			$ (195.45)
Net Acute Care			**$ 396.24**
Medical Component [2]			**$ 2,985.30**
Case Management [3]			$ 110.53
Administration [4]		4.95%	$ 162.92
Sub-Total of Scored Components			**$ 3,258.75**
Risk/Contingency at 1%			$ 34.54
Net Capitation			**$ 3,293.29**
Premium Tax (98% of Final Cap)			$ 67.21
Net Cap w/ Premium Tax			**$ 3,360.50**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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.

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Section F - Capitation Bid Template

GSA52 Bid Form

AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission [1]

Service Category	Evercare / GSA 52		
	Gross	MIX	Net
Nursing Facility	$ 6,016.83	25.82%	$ 1,553.54
Share of Cost			$ (223.08)
Net Nursing Facility			**$ 1,330.46**
HCBS Home and Community	$ 1,568.19	74.18%	$ 1,163.29
Net HCBS			**$ 1,163.29**
Acute Care Prior to Reinsurance			$ 496.30
Reinsurance Offset			$ (229.85)
Net Acute Care			**$ 266.45**
Medical Component [2]			**$ 2,760.20**
Case Management [3]			$ 94.99
Administration [4]		4.90%	$ 151.17
Sub-Total of Scored Components			**$ 3,006.36**
Risk/Contingency at 1%			$ 32.36
Net Capitation			**$ 3,038.72**
Premium Tax (98% of Final Cap)			$ 62.01
Net Cap w/ Premium Tax			**$ 3,100.73**

Key

user input
user input using AHCCCS provided numbers
formula

Notes

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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.

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3/25/2011

EVERCARE
Actuarial Certification

I, Erika Holmes, Associate Director, am associated with the firm of Ingenix Consulting, and am a Member of the American Academy of Actuaries. Ingenix Consulting has been retained by Evercare to assist in the preparation of the Arizona Long Term Care System (ALTCS) capitation rates for the period October 1, 2011 through September 30, 2012. Ingenix Consulting is a wholly owned subsidiary of Ingenix Health Intelligence (Ingenix). Ingenix is a wholly owned subsidiary of UnitedHealth Group (UHG). Evercare is also a wholly owned subsidiary of UHG.

I have relied on data and information provided by Evercare, including capitations, detailed claim and membership data, administrative expenses, restated incurred claims, medical management initiatives and case management expenses. I have relied on Evercare for the accuracy of the data. I have also reviewed long-term care encounter data provided by the Arizona Health Care Cost Containment System. In other respects, my examination included such review of results in the aggregate for Evercare as I considered necessary.

This certification applies to the capitation rates developed for GSAs 40, 42, 44, 46, 48, 50 and 52.

Except as noted above, I certify that the actuarial methods, considerations and analyses used to prepare Evercare's proposed capitation rates conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board.

Erika Holmes

3/23/2011

Erika Holmes, F.S.A., M.A.A.A
Ingenix Consulting
12125 Technology Drive
Eden Prairie, MN 55344
Phone: (952) 942-3250
Fax: (952) 942-3201

Date

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C. Organization

C. ORGANIZATION

Moral and Religious Objections

2. Submit a statement of any moral and religious objections to providing any services …..

Evercare Select provides all covered services and places no restrictions on covered services due to religious or moral objections.

We do not restrict coverage for any services because of moral or religious objections, nor do we place any constraints on the coverage, reimbursement or delivery of services based on moral or religious principles. We provide access to all Medicaid services covered under our contract with AHCCCS. All of our provider agreements contain a clause that allows the provider to refuse to provide any service they find objectionable because of moral or religious grounds. In that situation, we assist the member to access another provider who is willing to provide the service.

3. Submit current resumes of key personnel as required in Section D, Paragraph 25 …..

Evercare Select's key personnel meet the requirements of Section D, Paragraph 25, and have experience with the following types of programs:

- Medicaid managed care (an average of 12 years and total of 600 years collectively)
- Long-term care
- Elderly and persons with disabilities

Building on a Strong Foundation

Evercare Select values our long-standing relationship with AHCCCS as an ALTCS program contractor for the past 22 years and will continue our partnership with AHCCCS to help even more elderly and physically disabled (E/PD) members live healthier lives. Our dedicated, local personnel have over 600 years of collective experience in managing and serving the ALTCS program.

We continue to recruit and retain experienced and educated staff to operate our plan. The table below provides an overview of key personnel responsible for administrating our ALTCS plan for AHCCCS as defined in Section D, Paragraph 25 of the RFP. In addition to the required key personnel, we have provided information on current case management managers. However, should membership increase, we will adjust staffing in a manner that continues to ensure success in the administration of the ALTCS program.

All key staff are located in Arizona. We have provided their resumes, which include the years in their respective positions, years of LTC experience and their E/PD experience. Additional required staff members are also located in Arizona as required in Section D, Paragraph 25 of the RFP.

Summary of Key Personnel

Position Title	***Name***	***Years of LTC Experience***	***Years in Current Position***	***Page***
a) Administrator/CEO/COO	Karen Brach, RN	7 years	1 ½ years	29
b) Medical Director/CMO	Timothy Peterson, MD	12 years	3 ½ years	31
c) Chief Financial Officer/CFO	David Hoffmeister	15 years	Less than 1 year	33
d) Pharmacy Director	Dr. Sandra Brownstein, PHARM.D., FASCP, CGP	16 years	6 ½ years	35
e) Dental Director	Herb Kaufman, DDS	8 years	5 years	37
f) Compliance Officer	Kelly Kreiselmeier, MPA (formerly Kelly Morken)	17 years	2 ½ years	38
g) Dispute and Appeal Manager (Provider Claim Disputes)	Regina M. Lara-Ybarra* (6 years of appeal and grievance experience)	Less than 1 year	Less than 1 year	40
Grievance Manager (Member Services)	Scott Jewart	22 years	2 years	42
h) Business Continuity Planning and Recovery Coordinator	Karen Brach, RN	7 years	1 ½ years	29
i) Contract Compliance Officer	Kelly Kreiselmeier, MPA (formerly Kelly Morken)	17 years	2 ½ years	38

Summary of Key Personnel				
Position Title	***Name***	***Years of LTC Experience***	***Years in Current Position***	***Page***
j) Quality Management Coordinator	Myra Kingsley, RN, MSN	2 ½ years	2 ½ years	44
k) Performance/Quality Improvement Coordinator	Myra Kingsley, RN, MSN	2 ½ years	2 ½ years	44
l) Maternal Health/EPSDT (child health) Coordinator	Cindy Rose, LPN	7 ½ years	1 year	46
m) Medical Management Coordinator	Linda Morse, RN, MSN (Previously held this position for two years - August 2005 – January 2008)	11 years	Less than 1 year	48
n) Behavioral Health Coordinator	Theresa Robben, LBSW	22 years	4 ½ years	50
o) Provider Services Manager	Larry O'Connor	6 years	2 years	52
p) Claims Administrator	Helen Bronski, CPA	11 ½ years	2 years	54
q) Provider Claims Educator	Larry O'Connor	6 years	2 years	52
r) Case Management Administrator/Manager	Francine Pechnik	22 years	5 years	56
Case Management Manager	Mary Ashford, RN	10 ½ years	5 years	58
Case Management Manager	Joanne Helmer, RN	11 years	8 years	60
Case Management Manager	Jolie Keys, LMSW, MBA, CCM	13 years	5 years	62
Case Management Manager	Brenda Sharp, LPN	20 years	6 ½ years	64
Case Management Trainer/Program Development	Angela Farley, LPN	9 years	5 years	66

* *During her orientation period, Helen Bronski, Claims Administrator, will mentor Ms. Ybarra. Ms. Bronski has over eleven years of LTC experience and currently serves as the interim Dispute and Appeal Manager for the ALTCS program. In addition, Ms. Ybarra has over 30 years of experience in the health care insurance industry including experience with Medicaid and Medicare programs, as well as 6 years of appeal and grievance experience. We are confident Ms. Ybarra will continue to manage the ALTCS appeals/grievances in a manner that meets and exceeds AHCCCS' expectations.*

Karen Brach, RN

Administrator/ Chief Operating Officer/Chief Executive Officer
Business Continuity Planning and Recovery Coordinator

Overview

- Managed Care Executive with seven years of Long Term Care experience
- Five years of Elderly Physically and Disabled (E/PD) experience, including over one year serving the ALTCS program
- Over 15 years Health care/Managed Care Leadership Experience including Lead and Manage Health Plan Operations for Government Funded and Commercial Health Insurance Programs
- Experienced with Due Diligence Proceedings and Acquisition Integration.

Professional Experience

UnitedHealthcare October 2006 – Present
Evercare Select (a UnitedHealthcare Company) August 2009 - Present, Executive Director/Health Plan Administrator-COO-CEO-AZ

- Executive Director/Health Plan CEO for Medicaid Long Term Care Health Plan (ALTCS) and Medicare Institutional Special Needs Plan (Evercare Select)
- Accountable for execution and performance of all aspects of program contract including: revenue and medical expense management; network development of home and community based, assisted living, skilled nursing, behavioral health and acute care providers; medical and community care management programs; quality and compliance programs
- Serve as primary contact for all state, regulatory, and advocacy stakeholders
- Lead and manage a senior team including Medical Director, Network Manager, Operations Director, Health Services Director and Director of Compliance
- Achieved and exceeded all budgeted revenue, membership, medical expense, quality and SGA metrics and responsible for strategic growth initiatives and contract renewal.

UnitedHealthcare Community & State, August 2008 – August 2009, Vice President, Business Development

- Member of senior leadership team responsible for state-wide expansion of Tennessee's Medicaid program.

Evercare Select (a UnitedHealthcare Company), October 2006 – August 2008, Executive Director for Medicare Institutional and Dual Special Needs Health Plan-Chicago, IL

- Led and managed operations of new market start up health plan and responsible for strategic growth initiatives in five counties
- Successful service area expansion into Cook County
- Revenue and medical expense management; Marketing and sales; Network development of assisted living, skilled nursing and primary care providers; Medical and community care management programs; Quality and compliance programs
- Served as primary contact for regulatory and advocacy stakeholders
- Led and managed a senior team including Medical Director, Director of Business Development and Sales, Network Manager and Health Services Director.

AMERIGROUP Florida (an AMERIGROUP Corporation Company, Chief Operation Officer)-Tampa, FL/ November 2002 – October 2006

- Chief Operating Officer of statewide 240,000 member Medicaid and SCHIP Managed Health Plan
- Accountable for achieving health benefits ratio (HBR), revenue/membership and administrative budget targets
- Accountable for compliance with all regulatory and quality accreditation program requirements Direct reports include: Chief Medical Officer, Vice President of Network Development, Director of Health Plan Operations, Associate Vice President of Behavioral Health, and Director of Decision Support
- Areas of responsibility include medical management and quality programs, provider contracting and relations, behavioral health programs, earning improvement initiatives, regulatory compliance including HIPAA and Sarbanes-Oxley
- Serve as liaison to all state and federal regulators.

Bluegrass Family Health-Lexington, KY/March 1994 – November 2002
Chief Operation Officer/October 1998 – November 2002

- Chief Operating Officer of 120,000 member IPA model Health Plan with HMO, POS and PPO products. Direct reports included managers and directors of Compliance and Government Affairs, Information Systems, Claims Administration, Network Development, Customer Service and Marketing
- Instrumental in preparing operation for membership growth from 20,000 to 80,000 members in two years and member of management team responsible for profitability and financial turn-around; Managed and maintained administrative expenses less than nine percent of premium
- Negotiated provider contracts and evaluated financial performance of provider network
- Responsible for new product development including “open access” model and corporate compliance/regulatory oversight
- Responsible for reporting and analysis of claim lags; Implemented claim-processing technology resulting in over 60 percent auto-adjudication of claims
- Liaison between health plan, Kentucky HMO Association and Department of Insurance regarding health care reform initiatives
- Responsible for E-Health Strategy and implementation and member of Board of Directors.

Vice President Operations, Health Services March 1994 – October 1998

- Direct supervision of Medical Management, Network Development/Provider Relations, Customer/Group Service, Claims Processing, and Regulatory Compliance. Responsibilities included Utilization and Clinical Quality Management
- Oversight of UM, Pharmacy and Therapeutics, Credentialing, Customer Service and Quality committees
- Loss ratio and fee schedule analysis
- Improve COB and subrogation recovery and develop and evaluate health plan service standards and prepare for NCQA application and inform and educate health plan stakeholders, including Board of Directors and member of development team for Medicare Risk Product
- Participate in ongoing development and integration of Diamond/HSD system.

Education/Credentials

- Bachelor of Science, Major in Nursing - RUSH University Chicago
- Pre-nursing Curriculum, Calvin College.

Timothy J. Peterson, MD
Medical Director/CMO

Overview

- Senior Medical Director with 12 years of Long Term Care experience
- 34 years of Elderly Physically and Disabled (E/PD)experience, including 12 years of serving the ALTCS program
- Licensed Arizona physician
- Provides clinical oversight of medical management and quality management programs.

Professional Experience

Evercare Select (a UnitedHealthcare Company), Senior Medical Director/ CMO/ November 2007 – Present

- Responsible for oversight of all ALTCS Medicaid members, providing medical services and oversight for members with both sub-acute and chronic care needs.

Bridgeway Health Solutions, Vice President Medical Affairs/ August 2006 – November 2007

- Responsible for the Arizona Health Care Cost Containment System (AHCCCS) /ALTCS contractually required functions of the plan medical director
- Directly supervised the Director of Quality Management, a division that includes credentialing functions and the Director of Medical Management, a division that includes utilization management, concurrent review, and case management.

Pima Health System, Medical Director/ April, 1999 – August, 2006

- Oversee Utilization Management, Concurrent Review, Prior Authorization, Quality Management, and Credentialing
- Participate with other Divisions in Contracting and Network Development.

Thomas-David Medical Centers, P.C.-Tucson, AZ/ 1987 – 1998
President and CEO/ 1996 – April 1998

- Responsible for all policy, patient care, quality, and human resource issues
- Experience in budgeting, contracting, and planning.

President and Chairman of the Board of Directors/ 1993 – 1996

- Chaired Task Force that led to merger of TDMC and Intergroup with FHC (now FHS).

Site Medical Director/ 1990 – 1996

- Chairman - Utilization Review: Decreased Hospital Days/1000 Members
- Eliminated more than 10 percent budget overrun in outside purchased medical services
- Established and implemented new physician orientation program
- Resolved patient complaints
- Surgi-Center physician credentialing
- Served as member on the following committees:
  - Member - Joint Quality Management Committee, Southern Region Quality Management, and Referral Task Force. Committee
  - Initiated Outpatient UTI Treatment Protocol.

Treasurer, Board of Directors/ 1989 – 1993

- Served as member on the following committees:
  - Chairman - Finance Committee
  - Member - Compensation Committee, Defined Contribution Plan Committee, Budget Committee, Contracting Committee.

Staff Physician - Department of Urgent Care/ 1987 – 1993

Canyon Ranch-Tucson, AZ/ 1988 – 1989

- Preventive Medicine consultant to spa clients
- Chosen to appear on "CBS - 48 Hours" interview.

Frederic Clinic, Ltd.-Frederic, WI/ 1977 – 1987

- Active Family Practice for ten years in rural Wisconsin
- President of Frederic Clinic, Ltd.
- Active in all phases of practice management
- Negotiated practice buy-out and affiliation with St. Paul Ramsey Clinic
- Member of BOD, Frederic Municipal Hospital
- Active speaker/community educator
- Initiated community health events
- Rural Delegate to State Cancer Society
- Case Reviewer - State of Wisconsin Medicaid Program
- Assistant Professor - University of Minnesota Family Practice Department, St. Paul Ramsey Hospital.

Education/Credentials

- Family Practice Resident, University of Minnesota/Methodist Hospital/ 1974 – 1977
- MD, University of Wisconsin Medical School/ 1974
- BS Chemistry, University of Wisconsin-Madison, WI/ Honors Graduate 1970
- Peshtigo High School-Peshtigo, WI/ Valedictorian 1966.

Licensure/Certifications/ Professional Associations

- Diplomate, National Board of Medical Examiners/ 1975
- Diplomate, American Board of Family Practice/ 1977; Recertified/ 1984, 1991, 1998, 2005 (through 2012)
- Licensure: Arizona, Wisconsin, Minnesota
- Governing Council-AAAHC/ April 2010 – Present
- Board of Directors-AAAHC/ April 2009 – Present
- Surveyor Training and Education Committee of AAAHC/ 2005 – Present
- Surveyor - Accreditation Association for Ambulatory Healthcare (AAAHC)
- Surveyor Instructor-Accreditation Association for Ambulatory Healthcare: AAAHC is a deemed status organization for Medicare
- American Academy of Family Physicians
- Past Member American College of Physician Executives.

David Hoffmeister
Chief Financial Officer

Overview

- Over 15 years of Long Term Care experience
- Seven years of Elderly Physically and Disabled (E/PD) experience, including four years serving the ALTCS program
- Oversight of the budget, accounting systems and financial reporting of the ALTCS program.

Professional Experience

Evercare Select, a UnitedHealthcare Company/ January 1999 – Present
Chief Financial Officer / February 2011– Present

- Direct accounting and financial operations for the ALTCS program
- Work with plan leaders to set goals and objectives for department to align with company strategic goals and ensure accurate and timely regulatory reporting
- Provide financial direction on Medicaid strategic initiatives and opportunities to maximize revenue, medical expense management, administrative effectiveness and profitability.

Director of Finance/ August 2001 – February 2011]

- Direct accounting and financial operations for the APIPA Medicaid Products including Acute, ALTCS, CRS, Medicare and DD lines of business
- Work with plan leaders to set goals and objectives for department to align with company strategic goals and ensure accurate and timely regulatory reporting
- Provide financial direction on Medicaid strategic initiatives and opportunities to maximize revenue, medical expense management, administrative effectiveness and profitability.

Interim Director of Finance/ November 2000 – August 2001

- Lead finance department responsible for Acute, ALTCS (Arizona Physicians, IPA program), DD and HCG lines of business
- Prepare financial statements, regulatory reporting, contract analysis, reinsurance, Medicaid rate setting, budgeting, utilization reporting, reserve setting, and ad hoc analysis.

Manager Underwriting and Actuarial Services/ January 1999 – November 2000

- Manage department responsible for Acute, ALTCS (Arizona Physicians, IPA program), DD, and HCG lines of business
- Duties included contract analysis, Medicaid rate setting, budgeting, utilization reporting, month-end reconciliations, reserve setting, and ad hoc analysis.

North American Medical Management
Financial Supervisor/ March 1998 – January 1999

- Oversee all functions of finance and IS department
- Maintain EZCap system for five IPA's, administer LAN
- Develop claims auditing and reporting process and analyze contracts.

Senior Financial Analyst/ December 1997 – March 1998

- Produce physician utilization profiles and load monthly eligibility and process PCP and specialist cap checks
- Analyze proposed capitation contracts with health plans
- Prepare month end financial statements including IBNR amounts
- IS support.

Arizona Physicians IPA, Senior Financial Analyst/ April 1997 – December 1997

- Analyze contracts
- Calculate IBNR and other month end items for financial statements for all products including ALTCS (Arizona Physicians, IPA program)
- Produce rate proposals for Health Care Group
- Prepare annual budget
- Develop bids for AHCCCS products
- Respond to ad hoc requests.

Humana Health Care Plans
Provider Management Representative/ November 1995 – April 1997

- Analyze utilization of PCP's and specialists
- Prepare profiles for physicians to review
- Counsel physicians on utilization trends
- Educate provider staffs
- Handle claims appeals.

Financial Analyst/ February 1995 – November 1995

- Track inpatient utilization
- Perform claims audits
- Process account payables
- Update financial projections
- Analyze budget variances
- Produce ad hoc reports as needed.

Bryans Extended Care Center, LTC Financial Analyst/ August 1992 – February 1995

- Track census statistics
- Develop contract and capitation rates
- Process admissions
- Produce utilization reports.

Education/Credentials

BS in Accountancy, Arizona State University/ June 1990 – August 1992.

Sandra Brownstein, PHARM.D., FASCP, CGP
Pharmacy Director

Overview
- 16 years of Long Term Care experience
- 15 years of Elderly Physically and Disabled (E/PD) experience, including 6 years serving the ALTCS program
- Licensed Arizona pharmacist.

Professional Experience

Evercare Select (a UnitedHealthcare Company), Pharmacy Director (AZ)-Phoenix, AZ/ May 2004 – Present
- Manage the pharmacy benefit for Medicaid and Medicare recipients in both Arizona for Evercare Select
- Work with pharmacies and medical providers to ensure members receive medically necessary medications timely including follow through on denials and NOA letters
- Responsible for oversight of pharmacy benefit manager to administer the prescription drug plan
- Participate in formulary management through P&T
- Provide pharmaceutical care to help prevent medication related problems
- Work collaboratively with medical management on medication reconciliation as our members transfer through different health care systems.

NCS Healthcare, Director of Pharmacy-Phoenix AZ/ 2002 – 2004
- Management of day to day operations of a 6500 bed nursing home pharmacy contracted with numerous long term care and assisted living facilities throughout Arizona
- Manage staff in all aspects of operations including billing and delivery
- Pharmacist consultant to several of these homes under contract.

SeniorCare Strategies LLC, President -Tucson, AZ/ January 1999 – 2008
- Developing customized long-term care preceptorship programs for the pharmaceutical industry
- Providing strategic planning for clinical contract pull-through between industry and institutional pharmacies
- Developing and implementing disease state management programs in disease states such as Osteoporosis, Pain Management, Dementia, Alzheimer's, and Parkinson's Disease
- Participating in and moderating industry long-term care advisory boards
- Educating both medical professionals and the public on pharmaceutical issues affecting the senior care market and maximizing partnerships in the senior care marketplace.

NeighborCare Pharmacy / Vitalink Pharmacy Services, Divisional Clinical Manager (Central Region)-Naperville, IL/ October 1997 – April 1999
- Implementation of clinical program for the central region including 26 pharmacies, servicing 60,000 chronic care beds
- Provided training and resource support to all clinicians in the central region
- Participated on Vitalink's National Pharmacy and Therapeutics Committee that develops and maintains a national formulary template and oversees customization of customer specific formulary
- Worked in conjunction with research and development to train and implement the disease state management program, OPTIMA

- Participated in the Phase II research project, Fleetwood that identified a methodology for prospective clinical review.

WHP Health Initiatives; Alternate Site Services, Manager/Director, Institutional Pharmacy, Clinical Services, Walgreens Advance Care Pharmacy-Deerfield IL/ May 1995 – October 1997

- Developing clinical services program for the long-term care division of Walgreens
- Provided training of pharmacy consultants in pharmaceutical care and clinical services
- Conducted retrospective and prospective utilization review in long-term care
- Participated with industry on drug studies and outcomes documentation
- Developed formularies to be implemented in long-term care facilities and hospice programs
- Developed disease management protocols to be used by the interdisciplinary health care teams.

Walgreens Advance Care Pharmacy, Long-Term Care Specialty Residency/University of Arizona-Phoenix, AZ/ July 1994 – July 1995

- Advanced training in long-term geriatric pharmaceutical care, conducted a variety of geriatric-oriented projects
- Conducted retrospective and prospective utilization reviews in long-term care
- Participated in interdisciplinary projects in disease management protocol development.

Walgreens Retail Pharmacy, Registered Pharmacist-Tucson, AZ/ August 1994 – May 1995

University of Arizona, Clinical Clerkship-Tucson, AZ/ May 1993 – May 1994

Education/Credentials

- Doctor of Pharmacy Degree, University of Arizona-College of Pharmacy – Tucson, AZ/ May 1994
- Long-Term Care Specialty Residency, University of Arizona- College of Pharmacy/Walgreens Advance Care – Tucson, AZ/ July 1995
- ASCP Foundation/Bayer Corporation Alzheimer's/Dementia Traineeship Program, Oakwood Medical Center – Dearborn MI/ December 1999
- ASCP Foundation/DuPont Pharma Parkinson's Traineeship Program, Sinai Clinical Neuroscience Center – Bloomfield, MI/ September 1996
- Gerontology Certificate, University of Arizona Committee on Gerontology – Tucson, AZ
- Bachelor of Science Degree in Med. Technology, University of Arizona, School of Health Related Professions – Tucson, Arizona/ July 1985.

Licensure/Certification

- Certified Geriatric Pharmacist #0100/ January 1998
- Minnesota State Board of Pharmacy License #116174-4
- Arizona State Board of Pharmacy License #10619/ August 1994
- Certified by American Society of Clinical Pathologist and National Certification Agency for Clinical laboratory Scientist.

Herb Kaufman, DDS
Dental Director/Coordinator

Overview
- Eight years of Long Term Care experience
- Five years of Elderly Physically and Disabled (E/PD) experience with ALTCS
- Licensed Arizona dentist
- Executive Dental Director with over 13 years experience working with both state and federal government and private sector clients to measurably improve patient care and quality outcomes in vulnerable populations.

Professional Experience

Evercare Select (a UnitedHealthcare Company), Director, Dental Operations ALTCS - /2009 – Present
Arizona Physicians, IPA (a UnitedHealthcare Company), Director, Dental Operations/2005 – Present
- Maintain, review, and enhance dental organization processes and activities to align with AHCCCS's objectives
- Oversee claims, pre-authorization, quality assurance, and network management of the dental segment
- Facilitate coordination and communication between APIPA and AHCCCS with regard to dental activities, issue resolution, and initiatives
- Implement strategic outreach objectives, designed to engage members and providers, in order to increase opportunities to achieve and exceed AHCCCS's ongoing goals.

ATSU, AZ School of Dentistry, Director Clinical Operations/2007 – Present
- Establish direction and leadership for clinical operations
- Realign Staffing, Budget, Contracting, and Organizational components to achieve optimal efficiency.

Mercy Care Plan/Schaller Anderson, Dental Director/ 2003 – 2005
- Oversaw pre-authorization, claims, utilization management, quality assurance, and outreach components.

Dental Management Network LLC/Partner/2000 – 2003
- Business and Health care strategic planning and consultative services to the dental benefits industry, dental profession, and associated organizations.

Safeguard Health Enterprises, Sr. Vice President and Chief Dental Officer/1997 – 2000
- Strategic and operational leadership role for PPO, Indemnity, and Managed Care, with over 1 million members
- Key impacts in utilization management, quality, professional and network relations, training, sales, plan design, integration of acquired companies.

Education/Credentials
- Doctor of Dental Surgery, University of the Pacific School of Dentistry-San Francisco, CA / 1976

Certifications
- Active Dental Licenses: Arizona, California, Colorado
- American Association of Dental Consultants
- Association Membership: ADA, AZDA
- Arizona School of Dentistry and Oral Health – Faculty.

Kelly Kreiselmeier, MPA (formerly Kelly Morken)

Compliance Officer
Contract Compliance Officer

Overview

- Compliance Officer with over 17 years of experience in Long Term Care/Medicaid, serving and enhancing the quality of life for the elderly and physically disabled population
- Eight years as a case manager serving the Arizona Long Term Care/ Elderly and Physically Disabled (E/PD) members.
- Three years as a Case Management Manager, oversight of up to 16 case managers, rural and urban managing services for the ALTCS/EPD members.
- Two years as a ALTCS/EPD Case Management trainer
- Two years as Member Service Manager serving the ALTCS/EPD Population
- Over two years Compliance Officer/Contracts Compliance for the ALTCS/EDP contract
- Comprehensive knowledge of the ALTCS Contract, AHCCCS policy, and procedures operations manual
- Primary point of contact for all ALTCS contractual issues.

Professional Experience

Evercare Select (a UnitedHealthcare Company)/ 2001 – Present
Compliance/Contract Compliance Officer-AZ / 2008 – Present

- Compliance Officer and Contract Compliance Officer for 3000 member Long Term Care Plan
- Management official, available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS Office of the Inspector General
- Responsible for coordination of all ALTCS deliverables and compliance with submission
- Fraud and Abuse Coordinator and Business Continuity Coordinator.

Phoenix College, Adjunct Faculty-Phoenix, AZ/ August 2004 – Present

- Instructor for required core course, “Fundamentals in Health Care Delivery”
- Provides an overview of health care delivery systems (Medicaid, Ethics, etc.)

Member Service Manager-Phoenix, AZ/ February 2006 – September 2007

- Fraud and Abuse Coordinator
- Transition Coordinator, Program Changes and Open Enrollment
- Manage member Grievance and Appeals
- Produce Medicaid Newsletter and Handbook

Case Management Trainer-Phoenix, AZ/ August 2004 – February 2006

- Develop, Implement and train on policies and procedures.

Case Management Manager-Phoenix, AZ/ 2001 – 2004

- Manager of up to 18 long-term care case managers

Ventana Health Systems by UnitedHealthcare, Case Manager-Flagstaff, AZ/ 1998 – 2001

- Successfully managed caseload of home and institutionalized members.

Arizona Physicians, IPA by UnitedHealthcare, Case Manager-Yuma, AZ/ 1994 – 1998

Education/Credentials

- Northern Arizona University-Flagstaff, AZ
  - Masters in Public Administration with an emphasis in Gerontology/ 2001
  - Bachelor of Social Work/ 1992
- Member of the Health Care Compliance Association
- Member of the Arizona Geriatrics Society.

Regina M. Lara-Ybarra
Dispute and Appeal Manager (Provider Claims Disputes)

Overview

- Third Party Administration Licensing for the State of Arizona
- Thirty years experience in the health care insurance industry (AHCCCS, HMO, Commercial, and Medicare)
- Six years appeals and grievances experience

Professional Experience

Evercare Select, Dispute and Appeal Manager / March 2011 – present

- Manages and adjudicates provider disputes arising under the Grievance system
- Responsible for provider grievances, research and resolution in accordance to AHCCCS guidelines.

Arizona Department of Insurance, TPA Licensing/Health Care Compliance Officer/2006 – March 2011

- Responsible for review and approval of new all applicants and the renewal of existing applicants for Third Party Administrator licensing in accordance to Regulation and Statute for Arizona.
- Responsible for the oversight of Health Care Service Organizations to ensure an adequate provider network is in place in all licensed geographical areas in accordance to Regulation and Statute for Arizona.
- Performed Compliance Examinations on insurers to validate compliance with Arizona Revised Statutes. This included claims, member appeals and provider grievances.

UnitedHealthcare, Compliance Consultant/ 2003 – 2006

- Responsible for creating work plans and preparing documentation for Market Conduct Examinations.
- Collaborated with various business units and functional areas regarding Regulatory findings for corrective action and to meet compliance needs.
- Performed pre-assessments of various functional areas within the organization.

UnitedHealthcare Community Plan (A UnitedHealthcare Company), Appeals Coordinator/ 2002 – 2003

- Responsible for member appeals and provider grievances research and resolution in accordance to company and Medicaid guidelines.
- Represented the organization at the Office of Administrative Hearings (OAH) on behalf of the Medicaid line of business for AHCCCS related issues.
- Responsible for assisting with Division of Developmental Disabilities (DDD) grievance and appeal case resolution.
- ***UnitedHealthcare, Business Analyst/Project Management Team/ 2002 – 2002***
- Performed pre-assessments within various functional areas of the organization.
- Team participant for root cause analysis findings and corrective action.

UnitedHealthcare of Arizona/ Grievance/Appeals Manager/ 2000 – 2001

- Originated and implemented policy and procedure within the commercial Grievance and Appeals Department, including training of new hires.
- Responsible for research and resolution of complaints originated in Corporate Consumer Affairs, Executive Complaints, Department of Insurance Complaints and complaints from the Better Business Bureau. In addition, responsible for handling all health plan subpoena's.

- Responsible for the tracking and trending of commercial Grievance and Appeals, including turnaround timeframes.

UnitedHealthcare of Arizona, Abuse and Fraud Specialist/ Reimbursement Policy Manager/ 1997 – 2000

- Prevented and recovered inappropriate benefit payments to abusive and fraudulent practices and verified compliance to Plan contractual requirements.
- Developed and coordinated monthly BPL (Benefit Outline-Pay Summary) meetings for the health plan and attended monthly meeting and contributed feedback regarding the member Certificate of Coverage questions and clarification.
- Liaison for the organization to ensure Corporate and Plan reimbursement policies were communicated, implemented and maintained, in addition to providing claims training for processors on as as-needed basis regarding new polices and contractual amendments.

Education/Credentials

- Phoenix Community College, Phoenix, AZ, Business Administration courses, 1980-81
- St. Mary's High School, Phoenix, AZ, majored in Business Administration, graduated 1979

Scott Jewart
Grievance Manager (Member Services)

Overview

- Manager with 22 years of Long Term Care experience
- 22 years of Elderly Physically and Disabled (E/PD) experience, including 19 years serving the ALTCS program
- 28 years of experience working in health care, ranging from ranging from member services, direct case management, case management supervision, and provider relations/contract management.

Professional Experience

Evercare Select-Phoenix, AZ/ December 2003 – Present
Grievance/Member Services Manager/ 2008 – Present
Case Manager/ June 2003 – December 2008

- Receive, track, and adjudicate member grievances and appeals
- Manage member communications including newsletters, member handbook, and other communications to members
- Responsible for development and implementation of the Cultural Competency plan
- Implementation and revision of policies and procedures
- Assess and interpret customer needs and requirements
- Provide education to members on program and alternative available resources
- Implementation and monitoring of plan of care
- Assist members to solve problems and coordinate care.

Pinal Gila Long Term Care, Case Management Administrator-Florence, AZ/ February 2001 – June 2003

- Complete programmatic oversight of the ALTCS Case Management program for Pinal and Gila Counties
- Direct and indirect supervision of up to 27 staff (case management supervisors, case managers, and support staff)
- Development, implementation and revision of policies and procedures
- Function as lead in internal and external audits, including development and implementation of corrective action plans
- Act as resource for others with less experience
- Resolution of informal complaints.

Lifemark (now Evercare Select)-Phoenix, AZ, Case Management Manager/ August 2000 – February 2001

- Implementation of ALTCS case management program in Maricopa County
- Hire, train and supervise up to 12 case managers
- Participate in external and internal audits, including development of plans of corrections
- Reconcile monthly AHCCCS reports and complete department reports
- Coach, provide feedback, and guide others
- Additional responsibilities included the role of Behavioral Health Coordinator.

Pinal County Long Term Care/Pinal Gila Long Term Care-Florence, AZ/ September 1990 – August 2000

- *Case Management Supervisor Title III/ Title XX program/ September 1990 – December 1992*
- *Case Management Supervisor ALTCS program/ December 1992 – April 1998*
- *Contract Administrator/ April 1998 – August 2000*

- Contacts administration and monitoring
- Grievance coordinator to include resolution and reporting of grievances and appeals
- Behavioral Health Coordinator
- Employee hiring and supervision
- Development of policies and procedures
- Provider relations
- Updating Provider Manual
- Credentialing and conducting Peer review meetings
- Preparation and monitoring of budget for grants
- Solving complex problems and conducting complex analysis of reports.

Maricopa County Long Term Care, Case Manager (SAIL program and ALTCS program)/ September 1988 – September 1990

Education/Credentials

- Licensed Bachelor of Social Work – Arizona Board of Behavioral Health Examiners.

Licensure

- Mesa Community College, LPN Certification/ May 2005
- Certified Public Manager Certificate, Arizona State University/ 1997
- Bachelor of Science, Psychology-Northern Illinois University/ December 1982
- Minor: Math.

Myra Kingsley, RN, MSN
Quality Management Coordinator
Performance/Quality Improvement Coordinator

Overview

- Two years of Long Term Care experience
- Over four years of Elderly Physically and Disabled (E/PD) experience, including 2 ½ years serving the ALTCS program
- Registered Arizona nurse - Nursing professional with over 15 years experience in both the clinical and managed care setting
- Medicaid quality management experience includes 10 years with AHCCCS programs and 13 years in a leadership role
- Summary of years Quality Management experience:
  - Leadership roles in program development and improvement of existing projects
  - Ensure individual and systemic quality of care and integrates quality throughout the organization
  - Implement process improvement and resolve, track and trend quality of care grievances
  - Ensure a credentialed provider network
  - Leads multidisciplinary teams to achieve compliance in all areas of Medicaid managed care programs

Professional Experience

Evercare Select, Director Quality Management/Quality Management Coordinator/Quality Improvement Coordinator/ November 2008 – Present

- Responsible for directing quality improvement activities for the Health Plan and improvement of outcomes
- Developed quality initiatives to improve member care for the ALTCS population and meet state regulatory requirements
- Work in collaboration with Case Management to monitor, measure performance and improve performance indicators
- Responsible for monitoring and resolution of all quality of care issues
- Planned and implemented activities necessary to measure quality of care to Health Plan members
- Trended clinical and service indicators that monitored quality of service delivered, developed and facilitated corrective action plans as needed to improve results.

St. Joseph's Hospital and Medical Center, Manager, Regulatory and Compliance (Children's Rehabilitative Services (CRS) program)/ January 2006 – November 2008

- Developed systematic approach to ensure compliance with all Arizona Department of Health Services (ADHS) policies, rules and regulations
- Created and facilitated action plans and other strategies to address any deficiencies
- Responsible for all regulatory aspects of the program, and ensuring submission of all required deliverables
- Acted as facilitator between departments to promote and implement change to ensure program compliance
- Collaborated with St. Joseph's Corporate Compliance program to incorporate program monitoring to identify fraud and abuse within the program.

Phoenix Health Plan, Director Quality and Compliance/ January 2001 – January 2006
Quality Program Manager/ March 1999 – January 2001

- Developed programs to operationalize continuous quality improvement activities.
- Supported and developed programs and systems within the Health Plan that demonstrated quality initiatives and ultimately improved outcomes
- Ensured Health Plan compliance with AHCCCS rules and regulations and facilitated development of action plans to address any gaps
- Responsible for the implementation of the Quality Improvement System for Managed Care and other regulatory standards, such as Cultural Competency and Privacy standards.
- Responsible for oversight of all aspects of the Credentialing Unit
- Ensured that Health Plan Credentialing Policies and Procedures met AHCCCS and NCQA standards
- Accomplished successful implementation and start up operation of credentialing software, which allowed for increased efficiency, timeliness and accuracy of the credentialing process
- Responsible for monitoring and follow up of quality issues
- Planned and implemented activities necessary to measure quality of care to Health Plan members.
- Trended clinical and service indicators that monitored quality of service delivered, developed and facilitated corrective action plans as needed to improve results.

Arizona Health Care Cost Containment System (AHCCCS), Quality Management Coordinator/ July 1998 – March 1999

- Responsible for monitoring and resolution of quality of care issues in a timely manner
- Effectively communicated both verbally and in writing with AHCCCS members, staff, health plans and providers
- Participant in operational and plan reviews of contracted health plans to ensure accessibility and delivery of quality health care to AHCCCS members.

Scottsdale Healthcare - Shea, Cardiovascular Case Manager-Scottsdale, AZ/ January 1994 – July 1998

- In collaboration with administration, conducted research and design of case management model
- Facilitator, educator and change agent for integration of case management
- Utilization of advanced nursing skills and knowledge of resource management to coordinate the care of a designated population
- Developed and implemented telephone case management for the congestive heart patient.

Scottsdale Healthcare- Shea, Staff Nurse-Scottsdale, AZ/ May 1989 – January 1994

- Staff nurse for the critically ill patient in the Cardiovascular Intensive Care Unit and the Medical Intensive Care
- Participated in Shared Governance Structure, served as relief charge nurse and preceptor for new staff
- In collaboration with administration developed and implemented a progressive ventilator care unit.

Education/Credentials

- BSN, MS, Nursing Administration-Arizona State University, College of Nursing-Tempe, AZ.

Cindy Rose, LPN
Maternal Health/EPSDT Coordinator

Overview

- Over seven years of Long Term Care experience
- Over seven years of Elderly Physically and Disabled (E/PD) experience with ALTCS
- Six years Long Term Care/ALTCS Case Management experience
- Arizona licensed nurse with 34 years experience.

Professional Experience

Evercare Select-Phoenix, AZ / March 15, 2010 – Present
LPN Quality Management Clinical Analyst/Maternal Health-EPSDT Coordinator

- Ensures receipt of EPSDT services and maternal ad postpartum care
- Promotes family planning services and preventive health strategies for ALTCS program members
- Responsible for reviewing, identifying or reporting quality of care (QOC) issues that may potentially, or have impacted clinical care or services to a member and that care potentially or does not meet the community standard and or recognized clinical standard of care
- Reviews investigates, researches reported issues or actual clinical/medical/social impact and in conjunction with the Medical director determines whether or not the reported (QOC) issue is substantiated or unsubstantiated
- Communicates quality of care findings with providers, other clinicians/case managers and the multidisciplinary QOC committee
- Identifies trends to data and created/educate and supports providers to develop and act upon required corrective action plans in response to substantiated QOC findings and conducts audits per AHCCCS AM/PM requirements for contracted providers
- Management of special projects as assigned by QM Director such as assisting in implementation of the Direct Care Worker Training Program audit and monitoring process
- Management and monitoring of internal provider audit tools to ensure compliance with current AHCCCS AMPM requirements.

Evercare Select-Phoenix, AZ/ November 3, 2003 – March 15, 2010
Case Manager, LPN:

- Comply with all ALTCS mandates and perform new member intake assessments and member reassessments to assess members' needs according to the rules and regulations set forth by ALTCS.
- Act as Services Planner performing cost effective assessment of all services provided and coordinating all activities with members PCP as needed
- Act as Service Broker: planning and monitoring of all medical, behavioral health and long term services in institutional and or HCBS setting, determining the appropriate mix of services to best meet members needs and act as facilitator for resolving issues including but not limited to trouble obtaining PCP, family oriented conflicts which may prevent the member from obtaining the highest level of independent functioning
- Accurate entry of required data into the AHCCCS CATS system in a timely manner according to rules and regulations set forth by ALTCS

Care Connection Home Health Services/ September 1999 – November 2003
Authorization/Intake Supervisor/ May 2001 – November 2003

- Developed authorization request form for submission to insurance companies for continued services

- Developed system for monitoring authorization to ensure current authorization of visits and negotiated billing rates for billing for non contracted insurance companies
- Supervised and assisted authorization coordinator in obtaining further requested authorization of necessary services and coordinated services between agencies when multiple agencies providing services to client
- Functioned as a liaison between clinical staff and the insurance authorization department

LPN Clinical Staffing/Scheduling Coordinator/ September 1999 – May 2001

- Coordinated and scheduled per diem staff for general nursing, therapies and infusion visits teams within the agency as well as field staff initial visits according to patient acuity, needs, preferences and location and subsequent revisits as needed including assignment of over flow visit coverage to appropriate staff
- Revised weekly staffing schedules to provide a more accurate method of scheduling and oversaw all field staff schedules to ensure compliance with frequency and duration of services provided in accordance with physician orders
- Monitored and reported Performance Improvement indicators e.g.: continuity of care, unscheduled hospital admissions

Staffing Partners', Inc., Marketing/Staffing Director/ August 1998 – August 1999
Samaritan Health Systems/ July 1975 – July 1998
Samaritan Health Systems/IHS Home Care, LPN Clinical Staffing/Scheduling Coordinator/ July 1993 – July 1998

- Coordinated and scheduled per diem staff for general nursing teams within the agency as well as field staff initial visits according to patient acuity, needs, preferences and location and subsequent revisits as needed including assignment of over flow visit coverage to appropriate staff
- Oversaw all field staff schedules to ensure compliance with frequency and duration of services provided in accordance with physician orders
- Monitored and reported Performance Improvement indicators e.g.: continuity of care, unscheduled hospital admissions
- Lead staffing coordinator for seven General Home Care Nursing Teams (five Medicare and two managed care teams) trained new hire staffing coordinators as well as serviced current coordinators regarding changes of staffing processes within the agency

Samaritan Health Plan Member Services, Nurse Coordinator/ February 1990 – April 1993

- Primary coordinator for Medical Underwriting for health plan and reviewing new member utilization of services.
- Educated members on covered services and benefits, assisted members with denied medical claims, billing issues, obtaining prior authorization and accessing services within the health plans network
- Facilitated in the development of "*BabyWise*" program and participated in discharge planning and transferring of members to facilities within plan services.

Education/Credentials

- Phoenix Union Area Vocational Center
  - Practical Nurse Diploma, Practical Nursing School-Phoenix, AZ
  - Arizona licensure, Practical Nursing/ 1977
- Veni-puncture Certification, Gateway Community College
- Nursing School General Studies, Maricopa Community College
- Paradise Valley High School Graduate.

Linda Morse, RN, MSN
Medical Management Coordinator

Overview

- 11 years of Long Term Care experience
- 10 years of Elderly Physically and Disabled (E/PD) experience, including six years serving the ALTCS program
- Background encompasses clinical experience in Intensive Care, Cardiovascular Intensive Care, and Coronary Care Units, multiple positions in administration, education, case management and utilization review with focus on gerontology, Medicare and Medicaid population.

Professional Experience

Evercare Select/ August 2005 – Present
Medical Management Coordinator/ March 2011 - Present
Senior Utilization Review Nurse/ September 2008 – Present
Data Specialist, Clinical Technology/ January 2008 – May 2008

- Ensure adoption and consistent application of appropriate and outpatient medical necessity criteria
- Analyze utilization reports for presentation to Medical Management
- Assist with development of strategies, track and trend results
- Medical Managers utilized this role as a consultant and content expert for interpretation of reports and development of interventional strategies.

Manager, Utilization Management/ August 2005 – January 2008

- Developed and managed the Concurrent Review and Prior Notification Departments
- Assisted with the development and implementation of the Post Acute Services program to place and manage Senior Horizon members within skilled care facilities.

Health Net of Arizona/ November 1999 – July 2005
Manager of Care Management/ October 2001 – July 2005

- Responsible for management of the utilization review and case management departments
- Concurrent review nurses were responsible for utilization review, discharge planning and authorization of services for next level of care
- Case managers were responsible for coordination of care for community-based members and achieved URAC and NCQA accreditation.

Care Manager/ November 1999 – October 2001

- Performed onsite and telephonic review for acute care, skilled nursing facilities, acute rehabilitation and long-term acute care.

Phoenix Baptist Hospital/ February 1987 – August 1999
Resource RN, Call Center/ September 1998 – August 1999

- Utilized computer-based guidelines to answer clientele's health related questions and triage calls concerning appropriate level of care.
- Assisted members to access resources within the health plan and community.

Nursing Case Manager/ August 1996 – August 1998

- Reviewed medical records and interviewed patients for severity of illness, scope of care and discharge needs, ensuring quality of care in most cost effective manner
- Worked with multi-discipline team to plan and implement care from admission to discharge for a sub-acute medical unit and for a skilled nursing care facility.

Staff Nurse, Critical Care Units/ February 1987 – August 1996

- Functioned in a variety of roles within the Intensive Care Units (Coronary Care, Intensive Care and Cardiovascular Intensive Care) serving as staff nurse, clinical instructor, preceptor, patient care supervisor and relief charge nurse.

Boswell Hospital/ July 1982 – August 1986
Director of Nursing, Boswell Extended Care/ January 1986 – August 1986

- Responsible for all functions related to nursing services
- Implemented nursing services for the extended care center, meeting state and JCAHO requirements.

Assistant Director of Nursing/ July 1982 – December 1985

- Shared responsibility for developing and achieving operational and financial objective of the nursing division
- Supervised the clinical coordinators for the nursing units.

Additional Work History

- Relief Clinical Instructor, Grand Canyon University/ 1995
- Staff Assistant to the Director of Nursing, University of New Mexico Hospital/ 1997 – 1981
- Associate Director of Nursing, St. Luke's Hospital and Medical Center/ 1978 – 1979
- Clinical Education Coordinator, St. Luke's Hospital and Medical Center/ 1976 – 1978.

Education/Credentials

- Master of Science in Nursing, University of New Mexico/ 1982
- Bachelor of Science in Nursing, Arizona State University/ 1970.

Theresa Robben, LBSW
Behavioral Health Coordinator

Overview

- Over 22 years of Long Term Care Experience:
  - Eight years as a manager of a team of long term care case managers serving persons with behavioral health disorders
  - Six years as a provider of long term care services including home care, adult day care, adult foster care, home nursing and home delivered meals
  - Eight years of experience in developing policy for long term care programs and implementing social service programs through federal block grant funds
- 20 years of Elderly Physically and Disabled (E/PD) experience, including 8 years serving the ALTCS program
- Licensed behavioral health professional as required by ALTCS
- Skilled professional with 35 years of experience in managing social service and health care programs, including working as a manager for Evercare Select, 2 government agencies and a large local non profit social service agency
- Specialized skills include knowledge about the continuum of care needed for persons who are elderly, health care budgeting, statistical analysis, contract compliance, grant management, social service planning, contract negotiations and knowledge of Medicaid and Medicare regulations
- Behavioral Health and Social Work Experience:
  - Seven years as a behavioral health program specialist and planner
  - One year operating a program for low income families in crisis
  - Three years as a social worker.

Professional Experience

Evercare Select (a UnitedHealthcare Company), Behavioral Health Coordinator/Case Management Manager/ August 2006 – Present

- Management position, responsible for the operation and quality management of behavioral health services for Evercare Select's Medicaid long term care plan
- Duties include ensuring Medicaid and Medicare compliance and supervising the High-Risk Behavioral Health Team, consisting of four behavioral health case managers
- An integral part of job includes ensuring that all of the Evercare Select's staff and providers that provide direct care to the 3,000+ plan members, have access to behavioral health resources.

Arizona Department of Economic Security, Grant Administrator (Arizona Aging and Disabilities Resource Center)/ February 2006 – August 2006

- Grant funded position to develop the Arizona Aging and Disabilities Resource Center (ADRC)
- Major duties included developing promotional materials, setting up and staffing the advisory council for the grant, ensuring that the requirements in the contract with The Center for Medicare/Medicare Management were following and attending monthly meetings with the Center for Medicare/Medicaid Management in order to fully implement the grant per federal regulations.

Maricopa Health Plan/University Physicians Health Care, Behavioral Health Case Worker/ October 2005 – February 2006

- Staff position responsible for the daily operation of behavioral health services for the Maricopa Health Plan

- Duties included coordinating medical and behavioral health care for plan members who have behavioral health disorders, writing informational materials about behavioral health services and assisting plan members with health care needs.

Maricopa Integrated Health Systems/ Maricopa County Long Term Care Plan, Behavioral Health Administrator/ October 2002 – October 2005

- Management position, responsible for the operation of behavioral health services for the managed care health plans operated by Maricopa Integrated Health Systems that included two Medicaid funded plans (Maricopa Long Term Care Plan, Maricopa Health Plan and a Medicare Choice funded plan)
- Duties included ensuring ALTCS/Medicaid compliance and supervising the Maricopa Long Term Care High-Risk Behavioral Health Case Management Team, consisting of 12 behavioral health long term care case managers
- An integral part of daily operations included ensuring that the provider network was adequate to meet the needs of each health plans' membership.

Maricopa Managed Care Systems, Financial Analyst/ October 2001 – October 2002

- Staff position, responsible for analyzing health care costs for the three managed care health plans operated by Maricopa Managed Care Systems, including the Maricopa County Long Term Care Plan.

Arizona Department of Health Services/Division of Behavioral Health Services, Chief of Planning/ March 1994 – September 2001

- Management position, responsible for strategic planning, policy development and provider network analysis for the Division of Behavioral Health Services
- The job also included ensuring that the Annual Behavioral Health Service Plan met the requirements of the Governor's Office and providing professional support to the Division's planning councils
- Regular duties included mediating behavioral health treatment appeals, monitoring Regional Behavioral Health Authority contracts, managing federal grants and serving as a member of the Arizona Behavioral Health and Aging Coalition.

The Arizona Department of Economic Security/Community Services Administration, Human Services Program Specialist/ February 1993 – March 1994

- Staff position, responsible for the operation of the Emergency Assistance to Needy Families Program Grant
- Duties included writing the annual plan to ensure program operated within guidelines, in order to obtain maximum federal funding
- Developed new emergency assistance programs such as food banks, domestic violence shelters, and emergency utility assistance were a part of the ongoing duties of the position.

The Foundation for Senior Living, Director of Community Programs/ September 1985 – February 1993

- Responsible for the operation and financial management of five departments and the supervision of a staff of sixty-five.
- Duties included managing the Adult Foster Care Program, the Home Care Program, the Senior Center Programs, Senior Village and the Community Action Programs and maintaining the budgets for all of the Foundation's social service programs.

Education/Credentials

- Bachelor of Science, Social Work/Psychology - Kansas State University/ 1975
- Licensed Baccalaureate Social Worker, State of Arizona - #LBSW-10553/ Present.

Lawrence O'Connor

Provider Services Manager
Provider Claims Educator

Overview

- Six years of Long Term Care experience
- Three years of Elderly Physically and Disabled (E/PD) experience, including three years serving the ALTCS program
- Extensive experience in contract negotiation, provider relations, and operations management.

Professional Experience

Evercare Select, Manager, Provider Services/Claims Educator-Phoenix, AZ/ February 2008 – Present

- Manage staff to ensure timely and accurate resolution to provider issues
- Ensure clear and timely communication with provider network
- Ensure all AHCCCS provider network requirements are met
- Ensure a sufficient provider network is maintained
- Ensure providers and staff is educated appropriately about participation in the AHCCCS program.

Schaller Anderson HealthCare, Senior Contract Negotiator-Phoenix, AZ/ 2007 – 2008

- Responsible to negotiate hospital agreements to include all lines of business.

LifeWise Health Plan of Arizona, Regional Contacting Manager-Phoenix, AZ/ 2004 – 2007

- Managed staff to develop statewide provider network including hospitals, physicians, hospital based, and ancillary providers
- Directly negotiated hospital and high profile provider agreements
- Ensured Provider Relations call center service levels were above company standards
- Developed network recruiting strategy and adequacy reports
- Worked closely with Sales and Marketing to address network concerns with potential customers.

Arizona Heart Institute, Managed Care Director-Phoenix, AZ/ 2003 – 2004

- Negotiated payer contracts leading to increased revenue
- Automated physician credentialing process
- Successfully lead HIPAA implementation team to ensure full compliance with HIPPA Privacy Standards
- Worked closely with CFO to recruit and retain new physician

UnitedHealthcare, Contract Manager -Phoenix, AZ/ 2000 – 2003

- Managed operations staff through integration of LifeMark and UnitedHealthcare provider data system conversion
- Initiated and implemented pended claim tracking and reporting processes which identified root cause issues and significantly reduced pended claim volume
- Centralized provider data entry and fee schedule loading processes.

LifeMark Corporation, Corporate Provider Network Manager -Phoenix, AZ / 2000 – 2000

- Hired to standardize contract language and rate structure to optimize operational performance and claims processing for four states. UnitedHealthcare purchased company shortly after my hire.

UnitedHealthcare, Network Manager -Phoenix, AZ/ 1998 – 2000

- Developed and maintained the operational success of a portion of the provider network
- Negotiated hospital and physician agreements in Maricopa county, as well as ancillary provider's state wide
- Managed team of provider relations and contract specialist staff.

Intergroup of Arizona, Provider Contract Manager-Tucson, AZ/ 1995 – 1998

- Assisted in the development, maintenance, and operational success of the provider network
- Negotiated risk-sharing agreements with medical groups, hospitals, referral specialist, and ancillary provider agreements
- Monitored analyzed, and make recommendations to adjust financial risk pools and funds.

Provider Relations Coordinator/Supervisor/1991 – 1995

- Supervised staff to educate providers on Intergroup products and operations
- Supervised the negotiation of contracts for referral specialists in Southern Region.

Education

- Pace University-New York, NY.

Helen Bronski, CPA
Claims Administrator

Overview

- Over 11 years of Long Term Care experience
- 11 years of Elderly Physically and Disabled (E/PD) experience, including 5 years of serving the ALTCS program
- Develops, implements, and administers a comprehensive claims processing system that pays claims in accordance with AHCCCS requirements
- Oversees all claims processes and member/provider appeals and grievances for ALTCS

Professional Experience

Evercare Select, Operations Director/Claims Administrator, March 2009 – Present

- Manage and supervise member and provider grievance processes, reporting and state fair hearing activity under the Grievance System that includes member grievances, appeals and request for hearing and provider claim disputes
- Supervise member services for development of member newsletter, cultural compliance, member survey, or other member notification/services responsibilities
- Responsible for claims operations oversight, maintaining processing metrics
- Review monthly encounter results, identify process enhancement to improvement encounter performance with regulator through claims operations, network, provider education
- Supervise nursing home roster billing process to insure claims paid promptly and correctly
- Regulatory responsibilities for deliverables to the state: claims dashboard/footer, cost avoidance, quarterly financial reports, verification of paid services, HIPPA 5010 milestones, etc.
- Work with information systems department to develop and implement 5010 technology requirements and any other stated required changes.

Evercare Select, Associate Director of Finance, July 2008 – February 2009

- Worked with the Evercare Select AZ products, both Medicare and Medicaid (ALTCS, Dual SNP, ISNP, Chronic, and ESRD products)
- Maintained oversight of annual budgeting and forecasting process for market
- Developed medical analysis for market trending
- Supervised analysts
- Developed financial/regulatory reporting out of the health plan.

Evercare Select, Region Finance Manager, May 2006 – Present

- Managed budgeting and forecasting for all Medicare and Medicaid (LTC) products in the region
- Reviewed monthly accounting close process for all products
- Prepared region financial summary by product, trend medical expense
- Collaborated with clinical staff to trend utilization/medical expense and analyze costs
- Collaborated with contracting director to analyze new changes to contract costs and impact to plans
- Participated in implementation teams for set up of new Medicaid
- Reviewed staffing compared to budget and forecasts, and consult on needed changes.

Evercare Select, Corporate Finance Manager, April 2003 – May 2006

- Worked with Medicaid (LTC) and Medicare health plans in multiple states on planning and budgeting; Prepared annual budgets and quarterly forecasts with each market
- Reviewed monthly financials and explained variances in revenue and expense
- Assisted plans with identifying areas for medical cost reduction
- Conducted premium revenue rate and variance analysis
- Worked with state regulatory agencies as needed.

Evercare Select, Accounting Manager, August 2001 – April 2003

- Responsible for financial management and accounting of Texas Medicaid (LTC) health plan
- Supervised month end closing of general ledger
- Verified revenue activity and conducted revenue rate analysis
- Monitored medical accruals and payments for reasonableness
- Prepared quarterly/annual State of Texas, NAIC, and other regulatory filings as required.

Lifemark/Evercare

- *Senior Accountant, February 2000 – July 2001*
- *Accountant, May 1999 – January 2000.*

Enterprise Rent-A-Car

- *Financial Statement Supervisor-Fresno, CA/ August 1998 – March 1999*
- *Senior Area Accountant-Albuquerque, NM/ June 1998 – August 1998*
- *Accountant, December-Mesa, AZ and Albuquerque, NM/ 1996 – June 1998.*

Education/Credentials

- Bachelor of Science, Accountancy-Arizona State University-Tempe, AZ/ December 1996.

Certifications

- CPA License, State of New Mexico.

Francine Pechnik
Case Management Administrator/Manager

Overview

- 22 years of Long Term Care experience
- 22 years of Elderly Physically and Disabled (E/PD) experience, including over 22 years serving the ALTCS program
- 12 years in a managerial or director level position in the health care field
- 8 years in a case manager position
- 6 years of managerial experience in the commercial industry.
- 2 years in a finance position.

Professional Experience

Evercare Select/ September 2005 – Present
Health Services Director/Case Management Administrator/ March 2006 – Present

- Oversight of the implementation, maintenance and monitoring of operational processes within Evercare Select case management programs to assure the Plan meets and exceeds federal and state regulatory and contractual requirements
- Responsible for formalized review of the delivery of case management services for Medicare and ALTCS Medicaid membership
- Responsible for all the systems supporting this review
- Monitor the access to effective treatment modalities that meet member needs and comply with standards of care and appropriate state and federal regulations
- Assist in the timely reporting to government agencies such as AHCCCS, ADHS, CMS and other regulatory agencies
- Direct a system of monitoring progress towards and the development of case management programs to meet the goal of participating in initiatives focused towards increasing the number of members living in a home community setting
- Monitor the training and ongoing professional development of case management staff to meet department business goals
- Ensure that key staff members are knowledgeable concerning state regulations and contractual requirements for their area of responsibility
- Responsible for developing and implementing a case management work plan submitted to the state Medicaid plan for approval on an annual basis
- Complete an annual assessment and evaluation of the case management program including the case management annual plan
- Responsible for developing and implementing the annual Advisory Council Plan that includes conducting quarterly meetings in four counties across the State of Arizona
- Complete an annual evaluation of the plan and it's effectiveness in each of the respective counties, which is submitted to the state Medicaid plan annually for approval
- Responsible for developing, implementing, monitoring and evaluating the effectiveness of an annual cultural competency plan for our members, staff and providers that is submitted to the state Medicaid plan for approval
- Develop and maintain Case Management policies and procedures to comply with regulatory standards and adhere to Evercare Select goals and objectives

- Implement and maintain systems and procedures necessary to effectively control and monitor case management performance
- Assist in the budget, as well as manage resources allocated in order to obtain optimum budgetary results
- Additional responsibility has included the 2008 implementation of the UnitedHealthcare Alzheimer's SNP Plan and oversight of the case management programs supporting the Plan
- Health Services Director for the level 3 and level 4 case management programs for Evercare Select DP/MP Medicare Advantage Plans in Maricopa County.

Case Management Manager/ September 2005 – March 2006

- Managed, mentored and supported case management staff responsible for the support of the ALTCS population
- Developed clear goals and objectives for performance management and effectively communicated accountability
- Recruited, hired, supervised and evaluated case managers and support staff
- Identified areas of strength and concerns, and developed specific goals to improve performance and established systems for tracking performance
- Assisted in strategic development of processes that ensure efficient and systematic operational plans were created and executed
- Managed the utilization program as a result of day-to-day management
- Managed successful implementation of several initiatives
- Created a team oriented management environment, enhancing the integration and communication between departments
- Ensured standardized execution of workflow processes, such as authorizations and non-certifications and analyze outcomes of standardized audits for CQI purposes
- Acted as regional interface with other departments to coordinate workflow processes and implementation plans (Claims, Medical Policy, Contracting, etc.)
- Participated in the development and execution of educational programs for the purpose of staff development
- Monitored performance metrics specific to functional area
- Evaluated metrics in addition to developing action plans to address variance from standards
- Participated in the development of department policies and procedures.

Maricopa Long Term Care Plan-Phoenix, AZ

- *Case Management Administrator/ November 2004 – September 2005*
- *Case Management Manager/ June 1999 – November 2004*
- *Case Manager/ February 1991 – June 1999*
- *Account Clerk III, Department of Finance/Income Management/ June 1989 – February 1991*

Education

- B.S., University of Connecticut-Storrs, CT/ 1985
- University of Phoenix-Phoenix, AZ
- MBA coursework.

Mary Ashford, RN
Case Management Manager

Overview

- Over ten years of Long Term Care experience
- Over five years of Elderly Physically and Disabled (E/PD) experience with ALTCS
- 11 years experience in managerial positions in the health care field
- Three years experience in case management which includes one year serving the ALTCS program
- Five years director of nursing in skilled nursing facilities.

Professional Experience

Evercare Select/ 2005 – 2011
Case Management Manager/ February 2006 – Present

- Supervise and mentor a team of case management staff who are responsible for supporting the ALTCS member population
- Monitors adherence to the state contract requirements and performance measurement outcomes
- Develops and communicates clear goals and objectives for performance management and communicates accountability
- Ensures standardized execution of workflow processes and analyzes member record review audits for CQI purposes
- Participates in the development of department policies and procedures
- Monitors performance metrics specific to a functional area, evaluates metrics and develops action plans to address variances from standards
- Assists in the development and execution of educational programs to enhance staff development
- Identifies, selects, structures and prioritizes process improvement projects, with revisions to meet changing needs and requirements
- Leads/participates in workgroups across teams and acts as liaison between case management and other departments in support of shared goals and processes.
- Fosters a team oriented management environment and assists with design and implementation of global and regional medical affairs initiatives.

Evercare Select Case Manager/ June 2005 – February 2006

- Supported a caseload of HCBS members in Maricopa county and conducted initial and re-assessment visits
- Facilitated a member-centered care plan with all required disciplines that was flexible in meeting member needs and desires for their care delivery and that addressed functional, behavioral, medical, cultural and social components
- Completed all relevant documentation to include narrative notes, UAT, 2060 tool, CES and placement screens in CATS and coordinated appropriate services and equipment in support of maintaining member in the setting of their choice
- Educated members and responsible parties about ALTCS covered services and benefits, member rights and responsibilities
- Educated member and responsible parties about available community resources to assist in meeting member needs
- Monitored appropriate utilization.

Health Dialog, Inc., Case Manager (Disease Management)/ October 2003 – January 2005

SHPS Healthcare Services, Manager-Case Management/Account Manager/ November 2000 – April 2003

American Healthways, Clinical Team Leader (Disease Management)/ September 1999 – November 2000

- *Liberty Mutual/ March 1996 – August 1999*
- *Manager-Utilization Management (2.5 years)*
- *Quality Assurance/Trainer (5 months)*
- *Telephonic Utilization Review staff (5 months)*

The Principal Financial Group, Utilization Management/Concurrent Review/ September 1993 – March 1996

Sierra Tucson, Utilization Manager/Quality Assurance/ September 1990 – December 1992

Education

- RN, Northwestern University – Passavant Memorial Hospital-Chicago, IL/ 1971
- BS, University of St Francis-Joliet IL/ 1987

Joanne Helmer, RN
Case Management Manager

Overview

- Manager with experience serving 11 years in Long Term Care skilled nursing facilities
- 18 years of Elderly Physically and Disabled (E/PD) experience, including 11 years of serving the ALTCS program
- Eight years in a management role in the health care field (with Evercare Select)
- Three years serving in a case management position (with Evercare Select)
- One year as a SNF Director of Nursing and one year as a SNF Assistant Director of Nursing
- Five years as a Medicare Consultant for a SNF chain
- Nine years experience in medical sales.

Professional Experience

Evercare Select-Phoenix, Arizona/ 1999 – Present
Case Management Manager

- Recruited, hired, supervised and evaluated case managers and support staff. Identified areas of strength and concerns, and developed specific goals to improve performance and established systems for tracking performance
- Assisted staff in identifying and accessing resources, provided consultation and guidance to assure that client responsibilities and regulatory obligations were met
- Routinely audited case management records to ensure compliance with contractual standards, effectiveness of client assessments, interventions, problem-solving outcomes and overall quality of work
- Participated in the revision of case management policies and the enhancement of the assisted living program
- Manages utilization program as a result of day-to-day management and successful implementation of initiatives
- Creates a team oriented management environment, enhancing the integration between the clinical and operations sections of Medical Affairs
- Manage, mentor, and support staff in designated department or region. Develops clear goals and objectives for performance management and effectively communicate accountability
- Assists in strategic development of Medical Affairs processes to ensure that efficient and systematic operational plans are created and executed
- Ensures standardized execution of workflow processes, such as authorizations and non-certifications and analyze outcomes of standardized audits for CQI purposes
- Acts as regional interface with other departments to coordinate workflow processes and implementation plans (Claims, Medical Policy, Contracting, etc.)
- Assists in the development and execution of educational programs to enhance staff development
- Monitors performance metrics specific to functional area. Evaluates metrics in addition to developing action plans to address variance from standards.

Care Coordinator/Case Manager

- Responsible for overseeing the medical and home care needs of assigned ALTCS members in Kingman, Arizona and surrounding communities in Mohave County
- In addition to case management responsibilities, responsible for hospital utilization reviews at Kingman Regional Medical Center.

Life Care Center of Aurora, Director of Nursing Service-Aurora, CO/ 1998 – 1999

- Managed all aspects of clinical care and services in a 94 bed skilled nursing facility, including a 46 bed sub-acute rehabilitation/nursing unit.

Vencor, Inc./ 1992 – 1998
Medicare Nurse Specialist-Louisville, KY

- Provided Medicare orientation to all levels of personnel in Vencor LTC facilities
- Consulted with facility staff to evaluate and maintain an effective Medicare program.

Assistant Director of Nursing-Villa Campana-Tucson, AZ

- Assisted the director of nursing in the management of nursing services in a 120 bed skilled nursing facility
- Coordinated documentation required for Medicare Part A reimbursement
- Monitored facility quality indicators such as pressure sores, weight loss, chemical and physical restraints with the goal of demonstrating continuous quality improvement.

Hill-Rom, Inc.-Charleston, SC/ 1983 – 1992
Long Term Care Consultant

- Responsible for marketing and sales of specialty beds to long term care providers, physicians, HMO's, Medicaid programs and other insurance companies.

Medical Sales Consultant

- Marketed and sold specialty beds systems to hospitals, physicians, HMO's and other insurance companies.

Education/Credentials

- Bachelor of Science in Nursing, University Of Arizona/ 1975

Jolie Keys, LMSW, MBA, CCM
Case Management Manager

Overview

- 13 years of Long Term Care experience
- 13 years of Elderly Physically and Disabled (E/PD) experience, including ten years serving the ALTCS program
- Case Management Manager that has extensive experience and knowledge of Medicare and Medicaid, government programs that has directly managed the care of individuals in the State Medicaid program and Medicare for the past 12 years that has included:
  - Five years experience as a Case Manager serving the ALTCS population (three years with Long Term Care and two years with DDD)
  - Two years as a Program Supervisor for an organization serving the ATLCS/ DDD population
  - Seven years of Management/Supervisory Experience in the health care field
  - Five years experience as a Case Manager serving the Medicare population.

Professional Experience

Evercare Select (a UnitedHealthcare Company)-Phoenix AZ/ March 2006 – Present
Case Management Manager/ 2006 – 2011

- Supervise case managers who coordinate benefits for Medicaid and Medicare beneficiaries, in the urban and rural areas of AZ
- Responsibility to provide supervision for 10-15 nurse and social work case managers
- Oversee the authorization of cost effective services
- Host Member Advisory Council meetings quarterly in the Rural areas.

Alzheimer's Dementia Program Manager/ 2008 – 2009

- As the program manager for a new/pilot special needs program, acted as a clinical partner and liaison with providers
- Participated in work groups tailoring a case management approach when working with individuals and families with Alzheimer's Dementia
- Acted as marketing representative, presenting to groups and providers
- Responsible for tracking, analyzing and reporting on program metrics to management and business leaders
- Participated in contract negotiations
- When the pilot project ended, developed a transition plan for existing members and providers.

Cigna Healthcare, Medicare Care Manager-Phoenix, AZ/ 2000 – 2006

- Conducted comprehensive assessments, collaborated with medical providers, and partnered with members in an effort to obtain medical stability and independence
- Participated in various project work groups aimed at retaining nurse case managers
- It was vital to possess knowledge of state and federal mandate laws and its effect on the insurance industry
- As a leader, was often tasked to communicate company objectives to peers and report barriers to Medical Directors, management staff.

Maricopa Integrated Healthcare Systems, Counselor II-Mesa, AZ/ 1997 – 2000

- Knowledgeable of state and government laws pertaining to managing and delivering Medicaid or long-term care benefits to recipients residing within the nursing home setting
- Identified reoccurring problems, advocated for patient rights, and actively coordinated discharges to lower level of care.

Department of Economic Securities (Division of Disabilities), Human Services Specialist II/ 1995 – 1997

- Creatively matched community resources to meet members' social and vocational needs when state and federal resources were exhausted
- Managed a caseload of approximately 300 developmental disabled individuals.

Tungland Corporation, Employment Relations Program Supervisor/ 1992 – 1995

- Responsible for coordinating home and community based services and matching staff with members
- Functioned as a job coach, assisting disabled adults through the job interview process
- Previous to this role, responsible for creating and managing behavioral modification plans and implementing them during the time members were participating in the day program.

Education/Credentials

- Master of Business Administration/Global Management (MBA/GM), University of Phoenix-Phoenix, AZ/ July 2004
- Master of Social Work (MSW), Arizona State University-Tempe, AZ/ May 1996
- Bachelor of Social Work (BSW), Northern Arizona University-Flagstaff, AZ/ May 1992.

Licenses/Certifications

- Licensed Master of Social Work/ 2001
- Certified Case Manager/ 2002
- Diversity Committee member with the Alzheimer's Association/ 2009.

Brenda Sharp, LPN
Case Management Manager

Overview

- Manager with over 20 years of Long Term Care experience
- Over 11 years of Elderly Physically and Disabled (E/PD) experience with ALTCS
- Over 11 years serving in a management role in the health care field.

Professional Experience

Evercare Select (a UnitedHealthcare Company), Manager, Case Management/ July 2004 – Present

- Recruited, hired, supervised and evaluated case managers and support staff in designated department or region
- Identified areas of strength and concerns, and developed specific goals to improve performance and established systems for tracking performance
- Assisted staff in identifying and accessing resources, provided consultation and guidance to assure that client responsibilities and regulatory obligations are met
- Evaluates metrics in addition to developing action plans to address variance from standards
- Routinely audits case management records to ensure compliance with contractual standards, effectiveness of client assessments, interventions, problem-solving outcomes and overall quality of work
- Participates in the development and revision of case management policies
- Assists in strategic development of Medical Affairs processes to ensure that efficient and systematic operational plans are created and executed.
- Ensures standardized execution of workflow processes, such as authorizations and non-certifications and analyzes outcomes of standardized audits for CQI purposes.
- Acts as regional interface with other departments to coordinate workflow processes and implementation plans (Claims, Medical Policy, Contracting, etc.).

TLC/Staff Builders Home Health Care/ July 1998 – July 2004
Private Duty Manager/ July 1998 – July 2003

- Recruited, hired, supervised and evaluated caregivers and support staff, who serviced member's on the ALTCS and Sail program
- Identified areas of strength and concerns, and developed specific goals to improve performance and established systems for tracking performance
- Admitted member's onto service, completed reassessment visits per protocol
- Coordinated service plans and member care
- Made field visits to evaluate competency of caregivers
- Completed payroll and billing processes
- Customer service, dealt with issues and concerns as they arose
- Investigated all concerns and took appropriate action as required.

Intake Coordinator/ July 2003 – July 2004

- Took new referrals for skilled care
- Verified insurance eligibility
- Verified patient's address
- Informed new patient of referral being received.

Integrated Health Services, Staffing Coordinator/Licensed Practical Nurse-Phoenix, AZ/ February 1993 – June 1998

- Coordinated scheduling of visits for skilled service staff
- Tracked compliance of visits
- Collected data and compiled reports
- Made home visits.

Desert Samaritan Medical Center, Licensed Practical Nurse-Mesa, AZ/September 1978 – February 1993

St. Joseph's Hospital, Licensed Practical Nurse-Syracuse, NY/ December 1977 – August 1978

Loretto Geriatric Center, Licensed Practical Nurse-Syracuse, NY/ August 1976 – November 1977

Gerritt Smith Nursing Home, Licensed Practical Nurse-Eaton, NY/ September 1973 – July 1976

Education/Credentials

- Diploma, Licensed Practical Nurse - Board of Cooperative Educational Services-Verona, NY/ June 1973
- Stockbridge Valley High School-Munnsville NY/ June 1973.

Licensures

- Licensed Practical Nurse-AZ/ Active.

Angela Farley, LPN
Trainer/Program Development

Overview

- Nine years of Long Term Care experience
- Nine years of Elderly Physically and Disabled (E/PD) experience serving the ALTCS Population, which includes:
  - Three years as a Case Management Manager
  - Five years as a Training and Program Development Manager
  - One year serving as a case manager
- Extensive combined experience in the health services industry:
  - 17 years of Management in the health care field
  - 27 years of Training experience
  - 27 years of Program Development
  - 32 years of Nursing as an LPN
  - 5 years in a Supervisory and Training Role.

Professional Experience

Evercare Select/ 2002 – Present
Training and Program Development Manager/ 2006 – Present

- Keep abreast of updates to AHCCCS Program requires as outlined in contract, the AHCCCS AMPM, and the ACOM
- Identify, analyze, plan and implement new programs, policies and processes or modifies existing processes as appropriate to meet program requirements, departmental goals, and increase staff skills, compliance to program standards and consistency in member needs determination, service plan implementation, authorization of service under the ALTCS benefit and monitoring
- Monitor and Resolve implementation issues
- Created site case management training program for new employees and ongoing case management training programs
- Assess learning and implementation of strategies to improve retention of learning objectives
- Mentor individual case managers to improve processes, standards are care and progress toward their own personal development goals
- Developed and implemented programs and function as the subject matter expert for the departmental inter-rater reliability program, member record management monitoring program which includes monitoring, reporting
- Work with peer Case Management Managers to develop actions plans to improve staff retention and application of policy and procedures
- Act as Subject Matter Expert and Program Lead for Self-Directed Attendant Care and all Housing, Education, and Employment activities including the Resource Team
- Leader of multiple internal workgroups focused on empowering members to live healthy and quality lives by becoming engaged in their communities
- Develop collaborative working relationships with other departments within the organization, members, contracted providers, and other key stakeholders to promote quality drive care and best practice stand

- Active participant in workgroups that align with current and future AHCCCS initiatives such as the Direct Care Workforce initiative, Self-Directed Care, and the AHCCCS HCBS service assessment tool.

Case Management Manager/ 2003 – 2006

- Direct management of urban or rural case managers providing services to the members enrolled in the ALTCS Program
- Provide leadership in setting team and individual case manager performance directives including mentoring staff to develop key skill sets crucial to assessing, planning, implementing, coordinating, and monitoring of services for enrolled members
- Participate with peer manager under the leadership of the Health Service Director to enhance departmental policy and procedures that support departmental goals, and statutory requirements
- Recruit, train, orient, and develop new and existing department staff
- Develop goals for staff performance that align with, and support, achievement department objectives
- Provide coaching to staff and monitor progress when staff is unable to meet individual goals or fails to follow policy and procedure.

Case Manager/ 2002 – 2003

- Case Manager for ALTCS enrolled members in Maricopa County
- Member primarily home and community based with higher percentage of home placed members
- Provided case management services that included using a holistic approach that is member centered to assess, coordinate, and implement service plans, according to meet the member's goals and preference, for medical, behavioral, social, or environmental unmet needs
- Services were coordinated through both external sources including other insurers or community partners and under the ALTCS benefit
- This role also included, but was not limited to monitoring, reassessing, problem solving, managing risks, and member/family education and support.

Cigna Medical Group 1997-2002

- *LPN Lead Back Office Nurse, OSHA Coordinator, Employee Health Coordinator, Flu Program Manager.*

Life Care Centers of America/ 1993 – 1997

- *LPN, Shift Supervisor, OSHA Coordinator, Training and Development Specialist.*

Phoenix Day School for the Deaf/ 1990 – 1993

- *School Nurse, Student and Staff Health Education Program Manager and Trainer*

Sunshine Acres Children's Home/ 1986 – 1990

- *Health Services Manager, Staff Education Program Trainer, Resident and Family Health Education Trainer.*

Education/Credentials

- Licensed Practical Nurse/ Graduate 1980.

4. For key positions/employees which are not full time provide justification as to …..

All ALTCS key staff positions are staffed with full-time employees with exception of our Dental Director, Herb Kaufman, who is a part-time staff member.

Justification of Non Full-Time Positions

Evercare Select is conscientious of the personnel requirements needed to continue the success of the ALTCS program. For Key Staff positions, five employees serve dual roles within the ALTCS program (as permitted by AHCCCS) and are 100 percent dedicated to the ALTCS plan. **Only one Key Staff position has additional duties outside of the ALTCS program** as detailed below. However, should membership increase, we will adjust staffing in a manner that continues to ensure success in the administration of the ALTCS program.

Administrator, Chief Executive Officer (CEO), Chief Operating Officer (CEO)/Business Continuity Planning and Recovery Coordinator

Karen Brach is a full-time employee and serves dual roles as administrator/CEO/COO and business continuity planning and recovery coordinator. One hundred percent of her time is dedicated to the ALTCS program with 98 percent serving as administrator/CEO/COO and 2 percent serving as business Continuity planning and recovery coordinator. Because the **duties of business continuity planning and recovery coordinator fall directly under the scope of her overall responsibilities as administrator/CEO/COO**, the business continuity planning and recovery coordinator position is less than full-time.

Dental Director

Our Dental Director, Herb Kaufman, DDS, monitors, reviews and enhances our dental organization processes and activities to align with AHCCCS objectives. He oversees claims, pre-authorizations, quality assurance and network management for the dental segment. Dr. Kaufman implements strategic outreach objectives designed to engage members and providers in order to increase opportunities to achieve and exceed AHCCCS' ongoing goals. Dr. Kaufman is a part-time employee who is on call for all dental related needs. Ten percent of his time is dedicated to duties associated with the ALTCS program; the remaining time is allocated to UnitedHealthcare Arizona Physicians IPA Medicaid programs, which include providers who serve both programs. At this time, **due to adult dental benefit elimination and low number of members under age 21, Dr. Kaufman's position is less than full-time**. Should enrollment increase, we will reevaluate Dr. Kaufman's time and revise resources proportionately to meet the demands of the ALTCS program. Dr. John Hysong supports Dr. Kaufman on medical reviews.

Compliance Officer/Contract Compliance Officer

Kelly Kreiselmeier (formerly Kelly Morken) serves dual roles as compliance officer and contract compliance officer for the ALTCS program. Ms. Kreiselmeier is a full-time employee and 100 percent of her time is dedicated to the ALTCS program. She has been serving as the lead compliance resource for over two years. **Because the responsibilities, objectives and skill sets for both positions are complementary and so closely aligned with Evercare Select's corporate compliance structure and culture** (including adherence to AHCCCS requirements), we feel it is effective and beneficial to have Ms. Kreiselmeier serve in both capacities.

Quality Management Coordinator/Performance Improvement Coordinator

Myra Kingsley, our director of quality management, is a full-time employee and splits her time in dual roles as quality management coordinator and performance Improvement Coordinator for the ALTCS plan. **One hundred percent of Ms. Kingsley's time is dedicated to the ALTCS program**. She is responsible for directing quality improvement activities and improvement of outcomes. She has developed quality initiatives to improve member care for the ALTCS population and works in collaboration with case management to monitor/measure performance and improve performance indicators plan-wide**. Dr. Anna Scott, Vice President of Quality Management for UnitedHealthcare Arizona Physicians, IPA,**

provides additional support to Ms. Kingsley as needed. As membership increases, we will adjust staffing resources to ensure effective quality management for the ATLCS program.

Maternal Health/EPSDT Coordinator

Cindy Rose is a licensed nurse with over 34 years of experience and serves dual roles as maternal health/EPSDT coordinator and quality management clinical analyst for the ALTCS program. **Ms. Rose is a full-time employee and 100 percent of Ms. Rose's time is dedicated to the ALTCS program** and she will attend AHCCCS required meetings or trainings on behalf of Evercare Select. We initially expect approximately 10 percent of Ms. Rose's time to be allocated to the maternal health/EPSDT coordinator role but **we will continue monthly and quarterly monitoring of maternal health/EPSDT services and will reevaluate Ms. Rose's time and revise staffing proportionately**, should enrollment or utilization increase.

5. Submit a functional organizational chart of the key program areas, responsibilities …..

Functional Organizational Chart

Since the inception of the Arizona Long Term Care System (ALTCS) program in 1989, Evercare of Arizona, Inc. (Evercare Select) has been privileged to serve the elderly and physically disabled population. Our local team is familiar with the special needs of this AHCCCS program and we have many employees who have been serving the ALTCS program since 1989. **All Key Staff positions, as well as Required Staff positions, are located in the state of Arizona as required in Section D, paragraph 25 of the RFP.** As illustrated on the organizational chart, Quality Management and Medical Management functions report to the chief medical officer and Claims operations reports to the director of operations. Staff members are limited to occupying a maximum of two Key Staff positions.

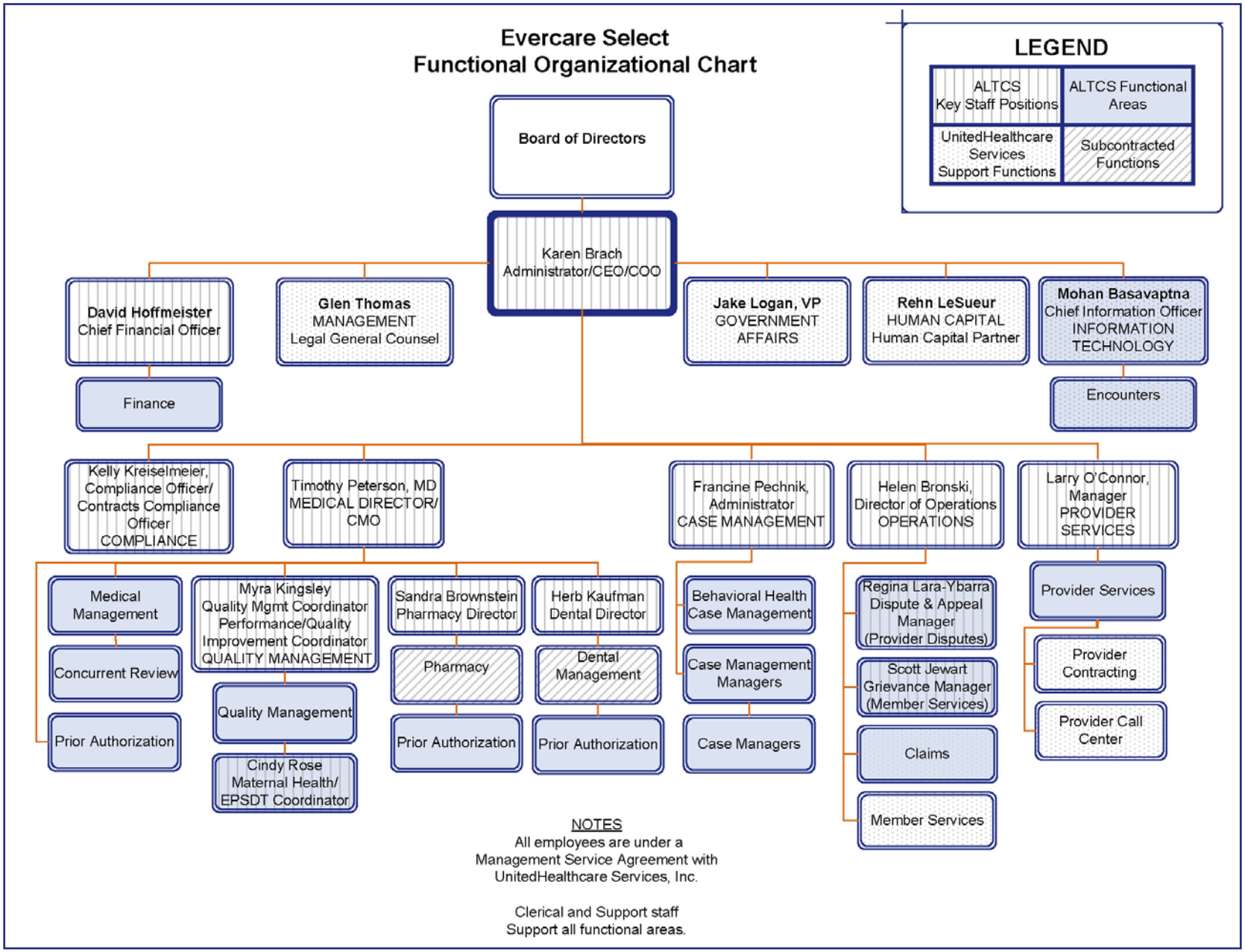
All Evercare Select staff are employed by UnitedHealth Group's management services company, UnitedHealthcare Services, Inc., pursuant to a Management Services Agreement (MSA).

Evercare Select's Board of Directors delegates responsibility of strategic decisions and day-to-day operations to Karen Brach, Evercare Select's chief executive officer (administrator/chief operations officer). Ms. Brach, her executive team and our Board of Directors are committed to ensuring the AHCCCS contract is fully implemented and executed in a manner that meets and exceeds AHCCCS' expectations. They also validate that AHCCCS contractual requirements are outlined in policies, procedures, deliverables or organization and performance metrics.

As evidenced by our Operational and Financial Review (OFR) results over the past several years as shown below, we have always focused on providing outstanding performance and service to our members, providers, AHCCCS and the communities we serve. We clearly have the capacity, administrative support staff, necessary resource, and flexibility to expand our services to meet the ALTCS program's needs.

2008 - 2010 Evercare Select OFR Results Substantially and Fully Compliant Standards		
2008	***2009***	***2010***
88%	93%	93%

The following organizational chart depicts the functional areas of Case Management, Quality Management, Medical Management, Prior Authorization, Grievance System (Member Grievances and Appeals and Provider Claim Disputes) Provider Services, Finance, Claims, Encounters and Information Systems as requested.


Evercare Select
Functional Organizational Chart
LEGEND
ALTCS Key Staff Positions
ALTCS Functional Areas
UnitedHealthcare Services Support Functions
Subcontracted Functions
Board of Directors
Karen Brach
Administrator/CEO/COO
David Hoffmeister
Chief Financial Officer
Glen Thomas
MANAGEMENT
Legal General Counsel
Jake Logan, VP
GOVERNMENT AFFAIRS
Rehn LeSueur
HUMAN CAPITAL
Human Capital Partner
Mohan Basavaptna
Chief Information Officer
INFORMATION TECHNOLOGY
Finance
Encounters
Kelly Kreiselmeier,
Compliance Officer/
Contracts Compliance Officer
COMPLIANCE
Timothy Peterson, MD
MEDICAL DIRECTOR/
CMO
Francine Pechnik,
Administrator
CASE MANAGEMENT
Helen Bronski,
Director of Operations
OPERATIONS
Larry O'Connor,
Manager
PROVIDER SERVICES
Medical Management
Concurrent Review
Prior Authorization
Myra Kingsley
Quality Mgmt Coordinator
Performance/Quality Improvement Coordinator
QUALITY MANAGEMENT
Quality Management
Cindy Rose
Maternal Health/
EPSDT Coordinator
Sandra Brownstein
Pharmacy Director
Pharmacy
Prior Authorization
Herb Kaufman
Dental Director
Dental Management
Prior Authorization
Behavioral Health Case Management
Case Management Managers
Case Managers
Regina Lara-Ybarra
Dispute & Appeal Manager
(Provider Disputes)
Scott Jewart
Grievance Manager
(Member Services)
Claims
Member Services
Provider Services
Provider Contracting
Provider Call Center
NOTES
All employees are under a Management Service Agreement with UnitedHealthcare Services, Inc.
Clerical and Support staff
Support all functional areas.

Sanctions

6. Describe any sanctions levied against the Offeror, its parent corporation or any legally …..

Regarding Evercare Select's sanctions, all sanctions were resolved within 30 days and none of the sanctions included an enrollment CAP.

Arizona Sanctions Submission

Evercare Select has participated in the ALTCS program since 1989, serving clinically and financially vulnerable members in geographic regions across the state. Over that extended duration, Evercare Select has matured with the program, developing programs and expanding services to meet the needs of our members.

Evercare Select is a part of UnitedHealth Group, one of the nation's largest health and well-being organizations in the country. Through many subsidiaries and affiliates, UnitedHealth Group provides health care-related services for over 70 million members nationwide, with services, operations, contracted providers, and members in all fifty states. Each of these entities is subject to local, state and federal regulations, including many that participate in Medicaid and Medicare programs. They have been and are currently involved in various governmental audits and reviews, which, from time to time, can result in the assessment of sanctions from the Medicaid regulator, Medicare, or State Insurance Department, as part of the course of business. The following table includes monetary and non-monetary sanctions levied against Evercare Select and its affiliated entities in Arizona since January 1, 2008.

Monetary and Non-Monetary Sanctions for Offeror and Arizona Affiliates (Levied On or After 01-01-2008)

Sanction Description/Reason	*Entity*	*Resolution Date*	*Agency*	*Status*	*Resolution Timeframe*
Marketing and outreach initiatives by Evercare Select of Arizona	Evercare Select of Arizona	Sep 2008	AHCCCS	Paid/ Distributed	30 Days or Less
Encounter Sanction – Quarter Ending September 2010	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending June 2010	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending December 2009	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending September 2009	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending June 2009	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending March 2009	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Encounter Sanction – Quarter Ending December 2008	Evercare Select of Arizona	Not Applicable	AHCCCS	Suspended	30 Days or Less
Level of detail in a Notice of Action letter	Arizona Physicians, IPA	July 2009	AHCCCS	Paid/ Distributed	30 Days or Less
Failure to meet minimum required performance levels for childhood immunizations	Arizona Physicians, IPA	July 2009	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending June 2008	Arizona Physicians, IPA	October 2008	AHCCCS	Waived	30 Days or Less

Monetary and Non-Monetary Sanctions for Offeror and Arizona Affiliates (Levied On or After 01-01-2008)					
Encounter Sanction – Quarter Ending September 2008	Arizona Physicians, IPA	January 2009	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending December 2008	Arizona Physicians, IPA	May 2009	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending March 2009	Arizona Physicians, IPA	June 2009	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending June 2009	Arizona Physicians, IPA	September 2009	AHCCCS	Waived	30 Days or Less
Data Validation Study Sanction – Provider Medical Record Files and Claims Submitted CYE05	Arizona Physicians, IPA	November 2009	AHCCCS	Paid	30 Days or Less
Encounter Sanction – Quarter Ending September 2009	Arizona Physicians, IPA	January 2010	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending December 2009	Arizona Physicians, IPA	March 2010	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending March 2010	Arizona Physicians, IPA	June 2010	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending June 2010	Arizona Physicians, IPA	August 2010	AHCCCS	Waived	30 Days or Less
Encounter Sanction – Quarter Ending September 2010	Arizona Physicians, IPA	December 2010	AHCCCS	Waived	30 Days or Less
Failure to file Annual Statement in a timely manner by	UnitedHealthcare of AZ	June 2009	Dept. of Insurance	Paid/ Distributed	30 Days or Less

Non-Arizona Sanctions Submission

As part of our broad participation and long tenure, Evercare Select and our affiliates have at times been sanctioned by our regulators. Since January 1, 2008, non-Arizona affiliates of Evercare Select have incurred approximately 600 sanctions for a variety of reasons, including but not limited to: late filing of financial and non-financial documents; claims issues; market conduct exam penalties; and defective notices of adverse actions. In each instance, we have worked collaboratively with our state partners to fully understand the reason for the sanction and to remedy the situation to the satisfaction of our regulator.

Due to page limitations, we are unable to provide a complete listing of monetary and non-monetary sanctions levied after January 1, 2008, for non-Arizona affiliates, which includes other Medicaid plans, Medicare plans and commercial plans. We will provide a complete listing upon request.

Although we do not plan for operational deficiencies, Evercare Select has implemented a proactive approach to monitoring our operations, communicating with AHCCCS, and anticipating requirements so that we can avoid sanctions. In instances when sanctions are levied, we have also implemented a quality assurance approach that corrects deficiencies through a deliberate, yet urgent process. Key elements of our approach to avoiding and addressing operational deficiencies and consequential sanctions include:

- ***Culture of Quality:*** Led by Ms. Karen Brach, Chief Executive Officer, Evercare Select has developed a culture of high quality services delivered through compliant operations. During the past two years, we have not only addressed sanctions, but also developed an education training program through which we educate staff about program requirements and give them the tools to maintain compliance. This has included increasing our staff to meet the demands of our enrollment, adding staff for internal

compliance monitoring and reporting, and enhancing our technological capabilities for tracking administrative items (such as member grievances and claims disputes).

- ***Compliance Team:*** Our compliance team is led by Kelly Kreiselmeier, who is responsible for overseeing Evercare Select's operational compliance with the requirements of our AHCCCS contract.
- ***Internal Monitoring:*** Evercare Select has renewed our commitment to self-monitoring, self-reporting, and self-correcting operational issues. In January 2008, we identified pharmacy and utilization management cases where members had not received a Notice of Action letter (which provides information on appeal rights). **We self-reported the issue to AHCCCS and initiated a successful corrective action plan**. We have created a continuous monitoring tool, based on the AHCCCS Operational and Financial Review (OFR), which we use to ensure that each functional department and subcontractor is audited at least annually. These audits are completed by the functional area lead and reported to our Compliance Department, with results presented during our monthly Compliance Committee meetings. Issues of significant non-compliance are reported immediately to Ms. Brach and to AHCCCS as part of our communication and remediation effort.
- ***Quality Assurance Process:*** While Evercare Select's leadership team has worked to instill a culture of proactive monitoring and a commitment to operational excellence, we also recognize the importance of a responsive mechanism for working with AHCCCS when deficiencies are identified and sanctions are levied. Working through our Quality Management Committee, each department within Evercare Select has a clear process for goal setting, measuring performance, implementing improvements, and re-measurement to ensure that we can re-establish compliant status after deficiencies are notes. **We are committed to continuous improvement and believe that our progress in the last 18 months demonstrates this commitment.**

Claims

7. Provide a detailed flowchart and narrative description of the claims adjudication process…..

Evercare Select has been successfully processing and paying claims related to the ALTCS program since 1989. We are committed to using advanced technology to accurately process claims in a timely manner, consistent with contract requirements. Our system is **HIPPA-complaint**, **coordinates benefits**, identifies **liable third parties**, adjudicates claims in accordance with correct coding edits (CCI), and pays claims in accordance with A.R.S. 36-2903 and 2904; AHCCCS Rules R9-28 Article 7; and R9-22-705. Evercare Select complies with **timeliness standards** and pay 90 percent of clean claims within 30 days of receipt and 99 percent within 60 days of receipt. We use inventory reports and focused **audits** to monitor **claims payment accuracy** and timeliness. If we identify claims payment deficiencies and they are not corrected, a **corrective action plan** is established and monitored until completion. Our **remittance advice** identifies specific reasons for denial or partial payment. Our Chief Executive Officer, Karen Brach, has ultimate oversight of the claims adjudication process and the team responsible for **researching claims** inquiries and **communicating results** to providers within three business days.

***For the current contract year through 1/31/11, 75.6 percent** of all claims are received in an electronic format **exceeding** the AHCCCS benchmark of **60 percent**.*

Evercare Select's claims adjudication process adheres with the ACOM policies listed below:

- Chapter 200, Policy 201, Medicare Cost Sharing for Members in Medicare FFS
- Chapter 200, Policy 202, Medicare Cost Sharing for Members in Medicare HMO
- Chapter 200, Policy 206, Claims Payment Responsibility and Claims Filing/Dispute Process for Behavior Health.

Claims Submissions and Receipt Process

Providers are required to submit HIPAA-compliant claims on the appropriate claim form (UB04, UB92, HCFA 1500). We accept claims electronically or manually via paper forms. Providers are able to submit claims online via our provider portal, www.uhconline.com, which is integrated with our COSMOS transaction processing tables. This integration allows for instant error validation while data is being input.

Evercare Select has successfully initiated provider outreach and education programs to encourage greater reliance on electronic submission to facilitate more expedient processing and payment. Evercare Select has already begun working with providers to assist in transitioning them from roster billing to electronic UB submissions to ensure nursing home claims are administered on our claims platform. We are using an expedited process, through our billing support services team, working with AHCA and other not-for-profit nursing home organizations to assist our providers with this transition.

The table below illustrates our current paper and electronic submissions rates from contract year 2008 through 1/31/2011.

Type of Claim	*CYE08*	*CYE09*	*CYE10*	*CYE - 1/31/11*
Percent Electronic Claims	40.6%	59.7%	70.0%	75.6%
Percent Paper Claims	59.4%	40.3%	30.0%	24.4%

Paper Claims

Paper claims are mailed to a designated post office box, opened, sorted by claims type and prepared in a format ready for electronic submission into the system. Each claim is captured with the date the claim was

received at the post office and a unique claim number assigned.

Electronic Claims

Electronic claims submitters receive an electronic acknowledgement that the claim is accepted and being processed. Claims are automatically assigned a unique claim number for tracking, logging, and audit control purposes.

Pharmacy and Dental Claims

Pharmacy claims are administered by Prescription Solutions, Inc. (PSI). Dental claims are administered by Dental Benefit Providers (DBP). PSI and DBP process claims in accordance with relevant Arizona and AHCCCS laws and regulations. PSI and DBP adhere to the ACOM Policy 203 for Contractor Claims Processed by Subcontracted Providers.

Claims Processing

Evercare Select uses the Comprehensive Online Software for Management and Operational Support (COSMOS) health information system that integrates member demographic data, case management information, prior authorization, provider information, service provision, claims submission and reimbursement. COSMOS is configured to meet AHCCCS' requirements and is capable of handling unlimited increases in claims volume due to increased enrollment.

COSMOS supports all claims processing functionality including receipt, tracking and processing of both paper and electronic claims; automated adjudication; incorporation of extensive edits and overrides; maintenance of key coding reference files (CPT, HCPCS, ICD9); claims and encounter reporting to AHCCCS; preparation of payment checks and remittance advices; coordination of benefits; payment of claims interest; securing claims information; and reporting features. COSMOS uses AdjudiPro and Smart Audit Master (SAM) to support claims editing (CCI, MUE). We have the ability to pay/adjudicate crossover claims for our dual members on our Medicare and Medicaid products. As claims enter the system, they undergo initial validation edits in the United Front End application Correction Processing Queue (CPQ) such as member and provider validation, provider set up not configured, etc. Claims may be rejected or placed in the Corrections Processing Queue (CPQ) to be reviewed for corrections before transferring to processing. Claims that successfully pass the initial validation edits are then transferred into COSMOS for processing.

Once in COSMOS, there are further edits for member eligibility, provider contracting, prior authorization, and professional claims pass through the Adjudipro edits. The COSMOS system has built-in logic to automatically process and price (contract pricing, AHCCCS fee schedule, state procedure tables, modifiers, OPFS) certain claim types. Claims that require a manual review are adjudicated by our claims processors. Claims can edit to a manual review for varying reasons, such as COB, driven by configuration of the system, so that such specialty processes can be handled by more skilled claims processors outside the normal claims processing cycle. After adjudication, SAM edits are applied and claims enter their final stage processing for interest calculation depending on type (if applicable) and payment.

Payments are issued to providers by electronic funds transfer (EFT) or check. To expedite payment, Evercare Select has successfully initiated provider outreach to providers to apply for EFT payments.

Percent of Claims Paid by EFT	*CYE08*	*CYE09*	*CYE10*	*CYE11 through 1/31/11*
Electronic Funds Transfer	21.9%	40.9%	63.5%	68.6%

We issue provider payments twice a week. COSMOS produces remittance advices and sends them with the payments. Providers who receive payment by EFT receive a paper remittance. Providers who submit electronic claims online can also access their remittance online. Provider rights for claims disputes are

inserted with every remittance mailed – a copy is attached to this narrative. A sample remittance advice is attached to this narrative and information includes:

- Description of all denials and adjustments
- Amount billed
- Application of COB and SOC
- Reasons for such denials and adjustments
- Amount paid
- Provider rights for claims disputes.

Monitoring for Accurate and Timely Claim Adjudication

We use a variety of methods to monitor our claims timeliness and payment:

- ***Inventory Reports:*** Produced on a daily and weekly basis to monitor timeliness standards
- ***Claims Aging Reports:*** Monitored daily and weekly, based on date of receipt
- ***Focused Contract Audits:*** Audits contract terms against claims paid standards
- ***End-to-End (ETE):*** Evaluates the accuracy of the full population of claims.
- ***High Dollar and Outliers:*** Reviews physician claims in excess of $10,000 and facility claims in excess of $25,000, for potential inaccurate payments
- ***Post Training:*** Reviews claims processor claim payment accuracy, post-classroom training, to identify training gaps or training opportunities
- ***Provider Account Management (PAM):*** Meetings with key providers to assess their "accounts receivable" days against our payment timeliness and accuracy, allowing for "voice of the customer" feedback. This process is used to check our payment system against the provider's billing system to identify setup issues and provider billing practice issues that have led to gaps or discrepancies in processing and payment.

Claims Timeliness Standards

Claims processors are required to meet minimum standards for production and quality. In accordance with the ALTCS contract, Evercare Select complies with timeliness standards ensuring 90 percent of clean claims are paid within 30 days of receipt and 99 percent are paid within 60 days of receipt.

Percent of Claims Processed	*CYE09*	*CYE10*	*CYE11 - 1/31/11*
Claims Processed in 30 days	92.5%	94.5%	91.4%
Claims Processed in 60 days	95.8%	99.3%	99.6%

Identifying and Resolving Deficiencies

We gather information at all key provider touch points (e.g. provider calls, claims disputes, service visits) to determine root cause of issues and resolution. In compliance with the ALTCS contract, provider calls are responded to in 3 business days, and the issues is resolved in 30 days. If the issue is not resolved in 30 days, we document the reason why and resolve it within 90 days. We identify deficiencies resulting from:

- ***Retrospective review:*** Use to detect patterns in provider issues logged through calls or claim disputes
- ***Post processing review of claims data:*** Examination of claims denials or payment pattern trending to determine changes in patterns
- ***Operational meetings:*** Held with claims, call center and authorization staff
- ***An analysis of identified issues:*** Determination of solutions or changes to existing processes; if required, we test for accuracy before implementation and monitor post-implementation for resolution.

We have found that most deficiencies tend to be categorized into one of three areas: provider education, system issues and staff training related to manual processing issues.

When we identify subcontractor claims payment deficiencies and they are not corrected, we establish a corrective action plan. We monitor these plans through additional subcontractor reporting requirements and existing service level agreements.

Cost Avoidance/Third Party Liability Activities

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations, and after all other sources of payment have been exhausted. Evercare Select coordinates benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. that include:

- ***Cost Avoidance:*** If a third party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, Evercare Select makes these payments using the lesser of the difference methodologies as explained in Paragraph 63, Coordination of Benefits/Third Party Liability in the RFP for CYE12.
- ***Post-payment Recoveries:*** We recover payments through recoupment of claims payments following all protocols established in the ACOM Recoupment Policy. Recouped claims encounters are voided in full, unless the recoupment is an adjusted claim value, then we submit a replacement encounter.
- ***Other Recoveries:*** We identify potentially liable parties through use of trauma code edits, using diagnostic codes 800 - 999.9 (excl. 994.6), external causes of injury codes E000 - E999 and other procedures. Evercare Select contracts with an outside vendor, Health Management Systems, to review flags and TPL functions. The claims administrator, Helen Bronski, coordinates and supervises the activities of the vendor including providing identification of possible recoveries, provision of claim information, monitoring and reporting activities.

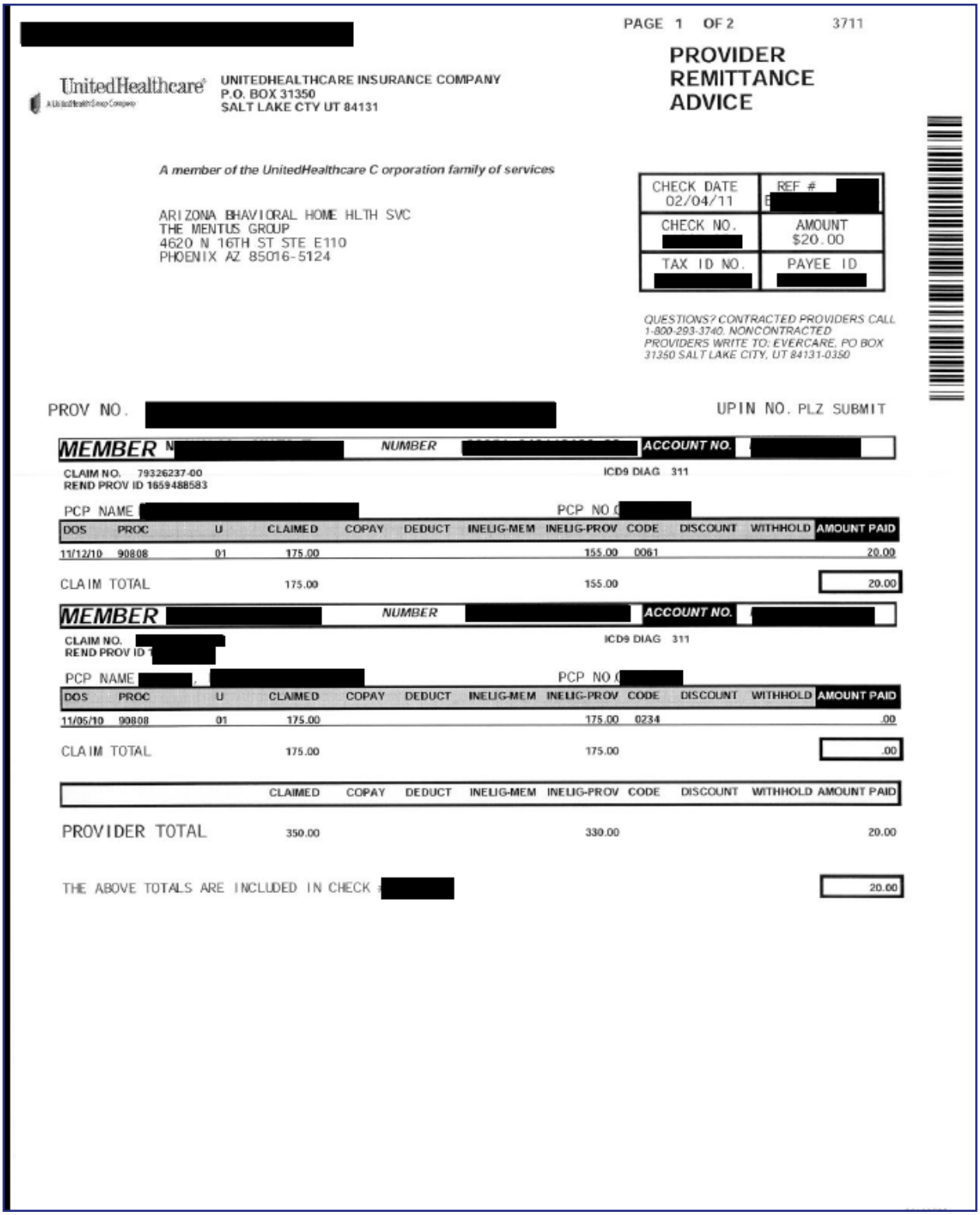
In certain circumstances (e.g., uninsured/underinsured motorist insurance, workers' compensation, estate recovery, etc.) we do not pursue recovery unless AHCCCS or an AHCCCS-authorized representative refers the case. We report these types of cases within 10 days of identification to an AHCCCS authorized representative for determination of a total plan case or joint case.

- ***Medicare Services and Cost Sharing:*** Evercare Select applies the ACOM Medicare Cost Sharing Policy to contracted facilities who have signed a contract amendment and to non-contracted facilities. If a dually eligible member has Medicare Part A or B coverage, Evercare Select will pay any copayment, coinsurance and applicable deductibles. Evercare Select has no cost-sharing obligation if the Medicare payment exceeds what we would have paid for the same service for a non-Medicare member.

Liability is identified through sources such as AHCCCS file of third-party coverage, provider claims, initial new member assessment by a case manager, and the member services and prior authorization departments. Subsequent claims edit to a COB review and the claim does not pay until Evercare Select receives the other carrier's explanation of benefits, notification from AHCCCS or another source that the other coverage is not in effect.

Provider Claims Inquiries

Providers are encouraged to contact our call center or their Provider Representative for assistance before filing a claim dispute. In compliance with the ALTCS contract, we respond to provider inquiries in 3 business days, and resolve issues within 30 days. If the issue is not resolved in 30 days, we document the status and resolve within 90 days. We contact the provider by phone, email or letter depending upon the provider's preference. Providers can access our secure provider portal at www.uhconline.com to review the status of their claim. Our provider service representatives help providers understand information contained in their remittance advice and may review the claim with the provider to determine if it is appropriate to file a written claim dispute. The provider claim dispute (grievance) resolution accompanies all remittances and includes specific information on how and where to file the dispute with documentation of relevant timelines in accordance with ARS 36-2903.01(4).



[redacted]

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UnitedHealthcare
A UnitedHealth Group Company

UNITEDHEALTHCARE INSURANCE COMPANY
P.O. BOX 31350
SALT LAKE CTY UT 84131

PROVIDER REMITTANCE ADVICE

A member of the UnitedHealthcare C orporation family of services

ARIZONA BHAVIORAL HOME HLTH SVC
THE MENTUS GROUP
4620 N 16TH ST STE E110
PHOENIX AZ 85016-5124

CHECK DATE 02/04/11	REF # [redacted]
CHECK NO. [redacted]	AMOUNT $20.00
TAX ID NO. [redacted]	PAYEE ID [redacted]

QUESTIONS? CONTRACTED PROVIDERS CALL 1-800-293-3740. NONCONTRACTED PROVIDERS WRITE TO: EVERCARE, PO BOX 31350 SALT LAKE CITY, UT 84131-0350

PROV NO. [redacted] UPIN NO. PLZ SUBMIT

MEMBER [redacted] NUMBER [redacted] ACCOUNT NO. [redacted]

CLAIM NO. 79326237-00
REND PROV ID 1659488583 ICD9 DIAG 311

PCP NAME [redacted] PCP NO [redacted]

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
11/12/10	90808	01	175.00				155.00	0061			20.00
CLAIM TOTAL			175.00				155.00				20.00

MEMBER [redacted] NUMBER [redacted] ACCOUNT NO. [redacted]

CLAIM NO. [redacted]
REND PROV ID [redacted] ICD9 DIAG 311

PCP NAME [redacted] PCP NO [redacted]

DOS	PROC	U	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
11/05/10	90808	01	175.00				175.00	0234			.00
CLAIM TOTAL			175.00				175.00				.00

	CLAIMED	COPAY	DEDUCT	INELIG-MEM	INELIG-PROV	CODE	DISCOUNT	WITHHOLD	AMOUNT PAID
PROVIDER TOTAL	350.00				330.00				20.00

THE ABOVE TOTALS ARE INCLUDED IN CHECK [redacted] 20.00

034ZDDPIU00086302 EVC/EPS/004/02042011 PAGE 2 OF 2 3712

PROVIDER REMITTANCE ADVICE

CODE DESCRIPTIONS

CHECK DATE	REF #
02/04/11	[redacted]

PROV NO. [redacted] NAME [redacted] UPIN NO. PLZ SUBMIT

INELIGIBLE EXPLANATION CODES

0061 MEDICARE APPROVED FOR THESE SERVICES
0234 DUPLICATE-ORIGINAL CLAIM IN PROCESS

EVERCARE SELECT CLAIM DISPUTE RESOLUTION

For Medicaid claims, please contact the customer service center at 1-800-377-2055 before filing a claim dispute for assistance.

A provider may file a claim dispute with the contractor if the provider meets the requirements below:

Per ARS 36-2903.01(4): A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the program contractor within:

1) Twelve months after the date of service,
2) Twelve months after the date that eligibility is posted, or
3) Sixty days after the date of the denial of a timely claim submission, whichever is later.

AAC R9-34-404 indicates that the written claim dispute must state the factual and legal basis for the dispute and the relief requested. Failure to meet these requirements shall result in the denial of a claim dispute.

All claims disputes must be in writing and mailed to the contractor below:

EVERCARE SELECT
Attn: Claim Dispute Coordinator
3141 N. 3rd Avenue, Suite 100
AZ060-N120
Phoenix, AZ 85013

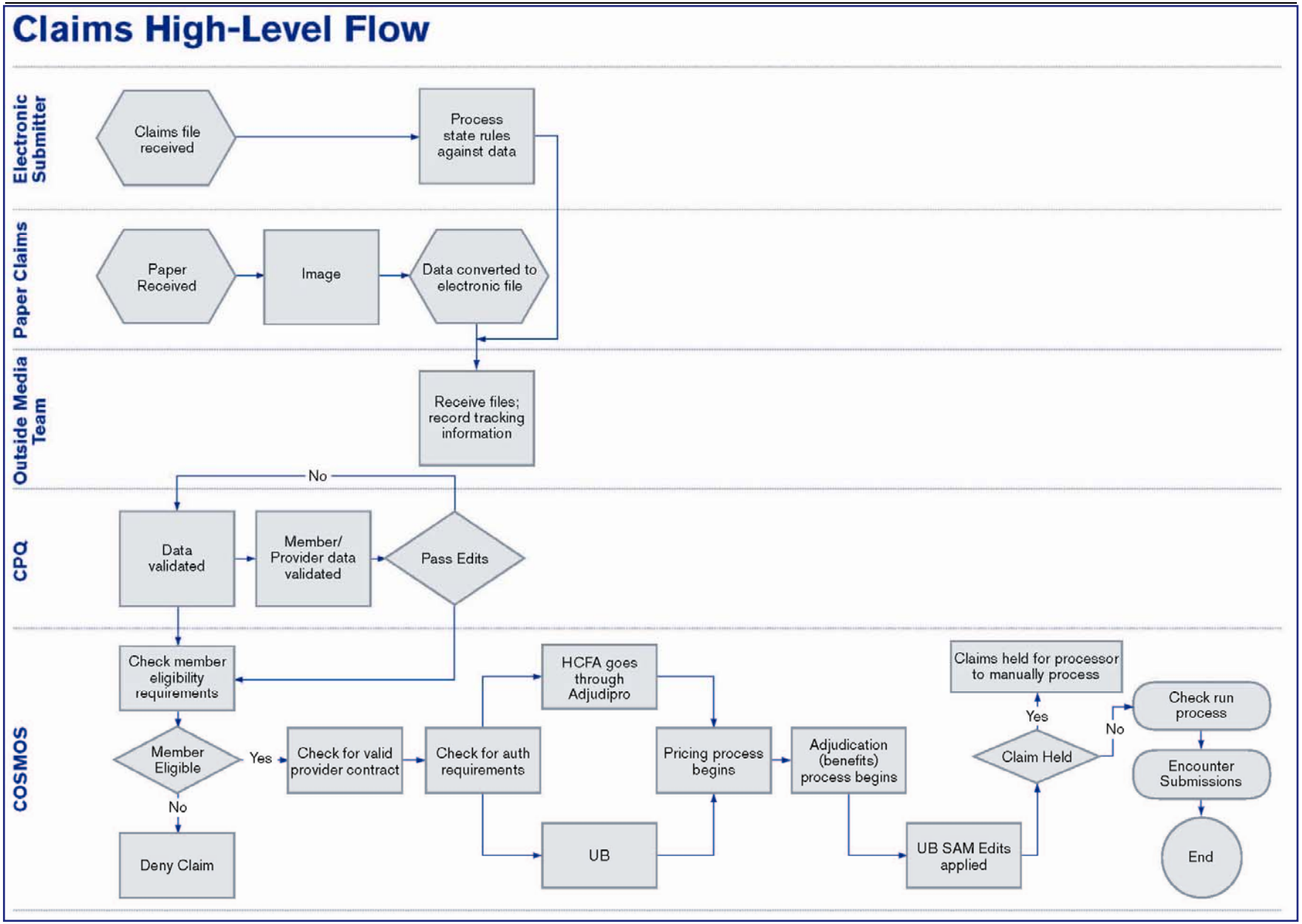
A claim inquiry or research request does not extend the claim dispute filing deadlines.

In the event that the provider disagrees with the contractor's decision, the provider may request a Hearing within 30 days of the decision. The contractor will forward the Hearing request to AHCCCS, Office of Grievance and Appeals.

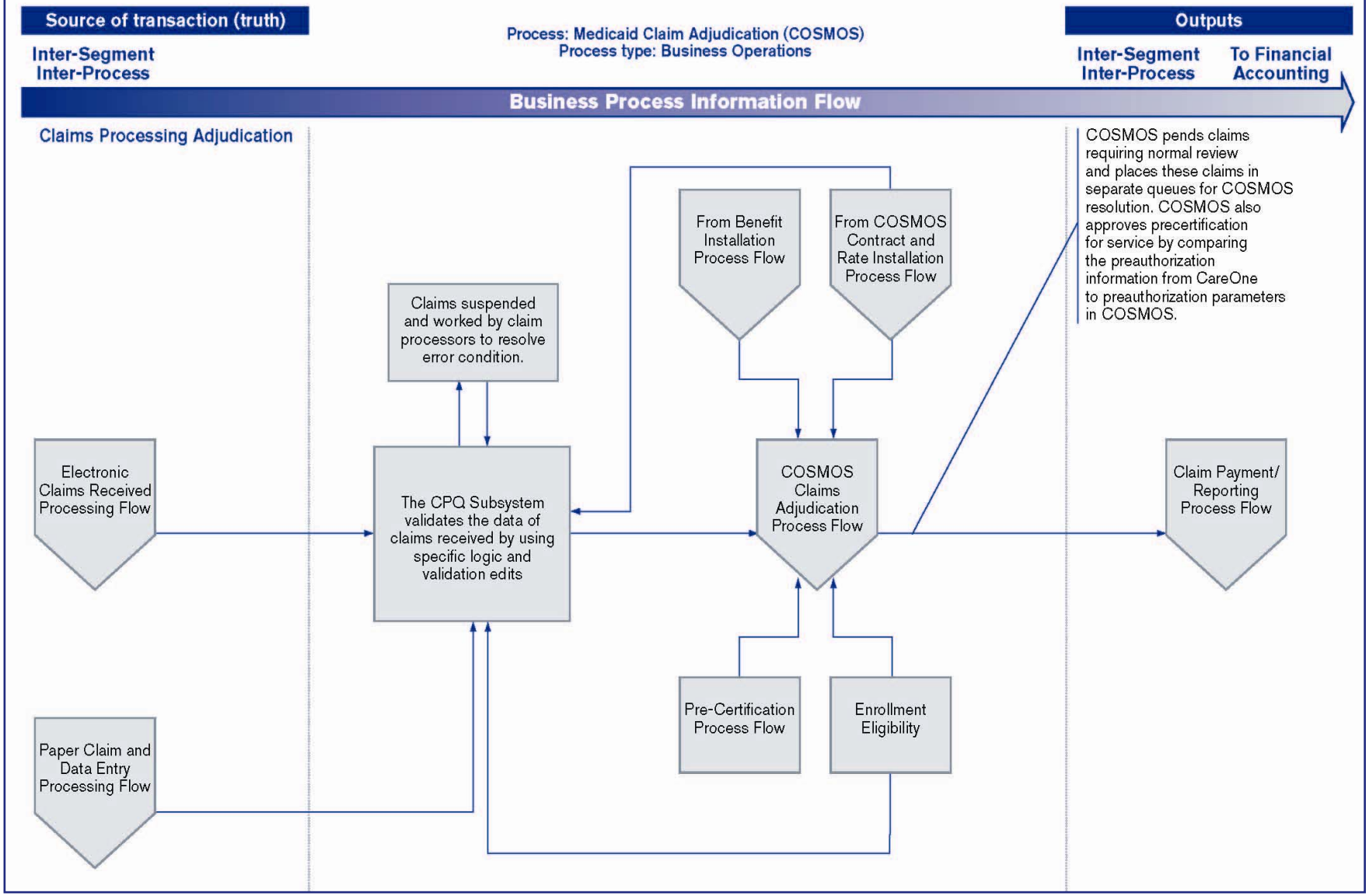
Claims Flowcharts

The flowcharts on the following pages detail our claims adjudication process.

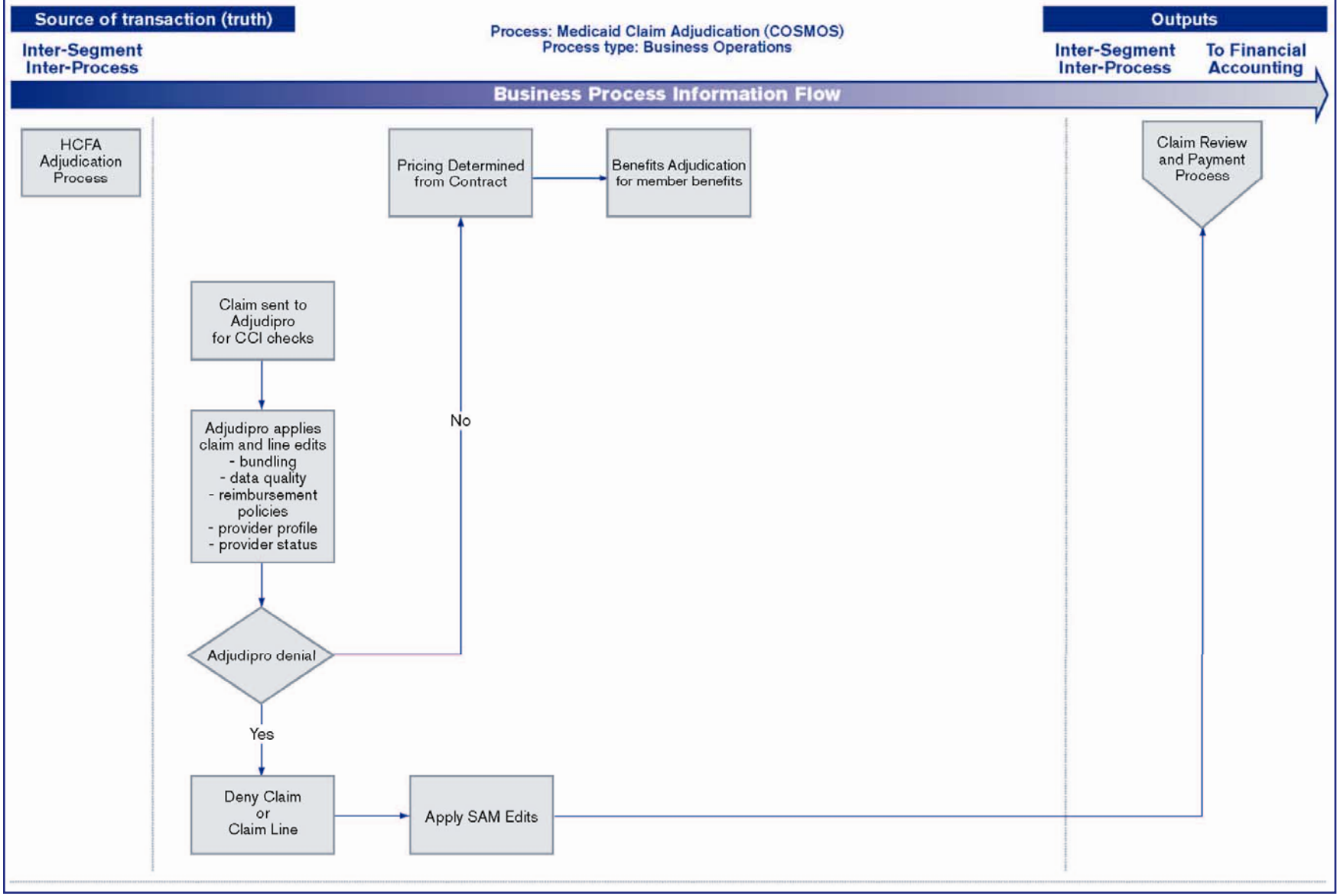
Claims High-Level Flow



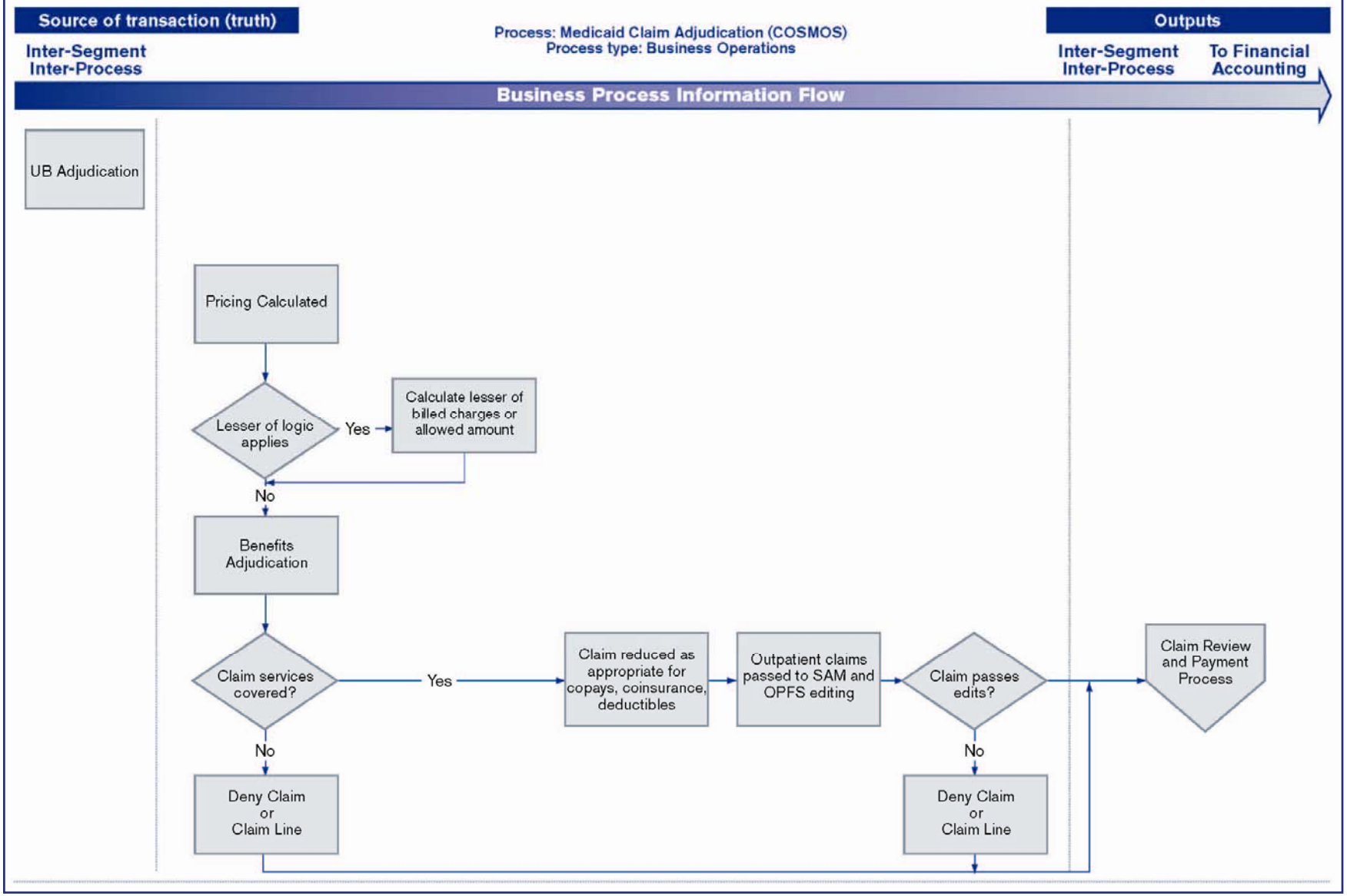
Claims High-Level Flow



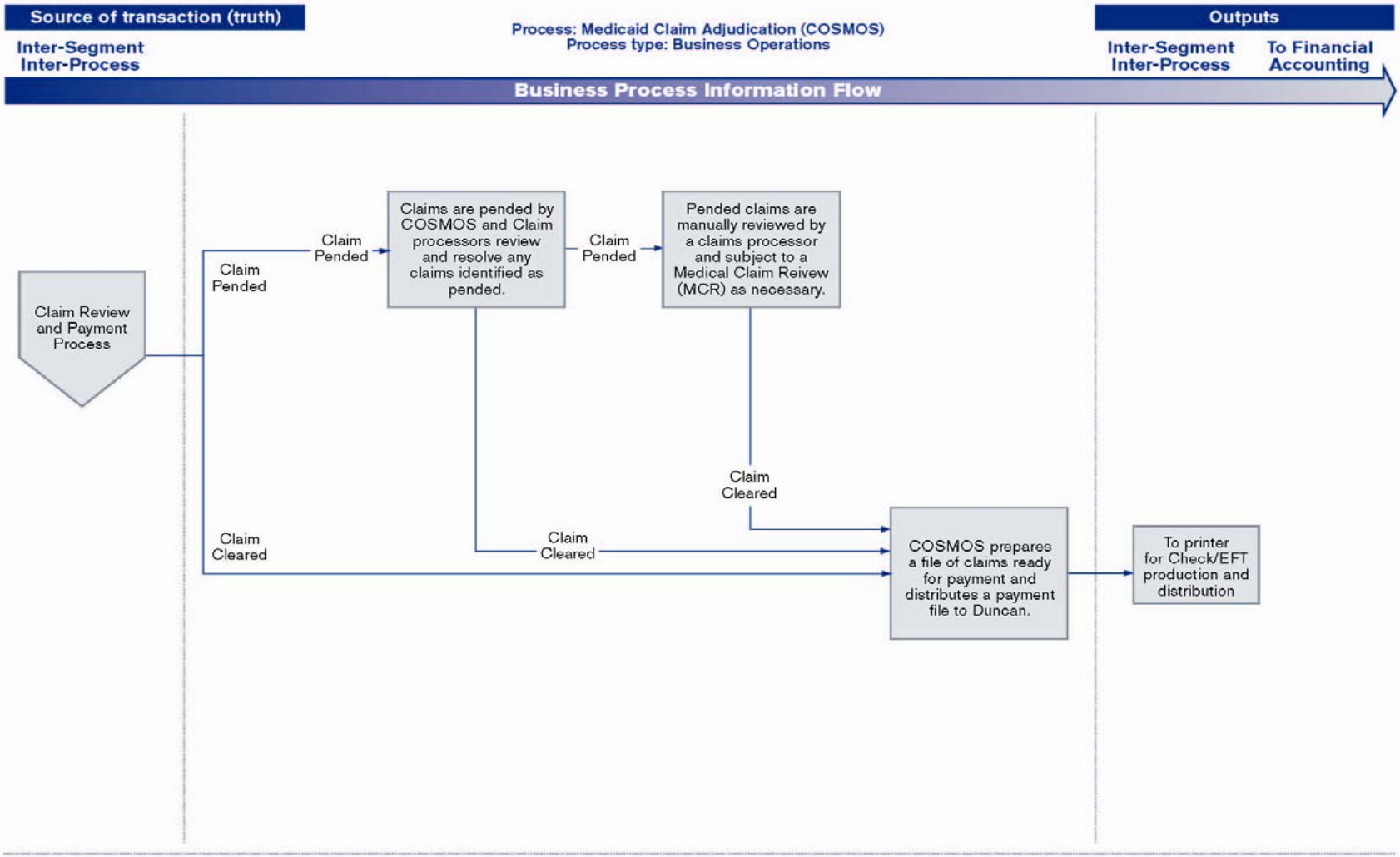
HCFA Claims


Source of transaction (truth)
Inter-Segment
Inter-Process
Process: Medicaid Claim Adjudication (COSMOS)
Process type: Business Operations
Outputs
Inter-Segment
Inter-Process
To Financial
Accounting
Business Process Information Flow
HCFA Adjudication Process
Pricing Determined from Contract
Benefits Adjudication for member benefits
Claim Review and Payment Process
Claim sent to Adjudipro for CCI checks
Adjudipro applies claim and line edits
- bundling
- data quality
- reimbursement policies
- provider profile
- provider status
No
Adjudipro denial
Yes
Deny Claim or Claim Line
Apply SAM Edits

UB Claims

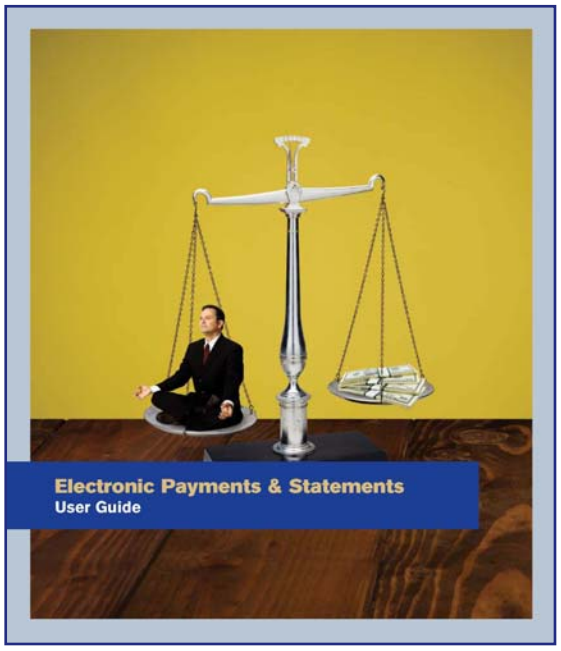

Source of transaction (truth)
Inter-Segment
Inter-Process
Process: Medicaid Claim Adjudication (COSMOS)
Process type: Business Operations
Outputs
Inter-Segment
Inter-Process
To Financial
Accounting
Business Process Information Flow
UB Adjudication
Pricing Calculated
Lesser of logic applies
Yes
Calculate lesser of billed charges or allowed amount
No
Benefits Adjudication
Claim services covered?
Yes
Claim reduced as appropriate for copays, coinsurance, deductibles
Outpatient claims passed to SAM and OPFS editing
Claim passes edits?
Claim Review and Payment Process
No
Deny Claim or Claim Line
No
Deny Claim or Claim Line

Claim Review and Payment Process



8. Describe what the Offeror will be doing to promote and advance electronic claims ..

Promoting and Advancing Electronic Claims Submissions and Electronic Funds Transfers



Evercare Select recognizes the importance of supporting providers with electronic claims submissions and electronic funds transfer. As previously noted, we have demonstrated an 87 percent improvement in electronic claims filing since 2008. Our Provider Services team, led by Provider Services Manager, Larry O'Connor, works with our providers to assist with electronic claims submissions and payments. Each month, Provider Services identifies the highest users of paper claims submissions and follows up individually with these providers for additional training and support. Some providers, typically smaller practices, still choose to elect paper claims because of its practicality for their particular needs and this is one of the challenges in this effort. Provider Services staff works closely with these providers to encourage billing through our online claim portal, www.uhconline.com.

As a result of our training, education and outreach efforts, Evercare Select currently exceeds the 60 percent standard for electronic claims submission and electronic funds transfers. The table below summarizes the of provider claims submitted electronically as well as the percent of claims paid via electronic funds transfer in 2010.

2010 ALTCS - Percent of Electronic Claims Submitted											
Jan	***Feb***	***Mar***	***Apr***	***May***	***Jun***	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***
64.5%	67.4%	72.6%	74.4%	72.3%	74.8%	78.1%	73.5%	73.0%	74.6%	75.4%	77.6%

2010 ALTCS - Percent of Claims Paid via Electronic Funds Transfer											
Jan	***Feb***	***Mar***	***Apr***	***May***	***Jun***	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***
52.4%	63.3%	68.6%	73.3%	66.6%	64.9%	68.1%	70.9%	74.4%	67.3%	66.1%	70.4%

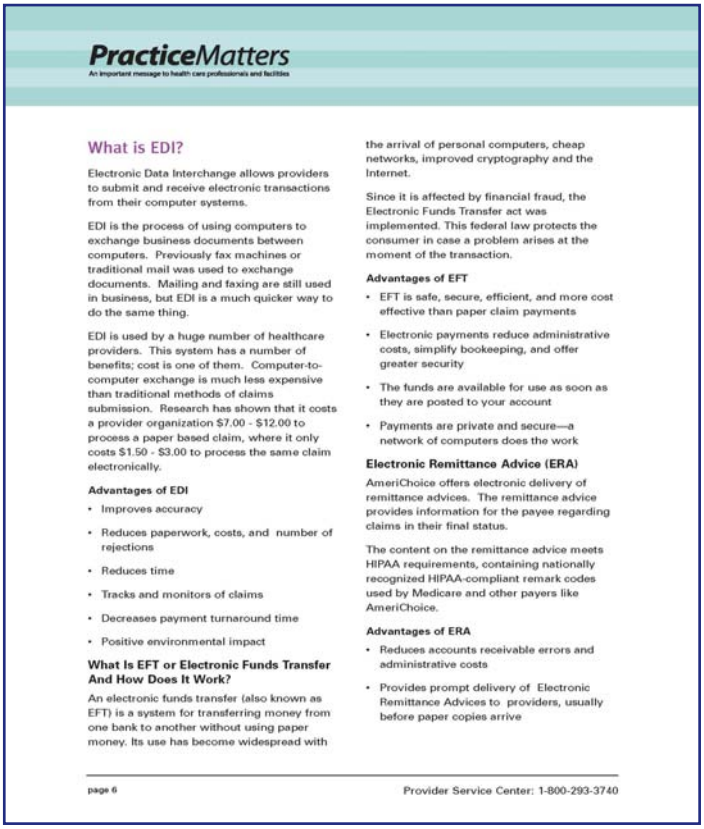
Dedicated Billing Staff

As part of our commitment to meet the new AHCCCS standard to receive and pay 60 percent of all claims electronically – based on volume of actual claims for urban providers – and to receive and pay 30 to 60 percent of all claims electronically for rural providers (based on a graduating scale as described in Section D - 44 of the RFP), Evercare Select is partnering with a provider billing firm located in Navajo County. This firm specializes in working with small rural providers and offers creative solutions to enhance electronic billing for even the smallest of providers. The result is improving electronic billing submissions, and at the same time, supporting a small local business.

Electronic Payments and Statement Support and Training

Face-to-Face Education and Training

- ***New Provider Orientation:*** Newly contracted providers and their office staff (including the office manager, billing manager, referral coordinator, nurses or medical assistants) participate in orientation training conducted by our Provider Services staff located in Arizona. Orientation training is scheduled to occur within 30 days of provider agreement effective date or anytime at the provider's request. The orientation sessions are extensive and include in-service, face-to-face training to communicate all applicable ALTCS and Evercare Select policies, procedures, rules, regulations and expectations, including the encouragement of electronic claims submissions and assistance with electronic funds transfers.
- ***Provider Advocates/Office Visits:*** Our field-based provider advocates and office-based representative are available to assist providers with questions or problems, including issues with electronic claims submission and electronic claims payment and statements. The field-based advocates conduct provider visits and educate providers on a variety of claims payment topics.
- ***Provider Claims Educator:*** Although not required, Larry O'Connor serves as our provider claims educator. He presents at provider forums and is available to educate providers on appropriate claims requirements in their offices. Mr. O'Connor reviews denial, call center and adjustment trends to address issues with providers and provide education to help alleviate those issues. He develops and maintains internal educational materials for the call center, provider representatives, and claims staff to improve claims payment processes. He also identifies claims that have paid incorrectly based on provider complaints and initiates claims repayment projects on their behalf.



PracticeMatters
An important message to health care professionals and facilities

What is EDI?

Electronic Data Interchange allows providers to submit and receive electronic transactions from their computer systems.

EDI is the process of using computers to exchange business documents between computers. Previously fax machines or traditional mail was used to exchange documents. Mailing and faxing are still used in business, but EDI is a much quicker way to do the same thing.

EDI is used by a huge number of healthcare providers. This system has a number of benefits; cost is one of them. Computer-to-computer exchange is much less expensive than traditional methods of claims submission. Research has shown that it costs a provider organization $7.00 - $12.00 to process a paper based claim, where it only costs $1.50 - $3.00 to process the same claim electronically.

Advantages of EDI

- Improves accuracy
- Reduces paperwork, costs, and number of rejections
- Reduces time
- Tracks and monitors of claims
- Decreases payment turnaround time
- Positive environmental impact

What Is EFT or Electronic Funds Transfer And How Does It Work?

An electronic funds transfer (also known as EFT) is a system for transferring money from one bank to another without using paper money. Its use has become widespread with the arrival of personal computers, cheap networks, improved cryptography and the Internet.

Since it is affected by financial fraud, the Electronic Funds Transfer act was implemented. This federal law protects the consumer in case a problem arises at the moment of the transaction.

Advantages of EFT

- EFT is safe, secure, efficient, and more cost effective than paper claim payments
- Electronic payments reduce administrative costs, simplify bookeeping, and offer greater security
- The funds are available for use as soon as they are posted to your account
- Payments are private and secure—a network of computers does the work

Electronic Remittance Advice (ERA)

AmeriChoice offers electronic delivery of remittance advices. The remittance advice provides information for the payee regarding claims in their final status.

The content on the remittance advice meets HIPAA requirements, containing nationally recognized HIPAA-compliant remark codes used by Medicare and other payers like AmeriChoice.

Advantages of ERA

- Reduces accounts receivable errors and administrative costs
- Provides prompt delivery of Electronic Remittance Advices to providers, usually before paper copies arrive

page 6 Provider Service Center: 1-800-293-3740

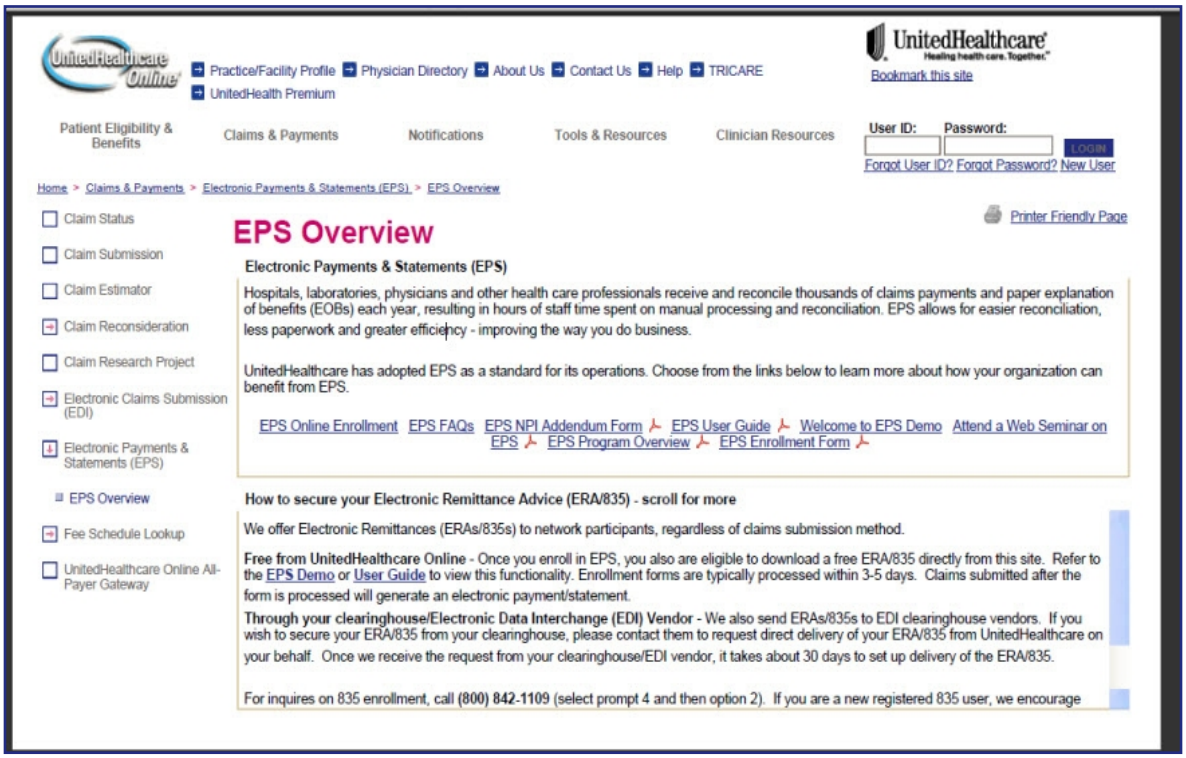
Other Education and Training Resources

- ***Provider Newsletters:*** Our Summer 2010 newsletter includes an article educating providers on electronic claims (see screenshot). We produce and distribute the provider newsletter to the network at least four times per year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, and information on electronic claims submissions and electronic funds transfer. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements.
- ***Provider Manual:*** We work with providers to make claim filing as straightforward and effortless as possible. We educate providers on our claims processing methods and direct them to a website that provides additional information and training as described below. The website and provider manual

contain information pertaining to the process, working with paper versus electronic claims, and changing general demographic data. Chapter 11 of the provider manual addresses claims and has detailed information covering EDI/electronic claims submission and electronic funds transfer (direct deposit). The provider manual includes contact phone number to assist providers with questions.

- ***Provider Portal:*** Our provider portal is one method we use to assure providers submit encounter data. Our provider orientation includes a demonstration of the provider portal (www.uhconline.com) covering portal functionalities and includes hands-on computer training. The provider portal is integrated with our COSMOS transaction processing tables, allowing for instant error validation during data input.

  The provider portal includes detailed instruction and education on electronic payments and statements. Once they have completed training, providers have access to all relevant information necessary to conduct business with us, including electronic claims submissions and electronic funds transfers. Below is a screenshot of the electronic payments and statements site.



  - ***Provider Webcasts:*** Webcasts are available through the provider portal and cover many critical training areas. As part of our eSolutions training series, Evercare Select provides training throughout the year on a number of topics, including electronic claims submission. Providers may pre-register for this webcast online at www.uhconline.com. Sessions generally run between one and one-and-a-half hours and pre-registration is required. Scheduled 2011 Electronic Payment and Statements Webcast training dates for the first six months of the year include:
    - February 17, 2011
    - March 17, 2011
    - April 21, 2011.

9. Provide a description of the clinical edits and data related edits …..

Our claims processing system incorporates an extensive list of edits to ensure accuracy in billing and payment in the adjudication process as well as to prevent fraud and abuse. We use industry-standard coding methodology and reimbursement logic, clinical rationale, and integrate required regulatory and business rules. Evercare Select's **key clinical and data assessment** edits include a variety of algorithms to ensure that claims are paid timely and that questionable claims are identified for further review.

Our claim payment system can be configured for the business rules that are necessary to pay claims according to standard claim payment rules, such as valid procedure code, valid diagnosis code, timely filing and duplicates claims.

In accordance to ACOM 200, the initial processing of a claim includes a review for member eligibility, covered services, excessive or unusual services for gender or age, duplication of services, prior authorization, invalid procedure codes and duplicate claims. Any unusual items will cause the claim to pend for review.

We also automatically pend claims over a certain amount for review to:

- Prevent/detect payments to providers for services not performed, not authorized, or otherwise inappropriate
- Test for validity of the original claims process for detecting fraud and misuse

Clinical Edits

We use both AdjudiPro and Smart Audit Master (SAM) within the COSMOS application to support claims editing. For professional claims, we leverage both AdjudiPro claims editing software and SAM editing tool. For institutional (UB) claims, we leverage the SAM editing tool. These tools analyze health care claims based upon business rules designed to automate Evercare Select's reimbursement policies, industry standard coding practices (CCI and MUE), and AHCCCS' specific editing rules. Claims are validated through these tools to minimize inaccurate claims payments. New edits are added based on emerging regulatory requirements or new business rules defined by manufacturer guidelines. These clinical-related edits generally apply to professional and institutional claims and include but are not limited to:

- ***Prior Authorization:*** This edit ensures that if an authorization is required, it is in the system.
- ***Max Frequency Limits:*** This edit can flag when a service is limited in frequency.
- ***Gender/Age:*** Our system identifies when a provider bills for an age-specific or gender-specific procedure or diagnosis code to a member whose age/gender is outside the designated range.
- ***Bundling:*** These edits monitor claims to ensure we pay bundled services as a global, rather than allowing individual services to be unbundled and separately paid.
- ***Bilateral Services:*** This edit ensures that procedures that can be done bilaterally, such as surgery on each arm, are billed appropriately.

We continue to develop mechanisms to enhance the number of edits and our ability to rapidly, accurately adjudicate claims, such as those listed below:

- Correct Coding Initiative (CCI) for professional and outpatient services
- Global Day E&M Bundling
- Multi-channel Lab Test Bundling.
- Multiple Surgical Reductions
- Assistant Surgeries
- DME Modifier Requirements
- POS/Procedure Code Combinations
- Procedure Code/Modifier Combinations

Data Related Edits

Our claims processing system incorporates an extensive list of edits to ensure accuracy in billing and payment, and to prevent fraud and abuse. A submitted claim must undergo these edits in order to ensure (1) enrollment is consistent with the date of service; (2) benefit package rules as defined by member eligibility are properly applied to the claim (e.g., covered benefits, deductibles, limits); (3) the claim was submitted within the required timeframes; and (4) national coding standards are followed (e.g., place of service appropriate to procedure, procedure appropriate to diagnosis. Examples of data related edits used by Evercare Select include:

- Completion of all required claim fields
- Provider is a **valid provider** in the AHCCCS program for the dates on the claim
- **Over-utilization standards**
- Member **eligibility and enrollment** (member enrolled in program specifically on date of service)
- Prior Authorization/Share of Cost Edit for Services
- **Timeliness standards**
- Duplication Logic to Prevent Claims from Processing
- **Benefit package requirements**
- Code used for the claim is a valid AHCCCS CPT code, allowed for the AHCCCS program and for the provider specifically as licensed
- Coordination of Benefits/Cost Avoidance

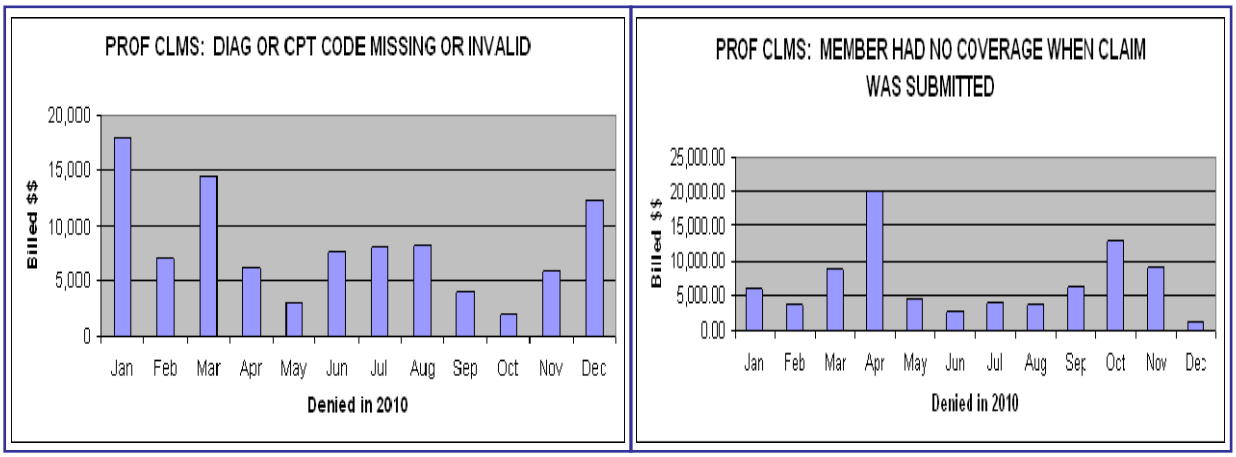
AHCCCS and ALTCS Specific Rules

Evercare Select accommodates specialized edits and reimbursement policies requested or required by AHCCCS to ensure that proper claims editing exists at all times. AHCCCS-specific clinical edits include:

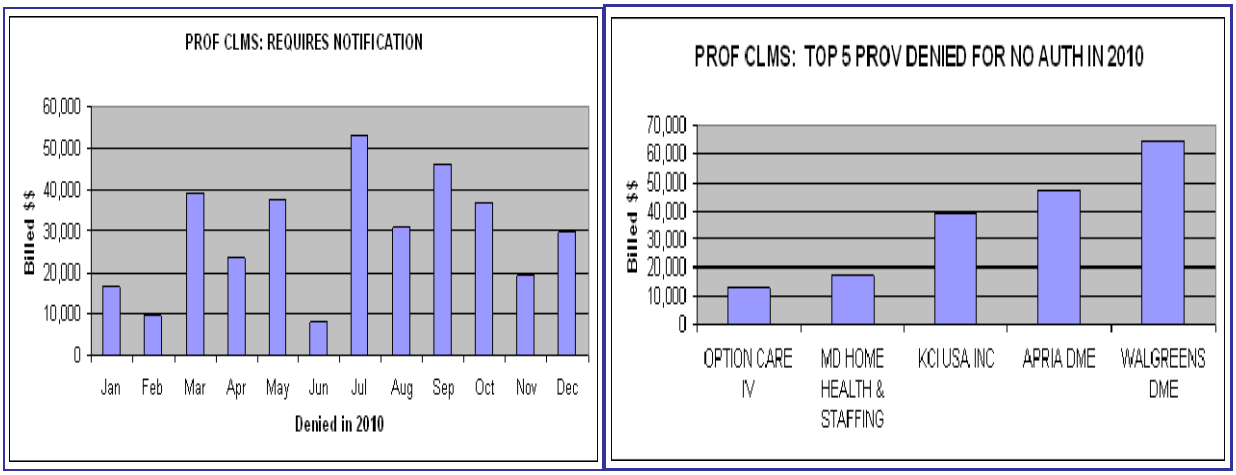
- ***Category of Service:*** We use the provider, profile, and subset of reference interface files to edit claims to ensure that provider has valid AHCCCS ID and is properly registered with AHCCCS to render the services submitted on their claims.
- ***NPI Validation:*** We use the provider interface file to validate that the provider has registered their NPI with AHCCCS.
- ***OPFS:*** We use the AHCCCS reference files to both edit and price outpatient hospital claims.
- ***Medicare Services and Cost Sharing:*** We apply the ACOM Medicare cost-sharing policies to contracted facilities who have signed a contract amendment and to non-contracted facilities. If a dually eligible member has Medicare Part A or B coverage, we pay any copayment, coinsurance and applicable deductibles. We have no cost-sharing obligation if the Medicare payment exceeds what we would have paid for the same service for a non-Medicare member.

Progress Tracking

We monitor progress of our editing tools and have the ability to monitor by individual edit and by provider. The following charts show examples of tracking of the denied edit trends.



These charts represent two types of denial trending monitored by Evercare Select – one by denied billed dollars in 2010 by month for no notification (prior authorization), and the other identifying the top five providers denied for no authorization. These charts are used to provide education opportunities to our providers or claims processing staff once thorough analysis has been conducted.



10. Submit a description of the Offeror's encounter submissions process …..

Encounter Submissions Process

Evercare Select understands that accurate, timely, and complete reporting of encounter data is one of the fundamentals to successful participation in the AHCCCS program. We submit encounter data to AHCCCS for all services rendered for which we incur a financial liability and claims for services eligible for processing by Evercare Select where no financial liability was incurred, including services provided during prior period coverage. For 22 years, we have demonstrated our ability to submit encounters in the format and timelines required in the **HIPAA Transaction** Companion Documents & Trading Partner Agreements, the AHCCCS Encounter Reporting User Manual, and the AHCCCS Technical Interface Guidelines. Encounters are submitted to AHCCCS no later than **240 days** after the end of the month in which the service was rendered, or the effective date of enrollment, whichever date is later. Pharmacy-related encounter data is provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. The age of pended and denied encounters is monitored carefully through the use of management reports to ensure pended and denied encounters are resolved within **120 days** of the original AHCCCS processing date.

Our response below also outlines our processes for maintaining records of all deleted encounters, submitting replacement or voided encounters for all corrected claims, producing management reports reconciling the claims system to the encounter system, and tracking the timeliness of our encounter submissions in aggregate. We also have in place processes for improvement when standards are not met, submitting non-covered or denied line encounters and for reporting billed and paid units and charges.

Our approach to encounter submissions includes an end-to-end process through which we emphasize continuous **quality improvement**. The key functions that support our encounter submissions are overseen by our Chief Executive Officer, Karen Brach, and our Claims Administrator, Helen Bronski, and include:

- ***Claims:*** In addition to ensuring prompt claims payment, we develop and implement front-end edits to minimize inaccurate data, run quality and data validity audits, train claims processors, update claim operating instructions, review root cause, and develop and implement solutions to permanently avoid inaccuracies in the future.
- ***Encounter Submission Team:*** We submit accurate and complete encounters in a timely manner including:
  - Collecting data and prepare encounters for submission in an 837 format
  - Running the pre-edit processor, which helps to ensure encounter completeness and accuracy
  - **Maintaining records** of all **deleted** encounters
  - Submitting **replacement** or voided encounters for all corrected claims
  - **Tracking the timeliness** of all encounter submissions in aggregate
  - Receiving and translating AHCCCS responses
  - Attending AHCCCS meetings and trainings on encounters
  - Reviewing monthly encounter keys, reinsurance hot news, and claims clues to ensure our technical setup is correct.
- ***Encounter Quality Assurance Team (EQAT):*** EQAT is responsible for ensuring the completeness and accuracy of submitted encounters and continuously improving our processes. This team is responsible for reviewing pre-edit processor reports and pended encounter reports to determine trends and root causes to then develop solutions through a defect management process. The EQAT team

attends AHCCCS meetings and reviews monthly encounter keys, reinsurance hot news, and claims clues to ensure proper system set-up.

- ***Subcontractor Management:*** We work with subcontractors to collect and monitor data through validation edits and lag reports; obtain corrections from the subcontractor; ensure completion of reconciliation reports from finance and the subcontractor; and participate in the subcontractor's defect management program.
- ***Annual Validation Studies:*** Evercare Select participates in annual encounter validation studies to compare recorded utilization data from medical records or other sources with submitted encounters.
- ***Finance:*** We run reports to ensure that all data is sent to AHCCCS, to ensure the COSMOS claims system reconciles to the encounter submission reports, and to ensure the financial fields of claims matches the financial fields of adjudicated encounters. We also oversee the reinsurance and transplant reconciliation and reporting.

Extracting Encounter Data

Evercare Select uses a Medicaid encounters system known as the National Encounter Management Information System (NEMIS), used throughout the complete encounters cycle process from submission and tracking, to error corrections and resubmission. NEMIS is also flexible enough to accommodate any future changes required by AHCCCS. On a monthly basis, we extract encounter data from our claims system and load the information into NEMIS. Our Encounter Submission team uses claims extract programs to sweep the claims database to identify all finalized claims with the status of paid, denied or reversed. The extract program also applies a date stamp to identify the last encounter extraction (sweep) process. Claims extracts are submitted to NEMIS for AHCCCS submission as outlined in the X12, NCPDP Transaction Companion Documents & Trading Partner Agreement and AHCCCS Encounter Manual.

We have extensive experience **submitting and receiving encounters in standard HIPAA transaction formats required by AHCCCS** such as 837P (professional claims), 837I (institutional claims), 837D (dental claims) as well as NCPDP format (pharmacy claims). All 837 transactions, including paid, denied non-covered and reversed claim lines with applicable billed and paid units and charges, are submitted with an appropriately completed certification of accuracy, completeness and truthfulness as required by 42 CFR 438.606. Encounter files are then transmitted electronically to AHCCCS via an FTP server. Our encounter files contain header/trailer claim counts and total billed charges used to reconcile with accepted/pended information received from AHCCCS. We also monitor 997 response transactions to ensure the files were read and accepted by AHCCCS. NEMIS is also designed to accommodate multiple data sources and provides a single repository from which we submit encounters to AHCCCS. Claims data from other sources, such as dental and pharmacy, are loaded on a monthly basis into NEMIS. To ensure timeliness of data collections, subcontractor transmissions (dental, pharmacy) are scheduled and tracked by our media tracker access database. The Subcontractor Management team confirms receipt of the subcontractor data file and loads it into database tables.

Data Validation

We validate encounter data for accuracy and completeness through process checkpoints during which we identify and correct potential data issues early in the process. Process checkpoints include:

- ***AHCCCS Information:*** We use state provider files, member files, and encounter reference tables in PMMIS.
- ***Claims Processing:*** Our encounter claims processing system includes edits to maximize accuracy. Edits are based on AHCCCS requirements; they include reference validation, duplicate claims, and appropriate use of standard service codes.
- ***Subcontractor Management:*** We evaluate third-party encounter data for accuracy and completeness. The verification process ensures the file is not a duplicate and primary dates of service or claim post dates fall within expected ranges. We validate original input filename, expected received date, actual

received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted into encounter claims processing system, and number of claims failing initial edits.

Encounter Corrections

We document corrected encounters and maintain a record of any replaced/deleted/voided by maintaining a unique claims reference number (CRN) with appropriate supporting evidence of the replacement. As an example of a correction, we would void encounters for claims that are recouped in full. We submit replacement encounters for re-coupments that result in a reduced or increased claim value. Replacement or voided encounters are submitted to AHCCCS for all claims that are corrected following the initial encounter submission. Upon request, the documentation is made available to AHCCCS for review. When we receive the monthly report containing rejected submissions, we research and correct the rejected submissions. Once the encounters are validated and accepted by the AHCCCS Transaction Insight Portal, they are forwarded to the State.

Pended encounters are prioritized to ensure acceptance within the recommended timeframes. Corrections may be made in PMMIS, via an 837 or on the pend corrections file. We complete corrections, allowing encounter corrections to be submitted to AHCCCS. Those requiring adjustments are forwarded to our Claims Department for reprocessing and then resubmitted as voided and replaced encounters.

Processes for Improvement when Standards Are Not Met

Encounter data is validated for timeliness, accuracy and completeness at numerous process checkpoints. This monitoring identifies and corrects potential data issues early in the process as well as ensuring pended and denied encounters are resolved within 120 days of the original AHCCCS processing date. When trends or system issues emerge (whether internal or subcontractor-related), our team quickly identifies root causes, works to remediate the problem, and tracks progress through resolution. Remediation involves creating a new claims system edits, providing education to providers or subcontractors, requiring corrective action, or revising membership information. In an effort to mitigate encounter issues before they emerge, we also continuously work to address any system issues with the AHCCCS Encounter Analyst via email as well as attend monthly or quarterly encounter meetings. We work diligently to maintain communication with AHCCCS to remain current as well as continuously work to improve our encounter data collection and submission process.

Tracking, Trending, Monitoring for Accuracy and Timeliness

Working with the Encounter Submission Team, Evercare Select and the EQAT teams are responsible for ensuring the accuracy, timeliness, completeness of submitted encounters and continuously improving our processes. These teams are responsible for the end-to-end tracking of encounters from claims payment or denial to encounter acceptance and for reviewing pre-edit processor, pended and denied encounter reports to determine trends, encounter resubmission corrections/updates and error root causes. The team then coordinates the development and implementation of source solutions to permanently avoid these types of errors from occurring in the future. Our process incorporates the following reports:

- ***NEMIS:*** Our encounter submission system supports the tracking, correcting and reporting needed for remediation of identified problems. Defects in submissions are logged and analyzed for identification of any systemic issues. Encounter adjustments, reconciliations and post submission completeness reports ensure all transactions are balanced and reported.
- ***Aging Report:*** The age of existing encounters are monitored carefully to ensure their submission is within AHCCCS time requirements, which is no later than 240 days after the end of the month in which the services were rendered, or effective date of enrollment with us, whichever is later.
- ***New Day Trending:*** Current cycle new day counts are benchmarked against those of previous cycles and inconsistencies are identified and researched to ensure data completeness.

- ***Encounter Error Trending:*** We analyze error trends to identify incomplete or inaccurate data. Appropriate claims, membership or provider remediation projects are implemented to mitigate the occurrence of future issues.
- ***Encounter Submission Tracking Report (ESTR):*** We maintain an ESTR to link each claim to an adjudicated, pended or denied encounter returned to us from AHCCCS.
- ***Encounter Acceptance Completeness Reporting:*** We run bi-weekly completeness reports. We reconcile paid claims with encounter data to ensure records are submitted appropriately and within contractual time limits of no later than 240 days after the end of the month in which the services were rendered or effective date of enrollment with us, whichever is later.
- ***Financial Reconciliation Reporting:*** We reconcile financial fields of a claim (e.g., health plan paid, billed amount, etc.) with the financial fields of adjudicated encounters. The encounter submission team runs reports to ensure that all data is sent to AHCCCS and to ensure the COSMOS claims system reconciles to the encounter submission reports, and to ensure the financial claims fields match the financial fields of adjudicated encounters.
- ***Replaced/Deleted/Voided Encounters:*** We document and maintain a record of the replaced/deleted/voided claims reference number (CRN), along with appropriate supporting evidence and reasons.
- ***Pended Encounters:*** We resolve and correct encounter pends and denials within the first 120 days. On receipt of the monthly pended encounter reports from AHCCCS, the EQAT and Evercare Select teams work together to research and resolve the pended and denied encounters. The teams also reviews pending and denied root causes and identifies upstream processing or system changes that may reduce the genesis of future pending and denied encounters. Encounters requiring adjustments are forwarded to our Claims Department for reprocessing or recoupment.

Pended Encounters	*Dec 2009*	*Dec 2010*	*Percent Decreased*
Pend Count	68,900	18,686	-72.9%

- ***Analysis and Continued Process Improvement:*** Pended, denied and rejected encounter reports are reviewed for trends to identify where edits may increase reporting.

Improvement Feedback Mechanisms to the Encounter Process

Subcontractor Management Team

We undertake certain key activities with subcontractors and providers to ensure accuracy and completeness of encounter data. Our Subcontractor Management team oversees that all required encounter data is received from our subcontractors as scheduled. The team employs validation edits and uses lag reports in this data collection and monitoring process. Once received, the team evaluates third-party data for accuracy, timeliness and completeness through a verification process that ensure files are not duplicates and that primary dates-of-service or claims post-dates fall within expected ranges. Additional validation edits include: original input filenames; expected received date; actual received date; insert date; batch load ID; number of claim header and detail records; number of claims accepted into encounter data management system; and number of claims failing initial edits. The Subcontractor Management team either hosts or attends periodic, at times weekly, calls with our subcontractors to discuss outstanding issues and identified data trends, possible solutions to remediate or prevent problems, and process improvements.

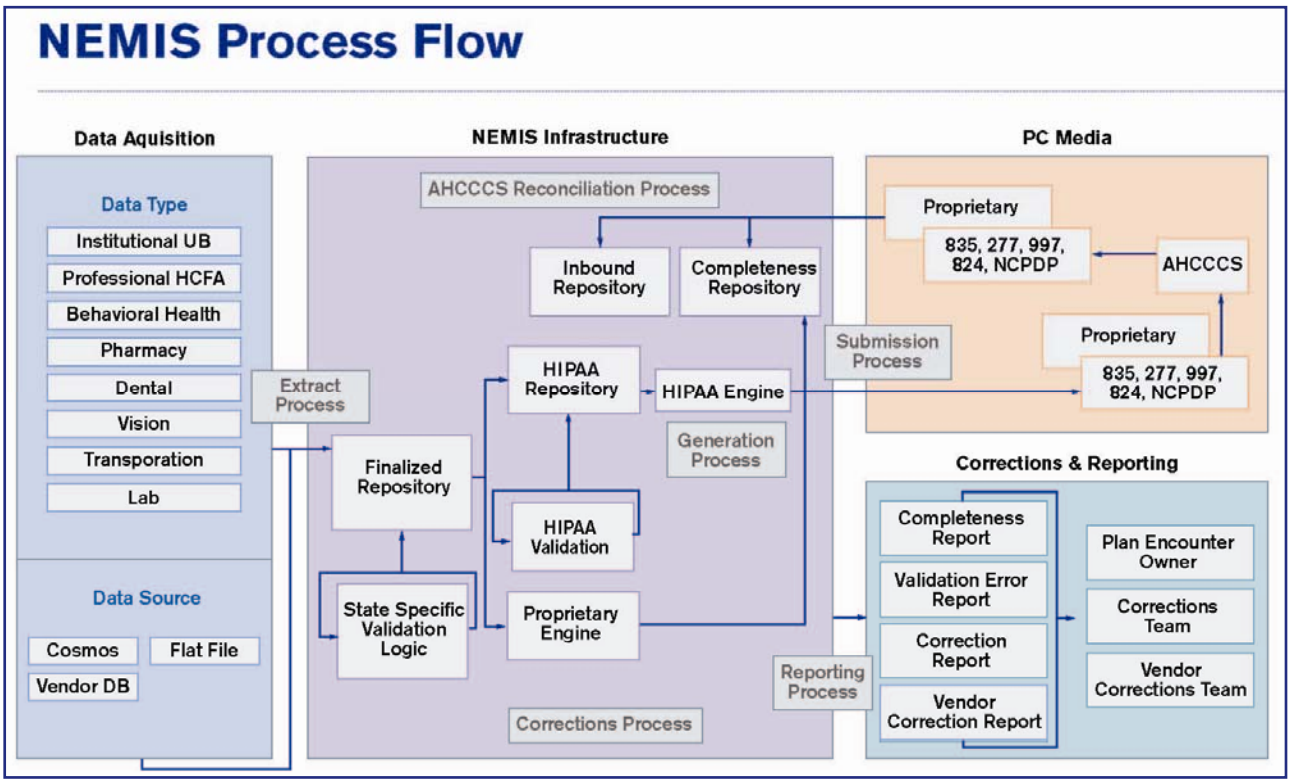
Providers

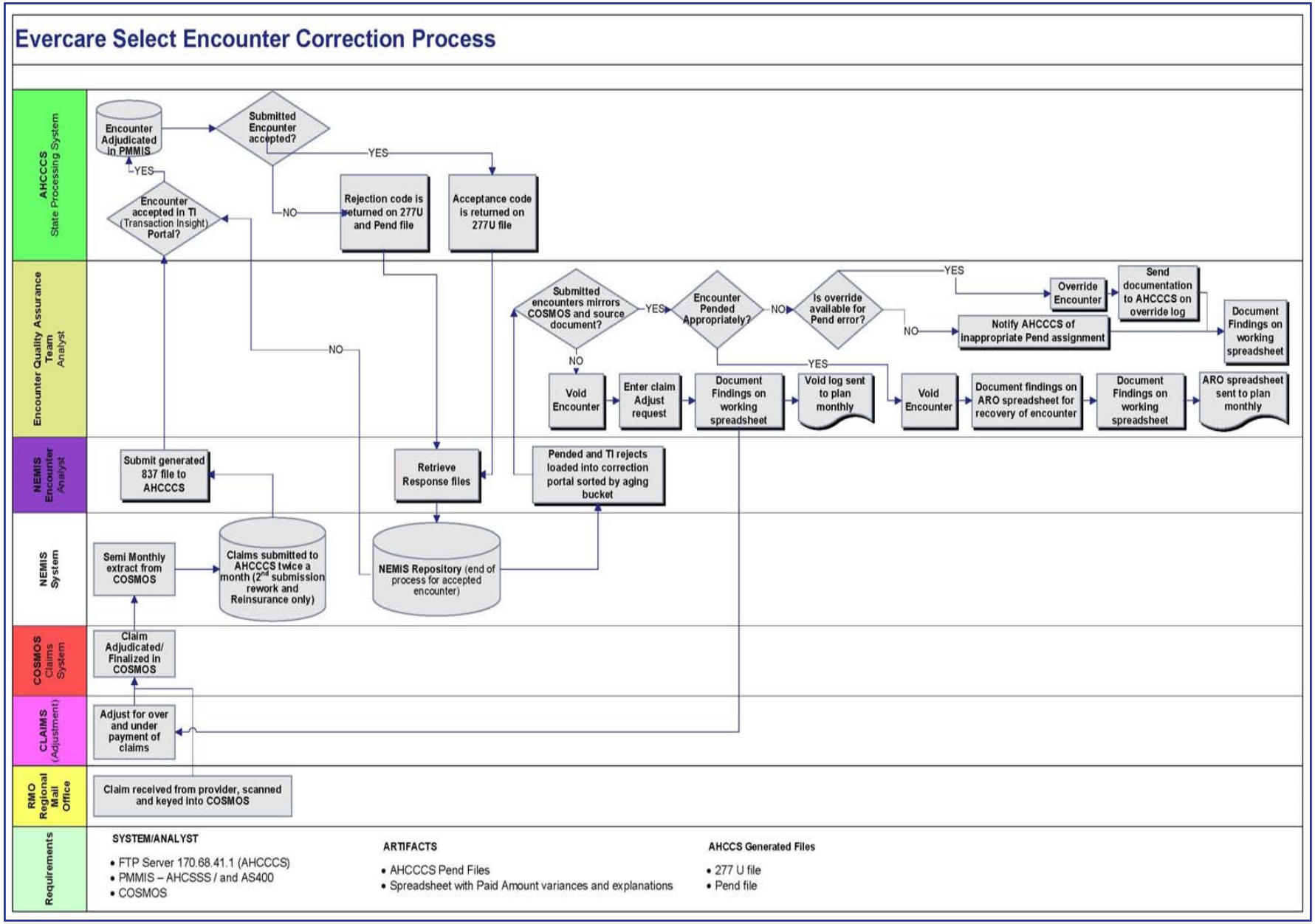
We routinely educate and train our providers on claim and encounter submission requirements. Each contracted provider receives an Evercare Select Provider Manual containing detailed information claims submission requirements, and the importance of timely and complete encounter reporting. Evercare Select's provider manual is available to providers at www.evercareselect.com.

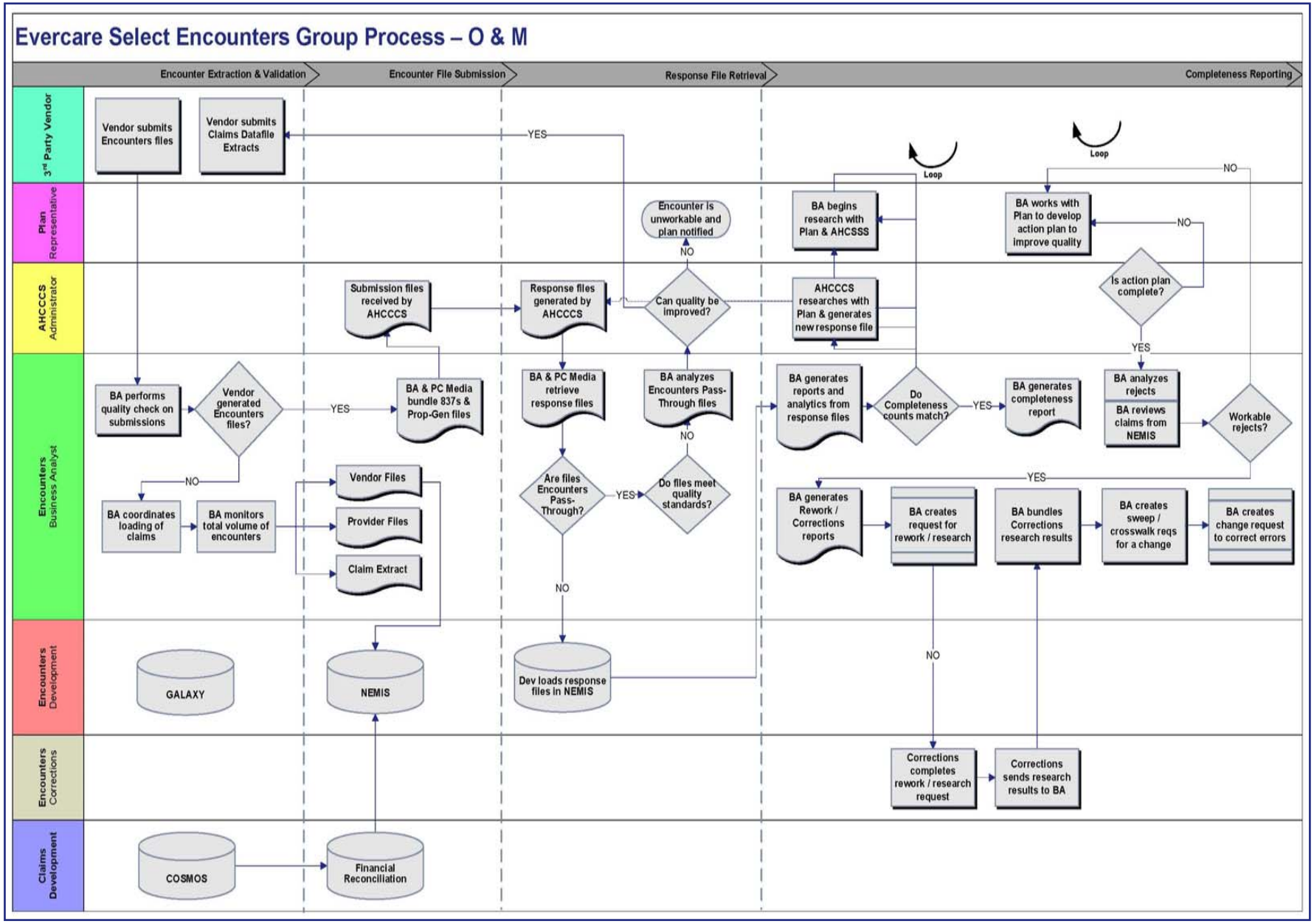
Flowcharts

The flowcharts and diagrams on the following pages illustrate the data flows for a variety of key Evercare Select functions including:

- Evercare Select NEMIS Process
- Evercare Select Encounters Group Process
- Evercare Select Encounter Correction Process.




Evercare Select Encounter Correction Process
AHCCCS State Processing System
Encounter Adjudicated in PMMIS
Submitted Encounter accepted?
YES
NO
Encounter accepted in TI (Transaction Insight) Portal?
YES
Rejection code is returned on 277U and Pend file
Acceptance code is returned on 277U file
Encounter Quality Assurance Team Analyst
Submitted encounters mirrors COSMOS and source document?
YES
NO
Encounter Pended Appropriately?
NO
YES
Is override available for Pend error?
YES
NO
Override Encounter
Send documentation to AHCCCS on override log
Notify AHCCCS of inappropriate Pend assignment
Document Findings on working spreadsheet
Void Encounter
Enter claim Adjust request
Document Findings on working spreadsheet
Void log sent to plan monthly
Void Encounter
Document findings on ARO spreadsheet for recovery of encounter
Document Findings on working spreadsheet
ARO spreadsheet sent to plan monthly
NEMIS Encounter Analyst
Submit generated 837 file to AHCCCS
Retrieve Response files
Pended and TI rejects loaded into correction portal sorted by aging bucket
NEMIS System
Semi Monthly extract from COSMOS
Claims submitted to AHCCCS twice a month (2nd submission rework and Reinsurance only)
NEMIS Repository (end of process for accepted encounter)
COSMOS Claims System
Claim Adjudicated/ Finalized in COSMOS
CLAIMS (Adjustment)
Adjust for over and under payment of claims
RMO Regional Mail Office
Claim received from provider, scanned and keyed into COSMOS
Requirements
SYSTEM/ANALYST
• FTP Server 170.68.41.1 (AHCCCS)
• PMMIS – AHCSSS / and AS400
• COSMOS
ARTIFACTS
• AHCCCS Pend Files
• Spreadsheet with Paid Amount variances and explanations
AHCCS Generated Files
• 277 U file
• Pend file


Evercare Select Encounters Group Process – O & M
Encounter Extraction & Validation
Encounter File Submission
Response File Retrieval
Completeness Reporting
3rd Party Vendor
Plan Representative
AHCCCS Administrator
Encounters Business Analyst
Encounters Development
Encounters Corrections
Claims Development
Vendor submits Encounters files
Vendor submits Claims Datafile Extracts
YES
Loop
Loop
NO
Encounter is unworkable and plan notified
NO
BA begins research with Plan & AHCSSS
BA works with Plan to develop action plan to improve quality
NO
Submission files received by AHCCCS
Response files generated by AHCCCS
Can quality be improved?
AHCCCS researches with Plan & generates new response file
Is action plan complete?
YES
BA performs quality check on submissions
Vendor generated Encounters files?
YES
BA & PC Media bundle 837s & Prop-Gen files
BA & PC Media retrieve response files
BA analyzes Encounters Pass-Through files
NO
BA generates reports and analytics from response files
Do Completeness counts match?
YES
BA generates completeness report
BA analyzes rejects
BA reviews claims from NEMIS
Workable rejects?
NO
BA coordinates loading of claims
BA monitors total volume of encounters
Vendor Files
Provider Files
Claim Extract
Are files Encounters Pass-Through?
YES
Do files meet quality standards?
YES
BA generates Rework / Corrections reports
BA creates request for rework / research
BA bundles Corrections research results
BA creates sweep / crosswalk reqs for a change
BA creates change request to correct errors
NO
GALAXY
NEMIS
Dev loads response files in NEMIS
NO
Corrections completes rework / research request
Corrections sends research results to BA
COSMOS
Financial Reconciliation

11. Describe the structure (internal and external) of the Offeror's information system…..

Evercare Select has an Information System (IS) in place with the hardware and software to support the AHCCCS program system requirements for the ALTCS line of business. The key subsystems/functions of Evercare Select's IS organization supports enrollment, prior authorization through our CareOne system, claims, data entry, adjudication, storage, payment and adjustments, encounters, and provider contracts/demographics.

Our Structure and Experience with the ALTCS Program

Our Information Technology team brings critical experience from working within the AHCCCS program for over 22 years. In addition to the ALTCS program, we provide support to the Department of Economic Security to the 11,500 developmentally disabled members in 15 counties and over 275,000 members in the AHCCCS program.

Our Evercare Select Chief Executive Officer, Karen Brach, is supported by our local IT team and has a direct line of support to our national Information Technology (IT) department through Mohan Basavapatna, local CIO, located in Arizona. Mohan is fully accountable to Ms. Brach for IT support and is focused primarily on the guidelines of the ALTCS program and the needs of our members and providers. Mohan is an experienced information management and technology executive with 22 years of experience. She leads several key initiatives for the company such as software development lifecycle project management, business analysis, quality assurance intake, and demand management, leading the IT capital planning process and portfolio management.

There are 25 dedicated full-time employees in our Phoenix office supporting the business requirements of the AHCCCS and the ALTCS programs. They are joined by 230 other IS associates based in Phoenix who are able to leverage the skills and experience of over 11,000 IT professionals in UnitedHealth Group IT. Through the combined efforts of this team, we support the information systems requirements for over 3.2 million members in publicly funded health care programs in 24 markets across the nation.

Evercare Select's health information system integrates member demographic data, case management information, provider information, service provision, claims submission and reimbursement. This system is capable of collecting, storing and producing information for the purposes of financial, medical and operational management. Our standard support and compliance of the ALTCS program requirements includes our daily processing of the enrollment data (daily 834s) as well as the monthly 834 reconciliation file/data. We also utilize the CATS system to ensure complete and valid data for case management purposes. We process the weekly capitation data (820) and update rates in our core processing system accordingly. These data sets are all processed through our core processing platform's interface engine and loaded into our core processing system (COSMOS) to support accurate claims processing.

Our health information systems are fully compliant with HIPAA privacy and transaction and code set standards adaptable to updates in order to support future AHCCCS claims-related policy requirements as needed. We maintain a HIPAA-compliant claims processing and payment system capable of processing, cost-avoiding, and paying claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules R9-28 Article 7. We support standard 820, 834, 835, 837, 270/271 and 277/278 file formats for all electronic transactions (EDI). To comply further with HIPAA privacy requirements, all applications use role-based access to ensure that we only share information on a need-to-know basis. Access is further controlled by using some of our best security practices: firewalls and physical separation of processing systems. Our systems provide information on areas including, but not limited to service utilization and claim disputes and appeals [42 CFR 438.242(a)].

We create and submit encounter files in the requisite formats: 837P (professional), 837I (institutional), 837D (dental), NDPDP PAH (pharmacy) using our NEMIS encounter system. We process all Acknowledgement files (999, 277CA, TA1) when received as well as all Pend/Denied files (277CA, 277U) twice per month. We process and utilize all other reference files, including Provider Records/Profiles, Procedure Tables, and Fee Schedules. Member data is integrated between our core claims processing system and our care/case/disease management system CareOne, where our case managers create and manage member care plans and proactively track results of implemented plans. Prior authorizations are logged in CareOne and automatically (several times/day) shared with our core claims processing system to facilitate claims processing.

System Requirements to Support ALTCS Requirements

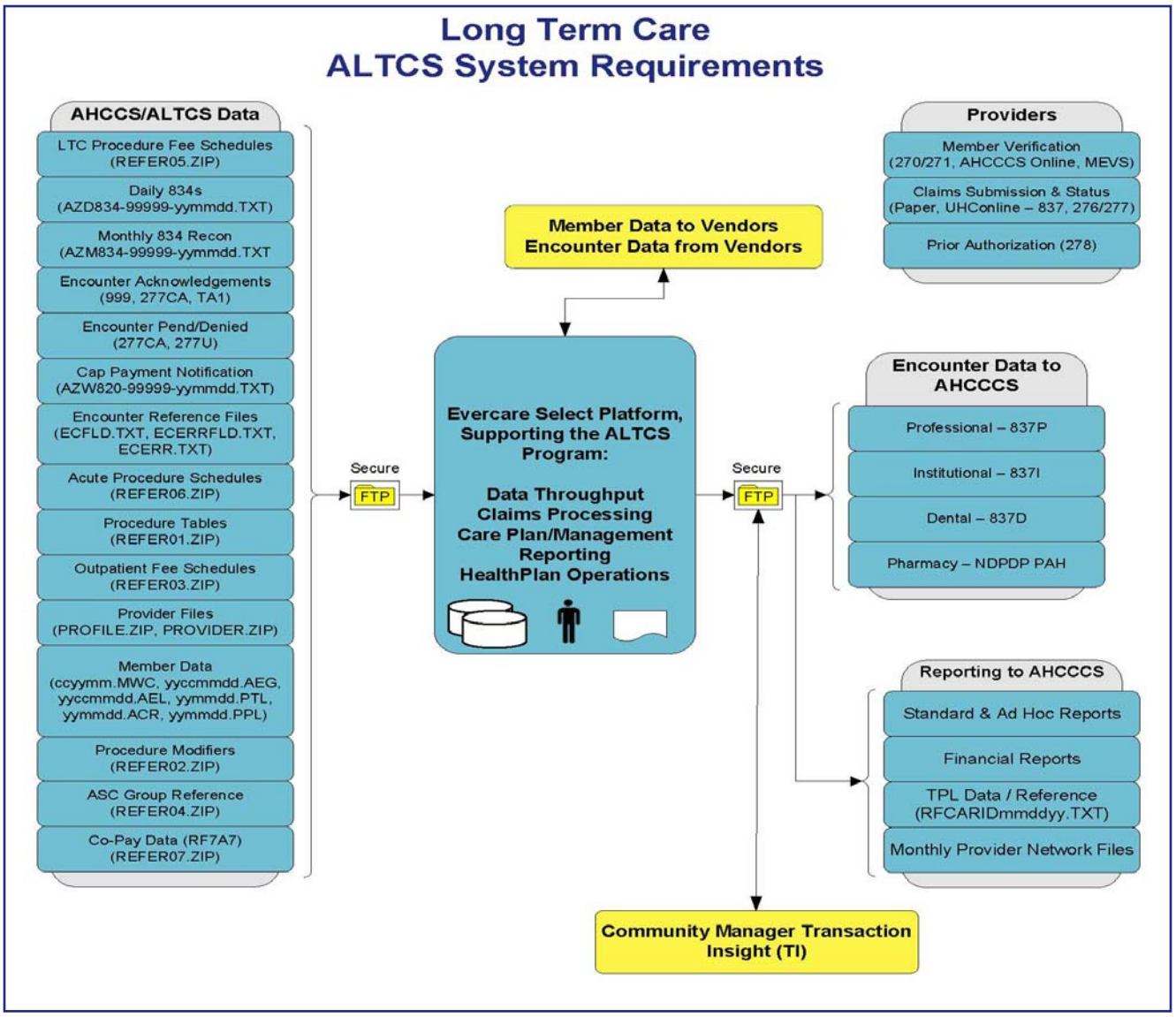
We include nationally recognized and state specific methodology to correctly pay claims including but not limited to the following data related edits:

- Benefit Package Validations
- Timeliness Standards
- Multiple Surgical Reductions
- Duplicate Claims
- Data Accuracy (e.g., numeric, formats)
- Correct Coding Initiative (CCI) for Professional and Outpatient Services
- Over-Utilization Standards (e.g., units, frequency)
- Provider Qualifications (e.g., licensing)
- Member Eligibility and Enrollment
- Global Day
- E&M Bundling
- Outpatient Fee Schedule (OPFS)
- Adherence to AHCCCS Reimbursement Policy (e.g., COS)

Additionally, our system produces a remittance advice related to payments or denials to providers and includes, at a minimum:

- Description of all denials and adjustments
- Reasons for such denials and adjustments
- Amount billed
- Amount paid
- Application of COB and SOC
- Provider rights for claim disputes

Lastly, as required, a monthly Provider Network file will be generated and submitted to AHCCCS.



Critical Interfaces

As a current AHCCCS Long Term Care contractor, **Evercare Select has all of the required critical technical interfaces in place as prescribed by AHCCCS for the ALTCS program**. These interfaces include:

- ***Interface Subsystem*:** Our IT staff has extensive experience in developing and maintaining electronic interfaces for AHCCCS. We have designed our systems with open services based interface architecture that allows for fast, easy integration with AHCCCS systems, as well as other state and federal IS systems and data sources. This interface architecture is flexible and we can quickly reconfigure it to support changing file formats and data elements with little or no change needed on the part of the sending systems. Interfaces support the UnitedHealthcare Community & State's ability to administer and maintain its core business of policy administration, network management, and clinical management. Key interfaces include:
  - Pharmacy data capture from Prescription Solutions for encounter reporting

- NSF and Internet protocol image transfer for use with work flow processes
- Approved interfaces with AHCCCS
- Interfaces to print vendors for collateral, fulfillment, remits, roster, and reports
- 70+ standard reports from COSMOS, designed for general business processing
- Enhanced member editing specific to health plan needs surrounding HIPAA 834 processing
- Updated ICD-9/CPT-4 codes as needed, with the capability to crosswalk to state-specific coding schemes
- Evercare Select uses the common www.uhconline.com web-based, real-time authorization system. In addition, we have capability to receive HIPAA 278 transactions. Both interface with our common CareOne care management system.

- ***Recipient/Health Plan*:** We currently accept and process enrollment files and enrollment reconciliation files from ALTCS via HIPAA-compliant 834 transactions. These files include eligibility information, which provides important insight for Evercare Select's responsibility with respect to prior period coverage. Our automated enrollment processing currently yields 99 percent throughput, requiring minimal manual intervention. In addition, through our preprocessing system we accept capitation files from AHCCCS through HIPAA-compliant 820 transactions. As demonstrated through our participation in the AHCCCS program, our systems are capable of numerous types and levels of information processing and data exchange.
- ***Reference*:** Evercare Select accepts AHCCCS reference files, which include ALTCS-specific data definitions (REFER).
- ***Case Management System*:** Our **CareOne** application is a comprehensive, integrated care management software application that provides tools to better understand and address our members' medical, behavioral, and social needs, and is designed to facilitate the information flow among caregivers, case managers, members, and providers. CareOne includes basic and comprehensive assessments while case managers can enter responses and print automated assessment summaries. CareOne also assists case managers in developing care plans and includes tools for ongoing monitoring and evaluation. CareOne includes a comprehensive depression screening assessment.
- ***Enrollment/Eligibility Subsystem*:** Our COSMOS technology platform processes enrollment automatically and enables manual entry for off cycle enrollment and error correction. The COSMOS system allows for the maintenance and verification of eligibility by storing detailed member information, including eligibility segments, addresses, and primary care providers. We process the enrollment data, transmission, or media to add, delete, or modify membership records with accurate begin and end dates. COSMOS is configured to accept daily and monthly transaction files from AHCCCS as the official enrollment record, and immediately report any inconsistencies to AHCCCS for investigation. Our enrollment subsystem also maintains a history of changes and adjustments and audit trails for current and retroactive data. The system uses logging, journaling and audit tables to maintain a record of all changes to transactions and data within each application. Our platforms actively store seven years of membership, eligibility, and claims data.

  Membership and eligibility information can be received daily and the system automatically assigns the member to the appropriate primary care provider (PCP) that is listed within the enrollment file received. If a member requests a change of their PCP, he or she notifies member services, and the change is made in COSMOS. The COSMOS platform has edits to make certain the PCP is valid, and then the member record is updated. The change is also processed onto the recipient PCP change file so the most current PCP is communicated to AHCCCS and appears on the next enrollment file. COSMOS is fully automated with automatic error alerting capability that triggers error correction processes and procedures. Membership roster and error reporting are also included and configured to the specific formats required by the program and AHCCCS.

- ***Electronic Data Interchange (EDI)*:** Arrangements with AHCCCS allow for timely processing of enrollment and disenrollment information. Given Evercare Select's experience and the automatic processing of the enrollment files, we can notify AHCCCS if there are problems or errors found within the enrollment files.
- ***Reinsurance*:** The data provided through our encounter submissions is used by ALTCS to support reinsurance calculations. We reconcile payments to the AHCCCS capitation file.
- ***Claims Processing Subsystem*:** We maintain a claims payment system capable of processing, cost-avoiding and paying claims. The system generates a remittance advice statement to the provider that includes a description of denials and adjustments and the reason, the amounts billed and paid, application of coordination of benefits and subrogation of claims, and provider rights for claims disputes.
- ***Encounters*:** Encounter data, based on extracts from our claims system, is collected, validated and submitted regularly through our National Encounter Management Information System (NEMIS) system and established interfaces between Evercare Select and ALTCS.
- ***AHCCCS Provider Reference Files*:** We accept Provider and Profile Reference Files and load them to our provider subsystem used by our claims platform for editing and resolving provider data discrepancies. We also generate Monthly Provider Network Files as required.
- ***Provider Subsystem*:** The COSMOS system allows for setup of physician and hospital networks and acute and long-term care provider demographics, and the storage of unique state provider identifiers (e.g., AHCCCS IDs) utilizing the weekly provider files from the AHCCCS FTP site. The provider portal, www.uhconline.com, provides links for our providers to submit claims online and is integrated with our COSMOS transaction processing tables. This integration allows for instant error validation while data is input. Other links include formulary, provider survey results, performance measure results, prior authorization criteria and evidence-based guidelines.
- ***Financial Subsystem*:** We pull all claims data from COSMOS, our claims processing platform, and feed it into the Financial Summary Database (FSDB). The FSDB stores a summarized history of paid claims, payable claims and pended claims. FSDB serves two purposes–it is a tool for automatically booking paid claims to the ledger, and serves as a database that feeds our Reserve Production System (RPS) to support the actuarial model. FSDB interfaces with RPS and PeopleSoft G/L. The data that is fed to RPS is summarized paid, payable and pended claims information along with G/L tags. The data fed to PeopleSoft G/L is paid claims journal entries.
- ***Claims and Authorization Matching*:** We monitor the utilization of services and concurrently track the financial impact of the medical services provided to Evercare Select members. We track the decisions in COSMOS as it checks if authorizations for specific services exist before processing claims using system referral processing. This functionality is tailored to the service authorization requirements used by AHCCCS. Furthermore, the system has the capability to view prior authorizations and preadmission certifications such as:
  - Automatic search of the authorization file from claims for potential matching authorizations and automatic linking when there is an unambiguous match
  - Automatic application of benefits depending on whether a claim is authorized
  - Different rules for determining what constitutes a matching authorization for each Medicaid program
  - Flexible criteria and logic for determining a matching authorization
  - Automatic rules for waiving the requirement for an authorization depending on user-defined characteristics of the claim, such as the provider's specialty, service, diagnosis and state requirements

  - Automatic matching of authorization to member information to allow for accurate benefit management by eligibility category; our authorization system for Evercare Select links to the member benefits to prevent authorization of non-covered services without a manual override.

- ***Reporting Subsystem*:** We use our Strategic Management Analytic Reporting Tool (SMART) as the custom Medicaid data warehouse for reporting and data analytics. The SMART environment integrates claims care delivery data organized in a fashion to support a variety of data mining and analysis applications. We feed data to this data warehouse out of the transaction systems at various intervals from a variety of internal systems, including our claims processing system COSMOS and our CareOne medical management platform. SMART enables us to perform sophisticated analysis without affecting our transaction databases. Within SMART, we can perform data-intensive analysis such as medical cost trending to pinpoint issues with member care. Our management information systems enable us to be fully prepared to meet the data element and format requirements to produce all AHCCCS-required management reports.

Hardware and Software Supporting ALTCS Program

Evercare Select has invested in providing an integrated solution that not only meets the needs of ALTCS claims adjudication, but also has positioned us to manage costs and to increase provider satisfaction with access to enhanced reports, member information and claims information through internet portals. The following table describes the various functionalities of our hardware and software components:

Hardware and Software Supporting the ALTCS Line of Business	
Claims Processing and Management	***Functionality***
COSMOS - Comprehensive Online Software for Management and Operational Support	Our medical claims processing engine and core transactions system; general and institutional claims editing, enrollment and eligibility data
COSMOS Interface Engine	Used to electronically link all member, provider and claims from/to our electronic partners, outbound eligibility extracts
AdjudiPro (CCI Editing)	COSMOS professional claims editing (CCI – Correct Coding)
UFE - United Front End	Claims intake and routing expedites timely payment
iDRS - Intranet Document Retrieval System/CPW	Claims workflow/queuing and imaging
ORS - Adjustment Request Tracking	Tracking tool for claim adjustments requested; ensures accountability for claims research
CDB - Corporate Member Database	UnitedHealthcare centralized member database
NEMIS - National Encounter Management Information System	Our internally developed encounter system used for encounter submissions and tracking, error correction and resubmission
STARS	Grievance and appeals logging and tracking
FSDB - Finance Systems Data Base and RPS-Reserve Processing System, Backend Financials	Used to manage financial transactions to our GL and reserving process
NDB - National Provider Database/Aperature	IBM DB2-based system, housing information on all providers having contractual relationships including credentialing
MCD - Medicaid Comparison Database	Member capitation payment reconciliation engine
SMART/Microstrategy	Data mart for reporting and analytics; enables access for ad hoc reporting to ALTCS
Medical Management and Quality Management	***Functionality***
CareOne	Our utilization management, prior authorization, care management, and support system

Hardware and Software Supporting the ALTCS Line of Business	
UnitedHealth Group CareTracker (planned)	Physician Electronic Health Record and practice management
Impact Pro by UnitedHealth Group	Claims-based database and tool with the ability to coordinate care for Medicaid-only members and dual-eligible members to identify care opportunities that include potential medication interactions, compliance with clinical care guidelines, and recommended screenings
Provider Issue Tracker 3/30	Online tool developed/integrated with our IDT and accessed via our secure Provider Portal. Allows online access for our providers to manage inquiries and check status of information requested to ensure3-day acknowledgment and 30-day response
ViPS Med Measures/Catalyst	Our system for HEDIS measuring/reporting and quality management efforts, including provider profiling
Member and Provider Service	***Functionality***
IDT - Intelligent Desk Top	A call center integrated desktop centralizing access to several systems at the fingertips of our member and provider services representatives. IDT accelerates our ability to answer calls precisely and quickly, and enables us to track phone calls and allows the routing of issues to individuals responsible for resolution.
Provider Portal - www.uhconline.com	An internet-based, self-service portal for providers to check membership eligibility, submit claims, and check claims status, electronic remits, payment and quality measures
EFT - Electronic Funds Transfer	Electronic funds transfer and funds management
Member Website - www.evercareselect.com	Member materials such as Member Handbook, Welcome Packet and other materials
IVR - Interactive Voice Response/ EVP - Enterprise Voice Portal	Providers can telephonically check claims status, member eligibility and privacy practices, route through to the various call centers for credentialing status, and request demographic changes and prior authorizations.

COSMOS Features

Evercare Select's IS application suites are integrated with required data and transactions in one application suite being available, some in "real time", to the other application suites. Some features of this integration require nightly feeds. We have tailored our application portfolio to the specific requirements unique to AHCCCS. We have chosen and invested in a system platform that meets Arizona requirements and enables us to effectively manage systems critical to the Medicaid business functions. Our COSMOS system contains functionality covering enrollment, provider services, benefits and claims processing. This flexibility has allowed us to meet changing regulatory requirements without disruptions in the claims processing flows. The security subsystem includes individual sign-on security. System privileges are established at the sign-on level. COSMOS system features include:

- HIPAA transaction and code set compliance
- High-volume system capabilities
- Flexible claims processing rules
- Flexible provider networking and reimbursement
- Multiple site processing
- Accepts inputs from paper, tape or electronic
- Free-text comments
- User-defined rules for dollar/coverage amounts
- Batch or online claims processing
- Unlimited point-of-service functionality
- Flexible benefit designs
- Real-time adjustments and voids
- Selects claims for pre-payment quality review
- System-wide navigation assistance
- Error tabling (all errors can be viewed at once)
- Claims inquiry by member

- Secured error override capability
- Claims inquiry by partial claim number
- Claims inquiry by provider
- Claims inquiry by service and service dates
- Claims inquiry by process improvement projects.

We maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure. Incremental systems backup are processed nightly while full systems backups occur weekly. We also make sure that our written processes and procedures manuals describe all automated and manual system procedures and processes.

Medical Management and Quality Management Technologies

Multiple care management technologies surround the core system, closely integrated with the claims processing platform to coordinate authorization, utilization, and claims payment with medical management. These tools make up one of the most sophisticated care management platforms in the country and include:

- ***CareOne:*** We link CareOne to our administrative platform, COSMOS, to authorize services automatically for claims processing purposes based on the plan of care. The CareOne system is the foundation for both the assessment and care planning processes. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne includes assessment information, facilitates the development of a care plan, and includes ongoing monitoring and evaluation tools. CareOne includes behavioral health screening and assessment data. This is an important tool for promoting integration of somatic and behavioral health services.

  The **care plan serves as the roadmap** for each member's support team. Through the care plan, the case manager documents the member's goals, objectives, and desired outcomes, needed services and service parameters, and both formal supports and informal resources that could enhance care for the member. The case manager works to meet the needs of the member by accessing all possible resources for assistance by reaching out to community-based providers, physicians, and all those involved to facilitate a holistic approach to the management of the member's identified needs. The member is the center of the team and the case manager makes sure that the evolving plan is understood by and agreeable to the member each step of the way. CareOne features include:

  - Creating and maintaining Plans of Care (POCs)
  - Maintaining Health Risk Assessments (HRAs)
  - Care/case management
  - Standard and ad hoc reporting
  - Managing prior authorizations.

- ***MedMeasures by ViPS*:** Evercare Select uses MedMeasures, an NCQA-certified HEDIS software package to ensure our HEDIS metrics are measured consistently and accurately and are auditable for reporting purposes. The system's enhanced measure analysis function gives us access to member detail, providing information on specific members qualified for each measure. Data from the MedMeasures systems is compiled into "scorecards" which display performance measures start and stop dates for specific interventions, output of calls, mailers, health fairs and trended performance rates. ViPS offers provider profiling and HEDIS quality reports for the provider network.
- ***Impact Pro*®:** Evercare Select uses Impact Pro to identify care opportunities that include potential medication interactions, compliance with clinical care guidelines, and recommended health screenings. Impact Pro is a claims-based database and tool that gives us the ability to coordinate care for Medicaid-only members and dual-eligible members who are enrolled in our Arizona Physicians IPA Dual Complete MA plan.

National Encounter Management Information System (NEMIS)

NEMIS, our advanced encounter submission system, uses our proprietary, relational database design based on years of experience with encounter submission scenarios. This system supports rapid identification of problems with submitted encounters and serves as an additional audit checkpoint for our claims payment process. Specifically, the system ensures our claims payments match state-specific coding and encounter requirements. NEMIS supports the tracking, correcting and reporting needed for remediation of identified problems. Defects in submissions are logged and analyzed for identification of any systemic issues, allowing for ongoing improvements in the quality of encounters submitted. Encounter adjustments, reconciliations and post-submission completeness reports provide detailed insight into the process with key checkpoints to ensure that all transactions are balanced and reported. NEMIS completeness reports provide a systematic approach to data quality that further improves claims adjudication accuracy—even all the way back to the source if necessary. NEMIS acts as an automated supervisor, reporting monitor and data interface exclusively for the encounter submission process. NEMIS enables us to manage the entre "loop" for encounter submissions, from claims processing through encounter submission and back. We find NEMIS to be of tremendous value in enhancing the quality of encounter data submitted, thus increasing our acceptance rates. We reconcile our accepted encounters with our general ledger claims database.

Hardware Server Platforms

COSMOS resides on the IBM z\OS server platform running the DB2 database. Along with redundancy within the hardware itself, the server platform is configured with a second system backup should a failure occur on the first. This switchover takes place in approximately five minutes from detection of a failure event, minimizing the potential for data loss. The server platforms are scalable and run software that allows for the dynamic reallocation of system resources to different applications as necessary to support fluctuations in demand. As additional capacity is needed, more CPUs and more memory can be added to the server platform. This scalability enables us to add additional members, provider networks, reporting and care management transactions for AHCCCS quickly and often without adversely affecting the platform or requiring downtime. Through more than twenty years of experience with the platform, we have developed a model that accurately forecasts capacity requirements based on membership and care management volume metrics.

CareOne resides on HP ProLiant DL servers running the Microsoft Windows Server 2003 operating system. Because of these high-end rack servers, we have a scalable platform that is ideal for large databases and data-intensive, mission-critical applications like our CareOne case management system.

NEMIS resides on a Sun Sunfire V490 server running the Sun OS v5.9 operating system. The Sunfire server is geared toward business processing, business intelligence and data warehousing, which is why we chose it for our NEMIS application. It provides superior performance (using the UltraSPARC IV+ processor based on 90nm technology at 2.1 GHz frequency), scalability (cost-efficient, enterprise-class rack-optimized system), seamless upgrades (Solaris OS and binary compatibility) as well as flexibility (support for mixed generations of CPU boards in the same server).

The remainder of the applications run on Windows 2000 servers and is configured with different levels of redundancy depending on the criticality of the application. With the exception of the Internet-based provider website/portal, all components of COSMOS are accessed via a Citrix thin-client layer. This allows for consistent, secure access to the various applications through a single secure website and does not require installation of the various applications onto an end user's desktop. Case managers can therefore access the system remotely. In addition, Citrix enables us to control access to applications and databases using role-based access. Access to information specific to the key business process is limited to a person or group of persons based on their role and need to access the information to perform their job function. The provider portal is integrated directly with our transaction processing tables and configured in a load-balanced configuration that instantly responds to any failure within any component. The entire

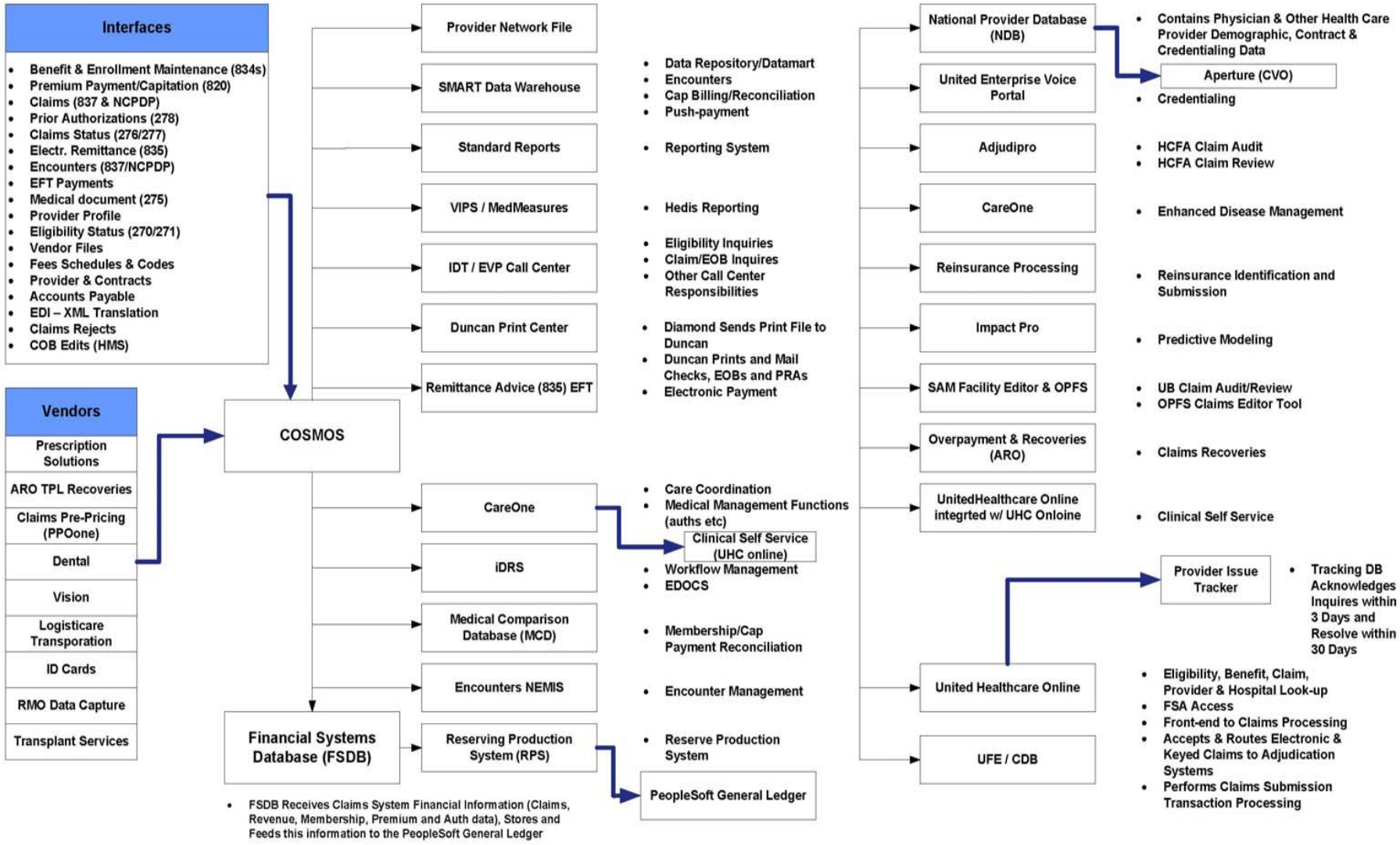
infrastructure associated with these components is located in the data center located in Elk River, Minnesota. This facility is a fully hardened data center with N+1 redundancy for basic infrastructure systems: power delivery, cooling, fire protection, etc. We further protect all equipment within this data center with a comprehensive disaster recovery plan that makes certain that all primary equipment has a recovery counterpart.

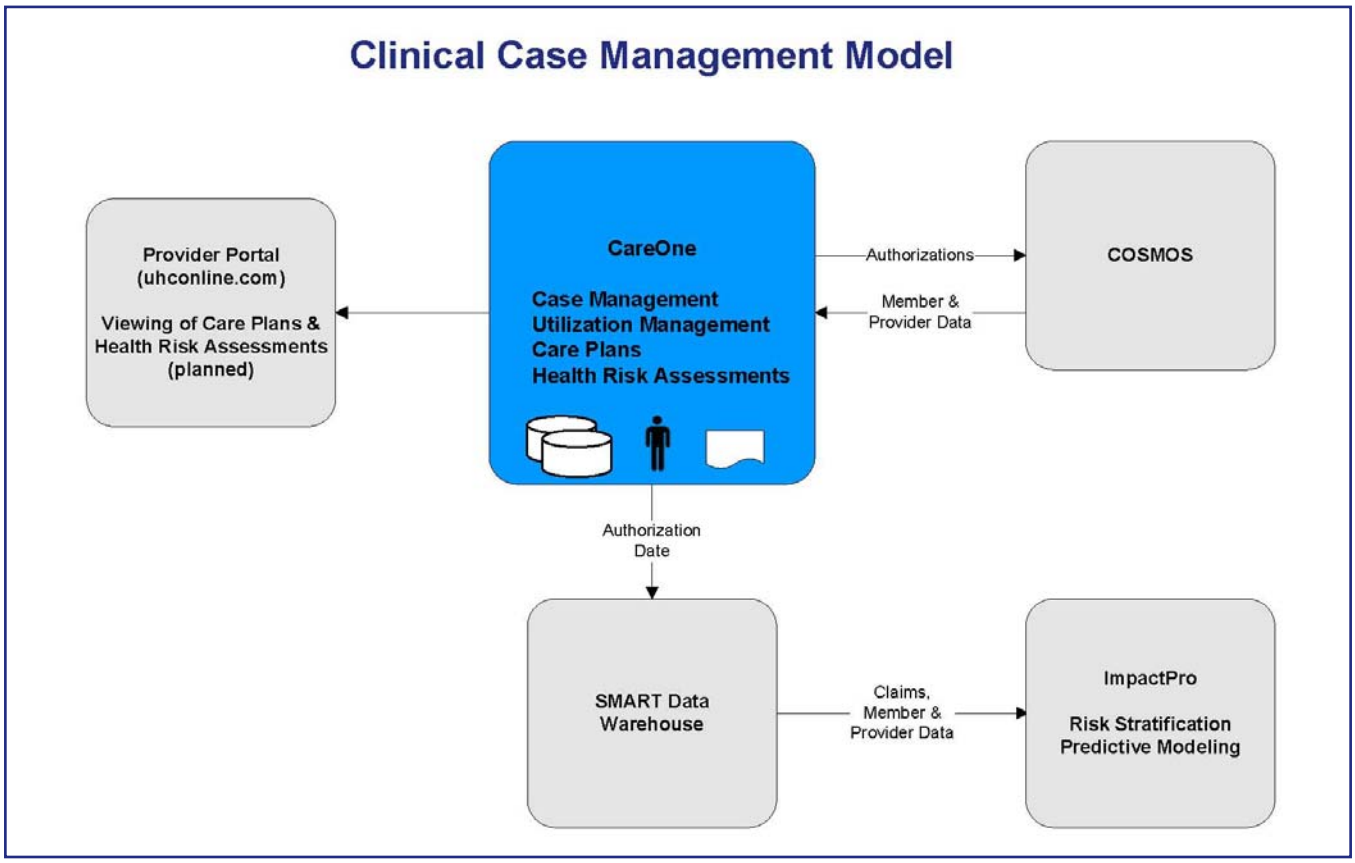
Flowcharts

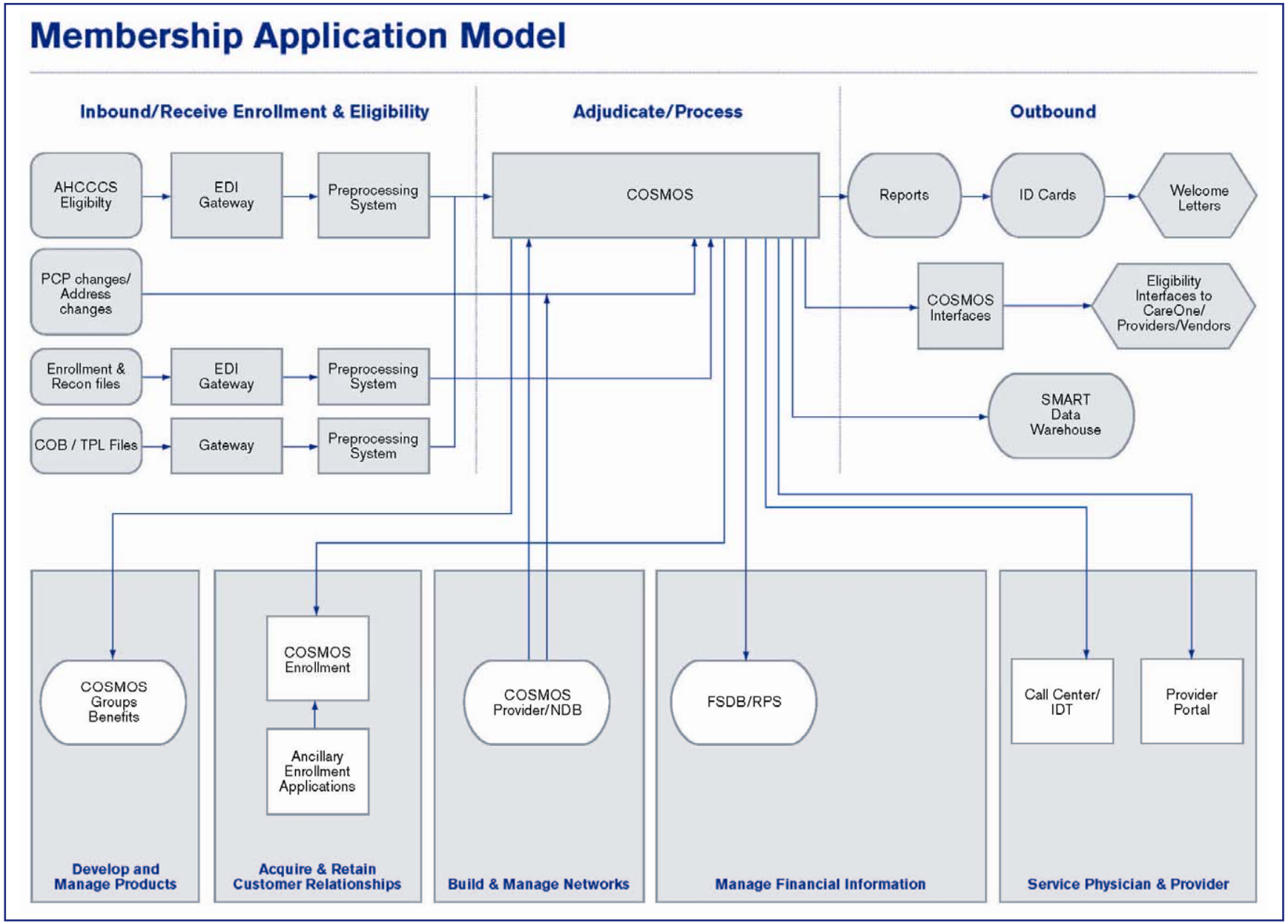
The flowcharts and descriptions of the following key subsystems/functions of Evercare Select's internal and external structure include:

- COSMOS Architecture Diagram
- Clinical Case Management Process Model
- Membership Enrollment Model
- Claims Application Model
- Claims Process - EDI
- Claims Process - Paper
- Finance Application Model
- Encounter Process Model
- Reinsurance Process.

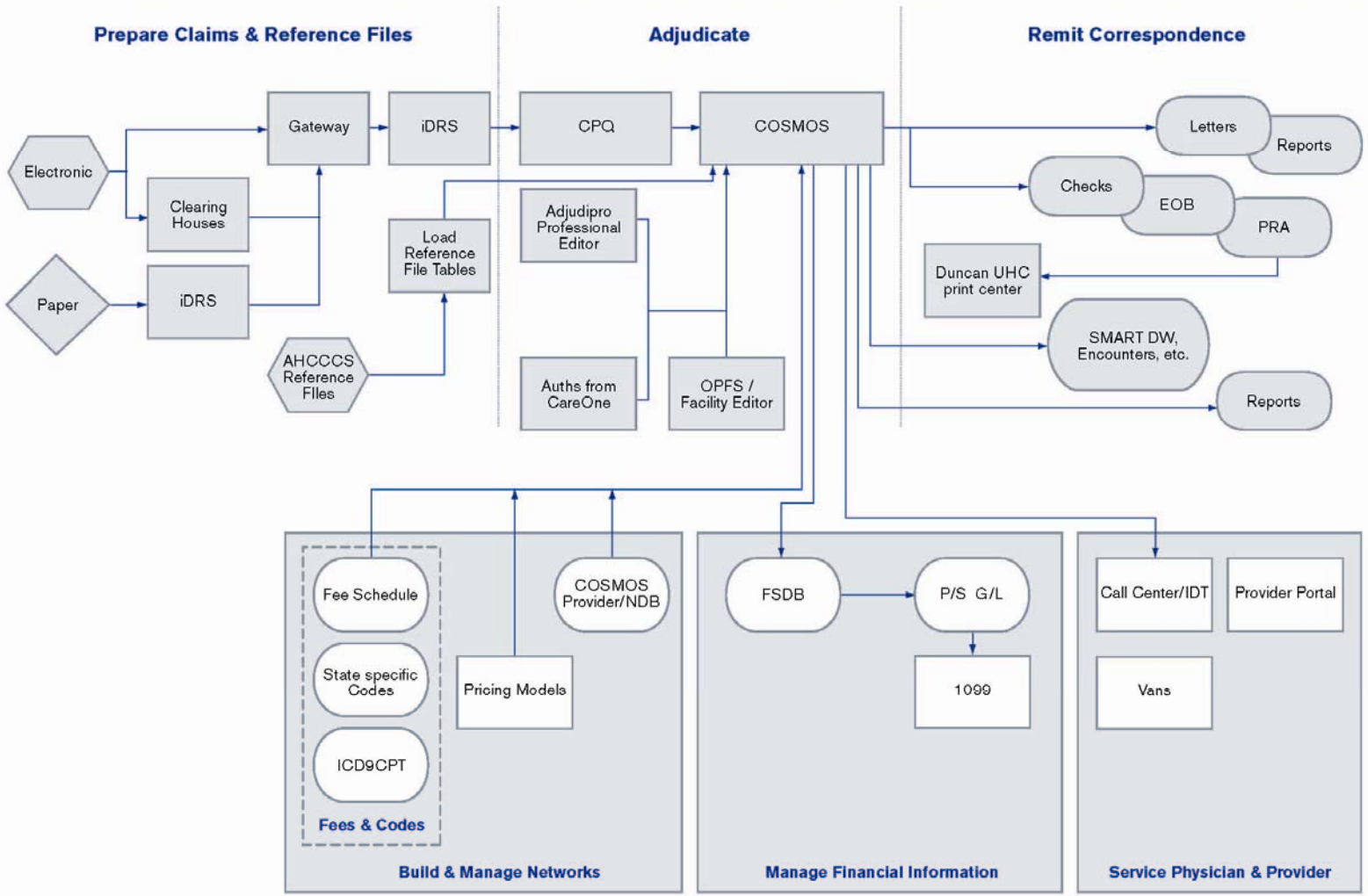
Evercare Select COSMOS Architecture Diagram

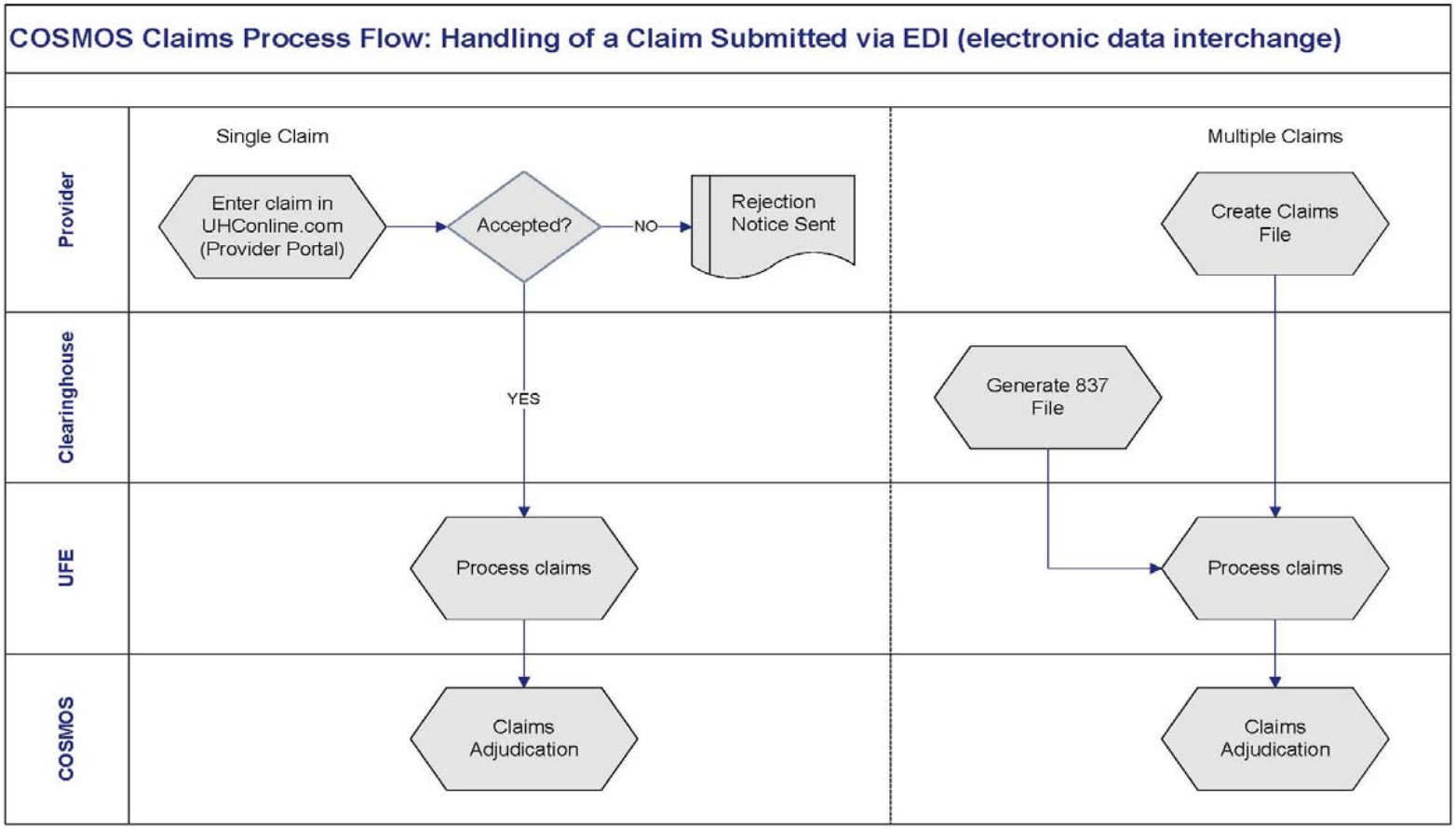



Clinical Case Management Model
Provider Portal
(uhconline.com)
Viewing of Care Plans &
Health Risk Assessments
(planned)
CareOne
Case Management
Utilization Management
Care Plans
Health Risk Assessments
Authorizations
Member &
Provider Data
COSMOS
Authorization
Date
SMART Data
Warehouse
Claims,
Member &
Provider Data
ImpactPro
Risk Stratification
Predictive Modeling

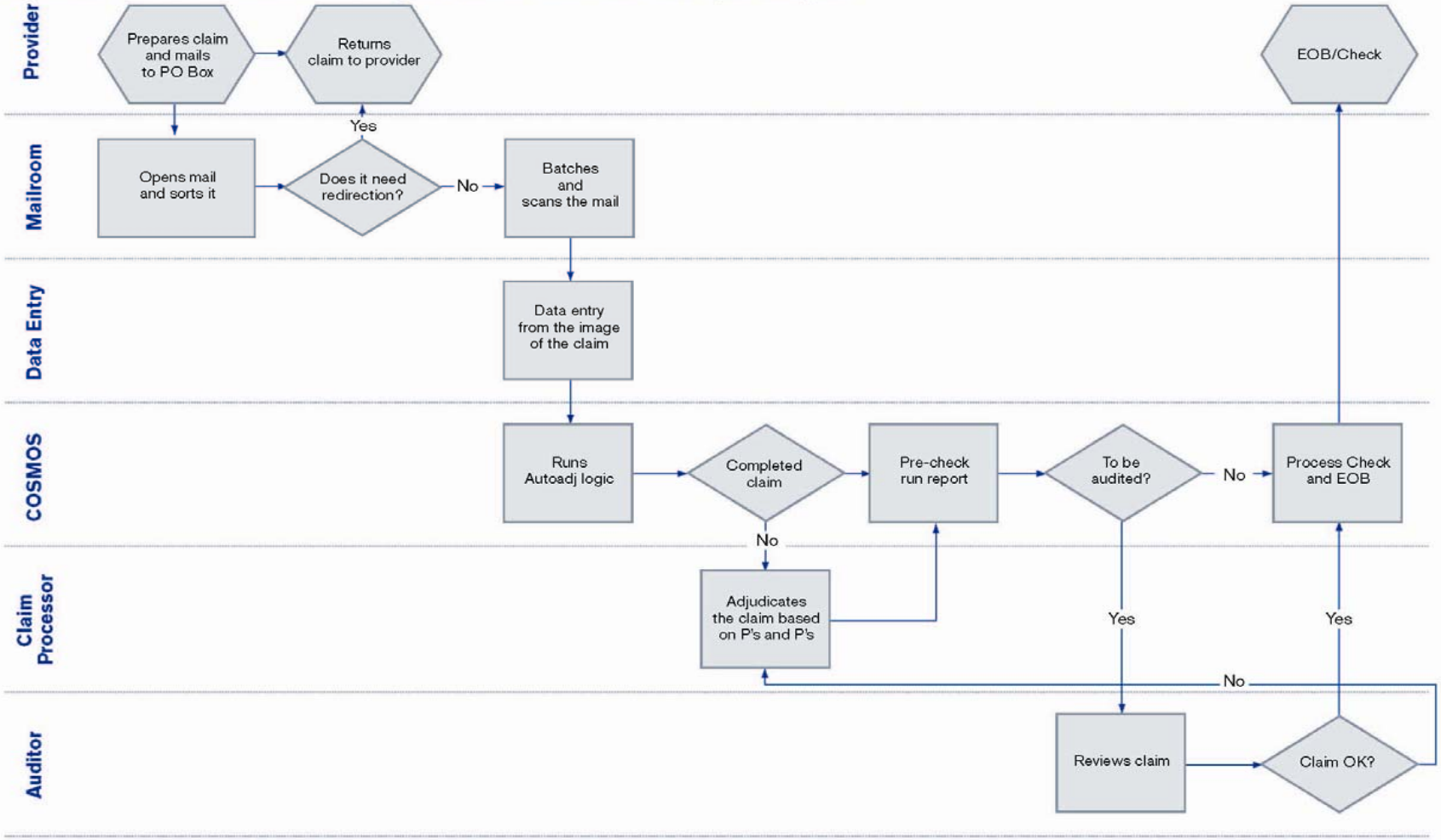

Membership Application Model
Inbound/Receive Enrollment & Eligibility
Adjudicate/Process
Outbound
AHCCCS Eligibilty
EDI Gateway
Preprocessing System
COSMOS
Reports
ID Cards
Welcome Letters
PCP changes/ Address changes
COSMOS Interfaces
Eligibility Interfaces to CareOne/ Providers/Vendors
Enrollment & Recon files
EDI Gateway
Preprocessing System
SMART Data Warehouse
COB / TPL Files
Gateway
Preprocessing System
COSMOS Groups Benefits
COSMOS Enrollment
Ancillary Enrollment Applications
COSMOS Provider/NDB
FSDB/RPS
Call Center/ IDT
Provider Portal
Develop and Manage Products
Acquire & Retain Customer Relationships
Build & Manage Networks
Manage Financial Information
Service Physician & Provider

Claims Application Model

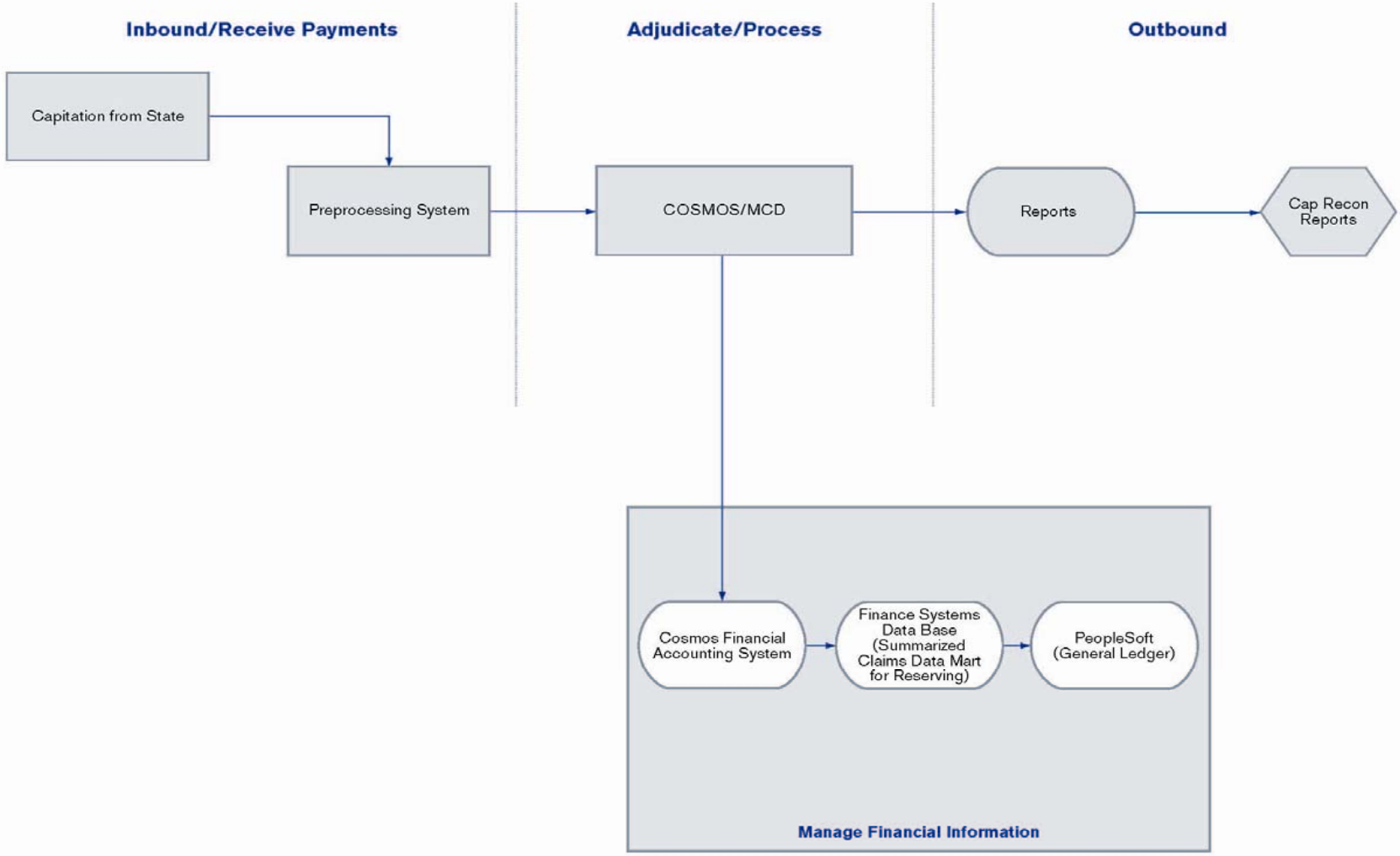



COSMOS Claims Process Flow: Handling of a Claim Submitted via EDI (electronic data interchange)
Provider
Clearinghouse
UFE
COSMOS
Single Claim
Enter claim in UHConline.com (Provider Portal)
Accepted?
NO
Rejection Notice Sent
YES
Process claims
Claims Adjudication
Multiple Claims
Create Claims File
Generate 837 File
Process claims
Claims Adjudication

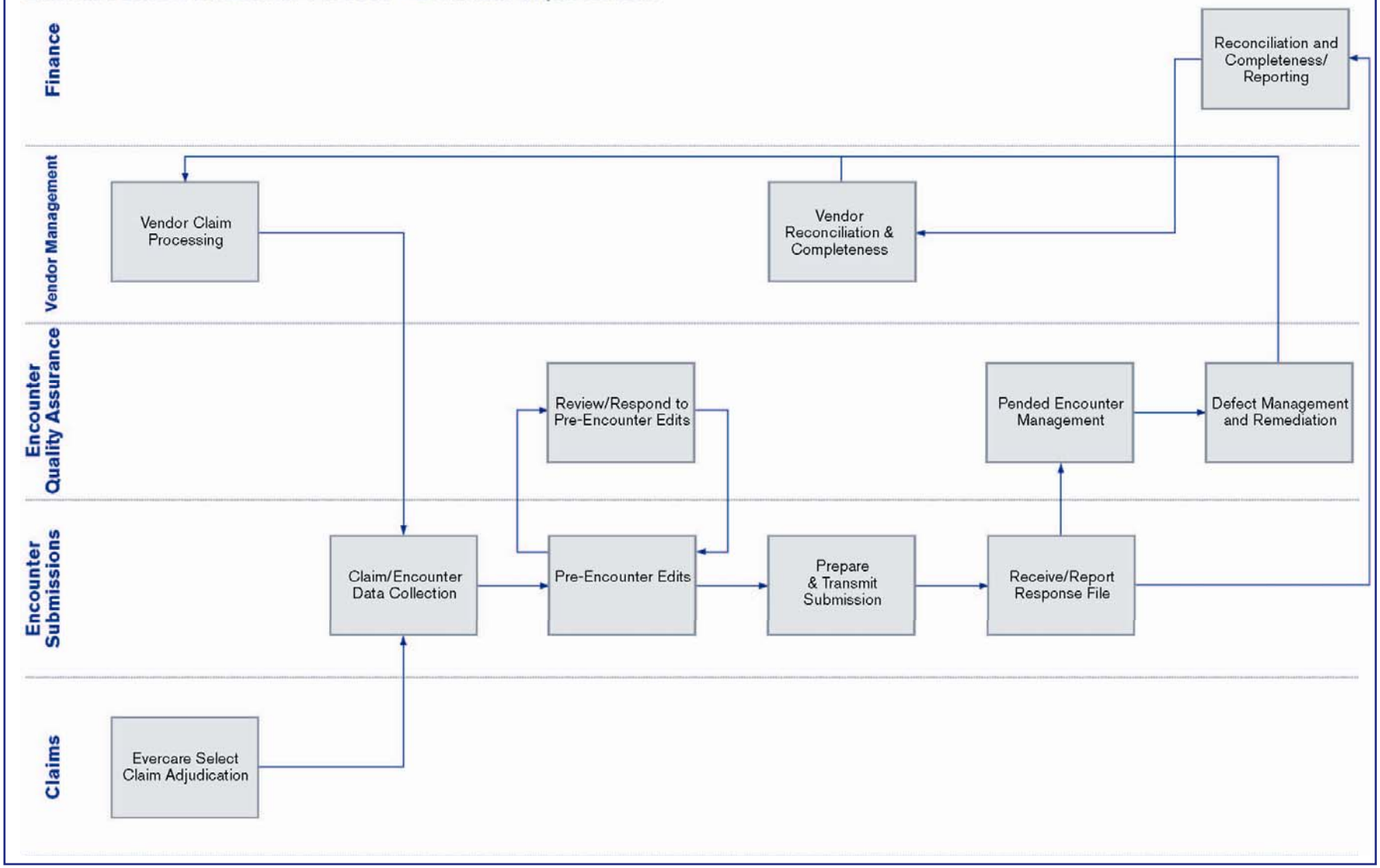
Claims Process Flow - Paper



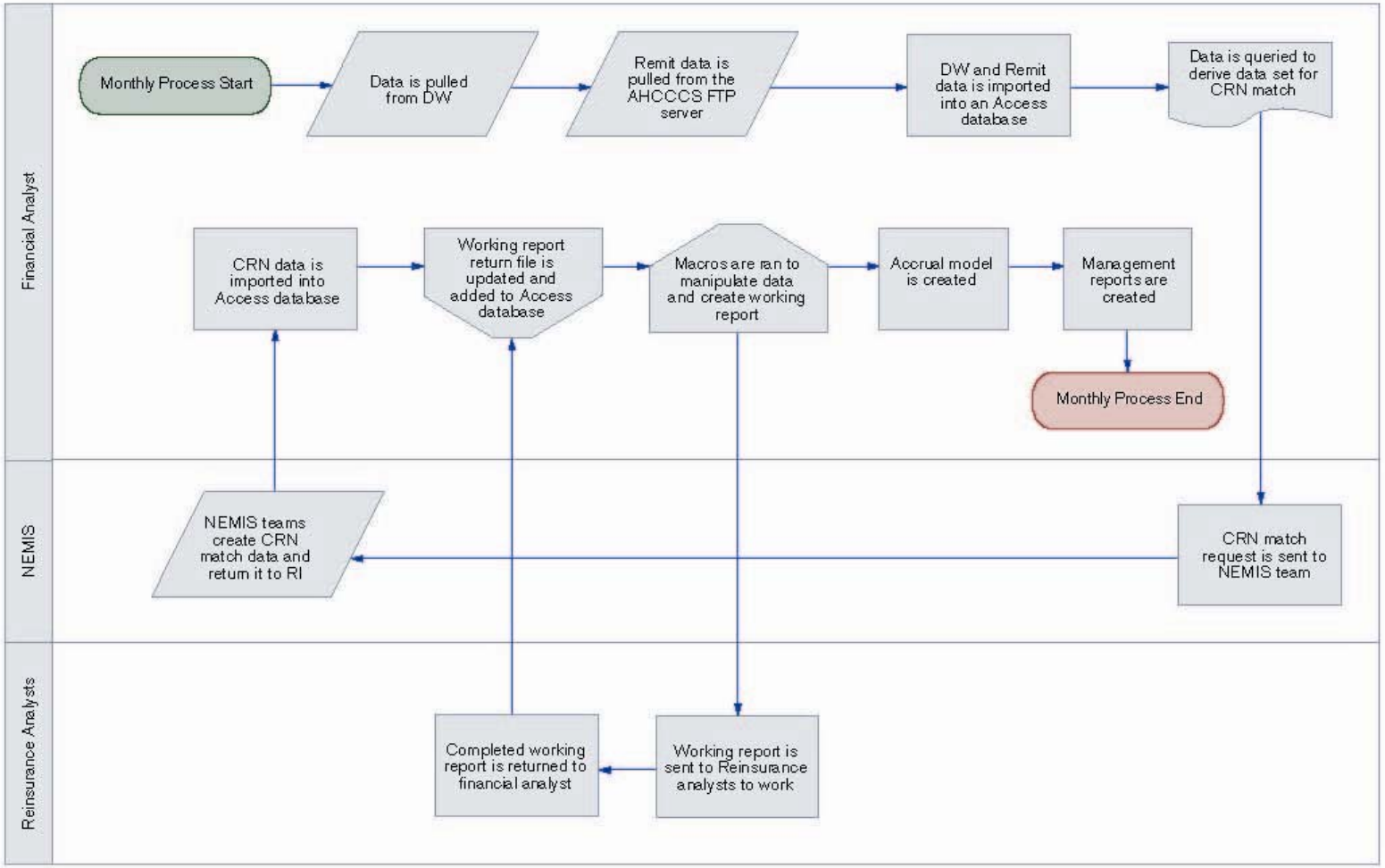
Finance Applications Model



Encounter Process Model



Reinsurance Process



Change Order Process

Evercare Select's information system change order and software modification processes include how requests are made, evaluated and prioritized, who is responsible for implementing changes and software modifications, and how changes and software modifications are tested after implementation.

All UnitedHealth Group development initiatives follow a formal and approved development methodology, which includes documentation and approval requirements including:

- Business and functional requirements
- Scope management
- Design
- Input and output process validation controls
- Logging of system changes
- Test planning and execution
- Deployment planning and execution
- Back-out procedures.

Changes to an application or to the infrastructure must include clear requirements, a back-out plan, and an appropriate test plan for implementation into production. All reasonable and industry practices are applied to ensure any system changes are free from defect. In accordance with UnitedHealth Group development and change control standards, all new code and any changes to existing code must be tested thoroughly from both a system and then user perspective. The data owner must authorize all changes or updates to production before permitted to propagate into production.

Software Modification Processes at the Application Level

At Evercare Select, we understand there are always potential risks to implementing new technologies and enhancements to existing tools and applications. All changes are validated against AHCCCS requirements to mitigate gaps or errors. Our local IS team oversees the requirements, development, testing and implementation of changes and reports status during all phases to Chief Executive Officer, Karen Brach. We take the following steps to **test changes and software modifications** after implementation to mitigate risk as much as possible:

- We engage impacted business areas to perform an impact analysis to fully understand and plan for the operational impacts.
- We communicate pending changes and provide information, including updated processes and procedures, and support to our operations and front-line staff before, during and after all technology implementations.
- Ms. Brach communicates all planned changes that impact the systems supporting the ALTCS program with AHCCCS and other key stakeholders at least six months in advance (or timelines stipulated in the contract) to ensure appropriate planning, testing and audits are in place to fully monitor and measure the level of success of such changes.
- We make changes to our implementation process based on best practices and lessons learned from previous implementations and continuously fine-tune and improve our processes to keep up with required quality implementations.

Software Change Management

Evercare Select follows a stringent change management process to define, control, document and track software-related changes for our production systems and environments. Our uniform Change

Management process and tools ensure consistency through the system's development life cycle and ultimately the quality and effectiveness of our business. Evercare Select's change management process is governed by our Software Change Management Policy and Procedure, and undergoes annual internal audit and Sarbanes-Oxley (SOX) (independent/external) reviews.

Evercare Select's process for information system changes is overseen by our Chief Executive Officer, Karen Brach. Ms. Brach leads the process for **identifying, evaluating, testing, prioritizing and proposing technology changes**, as described below. This enables our executive leadership to thoroughly consider the potential changes and, when appropriate, discuss them with ALTCS and provide appropriate notification prior to implementation. Ms. Brach also works with our finance team to secure and manage a budget for system changes and upgrades, ensuring that our upgrades add value for Evercare Select, our members, providers and ALTCS.

Our information system change order and software modification process documents the procedures for source code changes to various resources, including but not limited to: COSMOS, CareOne care management software (and related medical management technologies) and encounter documenting and reporting software (NEMIS). Evercare Select has identified a series of standard documents, forms and approvals for each step of the Software Development Life Cycle (SDLC) to make changes uniform throughout our technology department. These requirements are incorporated into our Software Change Management Policy and Procedure, which is supplied to every staff person involved in the process. The parameters of this policy are built into our process management technologies, thereby disallowing anyone involved in the process from missing steps or approvals.

A variety of needs drive software changes, which may include reasons such as defects, change controls, innovations, enhancements, or migrations/new implementations. Initiation of requested changes can begin at the front-line staff level, such as claims processors or care managers, or at the executive level of our information systems and technology team. Regardless of how or where initiated, all changes must be reviewed and approved by our Ms. Brach. All changes follow a pre-defined approval process depending on the type of change requested:

- Defects are opened in HPSD, a tool used for issue escalation/documentation purposes, by any staff person who uncovers a system anomaly. All defects are automatically assigned to an appointed "Functional Area Expert" who reviews and approves the work to be done.
- Project request, system enhancements and system implementations are reviewed and approved by Ms. Brach, and submitted into intake. Once the project is approved, it is assigned a project number and manager for tracking, estimation, approval by capital committee and scheduled with assigned resources to support successful completion. A given project may have several sub projects depending on the complexity and systems impacted. All intake is handled through our corporate Prompt Request Online Management Planning Tracking (PROMPT) tool.

Software Development Life Cycle (SDLC) Process

UnitedHealth Group manages a robust change control protocol based on ITIL practices. All changes to UnitedHealth Group's environment must follow UnitedHealth Group's Change Management Policies and Procedures to ensure that standardized methods and procedures are used for efficient and prompt handling of all changes including testing following implementation. This process is used to minimize the impact of change-related incidents upon service quality, and consequently to improve the day-to-day operations of the organization.

Our SDLC process follows a stringent set of steps, with various required/standard documents and approvals for each. The standard process begins with identification of new features or functionality and, once documented and approved, moves into the analysis and design phase. Again, standard and required documents must be created, reviewed and approved prior to moving to the next phases, which are

development/unit testing, QA (quality assurance) testing, UAT (user acceptance testing) and deployment into our production environment. Detailed information about the activities, responsible resources, standard documents, approvers and progression from phase to phase is available and can be provided/reviewed as desired.

Date of Last Major Version Update

The COSMOS suite of applications was migrated from a Unisys mainframe to an IBM mainframe in 2009. The XGEN development language allows Cobol 74 to be generated to either Unisys or IBM, thereby allowing UnitedHealth Group to retain the same code base on the IBM platform and reducing potential for errors. Minor updates and enhancements are scheduled and implemented on a monthly/quarterly basis.

Since 2009, there have been many system enhancements and upgrades. Our Release Management team maintains a schedule outlining the specific upgrades/enhancements implemented within each monthly/quarterly release. Thorough testing is performed prior to deployment into our production environment and a back-out plan is always in place should problems arise during deployment, in accordance with our Software Modification Process. During the last contract period, Evercare Select did implement new technology to administer the encounters and grievances processes, resulting in added capabilities and improved services for members and interfaces with the State.

Planned System Conversion within Contract Period

While we continue to make updates to fully comply with HIPAA 5010 and ICD10, there are currently **no plans** during **the contract period (5 years)** for a **major system upgrade** to the information systems affecting claims processing, or any other major business component for the ALTCS program**.** If a major system upgrade is planned, we will notify the ALTCS Administration a **minimum of six months** before the anticipated implementation date and provide a full migration plan, which includes a timeline, milestones, and adequate testing before implementation. We will outline all interfaces and subsystems affected and provide regular updates to AHCCCS regarding development and testing against AHCCCS requirements and deployment.

13. Indicate how many years the Offeror's IT organization or software vendor has supported…..

Years of IT Organization and Software Support

Our internal IT team has supported Evercare Select since its inception in 1989, and our parent IT organization further supports us. Evercare Select's core processing platform, **COSMOS, was developed in November of 1990** on a Unisys platform. As of 2009, we are on the platform and associated applications of IBM technology; hosted within the UnitedHealth Group IT Data Center and managed by our local and national IT staff.

Our focus is simple:

- Commitment to quality
- Dedication to the customer experience
- Drive for efficiency.

UnitedHealth Group IT manages to a Managed Services environment, hosting many applications from each of its operating businesses within its secured data centers facilities. For purposes of this arrangement, UnitedHealth Group hosts the claims, provider portal and care management applications. UnitedHealth Group supports a shared managed services environment in which various systems and applications share the same hardware. ALTCS data resides in databases along with other customers' data. Each customer's data is logically separated from other customers' data by the assignment of a unique ID to each customer.

The Evercare Select information system architecture contains several software solutions to meet the functional needs of serving our members, providers and the AHCCCS Administration. We have taken a systems integration stance to implement best-in-breed technologies, including building systems internally and collaborating with vendors for other applications. To supplement industry-leading technologies like COSMOS, we have also developed targeted technologies that enhance our ability to work with Medicaid members and providers. All of the software identified in the table that follows is currently supported by internal resources and have been in place for at least five years or more.

We have internal maintenance agreements for all of our applications, infrastructure and to support individual users for computer and other technical issues. Our 24-hour helpdesk is available to report all issues, and established performance standards are in place to ensure continuous and smooth operations and expedient problem resolution. Issues are tracked to completion and are measured against the established performance standards to ensure compliance. Additionally, only 2 of the 18 software programs listed rely on external resources for support: MedMeasures by ViPS and iDRS developed by Imaging Solutions.

Applications Supporting the ALTCS Program

Function	*Software/ Application*	*Years Supported*	*Systems Maintenance*	*Contact Person*	*Contact Information*
Claims Processing and Management					
	COSMOS & COSMOS Interface Engine AdjudiPro UFE iDRS ORS CDB NEMIS STARS FSDB & RPS NDB/Aperature MCD SMART/ Microstrategy	20 16 20 13 6 5 6 2 11 5 12 8	Internal Internal Internal External Internal Internal Internal Internal Internal Internal Internal Internal	Mohan Basavapatna	mohan_basavapatna@uhc.com UnitedHealthcare C&S Evercare Select 7600 North 16th St. Suite 230 Phoenix, AZ 85020
Medical Management and Quality Management					
	CareOne UnitedHealth Group CareTracker (Planned) Impact Pro Provider Issue Tracker ViPS MedMeasures	11 N/A 4 2+ 6	Internal Internal Internal Internal External	Mohan Basavapatna	mohan_basavapatna@uhc.com UnitedHealthcare C&S Evercare Select 7600 North 16th St. Suite 230 Phoenix, AZ 85020
Member and Provider Service					
	IDT UnitedHealthcare Online Provider Portal EFT Transfer Member Website IVR/EVP	6 8 10 15 5+	Internal Internal Internal Internal Internal	Mohan Basavapatna	mohan_basavapatna@uhc.com UnitedHealthcare C&S Evercare Select 7600 North 16th St. Suite 230 Phoenix, AZ 85020

Notes:

- All software/applications were developed and are supported via Evercare Select IT/UnitedHealth Group IT with the exception that iDRS was developed by Imaging Solutions vendor.
- All software/applications versions are considered proprietary versions.

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

As part of our core mission to help people live healthier lives, we continuously deliver innovations that significantly improve the way Arizona's health care system works. We apply careful analysis to one of the largest collections of health care data to solve complex problems, develop practical technology for both providers of care and consumers, and advance financial and operational connectivity across the system. We are actively working across the nation with states and the federal government to support broader health care coverage, lower health care costs and improve the delivery of care.

Supporting Current and Future Mandates

As a long-time partner in the ALTCS program, we have been committed to the sensitivity of the dignity, privacy and independence of the members we serve. Because health care is delivered and accessed locally by the people we serve, UnitedHealth Group closely aligns our businesses with local communities. We use our resources and expertise to support consumers, patients, care providers, employers, governments and benefit sponsors so they can make informed health care decisions.

Evercare Select has consistently demonstrated our ability to adhere to Health Insurance Portability and Accountability Act (HIPAA) regulations. This includes our historical compliance in core health plan functions such as claims acceptance and payments. This has continued as we have developed new E-Health initiatives such as online EPSDT and Electronic Data Interchange (EDI). As we embark on new and vital initiatives such as EHR, Evercare Select assumes accountability to develop and test platforms that allow accessibility, ease of use and above all, privacy and security. To accomplish this, Evercare Select incorporates proven, compliant technologies while aligning our goals with the State's objectives, focusing on better serving the member population, and continually evaluating and using best practices. We also leverage the significant capital investment in technologies by our parent UnitedHealth Group IT organization, our EHR/EMR tools that offer a "Meaningful Use" guarantee, as well as HIE technologies by the recently acquired Axolotl.

Evercare Select prioritizes HIPAA compliance and continually monitors regulations to ensure that we comply with regulatory mandates. At present, we are fully compliant with HIPAA version 4010A; we are working toward completing our updating to version 5010 and we are working on the development of ICD10 coding so that we will be prepared and compliant on the respective effective dates. To date, we have already updated and implemented many of our interfaces to be compliant with 5010 and will have the remaining interfaces compliant well before the required date of January 1, 2012. Chief Executive Officer, Karen Brach's HIPAA Migration team will be ready for 5010 testing with AHCCCS in the October 2011 timeframe, with ICD10 development and testing to follow, and implementation/full ICD10 compliance prior to the required date of October 1, 2013.

UnitedHealth Group Privacy Program

The UnitedHealth Group Privacy Program is designed to promote compliance with UnitedHealth Group's mission and various federal and state privacy regulations, including HIPAA and GLBA. It is structured into two major components. The first is to provide employees with various training and resources to support their day-to-day compliance activities. Second, through various monitoring and controls tools, it seeks to ensure employees are actually complying with existing processes and promotes ongoing compliance through a proactive change management approach.

Regarding monitoring of ongoing compliance with the components of HIPAA Administrative Simplification that have been promulgated by the U.S. Department of Health & Human Services – thus far compliance processes are proprietary, but have included the UnitedHealth Group Security Policies as documentation supporting our HIPAA guidelines. These include:

- ***Sarbanes-Oxley Section 404*:** The provisions of Sarbanes-Oxley Section 404 became effective for UnitedHealth Group as of December 31, 2004.

UnitedHealth Group has developed the appropriate documentation, assessments, testing, ongoing compliance processes and resources, and technology tools to ensure full compliance with this legislation.

Adoption of Future Requirements

We participate in many community-based workgroups seeking to develop innovative solutions to advance health care technology for both our members and providers including:

- ***Community First Choice Option:*** (authorized by the Patient Protection and Affordable Care Act (PPACA) 2010) – Evercare Select has been chosen to serve on the advisory council with AHCCCS, which is charged with offering input on a variety of issues related to the fulfillment of the Community First Choice Option, including recommendations on operational and information system considerations.
- ***Health Information Technology for Economic and Clinical Health Act (HITECH):*** UnitedHealth Group's participates with AZ Health-e Connection and highlights the current activities Evercare Select is undertaking to support electronic health records. Axolotl (owned by UnitedHealth Group) committed over $1 million to Phase I of the rollover for Arizona EMR/HIE.
- ***Health Care Acquired Conditions:*** We understand AHCCCS is taking steps to develop a system to identify health care acquired conditions and prohibit payment for certain identified conditions. We will work with AHCCCS to implement the needed changes when finalized.
- ***Electronic Case Management Assessment and Planning System*:** Evercare Select supports the steps AHCCCS is making to replace their CATS system with a web-based system that enables members, providers and case managers to share data and communicate as needed. Our CareOne medical management system was developed internally as one of the first electronic care management systems used in the ALTCS program. We look forward to working with AHCCCS and continuing to provide leadership in this area with enhanced electronic case management systems.
- ***PPACA:*** Requires that states pay Medicaid primary care providers at parity with Medicare rates in 2013 and 2014. Evercare Select will support AHCCCS as they address the policy and technical issues related to the implementation of the rate increases.

Electronic Medical Record and Health Information Exchange

UnitedHealthcare Community & State has been working with and leading the Arizona Health-e Connection (AzHeC) since its inception, helping to guide electronic medical record (EMR) and health information exchange (HIE) policy and deployment in Arizona. Benton Davis, CEO of UnitedHealthcare-Western States, has served on the AzHeC Executive Committee since 2009 and is currently Chairman of the Board of Directors for AzHeC. UnitedHealthcare is committed to modernizing the health care delivery system in Arizona through effective EMR and HIE deployment. We have invested and continue to invest significant financial and technical resources, working with AzHeC and other institutions to execute this strategy including our practice-centric medical home. UnitedHealth Group owns a portfolio of companies that are leaders in their respective areas for HIE and EMR policy and technology with products in active stages of deployment in Arizona. Collaborating with AHCCCS and other stakeholders, we continue to move forward a statewide solution for EMR and HIE capabilities consistent with AzHeC policies to advance health care quality throughout Arizona.

To advance our ability to support E-health connectivity and drive strategic adoption of Health Information Technologies, we continue to collaborate with UnitedHealth Group to support the enhancement of our E-Health infrastructure. UnitedHealth Group recently acquired Axolotl, the nation's leading HIE company (KLAS 2010). Axolotl develops and implements HIE solutions for states, communities, hospitals and

health systems, while UnitedHealth Group brings decision-support capabilities that can be combined with an HIE solution to further enhance health outcomes and improve efficiencies.

UnitedHealth Group and Axolotl both offer solutions that are interoperable with multiple health information solutions. Nearly 30,000 physicians, 100,000 health care professionals, over 200 hospitals, 20 Regional Health Information Organizations (RHIOs) and 4 statewide HIEs—touching the lives of more than 35 million patients—use axolotl's Elysium® Exchange solutions. UnitedHealth Group's CareTracker™ EHR solution was selected this year by the American Medical Association for consideration by their members and is fully CCHIT™ 2011-certified. It is a highly affordable and simple deploy solution that transforms physician workflow with minimal disruption. UnitedHealthcare is committed to promoting provider adoption and usage of electronic medical record (EMR) technologies to all providers, with particular focus on those less able to afford the typically high upfront costs. We strongly believe that the widespread adoption of EMR by providers will help achieve several objectives important to our organization and to Medicaid members in the state of Arizona:

Winning E-Health Solutions:

UnitedHealth Group's Ingenix named 2010 Technology Innovation Award Winner by the U.S. Department of Health and Human Services for its Connect software design for exchanging electronic medical records.

- Improve patient care outcomes for Medicaid members
- Slow the rising costs of care
- Help eliminate system fraud, waste, and abuse.

To that end, UnitedHealthcare has aligned with UnitedHealth Group to help ensure that all Medicaid providers in our network have the knowledge and means to adopt an affordable and effective EMR solution (CareTracker EHR) that will allow them to qualify for stimulus funds. We back this up with Zero Percent Interest Financing and a Meaningful Use Guarantee to ensure minimal risk to providers when adopting our EMR solution.

15. Provide a flowchart and comprehensive written description of the Offeror's grievance system.

Grievance System

Evercare Select has maintained a **compliant system and process to respond to and resolve member grievances for 22 years** which includes when, where and how to file grievances, appeals and provider claim disputes. In an Operational Financial Review conducted in January, 2010, AHCCCS deemed the Evercare Select grievance system to be fully compliant. We follow AHCCCS' timelines and requirements for grievance, appeals and provider claim dispute resolution. Our grievance system complies with applicable state and federal laws, regulations and policies, including but not limited to **ACOM Policies 206, 406, 407, 414, and 42 CFR Part 438 Subpart F**, as well as the Enrollee Grievance System and Provider Claim Dispute System Standards Policy, Attachments B(1) and B(2) in the ALTCS contract. Our Grievance Manager, Scott Jewart, handles member grievances and appeals. Our Dispute and Appeal Manager, Regina Lara-Ybarra, handles provider claim disputes. These managers have been overseeing this process since 2008. Both individuals report to Claims Administrator, Helen Bronski. Flowcharts follow our narrative description.

Process for Filing a Member Grievance

Upon enrollment, case managers review the grievance process as written in the Evercare Select Member Handbook with each member. The handbook explains that members may file a grievance with Evercare Select, in writing or verbally by calling our toll-free customer services office at 1-800-293-3740. The member can report to the customer service representative or request to speak to the Evercare Select case management manager or the Grievance Manager. The handbook also lists the Phoenix mailing address for submitting a member grievance in writing. Members can file grievances when they are dissatisfied with any aspect of their care other than an action such as: quality of care or services provided, rudeness, or failure to respect the member's rights. The Member Handbook is also available online at: www.evercareselect.com.

Process for Resolving a Member Grievance

*Our average number of days to resolve grievances in 2010 was **8.24 days** from receipt, exceeding AHCCCS' within 90 days standard.*

Grievances are date stamped, entered into the grievance database and a case file created into our grievance database (GDB). We log and track member name/identification number; date grievance received and acknowledged; grievance description; staff assigned for disposition; disposition; disposition date; disposition cause of delay (if greater than 10 business days from date of filing) and member notification date (if grievance response is requested by the member). Receipt of all member grievances, written and verbal, are acknowledged. If a written grievance is submitted, written acknowledgment is within 5 business days of receipt. Our Member Services call center addresses various issues including member grievances. All member grievance calls are reported to the Evercare Select Member Concerns email account and logged into GDB. The majority of member grievances are resolved during the initial call; however, those requiring research are pulled from the Member Concerns email. Grievances are reviewed with Quality Management (QM) staff to determine if it is a grievance or Quality of Care issue. If it is identified as a Quality of Care issue, the issue is handled by our QM Team.

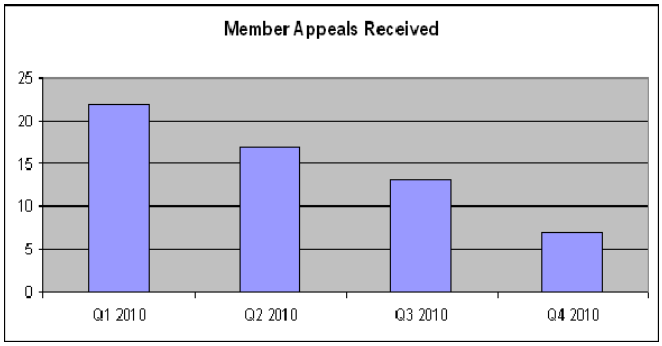
Our Grievance Manager, Mr. Jewart, conducts preliminary research to verify the appropriate path of the grievance. Mr. Jewart researches and processes the grievance for resolution. Members receive notification of the grievance resolution within 10 business days, but no longer than 90 days. Mr. Jewart updates the case file in the grievance database with all applicable data. We ensure that individuals who make decisions regarding grievances and appeals have not been involved in any previous level of review or decision making related to the grievance. Individuals who make decisions regarding: 1) appeals of denials

based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal, or 3) grievances or appeals involving clinical issues, are health care professionals with the appropriate clinical expertise in treating the member's condition or disease.

Member Notice of Action Letter

When Evercare Select makes a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, **we mail a Notice of Action (NOA) to the member within the timeframes specified in 42 CFR Part 438 Subpart F, Enrollee Grievance System Standards and Policy.** We provide an NOA to the member no later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days. Each NOA explains: the action taken or intended to be taken; the reason for the action; the member's right to file an appeal with Evercare Select; the procedures for exercising appeal rights; circumstances when expedited resolution is available and how to request it; and procedures for continued benefits and the member's potential financial obligation for them. Our NOA letter complies with the ACOM Content of Notice of Action for Service Authorization Policy, and our NOA scoring has exceeded AHCCCS standards. We have worked with AHCCCS and other program contractors to create a standard medical terminology database that can be used for all program contractors for NOA letters.

Our NOA Scoring	*Percent*
NOA Score for 2010	93.1
AHCCCS Standard	90.0



Process for Filing a Member Appeal

Our Grievance Manager, Mr. Jewart, **acknowledges the receipt of each appeal in writing within one working day for expedited appeals and within five working days for standard appeals**, which follows AHCCCS rules. The member has 60 days from the date of the NOA letter to file an appeal, in writing or verbally. The chart above depicts the pattern in appeals received in 2010.

Timeliness for Resolving an Appeal

Standard appeals are resolved within 30 days from receipt date unless an extension (of up to 14 days) is in effect and agreed to by the parties. We expedite resolution of an appeal if the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. We resolve the expedited appeal within three working days, unless extended. We make every effort to contact the member and provide verbal follow-up within two days with a written notice of denial of expedited resolution.

*Our average number of days to resolve appeals in 2010 calendar year was **19.98 days**, exceeding AHCCCS' within 30 days standard.*

Process for Resolving an Appeal

Evercare Select provides each member a reasonable opportunity to present evidence and allegations of fact. The member is given the choice to meet at the Evercare Select office in a face-to-face meeting or by telephone, to present their evidence. The member is informed of the limited time available in cases involving expedited resolution. Any information received during the resolution process is date-stamped and incorporated into the case file. Our Grievance Manager, Mr. Jewart, assembles relevant background information from Evercare Select's prior authorization or case management teams, obtains relevant clinical information and forwards the matter to a medical director or other health care professional who has appropriate clinical expertise to review the matter. The medical director or other health care

professional making the decision is not involved in any decision-making or previous review surrounding the action or appeal. Upon completion of this process, Mr. Jewart provides verbal notice of Evercare Select's decision for an expedited resolution and issues a written Notice of Appeal Resolution for both expedited and standard resolutions via certified mail.

The Notice of Appeal Resolution (NOAR) contains the results of the resolution process, including the legal citations or authorities supporting the determination, along with the date it was completed. For appeals not resolved wholly in favor of the member (1) the member's right to request a State Fair Hearing (including the requirement that the member must file the request for a hearing in writing no later than 30 days after the date the member receives the NOAR) and how to make the request, (2) the right to receive continued benefits pending the hearing and how to request continuation of benefits, and (3) information explaining that the member may be held liable for the cost of benefits if the hearing decision upholds Evercare Select's decision.

Request for State Fair Hearing - Member

The member may appeal our decision and request a State Fair Hearing in writing no later than 30 days after the date the member receives the NOAR. Members are informed that they may also file for a State Fair Hearing if a Notice of Appeal Resolution is not completed within required timeframes. Our Grievance Manager, Mr. Jewart, forwards the case file, cover letter, member's written request for hearing, copies of the entire file with supporting documentation, copy of the NOAR and other information relevant to the resolution to AHCCCS, OALS, no later than five working days from receipt. Mr. Jewart updates the member appeal database with the date and final disposition of each appeal. The case file is then closed and retained for a minimum of six years after the last level of review.

Provider and Subcontractor Claim Dispute Process

Evercare Select has a written claim dispute process and policy for providers, non-contracted providers and subcontractors defining their rights. Our written process and policy can be found in the Evercare Select Provider Manual and is available to the provider via hard copy and at www.evercareselect.com. Non-contracted providers receive the claims dispute process and policy information with remittance advices. The claim dispute information specifies that claim disputes challenging claim payments, denials or recoupments must be filed in writing with us no later than 12 months from the date of service or after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Our provider education team also meets with new providers to review and supply them our written dispute policy.

Process for Filing a Claim Dispute

The claim dispute must state with particularity the factual and legal basis for the relief requested, along with supporting documentation, such as claims, remittance advice, medical review sheets, medical records, correspondence, etc. Evercare Select date-stamps claim disputes received and logs them into a database for tracking and trending. We maintain separate databases for provider and behavioral health recipient claim disputes. Dispute and Appeal Manager, Ms. Ybarra, creates a claim dispute file that includes available and relevant information associated with the claim dispute. Within five business days of receipt, an acknowledgement letter is sent to the provider indicating the claims dispute has been received.

Process for Resolving Claim Disputes

Percent Disputes Resolved	*CYE08*	*CYE09*	*CYE10*
In 30 Days	41.6%	51.2%	89.7%

Ms. Ybarra investigates the nature of the dispute using the applicable statutory, regulatory, contractual and policy provisions. A notice of decision is issued no later than 30 days after the provider files a claim dispute. The decision letter includes: nature of dispute, issues involved, reasons supporting the decision, the provider's

right to request a hearing by filing a written request to us within 30 days after receiving the notice of decision, and, if claim is overturned, payment reprocessing of the claim. For all decisions overturned resulting in a reprocessing payment to the provider, the payment is reprocessed within 15 business days of the date of decision.

Request for State Fair Hearing - Provider

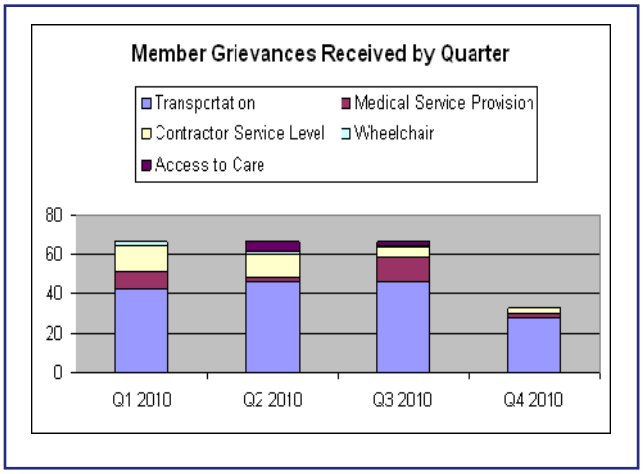
If the provider files a written request for a State Fair Hearing, Ms. Lara-Ybarra **files all supporting documentation with the AHCCCS, Office of Administrative Legal Services (OALS), no later than five days from receipt** of the provider written request for hearing. AHCCCS/OALS forwards its decision to Evercare Select. Our database is updated with the date and final disposition of each claim dispute and the case file is closed. Data is retained for six years. We are responsible for attorney fees and costs awarded to the claimant in a judicial proceeding.

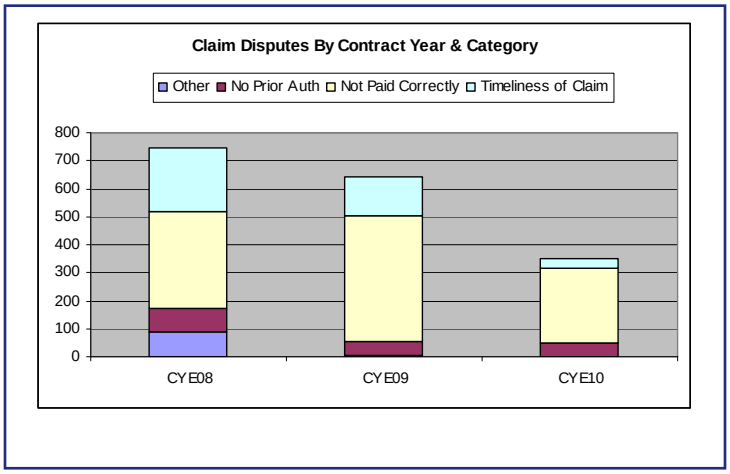
Improvement of Operational Performance

Evercare Select uses **a multi-departmental analysis** of grievance system data for identification of trends and areas for improvement to include the development and implementation of interventions based on identified trends and areas of improvement. Evercare Select **uses trending and analysis of grievances, appeals and claims disputes data as a means to identify deficiencies** within our operations and provider network to evaluate and modify interventions to improve performance. We may develop corrective action plans internally or with any of our contracted providers to address performance issues**.** The plans are monitored through the use of reporting or Joint Operational Committee (JOC) meetings until the performance issue is resolved. If a State Fair Hearing decision reverses our decision, it is closely reviewed to determine if a potential opportunity exists for operational performance improvement. We convene monthly JOC meetings with key providers or subcontractors. In addition, the monthly Member Grievance Report developed in accordance to the AHCCCS Grievance System Reporting Guide is also reviewed to identify trends. All trended concerns and potential action plans are reported on at least a quarterly basis to the Quality Management Committee (QMC) which monitors the quality of service delivery to the membership by the health plan and subcontractors. The QMC finalizes plans for operational changes and improvements to address any potential deficiencies.

Example of a Member Grievance Corrective Action

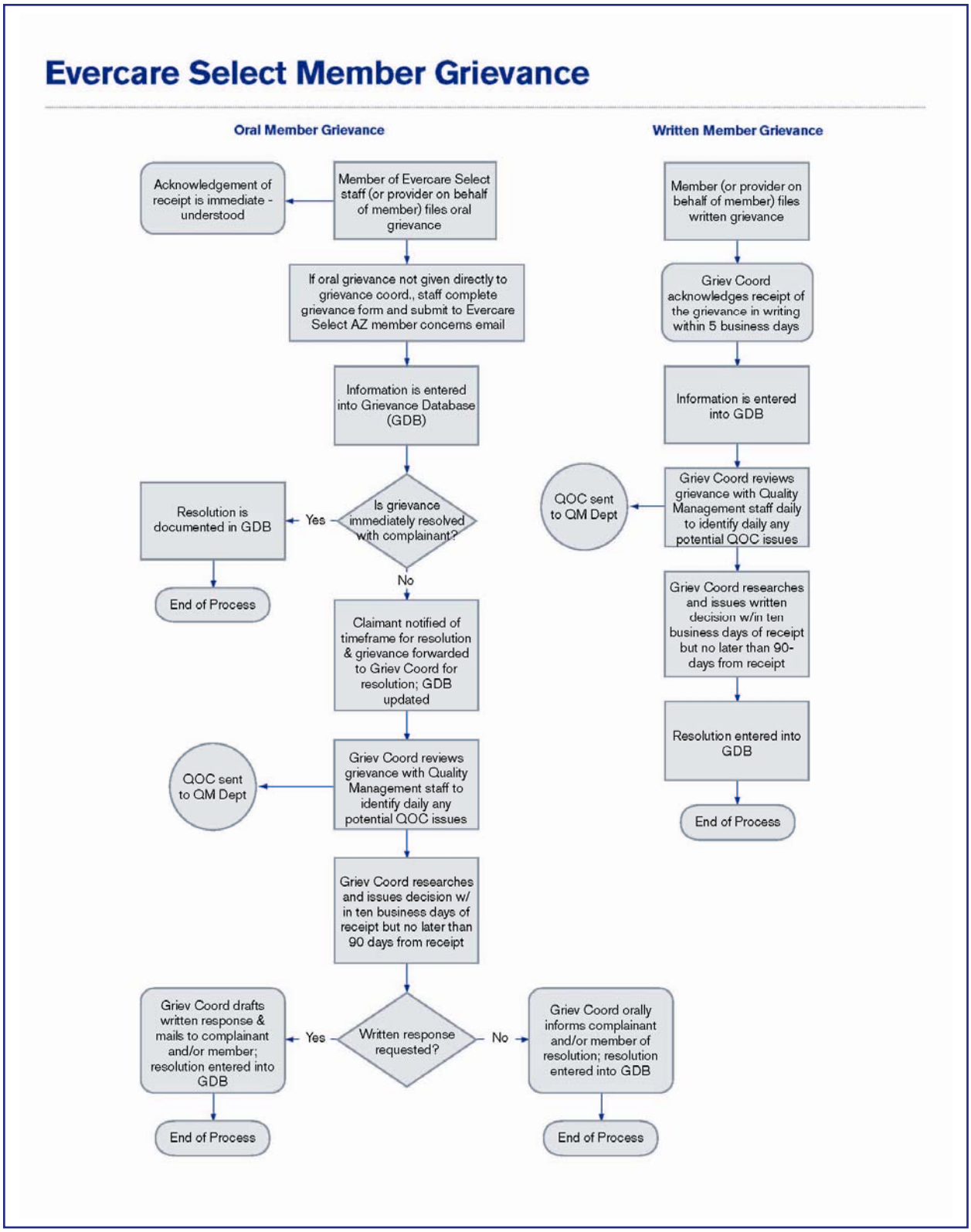
JOC meetings were implemented to troubleshoot complaints and improve processes with our transportation provider. Complaints were determined to be related to new providers in the network and it as determined that the providers needed additional training. Targeted training was provided and transportation grievances decreased in Q4 2010 (Member Grievances chart below). We analyze for trends and drill down to determine root cause problems. The member grievance chart depicts a material decrease in transportation grievances in 2010.



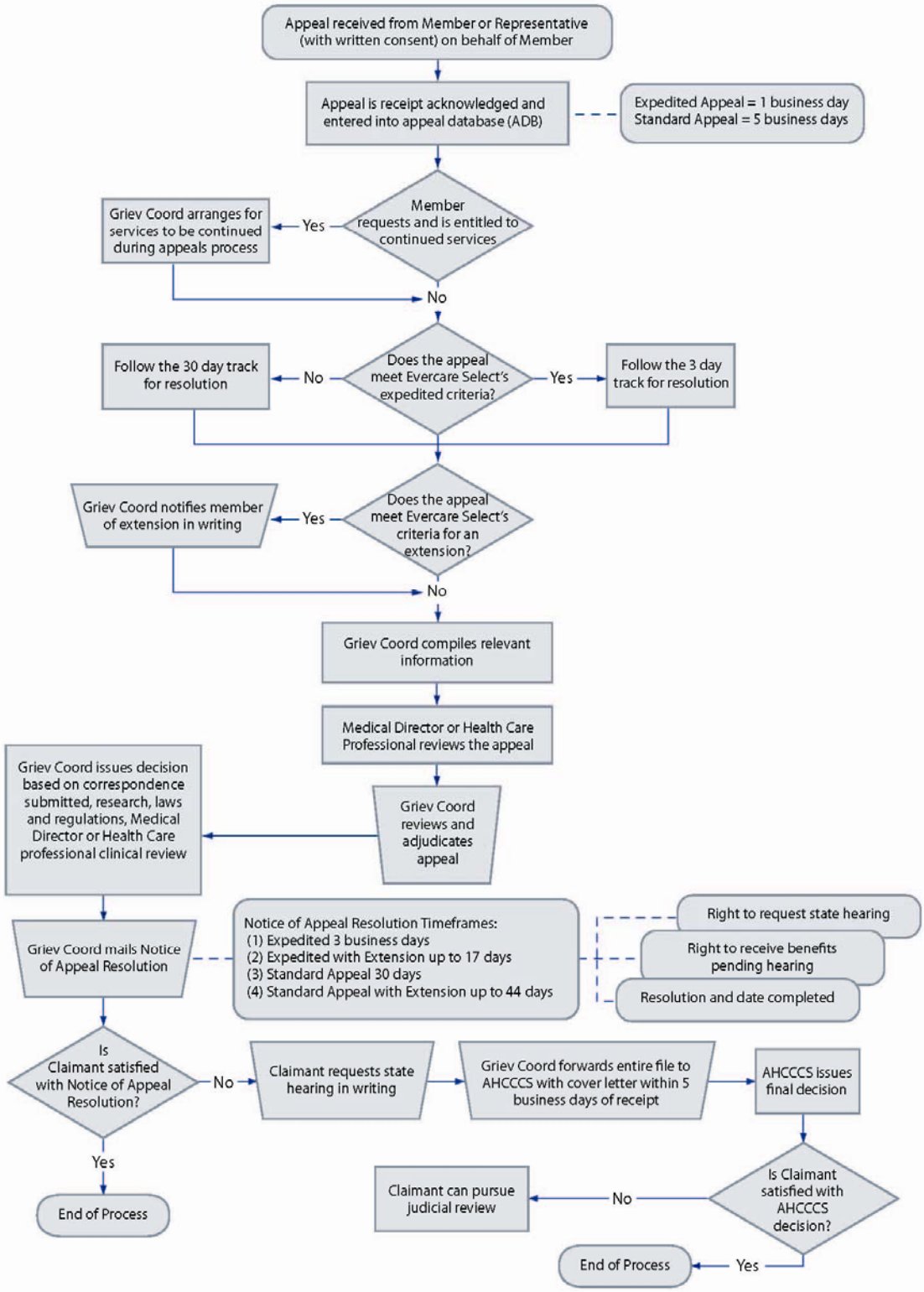


Grievance System Flowcharts

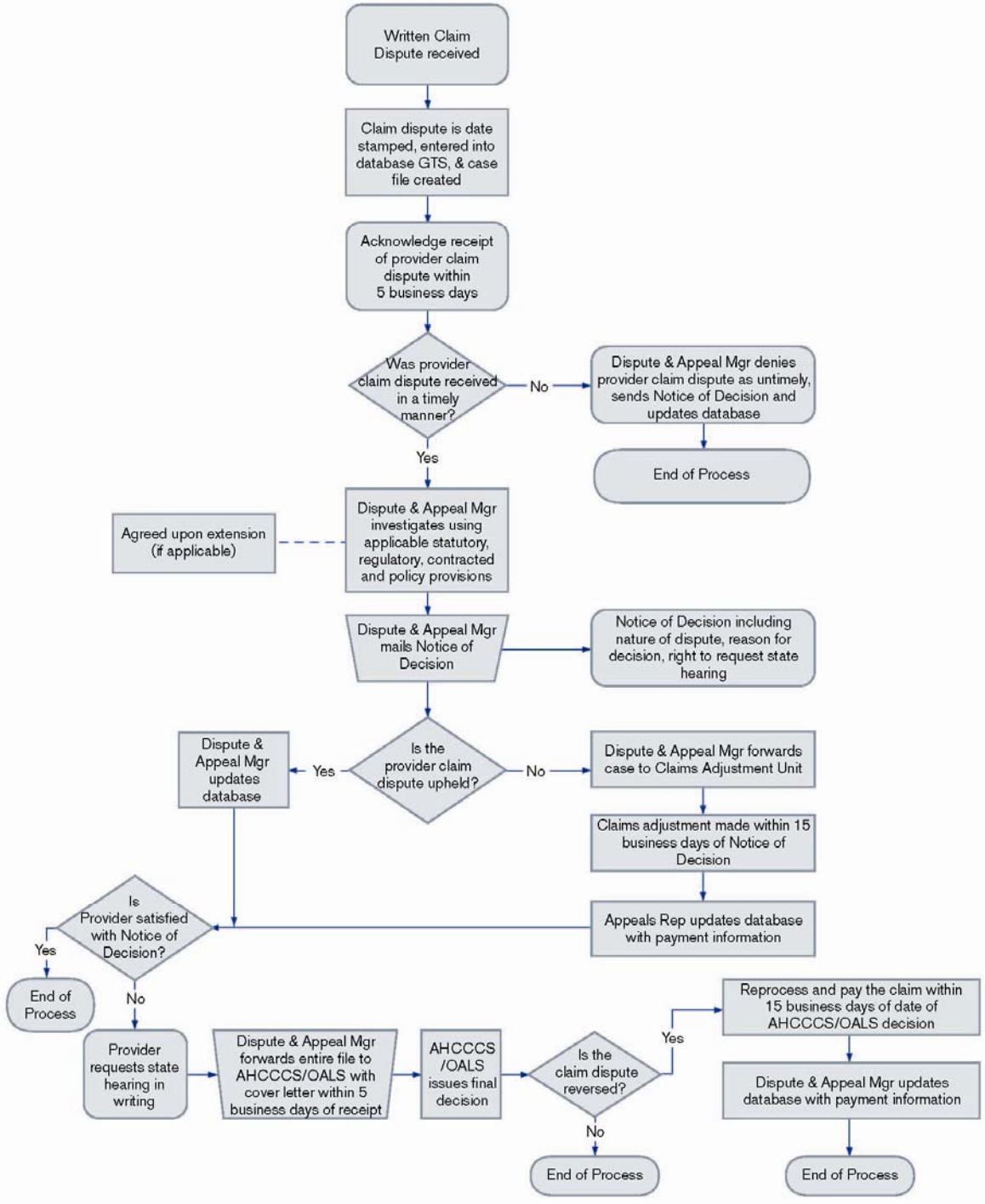
The flowcharts on the following pages illustrate the data flows for three key areas of Evercare Select functions including: (1) Member Grievance; (2) Member Appeals; and (3) Provider and Subcontractor Claim Dispute processes.



Evercare Select Member Appeals



Evercare Select Provider and Subcontrator Claim Dispute



16. Describe the Offeror's Corporate Compliance Program including …

Corporate Compliance Program

Evercare Select's mandatory compliance program is in compliance with 42 CFR 438.608 and includes provisions designed to prevent, detect, deter and report fraud and abuse, to promote our core values, to be good corporate citizens, and to be compliant with federal, state and contract guidelines requiring compliance. A key focus of our corporate compliance program is preventing, detecting and reporting fraud and abuse with the leadership from our Compliance/Contract Compliance Officer Kelly Kreiselmeier, MPA (formerly Kelly Morken), who reports directly to our Chief Executive Officer, Karen Brach. Evercare Select is committed to providing members with access to high quality medical care while complying with state, federal and local laws, regulations and other requirements of AHCCCS and the ALTCS EPD program. We have instituted the "Principles of Ethics and Integrity" program that employees are required to abide by. Core elements of our compliance program include:

- Written policies, procedures and standards of conduct that articulate Evercare Select's commitment to and processes for compliance with all federal, state and contract standards
- Compliance/Contract Compliance Officer is an onsite management official who reports directly to the Chief Executive Officer
- Compliance/Contract Compliance Officer and the Compliance Committee are accountable to senior management and the Board of Directors
- Initial and ongoing education for compliance officers, employees, subcontractors and providers
- Effective communication between the Compliance/Contract Compliance Officer and employees
- Enforcement of standards through well-publicized disciplinary guidelines
- Provisions for internal monitoring and auditing to detect offenses, including fraud and abuse
- Provisions for prompt response to problems detected and the development of corrective action initiatives relating to contracts.

Annual survey results show 100% of all employees complete compliance training.

Our compliance program, featuring these elements, is the vehicle through which we commit to business operations of the highest ethical standard, advocate compliance with legal and regulatory requirements for health plan functions and build integrity in our work, furthering a culture of compliance.

Written Policies, Procedures and Standards of Conduct

Our Compliance/Contract Compliance officer has the authority to access all records and independently make direct referrals to AHCCCS, Office of Inspector General (OIG) or other appropriate parties. Evercare Select's compliance program consists of the following policies and procedures:

- ***Code of Conduct*:** Code of conduct policy and procedures that are communicated to employees and contractors at the beginning of their relationship with Evercare Select and annually thereafter. The policy deters wrongdoing and promotes ethical conduct, compliance with laws and regulations, and full, fair, accurate and timely disclosures, as required.
- ***Fraud and Abuse*:** A primary element of our compliance program is our focus on detecting, deterring and reporting suspected fraudulent or abusive activity within the program. If an individual or team identifies employee, provider or member fraud, they may directly report the matter to AHCCCS, to Ms. Kelly Kreiselmeier, or to our Compliance Committee. If they are more comfortable, employees may also inform their manager or another member of the executive team or through the anonymous hotline number 24 hours a day/7 days a week. Ms. Kreiselmeier has the authority to access all records and independently refer suspected member or provider fraud or abuse cases to AHCCCS, OIG. Ms.

Kreiselmeier works closely with the Director of the OIG, Dr. David Botsko, and invites him to conduct Evercare Select all staff education on Fraud/Waste and Abuse (FWA). In accordance with A.R.S. Section 36-2918.01, we immediately notify (within ten business days of discovery) AHCCCS, OIG regarding any suspected fraud or abuse in writing using the AHCCCS FWA referral form [42 CFR 455.17]. This includes suspected fraudulent or abusive activity that may involve AHCCCS funds.

- ***Monitoring of Subcontractor Practices*:** Evercare Select's compliance program monitors provider and subcontractor practices to ensure they are consistent with sound fiscal, business or medical practices. This guards against unnecessary cost to the Arizona Medicaid program or inappropriate reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care. Our In-House Plan Counsel, Glen Thomas, JD, CPC, is an Arizona-licensed attorney and Certified Professional Coder. He oversees our subcontractors' compliance with their agreements with Evercare Select and the Arizona Long Term Care, Elderly and Physically Disabled program performance standards. Glen ensures that subcontracted processes are compliant and appropriate training is conducted for subcontractors, vendors and our related affiliates to promote compliance and consistency of practice.

Compliance Officer/Committee Level of Authority and Reporting Relationships

Ms. Kreiselmeier (formerly known as Kelly Morken) has 17 years of experience with the ALTCS and the Elderly and Physically Disabled program. **Ms. Kreiselmeier reports directly to our Chief Executive Officer, Karen Brach, and oversees the Evercare Select Compliance Program**. Ms. Kreiselmeier also has the authority to directly report issues to the Evercare Select Board of Directors and to the Board Chairperson. Ms. Kreiselmeier oversees our contract with ALTCS for the Elderly and Physically Disabled program and the associated reporting requirements, and is our direct contact with AHCCCS.

A key responsibility of Ms. Kreiselmeier is to convene and facilitate the Evercare Select Compliance Committee. The committee meets monthly or more often if needed to assist with monitoring and auditing program systems, reviewing policies and procedures, and discussing AHCCCS program changes and their impact to business processes to evaluate and take action when necessary. Evercare Select's Compliance Committee ensures that our required compliance plan is implemented and adhered. The Compliance Committee is comprised of our **Compliance/Contract Compliance Officer**, Chief Executive Officer (a budgetary official), Medical Director/CMO, the Quality Management Coordinator, the Director of Pharmacy, the Operations Director (who oversees claims, grievance system and member services), the Case Management Administrator and the Provider Services Manager. The Compliance Committee is accountable to the Board of Directors. The committee assists Ms. Kreiselmeier in monitoring, reviewing and assessing the effectiveness of the compliance program.

Training and Education for the Compliance Officer(s) and Employees

Evercare Select provides initial and ongoing education for employees, subcontractors and providers. We are committed to communicating our standards for ethical conduct and documented policies to employees. Completion of general compliance training is required by employees within 60 days of initial employment and annually thereafter. The initial training is conducted using computer-based training through the system known as Ulearn. Courses include topics on Ethics and Integrity (including communication of the hotline number to use 24 hours a day, 7 days a week reporting, which may be done anonymously) and the Health Insurance Portability and Accountability Act (HIPAA). Annual mandatory training is scheduled for each employee to include FWA, Medicaid 101, which includes the Deficit Reduction Act, and whistleblower protection information. The Compliance Officer conducts new employee training on our site compliance program, which includes review of our FWA policy, reporting requirements, review of the Evercare Select Compliance Committee and our structure, information about the regulator, and the ALTCS Medicaid program. All employees are surveyed on company ethics and integrity and the results reflect the training to be effective.

Additional compliance education and training includes but is not limited to: employee's individual responsibility for knowledge of and compliance with laws, regulations, and policies (e.g., Federal False Claims Act Provisions, which includes administrative remedies for false claims and statements and state laws relating to civil or criminal penalties for false claims and statements); reporting violations or questionable conduct, fraud, and abuse and the legal consequences of non-compliance; provision of culturally competent care; and protection of personal health care information. Grievance system processes and quality of care identification and reporting are taken annually. Our Compliance/Contract Compliance Officer receives all of the above training in addition to training through participation in the quarterly AHCCCS Office of Inspector General meetings and bi-weekly UnitedHealthcare Community & State compliance officer meetings. Evercare Select uses the tool created by AHCCCS to educate employees, providers and subcontractors and describes fraud, waste and abuse controls consistent with the requirements of the Deficit Reduction Act of 2005 (DRA).

Communication between Compliance/Contract Compliance Officer & Employees

Ms. Kreiselmeier is an onsite official available to all employees. The compliance staff participates in new employee training, encouraging staff to contact them with compliance concerns. Ms. Kreiselmeier also contributes compliance related information to all employees through a monthly update. This update via email provides education on a current compliance topic or policy. Additional compliance information is disseminated in highly trafficked areas via measures such as posters and flyers placed in break rooms or close to office printers. Managers are also expected to discuss legal requirements, company policies, and contractual obligations with their staff and evidence their commitment by their own conduct.

Enforcement of Standards through Well-Publicized Disciplinary Guidelines

Evercare Select has a progressive discipline process that includes notifying employees when performance is not consistent with expectations and rendering discipline commensurate with the infraction, which may include termination. All employees (in new employee orientation) and existing employees (through bi-annual training) receive orientation to the UnitedHealthcare Shared Policy and Resource Knowledgebase (SPARK). SPARK educates employees on disciplinary actions taken because of non-compliance.

Provision for Internal Monitoring and Auditing

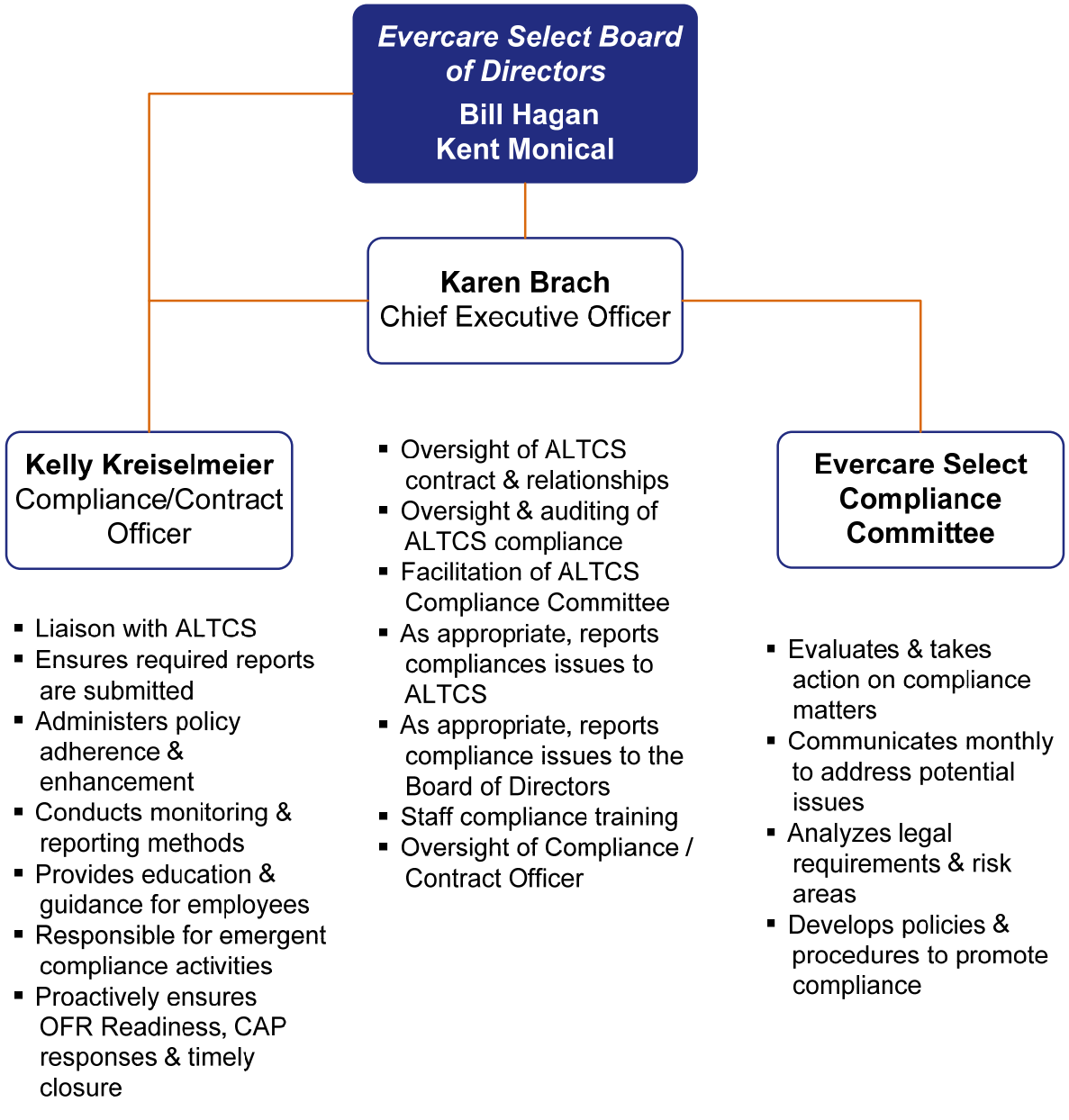
Evercare Select conducts annual and as needed internal audits of functional areas and areas of interest. The results of the internal audits are communicated to functional leads and used to correct or improve operational efficiencies. The internal audits and self-monitoring of the compliance program includes monitoring of compliance with laws, policies and contractual obligations. Self-monitoring activities allow the Compliance Officer to assess programs and processes, evaluate process data, and suggest internal process and systemic improvements. We notify AHCCCS of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions. We research potential overpayments identified by the OIG. After conducting a cost benefit analysis to determine if such action is warranted, Evercare Select should attempt to recover any overpayments identified. The OIG is advised of the final disposition of the research and any actions taken by us. Evercare Select is proactive in the OFR audits. To ensure compliance with OFR Corrective Action Plans (CAP), the Compliance Officer oversees functional area audits and monitoring of CAP closure.

Prompt Response and Development of Corrective Action Contract Initiatives

Evercare Select's compliance program includes a process for responding appropriately to compliance issues and initiating corrective action to correct the issue. Our first step is to correct the immediate issue to ensure we are compliant. During our second step, we evaluate the impact of our corrective action to ensure that it was effective and that we will continue to be compliant during ongoing operations. Ms. Kreiselmeier and the department head of the functional area involved lead this process. If the issue is with a subcontractor, the process is led by our In-House Counsel, Glen Thomas, and our Director of Operations, Helen Bronski, the applicable department head and representatives from the subcontractor.

Organizational Chart of Compliance Staff and Level of Authority

Evercare Select Compliance Officer Structure



Finance and Liability Management

17. Submit the organization's three most recent audited financial statements and …..

As a current long-term care contractor, **Evercare Select has met this requirement through the submission of our audited financials, submitted each year as part of our contract deliverables.** The three most recent audited financials that we have submitted were for the year ended December 31, 2007, 2008 and 2009.

18. Submit the organization's plan for meeting the Performance Bond or Bond Substitute…..

Evercare Select currently has a performance bond in the amount of $7M, which has been issued by Safeco Insurance Company of America. The bond is renewable annually with the next renewal date of December 31, 2011. Evercare Select is able to increase the bond as required using available unrestricted cash. Evercare Select intends to maintain the performance bond at the appropriate level as determined by AHCCCS for the duration of the contract, and subsequent to any terminations of the contract, at the discretion of AHCCCS. The bond amount will be increased to meet AHCCCS' requirements no later than 30 days after notification by AHCCCS of the amount required. No changes are made to the performance bond without prior written approval from AHCCCS, Division of Health Care Management.

19. Submit the organization's plan for meeting the minimum capitalization requirement.

Evercare Select's response below provides a methodology for achieving the minimum capitalization requirements per contract.

As of December 31, 2010, Evercare Select's unaudited financial statements include equity for its long-term care program totaling $27M (rounded) which is well in excess of the $15M capitalization requirement for a contract in every GSA in the state.

Evercare Select's equity per member standard is calculated as unrestricted equity, less on-balance sheet performance bond divided by the number of members at the end of the period. Evercare Select's Dec 31, 2010 reported equity per member of $8,812 exceeds the $2,000 per member requirement for Contractors. Evercare Select's audited financial statements for 2010 are not yet been finalized; however, it will be submitted within the contract requirement of 120 days following the year-end.

Evercare Select intends to remain fully compliant with AHCCCS' minimum capitalization requirements. If for any reason, AHCCCS requests additional capitalization, Evercare Select will meet the requirement within 30 days after contract award notification and with prior approval from AHCCCS.

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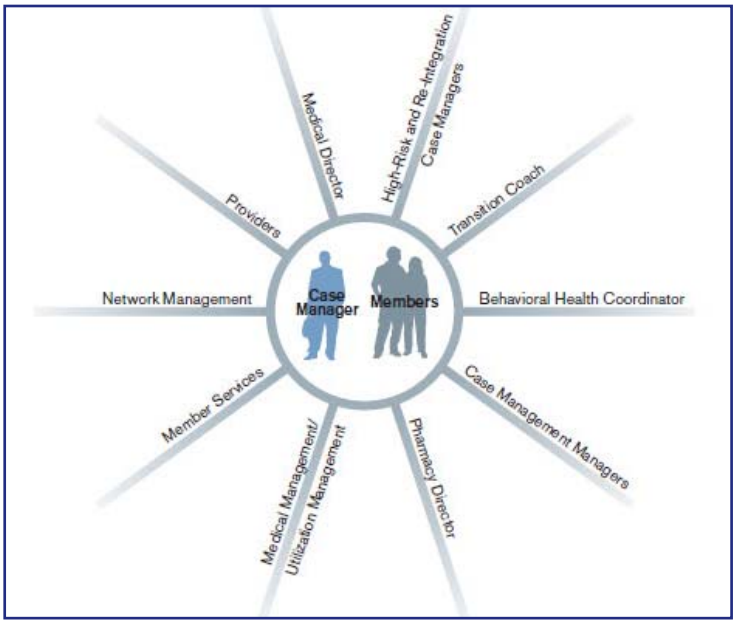
D. PROGRAM

Case Management

20. Describe how the Offeror has or will implement inter-departmental coordination…..



For 22 years, we have operated as a program contractor in Arizona for the ALTCS program, developing and maintaining a horizontal management structure and transparent operating processes aimed toward attaining the program's mission, values and principles. Our plan's culture focuses on the member, providing each member with an individualized plan of care that includes the appropriate and cost-effective medical, medically related social services, and behavioral services required to best meet their needs. The Evercare Select team, led by the case manager and supported by a inter-departmental team, engages the member, their family, their providers and other supports within the community in the decision-making process to provide the information and supports that empower the member (and their families) to make more informed choices and actively engage and participate in their own care.

All case management staff have both formal and informal direct access to personnel from other departments including our Medical Director, Pharmacy Director, case management managers, trainers, Member Services, Network Management, Medical Management, Quality Management, and Compliance to assist as needed with the development of the service plan and the ongoing monitoring and case management of each Evercare Select member. Communication between these departments occurs as needed on a daily basis via our "open door" policy as well as formally at our regularly scheduled inter-departmental meetings. The Case Management Administrator, Francine Pechnik, and the Medical Director, Dr. Tim Peterson, set aside time each day to meet with case managers and address any new issues that need their attention to resolve. At Evercare Select, our staff works as a team to meet the individualized needs and goals for every member.

Day-to-Day Inter-Departmental Coordination

In managing our members on a day-to-day basis, we ensure that the right resources are engaged and there is cooperation and collaboration between departments to get the best results for the member. From the outset, each member is assigned a case manager who has direct access to all of the resources within our organization. The resources and area of expertise included in each situation is dependent on the individualized needs of the member. Case manager resources within the Case Management team include the case management manager, case management administrator, behavioral health coordinator, trainer, transition coach, reintegration specialist, and high-risk and specialty (pediatric, respiratory and high-risk behavioral health) case managers.

In addition to the Case Management team resources, case managers have access on a day-to-day basis to Evercare Select leadership and personnel from other departments when resolving member issues or

addressing member plans of care including but not limited to:

- Executive Director, Medical Director, Concurrent Review Nurses, Pharmacy Director Prior Authorization and Member Services Staff
- Provider Relations Representatives and Contract Personnel
- Quality Management and Compliance Staff.

Everyone at Evercare Select is part of the member's care team and can respond with the resources necessary to resolve a member issue or concern, providing needed support. For example, case managers work in close collaboration with the Quality Management staff to identify and resolve any potential quality of care concerns in facilities or with provider agencies that have an impact on our members. Together they develop an action plan to address individual member or provider issues and concerns such as accessibility to services or member care. Our focus on coordination between the case management department and the other departments results in the delivery of high-quality health care services for our members.

Formal Inter-Departmental Processes

In addition to the day-to-day inter-departmental coordination and collaboration, Evercare Select has several formal processes and committees with representatives from across the organization. Through these committees and meetings, we report our progress on improved member outcomes, analyze and evaluate the progress, and collectively establish new initiatives to meet the goal of improving member care and service delivery across our entire organization. All clinical quality improvement and utilization management activities are monitored by the Healthcare Quality and Utilization Management Subcommittee (HQUM). The HQUM reports to the Quality Management Committee (QMC), which meets at least quarterly. All non-clinical quality of service delivery improvements are monitored by the Service Quality Improvement Subcommittee (SQIS), which reports to the QMC. The QMC and the supporting subcommittees include inter-departmental representation from all areas within the organization to ensure there is ongoing communication and collaboration between each of the functional areas of Evercare Select. Since many of our staff in the Quality, Medical Management and Network departments were previously in case management positions, our entire organization is very sensitive to the needs of our members and have a "real life" hands-on understanding of the case management function – a factor that has improved how all areas address member-centered issues.

Inter-Disciplinary Case Reviews

Case reviews are conducted daily, on both a pre-scheduled and as-needed basis. The Evercare Select Medical Director, Dr. Tim Peterson, and the assigned case manager lead the case review. The member's inter-disciplinary team may include both internal and external partners involved with the member's care. Internal resources, in addition to the case manager and Dr. Peterson, include but are not limited to the Case Management Administrator Francine Pechnik, Pharmacy Director Dr. Sandra Brownstein, Behavioral Health Coordinator Theresa Robben, and Quality Management, Utilization Management and Network personnel. Other parties involved in the member's care are invited to participate in the case review, including but not limited to the member's primary care physician (PCP), specialists, behavioral health providers and the member's representative. Anyone in our organization, including the case manager, can schedule an ad hoc member case review based on information they have that indicates there is a need for a inter-disciplinary approach to a particular member's care. The case manager is responsible for coordination between the all of the providers involved in a member's plan of care. The case review provides an opportunity to ensure that the member's service plan is appropriate, services are being delivered, barriers or issues are being resolved satisfactorily and member outcomes are positive.

Senior Management Meetings

The senior management weekly meeting is led by Chief Executive Officer (CEO) Karen Brach. Participants in this weekly meeting include directors and managers of the different Evercare Select departments. Representation by all departments provides an opportunity for each department to report on activities from the previous week and raise any issues or concerns that need to be addressed by collaboration between departments. Specific issues and challenges related to case management are presented and discussed during these meetings. Follow-up action plans are developed and progress toward resolution is reported at the following meeting or sooner when needed. The department leads provide feedback from these meetings to their staff at their weekly department-specific meetings.

Positive Outcomes through Inter-Departmental Coordination

Inter-departmental collaboration occurs on a regular basis throughout our entire organization. As an example, our Behavioral Health Network Management Committee that includes our Behavioral Health Coordinator, Theresa Robben; Case Management Administrator, Francine Pechnik; and our Network Manager, Larry O'Connor, meet regularly to discuss identified needs, barriers, trends and solutions related to our members' behavioral health services and placements. These meetings provide a forum to explore alternatives to improve both the member's services and their health outcomes. During one of these meetings, we identified a pattern in the northeast Arizona communities involving the transfer of members with complex behavioral health disorders who could not live in regular skilled nursing facility settings to high-risk behavioral health facilities in the Phoenix area. The great distances from the rural regions of the state to Phoenix made it particularly difficult for families to visit the transferred members.

These initial discussions led to collaboration between the Director of Case Management, the Behavioral Health Coordinator, Medical Director, Quality Management staff, and our Contracting and Provider Relations departments. To offer an option for members and their families living in Navajo and Apache Counties, we worked to develop a behavioral unit within the Rim Country Nursing Facility located in Payson. As a result, when the unit opened in 2008, five members who were living in a behavioral unit in the Phoenix were asked if they wanted to move to the Payson area. After discussions with the members and their representatives/family, all five members elected to move. The immediate use of the behavior unit at Rim Country underscored the need for the development of behavioral health treatment/placement options in rural areas. Evercare Select contracted with Dr. Gary Martin to help set up the Rim Country Behavior Unit and guide the program while it was in its development stages. For the past three years, the Rim Country Behavior Unit has been providing services to 24 members on an ongoing basis from various health plans, including Evercare Select. As a result of this success, Evercare Select is currently working with a provider developing a high-risk behavioral health community alternative in Yavapai County.

The development of the specialized unit at the Rim Country has resulted in numerous improvements in both members' health and service outcomes. One of the most significant outcomes was the successful discharge of a member who had been living at the Arizona State Hospital (ASH) for four years. The member's elderly parents lived in northeast Arizona, which made it difficult for them to participate in the member's life while he was in ASH. When the member's medical and functional status had declined to the point that he could no longer live in ASH, our Behavioral Health Coordinator worked with the member's family and the Rim Country Nursing Facility to coordinate the member's discharge and transfer from ASH. Consequently, this member was able to live in a far less restrictive setting than he had in many years and was able to see his family on a regular basis during the final years of his life.

At Evercare Select, we understand it takes teamwork across the organization to support our case management process. Our management strives to maintain a culture that promotes communication. We believe that we have the flexibility as well as the structure to ensure that we are supporting every member so we can meet and achieve the member's needs and goals. Our team model works today for ALTCS and we are confident that it will continue to serve the ALTCS program in the future.

21. Describe the Offeror's plan for monitoring and improving, as needed, the level of consistency….

Over the past 22 years, our case management program has continuously evolved to address the ever-changing needs of our ALTCS members. We have grown and learned through our participation in the program, and have leveraged this knowledge to develop **systematic methods of monitoring** our case management program to ensure the highest quality of care is **delivered to our members in a consistent manner**. Our monitoring system includes but is not limited to conducting quarterly case file audits and quarterly reviews of the **consistency of member assessments/service authorizations through inter-rater reliability**. We compile quarterly reports of these monitoring activities, including an analysis of the data and improvement strategies to resolve identified issues. These reports are available to AHCCCS upon request. We continuously assess the appropriateness and suitability of services and placements for HCBS members and ensure the coordination between case and quality management when service issues are identified. This is accomplished through case management training, standardized tools, audits, inter-rater reliability and our utilization review. We coordinate contingency planning and member service preference levels with the member and representative.

In 2008, our Case Management Administrator, Francine Pechnik, conducted an evaluation of our Case Management team to determine the consistency of assessments among case managers. She found that 72 case managers were conducting assessments inconsistently. Based on this finding, Francine developed a consistency monitoring tool to evaluate case managers' performance for consistency. Francine and her staff soon discovered a more formal organizational structure was needed and they developed a comprehensive approach to inter-rater reliability (IRR). This program has since been replicated by other ALTCS program contractors and AHCCCS now includes case management IRR as an operational requirement, measuring compliance in the annual operational and financial review. Evercare Select has received a rating of full compliance in the two operational and financial reviews (2009 and 2010) conducted by AHCCCS since IRR became a measurement.

Case Management Training

Evercare Select conducts extensive case management orientation for new staff as well as ongoing training programs for all case management staff that includes case management standards as outlined in AMPM Chapter 1600, the ALTCS guiding principles and Evercare Select specific policies, procedures, and standardized tools. Case managers are required to participate in our web-based training program, ULearn. Motivational Interviewing modules are included in ULearn based on the Prochaska Model, which illustrates how to conduct member interviews to clearly and efficiently identify a member's goals of care. The skills developed through these modules enhance the consistency in member assessments.

Every new case manager is assigned a preceptor/mentor to shadow in the field for up to three months depending on the experience, skills and background of the new employee. During this time the new employee interacts with members under the guidance of an experienced case manager. The preceptor assists the new employee in applying our policies and practices and assuming the responsibilities of a case manager. Case managers discuss questions and problems with their assigned preceptor daily, meet with their manager at least weekly, and attend regularly scheduled team and staff meetings.

All staff trainings are held at least monthly to address global training topics and selected topics are reinforced in the weekly team meetings led by the case management manager. When change forms or process change (internal or external) occurs, relevant policies are revised and case managers are retrained. In addition, the Trainer is also an ongoing resource for all case managers and the case management managers.

Standardized Tools

Working in collaboration with AHCCCS, Evercare Select has adopted or developed standardized case management tools to ensure **consistency among case managers with regard to the assessment of HCBS member needs and service authorizations**. The AHCCCS/ALTCS Uniform Assessment Tool

(UAT) is used for assigning an acuity level of care for members living in skilled nursing facilities (SNFs) assisted living facilities (ALFs) and it is used to complete the Cost Effectiveness Study (CES) for the HCBS member. The Evercare Select Member Functional Needs Assessment Tool (2060 Tool) is used to determine the member's informal support systems and appropriate allocation of time for tasks associated with the authorization of formal home and community-based services.

Our 2060 Tool Task Hour Guide provides descriptions that assist the case manager when completing the 2060 Tool; it identifies the member's level of care needs and provides recommended time allocation for eligible ALTCS services required to meet the member's unmet needs. Our 2060 Tool and our 2060 Task Hour Guide are consistent with the recommendations of the ALTCS program contractor workgroup that developed a draft uniform HCBS assessment and time recommendation tool. The Task Hour Guide is just a guide; the case manager must use member input when completing the 2060 tool. These tools provide a standardized approach to case management, resulting in a high degree of consistency across cases.

To assist the case managers in the consistent authorization of certain home-based services, Evercare Select has developed additional decision support tools to guide the case manager through evaluation criteria to consistently apply the ALTCS benefit for HCBS services. These tools include decision support tools for the authorization of ALF placements, Emergency Alert Systems and Home Delivered Meals.

Quarterly Case File Audits

Evercare Select conducts quarterly member case file audits (chart audits) to monitor individual case manager performance and departmental trends. Our chart audit tool contains **57 areas of measurement to evaluate staff compliance** with Evercare Select and AHCCCS policies related to multiple case management functions including member assessments and service authorizations. Our chart audit team, consisting of trainer Angela Farley and case management managers and team leads, meets regularly to review audits results and identify opportunities for additional training and remediation of any findings of inconsistency. Each auditor is assigned specific case managers to audit each quarter, allowing for tracking and trending. Auditors provide feedback and education to the case managers on an individual basis based upon audit findings. Audit results are reported to case management managers for review and development of individual corrective action or specific team education. Ms. Farley completes a quarterly departmental summary and works under the direction of Ms. Pechnik to identify any process improvement opportunities, staff education needs and potential policy revisions, and implements training activities focused on enhancing case manager consistency. Training is provided to all staff through weekly team meetings, monthly staff trainings and written communication.

Inter-Rater Reliability

Evercare Select has a quarterly inter-rater reliability (IRR) process that aggressively measures, programmatically reviews and **evaluates the consistency of case manager application of policies, procedures and tools** in conducting assessments and authorizing HCBS services. Our IRR program, overseen by Ms. Pechnik and our Medical Director, Dr. Tim Peterson, has been deemed as **fully compliant** in the Operational and Financial Reviews (OFR) conducted by AHCCCS.

Our IRR process requires the case manager and a peer case manager to complete a face-to-face member assessment together. All of our case managers participate in IRR field-based activities and are reviewed twice a year. One case manager serves as the assessing case manager (Assessor) and one as the observing case manager (Observer). Both case managers complete our 2060 Tool and the UAT to determine the member's level of care. The UAT is used for assigning a level of care for members living in SNFs or ALFs and is used to complete the Cost Effectiveness Study (CES) for the home-based member. Our 2060 Tool evaluates individual member strengths, needs and informal supports related to Activities of Daily Living (ADL) and Instrumental/Independent Activities of Daily Living (IADL). Although members assessed in a SNF or ALF are not receiving HCBS services, case managers approach completion of the

2060 Tool as if they were preparing a discharge plan for the member to move to a home-based setting.

During the field-based IRR visit, the case managers complete all activities and assessments normally completed during a reassessment. The case managers are prohibited from conferring with one another when they are completing their assessments.

Our Trainer, Angela Farley, who has over nine years' experience serving the ALTCS population and participates in various AHCCCS workgroups such as the Direct Care Workforce and Community First Option, leads the IRR program. She collates the data received from all assigned teams for the quarterly field-based IRR assessment activity. The results are reviewed for consistency between the Assessor and Observer related to the UAT level of care assignment for each category of care, overall level of care, 2060 allocation of time for each category of care and total time allocation for authorized services. Angela reviews each case manager's submitted 2060, UAT and narrative documentation for adherence to policy and procedures for consistent assignment of "level of care need" across all tools; assignment of authorized service time that appropriately corresponds to the member's level and frequency of care needs; assignment of time for authorized services for unmet needs only; adherence to secondary review requirements; and adherence to other criteria set in policy (independence, assessing informal support, objective decision making, physician orders, etc.).

During the post-field visit review, Angela is responsible for providing focused feedback and education to the case managers and their managers. This allows managers to tailor individual staff development and address trends that may be related to their assigned teams. All case managers are required to participate in IRR activities regardless of their results from previous quarters. As we identify training opportunities, specific training plans are developed based on IRR results. We compile reports of IRR activities each quarter and monitor results quarter over quarter for the effectiveness of training and the previous quarter's action plans. We adjust training plans and case management policies based on the results of IRR activities. Consistency rates between case managers have been consistently high overall. Evercare Select IRR criteria set a requirement for the two case managers to be within 90 percent of one another.

HCBS Utilization Review

Monthly, Francine Pechnik, our Case Management Administrator, and the case management managers review the HCBS service authorization report, which identifies changes in overall trends including under- and over-utilization patterns based upon Evercare Select benchmarks for each HCBS service and unique member circumstance, and identifies case manager specific authorization patterns including timely completion of authorizations. Authorization trends are identified at both a micro (member) and macro level by this report. The report details HCBS services by service category, number of members authorized for the individual HCBS services, average number of units per member for each service and total units authorized per service. Using this report, we identify on a "real time basis" the overall authorization trends and case manager-specific authorization trends. At the macro level, **any significant variations or questionable patterns are escalated** to the medical director and the Medical Management team for analysis and possible action. Managers review each service and the average number of units each of their case managers is authorizing compared to the overall average units per member. Case management managers evaluate case manager application of benefits by identifying case manager-specific services authorization patterns that fall above or below the "average" units for all members to identify potential under- or over-utilization of services. Case management managers review any significant authorization changes or deviations from the "averages" for a particular member or any other significant changes to the member's services since the prior month with the case manager for the case. The case management manager uses this opportunity to reinforce AHCCCS policies with the case manager.

Evercare Select has developed and implemented systematic methods of measuring, monitoring and maintaining a Case Management program that promotes consistency between case managers and compliance with ALTCS program policies and procedures and Evercare Select policies and procedures.

22. Describe the process the Offeror will employ in assessing and meeting the needs…..

Evercare Select has proven processes and tools to assess, identify and manage the complex care and behavioral health (BH) needs of our members that emphasize the **most integrated and least restrictive settings** for our members. Our **member-centered** approach promotes **early detection and intervention** for these members, as well as prompt identification and initiation of services and comprehensive service planning and coordination with all involved parties, including the member, the member's family, all service providers, formal and informal supports and **community resources**. With the recent addition of INSPIRIS to the UnitedHealth Group family of companies, we enhanced our home-based care resources for our most complex care members.

Members Needing Behavior Management

Often, more complex cases involve situations where certain behaviors are affecting the member's health, placement or medical care. All of our case managers can assess and refer members for complex BH situations. Case managers receive monthly training from the BH Coordinator Theresa Robben, the BH team – consisting of several behavioral health case managers, including a licensed BH specialist who conducts case reviews – and outside trainers. Training includes identifying BH disorders, referring for services, resolving crises, working with members with difficult behaviors (residing in facilities), accessing BH services, obtaining court-ordered treatment services, participating in initial and quarterly BH reviews, managing psychotropic medications and providing member-centered treatment planning. Other training is given on a variety of complex BH conditions such as Alzheimer's, schizophrenia, anxiety and depressive disorders, traumatic brain injuries, substance abuse, eating disorders and hoarding.

Case managers are responsible for coordinating care between the members, their family, primary caregiver, PCP and BH provider. Case managers send Coordination of Care forms to both BH and medical providers on a quarterly basis or when there are changes in members' medical or mental health service plans, detailing the medications and services the member is receiving. We conduct initial and quarterly BH consultations to evaluate the member's BH stability and assist with the development of care plans for members with complex BH needs. Each case manager has an assigned BH professional available to them as needed.

We instruct providers to contact the case manager at the first sign of changes in the member's behavior such as medication refusal, behaviors that cannot be redirected or an altered state of thinking. For members living in traditional long-term care facility settings, there are times when the member's behavior is in need of intervention to stabilize the situation. We promptly provide additional supports and services that may allow the member to remain in his/her current environment and avoid relocation while ensuring the safety of the member, staff and other residents. Upon notification of a behavior change, the case manager confirms the facility takes action to promote the safety of all parties. Within 24 hours, the case manager secures an appointment with a BH provider. If the member is in active BH treatment, the BH provider is notified and consulted about immediate treatment alternatives. The case manager maintains daily contact with the facility and team until the member is no longer a danger to himself or others or has been transitioned to an alternative setting if necessary. The BH provider re-evaluates both the member and care plan within seven days of the incident. The case manager notifies all parties of any changes to the care plan and provides ongoing updates.

While every effort is made to maintain members in the community, Evercare Select determines if a member needs specialized BH placement based on the following criteria:

- Places self or others at risk with a pattern of physically aggression or assaulting behaviors
- Is at risk of elopement
- Places self at risk with a pattern of refusal to follow both medication and behavioral interventions
- Places self at risk by not eating, refusing medication/treatment such as dialysis, and other behaviors

- Exhibits sexually inappropriate or predatory behavior
- Has health care needs requiring skilled nursing facility level (SNF) of care or supervision
- Has a history of substance/alcohol abuse that interferes with living at home in the community, in a traditional long-term care setting or assisted living facility
- Has failed placements in traditional long-term care settings due to behaviors
- Had a psychiatric inpatient event within past 12 months resulting in partial resolution of symptoms
- Has a cognitive impairment that causes difficult behaviors.

If a member needs specialized BH placement or has multiple BH challenges, we assign the member to the BH team, which manages our most complex BH cases and is a resource to assist all other case managers with complex cases, as needed.

Identification and Assessment of Complex Care Members

Evercare Select's assessment process begins upon initial notification of member enrollment. Members with potential complex care needs are immediately flagged. These members include, but are not limited to those with a combination of multiple chronic conditions/illnesses, significant medical and behavioral complexities (vent, chronic wounds, behavioral problems), and socioeconomic and environmental barriers. Our staff obtains copies of the member's Pre-Assessment Screening (PAS). If the member is residing in a nursing facility, we also obtain copies of the Pre-Admission Screening and Residence Review (PASARR) and Minimum Data Set (MDS) from the facility. The case management manager reviews the results to determine if the member has any identified complex care needs that can be addressed by assigning the case to one of our specialized case managers who focus on serving members with BH, respiratory, pediatric, high risk or language needs. For members transitioning from other program contractors, our Transition Coordinator reviews the Enrollment Transition Information (ETI) forms with our case management managers to determine if any of the complex care needs require coordination with the relinquishing program contractor.

The case manager calls the member within seven days of enrollment to schedule an initial assessment that is completed within seven business days for ventilator dependent members and within 12 business days for all other members. If the case manager determines during the call that the member's needs are urgent, we complete the initial assessment within two days. We conduct assessments at the primary residence of the member. The automated assessment in our CareOne case management system identifies behavioral and medical risks and includes triggers for supplemental assessments based upon initial assessment responses. These supplemental assessments help identify complex care needs for specific chronic conditions such as BH disorders, diabetes, or congestive heart failure. CareOne is designed to intelligently assist the case manager in identifying the member's care needs; developing an appropriate and effective case management plan; and facilitating the flow of information and collaboration between the member, case manager, PCP and other providers, and other care management team members.

Daily review of our inpatient census triggers case manager participation on concurrent review rounds. Complex cases are discussed in detail with our Medical Director Dr. Tim Peterson, Pharmacy Director Dr. Sandra Brownstein, Case Management Administrator Francine Pechnik, Medical Management Coordinator Linda Morse, concurrent review nurses, case management managers, and case managers. Details of the medical and complex care needs, behavioral, and psychosocial issues are reviewed and care plans are coordinated and revised to include any identified specialized service needs. When appropriate, the member's providers are contacted directly for input into a revised member care plan.

Evercare Select uses various reports to identify members with potential complex care needs. Through claims data, prior authorization notifications and Impact Pro®, our proactive care module for gaps in care, we identify members with chronic and complex needs. These reports are analyzed by our Case Management and Medical Management teams including Dr. Peterson on a monthly basis and substantiate

that members at risk are receiving the attention and support that is required to ensure optimal outcomes.

Service Planning and Coordination

Upon identification of members with complex care needs and after completion of a comprehensive assessment, our case managers conduct case reviews with our multi-disciplinary team. Our case review team led by Dr. Peterson includes the case manager, the case manager's manager, Ms. Pechnik, BH Coordinator (Ms. Robben), Dr. Sandra Brownstein (as appropriate) and other providers needed to develop the service care plan. Involving resources from different disciplines during the review ensures there is an effective service plan with options for members. The team discusses the member's stated care and functional goals, identifies appropriate placement options, determines potential providers and services and addresses any potential barriers. Even if the need for BH interventions is the primary reason for the review, all aspects of the member's conditions are considered, ensuring that medical and BH care needs are coordinated and service/provider options are made available to the member.

Based upon the team's recommendations, the case manager develops (with the member's input) a plan of care that promotes member choice, individuality and provides coordination between the member, family, and health care team. Interventions for these members include consideration of the member's cultural background and beliefs, psychological support, education, home physician services, referral to appropriate community agencies, arrangement of transportation, and monitoring of health care status until optimal health status is achieved. Our approach to care planning and coordination includes:

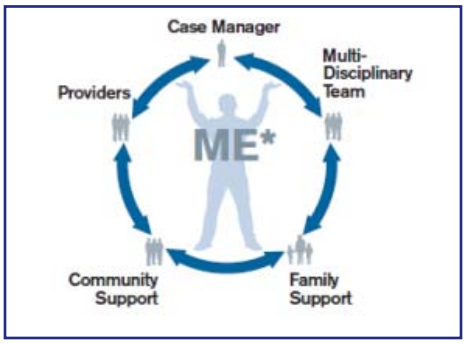
- Specialized case managers with focused areas of expertise including:
  - Licensed nurse case managers assigned to members with complex or unstable respiratory conditions including ventilator support
  - Licensed nurse or social worker case managers assigned to pediatric members
  - Bilingual case managers assigned to members with Spanish as their primary language
  - Licensed social workers assigned to members with complex BH needs
- Methods for supporting the member and the provider in establishing relationships that foster consistent timely interventions and ongoing understanding and adherence to the plan of care
- Collaboration with providers, including education on specific evidence-based guidelines, desired outcomes and monitoring/interventions to bring providers into compliance with practice guidelines
- Interventions with specific disease management programs founded on evidence-based guidelines
- Methodologies to evaluate the effectiveness of programs including education specifically related to the identified member's ability to self-manage their disease

Every case manager's goal is to help the member, family or caregiver learn more about their illness and chronic conditions, enabling them to better manage their own health and make their own decisions about how they receive care and maintain maximum independence. Our specialized case managers break down barriers to improve member outcomes using their extensive training and experience to increase member compliance with their medical care. For example, high risk case managers teach self-management skills, pediatric case managers participate in school-based education programs to develop individualized plans of care that include family and educational goals, bilingual case managers break down both cultural and health literacy barriers impacting the member's ability to make their own health care decisions and choices about how they receive services, and BH case managers address behavioral issues that are either the primary diagnosis or adversely affect the member's complex medical care plan. These case managers have reduced caseloads and have time to focus on the needs of complex care members.

Evercare Select's case managers and case review team ensures the special needs of these members are identified early and all care is coordinated appropriately with the goal of increased self-management, member choice, independence and improved health status.

23. Describe the Offeror's process for assessment and care planning of members for home-based…

The ALTCS program is viewed as a model across the country for managed long-term care Medicaid programs. One of its major successes is the number of members who are able to remain in a home or community-based setting as opposed to a nursing facility. Evercare Select's results are consistent with AHCCCS' overall results with over 65 percent of our members in these settings. Over 45 percent (of the 65 percent) of those members live at home. Evercare Select exceeds the overall HCBS targets set by AHCCCS both in our urban and rural GSAs. In Maricopa County, AHCCCS established a HCBS goal for Evercare Select of 61 percent and Evercare Select has achieved 64 percent HCBS placement, in spite of declining membership. Since the first year of the ALTCS program—when less than 10 percent of the ALTCS population resided in HCBS settings—to our current state of over 65 percent, Evercare Select is very proud of the impact we have in the lives of our members, allowing them to remain in the community.



Case management begins with a respect for the member and their family goals, preferences, interests, needs, cultural considerations, language and belief systems. Our care management philosophy centers around Member Empowerment (ME*): the premise that collaboration between the member and their family, formal and informal support systems and health care professionals results in the development of partnerships that promote more informed choices. Through this collaboration, we target our interventions more effectively to provide the appropriate health care and associated supports to promote keeping members in their communities and assisting those who would like to re-integrate back to the local community. In short, *our model helps people live healthier, higher quality lives.* Evercare Select has policies, training, strength-based member assessments, decision support tools and resources to assist our case managers to effectively develop a plan of care with the member/family that provides the opportunity for the member to live in the least restrictive environment of their choice, including their own home.

Assessment/Reassessment

Our care management capabilities are supported by CareOne, our proprietary clinical care management system solution that fully integrates seamlessly with our core operating systems. CareOne includes basic health and functional assessments and comprehensive supplemental assessments (disease-specific assessments such as diabetes), facilitates the development of integrated care plans, and includes ongoing monitoring/evaluation tools. CareOne maintains a global profile of the member's health record, facilitating a better understanding of our members' physical, behavioral and social needs. CareOne is the framework within which we share clinical information across clinical domains and departments and serves as the health plan's virtual medical record, tracking clinical information longitudinally. CareOne supports disease, care and utilization management for both physical and behavioral care.

We use initial assessments and subsequent reassessments to determine the member's current strengths, preferences and level of care needs. These assessments include determining unmet needs, identifying formal and informal support systems, and defining the member's health care-related goals, education, employment, housing and other personal goals of the member. For new members, a face-to-face visit is completed within 7 business days for ventilator-dependent members and within 12 business days for all other members. Our case managers typically see our members within one week of enrollment. If the case manager identifies during the outreach call completed within 7 days of enrollment or the member requires an urgent initial assessment, one is completed within 2 days. Assessments are completed at the primary residence of the member. The case manager completes face-to-face reassessment visits at least every 90 days for members in the home setting or the community including an assisted living facility (ALF) setting every 180 days for members in skilled nursing facilities, and at least annually for acute care only members. We also complete reassessments within two days of notification of a member's discharge from

the hospital and within ten business days of becoming aware of any the following situations: significant change in the member's circumstances such as living arrangement or informal supports, requests for increased services, decline in health status or change of placement setting. We also complete a face-to-face reassessment when the member, family or other representative, service provider or a community partner such as an Ombudsmen, Public Fiduciary or Adult Protective Services makes a request.

As part of the assessment process, the case manager completes both the AHCCCS' Uniform Assessment Tool (UAT) and our Member Functional Needs Assessment (2060 Tool) with the input of the member and their family. The UAT describes the level of independence a member has with their ADLs and identifies the acuity of the member's skilled needs, medical treatments and behavioral needs. The UAT is used to determine the authorized level of care for provider payment and for the completion of the room and board agreement. The 2060 Tool is completed for all home community-based members and for all facility-based members that desire community placement. The 2060 Tool is used to identify the member's informal supports and determine the appropriate allocation of time for tasks associated with the authorization of HCBS services. The accompanying 2060 Tool Task Hour Guide assists the case manager in determining the member's level of care need for specific tasks such as bathing, dressing and housekeeping. This is just a guide, as the case manager's decision about the type and quantity of services to authorize is made with input from the member and anyone else the member would like to be involved.

The member-focused Community Assessment, a **strength, preferences and needs assessment**, helps to determine members' physical, environmental, medical, behavioral and social needs. This assessment triggers supplemental assessments based on member responses, medical history, support, and individual strengths and needs. Members with conditions such as diabetes, cardiac disease, dementia and depression, for example, would trigger additional assessments tailored to their condition. The assessments provide guidelines related to chronic conditions/disease management best practice standards and links to additional support tools such as GlobeSmart, raising the case manager's awareness of potential cultural gaps. GlobeSmart aids in developing strategies to effectively bridge those gaps and gaps related to member supports required for positive health care outcomes, safety and social behavioral well being.

Other assessment tools include the Health Maintenance Assessment**,** which documents each member's choice and compliance with immunization schedules, and the Diagnostic Assessment, which is used to document laboratory testing and exams for members who need these services due to their health conditions. This information is collected so the case manager can assist the member with addressing their medical needs. The case manager also uses decision support tools that align with AHCCCS policy for authorization of services for ALF placements, home-delivered meals and emergency alert systems.

Evercare Select uses Re-Integration Readiness Assessments to assist in evaluating the potential for a member currently living in a nursing or ALF to transition back to a home community setting. Our Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment measures member abilities or resources available to meet the goal of discharge to and maintenance in a community setting (strengths); member abilities or conditions at risk for decline in a less restrictive setting, or resources with potential for collapse under strain (weaknesses); conditions appropriate to attain a goal including self-management of a disease or eligibility for programs such as housing or increased income (opportunities); and known conditions of the member or the anticipated living environment/arrangement that may place the member at risk (threats). The Independent Assessment Tool (IAT) is similar to the UAT. It identifies the member's levels of: independence with basic ADL needs (like the UAT) and length of time in the nursing or ALF, medical and behavioral health stability and current skilled treatment plan. The case manager uses these assessments to evaluate a member's potential for discharge. The tools help identify strengths, needs, barriers and existing formal/informal systems to support a member's transition back to the community.

Care Planning

Once all assessment are completed, a service plan is developed to address each member's functional

needs, medical conditions, behavioral health needs, social and environmental needs, keeping in mind the member's existing formal and informal support system of both natural and community resource supports. The case manager coordinates the service plan through collaboration with the member, their family, legally authorized representative, PCP, other professional and facility providers, non-ALTCS covered services and community resources. Our goal is to ensure the member has the essential services to maintain the highest level of self-sufficiency. Member education about available options is a critical factor in service plan development. The member is encouraged to exercise self-determination in their own care, as needs are identified, goals are set and the service plan is developed. Regardless of the member's residential placement, the case manager provides a comprehensive review and educates the member/representative on all ALTCS-approved settings and services such as respite care, attendant care and adult daycare available to them. The case manager discusses all direct care service options including traditional respite services, spousal and family caregiver options, Self-Directed Attendant Care (SDAC) programs, skilled service definitions, home care agencies, and informal caregivers for direct care service needs. The case manager provides the "Is it Right for You" brochure that provides information related to the SDAC option. Members are educated on the Community Transition service that provides resources to assist the nursing home placed member with setting up a new household in the community. The case manager works with the member to select the best option available to meet the member's specific needs.

For members in the community, a Cost Effectiveness Study (CES) is completed to demonstrate that residing in the community will not exceed the cost of living in a nursing facility. Case managers are required to have the member sign the acknowledgment form at each assessment or with any changes in the service plan. The form details the services the member wants and the frequency of services and evidence that the member agrees with the plan of care coordinated by the case manager.

The member and the case manager work together to **develop a Contingency Plan** to address how the member's needs will be met in the event the primary caregiver is not able to provide the care as scheduled. Education is provided to the member/representative regarding member rights and responsibilities, reporting of non-provision of services and specifying a member preference level to identify how quickly replacement services will be needed if the primary caregiver is not able to provide the regularly scheduled care. The Contingency Plan is reviewed and updated at each assessment and when there are any changes in the service plan. The case manager completes an evaluation that identifies any disaster preparedness needs for all members who reside in or plan to move to a home-based setting to identify their disaster preparedness needs. A Member Risk Agreement may be completed to implement appropriate methods of intervention if a member has behaviors or makes choices that may jeopardize the safety, health and well-being of themselves or others and impedes the provision of safe, effective and appropriate care or services. Risk agreements are used in all placement settings. The initial and ongoing planning process includes review of the member **Advanced Directive** status, member education regarding advanced care planning and provision of resources such as the "Five Wishes" booklet.

The member's assigned case manager works with a multi-disciplinary team familiar with their case that provides support and expertise as needed. The composition of this team is tailored to the member's needs and may change from time to time, as needs change. For instance, the team may include a behavioral health specialist and a nurse, and then if the member is hospitalized, a transition coach may join the team. The coach works with the hospital on discharges to ensure a smooth transition back to the community. Similarly, if a member is moving from a nursing home back to the community, we assign a re-integration specialist to work with the case manager, member and family to tailor the member's plan of care to provide necessary supports and overcome any obstacles for a successful move back to a home-based setting. The Medical Management team is part of the member's multi-disciplinary team. This team consists of Case Management Administrator, Francine Pechnik; Medical Director, Dr. Peterson; a Behavioral Health Coordinator; Pharmacy Director; Quality Director and others as needed. Our member-centered approach provides accessibility to needed services while promoting the values of dignity, choice, independence and individuality – making it all about our ME* culture.

Initial Interactions and Assessment

Based upon the initial member demographics and Pre-Admission Screening (PAS) information, Oscar is assigned to high-risk case manager, Gina Pawlaski, a licensed nurse with over nine years' experience serving physically disabled members. Gina's **initial interaction** with Oscar and the nursing facility is a call within seven business days of enrollment to confirm Oscar's enrollment and to identify urgent needs that require immediate action, including an expedited onsite visit. Gina schedules an onsite assessment visit at the nursing facility, coordinates any language service needs, and requests permission from Oscar to include April and other family members who may act as an advocate or who Oscar wants present at the assessment. If Gina identifies urgent needs, she schedules the onsite assessment within two days of initial contact; otherwise, the onsite assessment visit is completed within 12 business days of enrollment. Gina confirms the scheduled assessment with family members as directed by Oscar. Prior to the initial assessment and care plan development, Gina obtains and reviews Oscar's PAS, his nursing facility medical chart for information on his diagnosis, current medications and treatment orders, and reviews the Pre-Admission Screening and Resident Review (PASRR) and the Minimum Data Set (MDS) documentation at the nursing facility.

During **the initial onsite assessment**, Gina explains the Evercare Select ALTCS program and its benefits; enrollment; covered services and placement options; and Oscar's rights and responsibilities (including the process for filing a grievance/appeal). She provides a member handbook, reviews eligibility cards and provides Evercare Select and Gina's contact numbers. Gina obtains a signed statement from Oscar or his representative indicating the date they received the member rights in writing and acknowledging she provided a clear explanation. Gina assists Oscar and April with coordination benefits such as other medical insurance, including his homeowner's insurance, since it could be applicable due to the circumstances of the accident. She also reviews eligibility for and assists Oscar in obtaining any disability benefits for which he may be eligible including future Medicare benefits. Gina ensures Oscar understands she will provide assistance with coordination of benefits on his behalf.

Using a member-centered approach, Gina completes the Uniform Assessment Tool (UAT) to determine the appropriate level of care and face-to-face interaction, a systematic approach for assessing Oscar's strengths/needs related to his functional abilities, medical conditions, behavioral health, social/environmental/cultural factors and existing support systems. Gina uses motivational interviewing and observational skills to engage Oscar and his family. The automated community assessment tool in our CareOne case management software may trigger additional assessments based upon Oscar's responses to supplemental assessments such as Skin Integrity and the Depression Assessment. Gina, Oscar and his family develop goals to address identified care planning issues and discuss mutually agreeable services that best meet his needs. The service plan develops into a plan of care. Gina uses the **2060 Member Functional Needs Assessment** to determine the level of ADL/IADL care support Oscar requires when he returns home. Following the initial assessment, Gina obtains additional information from Oscar's treating physicians, therapists and nursing facility staff regarding his condition, progress, goals including barriers/challenges to greater independence. Within the assessment process, Gina consults with our Reintegration Specialist, Kyle Hammond, a social worker with over 10 years of ALTCS experience who will assist in Oscar's transition home.

Proposed Care Plan and Desired Outcomes

1. ***Identified Need*:** Oscar was recently placed in a nursing facility following a three-month hospital/rehab stay due to a debilitating injury and has expressed dissatisfaction with nursing facility services and staff. ***Plan***: Gina reviews Oscar's concerns regarding the nursing facility. If the concerns are related to quality of care, she immediately notifies Quality Management (QM) of the potential

quality of care issues for investigation. Gina discusses the immediate goals and placement alternatives with Oscar and the long-term goal of his return home with his family. Gina requests an interdisciplinary meeting to be held at the nursing facility with Oscar and his family, his PCP, therapists (physical and occupational), facility nursing, social services, nutritionist representatives, pharmacy consultant to discuss/develop short-term and long-term goals and treatment plans which become par of Oscar's care plan. Due to his age, recent disability and concerns about the frequency/amount of physical therapy, it is imperative Oscar receives proper therapies to regain as much functionality/motor skills as possible. If an alternative facility is better equipped to meet his specific needs, Gina presents alternative nursing facility placement options such as the East Mesa Care Center with a large younger disabled patient census or Plaza Healthcare with a strong rehabilitation program;. If the current nursing facility placement is agreed to be most appropriate, we develop a plan and schedule that allows Oscar to be active in the direction of his care and includes age appropriate activity options. Gina discusses the daily activities at the nursing facility with Oscar, ensuring his understanding of the differences in activities between a hospital, a rehabilitation center and a nursing facility. ***Desired Goal/Outcome:*** For his immediate needs, Oscar is placed in the least restrictive, most appropriate setting with an agreed upon schedule for treatment and services to his satisfaction

2. ***Identified Need:*** Oscar is frustrated and exhibits signs of agitation, anger, depression, bouts of forgetfulness and confusion. ***Plan:*** Gina requests a behavioral evaluation through Bayless and Associates to evaluate Oscar's recent behavioral changes. Gina also requests a medical evaluation through Oscar's PCP; this includes a medication review and an evaluation of Oscar's sleep disturbance. The psychologist and PCP take appropriate action based upon these evaluations. For example, if determined appropriate, Oscar's PCP may prescribe medication for depression. Based on the complexities of Oscar's care needs, Gina may request our Medical Director, Dr. Tim Peterson, and the multi-disciplinary team to conduct a review of Oscar's care needs. The recommendations of the team become part of the care planning process and may include Dr. Peterson contacting the PCP and specialists directly to coordinate clinical evaluations and care. In addition, Gina facilitates family and individual counseling for Oscar and his family through Jewish Family and Children Services to assist in the coping process related to Oscar's life-altering injury. Gina makes referrals for Oscar and his family to organizations like the Spinal Cord Association and ABIL for peer-mentor support. ***Desired Goal/Outcome:*** Oscar obtains the needed support to comprehend his current situation and his episodes of agitation, forgetfulness and confusion as identified by the nursing facility staff and his number of episodes decreases.

3. ***Identified Need:*** Oscar is having difficulties with his adaptive device for eating and maneuvering his custom wheelchair. ***Plan:*** Gina arranges for a complete evaluation with the physical and occupational therapists to specifically address Oscar's adaptive equipment and wheelchair maneuverability. She schedules a consult with a seating specialist to determine the adequacy of Oscar's wheelchair and the need for potential adjustments, additional wheelchair options and additional education and training on appropriate operation of the wheelchair. ***Desired Goal:*** To empower Oscar to be more self-sufficie**nt, satisfied with his ability to feed himself and independent, with improved wheelchair mobility.**

4. ***Identified Need:*** Oscar and April have expressed their desire for Oscar to return home in the future. ***Plan:*** Gina completes the 2060 Member Functional Needs Assessment in order to understand the level of ADL/IADL care support Oscar requires when he returns home. In completing the 2060 assessment, Gina discusses with Oscar, April and Oscar's brother the available formal and informal support systems. She reviews available home and community-based (HCBS) service options including Self-Directed Attendant Care and Spouses and family members as Paid Caregivers. Our Reintegration Specialist, Kyle, assists in addressing identified barriers to Oscar's successful reintegration to his home. Regardless of the service options chosen, specific goals and a plan are developed with Oscar and his family to meet his skilled (i.e., bowel care) and unskilled needs upon

returning home. The plan contains specific agreed upon milestones that must be achieved to enable Oscar's successful transition home, creating realistic goals and objectives for Oscar and his family. Oscar is offered a change in PCP to one experienced in treating spinal cord injuries. ***Desired Goal:*** With the appropriate formal and informal supports, Oscar is able to return to his family and home.

5. ***Identified Need:*** Request for more therapeutic home visits while Oscar remains in the nursing facility in order to prepare for Oscar's eventual homecoming. ***Plan:*** Gina coordinates with Oscar, April and family, PCP, nursing facility and therapists to develop a plan with specific goals and timeframes for additional therapeutic home visits. Gina coordinates all services required for the home visits. She also performs a home visit while Oscar is at home to assess the adequacy and level of services required in the home. The types and amount of services evaluated assist Gina in completing the Cost Effectiveness Study for Oscar's potential transition to home. ***Desired Goal/Outcome:*** Oscar and his family gain confidence in Oscar's ability to reside in the home with his family.

6. ***Identified Need:*** Accessibility barriers at Oscar's home. ***Plan:*** Gina arranges for the physical and occupational therapists to complete home evaluations to determine what home modifications are needed to ensure Oscar's successful transition home. The evaluations are conducted during a therapeutic visit when Oscar is home to observe Oscar's ability to function. The evaluation considers the necessity of wheelchair ramps, doorway widening, environmental safety and other DME and adaptive devices. Based upon Oscar's construction experience, he is given the opportunity to participate in the planning and oversight of the modifications. Kyle, the Reintegration Specialist, is also present at the evaluations to offer insight into available community supports. ***Desired Goal/Outcome:*** Oscar's home is deemed an appropriate environmental setting and Oscar receives the required environmental supports for his safe return home, maximizing his independence and participates in the planning of the home modifications.

7. ***Identified Need:*** April's concerns about full-time income needed to support Oscar and her family and the need for a wheelchair accessible van. ***Plan:*** Working together, Gina and Kyle review the available community supports including disability benefits, spouses as paid caregivers and other financial options with Oscar and April. They are also referred to agencies and community resources such as ABIL or the Spinal Cord Association to assist with the acquisition of a wheelchair-accessible van. Gina evaluates Oscar's desire to return to work through Evercare Select's Member Empowerment assessment. Based upon the outcome of the assessment and Oscar's experience, Gina refers Oscar to our Member Advocate, a new Evercare Select position responsible for assisting members with their transition into the work force. Working together, Gina and the Member Advocate provide Oscar the needed education regarding eligibility for SSI and SSDI cash programs, the Social Security Ticket-to-Work Program, the Mature Workers Program, and DES One Stop Employment Programs. The education details how these programs work and how to access the programs. ***Desired Goal/Outcome:*** Promoting independence and quality of life for Oscar in accessing employment (or volunteer) opportunities and community supports for needed resources including a wheelchair-accessible van.

Throughout this shared care plan development, Gina assists Oscar and his family to identify independent living goals and provide information about local resources that may help him transition to greater self-sufficiency in housing, education and employment. The final, collaborative care plan is presented to Oscar for his signature and a copy is provided to him for his records. Gina initiates all required referrals for services and ensures all new services are started. Care plan and placement information is updated in both CareOne and the CATS system within 10 business days of the date of action. Gina calls Oscar within 7 days of the initiation of services to verify his satisfaction. She continuously monitors Oscar's condition, assisting both Oscar and April to achieve the long-term goal of Oscar returning home. Gina reassesses Oscar and his progress with a formal reassessment in 90 days or upon notification of any change in his condition or service needs from his family or providers.

24 B. Case Management Scenario: Magda

Initial Interactions and Assessment

To ensure continuity when an Evercare Select member is transferred or assigned to a new case manager, the relinquishing case manager transfers the member's case file and reviews the member's demographic information, last three reassessments, cost effectiveness studies, placement history, service plans/authorizations, and other applicable information with the new case manager. Prior to completing Magda's reassessment, the new case manager, Viviana Rivera, a bilingual social worker with seven years of ALTCS experience and nine years of experience with a RHBA, reviews her case file and notes Magda's cultural background and language preference, living situation, current services, diagnoses, PCP and other specialists such as her nephrologist. Viviana **contacts Raquel** within 90 days of the last reassessment or as soon as a change in Magda's condition or service needs were identified, to arrange a time to **conduct a home visit with Magda**, Raquel and other family members advocates. Viviana requests permission to bring a dual headset telephone to connect with the AT&T language line, enabling Magda to communicate in her primary Romanian language.

During the **reassessment**, Viviana provides Magda and Raquel a card with direct contact numbers and information. The reassessment visit is an opportunity to learn about Magda's current strengths, needs and informal supports. Viviana reviews Magda's physical, behavioral, social and environmental needs, completing all applicable assessment tools, which capture all pertinent information. If Advanced Directives are not part of Magda's case file, Viviana provides educational materials and discusses them in a culturally appropriate manner. A copy of the "Five Wishes" pamphlet is given to Magda for review with her family that can also be made available in her native language. A direct care service plan that promotes independence and works to maintain Magda at her highest level of function is completed with the input of Magda and Raquel.

Proposed Care Plan and Desired Outcomes

1. ***Identified Need:*** Raquel requested an increase in attendant care hours. ***Plan:*** Using motivational interviewing, observation and critical-thinking skills, Viviana completes the 2060 Member Needs Assessment to determine the level of ADL/IADL care support required. The assessment gives Viviana insight into Raquel's request and Viviana asks Raquel her reasons for additional hours, including what tasks she feels the caregiver is not able to perform within the current authorized hours. Viviana provides additional education about covered services, explores the attendant caregiver tasks, and clarifies if services are addressing Magda's needs. Viviana reviews the frequency and amount of time it takes Magda to complete each task unassisted. She confirms the housekeeping and laundry time requested are only for Magda. Viviana explores informal supports available and their willingness to participate in Magda's care as well as their work and school schedules. Viviana explains the types of attendant care workers choices including family paid attendants and self-directed attendant care (SDAC). Other options to provide attendant care services under the self-directed attendant care model such as the son-in-law or a friend who speaks Romanian are reviewed. The SDAC option factors in Magda's level of dementia and her ability to self-direct or Raquel's guardianship status. Since the grandchildren are underage and cannot function as paid caregivers, other family members/friends are additional options for Magda. The need for home delivered meals or emergency alert services is evaluated. Viviana explains the Cost Effectiveness Study and the focus of providing services that allow Magda to remain at home without exceeding the cost of nursing home placement. If an agreement about the authorized hours is not reached after discussion of the 2060 tool results, Viviana reviews the results of the assessment with her manager prior to any decision to increase, decrease or deny the amount of authorized services. ***Desired Goal/Outcome:*** Magda is able to remain living with her daughter and her family with the appropriate support of attendant care and other HCBS services.

2. ***Identified Need:*** The attendant caregiver has not shown up on time and Raquel had to stay home from work until someone else could take over for her. ***Plan:*** Viviana discusses with Magda and Raquel how to report to the provider and Evercare Select any non-provision of critical services or gaps in delivery of those services, including the caregiver not showing up on time. Viviana reviews the original contingency plan with them that was developed when attendant care services were originally authorized and reviewed at the previous assessment. The contingency plan and preference levels may need to be updated to more accurately reflect how quickly any gap in care needs to be filled and by whom. Viviana stresses the importance of notifying her and the attendant care agency of any gaps in service delivery. The contingency plan has phone numbers for the service agency and Evercare Select that are answered 24 hours a day, ensuring the ability to arrange for a replacement caregiver as needed. ***Desired Goal/Outcome:*** Magda is able to receive all attendant care and other HCBS services as scheduled without experiencing any gaps in service.

3. ***Identified Need:*** Raquel has requested a change in PCP due to difficulty in making appointments. ***Plan:*** Viviana explores the PCP availability issues with Magda and Raquel. She offers to assist in scheduling an appointment or changing the PCP, possibly to a physician who speaks Romanian such as Dr. Sonia Giknavorian. During discussions, Viviana reminds Magda and Raquel of the importance of a consistent medical home with a physician who understands her chronic conditions. Due to the special care presented by Magda's diabetes and dialysis, Viviana discusses having Magda's nephrologist function as her PCP. Evercare Select has a Romanian-speaking nephrologist in our network, Dr. Valentin Zaharia, who can address Magda's chronic condition needs and her language and cultural issues. Upon Magda's approval and confirmation from Dr. Zaharia's to function as her PCP, Magda is reassigned. Viviana coordinates with the former PCP to ensure the transfer of medical records. ***Desired Goal/Outcome:*** Magda is reassigned and has an ongoing relationship with a PCP who is responsible for coordinating her health care services in a more culturally sensitive manner.

4. ***Identified Need:*** Magda is not always steady on her feet without guidance and has fallen a few times using her walker and fell in the shower last week. ***Plan:*** Viviana asks for details related to Magda's most recent fall. She explores the possibility of Magda being dehydrated, resulting in dizziness, and possibly missing required medications or meals. Magda's family is informed the paid caregiver can remind Magda to take her medications but cannot administer medications. If needed, Viviana can provide a medi-set with alarm reminders. QuickNote reference materials with educational information on diabetes care, the importance of nutrition, and end-stage renal disease are provided to Magda and Raquel. Based information provided, Viviana arranges for a medical evaluation by the new PCP and a physical therapy evaluation that includes guidance and training on the use of the walker and a home safety/DME needs assessment. Viviana arranges a visit to the FSAL caregiver house, providing Magda and caregivers with education and training on fall prevention. Since multiple prescribers are involved, Viviana makes a referral to our Pharmacy Director, Dr. Sandy Brownstein, to review of all medications. Dr. Brownstein looks for possible drug interactions and the use of sedating or anti-cholinergic medications that should be minimized for a person with dementia. ***Desired Goal/Outcome:*** Magda is compliant with her diet and medications, receives education on fall prevention strategies, remains ambulatory and has a reduction in the number of falls.

5. ***Identified Need:*** Magda was recently diagnosed with early stage dementia. ***Plan:*** Viviana checks with Magda's original PCP to determine if a neurological evaluation was completed. If Magda was not referred to a Memory Care specialist or neurologist for dementia evaluation and therapy, a referral is discussed with the new PCP. Viviana also provides additional educational material to Magda and her family regarding dementia, including expectations of disease progression. Viviana identifies community resources, including family support groups, such as the AZ Alzheimer Association and the Area Agency on Aging, which has special programs for non-English speaking seniors. Viviana provides education on Advanced Directives, Power of Attorney and Legal Guardianship. ***Desired Goal/Outcome:*** Magda's early stage dementia is addressed, enabling her to retain a high quality of

life for as long as possible. Magda's family also receives information and support needed to assist Magda with making decisions about her care as the disease progresses.

6. ***Identified Need:*** Magda indicates she misses getting out and going to church. ***Plan:*** Viviana discusses options for enhanced socialization through additional resources such as volunteers from Magda's church, support groups, local community services, respite caregiver, friends and family members who may be willing to assist. Viviana also suggests a day care center such as Sunflower Adult Day Care that serves the needs of diverse populations as an option. She encourages and assists setting up a tour at Sunflower Adult Day Care for Magda and her family. Viviana discusses Magda's desire to attend church and the stressors impacting the family. A congregational member who speaks Romanian may be willing to escort Magda to church services, allowing the family to worship independently. If a congregational member is not available, Magda's attendant or a respite attendant could escort Magda to church services. Evercare Select's Member Empowerment Resource Team assists Viviana to identify community supports such as peer-to-peer visitation service to enhance Magda's socialization. ***Desired Goal:*** Magda's socialization is increased and she is comforted to be able to continue to attend church without requiring assistance from Raquel.

7. ***Identified Need:*** Magda's daughter has asked about respite care on Sundays. ***Plan:*** With Magda living with her daughter's family, they may need respite services authorized intermittently or on a more routine basis. Viviana explores possible alternatives and advises Magda and her daughter that if respite is provided on a routine basis, it is calculated as part of the Cost Effectiveness Study, which may result in a reallocation of the services and their durations. Magda and her family, with Viviana's assistance, determine the best services combination to most appropriately meet Magda's needs and provide the family support. ***Desired Goal/Outcome:*** Magda is able to remain living with her daughter and her family while minimizing the stress of her family's caregiver responsibilities.

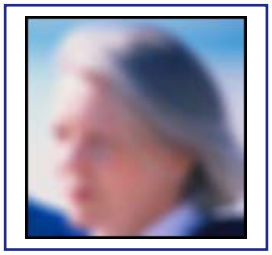
At the time of the assessment, Magda and Raquel are asked to sign the **Member/Guardian Acknowledgement** form. Viviana presents a revised member **Service Plan** with agreed upon services to Magda and Raquel for review/signature and ensures they understand their options to agree or disagree with the service plan. If they disagree, Viviana informs them about the appeal process and a Notice of Action letter is mailed within 14 days. Viviana completes the appropriate data entry including a Cost Effectiveness Study and Service Plan in the AHCCCS CATS system within 10 business days of the reassessment. She updates the placement and assessment date and all case notes in CareOne. Viviana calls Magda and her daughter within 7 days of the visit to confirm their satisfaction with services and to address any unresolved issues or concerns.

Vivian also notifies our Quality Management team and Provider Educator, Larry O'Connor, about the original PCP's appointment availability. Larry contacts the PCP's office to determine compliance with contractual appointment availability standards. Action is taken based upon the results. The QM team investigates the situation for potential quality of care issues and handles it according to established policies and procedures. Viviana contacts the attendant care agency regarding Magda's attendant care worker's tardiness and the agency's responsibilities regarding back up caregivers. Our Non-Provision of Critical Services (NPS) Coordinator, Joanne Helmer, researches any reported gaps in service and addresses them with the attendant care agency in accordance with AHCCCS and Evercare Select policies. The QM team may also investigate any gaps in service as a potential quality of care issue.

Since Viviana has already completed the assessment and identified differences in what she, the previous case manager and Raquel think is the right level of services, she staffed the case with her case management manager prior to decisions related to changes in the service plan. The case management manager reviewed the 2060 tool and additional member assessments with Viviana to determine how she made her decision regarding the quantity of formal services. If there appears to be issues with Viviana's use of the tool, the case management manager addresses discrepancies and provides individual education.

Initial Interactions and Assessment

Wanda has multiple, complex acute and chronic health challenges. Her recent hospitalization for falls and her diagnosis of pelvic cancer requires a complete reassessment of her needs and an updated service plan to meet those needs and takes into account her residence at an assisted living facility (ALF). Our High-risk Case Manager, Jean Pullen, a licensed nurse with over 20 years' experience with the elderly and physically disabled population, involves Wanda and her son (with her permission and consent) in this process and provides them with information on treatment and care options. Within two days of learning about Wanda's hospitalization and change in placement, Jean contacts Wanda, her son, and the ALF to complete an onsite reassessment at the ALF. Evercare Select's transition coach, Dawn Green, RN, is also present at the reassessment. Dawn's role is to provide specific member, provider and family education when a member is newly diagnosed with a chronic disease. Jean requests that Wanda's son bring copies of both Wanda's Advance Directives and Power of Attorney (POA). Jean discusses the circumstances related to his decision to move his mother into the ALF, her most recent falls and the resulting hospitalization. Jean reviews the Wanda's room and board obligations with the son and prepares a room and board agreement to for review by Wanda, her son and the provider during the reassessment visit. She discusses with the son the need for coordination with herself and Evercare Select related to Wanda's care and residential placement. Jean reminds the son of the member's rights and responsibilities that were reviewed with both Wanda and her son during the two previous home visits and ensures her son has copies of her card and has the Evercare Select 24-hour telephone number and Wanda's copy of the Member Handbook. Jean also checks with her son to see if he had any issues with HCBS services that were addressed with the contingency plan and the processes outlined with the plan for back up support.



Prior to the reassessment visit, Jean verifies if the ALF is a registered AHCCCS provider and contracted with Evercare Select. If the facility is an AHCCCS provider but not contracted with Evercare Select, Jean engages her case management manager, case management administrator, medical director and provider services manager to consider completing a Single Case Agreement for Wanda's placement. The provider services manager coordinates the execution of the agreement and delivery of new provider education. If the ALF has a contract with Evercare Select, Jean notifies the case manager assigned to that facility to provide education to the ALF staff regarding the requirement to notify Evercare Select when an Evercare Select member is admitted. The ALF is instructed to contact the Jean whenever there is a change of Wanda's condition including but not limited to any falls, an emergency room visit, hospitalizations and hospital discharges.

Since Wanda's PCP and specialists are not in Evercare Select's network, Jean requests that a Provider Relations representative verify that the providers are valid AHCCCS providers and contact their office to explain how to bill Evercare Select for Wanda's co-pays. If the PCP and specialists are not AHCCCS registered providers, Jean explains to Wanda and her son that Wanda is responsible for co-pays required through her Medicare Advantage Plan. In preparation for the scheduled visit, Jean obtains copies of the provider directory to provide to Wanda and her son in the event they choose to change Wanda's PCP to one that is in both networks.

Prior to the onsite reassessment, Jean contacts Wanda's PCP to determine the PCP's knowledge of Wanda's significant change in condition. In particular, they focus on her multiple falls and the sudden change in cognition; the discussions the PCP had with Wanda and her family regarding treatment options related to the diagnosis of pelvic cancer; what led to the discharge from the hospital back to the ALF (instead of a skilled nursing facility for rehabilitation); and any other relevant information including copies of medical records.

Jean and Dawn (the transition coach) meet with Wanda and her son at the ALF. Using a member-centered

approach and motivational interviewing skills, Jean completes the Uniform Assessment Tool (UAT). Using Evercare Select's automated assessment tools in our CareOne case management software system, Jean, with Wanda and her son's input, completes the Community Assessment, Health Maintenance Assessment, Diagnostic Assessment and supplemental Dementia Assessment and Mini-Mental State Exam tools in order to collect, assess and evaluate all information relating to Wanda's functional abilities; medical conditions including current medications and treatment orders; behavioral health; social/environmental/cultural factors; and existing support systems.

Proposed Care Plan and Desired Outcomes

1. ***Identified Need:*** Wanda needs to have the choice to live in the least restrictive, most appropriate setting to meet her extensive needs, as well as assistance in coordinating her Medicare and Medicaid benefits. ***Plan:*** Wanda has had a decrease in cognition and functional and medical status. Jean discusses both short- and long-term goals with Wanda and her family to better understand their needs and desires. Goals include not only Wanda's living arrangements, but also her cancer treatment options. Taking into consideration the particular beliefs Wanda and her family hold related to end of life issues, Jean identifies options of palliative and hospice care that are available. If agreeable with Wanda, a palliative care or hospice consult is requested by Jean. Placement options are reviewed with Wanda and her son that include: (1) placement in a skilled nursing facility with rehabilitation therapies; (2) palliative or hospice care options, both institutional and residential placements; (3) returning to the son's home with home and community-based support services; or (4) remaining in the ALF since the facility has agreed to continue her care and if it is found the ALF staff can meet Wanda's physical needs with or without additional services. Since the son transferred Wanda to the ALF without involving Jean, he may not be aware of the continuum of skilled and non-skilled home-based services available to support Wanda in his home. Based upon the assessment and significant changes in Wanda's condition (requiring near total care for ADLs), if Wanda intends to remain in the ALF, Jean completes and explains a Managed Risk Agreement between Wanda or her son as her representative and Evercare Select which identifies the risk associated with continued placement at the ALF. If Jean chooses a skilled nursing placement, Jean assists with the coordination of any Medicare benefits with Wanda's Medicare Advantage plan and provides information on Evercare Select contracted facilities. ***Desired Goal/Outcome:*** For Wanda to reside in the least restrictive, most appropriate setting to ensure all Wanda's care needs are met in accordance with her wishes.

2. ***Identified Need:*** Wanda was recently diagnosed and began treatment for pelvic cancer, while already having diagnoses of diabetes, peripheral neuropathy, hypertension and congestive heart failure. ***Plan:*** Due to the complexities of Wanda's multiple chronic conditions, Jean requests that Evercare Select Medical Director, Dr. Tim Peterson, and our multi-disciplinary team review Wanda's assessment and medical record information to assist in developing a comprehensive service plan. Dr. Peterson may directly contact the PCP and oncologist to clarify Wanda's diagnoses and treatment options. The Pharmacy Director, Dr. Sandy Brownstein, evaluates Wanda's medications for potential adverse interactions. The clinical information assists the team in determining service options and the need for any additional evaluations. For example, a behavioral health evaluation may be needed to evaluate Wanda's change in cognition or a physical therapy evaluation may be needed to evaluate Wanda's mobility. Jean discusses support systems available for both Wanda and her family. Referrals and information are provided to the Wellness Community, American Cancer Society and other community resources. ***Desired Goal/Outcome:*** Wanda and her family obtain the education and support to fully comprehend her disease state, treatment options and long-term prognosis to make informed and self-directed decisions about the type and amount of care services desired.

3. ***Identified Need:*** Wanda has experienced a sudden acute decline in her functional condition. She is now non-ambulatory, requires total assistance with her ADLs, is more confused and sometimes combative. ***Plan:*** Jean investigates Wanda's functional decline to help assess whether it is due to de-

conditioning and lack of rehabilitation after her falls, delirium, pain, dehydration or if a more extensive injury was sustained during the most recent fall. Since Wanda has also recently begun treatment for pelvic cancer. Jean in consultation with the PCP and Dr. Peterson assess the possibility that anemia, nausea/vomiting, dehydration, fatigue, and possible metastatic disease have exacerbated her risk for falls and confusion. Consideration is also given to sensory deficits such as impaired eyesight and peripheral neuropathy due to her diabetic condition, which could also be contributing to her falls. A physical therapy evaluation may be needed to determine Wanda's ability to use her walker correctly. Based on the assessments conducted by Jean and input from Dr. Peterson, either Jean or Dr. Peterson contacts her PCP to discuss the multiple changes of condition that have occurred and an appropriate care plan. Jean coordinates a follow up appointment for Wanda and ensures that all treating physicians/specialists in Wanda's Medicare Advantage Plan are communicating with one another and that there are no delays in authorization of services or treatment. Taking into consideration the particular beliefs Wanda and her family hold related to end of life issues, Jean identifies options of palliative and hospice care that are available. Jean discusses an advanced care plan, which includes discussions about treatment options Wanda has discussed with her PCP. Jean facilitates with the PCP the necessary referrals and physician orders for all applicable tests and services. Based upon the test results, Jean presents additional information and treatment options to Wanda and her son for consideration. ***Desired Goal/Outcome:*** The coordination between Wanda's treating physicians and specialists is increased, enhancing the care Wanda receives. Wanda's level of confusion and combativeness is reduced; her ability to participate with her ADLs and her ability to make choices about how she receives her care is restored to the highest level possible.

4. ***Identified Need:*** Wanda's son does not understand the role of the case manager. ***Plan:*** Jean explains her case manager role and responsibilities with Wanda's son. She discusses the circumstances related to his decision to move his mother into the ALF (her most recent falls and resulting hospitalization) and the need for coordination with herself and Evercare Select related to Wanda's service needs, care and residential placement. Jean reviews Wanda's rights and responsibilities and provides an additional copy of the member handbook. Jean ensures the son has copies of her business card and the Evercare Select 24-hour telephone number. Jean reminds the son to contact her any time Wanda has a change in condition, a newly identified need or if there is any problem coordinating services. ***Desired Goal/Outcome:*** Both Wanda and her son have an increased understanding of the importance of Jean's role to coordinate care and services, and Wanda's rights and responsibilities.

Additional Administrative Activities

In accordance with our established policies, Jean immediately notifies the Evercare Select Quality Management (QM) team upon receipt of notification of Wanda's fall at the ALF, which resulted in Wanda's hospitalization for investigation of potential quality of care issue. Jean also contacts the attendant care agency to inquire why Evercare Select was not notified of a discontinuation of service. This information is shared with the Evercare Select Non-Provision of Critical Services (NPS) Coordinator Joanne Helmer, and QM team for possible quality of care issues. Jean updates the authorization for attendant care services to reflect the appropriate end date of services and faxes it to the provider along with a request for copies of the attendant care worker's timesheet for the days that Wanda was hospitalized. Joanne reviews the timesheets and takes appropriate action as warranted including notification to the Compliance Officer for investigation. The attendant care agency is reminded of the need to inform Jean whenever changes in service occur to ensure the authorizations are correct.

Jean completes the appropriate assessment documentation and associated tasks in CareOne and the Client Assessment Tracking System (CATS) per AHCCCS and Evercare Select policies, including updating the Cost Effectiveness Study with the change in placement. The Placement in CATS is updated with the reassessment date. Jean calls Wanda or her son within seven days to verify their satisfaction with existing and new services, providing additional member/family education.

Initial Interactions and Assessment

Upon notification of Roger's enrollment with Evercare Select, the initial member demographics and Pre-Admission Screening (PAS) information is reviewed to determine case manager assignment. Based on this information, our high-risk behavioral health case manager, Rhonda Warner, a licensed BSW with 15 years of ALTCS experience, is assigned. Rhonda contacts Roger and his legal guardian, his sister Joyce, within seven business days of enrollment to confirm Roger's enrollment and to identify any urgent needs that require immediate action, including an expedited onsite visit. During this initial contact call, Rhonda schedules an appointment to meet Roger and Joyce in their home within the next two days due to information reported about Roger's escalating, aggressive behaviors. Prior to the appointment, Rhonda obtains and reviews Roger's PAS in addition to validating that Roger's PCP is an Evercare Select contracted provider, and identifies additional PCP options, including those specializing in treatment of TBI patients.

When completing **the initial onsite assessment**, Rhonda takes into account any cultural or religious considerations. She also explains the ALTCS program; explains enrollment with Evercare Select; provides a member handbook; reviews eligibility cards; explains all covered services and placement options; explains the Roger's rights and responsibilities (including the procedures for filing a grievance or appeal); provides Evercare Select and Rhonda's contact numbers; and obtains a signature from Roger or Joyce as legal guardian on a statement indicating the date they have received the member rights in writing and that they have been clearly explained. Rhonda also provides Roger and Joyce with information and assistance related to the coordination of benefits with other insurers including Medicare.

Using a member-centered approach, motivational interviewing and observations, Rhonda begins the assessment by asking Roger and Joyce for background information including any of Roger's past medical records and the names of his former treating physicians. Rhonda makes specific inquiries into the exact nature or events that led to Roger's head injury and Roger's lifestyle before the head injury or mental illness. In addition, she asks about the specific services Roger was receiving when he was living with his mother and which of those services he found the most beneficial. Copies of medical records from Roger's previous providers are requested by Rhonda. Additional inquiries are made regarding Roger's previous living arrangement and the death of their mother, providing Rhonda a better understanding of their grief.

Rhonda evaluates the ongoing formal and informal supports that Roger and Joyce currently need. With input from Roger and Joyce, Rhonda completes the following in-home assessments: Uniform Assessment Tool (UAT), the CareOne Community Assessment, Health Maintenance Assessment, Diagnostic Assessment, and all supplemental assessments triggered such as the Mini-Mental State Exam and Depression assessments. Rhonda uses the 2060 Member Functional Needs Assessment to determine the level of ADL/IADL care support Roger requires as well as the type and amount of HCBS services Roger needs to complement his informal supports. A part of all assessments includes discussing member Advanced Directive status and providing education about the importance of having an Advance Directive.

Due to Roger's complex needs, he requires continuous monitoring by Rhonda in order to achieve all goals set by Roger, his sister, Rhonda and involved providers. Rhonda develops an initial plan of care (to include services) with action plans to address both short and long-term goals. Goals may be redefined through time based on the feedback from Roger, Joyce and the providers involved in Roger's care. Rhonda sends quarterly coordination of care forms to the PCP and the behavioral health provider, detailing the behavioral health services provided and a complete medication list for Roger. This provides transparency and clinical information to enhance coordination of care between the behavioral health provider and the PCP.

Proposed Care Plan and Desired Outcomes

1. ***Identified Need:*** Roger's behaviors include: being resistive to care (refuses to bathe, change clothes and take medications); some verbal and physical aggression (uses profanity, throws objects and has taken a swing at Joyce twice since being in her care); fabrication (makes up stories about his past life and what others have done to or told him); and one recent attempt to leave home without supervision. ***Plan:*** Rhonda discusses the immediate need for an urgent referral to Liz Holmes, Psychiatric Nurse Practitioner with Bayless and Associates, for an evaluation, medication management and behavior management. His aggressive behaviors and elopement risks necessitate an urgent appointment. Rhonda assists with making the referral and ensures that an appointment is obtained within one day. If at any time during the assessment it became apparent to Rhonda that Roger needs more immediate attention or that his situation has rapidly deteriorated, she discusses this with Joyce and immediately calls the Evercare Select Behavioral Health Coordinator, Theresa Robben, LBSW, to discuss emergent outpatient evaluation or psychiatric inpatient treatment. If Joyce's guardianship does not include mental health powers, the process of how to pursue non-voluntary admissions needs to be addressed. Rhonda also asks what precipitated Roger's elopement and what immediate actions can be taken to ensure he does not elope again. Joyce is informed about local mobile crisis providers, such as Empact in Maricopa County, and how she can access them. Rhonda inquires if there are any triggers that Joyce and Roger can identify that precipitated his actions in order to prevent future aggressive behaviors. ***Desired Goal/Outcome:*** Roger's aggression and elopement risk is reduced and managed appropriately by a behavioral health specialist.

2. ***Identified Need:*** Joyce is struggling to manage Roger on her own despite having some training in behavior management. ***Plan:*** Until it can be determined if medication changes can help with his aggression, Joyce needs the immediate support of in-home behavioral health services such as a behavior management specialist and information about how to access the behavioral health crisis system. Rhonda discusses provider options with Roger and Joyce. A behavioral health provider is selected that offers in-home behavior management services, such as the MARC Center so that immediate help could start in the home to help with current aggression and lack of motivation. Rhonda requests this when making the referral for the urgent appointment. Additionally, a complete behavioral health evaluation and psychological testing, as appropriate, is requested by Rhonda to determine Roger's level of functioning, enabling the case manager to assist Roger and Joyce in selecting appropriate behavioral health services. Using cigarettes as a reward/punishment is a less than optimal approach, due to the obvious health concerns. Joyce and Roger are informed of smoking cessation programs such as the Arizona Smokers Hotline and the need to find other methods for rewards. The behavioral health provider also develops a behavior management program that does not rely on cigarettes. ***Desired Goal/Outcome:*** All treatable conditions such as depression and psychosis are evaluated and managed. In the short-term, Roger receives in-home behavior management services reducing his aggression and increasing his motivation and level of engagement. Roger receives the necessary treatments and services to stabilize his conditions and allow him to reside in the community with his sister. Long-term, Roger's aggressive outbursts are reduced and he increases his level of functioning. Cigarettes are no longer used as a reward or punishment as a part of Roger's behavioral management treatment plan and Roger has the option of a smoking cessation program.

3. ***Identified Need:*** Roger has seizures and occasional upper respiratory infections. ***Plan:*** Rhonda asks if Roger's PCP is aware of the frequency of the seizures and the respiratory infections, and if Roger had been referred to a neurologist for an evaluation. If these have not occurred, Rhonda contacts the PCP to arrange for an appointment and a possible referral to a neurologist. One of the first conditions to be treated is Roger's on-going seizures. With schizoaffective disorder and a traumatic brain injury, Roger's seizures could be secondary to the brain injury but might have preceded the brain injury. His medical history will be valuable to determine the date of onset of the seizures and any treatments that have been used to treat the seizures. Any knowledge of when and why the seizures frequency

increased is explored. The goal should be for Roger to be seizure-free with appropriate medical care. Due to the complexities of Roger's multiple conditions, Rhonda requests the Evercare Select Medical Director, Dr. Tim Peterson, and multi-disciplinary team including Theresa, the behavioral health coordinator, to review Roger's case and offer assistance in developing a comprehensive service plan. Dr. Peterson may contact the PCP directly about Roger's seizures and respiratory infections. Dr. Sandy Brownstein, the Pharmacy Director, evaluates Roger's medications for the possible identification of alternative medications to more appropriately control Roger's seizures. Rhonda asks when Roger last had his influenza and pneumovax vaccinations, and provides education and local resources so Roger can receive any necessary vaccinations. Control of Roger's seizure activity reduces the risk of aspiration and may lead to fewer respiratory infections. The case remains under the review of the multi-disciplinary team until the desired outcomes are achieved. ***Desired Goal/Outcome:*** The frequency of Roger's seizures and the number/frequency of upper respiratory infections are reduced.

4. ***Identified Need:*** Roger spends most of the day in his room without socialization. ***Plan:*** Roger is a young man who certainly has goals for his future. He says he is bored with nothing to do but watch television. Rhonda discusses with Roger and Joyce what types of day activities he is interested in experiencing. She provides a list of adult day health care centers including those in the area that have programs for persons with brain injuries and information about mental day programs such as Club Houses or other day habilitation programs. These provide Roger and Joyce with some day program options that can keep Roger active and moving toward more independence and lessen the boredom that may be increasing his aggression. Peer-mentoring programs, such as CHEEERS or Triple R, are additional options to help Roger explore goals and have regular socialization opportunities. Roger's needs cannot be easily met by any single set of services, as he has both a mental illness and a traumatic brain injury. It will take Roger, Joyce and Rhonda time to fully understand what types of long-term care services and community services can be best used to accomplish both his short- and long-range goals. Knowing what he wants, how he views his future and how Joyce views his needs is important to long-range planning. Evercare Select operates a **Member Empowerment Program (ME*)** that assists Rhonda with finding opportunities for Roger to keep active or pursue work opportunities. The ME* program is integrated into all of case management but is particularly important for Roger as it supports Rhonda with finding options for his long-range goals. This may include referrals to job program, therapeutic horseback riding or music programs, vocational rehabilitation, volunteer opportunities, community resources and benefit exploration. How Roger and Joyce view his future and the future of their family can be complemented by resources from the ME* program. ***Desired Goal/Outcome:*** Roger experiences an increased sense of empowerment through enhanced socialization and meaningful activities outside the home.

Additional Administrative Activities

Rhonda reviews and obtains Roger and Joyce's approval and any required signatures for the member acknowledgement form, the service plan, and disaster plans. She also reviews the contingency plan with the corresponding member preference level. Rhonda provides Joyce information about how to report a non-provision of services event and provide her with the envelopes for mailing to Evercare Select.

Following the assessment and development of the service plan, Rhonda completes a Cost Effectiveness Study prior to the initiation of services. She updates Roger's placement in the Client Assessment Tracking System (CATS) and the Evercare Select system. Rhonda reviews the plan of care with her manager and authorizes services that are initiated within 30 days or sooner based on Roger's identified needs. Further, Rhonda completes a follow up call within seven days of the visit to Roger and his authorized representative, Joyce, to assess satisfaction with the services provided.

Medical Management

25. Describe how utilization data is gathered, analyzed, and reported by the Offeror……

Evercare Select's process for gathering, analyzing and reporting utilization data is detailed in our response. We collect data including, but not limited to: claims data, prior authorization, and delegated entities from our health information system. We employ a systematic approach to the production of utilization information. Under the direction of our Medical Director, Dr. Tim Peterson, Evercare Select's medical management committees hold the primary responsibility for analyzing utilization data and our executive management team is accountable for monitoring and evaluating the utilization data.

Since the inception of the ALTCS program, Evercare Select has provided a comprehensive and compliant medical management/utilization management (MM/UM) program. This program ensures the provision of timely, appropriate, coordinated and cost-effective health care services to ALTCS members, driven by the desire to assure optimum health outcomes across the full continuum of care. Under the direction of our Medical Director, Dr. Tim Peterson, **our MM/UM program is a system-wide, integrated process in which data is systematically gathered internally** (such as claims data and prior authorization) and from delegated entities such as the pharmacy benefits manager (PBM). Data is analyzed to identify and develop interventions to address over- and under-utilization, ensuring that services are coordinated across the continuum from prevention to end-of-life care. The scope of services within the MM/UM program is comprehensive and includes, but is not limited to: pharmacy management, prior authorization and referrals, clinical practice guidelines, concurrent review, care coordination, monitoring of over- and under-utilization, new medical technologies and chronic care or disease management programs. Our philosophy and method is a holistic, cross-functional team approach to analyzing data and managing members through outreach, targeted discharge planning and disease/care management and by working closely with our members, their families, providers and community support systems. **All UM reports and activities are reported to our Healthcare Quality Utilization Management Subcommittee (HQUM), which is accountable to our Quality Management Committee (QMC).** Our Medical Director, Dr. Tim Peterson, is responsible for all MM/UM activities and chairs the HQUM and QMC. The QMC reports directly to our Board of Directors.

Data Gathering, Analysis, and Reporting

Evercare Select gathers utilization data from several sources including but not limited to: data from CareOne (our clinical case management database), our claims data, data from participating providers or delegated entities, and AHCCCS-supplied information. We collect, analyze, evaluate and report data. Reports generated on a regular, scheduled basis fall into the following general categories:

- ***Inpatient (IP) Utilization Data*:** Daily Admission Report (generates daily IP census), Daily Admission Extract (pulled monthly to create re-admission report), IP Data Extract (approved versus denied days compared to claims data for payment accuracy), Admits/1000, Days/1000, Average Length of Stay (ALOS), and other admissions statistics
- ***Outpatient Utilization Data*:** Emergency Room Visits, Physician Office Visits, Laboratory Utilization, Imaging Utilization, Immunization Rates (influenza and pneumonia)
- ***Home and Community Based Services (HCBS)*:** Durable Medical Equipment (DME), Attendant Care, Home Health Nursing, Home Delivered Meals, Emergency Response System, Transportation, Initiation of Services, Service Gaps
- ***Medication Utilization:*** Pharmacy costs by member/drug, Controlled Substance Use, Poly-pharmacy
- ***Nursing Facilities:*** Level of Care (LOC) by placement

Within Evercare Select, we have access to data contained in our Operational Data Store (ODS), CareOne, our clinical case management database, and our Strategic Management Analytic Reporting Tool,

(SMART). SMART provides extensive reporting capabilities for UM related to medical and behavioral health management and case management in our ALTCS population. SMART links with and receives data from CareOne to allow reporting on operational performance. Impact Pro®, a powerful claims-based predictive modeling tool, helps us identify our most at-risk members related to medical and behavioral health conditions and gives us the ability to coordinate care for Medicaid-only members and dual-eligible members who are enrolled in our Arizona Physicians IPA Dual Complete MA plan. We receive and share reporting capabilities with delegated entities such as Dental Benefit Providers (DBP), our dental management company and Rx Solutions, our PBM. Participating providers forward regular reports to Evercare Select that allows us to monitor performance and meet AHCCCS requirements (such as transportation data from Logisticare and Service Gap Logs from our attendant care service providers).

Our SMART database and its state-of-the-art reporting capabilities allow us to gather, analyze, evaluate and report data on a global basis or drilled down to a specific member or provider. We can report on dual versus non-dual eligible membership and on specific defined geographic areas at a sub-GSA level. With SMART, we have access to comparative cost data, cost trends, utilization data from both a lagging claims perspective and a leading authorization perspective, and profiling and predictive modeling capabilities. We can report on and track the timeliness of care plan completion and review by each of our case managers. We can do aging analysis on the time from enrollment to the initiation of HCBS services for our members. Also, we now have the ability to risk-stratify our HCBS population based on our functional assessments to predict relative risk of nursing home placement and customize our care plans to maintain the least restrictive HCBS placement and member independence for as long as possible.

The MM/UM committee (HQUM) has primary responsibility for analyzing data. Also, Evercare Select managers and directors from multiple departments receive, review, and analyze reports on a regular basis to ensure that appropriate care and services are being provided to our ALTCS members in a cost-effective and cost-efficient manner that meets their individual needs. Our Medical Director meets regularly with the QM Director (biweekly) and the CM Director (weekly) to review reports. Our UM process includes the evaluation and approval (or denial) of procedures, health care services, or settings based on appropriateness, efficacy, efficiency and medical necessity, incorporating prospective, concurrent, and retrospective review with case management to meet program objectives. All reporting, including our performance and trends, is reported to the MM/UM Committee (the monthly HQUM), the quarterly QMC, monthly operational meetings, executive management and ultimately our Board of Directors. **Our Medical Director, Dr. Tim Peterson, reviews the data and chairs both the HQUM and QMC.**

Upon identification of variances in our review and analysis of data, under the leadership of Dr. Peterson, **the MM/UM Committee develops an action plan to address the variances.** The action plans include steps necessary for monitoring utilization reports and creating strategies to address over- and under-utilization and disease management needs. Additionally, the action plans address performance gaps (actual results versus established goals set internally or by AHCCCS contractual requirements), communications between multiple departments, and working collaboratively with providers, members, Evercare Select staff and AHCCCS to achieve shared goals. Specific strategies may include:

- Creating metric-based scorecards to assist with evaluating data against AHCCCS standards, clinical criteria and internal performance standards
- Implementing daily rounds to analyze medical management reports and respond appropriately to urgent matters and trends
- Cultivating a culture of ownership amongst the multi-disciplinary team participants
- Improving automated standard reporting available through SMART
- Advanced care management interventions and outcomes reporting
- Coordinated Joint Operating Committee meetings with contracted providers to improve utilization outcomes.

Monitoring Under- and Over- Utilization for Members/ Providers

On an ongoing basis, our MM/UM Committee (HQUM) review and analyze data, interpret the variances, review outcomes, and develop or approve the interventions based on findings. Our regular review and analysis of data and reports is the first step in our process to detect and correct utilization variances (both over- and under-utilization) to Evercare Select targets and national standards. We also monitor under-utilization through care management, prevention and wellness using submitted claims, encounters, laboratory and pharmaceutical encounters. Reporting of our analysis within our various departments and to our multi-departmental committees is the next step in our process. We recruit the necessary and appropriate individuals to meet and develop a member- or provider-specific plan to correct the variance and monitor ongoing performance. Interventions include but are not limited to education, training, or further investigation such as case reviews. If our analysis identifies a systemic problem, we develop communication tools and education or training for our case managers to use during member interactions or to make available to our provider network in general. If the issue is broad enough, we incorporate the change in our member or provider manuals, in our member and provider newsletters, and post the information on our Evercare Select website. Reports are presented at the monthly MM/UM (HQUM) and quarterly QMC meetings where decisions on effectiveness and continuation of programs are addressed. Reports typically include a description of the variance, the intervention, responsible party, evaluation, and any further recommendations or modifications.

Care Opportunities

Evercare Select monitors care (including HCBS) utilization patterns, cost/expense variances and care gaps, analyzing data on a global basis and drilled down to a specific member or provider. We use Impact Pro®, our claims-based tool, to identify care opportunities that include potential medication interactions, compliance with clinical care guidelines, and recommended health screening customized for each member. Using this tool, we profile care opportunities by provider and by member. Review of this information by the case manager and by medical management leads to direct interactions with members and providers and is a powerful tool to address under-utilization, care opportunities, potentially harmful treatments or adverse medication interactions (Sample Report #1).

Pharmacy Management

Evercare Select analyzes overall pharmacy under- and over-utilization, trends and prescribing patterns and reports such as the *Top 100 Utilized Drugs by Frequency/Cost*, *Top 100 Members' Utilization*, *Top 100 Prescribers*, and therapeutic class reports. Drug utilization review is a systematic, ongoing review of the prescribing, dispensing and use of medications. This is done by Rx Solutions and our Pharmacy Director, Dr. Sandra Brownstein, to assure clinically appropriate, safe and cost-effective drug therapy to improve members' health status and quality of care. We evaluate information at both the member and provider level. Dr. Brownstein and our Medical Director, Dr. Peterson, meet to monitor and evaluate all pharmacy utilization reports and regularly report interventions (such as duplicate therapy and drug interactions) and improvement plans to appropriate committees and senior management (Sample Report #2).

Concurrent Inpatient Review

Our inpatient concurrent review process identifies and improves member and provider over-utilization by evaluating the appropriate use of resources and the medical necessity, including levels of care and service for institutional stays from admission to discharge. We review daily, weekly and monthly reports, and report our data and trends regularly to HQUM and QMC meetings. Inpatient admissions, length of stay, admission diagnoses, utilization patterns and discharge needs are compared to professionally recognized standards of care (Milliman) and other metrics to determine the overall success of the program. The daily census reports are also used to trend the inpatient admissions per 1000, days per 1000 and ALOS of members versus targets (Sample Report #3).

Utilization Management

Sample Report #1

Member Utilization and Care Opportunities

The HCBS Summary by Category report tracks and trends HCBS' per member per month (PMPM) costs and profiles the members, including identification of HCBS' high-cost utilizers. These Impact Pro® reports identify care opportunities and gaps in care that include potential medication interactions, compliance with clinical care guidelines, and recommended health screening customized for individual members.

PMPM	Month					
HCBS_CATEGORY	2009-01	2009-02	2009-03	2009-04	2009-05	2009-06
Adult Day Care	$ 9.18	$ 8.92	$ 10.07	$ 10.28	$ 9.08	$ 11.18
Adult Foster Care	$ 7.79	$ 7.42	$ 9.76	$ 8.95	$ 10.40	$ 9.94
Assistive Technology	$ -	$ -	$ -	$ -	$ -	$ -
Attendant Care	$ 520.02	$ 476.69	$ 530.18	$ 517.06	$ 520.65	$ 525.63
Case Management	$ -	$ -	$ -	$ -	$ -	$ -
Emergency Response	$ 3.39	$ 3.35	$ 3.50	$ 3.52	$ 3.50	$ 3.39
Habilitation	$ 18.11	$ 18.61	$ 21.31	$ 19.05	$ 26.34	$ 26.73
Grand Total	$ 938.13	$ 836.62	$ 954.50	$ 919.69	$ 932.11	

Clinical Indicators | **Care Opportunities** | Case Definitions | Care Alerts

Primary Condition	
Other Primary Condition	_AMC_GA_2 or more ER visits
OB & GYN	_Cervical Cancer Screening, no evidence of
Chronic Kidney Disease	_Chronic renal failure, no evidence of annual provider visit
Hypertension	_HTN, no evidence of annual physician visit

Care Opportunities and Gaps by Member

HCBS Top Utilizers by Cost

	MEDICAID ID	MEMBER NAME	Year	Amount Paid
1	A########	Member	2010	$ 177,441.34
2	A########	Member	2010	$ 128,147.67
3	A########	Member	2010	$ 113,383.90
4	A########	Member	2010	$ 113,018.66
5	A########	Member	2010	$ 110,703.86
6	A########	Member	2010	$ 102,089.63
7	A########	Member	2010	$ 95,418.98
8	A########	Member	2010	$ 92,052.42
9	A########	Member	2010	$ 91,414.25
10	A########	Member	2010	$ 90,976.28
11	A########	Member	2010	$ 90,955.71
12	A########	Member	2010	$ 90,244.24
13	A########	Member	2010	$ 89,925.55
14	A########	Member	2010	$ 87,682.89
15	A########	Member	2010	$ 85,837.68

HCBS Costs by Member

Care Gaps and Opportunities by Provider

Age	Months Enrolled	Future Risk, Costs	Future Costs	Future Risk, Inpatient	Inpatient Stay Probability
53	12	69.41	$205,730	32.37	90.0 %
61	12	23.12	$68,540	25.70	71.4 %
63	12	22.38	$66,320	32.37	90.0 %
62	8	18.59	$55,100	8.37	23.3 %

Utilization Management

Sample Report #2

Pharmacy Utilization and Trend Reports

This report allows Evercare Select to identify potential variances in pharmacy usage and potential pharmacy cost-saving opportunities. This report is produced on a monthly or an ad hoc basis and used as part of case reviews and pharmacy initiatives such as the Plavix® Proton Pump Inhibitor (PPI) intervention.

Medication Review Evercare Select Only
April Data

Total members = 473
Utilizing Members = 422

Total Reviewed = 422
Total Recommendations = 336
Members with no Recommendations = 207

Recommendation type	# recommendations	Potential Cost Savings
Initiatives	78	$9,187.97
Duplicate Therapy	19	$3,522.00
Drug / Drug	**8**	**$1,325.75**
Beer's Criteria Drugs	5	$136.24
Brand / Generic	17	$4,437.98
Dosing	3	$677.21
Indication	8	$664.00
Total	**138**	**$19,951.15**

Pharmacy Spend Breakdown April results:	
Member count	474
utilizing member Ct	427
Rx # 3996	3996
Amount paid	$269,726.34
PMPM april	$569.00
%Generic	78.18%

High Cost Drug Class	# recommendations	Cost paid now
Antipsychotics	61	$34,950.24
Pain	18	$14,071.00
Xopenex	9	$3,499.25
Misc medications	67	$64,350.08
Total	**155**	**$116,744.73**

Breakdown by Cost per member

<$1000.00 / mo	337
>$1000.00/mo	85
of those 85:	
$1000.00 -1999.00	55
$2000.00 - 2999.00	16
$3000.00 - 3999.00	8
$4000.00- 4999.00	3
>$5000.00	3

Breakdown by Age under 18

33 children under 18	
<$1000.00 / mo	23
$1000.00- 1999.00	4
$2000.00 - 2999.00	4
$3000.00 - 3999.00	1
>$5000.00	1

Definitions for the recommendations:
Initiative: These are defined initiatives such as Lipitor to generic product, Lexapro to Citalopram, PPI's to Omeprazole and actonel to Alandronate
Drug / Drug: The plavix / PPI drug drug recommendation
Duplicate therapy: Any 2 medications from the same class contributing to excessive polypharmacy
Beer's Criteria Drugs: This focused on propoxyphene N APAP
Dosing: If there is question about the appropriate dosing for a member
Indication: If there is question about an indication and if there is an indication to continue

High cost medications: (Separate from the other recommendations). These are all indiviualized and they were reviewed to see if there is a less costly product. These products many not have substitutes but were reviewed to make sure they are appropriate.

By Intervention (Plavix and PPI)

ID #	Last Name	April Rxs (#)	April Rxs ($)	Recommendation	Drug
1111	Member 1	15	$528.90	drug/drug interaction	Protonix/plavix
2222	Member 2	12	$384.11	drug/drug interaction	Plavix/omeprazole
3333	Member 3	12	$701.81	drug/drug interaction	Plavix/omeprazole
4444	Member 4	12	$780.88	drug/drug interaction	Nexium/plavix
5555	Member 5	13	$408.39	drug/drug interaction	Lansoprazole and plavix
6666	Member 6	14	$409.87	drug/drug interaction	Lansoprazole/ Plavix
7777	Member 7	38	$1,060.34	drug/drug interaction	Plavix / pantoprazole
8888	Member 8	9	$667.32	drug/drug interaction	Lansoprazole and Plavix

By Member

ID #	Last Name	Age	April Rxs (#)	April Rxs ($)	Recommendation	Drug	Cost savings
11111	Member 1	32	27	$1,220.63	Initiative	Actonel	$94.00
11111	Member 1	32	27	$1,220.63	Dosing	pantoprazole BID	$173.79
11111	Member 1	32	27	$1,220.63	Duplicate therapy	pantoprazole /Ranitidine	$173.79
11111	Member 1	32	27	$1,220.63	High cost	Xopenex	$470.20

Utilization Management

Sample Report #3

Inpatient Trend Reports

The report is a month-to-date and year-over-year summary of total inpatient activity by county and by member category. The report allows Evercare Select to analyze trends in admission rates, days/1000 and admits/1000. Strategies are developed for short stays and readmissions. Based upon the analysis, a drill-down by provider is used to identify potential over- and under-utilization.

Admission Rates

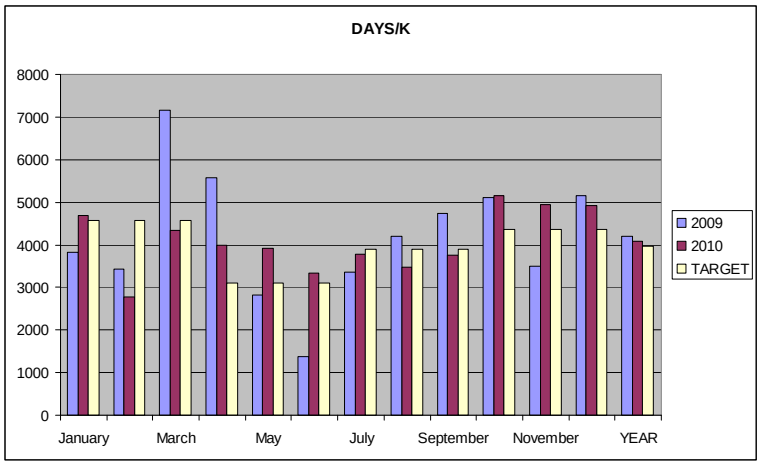
EVERCARE SELECT NON-DUAL MARICOPA ADMISSIONS

	January	February	March	April	May	June	July	August	September	October	November	December	YEAR
2009	15	11	32	20	13	11	13	21	19	17	16	20	208
2010	16	14	15	18	12	14	19	15	15	14	15	17	184

Days/1000

EVERCARE SELECT NON-DUAL MARICOPA DAYS/K 2010 TARGET = 3982

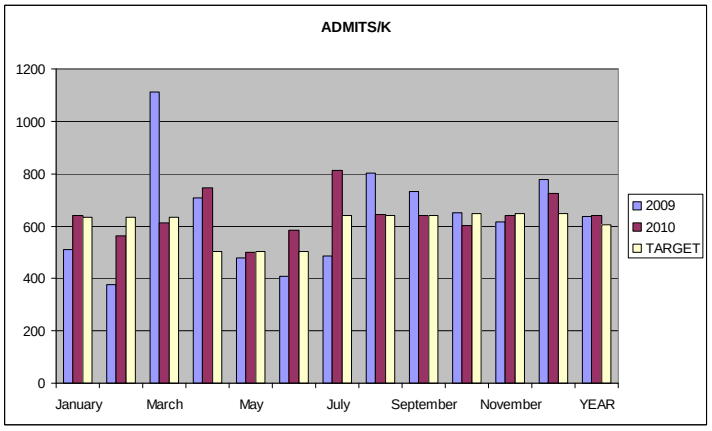
	January	February	March	April	May	June	July	August	September	October	November	December	YEAR
2009	3818	3427	7165	5577	2826	1370	3354	4204	4731	5099	3500	5143	4192
2010	4680	2769	4341	3986	3917	3345	3771	3484	3758	5161	4954	4911	4085
TARGET	4563	4563	4563	3095	3095	3095	3892	3892	3892	4352	4352	4352	3976



Admits/ 1000

EVERCARE SELECT NON-DUAL MARICOPA ADMITS/K 2010 TARGET = 606

	January	February	March	April	May	June	July	August	September	October	November	December	YEAR
2009	511	377	1113	706	477	407	485	803	731	652	615	779	637
2010	640	562	614	747	500	585	814	645	641	602	641	726	642
TARGET	634	634	634	504	504	504	639	639	639	648	648	648	606



26. Provide an example of how the Offeror's analysis of data resulted in successful interventions…..

Evercare Select monitors and evaluates utilization data for the purpose of interpreting variances and reviewing outcomes and development of interventions to ensure the provision of timely, appropriate, coordinated and cost-effective health care services to ALTCS members. The **decision to implement an intervention is based on the significance of the problem to our plan** and our membership, and occurs after a root-cause analysis determines which **intervention is a reasonable and logical** solution to the identified problem. We **evaluate the intervention for effectiveness and modify it as necessary**. Under the direction of our Medical Director, Dr. Tim Peterson, all of our medical management reports are monitored daily by our MM/UM staff with weekly and **monthly summary reports delivered and reviewed by our Healthcare Quality Utilization Management (HQUM) Committee**. The HQUM, chaired by Dr. Peterson and attended by cross-functional representation of the health plan, is accountable to the Quality Management Committee, Evercare Select's overall quality management governing body. The QMC reports to the Evercare Select Board of Directors. During our regular assessments and monitoring of our various medical, utilization and pharmaceutical reports, we have identified unfavorable trends or metrics that are not meeting performance expectations. When these unfavorable utilization patterns are identified, we explore strategies to address these performances and discover the most effective way to better meet the needs of our membership. Below we have provided the results of executed interventions addressing unfavorable utilization patterns related to transportation costs, as well as a medication safety concern.

Examples - Altering Unfavorable Utilization Patterns

Rising Non-Emergent Transportation Cost Intervention and Resolution

Through the regular gathering and analysis of financial data, Evercare Select's senior management identified a potential problem with rising non-emergent transportation costs that were significant to our plan. We performed an analysis of our costs with local and national unit cost and utilization benchmarks and trends. We learned that our non-emergent transportation costs exceeded expected expenditures. To determine the root cause of these higher expenses, we performed additional analysis of our transportation expenditures by procedure and modifier codes, mileage, geographic service area, administrative controls (such as prior authorization and service validation) and acuity, such as stretcher, wheelchair and car service (see tables below).

Non-Emergent Transportation Cost Analysis (All Procedure Codes/Modifiers)			
Procedure Description	***Code***	***Procedure Description***	***Code***
Advanced Life Support 1	A0426	Per Mile Social Worker	S0215
Ambulatory Van Per Mile	A0428	Stretcher Van Per Mile	A0160
Basic Life Support	A0425	Transport Wait Time	T2007
Ground Mileage	A0120	Transportation Taxi	A0100
Mountain Transportation	T2005	Wheelchair Van	A0130
Non-emergency Transportation	T2049	Wheelchair Van Mileage	S0209
Non-emergency Transport Per Mile Volunteer	A0090		

Additionally, we conducted an interdepartmental evaluation of our transportation services that included interviewing Case Management and Utilization Management staff members and examining provider grievance, quality of care concerns and administrative processes. The analysis and evaluation were reviewed by our medication management (MM) team and in the Healthcare Quality and Utilization Management (HQUM) Committee.

Findings and Interventions

We concluded that both our **unit costs** and **utilization patterns** (we had a disproportionate share of members being transported by the most expensive methods, such as by stretcher from rural areas) were contributing to our trend variances. The multi-departmental team engaged one of our transportation providers with a specialty managing transportation for this population to develop a corrective action plan that included: (1) establishing administrative guidelines for appropriate use of higher cost transportation, such as stretcher and wheelchair van transports; (2) contracting with a new provider and negotiating lower unit costs; (3) modifying the reimbursement structure to align our partnership; and (4) working with the provider for six months to monitor the utilization patterns. Interventions were communicated to staff, providers and members prior to implementation. A member communication plan was implemented since this was a new provider. We established a Joint Operations Committee (JOC) with the transportation provider to continue to monitor unit costs, utilization patterns, and any member concerns.

Monitoring, Measuring and Modifications

To ensure our implementations were producing positive results, we monitored our progress post-implementation. As part of continuous improvement using the PDSA cycle—(1) Plan, (2) Do, (3) Study, and (4) Act—Evercare Select monitored and measured the effectiveness of the initial interventions and made modifications including but not limited to:

- ***The approval criteria and administrative coverage*:** Review of the data demonstrated that our new provider was not providing transportation for our members to Member/Provider Advisory Council meetings, since it was not related to medical necessity. We believe that participation is critical to success for member engagement so we elected to provide this service. We modified the approval criteria and negotiated the coverage of these transportation services through our administrative process with funding from our retained earnings.
- ***Reimbursement rate and contract period definition*:** The contract allowed us to reevaluate the utilization and capitation rate based upon two three-month period intervals. Evercare Select measured utilization and cost for a three-month period, and based on the information, revised the capitation rate. We then measured another three-month period, revised the rate again and modified the contract.

Results

The interventions implemented successfully altered our unfavorable utilization patterns. We saved $10 PMPM for this service, our utilization changed to the most appropriate type of transportation for the member, and most importantly, our member grievances related to transportation services went down. As shown in the table below, our non-emergent transportation costs have decreased consistently year after year since implementing the interventions.

Non-Emergent Transportation PMPM Cost Analysis Percent Change (All Procedure Codes/Modifiers Paid for Claims Date of Service July-November 2008)				
All Procedures	***2007-08***	***2008-09***	***2008-10***	***2008-11***
PMPM Total Costs Percent Change	**6%**	**-7%**	**-15%**	**-11%**

Ongoing Monitoring of Performance

With oversight by our Medical Director, Dr. Tim Peterson, our Medical Management Coordinator, Linda Morse, and the HQUM (MM/UM Committee), we continue to monitor the transportation utilization, cost data and grievances to ensure that we maintain the desired results.

Medication Management (Plavix® and PPI) Intervention and Resolution

Based on a pharmaceutical literature review of potential complications/risk factors tied to the combined use of Plavix and PPI, and an analysis of Evercare Select members' utilization of Plavix and PPI, we developed and implemented an intervention to address a potential medication safety concern (drug-drug interaction). Clopidogrel, marketed as Plavix, is an antiplatelet drug that is used to prevent blood clots that could lead to heart attacks or strokes in patients at risk for these problems. One class of drugs commonly used with Plavix includes proton pump inhibitors (PPIs). Some reports suggest that use of certain PPIs may make Plavix less effective.

While the number of members involved in our study was small, this is significant to our plan due to the catastrophic personal and family effect of stroke or heart attack as well as the significant increased costs in providing medical and rehabilitative care for even a single stroke or heart attack. The Food and Drug Administration (FDA) recommends that patients inform their providers if they are taking both medications.

Findings and Interventions

Our Pharmacy Director, Dr. Sandra Brownstein, identified 21 members who were prescribed both Plavix and a PPI, and contacted our Medical Director, Dr. Tim Peterson, the assigned case managers, and the primary care provider to inform them of the situation, including the FDA's recommendations. Providers responded with their action plan or discussion of risk/benefit of continuing therapy.

Results

The initiative was evaluated for effectiveness. Prescribers had modified therapy for 71 percent of members (15). Dr. Brownstein is following up with those providers where the member remains on both medications and includes this intervention as part of the ongoing medication management monitoring.

Results of Medication Management Intervention: Patients taking both Plavix and a Proton Pump Inhibitor (PPI)						
Findings	***Discontinued Use of PPI***	***Discontinued Use of Plavix***	***Discontinued Both Plavix and PPI***	***Remained on Both Plavix and PPI***	***Other****	***Total***
Number of Members	11	2	2	4	2	21

* Data not available

Ongoing Monitoring of Performance

Dr. Brownstein continues to monitor the study population periodically for Plavix/PPI prescribing in the same member. Ongoing education is provided as necessary. Our most recent review indicated that no members are currently prescribed both Plavix and a PPI. We conclude that our directed education and general awareness regarding this drug-drug interaction has achieved and maintained the desired results.

27. Describe existing or planned Chronic Care/Disease Management programs…..

Evercare Select has over 22 years of experience effectively serving the high-risk complex needs of our ALTCS members. Our overall management of care approach takes into account the holistic health status of the complex needs of our members, inclusive of their disease/chronic conditions. Within this holistic approach, case management addresses each disease/chronic condition of our members through plans of care. Our Medical Director, Dr. Tim Peterson, leads our medical management (MM) team, providing support to our case managers in developing plans of care to meet our members' medical, psychosocial and behavioral health (BH) needs. This support includes continuous staff training/education and disease-specific programs that guide case managers in identifying, monitoring, educating and reporting member progress towards self-management of chronic conditions. With the recent addition of INSPIRIS to the UnitedHealth Group family of companies, our case managers are supported by our community-based providers including physicians and nurse practitioners focused on providing care where the members live, whether in facilities or their own homes. These clinicians will provide focused interventions based upon their personal observations. Selection of specific disease management programs is based on a strategic evaluation of **disease burdens or the financial impact to our plan** and our ability to **impact targeted members' health status.** Our chronic care/disease programs include member assistance, provider support/intervention and program evaluation. Annually, Evercare Select begins the development cycle to refine and improve our chronic care/disease management programs.

We adopt and **distribute evidence-based practice guidelines** to providers, monitor provider compliance with evidence-based practice guidelines, and when necessary, intervene with individual providers when noncompliance with guidelines is identified. Defined **measurable outcomes** are used in the evaluation of the program and outcome measures **influence modifications** to the program when necessary.

Existing Chronic Care/Disease Management Programs

Our chronic care/disease management approach integrates member-centered case management to ensure seamless, cost-effective delivery of quality care. Prevalent chronic conditions in our ALTCS population include chronic kidney disease, congestive heart failure (CHF), coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), dementia, depression and diabetes. Our members typically have more than one chronic illness—73 percent of members identified with depression have other chronic illnesses and 33.6 percent of diabetic members have a BH diagnosis (see table below for diabetes).

Chronic Disease Summaries: Percent Diabetes (Type II) Co-Morbid Condition Distribution With and Without Behavioral Health Diagnosis For Dates of Service Ended 09/30/2010		
Evercare Select members diagnosed with diabetes mellitus (DM)		24.4 %
Percent of DM members with at least one behavioral health (BH) diagnosis		33.6%
Co-Morbid Condition Distribution of Members With DM	***No BH Diagnosis***	***BH Diagnosis***
DM with Hypertension	32.6%	10.9%
DM with Class 3 Cardiac Conditions (CHF/CAD/etc.)	44.4%	14.8%
DM with Class 4 /5 Renal Disease (Chronic Renal Failure / ESRD)	20.4%	5.2%
DM with Class 3 Cardiac and Class 4 Renal Disease	13.2%	3.2%
DM with Class 3 Cardiac and Class 5 Pulmonary Disease (COPD)	11.0%	4.6%

Since 100 percent of our ALTCS members are case-managed, it is truly a "one member at a time" management approach to chronic care and disease management incorporating the management of conditions such as diabetes, CHF and BH into the overall management of the care for our members. **These programs allow for early detection and intervention for our members with chronic diseases.** Our chronic/disease management process is comprehensive and begins with an immediate health/disease

specific assessment of the member available in our CareOne system, such as Chronic Substance Abuse, Dementia, Respiratory, CHF, Depression, HIV/AIDS, CAD, Diabetes and End Stage Renal Disease.CareOne, our proprietary care/case/disease management system, recommends care interventions for each of these disease specific programs, generating a unique set of recommendations for the specifc co-morbidities of each member. The case manager develops a plan of care and educates the member and their health care team about services, treatment options and community resources. Our goal is to help the member better manage his/her own health. The case manager contacts care providers and **coordinates care across payors if the member is dually eligible or other Third-Party Liability** exists. Our chronic care/disease program includes: (1) members at risk or already experiencing poor health outcomes due to their disease burden; (2) use of ***Quick Notes*** **or other AHCCCS-approved educational** materials to facilitate member self-management; (3) **interventions** founded on **evidence-based guidelines**; (4) **provider education** regarding the specific evidence-based guidelines and desired outcomes that are disseminated to providers **via the Evercare Select website**; (5) Medical director/provider discussions regarding application of clinical guidelines to a specific member; and (6) methodologies to **evaluate the effectiveness of programs.**

Diabetes Mellitus Disease Management Program

Evercare Select case management identified 24 percent of ALTCS members with diabetes mellitus (DM) as an active diagnosis on their problem list. To improve the overall care of our diabetic members, an educational session was held for all case managers, provided by Dr. Peterson, trainer Angela Farley, and external subject matter experts. Topics focused on the difference between Type 1 and Type 2 DM, and DM management including medications and lifestyle change, co-morbid conditions, preventive medications, frequency of laboratory testing, the significance of laboratory values and frequency of primary care provider (PCP) visits for management. The session stressed more frequent PCP visits and HgbA1c testing until appropriate control is achieved. We provided handouts such as AHCCCS-approved *Quick Notes* for member education, and links to nationally accepted websites were provided to enable case managers to customize their discussions and educational approach with members. This approach provides **member-specific education on self-management,** and **customized tools to support** the member in **self-management.** Case managers monitor member compliance with obtaining diabetic screenings such as dilated retinal exams, lipid panels and HbA1c tests. Case managers may facilitate screenings, such as scheduling screenings at the member's residence. Our high-risk case manager (HRCM) monitors diabetic screening compliance for all our members, reviews the results obtained for diabetic screenings, identifies members that have out of range results and verifies that the member's PCP has the results. Our HRCM follows up with the member within two weeks to determine if the member's PCP made any changes to the member's medication, diet or other medical care. If there is a change, the diabetic screening is repeated in three months. The case manager coordinates appointments with the PCP and facilitates the exchange of clinical information. Our HRCM tracks all diabetic members for compliance with screening tests, response to interventions, medical stability, education effectiveness and acute utilization patterns. We **measure and report** to **diabetic indicators**, such as HbA1c testing, lipid measurement, and dilated retinal exams to AHCCCS. **Our scores improved** when compared to the initial quarter (see table below). We continue to monitor for sustained improvement and modify our program as necessary based on these and other outcomes measures.

Diabetes Care Performance Measures	*Initial Quarter Results (%)*	*Post Initiative Quarter Results (%)*	*AHCCCS Minimum Standard (%)*	*Met or Exceeded CYE 2010 Minimum Standard*
HbA1c Testing	71.2%	85.0%	80.0%	Yes
Lipid Profiles	63.0%	77.0%	72.0%	Yes
Retinal Exams	51.2%	58.0%	60.0%	97% of target

Congestive Heart Failure Self-Management Support

In 2010, congestive heart failure (CHF) exceeded $39 billion in health care, medication and lost productivity costs according to the Center for Disease Control (CDC). CHF, a prevalent condition in our population (18 percent), most often represents the end-stage of cardiac disease with 50 percent of those diagnosed with CHF dying within five years and 20 percent dying within one year of diagnosis according to the CDC. The impact of CHF is even more significant in the ALTCS population; our members often have co-morbid conditions that lessen their reserve capacity and their ability to participate fully in lifestyle changes necessary for optimum management. Evercare Select implemented a disease management program for members diagnosed with CHF called the *HomMed Genesis Telemonitoring Program* in 2005 continuing until 2010. While we were able to demonstrate modest improvement in re-hospitalization rates among members with CHF, the equipment was not as effective as we expected. Literature began to show that telemonitoring programs did not improve outcomes. This point was made in an article in the *New England Journal of Medicine* entitled "Telemonitoring in Patients with Heart Failure" (N Engl J Med 2010; 363:2301-2309). We revised and improved our CHF program to provide a more member-centered and cost-effective approach. We have a licensed nurse (HRCM) who assists the case manager by conducting telephonic outreach and onsite assessments of members diagnosed with CHF. The HRCM evaluates the member using the *Heart Failure Supplemental Assessment* in CareOne to address symptoms, medications, weight and lifestyle. Our goal is to **help the member better manage their own health;** the plan of care incorporates **self-management**. The member is **coached and supported** in the development of a **personalized tracking tool** for self-care metrics, such as weight, diet, medication compliance, exercise and communication with physicians. Dr. Peterson and our Pharmacy Director, Dr. Sandra Brownstein, provide additional clinical support through our case review process.

Future Chronic/Disease Management Programs and Initiatives

Our existing BH disease management program manages members' BH conditions. We are planning to implement an additional BH disease management program to improve overall health care outcomes in members with a specific BH diagnosis and an associated chronic medical condition. Literature has shown that health care costs for individuals with a BH diagnosis and an associated chronic medical condition are 50 to 75 percent higher than for those without BH challenges. Morbidity and mortality are also significantly higher for these individuals. Our program will provide education and support for our members, including community integration, self-image enhancement, work and employment opportunities, tools to increase adherence to medication regimens, and follow-up appointments with behavioral and medical providers. Members will be followed by a nurse case manager and a social worker case manager. A customized care plan will be developed in conjunction with our personnel, BH provider and the member's PCP for each enrolled member that addresses all behavioral and clinical needs. Medication refills will be monitored by our Dr. Brownstein and feedback provided to the case manager for near real-time intervention to improve medication adherence. Follow-up appointments will be facilitated. Outcomes measured will be percent of medication adherence and of follow-up appointments scheduled and kept per care plan requirements.

We plan to use MedMeasures, an NCQA-certified HEDIS software package, to ensure our HEDIS metrics are measured consistently and accurately (third quarter CYE 2011). The system will allow us to generate provider and member-level outreach reports for practices and PCPs.

Data Analysis to Improve Member Outcomes

Our chronic care/disease management program and includes: inpatient, outpatient, drug utilization, diabetic screenings results, member compliance with prescribed medical care regimens, initiation of services, service gaps and changes in placement (HCBS vs. nursing facilities). **Impact Pro®** identifies our most at-risk members related to medical and BH conditions. Case management review improves interactions with members and providers for care gaps, potentially harmful treatments or adverse medication interactions. Clinical analyses and trends are reported to Quality Management Committee.

28. Describe the process used by the Offeror for the adoption and dissemination of clinical…..

Evercare Select uses medical necessity determinations based on nationally and locally recognized standards of care. Our staff members that make medical necessity determinations have the appropriate clinical training and experience. As necessary, we consult with requesting providers when making determinations. We collaborate with facilities on the development of members' discharge plans. To ensure we consistently apply clinical criteria, we routinely and effectively use our inter-rater process.

For more than 20 years, Evercare Select has used evidenced-based guidelines to monitor and improve the quality of care provided by participating providers. We use multiple approaches to disseminate clinical criteria to our providers and staff. Our Medical Management/Utilization Management (MM/UM) process includes the evaluation and approval (or denial) of procedures, health care services, or settings based on appropriateness, efficacy, efficiency and medical necessity. Evercare Select uses multiple methods to ensure consistent application of disseminated clinical criteria including training, decision support tools, and an inter-rater reliability assessment process for all MM staff participating in utilization review processes (such as prior authorization (PA), concurrent review and retrospective reviews).

Clinical Criteria Adoption and Dissemination

Evercare Select adopts adult, adolescent, pediatric, and maternal preventive health and clinical practice guidelines that are reviewed at least annually and approved by the UnitedHealth Group's National Medical Technology Assessment Committee (MTAC). The MTAC evaluates guidelines from the most current and reasonable medical evidence available, including but not limited to: the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention, and specialty organizations. The MTAC information is monitored and reviewed by our Medical Director, Dr. Tim Peterson, Quality Management team and Provider Advisory Subcommittee (PAS). Evercare Select adopts MTAC-approved guidelines through PAS. We currently use the **following nationally and locally recognized criteria:**

- *Milliman Care Guidelines, Inpatient Surgical Care, 14th edition*. This is used for admission requests, length of stay, level of care, inpatient quality of care guidelines, and primary versus specialist care.
- *Milliman Care Guidelines, Ambulatory Care, 14th edition.* This is used to determine medical necessity and appropriateness of elective admissions, surgery, diagnostic testing and rehabilitative services.
- *Milliman Care Guidelines, Recovery Facility, 14th edition*. This is used to determine appropriate level of care for rehabilitation services following an acute care stay.
- *Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Database.* This is used to determine what is covered by Medicare for dual-eligible members.
- *Hayes, Inc. Health Technology Assessment Company*. An industry leader in providing evidence-based health technology assessment reports for new, emerging health technologies.
- *AHCCCS Medical Policy Manual (AMPM)*
- *Children's Rehabilitative Services (CRS) Policy and Procedure Manual*
- UnitedHealth Group guidelines that are based on nationally recognized criteria.

We develop and adopt clinical guidelines using current medical literature, peer reviewed publications and local community standards of medical practice. We share clinical guidelines with providers via our provider manual, provider newsletter and provider portal. We participate in AHCCCS or other organizational workgroups to develop evidence-based guidelines and provide input regarding AHCCCS policy changes. When nationally generated criteria are not available, we develop/generate health plan criteria, protocols or guidelines to incorporate current developments in clinical practice. Our Healthcare Quality and Utilization Management subcommittee (HQUM) review services that require PA annually. HQUM reports to the Quality Management Committee (QMC) and ultimately our Board of Directors.

Evercare Select analyzes utilization reports based on claims/encounter data, with established thresholds

for over- and under-utilization of services, to identify services that will benefit from clarification related to consistent application of clinical criteria. We also review grievances, fraud and abuse activity, new AHCCCS policies and clinical outcomes trends as for the development of clinical criteria. New technology and new uses of existing technology requests are tracked to evaluate the need for the development of new policies. Dr. Peterson reviews each of these requests, notifies AHCCCS and provides research and an assessment as applicable. All new technology requests or evaluations are presented to our HQUM and QMC at least quarterly.

Clinical Criteria Dissemination to Ensure Consistent Application

Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating providers. Our UM process includes the evaluation and approval (or denial) of procedures, health care services, or settings based on appropriateness, efficacy, efficiency and medical necessity. Providers, including internal Evercare Select providers, are educated about clinical practice guidelines via the Provider Newsletter, the Provider Manual, the provider portal (www.uhconline.com), the Evercare Select website, at advisory councils, and upon request. Evercare Select monitors and ensures 100 percent of the guidelines are posted and updated as needed.

We provide structured employee **orientation and training for clinical reviewers at all levels.** We train our clinical staff in the appropriate components and processes of medical or UM. Also, our Behavioral Health Coordinator, Theresa Robben, LBSW, provides annual and new employee training to case management staff regarding: 1) how to identify behavioral health (BH) needs; 2) the quarterly review consultation process; 3) crisis services; 4) high acuity services; 5) how to manage difficult situations in skilled nursing centers and assisted living homes; 6) medication management; 7) covered BH benefit; 8) Court Ordered Mental Health Treatment; 9) coordination of care between the primary care and BH providers; and 10) disease processes related to major mental illnesses.

Evercare Select's case management department uses several decision support tools (DSTs) to drive consistency in member service plan decisions made by the case managers when they are completing both initial assessments and reassessments of our members. Examples of the decision support tools include the functional assessment (2060 tool), the ALTCS Universal Assessment Tool (UAT), the emergency alert system DST and the home-delivered meals DST. The department's policies guide the case manager in the use of these tools. Theses policies outline step-by-step procedure/instruction in the completion of the tools to ensure case manager consistency in the completion of the tools that aide them in determining the member's need for a specific formal or informal service.

Prior Authorization (PA) Process

Evercare Select has Arizona-licensed, PA-trained staff (e.g., nurses, pharmacists, physicians, behavioral specialists) who apply our medical criteria for appropriate medical, pharmacy and dental decisions. Processes are in place to monitor and ensure all members, including those with special health care needs, have direct access to care; ensure consistent application of review criteria for decisions requiring authorization and confer with the requesting provider as needed (such as if additional information is necessary for a determination). Only Dr. Peterson issues denials. There is prompt notification to the requesting provider and the member authorized representative or Medical Power of Attorney, as applicable, of any decision to deny, limit or discontinue authorization of services. We follow AHCCCS guidelines in issuing Notice of Action (NOA) letters for all denials. PA management reports are produced to ensure timeliness of requests and review of NOA letters for appropriateness, completeness and accuracy. We conduct periodic PA audits to ensure consistent application of criteria and IRR.

Inpatient Concurrent Review

Our process evaluates the **appropriate use of resources and the medical necessity, including levels of care and service,** for institutional stays from admission through discharge, including collaboration with facilities on the development of members' discharge plans**.** We review daily, weekly and monthly reports,

and report our data and trends regularly to the HQUM and QMC. Inpatient admissions, length of stay, admission diagnoses, utilization patterns and discharge needs are compared to professionally recognized standards of care (Milliman) and other metrics to determine overall success of the program.

Behavioral Health Retrospective Review

Evercare Select adheres to AHCCCS-mandated BH requirements, conducting three types of BH reviews: (1) quarterly; (2) annual retrospective; and (3) pediatric reviews to help identify member treatment needs and system issues that may affect access to care. Member issues are resolved with the case manager and system issues are presented to the BH Coordinator, Theresa Robben, LBSW, for resolution. We use retrospective reviews as a tool to do IRR on BH coding and case record documentation requirements. We send any issues identified with coding or documentation to the case manager for correction. A licensed BH professional reviews, with the case manager, member stability, the appropriateness of the member's plan of care, all BH services, medications and member placement. The BH professional completes an annual retrospective review of a sample of members that have a BH code of A or F to review the accuracy of the member's BH code. Member's who have Code A status (members on psychotropic medications) are reviewed to ensure they have documentation that supports their condition is stable. Members with Code F are reviewed to ensure that there are truly no BH services in place, and if there is any indication that BH treatment may be needed, the case manager has discussed the issue with the member or representative and offered appropriate BH services. The annual review is completed for all pediatric members, regardless of behavioral code, to identify any issues that may be addressed with BH treatment or provide the case manager with information on how to help the family understand BH treatment options.

Inter-Rater Reliability (IRR) Assessment Process

To assure the consistency with which individuals involved in clinical decision making **apply standardized criteria for utilization/medical necessity decisions** concerning PA, concurrent review and retrospective review, **all MM staff participate in utilization review processes including the IRR assessment process**. Evercare Select meets the annual AHCCCS and NCQA requirement that managed care organizations conduct periodic IRR assessments to ensure consistency in MM decision-making for all clinical staff, up to and including Dr. Peterson. Our UM Supervisor, Julaine Sheridan, is responsible for tracking and trending the outcomes of the IRR assessments. The IRR Annual Tests (Inpatient and Surgical Care, Ambulatory Care, and Recovery Facility Care) is the method that we use to demonstrate individual medical necessity reviewer proficiency in the application of Milliman Care Guidelines. We administer the assessments online. Dr. Peterson and Ms. Sheridan began standard online testing with the Milliman Care Guidelines. Prior to that time, the Ms. Sheridan developed and administered IRR tests. The examinations are scored on an individual basis, with a passing score being 90 percent or above. Results are shared with the individual to address learning needs. Failure to meet target compliance goals may result in more frequent testing or other corrective actions that may include but are not limited to individual or group counseling, education, and re-testing. The result of corrective actions are documented in the IRR Assessment report and shared with the individual and their supervisor. The examination questions are scored for a group average; scores below 70 percent are discussed with the group for consistent interpretation of questions. Average scores are shared with the work group to examine variation among decision outcomes and reach a mutual consensus on the application of criteria and process. Ms. Sheridan uses the Sarbanes-Oxley and Quality Audit Tool criteria (SOX) to audit concurrent review nurses who make certification decisions for inpatient services monthly. The SOX audit addresses inpatient review management, application of Milliman criteria and discharge planning. Scores must be a minimum of 90 percent to pass. Individual SOX audit scores are sent to the review nurse for evaluation and discussed as needed. Overall scores are reported to the HQUM and QMC. Our SOX audit scores for the last fifteen months have averaged 95 percent or higher.

Quality Management

29. Describe how the Offeror identifies quality improvement opportunities…..

Since the inception of the ALTCS program, Evercare Select's quality management (QM) program has assessed our delivery systems and addressing the ALTCS members' concerns while optimizing our members' health outcomes and managing costs. Our current QM program adheres to ALTCS program requirements and has been reviewed and approved by AHCCCS. We strive to maintain a culture in which quality improvement (QI) is integrated into every aspect of our operations. Incorporating continuous QI concepts, our QM program is established to monitor, evaluate and improve the continuity, quality, accessibility and availability of health care and services provided to Evercare Select members. Our QM team works **in cooperation with other functional areas** such as case management (CM), medical management (MM), provider services , pharmacy, member services and operations to proactively identify **clinical and non-clinical** QI activities. Identification of improvement activities is based on **data analysis and member and provider input**. QI is based on **evidenced-based literature**. Interventions are **reasonably and logically** developed and address the **root causes** of identified issues and **barriers to the problem**. We evaluate the **effectiveness** of our interventions through the analysis of **statistical significance** of rate changes, comparison to national **benchmarks**, inter-departmental **feedback** and using the **PDSA cycle:** (1) Plan, (2) Do, (3) Study, and (4) Act. Processes and programs are continuously examined, improved and re-examined to look for opportunities for additional improvement.

The Board of Directors is the governing body of Evercare Select and has ultimate responsibility for the QM program and related processes and activities. The board performs an annual review of the QM Program Description and QM Work Plan, evaluates the prior year's QM activities and other reports and information. The board has delegated the Quality Management Committee (QMC) responsibility for the implementation, coordination and integration of all QI activities. Our Medical Director, Dr. Tim Peterson, chairs the QMC. QMC members include: Chief Executive Officer Karen Brach; QM Coordinator Myra Kingsley; CM Administrator Francine Pechnik; Provider Services Manager Larry O'Connor; Operations Director Helen Bronski; Compliance Officer Kelly Kreiselmeier (formerly Kelly Morken); QM analysts and case managers as needed. Dr. Peterson oversees the QM program, providing direction and continuous oversight for all QI activities related to the unique needs of ALTCS members and providers.

Quality Improvement Opportunity Identification and Selection

Ms. Kingsley tracks and trends AHCCCS mandated performance measures and function-specific quality indicators, such as behavioral health (BH) coordination, validation of quality, delivery and appropriateness of services and utilization patterns. We have work plans to address AHCCCS requirements and support our QM/performance improvement goals, such as (1) improving diabetic screenings, (2) prompt initiation of home and community-based services (HCBS) for elderly/physically disabled members, (3) inappropriate refusal of influenza vaccine and (4) increasing provider communication regarding and member execution of advance directives. On at least a monthly basis, work plan actions, interventions and trend reports are presented to the Healthcare Quality and Utilization Management Subcommittee (HQUM) for review, evaluation of actions taken, and recommendations for further actions – which are reviewed quarterly by the QMC. Other sources we use to identify QI opportunities include: external feedback from key stakeholders, such as members/families, providers, AHCCCS, other community agencies, information received through member and provider advisory groups and internal feedback such as case managers, member services, operations including grievances and appeals, and our quality subcommittees.

QI opportunities, identified through analysis and trending of data over time, are analyzed to determine the appropriateness of the development of a formalized QI project. Evercare Select initiates Performance Improvement Projects (PIPs) to **address issues** that impact groups of providers/members or require

restructuring of current operational processes. Via this assessment, our QM team – working with other Evercare Select teams – evaluates the **significance** to our members including: (1) the prevalence of the condition or need (for example, local community or statewide, all providers or certain specialists); (2) impact on members, such as effect on health outcomes and health risks); (3) member demographic characteristics; and (4) the interest of members, providers and AHCCCS, in the aspect of care or services to be addressed. Upon identification of a QI opportunity, a multi-departmental team, dependent upon the nature of the PIP, is assigned to the project. The team develops an action plan to bring our performance up to the desired goal using the **PDSA cycle**. Through these steps, we assess the quality of services we and our contracted providers deliver through CM disease management and utilization management activities, member satisfaction surveys, grievances and quality of care concerns. Based on our assessment of data from these sources, we plan PIPs and develop methodologies and work plans to implement PIPs. We than evaluate the results of all of our QI activities including PIPs. This is an ongoing process and each step feeds into the next. Evercare Select QMC has oversight of all potential QI initiatives reviews, approves all PIPs and oversees the ongoing strategic direction and progress of the PIP. In addition, all proposed PIPs (along with all required reporting) are submitted to AHCCCS for review and approval.

As an example of identification of a QI project, through analysis of pharmacy data and utilization over time, we determined that almost two-thirds (63 percent) of our membership has a BH component. Literature has shown that health care costs for individuals with a BH diagnosis and an associated chronic medical condition are 50-75 percent higher, and morbidity and mortality are significantly higher than for individuals without BHchallenges. A multi-departmental team including our QM, MM, CM and Provider Services departments is working on an action plan to identify system barriers to movement to lower levels of BH care and to improve communication regarding the clinical status of members in BH treatment.

Implementation of Interventions to Improve Care and Services

Prior to developing interventions, our QM team researches, when appropriate, the experience of other health care organizations or states and conducts a literature review to identify best practices or successful solutions to the issue being addressed through the PIP. The interventions chosen are member and provider focused with outcomes resulting in significant demonstrable improvement over time. We choose evidenced-based interventions that are directly related to identified **causes and barriers**. The selected interventions involve multiple departments within the health plan to assure successful implementation. Examples of previous interventions implemented include:

- ***Provider Interventions*:** 1) dissemination of educational information about advanced directives (ADs), involving participation by QM, CM and Provider Services staff and 2) education and feedback to providers on diabetic screenings, ADs and influenza through provider newsletters, direct mailings and advisory council meetings involving CM and PS staff.
- ***Member Interventions*:** 1) tracking of advance directive status in case member assessment tool and medical record audits, involving CM, QM and MM staff and 2) member education programs for disease management (diabetes, congestive heart failure and influenza) involving QM, CM, MM, pharmacy, and member services staff.

Implementation of selected interventions may involve partnerships with external agencies, such as developing a partnership with a provider group to facilitate the delivery of immunizations to our members located in home and community-based locations. Our QMC, which includes cross-functional membership, reviews and approves all proposed interventions. Our QM team develops work plans to implement recommended interventions with specific timelines. Successful implementation requires commitment of time and resources of multiple departments in the development, data gathering, implementation of interventions and evaluation for QI. Action plans document new or enhanced interventions for implementation to improve performance, including evidence-based practices that have been shown to be effective. Staff members responsible for realizing and overseeing the interventions with specific timeframes for implementation are included in the action plan. The team identifies the means for

measuring the results of new/enhanced interventions and the results of the analysis are reported to our QM committees. Interventions are refined based upon what is learned from different approaches or activities. This process is repeated until the desired results are achieved. Interventions are tracked and outcomes are captured and continuously monitored to ensure sustainability.

Evaluating Multi-departmental Intervention Effectiveness

A key component of our QI projects or PIPs is the ongoing evaluation of the effectiveness of the interventions through the analysis of established performance measures. Our PIP **methodology** includes a data analysis plan for the systematic, ongoing collection and analysis of accurate, valid and reliable data. For each PIP, a baseline measure of performance is established with ongoing re-measurement in order to demonstrate real and sustained improvement over time. Performance indicators and monitoring activities for QI projects are objective, measurable and based on national benchmarks or historical data; they are designed to improve outcomes while remaining member and provider focused. For each PIP we develop, specific levels of performance are defined prior to implementation. The goal of each QI activity is to result in statistically significant demonstrable improvement, sustained over time, for the performance being measured. We consider a project to have demonstrated improvement when the performance meets or exceeds projected levels of performance. We consider a project to have sustained improvement when the project maintains or increases the improvements in performance for at least one year after the improvement in performance is first achieved. Throughout PIP implementation, we measure and document how the improvement occurred due to the improvement project and its intervention. All clinical quality and service delivery improvement activities are reported to the QMC, which meets quarterly. If expected results are not obtained, the process is further analyzed to determine the reason and alternative interventions are identified, and implemented as part of the PIP.

Example–Advanced Directive (AD) PIP

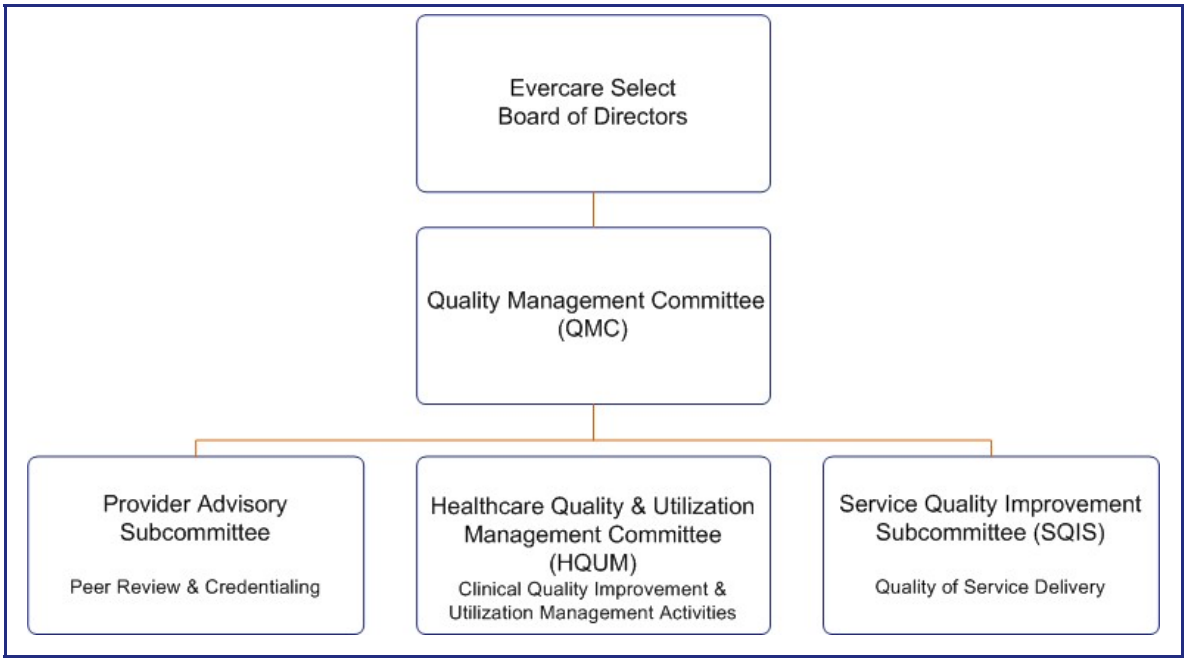
ADs ensure that ALTCS members receive care consistent with their values and belief systems. We spare members inappropriate interventions and help them to maintain their dignity through the dying process. AHCCCS requires that contracted health plans provide written information about ADs to members and ensure that their contracted providers give such information to patients. Baseline contract year for this PIP project was in 2007. There were 356 members included in the sample selected by AHCCCS. Analysis of the data indicated that 44 percent of the members had an AD in their medical record. As part of the PIP, a cross-functional team researched the literature and identified and implemented multi-departmental interventions including (1) collecting AD documentation and issuing letters to providers whose HCBS members lacked documentation or refusal; (2) CM addressing ADs upon enrollment and at each subsequent reassessment; (3) QM auditing evidence of AD documentation in the medical record; and (4) providing AD educational information in member/provider newsletters and in advisory council updates. After implementing the interventions, an analysis showed that 62 percent of the members had an AD on file as compared to the baseline measurement of 44 percent (see table below).

Count and Percent of Members with Advance Directives Re-measurement and Percent Change from Baseline				
Number of Members in Sample (n)	***Number of Members with Advanced Directives***	***Percent of Members with Advance Directives***	***Relative Percent Change from Previous Year***	***Statistical Significance***
342	212	62.0%	39.7%	**p<.001**

The most significant increase was in the HCBS members with a 32 percent increase as a result of the initiatives related to AD education and reminders to providers whose members did not have an AD on file or evidence of AD documentation. We continue to monitor performance. Through CM initial and scheduled re-assessments, case managers obtain AD information. This information is reviewed and analyzed by QM quarterly with results reported to HQUM for review, recommendation and subsequent follow-up and reporting to QMC.

30. Describe how the Peer Review Committee is structured and utilized by the Offeror…..

Peer review is an integral component of the Evercare Select's Quality Management (QM) program and is used to analyze and address quality of care (QOC) issues. The scope of Evercare Select's peer review process includes cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or services, by a participating or non-participating health care professional or provider. Peer review is the mechanism used to review suspected substandard or inappropriate care or inappropriate professional behavior by a provider while providing care to an Evercare Select member. If investigation findings indicate that a provider has potentially provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, the case is referred to the **Provider Advisory Subcommittee (PAS)** for peer review by our Medical Director, Dr. Tim Peterson. Our PAS performs peer review activities, including credentialing, review and disposition of concerns about quality of clinical care provided to members. To ensure standards of care are met, the PAS **ensures physicians of the same/similar specialties** are available for peer reviews. The PAS is responsible for evaluating and monitoring the quality, continuity, accessibility, utilization and cost of the medical care rendered within the network. The PAS is a stand-alone committee that reports to the **Quality Management Committee (QMC).** Functions include but are not limited to: (1) reviewing summary status **reports of clinical** issues referred by other subcommittees; (2) performing peer review of care and service issues, including recommendations for improvement action plans; (3) reporting to QMC all PAS actions concerning provider terminations, sanctions or board notifications; (4) reviewing summary data regarding **QOC** complaints, appeals, and grievances, and **identifying trends**, conducting barrier analysis and recommending corrective actions as needed – this information may also be used for QI or process improvement projects or other QI activities; (5) reviewing and accepting nationally endorsed clinical practice guidelines, providing input as appropriate; (6) reviewing and providing final approval of decisions by the Credentialing Committee for the credentialing and recredentialing process, including QOC or service issues (documented in provider files); and (7) **documenting and communicating results** to all functional areas within Evercare Select.



Peer Review Committee Structure

The **PAS, Evercare Select's peer review committee**, meets at least quarterly and is **chaired by our Medical Director, Dr. Tim Peterson**. Other members of the PAS include six contracted **providers from**

the community with expertise in general surgery, internal medicine, psychiatry, behavioral health, pediatrics and neonatology, the QM Coordinator, Myra Kingsley RN, MS, and additional ad hoc members including QM specialist nurses. Voting for peer review issues is restricted to the six contracted providers with Dr. Peterson voting in the case of a tie. Cases submitted for peer review are identified by specific indicators, sentinel events and by level of severity. During PAS, Dr. Peterson presents peer review cases and includes the recommended action along with medical record documentation or clinical information, and any information submitted by the provider. Each committee member signs a confidentiality and conflict of interest statement at each PAS meeting. Committee members may not participate in peer review activities, which they have a direct or indirect interest in the outcome. The peer review process ensures that **providers of the same or similar specialty participate in both the review of documentation. This ensures that the standard of care was met** and recommendation on individual peer review cases. We use external consultation if the specialty is not represented on the committee.

Review and Decision Process

Evercare Select reviews, evaluates and resolves actual and potential QOC issues raised by members, our staff, community and contracted providers. All issues regardless of source are tracked and trended to evaluate and improve delivery of care/service processes. We define QOC concerns as any written or verbal expression of dissatisfaction with the clinical care or other covered services provided to a member by a contracted or non-contracted provider. Evercare Select follows policies and procedures for receiving, acknowledging and resolving QOC concerns, along with allegations of abuse. All actual or potential QOC issues are entered into the grievance/QOC database and include the date and the name of the referral. All QOC files are maintained in a locked filing cabinet and the QOC database is accessible only to necessary staff responsible for grievances and QOC issues.

The QM nurse specialist prioritizes the QOC according to initial severity and determines if the member is at risk and acts accordingly. In cases of abuse or exploitation, the QM specialist immediately verifies the member's safety is secured and notifies the appropriate manager or director and ensures that notification has been made to the appropriate external agencies (such as Arizona Department of Health Services, AHCCCS, Child or Adult Protective Services, or law enforcement, etc.). Fraud and abuse cases are referred to the director of compliance or designee for appropriate and timely filing with AHCCCS. A *Member Abuse Check List* is included in the file when appropriate. All steps taken to investigate and research the issue are documented in a *Concern Report Outcome Summary*. Upon completion of the investigation, the findings are documented, including a severity level, if the issue was substantiated, unsubstantiated or unable to be substantiated for sign-off by Dr. Peterson. As a result of his review and assignment of severity level, one of the following actions are taken:

- ***Severity Level 0 (no quality issue identified)*:** The QM team sends a letter to the member and provider outlining the review findings. The outcome of the review is entered into the QM team's database for tracking and trending purposes, put in the provider's file for recredentialing, and the case is closed.
- ***Severity Level 1 (potential QOC concern identified, but the incident did not cause harm to the member)*:** Dr. Peterson may contact the provider by letter or phone to obtain additional information or an explanation regarding the incident. If a Level 1 issue is confirmed, a letter outlining the review findings is sent to the member and provider. Dr Peterson may request corrective action. The outcome of the review is entered into the QM team's database for tracking and trending purposes, put in the provider's file for recredentialing and the case is closed.
- ***Severity Level 2*** and higher are referred and reviewed by Dr. Peterson. As he deems necessary, an external review is conducted through Physicians Consultant Services (PCS). PCS locates a local market, board-certified, Arizona-licensed physician who specializes in the area related to the QOC issues. PCS review and sends their opinion back to Dr. Peterson. All severity Levels 2 and higher are reviewed by PAS, Evercare Select's peer review committee.

All cases referred to the PAS for review are evaluated based on the information made available through the QM process including the external review. When necessary, peer review activities are carried out in an executive session and voting members is restricted to the contracted providers.

The PAS is responsible for making recommendations for action to Dr. Peterson which may include but is not limited to: 1) development of an improvement action plan with time frames for improvement; 2) education; 3) counseling, monitoring and trending of data; 4) reducing, restricting, suspending, terminating or not renewing the providers credentials necessary to treat our members; and 5) referral to the appropriate state, federal or regulatory agencies. Dr. Peterson reports the final recommendations of the PAS to the QMC, which in turn reports to our Board of Directors. Prior to **informing the provider** of the recommended action, the Board of Directors must approve or modify any action to reduce, restrict, suspend or terminate for clinical reasons a provider's Evercare Select credentials or contract. If applicable, the final decision by the Board of Directors is reported by Dr. Peterson to the applicable state and federal licensure boards, supervisory authorities (e.g., National Practitioner Data Bank) to the extent required by law and AHCCCS regulations.

A provider may request a fair hearing appeal for certain recommendations that adversely affect their credentials or contract with Evercare Select. The Board of Directors has ultimate responsibility for making the final decision to uphold, modify or reverse a proposed action. Upon completion of the investigation, the findings are documented in the QOC file, including:

- If the issue was substantiated, unsubstantiated, or unable to be substantiated
- The main category and subcategory
- A summary of findings and if applicable a plan to reduce or eliminate the likelihood of reoccurrence
- Interventions taken, and supporting documentation of occurrence and success of intervention
- Summary of external/internal referrals and copies of all agency reports and correspondence
- Closing severity level
- Closure letter.

Incorporation into Quality Management Process

Peer review is an integral component of the Evercare Select quality process. QM staff compiles data on all QOC issues including the type of incident, the practitioner or provider involved and actions taken, if any. All peer review cases are documented in the confidential and secured QM database and **results of peer review activities and committee recommendations and actions are documented** in the providers' files. The PAS reviews these files together with other health plan information for the **purpose of recredentialing** and provider contract evaluation.

QM prepares monthly, quarterly and annual QOC reports and peer review trend reports on cases that were closed during the reporting period. The reports are reviewed by Dr. Peterson, PAS and the QMC and presented to the Board of Directors. All significant trends are identified, assessed and considered for potential development as a quality improvement project or disease management focus. Our QM Coordinator evaluates identified trends and prepares quarterly reports for the HQUM Subcommittee and QMC. The QMC uses the findings of aggregated concern data and interventions in the development of the QM program, or suggests or assigns new interventions as appropriate. Evercare Select's QM plan documents the major components of the QM program and incorporates the information gleaned from the PAS and peer review process and resulting impact. All planned improvement projects identified through this process are included in the QM Work Plan, which is used to monitor the effectiveness of the projects.

Quality Management

31.A. The Offeror is notified of an immediate jeopardy at a facility in a rural county …..

Evercare Select's established procedures for handling immediate jeopardy situations include an initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan, which includes assigning resources for implementation; implementation of action plan, including continuous monitoring; documenting successful interventions; and validation of successful intervention.

9:00 am The Quality Management (QM) Coordinator, Myra Kingsley, RN MSN, receives notification of immediate jeopardy.

9:05 am Ms. Kingsley immediately contacts the members of the Evercare Select Rapid Response Team with a "411" text and cell phone call. The members of the **Rapid Response Team** include Chief Executive Officer Karen Brach, Medical Director Dr. Tim Peterson, Case Management (CM) Administrator Francine Pechnik, Provider Services Manager Larry O'Connor, and Pharmacy Director Dr. Sandra Brownstein.

9:20 am The Rapid Response Team is convened **within 15 minutes of the notification**. The team discusses the immediate jeopardy situation and defines actions to be taken, resources to be deployed, and specific timeframes and touch points for monitoring. Ms. Kingsley is the designated point of contact to ensure all information and updates are captured and communicated appropriately, both internally and externally.

9:30 am Ms. Pechnik contacts the applicable CM manager for the facility and obtains a roster of members and their PCPs. Ms. Kingsley contacts the **other Program Contractor** to establish a line of **communication for sharing information**.

9:32 am The CM manager contacts the assigned case manager for the facility by cell phone to inform her of the immediate jeopardy and instructs her to **immediately** drive to the facility. In addition, the CM manager contacts the additional case managers for the geographic service area and assigns them specific tasks. If additional resources are needed, the CM manager contacts Ms. Pechnik for assistance. Upon receipt of the member roster, Dr. Peterson contacts each member's PCP to notify them of the situation and ask if there are any member specific needs that require consideration related to the member's transfer. Dr. Peterson confirms emergency contact information for the PCP and informs Ms. Kingsley and Ms. Pechnik of the results.

9:35 am The facility assigned case manager begins driving to the facility. Since this is a facility in the **rural area** and Evercare Select has case managers located throughout the geographic service areas, it is assumed that it takes two hours or less to drive to the facility. During the time the case manager is driving to the facility, the CM manager has assigned one of the other case managers from the area to contact the families and/or legal representatives (families) of the four members to notify them of the situation. The case manager discusses with them any **placement alternatives** (both short and long term) for the members, including return to home or placement with another family member, with appropriate HCBS support. The families are informed that the assigned case manager will be contacting them within the next few hours to solidify the plans for the member's transition and placement. Two additional case managers from the same geographic service area begin contacting facilities, both assisted living facilities and nursing facilities in the same county or in contiguous counties to identify placement alternatives.

11:00 am Ms. Kingsley **contacts AHCCCS** with a status on the situation, informing AHCCCS of the case manager's deployment to the facility, the list of affected members, status of contacting the families, and status of identifying placement options. Ms. Kingsley also informs AHCCCS that she will contact them by 3:00 pm (six hours post-notification) with the actual placement and **transition plans** for all four members.

11:30 am The case manager has arrived at the facility and immediately **meets with the owner** informing him/her of the situation, discusses the need to relocate the members and requests the cooperation of both the owner and staff during the transitions. The other case managers have reported to the CM manager the results of the conversations with the families regarding potential placement options and the bed availability in facilities.

11:45 am The case manager contacts Ms. Kingsley to discuss initial findings and to review the situation. It is determined that **no quality of care** issues exists and transition planning proceeds. Following the call, Ms. Kingsley contacts the other Program Contractor with information related to the facility and the situation based upon the onsite case manager's observations.

12:00 pm The onsite case manager interviews the members to assess their care needs, identify any immediate care needs and discuss the situation and potential placement options. The case manager also reviews each member's facility record, noting medications, orders and last TB screen (PPD or chest X-ray).

1:00 pm Within two hours of her arrival at the facility, the onsite case manager contacts her CM manager to discuss her findings. The CM manager establishes a conference call with all the case managers involved, as well as Ms. Pechnik, to discuss member-by-member assessments, placement options and preferences–for both member and families. Through this process, the members are triaged and prioritized for transition. A member-specific transition plan–which includes placement, necessary screenings, medications, DME, PCP orders, transportation, communication with any other providers (other than the PCP) involved in the member's care and any other special health care needs–is developed, and assignments are made by the CM manager.

2:00 pm The case manager, while onsite at the facility, reviews the transition plan with **each member**. She also calls each family to update them on her findings from the onsite visit with recommendations for relocation, and solicits the member and/or family agreement for the recommended placement. If agreement is not obtained, the case manager works with the member and family to amend and finalize the plan. The case manager also provides notification that another case manager is assisting with the transition, providing the name and direct cell phone number for the case manager. The case manager contacts the CM manager with the agreed upon transition plan information. Each of the four case managers from the region is assigned a member for transition coordination and is responsible for securing the placement and other services related to the transition.

2:45 pm The CM manager contacts Ms. Pechnik and Ms. Kingsley with specific member updates on the placement and transition plan for each.

STATEMENT: Based on the case manager's assessment, priority of the members' acuity and available alternatives, one member is transitioning to the nursing facility in the geographic service area, two of the members are transitioning to two different assisted living facilities in another county and one member is going home with her daughter with appropriate HCBS supportive services.

3:00 pm Ms. Kingsley **contacts AHCCCS** with the member-specific transition plans. She requests AHCCCS assist in obtaining a waiver for the TB screening prior to admission for the nursing facility and assisted living facility admissions. Evercare Select ensures screenings are completed within the granted waiver period. AHCCCS requests the waiver from ADHS.

The onsite case manager begins securing the members' belongings in preparation for their transfer. The other case managers continue to coordinate the member transfers.

5:00 pm Ms. Kingsley reconvenes the Rapid Response Team for updates and discussion of coordination efforts for the member transfers that will take place the following day. The CM manager coordinates an end-of-day conference call with the all of the case managers for updates on the

transition coordination events.

7:30 am Ms. Kingsley receives an **update** on transition coordination activities and the schedule of events for the day from the CM manager.

8:00 am Ms. Kingsley contacts AHCCCS to **verify the status** of the PPD/CXR waiver request and provide updates on the transition. The member moving home with her daughter is leaving the facility this morning. Upon confirmation of the waiver, the other three members are transferred by the **end of day.**

Transition activities are conducted including a case manager transfer, where appropriate. For the member moving to her daughter's home, the case manager coordinates the member's medications being transferred from the facility with the member. The case manager contacts the Dr. Brownstein to assist with provision of a 30-day supply of medications and ensures the member receives the medications. The case manager coordinates the transportation needs. Dr. Peterson contacts the PCP and informs him/her of the member's move. The case manager coordinates with the daughter to identify any immediate care needs and facilitates the implementation of these services. Within one day of the transition, the case manager goes to the daughter's home and completes the required assessments for the member. During the visit, the CareOne Community assessment, UAT and 2060 Member Functional Needs Assessment tool are completed to assist in determining HCBS needs (both formal and informal). The plan of care is developed with the member and family, with services coordinated and initiated by the case manager.

For the member being transferred to the nursing facility, copies of the member's medical records, medication and treatment record, specialized health care needs such as catheter care, wound care, etc., are made and moved with the member. Dr. Peterson contacts the PCP and informs them of the member's transfer to the nursing facility. The nursing facility contacts the PCP directly requesting orders when member arrives. The case manager arranges for the member transportation to the nursing facility. The facility orders medications based on the PCP's orders, with any needed assistance from Dr. Brownstein. The assigned case manager visits the member at the nursing facility within two days of the transfer and follows up with a call within one week of the transfer to the member and family to ensure their satisfaction.

For the two members transitioning to other assisted living facilities, copies of medical records, medication and treatment record, specialized health care needs such as catheter care, wound care, etc., are made and moved with the members. Dr. Peterson contacts the PCP for each member and informs him/her of the member's move. The case manager works with the members and families to select new PCPs and she initiates scheduling a visit to the new PCP. The case managers arrange for appropriate transportation to the facilities. They also contact Dr. Brownstein to assist with delivery of medications to the facilities, ensuring the members receive their medications. The newly assigned case manager conducts a reassessment visit with each member within two days on site at the facility with the member and family. The case managers also call within one week of the transfer to the member and family to ensure their satisfaction.

The case managers conduct all necessary follow up and reporting requirements including the Member Change Report submitted to AHCCCS for the change in each member's placement as well as updating CATS with the placement information and changes in service plans. Ms. Kingsley coordinates the notification and transfer of medical records between PCPs. In addition, a **final report** is forwarded to AHCCCS QM with the new placements identified. Ms. Kingsley also conducts a quality of care concern investigation to **document** the immediate jeopardy, document steps to resolve the situation, identify any areas for improvement in the process, and submit her report for review and further recommendations to the Healthcare Quality and Utilization Management Subcommittee and the Quality Management Committee.

31.B. The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a …..

Through years of addressing adverse events (i.e., unexpected nursing facility closures and natural diseases such as fires, floods and snowstorms) Evercare Select understands and has established policies and procedures to handle the unexpected crises that may affect the complex needs of our ALTCS members and the challenges our members may face as a result of catastrophic events. Our **Rapid Response Team** was established and strict response timeframes have been developed that ensure our senior health plan leaders (or their designee) are available **within 15 minutes** of notification, 24 hours a day, seven days a week.

Our established procedures for handling immediate jeopardy situations include: an initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan including assigning resources for implementation; implementation of action plan including continuous monitoring; documenting successful interventions; and validation of successful intervention. Due to the severity of this situation, a team **of Evercare Select staff is dispatched to the facility** to expedite the transfer of members. It should also be noted that the redundancy of our contracted network of nursing facilities in Maricopa County is sufficient to compensate for the loss of service in a given facility.

4:15 pm The Evercare Select Quality Management (QM) Coordinator, Myra Kingsley, RN and MSN, receives the telephone call from AHCCCS identifying this immediate jeopardy and the immediate need to relocate our members. AHCCCS also informs Ms. Kingsley of the other program contractors with members in the facility. Ms. Kingsley asks if AHCCCS has made any determination on **bed allocation** for predetermined receiving facilities (per the facility's established disaster plan) for the 48 ALTCS members. Ms. Kingsley requests the name and emergency contact information for someone at AHCCCS and ADHS for Evercare Select to refer all reporter requests.

4:20pm Ms. Kingsley immediately contacts the members of the Evercare Select Rapid Response Team in accordance with the Evercare Select policy, with a "411" text and cell phone call. The members of the Rapid Response Team include Ms. Kingsley, Chief Executive Officer Karen Brach, Medical Director Dr. Tim Peterson, Case Management (CM) Administrator Francine Pechnik, Provider Services Manager Larry O'Connor, and Pharmacy Director Dr. Sandra Brownstein. If any of the team members are unavailable, a **designee** is identified and provided to Ms. Kingsley per policy. The facility's roster is pulled, identifying the names of 15 members and the assigned case manager. Due to the nature of this situation, Ms. Kingsley, in coordination with Ms. Pechnik, **immediately** dispatches a QM nurse, the assigned case manager, the case management (CM) manager and an Evercare Select nurse practitioner to the facility with a member roster to assess the situation and **triage** the members for **relocation.** At the same time, the QM staff initiate the staff call tree, alerting all staff to the emergent nature of the situation and the need to deploy **all available resources**. Based on the emergent situation and the number of members affected, it is determined that **15 Evercare Select staff are required in the office** and an additional **10 staff members are needed onsite** at the facility. The office-based staff immediately begin to contact the members' families/legal representatives to alert them to the situation and ask if the member can return home or stay with a family member for the at least four days with appropriate HCBS support services. In addition, each family is provided with the specific name and contact information for the Evercare Select designated contact person for families. The office-based staff also begin calling facilities to determine bed availability.

4:35 pm The Rapid Response Team is convened within 15 minutes of the notification, in accordance with Evercare Select policy and procedure. The team discusses the immediate jeopardy situation and defines actions to be taken, resources to be deployed, and specific timeframes and

touch points for monitoring. In accordance with policy, Ms. Kingsley is the designated point of contact to ensure all information and updates are captured and communicated appropriately, both internally and externally. All media requests are forwarded to our Communications Director, Jeff Smith, to **coordinate all media requests with AHCCCS** or ADHS. An emergency email is distributed to all personnel alerting them of the situation and the need to refer any media requests to Jeff Smith, in accordance with established policy and procedures. Ms. Pechnik contacts the Evercare Select Member Service departments, our after-hours service provider (Cosmopolitan) and the NurseLine to inform them about the relocation of members and to provide them with a specific phone number to use if they need assistance in addressing any questions or issues. Ms. Pechnik instructs the CM staff to begin identifying potential relocation options for our members. The BH Coordinator, Theresa Robben, contacts our behavioral health (BH) providers, requesting their assistance and availability throughout the weekend for counseling. The BH provider's contact information is provided to the facility to address any needs during and following the member transition.

4:45 pm The Evercare Select staff who are onsite at the facility determine the air conditioner is off and the temperature in the facility is 85 degrees. They immediately talk to the facility director and DON to determine the status of the evacuation. The Evercare Select staff determine that the facility's **disaster plan** is appropriate and executed appropriately; however, the staff has offered and the facility has agreed to let Evercare Select handle the transfer of our members to identified facilities other than the facility disaster plan receiving facilities.

Ms. Kingsley contacts the **other program contractors** to discuss collaboration for relocation of members and onsite monitoring until the evacuation plan is fully executed. Ms. Pechnik and Ms. Kingsley leave the Evercare Select offices and drive directly to the facility with Evercare Select Condition Observation Forms and Emergency Transition Record packets. At the same time, Dr. Peterson begins contacting each member's PCP to notify him/her of the situation and he obtains after hours contact information for each PCP.

5:15 pm Upon arriving at the facility, Ms. Pechnik and Ms. Kingsley confer with the onsite Evercare Select staff. Ms. Pechnik and Ms. Kingsley speak directly with the facility administrator and DON, offering assistance to the facility. This includes: **resources to assist expediting** the transfer, including phone calls to families of non-Evercare Select members; our transportation provider to assist with transports; fans and generators, if needed to assist during the transition; delivery of bottled water; assistance with member safety, including hydration by our clinical staff (NP and RNs onsite); staff assistance with documentation of transition sheets for our members based on our CareOne files and facility staff input; assistance with packing members' belongings; offer to have Evercare Select staff present at the receiving facilities to assist with members moving into the facilities; and an offer to bring equipment and paper to assist with copying of our members' records and information to include in the transition packets. Ms. Pechnik and Ms. Kingsley work with the facility to identify ways to maintain members' safety and comfort, such as loading members into air-conditioned transport vans from our vendor.

The onsite Evercare Select QM nurse verifies that seven days of **medications** are packaged and appropriately secured for transport with the member. Our onsite clinical staff also complete the Condition Observation Form for each member that includes functional and medical status, BH information and identifies personal comfort items for the member (i.e., teddy bear, blanket, quilt, etc.). Our staff also complete the Evercare Select orange transfer packets that contains a copy of the facility face sheet; advance directives; medication list; history and physical; dietary instruction card; and Evercare Select contact numbers.

5:30 pm Under the direction of the Ms. Pechnik and Ms. Kingsley, **transfer plans** are developed for **each member** based upon identified placement options (determined by the office-based staff); members are triaged and prioritized for transition; and a one-to-one assignment is made of member to case manager, with the case manager responsible for handling all of the member's transfer needs. The office-based staff immediately contact the receiving facilities to finalize the number of members transitioning to their facility, and to determine all specialized DME needs are met or arranged for delivery of specialized DME. Ms. Kingsley directly contacts the DON at the receiving facilities to determine their designated coordinator, offer assistance and collaboration, and ensure that appropriate staffing and resources are available to handle an increase in residents.

Each case manager contacts the member's family and/or legal representative to inform them of the name of the facility where the member is transferred; they are informed that they are welcome to meet the member at the new facility to assist with the transition, if they wish.

6:30 pm The members are being transferred under Evercare Select's supervision. It is anticipated all of the members are moved from the facility within **three hours** of notification. Ms. Kingsley contacts AHCCCS with status updates throughout the process.

7:00 pm Ms. Kingsley reconvenes the Rapid Response Team for a debriefing and identification of any further actions such as additional resources or coordination efforts needed for the member transfers. Evercare Select continues to assist the facility throughout Friday night and into Saturday with non-Evercare Select residents.

Next day For each member, the assigned case manager performs an onsite visit to determine that all needs have been met, offering counseling to members needing additional emotional support. A follow-up phone call is also made to all families/legal representatives updating them on the members after the case manager has seen them.

12:00 pm All case managers contact Ms. Kingsley with an update on the condition of each member by noon. Ms. Kingsley **contacts AHCCCS** with the follow-up information.

The case managers update member information and records upon return to the office following the holiday.

Once the air conditioning problem is resolved at the facility, Evercare Select **coordinates** the orderly **return** of members to the facility by the assigned case managers. Following their return to the facility, members and families/legal representatives are surveyed to determine their satisfaction with Evercare Select's handling of the immediate situation and satisfaction with the overall outcome. Involved providers are also surveyed to determine satisfaction with process and outcome. QM convenes a **Post Operation Review** to determine effectiveness and efficiency of health plan and provider response to the immediate jeopardy situation, along with member, family and provider satisfaction. The review includes an assessment of what worked well, barriers, deficiencies and suggestions for improvement. QM initiates a quality of care investigation of the immediate jeopardy situation, steps taken to address the situation, and outcomes of these actions. The information is presented to the Healthcare Quality and Utilization Management Subcommittee and the Quality Management Committee along with the Post Operation Review for evaluation and recommendations.

32. Describe and provide an example of the Offeror's experience and commitment ……

Experience and Commitment

Evercare Select has been serving the needs of ALTCS members since the inception of the program in 1989. Over the past 22 years, we have learned a lot about the communities we serve in Arizona. From that experience, we have emerged more mature and committed to improving the quality of care (QOC) for our members and meeting the expectations of our members, our providers, AHCCCS and the communities in which we serve.

In partnership with our Board of Directors, Evercare Select's executive leadership, including but not limited to the Chief Executive Officer, Karen Brach and Medical Director, Dr. Tim Peterson, oversee and approve all Quality Management (QM) activities.

We continuously **evaluate our organizational structure, staffing and resources** in addition to a number of our processes and procedures in order **to improve and sustain our quality** and performance. As a result of our continuous self-examination, we have undertaken a number of initiatives in our commitment to enhance quality and performance, including but not limited to modifying staff and resources when improvement is not achieved or sustained.

As opportunities for improvement are identified through **our monitoring and evaluation** of overall performance, **corrective activities are developed and incorporated into our QM program structure**. These activities are incorporated into the QMC structure for monitoring and oversight. Results and their corresponding action plans are presented to the appropriate QM Subcommittee for tracking. The Healthcare Quality and Utilization Management Subcommittee (HQUM) monitors all clinical quality improvement (QI) and utilization management (UM) activities within Evercare Select. The Service Quality Improvement Subcommittee monitors the quality of service delivery to our members by the health plan and our subcontracted vendors, including oversight of non-clinical services. Cross reporting is made to the Provider Affairs Subcommittee (PAS, our peer review and credentialing committee) as appropriate for recommendations. The QM subcommittees review and report their recommendations and results of all quality activities to the QMC on a quarterly basis. The activities related to each corrective action plan are monitored by the QM team and are included in the departmental scorecard.

Evercare Select ensures all of our staff is trained at least annually to identify and appropriately refer all QOC concerns to our QM team for research, intervention and resolution. Our QOC referral process allows for the capture of all potential QOC concerns. We conduct mandatory annual and periodic trainings to **communicate any related QOC changes or interventions throughout our organization.** Also, Evercare Select, via monthly departmental operation meetings or QI initiatives, reviews and monitors whether staffing or other resources are adequate to improve or sustain performance, and modifies when improvement is not achieved or sustained. This is accomplished by working with department heads to determine capacity of the health plan, such as determining if existing staff can accommodate, or if there is a need to shift/add resources to address the issue.

Examples - Commitment to Improve Performance Measures

Evercare Select continues to focus on improving QOC and performance in specific measures of health care services, and has met or exceeded AHCCCS performance measures for CYE 2010 with one exception being retinal exams (see the following table). We are implementing an initiative to further meet this retinal exam standard. Since CYE 2011, performance standards are similar to CYE 2010. Based on CYE 2010 data, Evercare Select is already meeting or exceeding CYE 2011 performance standards.

AHCCCS Performance Measures and Evercare Select Results for CYE 2010 and Projections for CYE 2012			
Performance Measure		***Met or Exceeded CYE 2010 Minimum Standard for ALTCS population***	***Projection: Meeting or Exceeding CYE 2011 Minimum Standard***
Diabetes Care:	Hb A1c Testing	Yes	Yes
	Lipid Profiles	Yes	Yes
	Retinal Exams	97% of target	Yes
Initiation of Home and Community-Based Services (HCBS)		Yes	Yes
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Participation		Yes	Yes

- ***Diabetes care measures (retinal exams)*:** We are executing a plan of action to meet the minimum performance standard for CYE 2011 for retinal exams. A cross-functional team evaluated root causes, researched the literature and is employing multi-departmental interventions including:
  - ***Provider Outreach*:** We worked with contracted groups to expand retinal screening capability. We have a contract with a new provider group to conduct home based retinal exams when needed, and conduct outreach calls to members due for a retinal exam. Also, diabetic information and standards are included in provider newsletter and advisory councils.
  - ***Member Outreach*:** We provided diabetic educational information through member newsletters and advisory councils. Case managers work directly with assigned members to increase compliance.
  - ***Diabetic Database*:** This intervention created real-time tracking and identification of opportunities for care.
- ***HCBS Measures*:** We implemented a plan to meet the minimum performance standard of initiation of HCBS for elderly and physically disabled members. HCBS rates are calculated using case management documentation of initial assessment. Case managers work directly with assigned members to ensure services are initiated promptly when the individual is determined eligible and selects HCBS. Evercare Select exceeded both the performance standard and goal for CYE 2010. Analysis of the last two quarters for 2010 demonstrated a 100 percent compliance rating.
- ***Influenza Vaccine and Pressure Ulcer (new minimum performance standards published)*:** Evercare Select has created a performance improvement plan to address this new standard and expects to meet or exceed minimum performance standards.

Ventilator Quality of Care Issue and Resolution

Evercare Select CM submitted a referral to QM, reporting that re-hospitalization of an ALTCS member was possibly a result of poorly functioning equipment (suction machine and ventilator) and the lack of the durable medical equipment (DME) provider responding in a timely manner. The investigation determined that the DME provider failed to respond in a timely manner to reported concerns of equipment performance and also failed to follow company policy and procedure for Ventilator Equipment Maintenance and Clinical Respiratory Services. It was discovered that the DME company did not have a policy or procedure in place to monitor and assess compliance to the home ventilator policy, nor did it have a policy or process in place addressing agency response time for equipment repair for in home equipment. QM worked with Provider Services and this information became part of the provider profile for recredentialing that occurs with the PAS committee. Working with Provider Services, QM requested a specific corrective action plan for the DME provider. The DME company: (1) revised an existing policy making the policy more specific regarding time frames for home visits; (2) created a new performance indicator that was incorporated into the existing performance improvement process; (3) developed a written policy that defines response times and an internal process to report equipment malfunctions with a process in place to monitor compliance of the new policy; and (4) provided copies of new policies and

revised policies and form revisions. Based upon the outcomes and findings, we developed policies and procedures to address the timeframes for the delivery of services to home-based ventilator members, address educational needs of family members, and provide a checklist for case management monitoring. To monitor the interventions, the QM Director is receiving reports on a monthly basis from the vendor, as required.

Assisted Living Facility Quality of Care Issue and Resolution

The Director of QM evaluates trends and prepares quarterly reports for the HQUM subcommittee and QMC, as applicable. When analyzing QOC issues by type and provider, it was noted by HQUM that an Assisted Living Facility (ALF) had a significant trend of substantiated medication issues related to medication administration, wrong dose or time, and missed doses. The assigned case manager had concerns about the nursing staff and their understanding of the requirements for caring for this vulnerable population. Initially, within the terms of the facility's contract, HQUM recommended a hold be placed on the facility, which meant no new admissions without Dr. Peterson's approval until all issues were addressed and determined to be resolved. Our QM team worked with Provider Services and this information became part of the provider profile for recredentialing purposes**.** Due to the multiple concerns, a multi-disciplinary team met with the staff and administration of the ALF. After discussions about the issues and possible barriers to improvement, a corrective action plan was developed and agreed upon. QM staff worked with the ALF and offered technical assistance to write policies governing medication administration and staff responsibility in regards to oversight of medication. Our Pharmacy Director, Dr. Sandra Brownstein, performed a pharmacy chart audit, reviewing all of our members' charts who were residing there at that time. The review concentrated on Medication Administration Records (MARs) and uncovered systematic process errors. Dr. Brownstein worked with the facility and their pharmacy to address the issues, such as a quality improvement process for the medical records department at the pharmacy to improve accuracy of orders on MARs and one-on-one education with caregivers that distribute medications. While the ALF remains on an admission restriction, there has been a significant decrease (89 percent) in the medication related QOCs received. We continue to monitor and remain vigilant with this facility. QM staff work in concert with our case managers to ensure the highest quality of care for our members.

Commitment Throughout Evercare Select

The Board of Directors, our governing body and Evercare Select's executive leadership jointly own Evercare Select's commitment to quality improvement. This includes but is not limited to Karen Brach, Dr. Peterson, and the functional department directors. Collectively, these leaders play a critical role in QI, creating a cultural climate in which QI is integrated into every aspect of our operations. They create an environment in which quality can thrive. However, leaders do not make quality improvements alone. QI is carried out by managers and staff throughout Evercare Select who know how to run **rapid tests of change**, measure results, respond, and then start the cycle again.

The board and executive leadership have developed a communication strategy to ensure all employees are aware of our commitment to QI and the actual data driven measurements. Communication includes:

- All staff meetings conducted at least quarterly by Ms. Brach. During theses meetings, update reports are given on the performance measurements and QI activities.
- All staff participate in annual training to identify and appropriately refer all potential member quality of care concerns to our QM team for research, intervention and resolution.
- New Employee Orientation presents an entire section on QM and the significance of the performance measures. The expectation and responsibility of all employees to commit to QI is reviewed.

Our employees share our organization's strong commitment to improving quality and performance.

33. Describe how feedback (complaints, survey results etc.) from members and providers…..

Evercare Select uses feedback received from various sources, including members, providers, and other stakeholders, to drive change and improvement. We rely on member and provider feedback to continuously develop our health plan into one that is accessible and supportive for members. **Interventions are implemented** based on the opportunities identified, incorporated into work plans with specific timing, and **monitored for effectiveness**. Incorporating continuous quality improvement (CQI) concepts, our Quality Management (QM) program monitors, evaluates and improves the continuity, quality, accessibility and availability of health care and services provided to ALTCS members.

How Member and Provider Feedback is Used to Drive Change

Evercare Select employs a wide range of strategies for identifying member and provider quality improvement (QI) activities. These include but are not limited to:

- External feedback from key stakeholders, such as members/families, providers, AHCCCS, other community agencies
- **Member and provider satisfaction surveys** conducted periodically; results are **analyzed** to identify opportunities for improvement
- Member Advisory Council meetings held quarterly
- Analysis of data, such as utilization trends, **grievance** and appeals trends, member **disenrollment**, provider claim disputes, quality of care concerns, **provider complaints, turnover, and contract terminations** and results from onsite provider reviews.

As the central area for receiving potential quality/risk management issues and coordination of quality management activity – under the direction of our Medical Director, Dr. Tim Peterson and QM Coordinator, Myra Kingsley, RN–our QM team is a critical interface between members/representatives, practitioners, providers, AHCCCS and other regulators, as well as other various departments. Information received by the QM team is reviewed monthly, trended, analyzed and investigated. When a satisfaction trend or issue is identified, it is assigned to an interdisciplinary team or the appropriate functional area such as case management (CM), prior authorization, behavioral health, network management, pharmacy, appeals and claims disputes, or finance) for prioritization and end-to-end resolution, which is used to drive change. Our QM team, working with Provider Services, communicates and coordinates with impacted providers. Necessary research is performed, leading to development of the following: (1) problem summary; (2) root cause analysis; (3) impact; and (4) proposed solution. All non-clinical quality of service delivery improvements are monitored by the Service Quality Improvement Subcommittee (SQIS). All clinical QI and utilization management activities of the health plan are monitored by the Healthcare Quality and Utilization Management Subcommittee (HQUM). The Subcommittees review proposed QI initiatives and make recommendations to the Quality Management Committee (QMC), which is chaired by our Dr. Tim Peterson. QMC membership includes: Ms. Kingsley; CM Administrator, Francine Pechnik; Provider Services Manager, Larry O'Connor; Chief Executive Officer, Karen Brach; Operations Director, Helen Bronski; Compliance Officer, Kelly Kreiselmeier (formerly Kelly Morken); QM analysts and case managers as needed. If approved by the QMC, QI activities are incorporated into Evercare Select's QM and medical management work plans. Reports on all current QI activities are reviewed and discussed by the QMC and **interventions are monitored for effectiveness**. All clinical and non-clinical QI activities are monitored by the QMC and reported to our executive management team and Board of Directors.

Examples - Member and Provider Feedback Drive Change

Member Advisory Council Initiatives for Empowerment

In alignment with AHCCCS' mission and vision to empower members in their quest to attain their personal goals related to housing, education and employment, Evercare Select conducts member and

provider advisory councils in four regions, based on current membership, to proactively receive feedback from members and providers. As noted in the *2008-2009 External Quality Review Annual Report for ALTCS EPD and DES/DDD Contractors* conducted by Health Services Advisory Group, Evercare Select's Member/Provider Advisory Council was noted as a **best practice in the ALTCS program**. Evercare Select's member/provider advisory councils develop and promote a comprehensive approach to health education and enhance the delivery of services in local communities. The councils are member-focused and provide a forum for members, providers and community advocates to voice their opinions and interests regarding Evercare Select's operations. The councils target members' long-term care, medical/behavioral health, educational, vocational and housing needs, and develop delivery strategies that reflect the needs, risk factors and cultural values specific to each service area. Case managers support the council meetings in their county sites, providing orientation and support for council members to have an understanding of the council's role and are able to fully participate. Separate councils were established in counties in each AHCCCS-defined geographic service area served by Evercare Select. The **councils meet on a quarterly basis** and make recommendations as appropriate to the QMC. Evercare Select asked the advisory council, composed of members/member families and providers, to offer recommendations to improve member empowerment. Feedback from these sessions drove the following changes:

- CM leadership worked to create a new program member empowerment program called "ME*". This member-centered approach asks members to articulate their life goals such as returning to school, alternative housing, continuing education and volunteerism. We believe "ME*" empowers our members, their families, our providers and our staff with resources that allow members to realize their goals, improve their quality of life and enhance their engagement in their community, resulting in happy, healthier, productive, more satisfied members.
- Evercare Select hosted four Abilities Workshops for members across the state in 2010. Abilities Workshops were opportunities to provide resources and education to members to help them obtain their personal goals with support from their case manager, Evercare Select and their communities. Three additional Abilities Workshops have been scheduled for the spring of 2011. Vendors who attended the workshops in 2010 provided community volunteering, pet adoption and community program information. For those members, families or interested providers who could not participate in the workshops, we provided a teleconference/webinar.

Abilities Workshop Topics	**Expanded Topics Discussed During the Webinar**
■ Continuing education ■ Vocational training programs ■ Employment services ■ Housing options ■ Independent living or benefit specialists	■ Vocational rehabilitation ■ Employment networks ■ Ticket-to-work program ■ Continuing education and GED programs ■ Grants and financial aid programs ■ Career and disability counselors on college campuses

- To measure effectiveness, we conducted member surveys following the workshops and had positive results revealing that the majority of participants were very satisfied and exhibited an overall 96 percent approval rating. *One family's comment involved a mother who attended with her disabled daughter. She was so excited about what she learned and what was available in the community that she committed to becoming a volunteer herself to work with others in the community.* Based on feedback like this and other data, we are continuing the workshops and webinars.
- Created an Abilities Resource Brochure for newly disabled people; it includes resource information related non-ALTCS covered services and disability benefits available in the community.
- The establishment of a new position, the Reintegration Specialist, whose role is to assist the member and case manager to address barriers inhibiting a member's successful reintegration to the community

from nursing home or assisted living facility placements. The Reintegration Specialist assists the member with applying for financial assistance, housing, obtaining needed household items, coordination with providers and other available resources.

- A Member Advocate position to assist identified members in their return to school and work is under development. The preferred candidate for this position will be a member with a disability who has successfully returned to work and is able to assist in identification of the skills needed for members to return to school or work.

Enhanced Communication for New Transportation Provider

Member complaints/grievances are tracked and trended through our QM program. Grievances are categorized as: *Transportation Medical Service Provision*, *Contractor Service Issues*, *Wheelchair-related Grievances*, and *Access to Care*. Transportation is the area with the majority (an average of 73 percent) of the grievances received. During 2010, Evercare Select identified a trend in member and quality of service complaints related to our new transportation provider, related to late or missed appointments. The QMC called for a joint operations committee (JOC) with the provider to identify the issues and determine what could be done to ensure appropriate, safe and timely services for our members. The JOC meeting allows for communication and dialogue regarding Evercare Select's concerns, and to determine what caused the delays and missed services. Feedback from the provider identified that our members had many missed appointments or "no-shows" that increased the incidence of late or missed appointments. As the provider was a new vendor and involved a change in process for our members, we discovered members were having difficulty identifying how to access the service. The JOC and the provider developed a corrective action plan that included improving communication through an identified single point of contact at the provider and a single point of contact at Evercare Select. The goal was to quickly resolve issues and ensure ALTCS members receive coordinated, reliable transportation, with members arriving on time for scheduled appointments and secure timely pick-up upon completion of the scheduled treatment or appointment. We implemented a checklist for all wheelchair-bound members and the provider's driver to complete and sign indicating all necessary steps were completed to secure and safely transport the member. The QM Director monitors for the completion of the checklist by sampling up to ten wheelchair transports a quarter. The results of the monitoring is tracked, trended and reported through the QM subcommittee structure.

A review of trends demonstrates overall improvement in services for our members. Through the successful execution of the corrective action plan, the number of transportation grievances decreased this quarter (October-December CYE 2011) by approximately 40 percent compared to the previous three quarters. We continue to track grievances and meet with the provider as we monitor member satisfaction.

Improved Access to Diabetic Foot Care Provider

Provider accessibility and availability activities monitored by the SQIS – which reports to the QMC – are conducted on an ongoing basis to ensure that established standards for reasonable geographic location of providers, number of providers, appointment availability, provision for emergency care, and after-hours service are measured. Monitoring activities include provider surveys, onsite visits, evaluation of member satisfaction, evaluation of complaints, geo-access surveys and when applicable, monitoring of closed primary physician panels. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. Evercare Select became aware that due to a benefit change, certain ALTCS members no longer had access to a podiatrist for diabetic foot care. After the benefit change was discussed with AHCCCS, Evercare Select proactively implemented a program to address the gap in services. Evercare Select identified and contracted with a nurse practitioner (NP) who can provide this service to members. The NP provided service eliminated a gap in care and resulted in members continuing to have access to diabetic foot care. CM communicated the new service to the affected membership facilitating a smooth transition for those who wanted to continue the service. For our dual members, CM coordinates care with the Medicare benefit.

34. Describe the process that will be utilized by the Offeror to monitor services and service sites…..

Evercare Select's Quality Management (QM) team, under the direction of our Medical Director, Dr. Tim Peterson, has conducted extensive monitoring and evaluation across the continuum of care in all service sites, including home and community-based services (HCBS), to assess and improve the quality of services listed in the **AM/PM Section 920** (such as attendant care, homemaker and personal care). Monitoring includes **use of publicly reported data** (such as ADHS Survey reports, etc.) for licensed providers and includes feedback from members, their families and providers. The objective of the monitoring activities is to evaluate and improve the quality of care (QOC) provided to Evercare Select members. Monitoring includes obtaining and using input from providers, members and members' families. With the recent addition of INSPIRIS to the UnitedHealth Group family of companies, our ability to monitor services being rendered in the member's home have been enhanced. The INSPIRIS clinicians provide valuable information to our QM team based upon their personal observations and interactions with the members in their own homes. Our QM review and monitoring processes identify opportunities for improvement and education, along with monitoring of **corrective action plans** (CAPS) for continued effectiveness. Our program is designed to support best practices, maximize member satisfaction and treatment adherence, and promote safe and effective use of all needed services.

Monitoring Services

Evercare Select follows all state requirements for monitoring services provided in home and community-based settings, including Ball versus Betlach requirements. Monitoring and evaluation activities include but are not limited to: QOC trending; service and service site audits; medical record reviews; member and provider satisfaction survey results; grievance system trends; monitoring of key quality measures such as under- and overutilization of services; and critical gaps in service. Evercare Select monitors home and community-based (HCB) service sites and services a minimum of every three years or annually as required by AHCCCS policy and procedures. We accomplish this via site visits to new providers and annual monitoring visits for HCB services provided for members living in their own home. Service monitoring includes but is not limited to adult day health care, attendant care, homemaker, personal care and other services such as medical supplies, home health services, therapies and transportation. We recognize that services provided for members who reside in their own home require different methods of monitoring. Our approach to quality improvement for HCBS providers is a collaborative one, assessing both clinical and non-clinical aspects of each type of service and leveraging the experiences of case management (CM) in the field.

The participation of the case manager is strategic to the monitoring and evaluation of the QOC our members receive in their home. Case managers visit a member in their home on at least a quarterly basis and are the "eyes and ears" of the QM team. At each assessment, the case manager, member and family develop an agreed upon service plan to meet the member's care needs. A contingency plan is also developed that identifies the member's preference level and backup plan, both formal and informal, should the member's caregiver cancel or not show up for a regularly scheduled shift. The member and family are educated on the notification process for gaps in services and provided all applicable phone numbers and instructions for completing the Critical Gap in Service form. All contracted providers are required to report any non-provision of services (NPS) monthly. Evercare Select's NPS Coordinator reviews the NPS Log and Gap Log with the Directors of QM and CM to identify trends or need for corrective action.

Current Evercare Select providers have automated systems that track the arrival and departure of a caregiver at the member's home. Others use a manual process for visit verification for direct care service providers. Evercare Select's NPS coordinator and QM department monitor these visit verification processes through random audits of the weekly verifications and analysis with the NPS and gap logs to identify trends and/or need for corrective action. All results are documented and maintained in the provider's recredentialing file.

Service site audits conducted by Evercare Select QM nurses consist of annual reviews with interim visits as needed, to investigate QOC concerns and to evaluate improvement in or correction of deficiencies noted. When on site, QM nurses use standardized criteria and audit tools to evaluate compliance with Evercare Select and AHCCCS requirements. The nurses review policies and procedures that address services provided as well as a sample of member records and associated caregiver files. We require organizations to maintain complete, accurate and current personnel files for caregivers. Our QM nurses review files to verify that all caregivers are current in first aid and cardiopulmonary resuscitation, are free of tuberculosis and that the organizations screening and training processes meets Evercare Select and AHCCCS requirements. Confidentiality of all records reviewed is maintained throughout the entire audit process. After each review, findings and identified trends are discussed with the administrator of organization or facility, along with education on any areas of deficiency.

Service sites and services are monitored to collect data indicative of quality or delivery of service. Depending upon the provider type and nature of the review, the reviews are conducted by Evercare Select QM specialists and case management staff, or are delegated to an external agency such as the Area Agency on Aging (AAA). In carrying out these activities, we require AAA to follow Evercare Select policies and procedures, which are based on the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual. Evercare Select uses the same standards when conducting delegation audits of AAA.

Attendant care, homemaker services and personal care services agencies are audited annually to verify that AHCCCS and Evercare Select policies and requirements are followed. All attendant care, homemaker services and personal care service providers are required to report non-provision of services to case management. Non-provision of services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued QI.

Additional Methods for HCBS Monitoring

HCB Services are monitored in a variety of ways including:

- ***Member Satisfaction*:** An annual survey is conducted with the members/family during the contract year to access their satisfaction with HCBS services. This feedback is used to determine future action plans. After analysis of the survey, if trends are identified with the provision of care, a focused review may be required to determine the scope of the problem. Follow-up action may be requested by the Evercare Select Medical Director.
- ***Grievances (Complaints)/Concerns and QOC Issues*:** Concern reports are received as problems are identified. Complaints, grievances and QOC issues can be received from internal and external sources. All concern reports are investigated. Clinical QOC issues are investigated by QM Nursing staff. Provider Service investigates concerns related to delivery of services. Aggregating concerns and complaints quarterly help to identify problems within the provider network.
- ***Regulatory Agency Findings*:** The ADHS annual surveys and deficiency reports, along with information from the CMS website (www.medicare.gov), are used by the QM specialists as additional tools to evaluate issues within the provider network. Applicable information is brought to the QOC Committee for review to determine if there should be any follow-up actions.
- ***Medical Records Monitoring*:** Primary care practitioners and organizations (such as rehabilitation facilities, home health agencies, etc.) with panels greater than or equal to 50 and high volume specialists are monitored onsite every three years. The Evercare Select QM analyst monitors a five percent random sampling of medical records.

Steps if Non-compliance is Identified

Corrective Action Plans (CAPs) are required for those providers who did not achieve the required score of 85 percent on the service specific audit tools or when critical QOC issues are identified. Areas where we

might require a CAP include: no evidence of staff education, policies and procedures not fully documented, and no evidence that oversight of processes has been implemented and maintained.

A repeat of onsite audits may be conducted by QM Staff within three to six months after the CAP is approved by Evercare Select to evaluate the effectiveness of actions taken. Repeat audit scores below 85 percent may result in a limitation or restriction for the provider as determined by the QMC and within contractual terms. The effectiveness of the performance improvement actions taken by providers is determined during subsequent monitoring visits by Evercare Select staff. The frequency of monitoring is dependent on the scope of the deficiencies noted during an onsite review. It is the goal of the QM staff to provide education and technical support to providers to develop changes in their policies, procedures and internal monitoring to affect lasting improvement in areas found to be deficient.

If a pattern of deficiency is noted that impacts several members, a decision can be made through the QM committee structure to limit future referrals to the provider until corrective action has been completed and the provider has demonstrated that identified issues have all been resolved.

Example: Direct Care Worker (DCW) Agency Annual Audit

While we monitor member survey results, complaints, grievances, critical services and regulatory agency findings for all providers, we have specific procedures in place to evaluate the provision of quality services that are specific to our attendant care, personal care and homemaker agencies.

Direct care workers, nurse aides, personal care attendants and other unlicensed paraprofessionals who assist individuals with disabilities and frail older adults with daily living activities such as bathing, dressing or taking care of the home, and in some cases may provide health-related tasks such as taking blood pressure or making sterile dressing changes, are all monitored. Evercare Select conducts an annual DCW audit focused on the agency, the employee and the member (see table below).

Evercare Select Direct Care Worker (DCW) Audit Materials by Type		
Agency	***Employee (DCW)***	***ALTCS Member***
Administrative policies, recruitment and employment practices, training, monitoring and organizational procedures.	Pre-employment requirements, supervisory visits, training and educational requirements.*	Provision of services, care plan development, supervisory visits, change of condition, and advance directives.
* Successfully completed formal training in the necessary skills to meet certification requirements in personal care, homemaking, toileting, recognition of a change in a member's condition, cardiopulmonary resuscitation and first aid, transfer techniques, knowledge of member rights, disability types and basic nutrition, communication skills and service contract development before providing attendant care services.		

Evercare Select aligns QM activities with those of AHCCCS, the Arizona Department of Health Services and other program contractors. This is done to focus our providers' QI activities on areas of state and nationwide importance and to reduce duplication of service. For example, we worked with other program contractors (PCs) to define the assignment process of the DCW training programs in order to complete the **initial and annual audits** including:

- Completing an *initial* audit of each training program within 180 days of the approval by AHCCCS, *annual* audits on assigned training programs, and *follow-up* audits for any CAPS
- Reporting all results to AHCCCS
- Communicating with training programs to notify of audit date and materials to be provided and to communicate outcome of audit including corrective action requirements
  - Communicating and collaborating with all PCs that work with a particular training program as the need arises, agencies who use the same delegated training program and AHCCCS regarding issues, concerns and program enhancements.

Oral Presentation

35. Responsive Offerors shall participate in a scheduled oral presentation, ……

Evercare Select looks forward to meeting with the AHCCCS team to present solutions and respond to questions regarding our scenarios. We anticipate that the following individuals will represent Evercare Select at the oral presentation:

- Chief Executive Officer, Karen Brach
- Chief Medical Officer, Dr. Tim Peterson
- Case Management Administrator, Francine Pechnik
- Quality Management Coordinator, Myra Kingsley
- Provider Services Manager, Larry O'Connor.

We will confirm the name of our attendees via the EFT/SFTP server by 3:00 p.m. MST on April 8.

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E. Provider Network

E. PROVIDER NETWORK

36. The Offeror must submit a Network Development and Management Plan…...

Evercare Select's' network development and management plan includes a **proactive** process for evaluating deficiencies, gaps and limitations in our network. We analyze, **track and trend network metrics** to identify potential issues or problems in advance of concerns from providers or AHCCCS. We consistently **monitor** the network to ensure it is **sufficient t**o provide all covered services to ALTCS members. We analyze root causes of avoidable/preventable ER utilization and have implemented strategies to reduce avoidable/preventable ER utilization.

Our network development plan includes **input from members, providers** and Evercare Provider Services staff and includes an overview of covered services, evaluation of membership growth and changes in order to maintain and build the necessary networks; a process for interventions to fill network gaps and evaluation of those interventions; workforce and para professional development;

Our plan provides strategies pertaining to increasing participation, recruitment and training specifically in rural and medically underserved areas. Evercare Select will work with AHCCCS to further support **Graduate Medical Education** in Arizona.

NETWORK DEVELOPMENT AND MANAGEMENT PLAN

&

EVALUATION

FOR AHCCCS

CYE 12

OCTOBER 1, 2011– SEPTEMBER 30, 2012

3141 North Third Avenue • Phoenix, AZ 85013-4345

SECTION I. INTRODUCTION/OVERVIEW

Evercare Select is proud to have been serving the need of members in the ALTCS program for over 22 years. Evercare Select currently serves approximately 2900 members in five counties: Maricopa, Apache, Coconino, Mohave and Navajo. Under the direction of Chief Executive Officer, Karen Brach, Evercare Select's Provider Services Manager, Larry O'Connor oversees the development, management, monitoring and maintenance of our comprehensive, diverse and flexible provider network for our members. Evercare Select's network is designed to:

- Ensure services are as accessible to ALTCS members in terms of timeliness, amount, duration and scope as those services are to non-ALTCS persons within the same services area
- Ensure all covered services are provided promptly and are reasonably accessible in terms of location and hours of operation
- That there be sufficient personnel for the provision of all covered services, including emergency care on a 24-hour-a-day, 7-days-a-week basis
- Ensure home and community based services have provisions to be available 7 days a week, and for extended hours, as dictated by members needs
- Ensure our membership has access equal to, or better than, community norms
- Provide all covered services within designated time and distance limits. For example, in Maricopa and Pima Counties only, this includes a network such that 95 percent of our members residing within the boundary area of metropolitan Phoenix and Tucson do not have to travel more than 5 miles to see a Primary Care Provider (PCP) or pharmacy
- Meet the needs of ALTCS members today and tomorrow.
- Meet the unique cultural and linguistic needs of our membership.
- Ensure our business practices are in accordance with ALTCS Guiding Principles and AHCCCS Values and Vision.
- Allow members to select a Primary Care Physician (PCP) at the time of enrollment or are auto assigned should they chose not to select one. PCPs are responsible for providing or arranging for covered services as defined in their contract with Evercare Select and for initiating referrals to specialists as needed. Evercare Select ensures that there is **consistency of services** for members and that they can rely on these services to be there for them throughout the duration of their care. Members are allowed to switch Primary Care Physicians without restriction by contacting our Member services department.
- Ensure that all members have **accessibility to the network** and that access to service is **maximized** as members needs develop. Provider restrictions, limitations or assignment criteria are identified to the member and their family. We develop service networks that meet the member's needs and are not limited to normal business hours. Evercare Select's comprehensive network of providers is able to meets our members' changing needs including access to behavioral health and ancillary services.
- Ensure that all members are offered **the most integrated setting** and afforded a choice to remain in their own home environment or to choose an alternative residential setting versus admission to a nursing facility.
- Recognize that it is imperative to have **collaboration with stakeholders** and address the changing mix of services required by members. Evercare Select strives to align resources with member needs and preferences. All efforts are made to involve the member, family, service providers, PCP's and community resources in assessing and reviewing changes to service needs and continually evaluate, plan and implement service changes that meet the needs of our members.

Evercare Select's Provider Services team has primary responsibility for developing, managing and monitoring our provider network, and works continuously to maintain a network of providers capable of

providing care in compliance with all ALTCS guidelines and requirements. The staff monitors the status of our network, projecting future needs and identifying any network deficiencies or gaps. They work closely with the dental department staff to ensure an adequate dental network and with Evercare Select pharmacy director and Prescription Solutions, (Evercare Select's pharmacy benefits manager) to ensure an adequate pharmacy network. Additionally, Provider Services oversees provider education and training, Evercare Select's provider call center, and all of Evercare Select's high-touch provider service programs, as well as monitoring of provider satisfaction.

In developing, administering and monitoring the network, Evercare Select does not discriminate with respect to participation in the ALTCS program, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on that license or certification. Evercare Select does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Evercare Select continually monitors and enhances its' provider network to support the current and future needs of our members. The appropriate mix of providers continually changes as members' medical and cultural needs, technologies and available providers change. Evercare Select makes every effort to include members or their representatives, providers and other appropriate community organizations in the assessment and review of ongoing network changes. Evercare Select initiated network changes are planned, implemented and evaluated to ensure continuous improvement.

Evercare Select's Network Development and Management Plan (Plan) clearly demonstrates Evercare Select's capacity to serve the expected enrollment in each service area, in accordance with ALTCS contract requirements and sound business principles. The Plan is used by the Provider Services Department, in collaboration with other Evercare Select departments, as the basis for ongoing monitoring, evaluation and development of the provider network.

The Plan is reviewed annually, updated by the Provider Services staff and then submitted to Evercare Select's Quality Management Committee for approval. Within 45 days from the start of the next contract year, the approved Plan is submitted to AHCCCS.

The Plan is a living document – it is designed to continually evolve to address the changes in membership, cultures, situations, events, opportunities and concerns.

SECTION II. EVALUATION OF PRIOR YEAR'S PLAN

Prior to any revisions to the Plan, Evercare Select's Manager of Provider Services evaluates the prior year's accomplishments, progress toward achieving objectives, barriers to meeting objectives, current and planned enrollment and any network gaps. This evaluation provides the baseline for establishing priorities for network development and management in the upcoming year.

Evercare Select's accomplishments for the ALTCS program are summarized below:

- Network gaps continue to be filled. The Banner Health System was added to our network and significantly enhanced our network in Maricopa County and in Page, Arizona. Extensive development continues in all GSAs in anticipation of Evercare Selects expansion.
- Reviewed and revised all provider-related materials to improve readability and to verify compliance with contract requirements. A full review and revision of the provider manual, provider newsletters and provider forum materials were completed in 2010.
- Increased coordination with the Medical Management Department to identify network needs, ensuring services are available when and where they are needed.
- Evercare Select supported e-health statewide initiatives with the use of Electronic Medical Records (EMR) through CareTracker.
- Expanded electronic exchange and e-health initiatives by:
  - Increasing Evercare Select EDI claims and EFT rates.
    - Increased EDI rate to **exceed** the State requirement of 65 percent or above.

      Provider Services staff continually educate providers on the benefits of EDI and to identify and remove barriers to EDI submission. Provider Services staff have developed and implemented an EDI work plan that includes increasing both electronic claims and electronic funds transfer rates. The work plan includes targeting providers who are submitting electronic claims but not enrolled in EFT and identifying/removing barriers to electronic claims submission. Additionally, Evercare Select has enhanced the EDI training materials shared in provider forums and publishes EDI provider newsletter articles in each provider newsletter.

These electronic capabilities are furthering our interactions with physicians to improve quality and efficiency of care to our member

Evercare Select continues to manage the programs developed and implemented in 2011 designed to identify, analyze and resolve provider and operational issues. Updates on the progress of the key programs are described below.

Provider Account Management (PAM) Program

The Provider Account Management (PAM) program was initially implemented as a mechanism to address immediate and significant complaints around claims payment, focusing on institutional providers. The Provider Account Management Program was employed to provide a dedicated resource to act as a single point of contact for escalated claim issues. The PAM program focuses on end-to-end root cause analysis as well as appropriate and complete issue resolution. The success of the PAM program is measured by provider satisfaction surveys, an increase in auto-adjudication rates, a reduction in claim adjustments and a reduction in provider Accounts Receivable (A/R) balances for our partner hospitals. The PAM program Network Account Managers (NAMs) continue to work with the hospitals to maintain an aggregate A/R over 60 days and 90 days of 15 percent or less. As of October 2010, the aggregate A/R over 60 days and 90 days was at 17.72 percent. We continue to work with the hospitals participating in the PAM program to bring their A/R down to the established level.

Face-to-Face Initiatives

Evercare Select continues to manage the face-to-face initiatives designed to help address the unique needs of PCPs, specialists and members in both rural and urban GSAs.

- ***Joint Operating Committee Meetings:*** Evercare Select held quarterly Joint Operating Committee meetings with key providers to ensure consistent communication and issue resolution with key providers.
- ***One on One Electronic Education:*** Evercare Select targets assisted living facilities to educate them on the use of the on-line claim portal and electronic claim payments.
- ***Network Development Activities:*** Evercare Select has conducted extensive contracting and development activities in expansion GSAs. Evercare Select staff were on the ground from Yuma to Cochise counties meeting face-to-face with many HCBS providers in these communities. We encouraged face-to-face meetings with prospective providers in the communities we serve.

SECTION III. NETWORK CAPACITY ASSESSMENT

Methodology Used to Assess Network Status and Identify Network Gaps

Evercare Select has established an in depth process to monitor the current status of our network, project future needs and readily identify any network deficiencies or gaps. Evercare Select works continuously to maintain a network of providers capable of providing care in compliance with all ALTCS guidelines and requirements. Several data sources are used to gather and analyze information. These sources include:

- Evercare Select conducts a comparison of Evercare Select's network to the ALTCS Minimum Network Standards. Evercare Select's goal is to meet and exceed, whenever possible, the ALTCS standards.
- Evercare Select produces Geo-Access reports on a quarterly basis to verify the adequacy of the PCP, hospital, pharmacy, and home and community based provider networks. These reports map the existing Evercare Select membership to the contracted hospitals, practice sites of PCPs, pharmacies and home and community based providers in all of Evercare Select's contracted Geographic Service Areas (GSAs). Through analysis of these reports, Network Strategy & Provider Services staff target zip codes in any GSA identified as at risk for failure to meet ALTCS and Evercare Select standards. Using various resources for recruitment, including the AHCCCS Provider File, input from Medical Management Department, existing Evercare Select providers and provider listings from all applicable regulatory boards of licensed providers, staff identify and recruit the necessary providers. Evercare Selects' process for identifying network gaps is discussed below. Evercare Select works continuously to maintain a network of providers capable of providing care to ensure sufficient network primary care and specialty coverage for ALTCS members.
- Our Geo-Access analyses indicates that our network exceeds the standard for 95% of our members not having to travel more than five miles for a PCP or pharmacy for the metropolitan Phoenix and metropolitan Tucson boundary areas.
- Evercare Select's ancillary network provides increased access to care by providing quality services closer to the member's home, and saves transportation costs throughout the state. Evercare Select is contracted with community-based pharmacies, vision services, durable medical equipment, dental, physical therapy, occupational/speech therapies, radiology and laboratories throughout the state.
- Evercare Select's Pharmacy Benefit Manager, Prescription Solutions, is responsible for the recruitment and management of the pharmacy network. Evercare Select holds operational meetings to review utilization and provider profiling reports to ensure proper drug utilization by members and providers. In addition, Evercare Select and Prescription Solutions hold joint operational meetings that provide the forum for discussion of any issues related to delivery of pharmacy benefits and the development of interventional strategies.
- Evaluation of provider compliance with accessibility standards such as appointment availability, wait time in the office, phone and after-hours accessibility.
- Evaluation of the number of physicians who have privileges at and practice in hospitals and the adequacy of specialist coverage at each contracted hospital for all major specialties
- Evaluation of Evercare Select's member population in terms of :
  - Future needs based upon membership growth
  - Expected utilization of services
  - Characteristics of the population such as special health care needs.
  - Demographic profile
  - Disease states (e.g. behavioral health)

- Results of provider and member input. This feedback is obtained through a variety of mechanisms including but not limited to analysis of:
  - Satisfaction surveys
  - Complaints, grievances and appeals
  - Meetings with providers or members
  - Provider Call Center Reports
  - Meetings of Evercare Select's Member Advisory Councils
- Input from staff who are actively involved in working with members and the provider community to identify up-to-date information concerning network issues.

Current Network Status and Network Gaps for GSA 40 Pinal and Gila Counties

A summary of the current network status and any identified gaps, by type of provider is presented below:

- ***Hospitals:*** Evercare Select has two contracted hospitals in GSA 40. Evercare Select **meets** the AHCCCS network standard for hospitals in Pinal but does not meet the AHCCCS network standard for a hospital in Gila County. Our leadership made numerous attempts to contract with this provider including contacting their corporate office in Tennessee. Upon award of this GSA Evercare Select is confident we will be able to secure an agreement with this facility.
- ***Nursing Home Facility:*** Evercare Select has 18 contracted nursing home facilities servicing GSA 40. We do not meet the AHCCCS network standard for Gila County where we have two of the four required facilities. Our leadership made numerous attempts to contract with this provider including contacting their corporate office. Upon award of this GSA Evercare Select is confident we will be able to secure an agreement with this facility.
- ***Acute Services:*** Evercare Select's acute network for GSA 40 **meets** the AHCCCS network standards. It includes durable medical equipment (DME), laboratory, medical imaging, non-emergent transportation and therapies
- ***ALF:*** Evercare Select has eight contracted Assisted Living Facilities in GSA 40 but does not meet the Assisted Living Facility network standard for Pinal County. We made numerous attempts to contract with these facilities however; rate demands far exceeded what is reported in the databook. Upon award of this GSA, we are confident we will be able to secure agreements with these facilities.
- ***Ancillary Services:*** Evercare Select's ancillary network for GSA 40 **meets** the AHCCCS network standards. It includes home health, DME, infusion care, vision, dental, non-emergent transportation, home and community based service providers and other non-physician providers.
- ***HCBS Home:*** Evercare Select's HCBS Home network for GSA 40 **meets** the AHCCCS network standards for Attendant Care, Emergency Alert, Home Modifications, Home Health Care, Homemaker, Hospice, Personal Care and Respite Care. Evercare Select does not meet network standards in Gila County for Adult Day Health, Habilitation and Home Delivered Meals. This gap is addressed in our network gap analysis section
- ***Primary Care Providers:*** Evercare Select's PCP network **meets** the AHCCCS network standards for PCPs in GSA 40. The network includes internists, family practitioners, nurse practitioners and physician assistants. Existing PCP capacity is capable of handling current and future membership growth.
- ***Dentists:*** Evercare Select's dental network **meets** AHCCCS standards in GSA 40
- ***Pharmacies:*** Evercare Select's pharmacy network **meets** AHCCCS standards in GSA 40. Prescription Solutions administers Evercare Select's pharmacy network. We monitor the network closely.
- ***Specialists****:* Evercare Select's specialty network **meets** AHCCCS standards in GSA 40 and includes an adequate array of specialty providers.
- ***Behavioral Health:*** Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 40 and includes an adequate array of behavioral health providers with the exception of Behavioral Health Day Programs in Gila County

Current Network Status and Network Gaps for GSA 42 – Yuma and LaPaz Counties

A summary of the current network status and any identified gaps, by type of provider is presented below:

- ***Hospitals:*** Evercare Select **meets** the AHCCCS network standard for hospitals in GSA 42 in both hospital districts.
- ***Nursing Home Facility:*** Evercare Select's nursing home facility network for GSA 42 **meets** the AHCCCS network standards.
- ***Acute Services:*** Evercare Select's acute network for GSA 42 **meets** the AHCCCS network standards.
- ***ALF:*** Evercare Select **meets** the Assisted Living Facility network standards for GSA 42
- ***Behavioral Health Facilities:*** Evercare Select **meets** AHCCCS network standards for behavioral health facilities in Yuma County. There are no behavioral health facilities located in LaPaz County.
- ***DD Group Homes:*** Evercare Select **meets** AHCCCS network standards for DD Group Homes in Yuma County. There are no DD Group Homes located in LaPaz County
- ***Ancillary Services:*** Evercare Select's ancillary network for GSA 42 **meets** the AHCCCS network standards. It includes home health, DME, infusion care, vision, dental, non-emergent transportation, therapy, home and community based service providers and other non-physician providers.
- ***HCBS Home:*** With the exception of Adult Day Health in LaPaz County, Evercare Select's HCBS Home network for GSA 42 **meets** the AHCCCS network standards. It includes Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care, and Respite Care
- ***Primary Care Providers:*** Evercare Select **meets** the AHCCCS network standards for PCPs in GSA 42. Evercare Select's PCP network includes internists, family practitioners, nurse practitioners and physician assistants. Existing PCP capacity is capable of handling current and future membership growth.
- ***Dentists:*** Evercare Select has 12 contracted dentists in GSA 42. Evercare Select's dental network **meets** the AHCCCS network standard in Yuma County, but does not meet the AHCCCS network standard in La Paz County. This gap is addressed in our network gap analysis section.
- ***Pharmacies:*** Evercare Select's pharmacy network **meets** the AHCCCS network standards in GSA 42. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards in GSA 42 and includes an adequate array of specialty providers and.
- ***Behavioral Health:*** Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 42 and includes an adequate array of behavioral health providers.

Current Network Status and Network Gaps for GSA 44 – Apache, Coconino, Mohave and Navajo Counties

- ***Hospitals:*** Evercare Select **meets** the AHCCCS network standard for hospitals in GSA 44 including Apache, Coconino, Mohave and Navajo Counties.
- ***Nursing Home Facility:*** Evercare Select's nursing home facility network **meets** the AHCCCS network standards for all counties except Apache in GSA 44. We have attempted to contract with this facility on numerous occasions however, the facility is on the reservation and has declined to contract for ALTCS services.
- ***ALF:*** Evercare Select's Assisted Living Facility network for GSA 44 **meets** the AHCCCS network standards in Apache and Coconino Counties with 14 contracted facilities. The AHCCCS network standard in Navajo County is five providers however there are only four registered AHCCCS providers and we have contracts with all four registered providers. The AHCCCS network standard in Mohave County is 28 providers and Evercare Select has contracts 20 facilities. While this does not meet the Assisted Living Facility network standards for Mohave County, Evercare Select has not experienced access or placement issues in this GSA. Further, several providers have elected to admit private pay patients only. This gap is addressed in our network gap analysis section
- ***Behavioral Health Facilities:*** With the exception of Apache County Evercare Select **meets** the AHCCCS network standards for behavioral health facilities.
- **DD Group Homes:** Evercare Select **meets** the DD group home AHCCCS network standard in all counties except Apache. There are no DD group homes in Apache County.
- ***Acute Services:*** Evercare Select's acute network for GSA 44 **meets** the AHCCCS network standards. It includes DME, laboratory, medical imaging, non-emergent transportation and therapies.
- ***HCBS Home:*** With the exception of Adult Day Health, Evercare Select's HCBS Home network for GSA 44 **meets** the AHCCCS network standards in Apache County. It includes Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care, and Respite Care
- ***Primary Care Providers:*** Evercare Select's PCP network **meets** the AHCCCS network standards for PCPs in GSA 44. PCPs include internists, family practitioners, nurse practitioners and physician assistants. Existing PCP capacity is capable of handling current and future membership growth.
- ***Dentists:*** Evercare Select's dental network **meets** the AHCCCS network standards in GSA 44. There is no concern with regard to dental capacity.
- ***Pharmacies:*** Evercare Selects pharmacy network **meets** the AHCCCS network standards in GSA 44. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards in GSA 44 and includes an adequate array of specialty providers.
- ***Behavioral Health:*** With the exception of Behavioral Health Day Programs, Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 44 and includes an adequate array of behavioral health providers. There are no behavioral health Day programs in Coconino County.

Current Network Status and Network Gaps for GSA 46 Graham, Greenlee and Cochise Counties

A summary of the current network status and any identified gaps, by type of provider is presented below:

- ***Hospitals:*** Evercare Select **meets** the AHCCCS hospital network standard for GSA 46 in all hospital districts.
- ***Nursing Home Facility:*** Evercare Select has five contracted Nursing Facilities in this GSA and **meets** the AHCCCS network requirement in Graham and Greenlee Counties. Evercare Select does not meet the AHCCCS network standard for nursing facilities in Cochise County. Our leadership made numerous attempts to contract with this provider including contacting their corporate office. Upon award of this GSA, we are confident we will be able to secure an agreement with this facility.
- ***Acute Services:*** Evercare Select's acute network for GSA 46 **meets** the AHCCCS network standards.
- ***ALF:*** Evercare Select has five contracted Assisted Living Facilities in GSA 46. Evercare Select does not meet the Assisted Living Facility network standards for in Cochise and Graham Counties. This gap is addressed in our network gap analysis section.
- ***Behavioral Health Facilities:*** Evercare Select **meets** the AHCCCS network standards for behavioral health facilities in Cochise County. There are no behavioral health facilities in Graham and Greenlee Counties.
- **DD Group Homes:** Evercare Select **meets** the DD group home AHCCCS network standard in Cochise and Graham counties. There are no DD group homes in Greenlee County.
- ***Ancillary Services:*** Evercare Select's ancillary network for GSA 46 **meets** the AHCCCS network standards. It includes home health, DME, infusion care, vision, dental, non-emergent transportation, therapy, home and community based service providers and other non-physician providers.
- ***HCBS Home:*** With the exception of Adult Day Health in Graham and Greenlee counties, Evercare Select's HCBS Home network for GSA 46 **meets** the AHCCCS network standards. It includes Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite Care.
- ***Primary Care Providers:*** Evercare Select's network of Primary Care Providers **meets** AHCCCS standards in GSA 46.
- ***Dentists:*** Evercare Select has six contracted dentists in GSA 46. Evercare Select's dental network **meets** the AHCCCS network standard in Cochise, but does not meet the AHCCCS network standard in Graham and Greenlee. These gaps are addressed in our network gap analysis section.
- ***Pharmacies:*** Evercare Select's pharmacy network **meets** AHCCCS standards in GSA 46. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards in GSA 46 and includes an adequate array of specialty providers.
- ***Behavioral Health:*** Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 46 and includes an adequate array of behavioral health providers.

Current Network Status and Network Gaps – GSA 48 Yavapai County

A summary of the current network status and any identified gaps, by type of provider is presented below:

- ***Hospitals:*** Evercare Select **meets** the AHCCCS network standard for Hospitals in GSA 48.
- ***Nursing Home Facility:*** Evercare Select **meets** the AHCCCS network standard for Nursing Facilities in GSA 48.
- ***ALF:*** Evercare Select **meets** the AHCCCS network standard for Assisted Living Facilities in GSA 48.
- ***Acute Services:*** Evercare Select's acute network for GSA 48 **meets** the AHCCCS network standards. It includes DME, laboratory, medical imaging, non-emergent transportation and therapies**.**
- ***HCBS Home:*** Evercare Select's HCBS Home network for GSA 48 **meets** the AHCCCS network standards. It includes Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite Care
- ***Primary Care Providers:*** Evercare Select's PCP network **meets** the AHCCCS network standards for PCPs in GSA 48. The network includes internists, family practitioners, nurse practitioners and physician assistants. Existing PCP capacity is capable of handling current and future membership growth.
- ***Dentists:*** Evercare Select's dental network **meets** the AHCCCS network standards in GSA 48. There is no concern with regard to dental capacity.
- ***Pharmacies:*** Evercare Select's pharmacy network **meets** the AHCCCS standards in GSA 48. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards in GSA 48 and includes an adequate array of specialty providers.
- ***Behavioral Health:*** Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 48 and includes an adequate array of behavioral health providers.

Current Network Status and Network Gaps for GSA 50 – Pima and Santa Cruz Counties

A summary of the current network status and any identified gaps, by type of provider is presented below:

- ***Hospitals:*** Evercare Select **exceeds** the AHCCCS hospital network standard in GSA 50 in both hospital districts. Evercare Select contracts with the majority of hospitals in the metropolitan Tucson area, which provides wide geographic coverage.
- ***Nursing Home Facility:*** Evercare Select's nursing home facility network for GSA 50 **meets** the AHCCCS network standards.
- ***Acute Services:*** Evercare Select's acute network for GSA 50 **meets** the AHCCCS network standards.
- **Assisted Living Facilities:** Evercare Select has contracts or LOIs with 80 Alfas in GSA 50. While Evercare Select **exceeds** the total requirement of 63 providers for the entire GSA there are minimal gaps in specific zones. There are no gaps for Alms. The gaps are outlined below:
  - ***ALC:*** Evercare Select has six contracted Assisted Living Centers in Pima County. Of the three remaining gaps, two of the three providers are not participating with the Medicaid program. Evercare Select's leadership contacted this provider's corporate office and received confirmation they are not participating with any Medicaid program contractor including the incumbent. The remaining provider refused to contract or execute an LOI but indicated would discuss participation should Evercare Select be awarded the GSA.
  - ***ALH:*** Evercare Select has 58 contracted Assisted Living Homes in Pima County. We **exceed** the AHCCCS network requirement for ALHs.
  - ***AFC:*** Evercare Select has 16 contracted Adult Foster Care Homes in Pima County. Evercare Select has a gap of one provider in the NW and SW zones. We made numerous attempts to contract with these providers and was advised if Evercare Select were awarded this GSA, the providers would participate at that time.
- **DD Group Homes:** Evercare Select **meets** the DD group home AHCCCS network standard in Pima County. There are no DD group homes in Santa Cruz County.
- ***HCBS Home:*** Evercare Select's HCBS Home network for GSA 50 **meets** the AHCCCS network standards. It includes Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite Care
- ***Primary Care Providers:*** Evercare Select's PCP network in GSA 50 **meets** the AHCCCS network standards for PCPs with 95 percent of our members within 5 miles of a PCP in metropolitan Tucson and within 10 miles of a PCP in Pima County. The network includes internists, family practitioners, general practice and geriatricians. Existing PCP capacity is capable of handling current and future membership growth.
- ***Dentists:*** Evercare Select's dental network **meets** the AHCCCS network standards in GSA 50. There is no concern with regard to dental capacity.
- ***Pharmacies:*** Evercare Select **meets** the AHCCCS pharmacy network standards in GSA 50 with 95 percent of our members within 5 miles of a pharmacy in metropolitan Tucson and within 10 miles of a pharmacy in Pima County. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards in GSA 50 and includes an adequate array of specialty providers.
- ***Behavioral Health:*** With the exception of Behavioral Health Day Program in Santa Cruz Evercare Select's behavioral health network **meets** the AHCCCS network standards in GSA 50 and includes an adequate array of behavioral health providers.

Current Network Status and Network Gaps for GSA 52 –Maricopa County

A summary of the current network status and any identified gaps, by type of provider, is presented below:

- ***Hospitals:*** Evercare Select **exceeds** the AHCCCS network standard for hospitals in all three hospital districts. We contract with the majority of hospitals in the metropolitan Phoenix area, which provides wide geographic coverage. The network includes Wickenburg Community Hospital, and the addition of Banner Health raised the total number of participating hospitals to 22 facilities.
- ***Nursing Home Facility:*** Evercare Select's nursing home facility network for GSA 52 **meets** the network standards.
- ***ALC:*** Evercare Select has 33 contracted Assisted Living Centers in GSA 52. The AHCCCS network standard in Zone 7 is four providers however there are only three registered AHCCCS providers and Evercare Select has contracts/LOIs with all three registered providers.
- ***ALH:*** Evercare Select's Assisted Living Home network for GSA 52 **meets** the network standards.
- ***AFC:*** Evercare Select has 74 contracted Adult Foster Care providers in GSA 52. The AHCCCS network requirement in Zone 1 is 20 and there are only 15 registered AHCCCS providers in this zone. Evercare Select has contracts/LOIs with 18 providers in this zone.
- ***Acute Services:*** Evercare Select's acute network for GSA 52 **meets** the AHCCCS network standards. It includes DME, laboratory, medical imaging, non-emergent transportation and therapies.
- ***HCBS Home:*** Evercare Select's HCBS Home network for GSA 52 **meets** the AHCCCS network standards. It includes Adult Day Health, Attendant Care, Emergency Alert, Home Modifications, Habilitation, Home Health Care, Home Delivered Meals, Homemaker, Hospice, Personal Care and Respite Care
- ***Primary Care Providers:*** Evercare Select's PCP network includes internists, family practitioners, general practice and geriatricians. Evercare Select **meets** the AHCCCS network standards for PCPs with 95 percent of our members within five miles of a PCP in metropolitan Phoenix and within 10 miles of a PCP in Maricopa county Existing PCP capacity is capable of handling current and future membership growth.
- ***Pharmacies:*** Evercare Select **meets** the AHCCCS pharmacy network standards in GSA 52 with 95 percent of our members within five miles of a pharmacy in metropolitan Phoenix and within 10 miles of a pharmacy in Maricopa County. Prescription Solutions administers our pharmacy network. We monitor the network closely with Prescription Solutions.
- ***Specialists:*** Evercare Select's specialty network **meets** the AHCCCS network standards and includes an adequate array of specialty providers.
- ***Dentists:*** Evercare Select's dental network **meets** the AHCCCS network standards. There is no concern with regard to dental capacity.
- ***Behavioral Health:*** Evercare Select's behavioral health network includes an adequate array of behavioral health providers and **meets** the AHCCCS network standards.

How Members Access the Behavioral Health Provider Network

Evercare Select members have open access to the Behavioral Health (BH) service system at any time services are needed. Out of network services are approved whenever necessary to provide continuity of care to the member and to supplement the contracted network where logistical or capacity concerns arise.

First and foremost, members are able to select a Primary Care Provider (PCP) that fits their specific needs. The member's PCP serves as a very effective means to access required medical and behavioral health care services.

In addition, if transportation to services is needed, case management and member service support is available to arrange transportation for the member to obtain the necessary services. In required cases an escort may also be arranged for the member. Evercare Select also arranges, whenever appropriate, for the care to come to the members' home through a diverse panel of BH providers that can visit members in home and community based, residential, and nursing home facility settings.

Case managers also assist members in accessing the BH system by educating them how to access their care and services. The Case manager also facilitates the member/ member's family in becoming involved in their BH care planning and informing them about the network and service options available.

Evercare Select does not require prior authorization of evaluation services, medication management or counseling. Members can contact a behavioral health provider directly to receive an evaluation for these services. Most often, the case manager assists with the referral.

Timeliness of referrals and appointment standards are tracked both through case manager reports and appointment standard calls made by Provider Services to ensure that members can receive an emergency appointment within 24 hours or for routine appointments, within 30 days–see page 61 for a sample Appointment Availability Provider Report.

We provide members an array of written communication and educational material such as their member packets, handbooks, provider directories and newsletters with information regarding their access to behavioral health resources and care. Evercare Select maintains an interactive website to assist members with internet capability to make informed decisions regarding their health care choices and their BH network of providers and services.

Members can also contact Evercare member service to have their questions addressed by a trained representative.

There are also many key Evercare Select departments that assist indirectly helping members to access the BH system. Provider Services plays a key role in this process by assuring that access to convenient and quality health care is available for members. If there is a gap in service, an action plan is put in place to resolve the gap or find the member the care that they need through alternative means.

SECTION IV. IMMEDIATE SHORT-TERM INTERVENTIONS TO ADDRESS A NETWORK GAP

Evercare Select recognizes it is our responsibility to provide our members with accessible services and providers, regardless of the contracting status of providers. When a network gap occurs, Evercare Select takes immediate steps to address the gap so that a member's care is not compromised. Evercare Select Provider Services Department, in collaboration with the Medical Management Department, Chief Medical Officer and other involved parties, immediately assess the availability of other providers in the community. The preferred intervention strategy is to refer the member to another contracted provider that is qualified and available. If a contracted provider is not available, the following short-term interventions are taken:

- ***Referral to a Non-contracted Provider:*** Special provisions such as a letter of agreement are made with non-contracted providers to accommodate the member's needs until an equivalent provider is located, or if possible, a contract with the non-participating provider is secured.
- ***Recruitment of a New Provider:*** To expedite the contracting process, providers recruited to fill a network gap are processed quickly through the use of a provisional and expedited credentialing process pending completion of the standard credentialing process. The Chief Medical Officer may approve provisional credentialing applications within 14 days of receipt of the provider's completed application. Overall, our average credentialing turnaround time is 28 days. Upon the final approval of the provider, Evercare Select executes the provider contract.
- ***Transportation of a Member to a Provider outside the Member's Community:*** If a provider is not available in the member's immediate community, Evercare Select makes arrangements for the member to temporarily receive care from a provider located in another community. This solution is generally used until an appropriate provider is available within the member's immediate community.

Evercare Select also has procedures in place for handling the loss of a hospital/hospital system or large provider group due to immediate contract termination, closure or natural disaster. The procedures are as follows:

Loss of Inpatient Facility (Hospital or Skilled Nursing Facility) Due to Unexpected Closure or Natural Disaster

Evercare Select understands and has planned for unexpected crises in providing services for the complex needs of our ALTCS member population and the resulting challenges the population may face from the closure of a hospital or skilled nursing facility. Evercare Select's Provider Services Manager, Larry O'Connor works in collaboration with other departments such as Quality Management, Case Management, Utilization Management, Member Services, Finance and Compliance to monitor providers with potential viability problems and ensure the coverage and continuity of medically necessary services to members in the event of a facility closure.

Evercare Select manages the loss of a facility, first and foremost, by assessing the impact on both the member and provider communities through a cross-functional approach. We have an established Rapid Response Team which can be convened within 15 minutes that includes senior management leaders including the Executive Director, Medical Director, Director of Case Management, Director of Quality Management, Pharmacy Director, Provider Services Manager and Compliance Officer. The Team assesses the situation and determines the action steps to be taken to arrange access to medically necessary services with minimal disruption to the members. Resources are identified and deployed to ensure the timely execution of the action plan. Common to all loss of service types (i.e., unexpected closure, natural disasters, termination) is a core set of activities vital to a successful transfer. These steps include:

- Identification of all members who will be relocated, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs
- Coordination with the member, the member's family and the caregiver to arrange for the transfer of the member to another facility with the appropriate level of care, including transportation
- Identification of all available facilities, both contracted and non-contracted that are available. If Evercare Select contracted facilities are not available, we will arrange for placement in non-contracted facilities
- Detailed documentation relating to each member and his/her transfer including when and where the member was transferred
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medications, charts, medical equipment and personal belongings of the member are transferred with the member to the new facility
- Monitoring of the new facility(ies) on a daily basis initially (including nights and weekends) to ensure the availability and quality of care is appropriate for each member.

If Evercare Select members experience a loss of service because of a natural disaster affecting a hospital or nursing facility, the redundancy of our network is sufficient to compensate for the loss. Provisions would be made to move residents to the nearest contracted facility(ies) with enough beds to accommodate them. For the rural areas we serve, this may require moving the members out of their county of residence. All hospitals and nursing facilities are required by the Arizona Department of Health Services to have a written disaster plan which includes a written transfer agreement with another facility in the event that members must be moved. In the event no Evercare Select contracted facilities are available, Evercare Select will authorize the use of non-contracted facilities. Depending upon the severity of the event, support will also include crisis counselors and federal, state, county and city first responders. The members' safety during the evacuation and transfer process are the highest priority.

Loss of Major Outpatient Provider Due to Natural Disaster or Unexpected Contract Termination (i.e., immediate termination for cause)

Evercare Select closely monitors all providers known to be at risk for closure. This serves as an early warning system, allowing Evercare Select to identify factors leading to the possible loss of a provider, prevent abrupt closure disruptions and assure coverage of medically necessary service to ALTCS members. The following are examples of warning signs used by Evercare Select in monitoring for potential problems:

- State licensure issues
- Medicare/Medicaid sanctions
- Credentialing or recredentialing concerns
- Failure to secure required insurance
- Multiple requests within a short period of time from a provider for advance payments to cover payroll or operating expenses
- Complaints or concerns raised by Evercare Select staff including but not limited to case managers, quality management nurses, member services staff, provider services, prior authorization staff

- Complaints or concerns from members, family members, caregivers, or PCPs about the availability of care or services.

Action steps which may be taken, based upon the severity of the situation with major outpatient providers who have been identified at risk for potential closures include:

- Increase communications with the provider, including an on-site visits by the Provider Services Manager to discuss the situation
- Request and approve a corrective action plan from the provider to adhere contract compliance
- Suspend all referrals to the provider
- Terminate the contract as appropriate and arrange for services from another contracted provider.

Evercare Select manages the loss of a major outpatient provider similarly to the loss of a facility, by focusing first and foremost, on the impact on both the member and provider communities through a cross-functional approach. Taking a cross-functional, interdepartmental approach, we would convene the Rapid Response Team. The Team will assess the situation and determine the action steps to be taken to arrange access to medically necessary services with minimal disruption to the members. Resources are identified and deployed to ensure the timely execution of the action plan. Common to all loss of service types (i.e., unexpected closure, natural disasters, termination) is a core set of activities vital to a successful transfer. These steps include:

- Identification of all members who will be affected by the loss, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs
- Coordination with the PCP, member, the member's family and the caregiver to arrange for the transfer of the member to another provider
- Identification of all available providers, both contracted and non-contracted that are available to meet the needs of the members. If Evercare Select contracted providers are not available, we will authorize non-contracted providers to deliver services and we will take steps to expedite the contracting process
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medical records transferred to the new provider
- Monitoring of the new provider(s) to ensure the availability and quality of care is appropriate.

A cross-functional team, including representatives from the Provider Services, Medical Management, Member Services, Quality Management, Finance and Compliance departments coordinates activities. Case Management will provide coordination with the affected members, families and caregivers to ensure care is not compromised in any manner. Provider Services will provide communication and coordination with the Evercare Select provider network.

SECTION V. OTHER INTERVENTIONS TO FILL NETWORK GAPS

Evercare Select uses a proactive approach in network development and management. Our objective is to anticipate and plan for potential future network gaps. Most network gaps are the result of a provider

- Ceasing to do business
- Leaving the service area
- Closing its panel to additional members
- Loss of credentials.

When network gaps are identified, Evercare Select uses a variety of integrated and comprehensive intervention strategies to fill these gaps. These include both short-term interventions as well as ongoing intervention strategies.

Ongoing Strategies for Filling Network Gaps

Based on an analysis of its current and future network needs, the Provider Services Department develops and maintains work plans that identify specific network development activities. The work plans are developed and managed consistent with company policies, specify staff positions or department responsibilities and the anticipated timeframes for completion. The work plans are used to track progress, document status and implement changes if necessary. The Manager of Provider Services reviews the work plans with Network Contracting staff and other departments to monitor progress and update or revise activities as necessary. Specific assignments are made to the appropriate staff to oversee the filling of the identified network gaps. The Manager of Provider Services also reports on the status of the work plans to the Service Quality Improvement Subcommittee, which reports on a quarterly basis to the Quality Management Committee.

Evercare Select is continually seeking potential providers who may be interested in contracting. Claims payment data is reviewed to identify non-contracted providers who have provided services more than 25 times in any contract year. When a new or non-contracted provider is identified in response to a network need, the Network Contracting staff contacts the provider to assess their interest in contracting. The Medical Directors or Medical Management staff may also contact or meet with potential providers in an effort to improve recruitment opportunities.

To increase a provider's willingness to participate in the network, Evercare Select may offer a number of "non-financial" incentives including:

- Processes to ease administrative burdens on the provider such as EDI claims submission
- Processes to enhance cash flow to the provider through electronic funds transfer
- In selected areas, use of hospitalists to support and manage inpatient care.

To fill some network gaps, Evercare Select will meet with contracted providers to explore the possibilities of the provider expanding their services. This may result in development of a new service or modification of the way services are delivered, such as a provider seeing members in their home rather than an office setting.

Barriers to Successful Network Development

Although Evercare Select has been successful in filling network gaps through both our short-term and on-going interventions, at times Evercare Select experiences barriers to successful network development. These barriers include but are not limited to:

- Work force shortages in all areas of health care. These shortages exist in both rural and urban settings, and are exacerbated by Arizona's rapid population growth.

- Unwillingness of some providers to see Medicaid members due to burdensome administrative/paper work requirements, low reimbursement rates and difficult to manage patients. In addition, the medical complexity of some members creates unwillingness on the part of some providers to care for high risk individuals.

Despite these challenges, Evercare Select continues to seek effective strategies to mitigate these barriers and provide our members with a comprehensive and responsive network.

SECTION VI. OUTCOME MEASURES AND EVALUATION OF INTERVENTIONS

Evercare Select systematically evaluates the overall adequacy of its network and success of its interventions to fill current and future gaps through the following measurements:

- Comparing Evercare Select's network to the AHCCCS Minimum Network Standards through a Geo-Access analysis of the network;
- Querying the availability of certain provider types in the State's Provider Info file
- Reviewing the AHCCCS PCP report of providers with greater than 1,800 to access PCP capacity
- Analyzing the numbers and types of specialists within each GSA in comparison to the numbers and types of contracted specialists
- Analyzing the results from reviews of compliance with the standards for appointment availability, wait-time in the office, phone and after hours accessibility of providers
- Assessing member and provider satisfaction with accessibility of various types of services, measured through satisfaction surveys, individual feedback, complaints, grievances and appeals
- Soliciting input from other Evercare Select departments such as Case Management, Medical Management, Member Services and Quality Management
- Reviewing utilization reports that identify emergency room and urgent care center usage
- Reviewing reports tracking gaps in services.

Using the information/data sources listed above, Evercare Select conducts, in addition to the quarterly assessments, an annual in-depth review of the network. The results of the 2011 review were used to develop this Annual Network Development and Management Plan and were used to track and measure progress and, as needed, modify network goals to better meet the members' needs. In addition to the annual reviews, these data sources are used on an ongoing basis to measure and evaluate the success of intervention strategies identified in the Network Strategy & Provider Services Department work plans. Based on the results, the work plans are modified to reflect successful closure of gaps, addition of newly targeted areas for network improvement or changes to the type of intervention strategies being employed.

SECTION VII. ONGOING ACTIVITIES FOR NETWORK DEVELOPMENT

Evercare Select continually evaluates the network status on an ongoing basis and implements specific interventions, as needed, to fill any network gaps or deficiencies. Evercare Select will expand the network to meet future growth in membership, to fill identified network gaps, to further enhance services designed to serve special population groups and to address cultural and linguistic issues the membership may have. Evercare Select strives to ensure providers are geographically positioned to ensure our members are able to fully access needed services in a timely manner. Upon identification of any network gap, Evercare Select Provider Services queries the AHCCCS provider file to identify all available providers within a GSA, reviews provider listings from other resources such as phone directories and websites. We develop a plan to address the gap, using multi-departmental representatives from provider services, case management, medical management and other departments to identify potential providers and options to meet our members' needs. These options may include providing the needed service through a provider in a contiguous county with appropriate transportation arranged; providing substitution services within the GSA until the network gap is filled (e.g., if home delivered meals are not available, homemaker or attendant care services may be substituted); and meeting with local community representatives and providers to explore the development or expansion of services and providers. In anticipation of GSA expansion, a significant amount of time will be spent meeting with and educating new Evercare Select providers on the ALTCS program as well as Evercare Select administrative processes. The Evercare Select strategy for CYE2012 is to orient new providers, align our networks and reduce gaps by contracting providers across all product lines. A description of specific network development activities for each GSA is listed on the following pages.

Network Development Activities for GSA 40 – Pinal and Gila Counties

- To address the Gila County hospital gap in Payson, Evercare Select has actively pursued contracting efforts with representatives at Payson Regional Hospital as well as their corporate offices. At this point in time, they are unwilling to sign a contract or letter of intent. They did however indicate they would be willing to revisit the issue should Evercare Select be awarded the ALTCS contract. Upon contract award, Evercare Select will reinitiate contracting discussions with Payson Regional Hospital.
- Upon contract award, Evercare Select will address the Nursing Facility gap in Gila County by working actively to contract with Payson Care Center and Heritage Health Nursing Facility to include them in our network. In speaking with the facilities' corporate ownership, Evercare Select believes they are willing to contract once Evercare Select is awarded the contract.
- We will continue to pursue contracting efforts with any available Assisted Living Facilities not currently part of the network. Evercare Select made numerous attempts to contract with these facilities however; rate demands far exceeded what is reported in the databook. Upon award of this GSA Evercare Select is confident we will be able to secure agreements with these facilities.
- Evercare Select will continue efforts to identify and contract with Adult Day Health, Habilitation and Home Delivered Meal providers in Gila County.
- Evercare Select will work to identify providers for Behavioral Health Day Programs. Services not available in the county will be provided at the closest available location.

Network Development Activities for GSA 42 – La Paz and Yuma Counties

- Evercare Select will continue to monitor and evaluate the network in Yuma County on an ongoing basis and will implement specific interventions, as needed; to fill any identified network gaps or deficiencies. Currently there are no gaps.
- The current dental provider in La Paz County is retiring. Evercare Select will work to identify and pursue available dentists in La Paz County.
- Evercare Select could not identify any behavioral health facilities with active AHCCCS provider numbers in the State's provider database. We will work with the local provider community to assess the feasibility of providing these services locally. Services not available in the county will be provided at the closest available location.
- Evercare Select could not identify any Adult Day Health or DD Group Homes in La Paz County. We will work with the local provider community to identify those providing these services and add them to our network. Services not available in the county will be provided at the closest available location.

Network Development Activities for GSA 44 – Apache, Coconino, Mohave and Navajo Counties

- Evercare Select has actively pursued contracts with the six non-contracted AHCCCS registered Assisted Living Facilities in this GSA and two additional non-AHCCCS registered providers. As an existing program contractor in this GSA, Evercare Select has never experienced placement or access issues. Below is a summary of contracting efforts:
  - Representatives from Jasmine House and Davis House specifically stated they no longer take ALTCS members and have no interest in contracting for the ALTCS program. The facilities are private pay and do not wish to provide ALTCS services at this time.
  - Lakeview Terrace is willing to sign an agreement but is requesting to limit their ALTCS placements to six residents. Evercare Select is continuing contract discussions.
  - Haven House, Shadow Lakes, Arlynn's, MD Care and White Oaks are private pay providers and have refused to participate in the ALTCS program.
- Evercare Select's nursing home facility network **meets** the AHCCCS network standards for all counties except Apache in GSA 44. Evercare Select has attempted to contract with this facility on numerous occasions however, the facility is on the reservation and has declined to contract for ALTCS services.
- Evercare Select will work with the Arizona Assisted Living Federation of America (ALFA) create a strategic plan to develop additional Assisted Living Facilities or Centers should capacity become an issue
- Evercare Select will work with local facilities to develop Adult Day Health programs where none are provided. Bannon Springs has recently expressed an interest in developing an Adult Day Health program and is pursuing licensure. Upon licensure, Evercare Select with pursue contracting efforts with Bannon Springs.
- Evercare Select will identify providers interested in providing Behavioral Health Day Programs and will assist them with licensure and contracting efforts. If services are not available in the GSA, services will be provided at the closest available location.
- Evercare Select will work with facilities in Apache County to contract for Behavioral Health Facility Services. We will work with the local provider community to assess the feasibility of providing these services locally. If services are not available in the county, services will be provided at the closest available location
- Evercare Select could not identify any DD Group Homes in Apache County. We will work with the local provider community to identify those providing these services and add them to our network. Services not available in the county will be provided at the closest available location.

Network Development Activities for GSA 46 – Graham, Greenlee and Cochise Counties

- Evercare Select with identify available Assisted Living Facilities and contract with those that are not currently a part of the network. Upon award of this GSA Evercare Select is confident we will be able to secure an agreement with this facility.
- Evercare Select will address the Nursing Facility gap in Sierra Vista by continuing contract discussions with Life Care Center of Sierra Vista. Our leadership made numerous attempts to contract with this provider including contacting their corporate office. Upon award of this GSA Evercare Select is confident we will be able to secure an agreement with this facility.
- Evercare Select will work with the local Dental community to fill the gaps in the network. Upon award of this GSA Evercare Select is confident we will be able to secure agreements with dental providers.
- Evercare Select could not identify any Adult Day Health or Behavioral Health facilities in Graham and Greenlee counties. We will work with the local provider community to identify those providing these services and add them to our network. We will also assist those providers interested in expanding their services to become licensed and will contract with them for services. If services are not available in the county, services will be provided at the closest available location.

Network Development Activities for GSA 48- Yavapai County

- Evercare Select will continue to monitor and evaluate the network on an ongoing basis and will implement specific interventions, as needed; to fill any identified network gaps or deficiencies. Currently there are no network gaps.

Network Development Activities for GSA 50 – Pima and Santa Cruz Counties

- Evercare Select has actively pursued contracts with the eight remaining Assisted Living Facilities not currently contracted. Below is a summary of contracting efforts:
  - Evercare Select identified two non-contracted Emeritus facilities within Pima County. Evercare Select's senior management has spoken with senior leaders in the Emeritus corporate offices who have indicated their facilities in Pima County are strictly private pay and they are not interested in contracting to provide ALTCS covered services at this time. They indicated they are not participating with any Medicaid program contractor including the incumbent.
  - The remaining facility refused to contract or execute an LOI but indicated they would discuss participation should Evercare Select be awarded the GSA. We are confident we will fill this gap upon award.
- Evercare Select will work with ALFA to create a strategic plan to develop additional Assisted Living Facilities or Centers should capacity become an issue
- Evercare will continue to pursue available Assisted Living Facilities that do not currently participate with AHCCCS, will assist the providers with obtaining an AHCCCS ID number and will contract with these facilities
- Evercare Select will work to identify providers for Behavioral Health Day Programs in Santa Cruz. We will work with the local provider community to assess the feasibility of providing these services locally. If services are not available in Santa Cruz, services will be provided at the closest available location.
- Evercare Select will work to identify DD Group Home providers in Santa Cruz. We will work with the local provider community to assess the feasibility of providing these services locally. If services are not available in Santa Cruz, services will be provided at the closest available location

Network Development Activities for GSA 52 – Maricopa County

- Evercare Select has actively pursued contracts with the remaining non-contracted Assisted Living Facilities. As an existing contractor in this GSA, Evercare Select has not experienced placement or access issues despite these four facilities not participating in our network. Below is a summary of contracting efforts:
  - The ALC requirement in zone seven is four facilities. Evercare Select has agreements or LOI's with the three facilities. There are only three facilities in the AHCCCS database with active identification numbers.
  - The AFC requirement in zone one is twenty facilities. Evercare Select has agreements or LOI's with 18 facilities. There are only 15 in the AHCCCS database with active ID numbers in this zone.
- Evercare Select will work with ALFA to create a strategic plan to develop additional Assisted Living Facilities or Centers should capacity become an issue
- Evercare Select will identify available Assisted Living Facilities that do not currently participate with AHCCCS and pursue contracting by assisting the providers with obtaining and AHCCCS ID number.

SECTION VIII. COORDINATION WITH INTERNAL DEPARTMENTS AND EXTERNAL ENTITIES

Evercare Select recognizes that effective network development and management requires communication and coordination within its own organization, as well as with outside organizations that affect the delivery of services. Input obtained through coordination/communication activities is also used in the development of the annual Network Development and Management Plan.

Coordination between Departments

Evercare Select uses an integrated, cross-functional approach in developing, maintaining and monitoring the provider network. Evercare Select considers this critical activity a health plan-wide endeavor, integrated by interdepartmental monitoring processes and activities, business application systems that are accessible to all areas and oversight committees structured with representatives from across the health plan. As stated in the Introduction, Evercare Select's Provider Services Department has primary responsibility for developing, managing and monitoring our provider network, and works continuously to maintain a network of providers capable of providing care in compliance with all AHCCCS guidelines and requirements. Provider Services staff monitors the status of our network, projecting future needs and identifying any network deficiencies or gaps. The Provider Services Department works closely with Evercare Select's dental department staff to ensure an adequate dental network; and with Evercare Select's pharmacy director and Prescription Solutions (Evercare Select's pharmacy benefits manager) to ensure an adequate pharmacy network. Additionally, the Provider Services Department oversees provider education and training, Evercare Select's provider call center, and all of Evercare Select's high-touch provider service programs, as well as monitoring of provider satisfaction. The organizational seating of the Provider Services Department within Operations ensures that the data points collected through its day-to-day provider servicing activities are continuously applied to help improve Evercare Select operations.

The Provider Services Department routinely communicates and coordinates with other internal departments, including Medical Management , Claims, Quality Management, Credentialing and Contracting, in a variety of ways including the following:

- Provider Services represents Evercare Select at a bi-weekly meeting which includes the UnitedHealth Network, pharmacy and dental contract staff, where there is an open and cross-functional discussion of network information. Network issues and strategies are discussed at these meetings.
- Provider call center conducts weekly conference calls with other Evercare Select departments to review trends on calls received.
- The Provider Services Manager educates the call center on a regular basis to ensure appropriate oversight and to ensure that the staff is familiar with Evercare Select's Network Development and Management Plan and all applicable work plans.
- The Service Quality Improvement Subcommittee which is chaired by the Director of Quality Management reviews and discusses provider service and network issues. The Subcommittee also reviews the results of complaint, grievance and appeals tracking and trending. Members of the Subcommittee include management representatives from Operations, Administrative Services, Member Services, Network Strategy & Provider Services, Quality Management, Appeals and Claims Disputes, Case Management, Utilization Management and Prior Authorization. A summary report of subcommittee activities is submitted to the Quality Management Committee (QMC) on a quarterly basis. The QMC reports to the Evercare Select Board of Directors.
- Representatives from Member Services, Medical Management, Care Management, Prior Authorization and other departments may identify a network issue or potential provider to be included in the network and inform the Provider Services Department. Due to their knowledge of local

communities and providers, these internal sources often assist the Provider Services Department with provider recruitment.

Coordination with External Organizations

- Evercare Select has built relationships with numerous external organizations, including advocacy groups, community groups and health care and business coalitions, all in an effort to develop a responsive network and promote the health and wellbeing of the Medicaid eligible population.
- In most instances, working with these organizations is a cross functional effort within Evercare Select, although the majority of community activities are coordinated through Evercare Select's Community Outreach program, who today works with over 90 organizations through the SHINE Arizona program.
- Evercare Select collaborates with community organizations on important public policy issues impacting the state, such as the uninsured and physician shortages. Some examples of these stakeholders include:
  - Foundation for Senior Living (FSL)
  - Arizona Statewide Independent Living Counsel
  - Arizona Alzheimer's Association
  - Maricopa Integrated Health System (MIHS)
  - Banner Sun Health
  - Arizona State Physician Association (AZSPA)
  - Arizona Health Care Association (AHCA)

    They represent skilled nursing facilities and the home and community based provider network. This forum allows Evercare Select to solicit feedback directly from the network and identify initiatives that are working well and determine future initiatives.
  - Arizona Department of Health Services
  - Arizona Association of Community Health Centers
  - Arizona Osteopathic Association
  - Arizona Medical Association
  - Arizona Hospital and Healthcare Association
  - Arizona Health Plan Association
  - Assisted Living Facility Association
  - Area Agency on Aging
  - Arizona Bridge to Independent Living.
  - Regular verbal communications and meetings with providers to educate and in-service on changes to policy and to act as a liaison to assist them in working with Evercare Select
  - Formal written communications and provider newsletters regarding changes and education on policies and procedures. The provider newsletter is published twice every contract year.

SECTION IX NETWORK FOR SPECIAL POPULATIONS

Evercare Select maintains a provider network designed to meet all the needs of our members. Special attention is given to recruiting and contracting with providers who offer specialized services targeted at the unique needs of special needs members. The Chief Medical Officer and other Medical Directors have significant involvement in the identification and recruitment of providers, based upon their experience with the medical community.

Evercare Select further supports the delivery of care to special needs members by assigning a case manager with the appropriate training and educational background to assist our most vulnerable members.

Evercare Select's network of special needs populations includes behavioral health, Alzheimer's patients, chronic ventilator dependent, pediatric members, homeless members, traumatic brain injury members, HIV patients and wound care. Evercare Select takes a proactive approach in identifying service alternatives for these populations.

Behavioral Health Members

Evercare Select continually recruits and builds this network to ensure that members in need of these services have their needs met. Although, Evercare Select's behavioral health network is strong, there are times that single case and letters of agreement need to be negotiated to address the specific and unique needs of the population. One initiative Evercare Select has initiated is developing work statements for behavioral health Nursing Facilities and Traumatic Brain Injury (TBI) homes. These work statements serve to ensure that member's needs are met through staffing ratios and activities and that Evercare Select's expectations are contractually stated. Please reference the behavior health section in this Network Development Plan for additional information on how Evercare Select recognizes and works to meet the needs of this subset of our population.

Pediatric Members

The needs of children and young adults are met through our contracted pediatric network. We recognize that many of these members have unique medical challenges and needs. Evercare Select has a comprehensive network of over 100 pediatricians statewide to serve the primary care needs of our 68 pediatric Evercare Select members. There is also a contracted network of pediatric subspecialties specializing in cardiovascular disease, dermatology, gastroenterology, infectious disease, nephrology, neurology, ophthalmology and surgery.

CHF Members

Evercare Select has a Clinical Case Manager focused on assisting Case Managers with the clinical management of high-risk members. This Clinical Case Manager conducts telephonic outreach and on site assessments of members diagnosed with Congestive Heart Failure (CHF) and Diabetes.

The type and frequency of outreach is determined by the member's stability, hospital and emergency room utilization patterns, frequency of primary care and specialist appointment needs, health screening results and input from the primary Case Manager. This program allows for early detection and intervention for our members with chronic diseases. Early detection and treatment of identified issues leads to reduced hospital admissions and further complications for these members. The high-risk Clinical Case Manager reviews the results from diabetic screenings completed and verify that the member's primary care physician has reviewed those results and is addressing any variances in results.

The high risk Clinical Case Manager focuses on additional disease management programs and process improvement activities as they are identified by the medical management team.

Diabetic Members

Evercare Select has a diabetic supply program to deliver diabetes supplies to the home and provide Case Management support to instruct members on how to successfully use the supplies. Case Managers review their diabetic members to identify those who have not had their scheduled diabetic screenings completed. The case manager will assist the member in making those appointments and scheduling member transportation if needed. Evercare Select continues to improve diabetic performance measures year after year.

HIV Members

Finally, Evercare Select recognizes the unique needs of patients currently diagnosed with HIV. Based on this need, Evercare Select has contracted a network of providers who can address these needs and coordinate the care for these members.

Name	*Specialty*	*Group Name*
Arey, Brian,	Nurse Practitioner	McDowell Family Practice
Culp, Anita MD	Pediatrics, Primary Care, Inf. Disease/HIV	McDowell Family Practice
Post, John MD	Internal Medicine	McDowell Family Practice
Easley, Foster MD	Family Practice/HIV	First Family Medicine
Cunningham, Donald, DO Cunningham, Douglas, DO	Family Practice	Pueblo Family Physicians

Note: Other specialist such as Internal Medicine and Infectious Disease practitioners also care for members with HIV but did not list HIV specialty in their provider profile.

Homeless Population

Evercare Select understands the importance of serving the homeless population. Providing health care services for this segment of the membership can be challenging. Evercare Select contracts with several providers who have expertise in caring for the needs of our homeless members. For example, Dr. Adele O'Sullivan's group, Maricopa County Health Care for the Homeless exclusively serves the homeless population. Providers such as the FQHCs and Rural Health Clinics throughout the state also serve a significant number of homeless members. Evercare Select contracts with all 15 FQHCs located in all GSAs throughout the state.

Establishing Medical Homes

In recent years the term "Medical Home" has been widely adopted as a way to describe optimal primary care. A medical home requires an entire health care team in alignment with clear goals to improve care. It is an approach that provides primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. We ensure that every member has a primary care home by confirming their PCP assignment, either through choice at enrollment or through auto-assignment conducted in a means that meets contract requirements. We make sure the PCP assigned is appropriate for the members' age, language spoken, within zip code and mileage range to the members' residence, and takes into consideration other family members PCP assignment.

Medical home practices are supported with health information exchange, patient registries, clinical outcomes measurement, as well as with care coordination management and support. The practices in turn work to achieve shared goals to improve access to care, reduce avoidable ER visits, reduce inappropriate utilization and address care opportunities for high-risk patients. Evercare intends to leverage existing medical home models established by our Acute Medicaid Plan provider UnitedHealthcare Arizona Physicians IPA, including eHealth solutions, which will provide enhanced information sharing with our

contracted hospital systems (including several ERs) and two of our contracted FQHCs. Through a web-based tool, we will provide, content that enables health care providers to access patients' health history.

Other Special Need Populations

Evercare Select uses cross-functional feedback to ensure that the needs of special need populations are met. Evercare Select works with the provider network to ensure that coordination occurs for members with special needs including but not limited to, multiple chronic conditions, behavioral health, members with complex medical needs, Children's Rehabilitative Services (CRS) and other populations as appropriate and that the health care needs of these populations are met.

Integrated systems and interdepartmental processes include, but are not limited to:

- Evercare Select integrated computer system, which allows for sharing of member, practitioner, and provider information
- Procedures for Evercare staff to coordinate services, follow-up on complex cases, educate providers, practitioners, members and members', representatives.

When necessary, members with special health care needs are assigned to a specialist for primary care services. For example, members identified with HIV/AIDS can be assigned to providers specializing in HIV/AIDS or members with severe kidney disease can be assigned to their nephrologist.

Evercare Select monitors PCPs to ensure members are receiving appropriate behavioral health management. Evercare Select conducts chart reviews to validate that behavioral health information is documented.

PCPs are informed that they may medically manage select behavioral health disorders, and the availability of medications on the Preferred Drug List to treat depression, anxiety and attention deficit hyperactive disorders.

SECTION X ADEQUACY OF THE GEOGRAPHIC ACCESS TO TERTIARY HOSPITAL SERVICES

Evercare Select evaluates the existing contracts with hospitals and tertiary facilities statewide for inpatient and outpatient coverage. Evercare Select's hospital network is comprised of 56 contracted hospitals and access to the UnitedHealthcare Network for coverage of specialty services not available in Arizona. Consequently Evercare Select's hospital network is comprehensive and robust. We currently do not have any tertiary hospital network gaps. We recently secured contracts with all of the Banner hospitals and have with the following tertiary care hospitals:

- Banner Good Samaritan Medical Center (Phoenix, AZ)
- Banner Desert Medical Center (Mesa, AZ)
- Scottsdale Healthcare – Osborn (Scottsdale, AZ)
- Maricopa County Medical Center (Phoenix, AZ)
- Flagstaff Medical Center (Flagstaff, AZ)
- Phoenix Children's Hospital (Phoenix, AZ).

In outlying or rural areas without tertiary hospitals, Evercare Select coordinates and facilitates the transfer of members needing tertiary hospital services to the nearest tertiary hospital. This is the established pattern of care in these areas and is the same level of service available to the general population. Members may be transported via contracted ground ambulance or air, based on their acuity

In addition to these tertiary hospitals, Evercare Select is able to meet inpatient care needs through a robust and geographically accessible acute care hospital network. Evercare Select is able to provide appropriate professional support in these hospitals through the broad and diverse physician network and through the use of the following strategies:

- ***Residency Programs:*** In order to further enhance access to hospital services, as well as support the needs of the community, Evercare Select currently contracts with hospitals that support residency programs in Maricopa and Pima Counties.
- ***Hospitalists:*** Evercare Select contracts with hospitalists to provide inpatient care management. Many PCPs have decreased or eliminated their hospital practice, preferring to allow providers who specialize in inpatient care management to care for their patients. Evercare Select has contracted with hospitalists that provide services within contracted hospitals.

SECTION XI ASSISTANCE TO PCPS WHEN REFERRING MEMBERS TO SPECIALISTS

Contracted providers are required to coordinate member care within the Evercare Select provider network. If possible, all Evercare Select member referrals are directed to contracted providers. Referrals outside of the network are permitted, but only with prior authorization. In addition, Evercare Select requires prior authorization before making referrals to certain specialists. Requests for prior authorizations are routed through the Prior Authorization Department where nurses and Medical Directors are available 24 hours a day, seven days a week. The Prior Authorization Department staff can also assist PCPs when referring members to specialists that require prior authorization.

If a provider needs assistance with locating a participating provider, they can either work with the member's case manager or contact our provider call center. The provider call center is staffed with Customer Care Professionals trained specifically to assist providers with a variety of issues including the process to refer members to specialists.

Evercare Select communicates the availability of assistance to providers in a number of ways including:

- Information in the Provider Manual
- Provider orientation and training
- Ongoing education and training sessions
- Provider mailings
- Provider site visits conducted by the Provider Services Department
- Provider Newsletters
- Evercare Select website.

SECTION XII ANALYSIS OF APPOINTMENT AVAILABILITY REPORT STATISTICS

Evercare Select uses secret shopper phone calls to ensure that contracted providers are compliant with access and availability standards. We educate our provider network regarding these standards stated in ACOM 417-Appointment and Availability Monitoring and Reporting Policy. Provider Services conducts these surveys on a quarterly basis via a random sampling for specific specialties. If the appointment standards are not met, the findings are presented to the Quality Management Committee and the providers could be placed on a corrective action plan. The standards that Evercare Select measures providers by are the AHCCCS standards:

- Primary Care
  - Emergency PCP appointments – same day of request
  - Urgent care PCP appointments – within two days of request
  - Routine care PCP appointments – within 21 days of request
  - Scheduled appointment wait time – no more than 45 minutes, except when provider is unavailable due to an emergency
- Specialty Referrals
  - Emergency appointments – with 24 hours of referral
  - Urgent care appointments – within three days of referral
  - Routine care appointments – within 45 days of referral
  - Scheduled appointment wait time - no more than 45 minutes, except when provider is unavailable due to an emergency
- Dental
  - Emergency appointments - with 24 hours of request
  - Urgent care appointments – within three days of request
  - Routine care appointments – within 45 days of request
- Maternity Care
  - First trimester – within 14 days of request
  - Second trimester – within seven days of request
  - Third trimester – within three days of request
  - High risk pregnancies – within three days of identification of high risk by Evercare Select or maternity care provider, or immediately if an emergency exists
- Behavioral Health
  - Emergency appointments within 24 hours
  - Routine Appointments within 30 days.

The most recent survey results for CYE11 Q1 are as follows:

- ***Providers Surveyed:*** 74
- ***Providers Passed:*** 69

Providers who are non-compliant and fail to meet the required appointment standards are re-educated regarding appointment time requirements and receive a letter outlining their results. We place a copy of this letter in the provider's contract file and the provider is re-surveyed to ensure improvement.

Results of the surveys are presented to the quarterly QMC for review. The QMC makes recommendations to Provider Services for provider improvement opportunities. Recommendations can include limitation of panel size; closure of the provider panel, reassignment of members and continued monitoring, or no actions if applicable.

Provider Services acts upon the recommendation and reports to the QMC to assure compliance and that corrective actions have been taken

Appointment Wait Times

Evercare Select monitors appointment wait times to ensure that members do not wait more than 45 minutes for their scheduled appointment. The only exception to this wait time standard is when the provider in unavailable due to an emergency.

Annually, Evercare Select conducts a survey of a sampling of providers in regards to appointment wait times. The data is collected by the Provider Services staff. The provider service staff sit in providers' offices and document how long it took an Evercare Select member to begin their appointment. We found that there is a need to increase education regarding appointment wait times with our PCP and Specialty providers. We include that education when we do training and have spoken with providers when there appears to be an issue.

Evercare Select will continue surveying during the 2011/2012 contract year and will be addressing appointment wait times with all provider offices.

Evercare Select is in full compliance with the Appointment and Availability Standards as outlined in ACOM 417-Appointment and Availability Monitoring and Reporting Policy. Evercare Select is in the process of updating the survey tool to differentiate between new and established members.

Provider Audit Methodology

Evercare Select contracts with CareCall, LLC to perform monthly telephonic appointment and availability surveys. The results are provided to Evercare Select monthly and combined quarterly. Evercare Select provides CareCall, LLC with a fill of all participating providers on a quarterly basis. CareCall, LLC selects a random sample of 5 percent of our provider network in each of the audit categories. Evercare Select identifies providers whose panels exceed 1,800 total AHCCCS members and forwards them to CareCall to be audited.

Provider Failure to Comply with Standards

Any provider that fails any standard that is applicable to their office are subject to the following corrective actions:

- Providers who are non-compliant and fail to meet the required appointment standards or wait time standards are be re-educated regarding appointment time and wait time requirements and will receive a letter outlining their results. A copy of this letter will be placed in the provider's contract file. Providers are automatically resurveyed the following month.
- Providers who fail to meet appointment or wait time standards a second time are contacted telephonically and re-educated regarding appointment time and wait time requirements as well as informed that further action may be taken including panel closure. Providers are also automatically resurveyed the following month.
- Providers who fail to meet appointment or wait time standards a third time are visited by their Provider Advocate. The Evercare Select Provider Advocate visits the provider's office and educates on the purpose of the standard and attempts to determine the root cause of the continue failure.

- The provider's panel may be closed to new members and submitted to the PAS/QM Committee for review and determination on next steps.
- The Provider Services Manager will also assess the practice to determine if recruitment of additional provider(s) is required and make a recommendation to the Director of Network Strategy as to whether recruitment of additional providers is needed.

SECTION XIII COLLECTION AND ANALYSIS OF FEEDBACK ABOUT NETWORK DESIGN AND PERFORMANCE

Evercare Select's network development and management activities are guided by provider, member, and staff input and feedback, with areas for improvement identified through such feedback. The Provider Services Department works in collaboration with other departments to gather, evaluate and trend input and to develop effective intervention strategies to address issues identified.

Obtaining Provider Feedback on the Network

The primary source of information related to provider inquiries, complaints and requests for information is the Evercare Select provider call center. All provider calls to our toll-free provider call center will be acknowledged within three (3) business days, and calls that cannot be resolved immediately by provider call center staff will be triaged and warm-transferred to other areas as appropriate for additional research, investigation and resolution. All triaged calls will be assigned a case number by call center staff, entered into Evercare Select's tracking system and communicated to the provider via email, written communication or web-based process. As issues are worked by these other areas (which may include, for instance, health services, contracting, or an interdisciplinary team that addresses specialized claims issues), progress will be documented in our tracking system to facilitate timely resolution. Evercare Select will notify the provider of resolution via email, written communication or web-enabled process, referring to the case number, within 30 business days. Our Manager of Provider Services will manage and monitor the communication and resolution process and timelines.

In addition to receiving provider feedback through our provider call center, Evercare Select uses a wide range of other methods to obtain continuous input from the provider network:

- ***Office Visits:*** Provider Advocates regularly visit PCP, specialist and ancillary provider offices. Each Provider Advocate is assigned a geographic territory to deliver face-to-face support to our providers across the state. These visits are often an excellent opportunity to obtain provider input and suggestions. Each visit is documented. The office visit documentation is reviewed by the Manager of Provider Services to determine if there is specific feedback from the provider.
- ***Provider Forums:*** In addition to the individualized training we conduct at provider offices, Evercare Select holds Provider Forums. The forums are half-day seminars led by the Provider Services Department with other Evercare Select subject matter experts speaking about important issues that affect all practices. Office managers, billing representatives and other office staff from provider offices are invited to attend and provide input.
- ***Committee Participation:*** Participation of providers in Evercare Select committees, such as our Quality Management Committee, Provider Affairs Subcommittee, Rural Advisory Councils and the Joint Operating Committees we have established with several of our key hospitals and provider groups, allows Evercare Select to solicit direct provider feedback.
- ***Provider Survey:*** Provider surveys are conducted as a method of obtaining specific feedback on identified issues, such as medical management procedures, claims processing, prior authorization, provider services and overall provider network adequacy.
- ***Provider Initiated Contact:*** Providers contact Evercare Select for a variety of reasons. Often times the providers contact Evercare Select with suggestions on ways to improve processes or care delivery. All suggestions and comments are documented and forwarded to the appropriate department.
- ***Evercare Select Staff:*** Personnel not affiliated with provider services are also in communication with providers. These personnel include medical directors, case managers, and medical management staff, as well as Evercare Select managers involved in provider claims dispute and appeals processes. Provider input received is communicated to the Provider Services Department for review and analysis.

- ***Meetings with Institutions and Associations:*** Evercare Select senior leaders meet regularly with leaders of institutions to discuss pertinent issues. In addition, Evercare Select meets regularly with regional medical societies, the statewide medical society and the statewide hospital association to discuss network-related issues.

Obtaining Member Feedback on the Network

Evercare Select also monitors network performance against standards through the following:

Member Grievances

Evercare Select staff document, research and follow-up as appropriate on member issues received that relate to dissatisfaction with care and services, such as wait times and appointment availability. The Quality Management Department tracks and trends grievances by provider on a quarterly basis. When an individual provider's trends indicate non-compliance with standards, the information will be given to the Provider Services Department as well as the Service Quality Improvement Subcommittee for intervention and follow up. The Service Quality Improvement Subcommittee reports their findings and interventions to the Quality Management Committee. The information will also be provided to the Provider Affairs Committee which conducts credentialing and peer review activities.

Member Surveys

An annual mail-in survey is conducted to assess areas of satisfaction or areas for improvement with the provider network from the members' perspectives. The member satisfaction survey results are analyzed and presented to the Service Quality Improvement Subcommittee for review and action, as appropriate. Member satisfaction surveys include questions relative to provider and transportation appointment scheduling and wait times. In compliance with ACOM Policy 417 for appointment and availability standards, beginning October 2008 we also will include a member survey component in our quarterly audits of provider appointment availability.

Obtaining Staff Feedback on the Network

Section VIII of this Plan outlines the ways in which Evercare Select's Provider Services Department routinely communicate with other internal departments. Through such communication, staff feedback is obtained regarding network design and performance. For instance, representatives from Member Services, Medical Management, Case Management, Prior Authorization and other departments may identify a network issue or potential provider to be included in the network and inform the Provider Services Department. Due to their knowledge of local communities and providers, these internal sources often assist with provider recruitment. For instance, care managers identify the need for specific provider types in specific GSAs based upon their daily care management of special needs members. The care managers submit requests to recruit additional providers to the Provider Services Department. Evercare Select has added physicians to the network for special health care needs members based upon input from care managers.

The Member Services Department performs provider monitoring activities by identifying and processing member-requested changes and addressing member grievances on a provider-specific basis. PCP changes are made in Evercare Select's management information system and are reviewed on a monthly basis to identify any trends that need to be addressed regarding the provider network. All member grievances are documented allowing extensive reporting on the provider-specific complaints received from members. This information is shared with the Provider Services Department to assist in monitoring the network.

The Quality Management Department uses the credentialing and recredentialing processes for various provider types such as physicians, physician extenders, skilled nursing facilities and dental providers as methods of ensuring the network consists of quality providers. The credentialing activities are performed in accordance with Evercare Select policies and procedures that are consistent with the standards of the National Committee for Quality Assurance (NCQA) as well as AHCCCS, DHES and AHCCCS

standards. These activities also include the granting of provisional credentials, an acceleration of the basic credentialing process, allowing for the execution of Letters of Agreement in response to specific provider network needs.

The Quality Management Department also monitors compliance with medical record standards through onsite review of provider medical records. Evercare Select verifies that all medical record components as defined in the AHCCCS Medical Policy Manual are met including maintaining legible records that are up-to-date, well organized and comprehensive. A medical record audit tool is used to verify medical record compliance. Providers with substandard scores are subject to interventions.

Addressing Identified Provider Network Issues

Feedback on network design and performance from all sources is collected, reviewed, trended and analyzed by the Provider Services Department for the purpose of identifying and prioritizing areas for immediate action, further investigation or development of a process improvement plan. These multiple data points of provider information are an early warning system to identify issues as early as possible and avoid escalation. The Manager of Provider Services presents the issues, recommended priority and proposed intervention(s) to the Service Quality Improvement Subcommittee. The Subcommittee is responsible for approving work plans and tracking progress against goals. A summary report of the activities is provided to the Quality Management Committee on a quarterly basis.

SECTION XIV ONGOING ACTIVITIES FOR NETWORK MANAGEMENT

Evercare Select's network management program is focused on developing, maintaining and monitoring the performance of the network. Network stability, coupled with flexibility and adaptability are essential to meet the needs of our members. Evercare Select's ongoing network management activities include but are not limited to initiation of new programs and activities, communication, education, training, monitoring and evaluating to ensure compliance with AHCCCS, CMS and AAHCCCS Minimum Network Standards.

New Programs and Activities

As previously mentioned in Section IX, "Network for Special Populations, Evercare Select will participate in our existing Medical Home Models. As a result of the success of the program with our Acute Arizona Medicaid Plan, it was expanded in 2010 to target the top 20 primary care practices. We will continue to develop best practices for medical homes with our ALTCS population.

INSPIRIS a care management company that offers proactive, high touch physician and nurse practitioner services through an in-home care model recently joined the UnitedHealth Group family of companies. In addition to our nurse practitioner model for institutionalized members, Evercare Select is expanding our in-home services for ALTCS members in Maricopa and Pima counties through INSPIRIS. We are commencing work with our new colleagues to leverage INSPIRIS' experience and capabilities throughout the state.

In addition to the medical home model, Evercare Select is pursing contracts with Nurse Practitioners to fill Primary Care Physician gaps after hours in our rural GSA. We are focusing on members residing in ALCs/ALHs/NFs that have more limited AHCCCS to their PCP after hours with the goal of reducing ER admission and hospital readmissions. We expect to be fully operational by Q4 CYE11.

Communications

The provider call center is the primary point of contact for most provider issues. The provider call center, located in Texas, is staffed with Provider Service Representatives trained specifically to assist providers with a variety of issues. In addition, Provider Services Department staff routinely meets with providers to offer education and support for any issue that may arise. Evercare Select employs both oral and written communication to convey to providers applicable federal and state laws, AHCCCS requirements, ADHS requirements, Evercare Select policies and procedures and resources for assistance. Additional components of our communication process include but are not limited to the following:

- ***Provider Notifications and Contract Amendments:*** Evercare Select will notify providers of any change to applicable laws and regulations 30 days prior to enactment. A formal contract amendment process is employed to incorporate these changes into the legal document. Likewise, any changes in contractual terms and conditions will follow this same process.
- ***Provider Website Link:*** To facilitate provider communications pertaining to administrative functions, Evercare Select offers an interactive website, which enables providers to electronically determine member eligibility, submit claims and ascertain the status of claims. Evercare Select has developed an internet based prior authorization system, iExchange, which allows providers who have internet access the ability to request their medical prior authorizations on line rather than telephonically. The Evercare Select website also contains an online version of the Provider Manual, the Preferred Drug List, clinical practice guidelines, quality and utilization requirements and educational materials such as cultural competency information, newsletters, recent fax service bulletins and other provider information.
- ***Provider Newsletter:*** Evercare Select produces and distributes a provider newsletter to the entire network at least four times a year. The newsletters contain any program updates, claims guidelines,

information regarding policy and procedure changes, information that may affect claims and encounters, information regarding cultural competency and linguistics, practice guidelines, notifications on Preferred Drug list enhancements or changes and articles regarding health topics of importance to Evercare Select members.

- ***Provider Surveys:*** Provider surveys are conducted as a method of obtaining specific feedback on identified issues, such as medical management procedures, claims processing, prior authorization, provider services and overall provider network adequacy.
- ***Office Visit:*** Provider Services Representatives regularly visit provider offices. These visits are often an excellent opportunity to obtain provider input and suggestions.

Education and Training

Evercare Select conducts orientation training with each newly contracted provider or anytime at the request of a provider. The orientation sessions include an in-service to communicate rules, regulations and expectations and identify resources and appropriate methods of communication with Evercare Select. The Provider Services staff meets with the provider's office staff, including the office manager, billing manager, referral coordinator, nurses or medical assistants to conduct the orientation. The Provider Manual is supplied to all contracted providers. The provider is informed that the Provider Manual can also be accessed via the Evercare Select website. A hard copy can be given to the provider upon request. The manual includes comprehensive information related to care requirements, service specifications, provider responsibilities and instructions on how to interact with Evercare Select. It also includes billing information for all provider types and information on health maintenance and practice guidelines. The Provider Manual is a primary source of information for the provider network. The manual is reviewed annually and updates are made as needed.

Monitoring

Evercare Select continuously monitors the provider network for accessibility, availability and quality. This is done to ensure that the network it is sufficient to provide all covered services, specifically HCBS, institutional, behavioral health and acute services to the ALCTS members. Additionally, the Provider Services Department is responsible for coordinating and conducting onsite provider visits. Provider Services visit primary care providers, specialists and ancillary provider offices on a regular basis. Each Provider Service Advocate is assigned to a geographic territory to deliver face-to-face support to our providers across the state. The prioritization and quantity of provider office visits by these staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography and other special needs. Evercare Select's frequency of visits increase if monitoring indicates issues of non-compliance with requirements.

Evercare Select's dental department staff visits all high volume dentists on a quarterly basis and all other dentists at least annually. If a provider or dental office needs immediate attention, both the Provider Service Representatives and dental department staff make themselves readily available to address provider needs.

Hospitals are categorized using volume and other criteria. Tier 1 hospitals are those facilities with either high utilization or spending patterns or critical access status (i.e., the only hospital provider in a given geographical area). Evercare Select's Provider Services Department, in collaboration with other functional areas, conducts Joint Operating Committee meetings with Tier 1 hospital providers on a quarterly basis and Tier 2 hospital providers twice per year or as needed.

The purpose of the site visits will be to determine contractual compliance, including but not limited to medical records, appointment availability, physical environment, appointment wait times, advance directives and service delivery documentation. Staff from other departments may accompany the Provider Services staff on site visits in order to provide specific information and education to the provider.

Availability

Evercare Select will routinely perform an analysis of provider availability using GeoAccess software. Information obtained through the availability analysis will be used to manage and monitor the network throughout the year and to focus recruiting efforts. If deficiencies are identified, the cause and opportunities for improvement are determined, with responsibility for intervention assigned.

The availability analysis will include ratio and radius analysis of PCPs, pharmacies, hospitals and high volume specialties and a review of open/closed PCP panel percentages. Key cities and zip codes without desired access are identified by specialty so that focused recruiting efforts may be made as noted above.

PCP open panels are monitored on a quarterly basis to ensure adequate availability to members. Evercare Select uses AHCCCS' quarterly report that indicates when a provider is nearing his/her capacity of assigned members exceeds 1,800 total members. The 1,800 members per PCP report is used alert the staff that the PCP is exceeds the threshold of 1,800 members per provider and initiates a review of their appointment availability and wait times.

Accessibility

Appointment scheduling and wait times are monitored during using the methodology found in the ACOM *Appointment Availability Monitoring and Reporting Policy*, and Described in Section XII of this Plan, to ensure that the following standards are met:

- Primary Care
  - Emergency PCP appointments – same day of request
  - Urgent care PCP appointments – within 2 days of request
  - Routine care PCP appointments – within 21 days of request
  - Scheduled appointment wait time – no more than 45 minutes, except when provider is unavailable due to an emergency
- Specialty Referrals
  - Emergency appointments – with 24 hours of referral
  - Urgent care appointments – within 3 days of referral
  - Routine care appointments – within 45 days of referral
  - Scheduled appointment wait time - no more than 45 minutes, except when provider is unavailable due to an emergency
- Dental
  - Emergency appointments - with 24 hours of request
  - Urgent care 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 Evercare Select or maternity care provider, or immediately if an emergency exists
- Behavioral Health
  - Emergency appointments within 24 hours
  - Routine Appointments within 30 days.

Results are entered into a database for tracking and trending purposes. All non-compliance issues are addressed with the provider upon identification. Additional follow up reviews are conducted to ensure future compliance.

Transportation

Evercare Select requires all 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 after the appointment for transportation home.

Additional Monitoring Measures

Evercare Select also will continue to monitor provider performance against standards through the collection and analysis of member grievances, member satisfaction surveys and quality management review, as Described in Section XIII of this Plan.

The overall goal of Evercare Select is to offer a provider network of the highest quality and to ensure that all ALTCS and Evercare Select standards are met. Evercare Select uses regular communication, education and ongoing monitoring of the network to measure the compliance of the network.

SECTION XV CYE12 NETWORK PLAN

Evercare Select is planning the following network changes or enhancements for the coming year:

- Evercare Select will change its provider for vision benefits from Spectera to Nationwide Vision
- Increase access to a wider array of therapy, radiology and ancillary services by leveraging contracts held by OptumHealth Physical Health, a UnitedHealth Group business to expand therapy services to rural and urban areas throughout Arizona
- Expansion of the medical home partnership model to include Evercare Select in Maricopa and Yuma counties.
- Facilitation of medical home concepts and hospitalists at our largest volume hospitals
- Pursuit of statewide HIE in collaboration with Health Information Network of Arizona (HINAZ)
- Enhance the monitoring and tracking of the Provider Service Center a regular reporting package for reviewed monthly at our network management meetings.

Listing of the non-Medicare Certified Home Health Agencies

Evercare Select has been able to meet the needs of our members through the Medicare certified Home Health network in most areas. We are not using any State certified agencies at this time. We do however realize that State certified Home Health agencies are a resource available to us. We are currently assessing other agencies for strategic expansion.

In Mohave County, we use:

- Carla Register, RN 488256
- Donna Pool, RN 469694.
- Sandy Walters, RN 465739.

Listing of the Assisted Living Facilities for which Evercare Select has obtained a waiver from the Single Choice Occupancy requirement.

We have not obtained any waivers from the Single Choice Occupancy requirement and are collecting the single choice occupancy form from members at all of our facilities when necessary.

Listing of the Nursing facilities which have withdrawn from the Medicaid Program, but are still being utilized by Evercare Select.

Evercare Select is not currently utilizing any Nursing facilities that have withdrawn from the Medicaid Program.

The Strategies the Program Contractor has for Work Force Development:

As is well known in the health care industry, there are experienced shortages in critical service providers. As the medical industry changes and evolves and members needs become more complex, it is getting more difficult to recruit and retain critical providers. A prime example of this shortage is nursing and paraprofessional care. Arizona is one of the top five states impacted by this shortage.

- Evercare Nurse Practitioners representatives actively participate on education panels and clinical perceptorship with undergraduate nursing program through the nursing program at Arizona State University and the University of Arizona
- Evercare Nurse Practitioners provide geriatric training for the University of Arizona School of Medicine Department of Family Practice

- Evercare staff members participate in the Arizona Geriatric Society for development of education programs throughout the State which includes caregivers, nurses, physicians and other allied professionals
- Evercare Nurse Practitioners are recognized by ADHS to provide educational programs which can be applied towards CAPs – we had to apply and provide credentials for this process
- Evercare Select staff is part of the Direct-Care Workforce Committee that is comprised of multiple community agency personnel including other program contractor staff
- An Evercare staff member has been an adjunct faculty member at Phoenix College for over five years as an Instructor for the Health Enhancement Program teaching, "Fundamentals in Health Care Delivery" a required core course for students pursing careers in health care
- Evercare Select will continue to participate on the work force development initiative in collaboration with other community parties
- Evercare Select will continue to drive this work force development initiative and use any resources that UnitedHealth Group can offer at the corporate level.

Strategies Evercare Select Will Take to Provide Members With "In-home" HCBS Versus Placing Members in an Assisted Living Facility or Nursing Facility:

Evercare Select has been effectively managing HCBS placements since the beginning of the contract. We have successfully maintained members in the least restrictive settings despite our capped enrollment in Maricopa County. Initiatives include:

- Member and family caregiver support
  - Case managers have received and will continue to receive education surrounding Palliative and Advanced Illness care. These trainings are intended to give the Case Manager the tools they need to assist the member and their family in identifying what is needed to maintain the member in the home setting. The Case Manager works with the member and their families to identify common goals that will help the member maintain their dignity and independence as they age in place.
  - Evercare Select Case Managers are expected to educate members and their families on the member's respite benefit. When the Case Manager identifies a caregiver or family member who appears to be or reports to be frustrated or overwhelmed in their current situation, they remind the member and their caregiver of this valuable benefit. Members are encouraged to use this benefit prior to any discussions regarding long- term placement in a nursing facility or assisted living facility.
  - Case managers assist their members in accessing community resources that may help the member remain in the home setting. Examples of these resources include utility and phone assistance, and home maintenance programs, volunteer respite care, support groups and companion services.
- Workforce development
  - Evercare Select has representation on the direct care workforce committee. The expected outcomes of this committee's work will be caregivers with better skills and more caregivers available to serve members in their homes.

    For members with a spouse, case managers will continue to educate the member and their spouse on this program, and will assist the member's spouse in obtaining training and employment with a contracted attendant care agency. Case managers will monitor the effectiveness of the spouse meeting the member's needs this will verify the member's satisfaction with the service provision. The Case Manager will also notify the member and their spouse of any training opportunities that are available to them. They will also avail the spouse access to caregiver support groups or other

community resources that provide a supportive structure for caregivers. Evercare Select has over 90 members' spouses currently participating in this program.

- Case managers will continue to update members on Self Directed Attendant Care (SDAC). Case managers will assist the member and their identified caregiver in obtaining the necessary training needed to provide this service. Evercare Select is working with two fiscal intermediary agencies to coordinate all the administrative tasks associated with this program. Members and providers are also being educated on the SDAC program through Member Provider Advisory Councils, member newsletters and provider newsletters. Case Managers will receive additional training facilitated by AHCCCS prior to the implementation of this program.

  Evercare Select has partnered with two FEA contracted providers to support the growth and educate our membership about the SDAC care option. To date, only one member has taken advantage of this benefit. Case Managers are continuing to educate all members and their responsible parties about this new service available to them. Members and their representatives from every placement setting are included in this education.

- Health maintenance and education
  - Evercare Select has physician**,** nurse practitioner and behavioral health providers that provide service to our members in their homes. These services are made available to members that cannot leave their home or refuse to leave their home to receive treatment because of physical or emotional reasons. This service delivery model has been very effective with diagnosing and treating children who may not otherwise receive appropriate treatment.
  - We have mobile laboratories that are able to conduct diagnostic testing in the home. An example of this is our program for diabetic testing in the home.
  - Evercare Select has obtained approval from AHCCCS to distribute educational materials on diabetes, heart disease, smoking–cessation, etc. Case Managers give those materials to our members and their family as a tool to improve the member's or family's understanding of the disease process and to give them tools to take better care of themselves.

Community Reintegration

The case management department has two initiatives geared towards helping members reintegrate in to the community from skilled nursing facility or assisted living facility placements.

One case manager has been identified as a Reintegration Specialist. Her role is to assist other case managers with addressing identified barriers to a member's successful reintegration to the community. Examples of barriers include housing, transportation, social supports, member specific network gaps and household items. The Reintegration Case Manager works with the assigned Case Manager, the member, providers and the member's family or friends to facilitate a safe discharge to the community. The Reintegration Specialist will assist the member with applying for financial assistance and other available resources to support the member's home placement.

Another way Evercare Select is focusing attention on reintegrating members to home community settings is the Member Empowerment (ME) resource team. The team is comprised of Case Managers and Managers from each of the Counties we serve. The role of this team is to identify "local" community resources that can be shared with members. The team is compiling a resource directory that all staff can access to identify community resources in all regions of the State. As the Reintegration Case Manager works with individual members and their families towards a community discharge plan both the resource directory and the ME resource team are used as tools to assist in meeting the member's goal of returning to a home community setting.

Other Activities

Evercare Select has one Medical Director dedicated to facilitating case reviews. This provides the Case manager with an additional resource to evaluate a member's stability whether it is medical in nature or if the member is at risk for a change in placement. Each manager has a designated time during the week to schedule with the Medical Director case reviews for their team. A case review is always completed when it is anticipated a member may be in need of or wants nursing facility placement.

In 2009, we completed case reviews on all Evercare Select only members and those living in an HCBS setting to see if the member's needs were being met.

Evercare Select continues to identify habilitation and occupational therapy providers who can assist members in improving their independence with activities of daily living. These providers help to maintain people who are currently in the home or help members increase their independence so they can move to a home community setting. These providers have historically been valuable for our pediatric and behavioral health members but are also used for our general population members.

Percentage of Members Residing in Alternative Residential Settings

Less than 25 percent of Evercare Select members reside in an Alternative Residential Setting *(ARS) per GSA so no action plan is needed.

Evercare Select's statewide HCBS community placement percentage is at **20.15 percent**. Despite a capped and aging population in Maricopa County, Evercare Select has **maintained less than 25 percent placement percentage for more than four consecutive quarters.** Establishing our Reintegration Specialist, as described in the Community Reintegration section, will further our efforts to maintain our low percentage.

Listing of the Assisted Living Facilities for which Evercare Select has obtained a waiver from the Single Choice Occupancy requirement

We have not obtained any waivers from the Single Choice Occupancy requirement and are collecting the single choice occupancy form from members at all of our facilities when necessary.

Listing of the Nursing facilities which have withdrawn from the Medicaid Program, but are still being utilized by Evercare Select

Evercare Select is not currently utilizing any Nursing facilities that have withdrawn from the Medicaid Program.

Below is a list of Evercare Select's contracted nursing home facilities. As previously stated Evercare Select ensures that all members are offered the **most integrated setting** and afforded a choice to remain in their own home environment or to choose an alternative residential setting versus admission to a skilled nursing institution. When Evercare Select members are inpatient, Evercare Select's Utilization Management (UM) Nurses work collaboratively with physicians, members and families to ensure a safe discharge. This includes the identification of and placement in alternative living settings instead placement in a nursing home facility for the duration of their recuperation in accordance with AHCCCS guidelines. Evercare Select implements Letters of Agreements (LOAs) on an ad hoc basis to facilitate placement of acute members in alternative health care setting when appropriate.

Nursing Home Facility	*County*	*Nursing Home Facility*	*County*
■ Apache Junction Health Care	Pinal	■ Archstone Care Center	Maricopa
■ Arizona State Veterans Home	Maricopa	■ Avalon Care Center- Shadow Mountain	Maricopa
■ Baptist Village - Sun Ridge	Maricopa	■ Beatitudes Campus of Care	Maricopa
■ Bella Vita Health & Rehab (FKA Desert Sky)	Maricopa	■ Capri at the Pointe Rehab	Maricopa
■ Carondelet Holy Cross Hospital	Pima	■ Catalina Health Care Center	Pima
■ Chandler Health Care Center - Avalon	Maricopa	■ Chris Ridge Premier Care & Rehabilitation Center	Maricopa
■ Christian Care Nursing Center	Maricopa	■ Citadel Care Center	Maricopa
■ Cook Health Care Center	Maricopa	■ Coronado Care Center	Maricopa
■ Desert Blossom (FKA Chula Vista)	Maricopa	■ Desert Cove Nursing Center	Maricopa
■ Desert Haven Care Center	Maricopa	■ Desert Highlands Care Center	Mohave
■ Desert Life Rehabilitation & Care Center	Pima	■ Desert Terrace Nursing Center	Maricopa
■ Devon Gables Health Care Center	Pima	■ East Mesa Care Center	Maricopa
■ Gardens Care Center	Mohave	■ Glencroft Care Center	Maricopa
■ Glendale Care Center	Maricopa	■ Good Samaritan - Prescott Valley	Yavapai
■ Good Samaritan - Prescott Village	Yavapai	■ Good Samaritan - Quiburi Mission	Cochise
■ Good Shepherd Retirement Care Center	Maricopa	■ Good Shepherd Villa	Maricopa
■ Grace Healthcare of Phoenix	Maricopa	■ Hacienda Rehabilitation & Care Center	Cochise
■ Hacienda Skilled Nursing Facility	Maricopa	■ Handmaker Jewish Services	Pima
■ Havasu Nursing Center	Mohave	■ Highland Manor - Mesquite	Mohave
■ Highland Manor Health & Rehab. Center	Maricopa	■ Immanuel Campus of Care	Maricopa
■ Kachina Point Health Care & Rehabilitation Center	Coconino	■ La Canada Care Center	Pima
■ La Colina Care Center	Pima	■ La Estancia Nursing & Rehab	Maricopa
■ La Mesa Healthcare Center	Yuma	■ La Solana Health Care & Rehab	Cochise
■ Lake Hills Inn	Mohave	■ Las Fuentes Care Center	Yavapai
■ Life Care Center Of North Glendale	Maricopa	■ Life Care Center Of Paradise Valley	Maricopa
■ Life Care Center Of Scottsdale	Maricopa	■ Life Care Center Of South Mountain	Maricopa
■ Life Care Center Of Tucson	Pima	■ Life Care Center Of Yuma	Yuma
■ Manorcare Health Center	Pima	■ Maravilla Care Center	Maricopa
■ Maryland Gardens Care Center	Maricopa	■ Meadow Park Care Center	Yavapai
■ Mesa Christian Health & Rehabilitation Center	Maricopa	■ Mi Casa Nursing Center	Maricopa
■ Mission Palms	Maricopa	■ Mountain View Care Center	Pima

Nursing Home Facility	*County*	*Nursing Home Facility*	*County*
■ Mountain View Manor	Yavapai	■ North Mountain Medical & Rehab Center	Maricopa
■ Northern Cochise Nursing Home	Cochise	■ Oasis Pavilion Nursing & Rehabilitation Center	Pinal
■ Osborn Health and Rehabilitation Center	Maricopa	■ Palm Valley Rehab & Care Center	Maricopa
■ Palm View Care Center	Yuma	■ Park Avenue	Pima
■ Park Regency Care Center	Maricopa	■ Phoenix Mountain Nursing Center	Maricopa
■ Plaza Del Rio Care Center	Maricopa	■ Plaza Healthcare	Maricopa
■ Ponderosa Pines Care & Rehab	Coconino	■ Posada Del Sol Health Care Center	Pima
■ Pueblo Springs Health and Rehab	Pima	■ Red Rock Care and Rehab	Yavapai
■ Ridgecrest Healthcare	Maricopa	■ Rim Country Health and Retirement Community	Gila
■ Sabino Canyon Rehab & Care Center	Pima	■ Santa Rita Care Center	Pima
■ Santa Rosa Care Center	Pima	■ Scottsdale Nursing & Rehab	Maricopa
■ Scottsdale Village Square	Maricopa	■ Sierra Blanca	Navajo
■ Springdale Village Health Care	Maricopa	■ Springdale West	Maricopa
■ Sun City Health & Rehab Center	Maricopa	■ Sun Grove Village Care Center	Maricopa
■ Sun View Care Center	Maricopa	■ Sun West Choice Healthcare & Rehabilitation	Maricopa
■ Sunbridge Estrella Care & Rehabilitation	Maricopa	■ Suncrest Healthcare Center	Maricopa
■ Sunset Hills Care & Rehab	Graham	■ Tall Pines Care & Rehab	Navajo
■ The Legacy Rehab & Care Center (FKA Silverridge Village)	Mohave	■ The Lingenfelter Center	Mohave
■ The Peaks	Coconino	■ Trillium East	Maricopa
■ Trillium West	Maricopa	■ Verde Vista Care & Rehab	Yavapai
■ Villa Campana Health Center	Pima	■ Westchester Care Center	Maricopa
■ Winslow Campus of Care	Navajo	■ Yuma Nursing Center	Yuma

Description of how the Contractor will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, larger provider group)

Evercare Select understands and has planned for the unexpected crises in providing services for the complex needs of our ALTCS member population as well as the challenges the population may face as a result of the closure of a hospital or skilled nursing facility. Evercare Select's Provider Services Manager, Larry O'Connor works in collaboration with other departments such as Quality Management, Case Management, Utilization Management, Member Services, Finance and Compliance to monitor providers

with potential viability problems and ensure the coverage and continuity of medically necessary services to members in the event of a facility closure.

Evercare Select manages the loss of a facility, first and foremost, by assessing the impact on both the member and provider communities through a cross-functional approach. We have an established Rapid Response Team, which can be convened within 15 minutes that includes senior management leaders including the Executive Director, Medical Director, Director of Case Management, Director of Quality Management, Pharmacy Director, Provider Services Manager and Compliance Officer. The Team assesses the situation and determines the action steps to be taken to arrange access to medically necessary services with minimal disruption to the members. Resources are identified and deployed to ensure the timely execution of the action plan. Common to all loss of service types (i.e., unexpected closure, natural disasters, termination) is a core set of activities vital to a successful transfer. These steps include:

- Identification of all members who will be relocated, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs
- Coordination with the member, the member's family and the caregiver to arrange for the transfer of the member to another facility with the appropriate level of care
- Identification of all available facilities, both contracted and non-contracted that are available. If Evercare Select contracted facilities are not available, we will arrange for placement in non-contracted facilities
- Detailed documentation relating to each member and his/her transfer including when and where the member was transferred
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medications, charts, medical equipment and personal belongings of the member are transferred with the member to the new facility
- Monitoring of the new facility(ies) on a daily basis initially (including nights and weekends) to ensure the availability and quality of care is appropriate for each member.

A description of methods the contractor will use to ensure that ALTCS members receive needed services in the event of a natural disaster

If Evercare Select members experience a loss of service because of a natural disaster affecting a hospital or nursing facility, the redundancy of our network is sufficient to compensate for the loss. Provisions would be made to move residents to the nearest contracted facility(ies) with enough beds to accommodate them. For the rural areas we serve, this may require moving the members out of their county of residence. All hospitals and nursing facilities are required by the Arizona Department of Health Services to have a written disaster plan which includes a written transfer agreement with another facility in the event that members must be moved. In the event no Evercare Select contracted facilities are available, Evercare Select will authorize the use of non-contracted facilities. Depending upon the severity of the event, support will also include crisis counselors and federal, state, county and city first responders. The members' safety during the evacuation and transfer process are the highest priority.

- Identification of all members who will be affected by the loss, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs
- Coordination with the PCP, member, the member's family and the caregiver to arrange for the transfer of the member to another provider
- Identification of all available providers, both contracted and non-contracted that are available to meet the needs of the members. If Evercare Select contracted providers are not available, we will authorize non-contracted providers to deliver services and we will take steps to expedite the contracting process
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medical records transferred to the new provider
- Monitoring of the new provider(s) to ensure the availability and quality of care is appropriate.

A cross-functional team, including representatives from the Provider Services, Medical Management, Member Services, Quality Management, Finance and Compliance departments coordinates activities. Case Management will provide coordination with the affected members, families and caregivers to ensure care is not compromised in any manner. Provider Services will provide communication and coordination with the Evercare Select provider network.

ATTACHMENT A RESPONSE TO SPECIFIC QUESTIONS RELATED TO NETWORK DEVELOPMENT

What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?

In an effort to reduce avoidable and preventable ER utilization, we:

- Expanded our urgent care network
  - Advertised the expansion to promote utilization
  - Resulted in an increase in urgent care utilization
- Implemented after hours nurse line resource for members
- Are implementing a pharmacy lockdown program for select hosp and pharmacies to prevent ER utilization for narcotic use
  - Outcome from an analysis of ER utilization that showed a large percentage of drugs prescribed in ERs were for short-term narcotics.

Our Post-Hospital Assessment/Return to Home Program provides timely follow- up for Evercare Select members after a hospitalization to assess a member's needs and any potential gap in the discharge plan. On site visits are made by the Case Manager within two days of notification of a member's discharge from the hospital. The Case Manager reconciles any changes to the member's medications orders against medication the member has, identifies any follow up specialist or PCP appointments needed and assists the member in making those appointments, reviews changes to the member's functional status and identifies new goals for the member's plan of care. This has proved beneficial in ensuring discharge plans are adequate and in place to prevent unnecessary re-admissions.

Evercare's UM department notifies the Case Manager of any member that they are aware has had an emergency room visit. The Case Manager reaches out to the member or their representative to identify the reason why the member opted to go to the ER rather than to their physician's office. The Case Manager can evaluate if there was something they could have done to deter the use of the ER, such as authorize a home health nursing visit or assist the member in making an appointment with their physician. The Case Manager may also identify if the member's current services are not meeting their current needs and an adjustment to the care plan may be needed.

Case managers remind their members of the available urgent care centers Evercare Select contracts with and encourages members to use the urgent care center before going to the ER if the member is unable to get an appointment with their physician.

Case managers schedule a case review with the Medical Director for any member who has had two or more ER or hospitalizations within three months. The Medical Director is an excellent resource for identifying contributing factors to the members' utilization patterns.

While outcome data is available, the small sample and number of avoidable/preventable days makes the outcomes statistically unreliable.

Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?

In some cases, we do allow members to be assigned to a specialist/PCP physician. For example, many nephrologists and endocrinologists are also Internal Medicine physicians and we do have contracts in which they are the member's PCP.

- ***HIV/AIDS:*** Evercare Select is contracted with several physicians who specialize in HIV/AIDS and we allow members to be assigned to them for this specialty.
- ***Asthma, Diabetes and CHF:*** Members are assigned to primary care providers for routine services. PCP's would complete a referral for the member to be seen by the appropriate specialist (e.g., pulmonologist for asthma, etc.). Prior Auth is only needed if member is under the age of 21 (allows for more rapid identification and coordination of CRS eligible conditions).

What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?

The lack of PCPs and specialists in the rural GSAs continues to be a significant barrier to efficient network development. Evercare Select, along with other Contractors continues to experience considerable difficulty in locating and recruiting physicians with specialties such as behavioral health, urology, dermatology, and gastroenterology.

Evercare Select has contracted with specialists in population centers such as Flagstaff and Phoenix, but the geographic distance can be a barrier to care.

Providers continue to cite the additional costs of treating ALTCS members as a reason for not contracting with ALTCS plans and add their concerns related to the previous and pending AHCCCS rate reductions to the State's budget crisis as reasons for not contracting with ALTCS plans.

A continuing challenge is the loss of physicians in Southern Arizona due to malpractice rates or lack of capacity. In Tucson and surrounding areas, there several zip codes where no physicians are currently practicing and new physicians are not moving to the region. This continues to impact capacity if providers leave the network. Likewise, the lack of providers negatively impacts rate negotiations, thereby increasing the cost of care. We expect this trend to continue due to the State's budget crisis and as future fee cuts are implemented.

Additional barriers:

- Willingness of the provider community to serve the ALTCS population due to complexity, time involvement and more labor intensive medical needs.
- The overall state of the economy prohibiting providers from establishing new businesses.
- Malpractice insurance and the overhead to run a practice outpace the yearly reimbursement increases. This makes is difficult to obtain contracts with some providers, especially those in high demand.
- Reimbursement demands from non-contracted provider set precedence and make it difficult to obtain contracted rates.
- Limited placement options in rural counties due to availability and insurance costs.
- Competition between Program Contractors for the limited placement options for the critically ill and mental health membership making it difficult to have patients in the least restrictive settings.
- Increase rate competition in Assisted Living Facilities.
- Demise of AFC Homes due to liability insurance differentials between AFC and ALH.

AHCCCS can best help support Evercare Select's efforts to improve the network and quality of care delivered to our membership by:

- Working to develop an alternative reimbursement strategy.
- Refining the fee schedule for providers to distinguish between urban, rural and remote providers. While AHCCCS should ensure competitive reimbursement rates for all providers, it should consider higher reimbursement levels for providers willing to locate to and serve rural populations. It should

consider even higher reimbursement levels to providers who serve in areas designated by the agency as remote.

- Creating a more specific link between the state's Graduate Medical Education and loan repayment programs to help fill service gaps to the ALTCS program, particularly in rural areas. Program benefits should be redesigned to create greater incentives for providers willing to serve the ALTCS population where PCP and specialty care gaps exist. The program should provide even greater benefits to participants willing to serve ALTCS members in rural areas where PCP and specialty gaps are identified.
- Working with the state's university system and other policymakers to help attract more students to the state's medical education program who are interested in providing primary care, and to expand residency program satellites. In order to encourage more students to serve as PCPs, the state should consider reducing tuition for those students.
- Increasing the use of Hospitalists to allow PCPs to focus on their practice and improve the continuity of hospital care to ALTCS members. AHCCCS may also wish to work with the state university system to enhance the training of Hospitalists and develop students' experience in working with the ALTCS population. It will also be important to implement enhanced communication and coordination within the Hospitalist model and to increase the use of eHealth solutions.
- Supporting policies that decrease participating providers' malpractice liability exposure where appropriate.
- Supporting state and federal policies that increase the availability of qualified providers trained outside of the United States who are willing to serve the AHCCCS program.
- Increased oversight to ALFs as they are allowed to have RNs off site proving many times minimal to no oversight of patients. This issue may result in the inability to place patients with complex needs in an ALF or in higher acute care utilization.
- Risk adjustment based reimbursement to ALTCS PCPs. (i.e. PCP who sees ALTCS and AHCCCS patient are paid more for ALTCS due to time needed to evaluate these individuals).
- Continue to monitor and adjust AHCCCS fee-for-service reimbursement since ALTCS members require more time and care to address their complex medical needs.
- Ease the process of allowing advance practice nurses (who are not nurse practitioners) in obtaining provider identification numbers from AHCCCS. In the past, they have had difficulty obtaining an AHCCCS number.
- Facilitate discussion related to expediting assignment of AHCCCS ID numbers to Assisted Living Facility Homes when they are changing ownership.

What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of those measures?

No-Show Identification Methods

Evercare Select educates all members on the importance of being active participants in their own health care and keeping all scheduled appointments. When members miss appointments, Evercare Select actively outreaches to these members to identify the root cause for the individual members and to track individual patterns (repeated no-show behavior) or patterns for individual provider offices or vendor practices (such as transportation), which may indicate a need for changes in how the practice schedules or treats members.

Evercare Select logs and tracks all reported incidents of member missing appointments, and follow up with interventions appropriate to the frequency of no-show behavior of the individual member. The reports of no-show behavior are presented at Healthcare Quality and Utilization Management (HQUM)

and Service Quality and Improvement Subcommittee (SQIS) meetings with recommendations based on findings.

Our No Show identification and Outreach Efforts

Evercare Select encourages providers to share responsibility for minimizing no-shows, by notifying Evercare Select every time a member misses an appointment without giving 24 hours advance notice. Providers are asked to report all missed appointments using the standard form called the Notification of Missed Appointments form and fax it back to Evercare Select on a daily or weekly basis. This member level record identifies the key facts: member ID, member name, date of appointment missed, provider ID, type of appointment missed, etc. Provider letters discharging members for repeated no-show behavior are also logged in the event that they have not previously been reported.

Evercare Select requires that the transportation vendor report no-show activity to Evercare Select every time a member misses a pick-up using the standard form called, the Notification of Missed Appointments. This member level record identifies the key facts: including member ID, member name, date of appointment missed, destination of appointment missed. These will be logged and matched to provider notification records to identify transportation missed pick-ups that resulted in a provider missed appointment, and those which did not.

Evercare Select also receives notification from staff, such as case management/disease management staff when during their member outreach they find that the member has missed a specific appointment. Evercare Select will complete a Notification of Missed Appointment form and forward to Member Services to be logged and tracked. The Staff also attempt to identify the root cause of the missed appointment, record the reason and recommend that the member reschedule their appointment with their provider.

Member Interventions

Evercare Select members are educated through member materials and the member manual on the importance of keeping appointments and the need to reschedule if they are unable to keep the appointment. Under Member responsibilities: the member has the responsibility to "keep your scheduled appointments" and "cancel appointments in advance when you can not keep them" page 27 in current member handbook.

Additionally, through cultural competency awareness, we strive to reduce common barriers to care including language and cultural barriers. Reducing common barriers to care increases not only the likelihood that appointments will be made, but also that they will be kept.

Specific Interventions include discharge planning for hospitalized members to assist with follow-up appointments:

- ***Missed One Appointment:*** Evercare Select sends a postcard to every member with a first incident of a missed appointment, reminding them of the importance of their appointment and inviting the member to contact Evercare Select for assistance. Evercare Select uses this contact to interview the member and collect data on root causes of why the appointment was missed.
- ***Missed Two Appointments within a Year:*** Evercare Select calls the member to follow up and attempt to identify if there are any physician office barriers recommend that the member reschedule the appointment help the member to understand that a third missed appointment may result in the member having to find a new doctor.
- ***Missed Three Appointments within a Year:*** Evercare Select calls to the member to follow up and educate the member on the impact on the provider office (and on other members) when there are missed appointments help the member to find a new provider (if the initial provider has removed them from their panel) recommends that the member reschedule the appointment.

- ***Missed Four or More Appointments within a Year:*** When a member misses four or more appointments within a single year, and has not responded to previous education and outreach, the member is referred to case management. The objective is to engage the member directly in order to help them make a commitment to their health care and identify underlying issues that may be causing barriers to the member keeping needed appointments.

Provider Interventions

Annually, Evercare Select shares reports with providers in the top ten practices that experience the highest volumes of no-show activity. We also provide regular education on appointment time requirements (from AHCCCS), and monitor access and availability and adherence to appointment standards.

Evercare Select partners with these practices to identify opportunities to minimize no-show activity within the practice, advising on best practices from research (i.e., reminder calls to members regarding next day appointments).

Evercare Select's No Show Program has shown to be effective in decreasing the number of provider missed appointments. We continue to focus on evaluating the effectiveness of the program, identifying provider practice trends and opportunities to improve the program.

Assessing Efficacy of Interventions

The enhanced data collection methods we plan to implement will allow us stratify no-show data—both by type of provider and by member. Similarly, the "no-show reason" data we collect from our telephone outreach to members with no-shows, and the tracking and trending of reason data, will enable us to assess the effectiveness of specific interventions. With accurate and available data, evaluations of specific interventions related to no-shows will become more meaningful. Evercare Select will develop a monitoring scorecard for each intervention, which will reflect the description and start/stop dates of the intervention and the volume of no-shows reported relating to reasons that are targeted by the intervention. Through comparing various month-over-month scorecards, an analysis can discern the more effective interventions. The scorecards also provide a reliable track record of that measure regarding what has/has not been effective. This historical information reduces the likelihood of repeating an ineffective intervention, and enhances our ability to identify best practices.

Evercare Select Appointment and Availability Survey Methodology Description

Appointment Availability (A&A) Surveys are conducted via telephone by the Provider Services Department.

Providers who are non-compliant and fail to meet the required appointment standards are re-educated regarding appointment time requirements and will receive a letter outlining their results. A copy of this letter is placed in the provider's contract file.

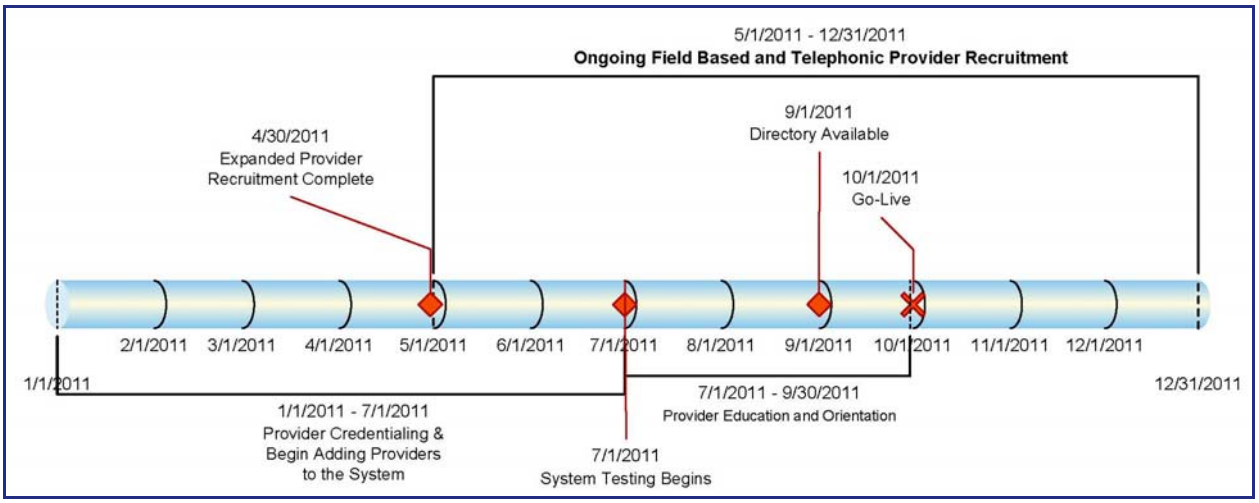
Results of the surveys are presented to the quarterly QM Council for review. The QM Council is responsible for making recommendations to Provider Services for provider improvement opportunities. Recommendations can include limitation of panel size; closure of the provider panel, reassignment of members and continued monitoring, or no actions.

ATTACHMENT A – APPOINTMENT AVAILABILITY PROVIDER REPORT	
Appointment Availability Survey Results: 1st Quarter 2011	***Total Number of Providers***
Primary Care Providers	32
■ Number of Providers that Passed	31

ATTACHMENT A – APPOINTMENT AVAILABILITY PROVIDER REPORT	
Appointment Availability Survey Results: 1st Quarter 2011	***Total Number of Providers***
■ Number of Non-Compliant Providers	1
■ Specialties include:	– Family Practice – Internal Medicine – Pediatrics
Specialty Care	30
■ Number of Providers that Passed	27
■ Number of Non-Compliant Providers	3
■ Specialties include:	– Urology
	– Cardiology/ Cardiovascular Disease
	– Gastroenterology
	– Nephrology
	– Neurology
	– Orthopedic Surgery
	– Hematology/Oncology
Behavioral Health Services	5
■ Number of Providers that Passed	4
■ Number of Non-Compliant Providers	1
■ No call back from Provider	0
Dental	N/A
■ Number of Providers that Passed	N/A
■ Number of Non-Compliant Providers	N/A
OB/ GYN	7
■ Number of Providers that Passed	7
■ Number of Non-Compliant Providers	0
Providers that were re-surveyed	N/A
■ Number of Providers that Passed:	N/A
■ Number of Provider that continued to be Non-Compliant	N/A
Questions Asked	
Do you know how to use the Language Line? 1877-261-6608	22 providers requested information on Language Line
Do you know where/how to access cultural competency materials?	22 providers requested information on cultural competency materials.

37. Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

Evercare Select has filed an expansion bid for GSA 40, 42, 46, 48, and 50 in addition to our current contract areas: GSAs 44 and 52. We have developed a detailed action plan for expansion areas that includes the planning, implementation, and evaluation elements necessary to ensure a successful network launch on October 1, 2011. Since the majority of our network development activity involves amendments to existing contracts, we are able to launch our expansion network in a very short period of time. Prior to the network launch on October 1, 2011, we will: convert all letters of intent (LOIs) to contracts; meet staffing requirements for credentialing, contracting and provider relations; distribute our provider manual; and educate our providers on referral procedures, claims submissions protocols and other provider responsibilities.



Evercare Select has developed provider networks in each of the new GSAs based upon the network requirements set forth in the RFP. The networks are a combination of contract amendments to existing provider agreements and Letters of Intent. Evercare Select realizes that a series of operational activities will need to occur in a relatively short period before contract implementation.

The network expansion plan has been developed and includes the following:

- All contract amendments will be loaded and tested in the claims payment system. This represents the vast majority of new providers; it is anticipated that the provider load will be completed within 30 days from contract award.
- Convert all LOIs to provider agreements within 60 days of contract award.
- Complete all new provider's credentialing within 60 days upon receipt of the provider agreement.
- Load and test all new provider agreements no later than September 01.
- Train and educate providers within 60 days of contract award on: **appointment availability standards, AHCCCS policies and procedures, ALTCS benefits, proper claim submission and payment (with an emphasis on electronic billing and fund transfers), prior authorization guidelines**, **clinical practice guidelines, the provider manual, drug formulary policies, how to access non-emergent medical transportation, cultural competency, fraud and abuse and the grievance and appeals process**. Education will be provided face-to-face or in group settings. Provider manuals will be supplied upon request. Providers are encouraged to use the website www.evercareselect.com and the call center as additional information sources.

Evaluation of provider networks in each GSA to ensure compliance with ALTCS network standards upon conversion of LOIs to provider agreements.

- Distribute a Provider Directory on September 1, 2011 with Updates Provided Throughout the Contract Year. New GSAs:

New GSAs

Provider Services Staffing Plan

If awarded a contract in Pima and Santa Cruz counties (GSA 50), Evercare Select plans to use the current staffing model used in Maricopa County. GSAs contiguous to both Maricopa and Pima will be supported by Provider Services staff in Phoenix and Tucson. It is our intent that non-contiguous GSAs will have a Provider Service representative within each county in the GSA. Staff will be recruited and hired prior to August 01 to ensure the completion of required training.

New GSAs-Summation:

Evercare Select has made a concerted effort in establishing a network of contracted providers to deliver services to ALTCS members in all new GSAs. We currently have Provider Agreements or Letters of Intent with more than 2,600 primary care physicians (PCPs), more than 56 hospitals, more than 122 skilled nursing facilities, and more than 477 assisted living facilities (ALFs). Our experience in caring for Arizona's underserved populations, including the ALTCS program, confirms our understanding that a strong provider network is fundamental to serving ALTCS members. Federally Qualified Health Centers (FQHCs), mental health clinics and other community health centers are part of our strategy in building a successful network, particularly in underserved urban neighborhoods and rural counties. Evercare Select has served rural regions throughout the state for years and has an understanding of the distinct needs of both providers and members in rural communities.

INSPIRIS a care management company that offers proactive, high touch physician and nurse practitioner services through an in-home care model recently joined the UnitedHealth Group family of companies. In addition to our nurse practitioner model for institutionalized members, Evercare Select is expanding our in-home services for ALTCS members in Maricopa and Pima counties through INSPIRIS. With the addition of Inspiris, we now have an additional 6 Physicians and 56 Nurse Practitioners providing in home services. Collaboratively, we are working together to evaluate the expansion of the in-home care model to additional geographic service areas throughout the State.

As the network rosters attest, there are minor gaps in some GSAs. This is largely due to the unwillingness of certain providers to effectuate an agreement or an LOI prior to bid award. Evercare Select is confident that, if awarded the bid, all GSAs will be fully compliant with respect to network standards by October 1, 2011.

Evercare Select's **Provider Services** team, led by Larry O'Connor, is responsible for the implementation of the aforementioned network action plan. We are confident that the developments (contracting/credentialing) we have made to our network to date–along with our ongoing network development, combined with our ample, dedicated resources and operational infrastructure–enables us to successfully launch appropriate networks in every GSA prior to October 1, 2011.

38. Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

Under the direction of the Provider Services Manager, Larry O'Connor, Evercare Select has developed and implemented an encompassing provider communication process. This communication process includes the following:

- Having a communication plan in place for the distribution of contract and program changes and requirements that includes a variety of modalities (fax blast, newsletters, provider visits, etc.)
- Sharing changes and updates with providers within 30 days prior to implementation
- Having a standard provider training program
- Employing a process that enables providers to bring issues to our attention and for responding back to providers regarding identified issues
- Using the Internet for communications.

Evercare Select's process for communicating with its provider network in explaining the program, changes in laws and regulations and changes in subcontract requirements are compliant with ACOM Chapter 400, Policy 416, Provider Network Information Policy.

Communicating Changes in Standards, Laws and Regulations

Evercare Select communicates any changes in ALTCS laws, rules, regulations and standards to providers 30 days prior to the effective date of the change. Similarly, providers are notified 30 days in advance of any material changes to Evercare Select policy and procedures. Changes to the ALTCS' minimum subcontract provisions are communicated and transmitted through the standard Evercare Select contract amendment process.

Evercare Select employs a variety of communication implements in notifications to providers. Depending on the nature and urgency of the notification, Evercare Select utilizes certified mail, email, fax blasts, website posting or regular mail service. The Provider Services Manager, Larry O'Connor, is responsible for provider communication initiation, dissemination, documentation and internal distribution.

By way of example, Evercare Select recently initiated a comprehensive provider communications campaign focused on the October 2010 ALTCS benefit changes. In addition to **posting the changes on our website,** we conducted targeted mailings, face-to-face meetings and telephonic outreach. We also outreached to a targeted subset of providers (orthopedic and nurse practitioners) to assess their ability and willingness to provide podiatry services to our members. Internally we developed FAQs and provided training and resources to Evercare Select staff on the benefit changes to ensure proper and consistent interpretation of information. This included our Member Services and Provider Services staff. Providers had the option of linking directly to the AHCCCS website for detailed information regarding the benefit changes.

We are committed to continuing a strong, user-friendly communication process with our providers. Our dynamic, integrated communication process involves all functional areas in cooperation with our Provider Services Department that has ultimate responsibility for ensuring effective provider communication. Our systematic approach enables effective communication with our providers on areas such as (1) contractual or programmatic requirements and changes; (2) applicable federal and state laws; (3) current ALTCS policies and procedures; (4) clinical practice guidelines; (5) our administrative processes including claims processing; and (6) quality and utilization requirements. We maintain current policies on how we communicate with the network regarding contractual or program changes and requirements. Our communication process includes comprehensive and frequent face-to-face interaction to accomplish educational and training objectives, as well as written and electronic vehicles and technologies to provide important notifications and updates. The following are the key vehicles we use for initial and ongoing

provider communication, including communicating changes in program standards, laws, regulations and subcontract requirements.

Face-to-Face Communication with Network Providers

Our goal is to offer a provider network of the highest quality and to ensure that all ALTCS and Evercare Select standards are met. **Our initial provider orientation and training activities introduce network providers to these standards, as well as to our process for communicating programmatic and contractual changes and updates.** We educate our providers about various mechanisms we employ to disburse information, such as the provider portal and provider newsletters, and encourage the use of such tools. Our standardized ongoing education and training activities reinforce providers' understanding of program standards; they provide information on applicable changes in laws and regulations, which are tracked and communicated throughout our organization by Kelly Kreiselmeier (formerly Kelly Morken), our Compliance Officer. Dr. Timothy Peterson, our Medical Director, is always available to assist providers and answer questions related to the ALTCS program. The components of our face-to-face communications are described below.

- ***Orientation*:** All newly contracted providers are required to participate in our orientation program, conducted by our Provider Services staff. The orientation session provides information on all applicable ALTCS and Evercare Select policies, procedures, rules, regulations, expectations and communication processes. Within 30 days of provider agreement effective date, our Provider Services staff meets with providers' office staff, including office managers, billing, referral coordinators and clinical staff to conduct the orientation. Orientation includes a thorough review of the Provider Manual, which incorporates all ALTCS policies and procedures relevant to the delivery of covered services to our members. It is available on our web-based provider portal and supplied to contracted providers in hardcopy upon request. (We also distribute the provider manual to non-contracted providers upon request.) The manual is reviewed semi-annually; updates are made as needed and posted to our website, with notification of updates posted on the website and included in provider newsletters. Information regarding covered dental services is also included in the provider manual. Our dental department staff reviews this additional section with newly contracted dental offices.
- ***Provider Visits***: Provider Services representatives visit primary care providers, skilled nursing facilities, assisted living facilities (ALFs) and HBCS provider on a regular basis. Each Provider Services representative is assigned to a geographic territory to deliver face-to-face support to our providers across the state. The prioritization and number of provider visits by these staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography and other special needs. All provider contacts are logged and tracked using the Advocate Resource Tool. Additionally, our local dental department staff visits all high volume dentists on a quarterly basis and all other dentists at least annually. If a provider or dental office needs immediate attention, both the Provider Services Manager and dental department staff make themselves readily available to address provider needs.
- ***Joint Operating Committee Meetings*:** We continue to conduct Joint Operating Committees (JOCs) with our key providers. **Each JOC meets regularly and develops project plans to address issues that arise,** including but not limited to claims, provider agreement loading, credentialing, prior authorization, utilization management, disease management, and membership issues. The JOCs also provide a forum for our staff to reinforce information regarding policy and regulatory changes and to provide any necessary training related to the changes.
- ***ALTCS-Requested Meetings*:** We conduct **meetings with providers to address issues**, provide general information, or offer technical assistance related to federal and state requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by ALTCS.

- ***Medical Management/Case Management*:** Our Medical Management/Case Management Department is a rich source of education opportunities for network providers. Medical Management/Case Management staff often accompanies our provider services manager during orientation and training sessions. As specific situations arise, the case managers educate providers about programs, resources and other providers available to assist with the management of special needs members. The Medical Management/Case Management Department reviews member care data on a regular basis that may identify provider education opportunities. The Medical Director contacts providers to discuss adverse trends and offer assistance. In addition, the Medical Director will visit provider offices when peer intervention and education is warranted.
- ***Communication to Pharmacies*:** Our Pharmacy Director works closely with Prescription Solutions, our pharmacy benefit manager responsible for the recruitment and management of our pharmacy network. Our pharmacy team meets weekly and communicates Evercare Select standards, requirements, and applicable changes in laws and regulations to the Prescription Solutions team.

Other Communication Vehicles

In addition to the methods described above, we educate our providers through various tools:

- ***Provider Portal and Website*:** Our web-based provider portal facilitates provider communications pertaining to administrative functions. Our interactive portal enables providers to electronically determine member eligibility, submit claims and ascertain the status of claims. Our website (www.evercareselect.com) contains an online version of the provider manual, the provider directory, the preferred drug list (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements, and educational materials such as cultural competency information, newsletters, recent fax service bulletins and other provider information. We also post notifications regarding changes in laws, regulations and subcontract requirements to the portal.
- ***Provider Call Center*:** Staffed Monday through Friday from 8 a.m. to 5 p.m. Arizona time, the call center is our **providers' point of contact for inquiries, registering complaints, or requesting information related to the ALTCS program.** The call center's toll-free number is prominently displayed in our provider manual, newsletters, web portal, and ad hoc communications. **Providers are instructed to call for assistance with any issue,** including but not limited to: provider notifications, covered services, eligibility, claims resolution, contracting and credentialing issues, forms required to report specific services, and billing questions.
- ***Provider Newsletters and Fax Blasts*:** We produce and distribute the provider newsletter to the network at least four times per year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines and information and articles regarding health topics of importance to our members. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements. We may choose to use facsimile service bulletins (fax blasts) to disseminate the information quickly for urgent messages impacting the network. The service bulletins are listed on the website and recapped in the provider newsletter.
- ***Provider Communication Meetings*:** We also conduct internal provider communication meetings to discuss how we might educate providers around program or organizational changes. These meetings include representatives from vital departments including Provider Services, Network, and Medical Management/Case Management. By coordinating communication our providers, we streamline messaging in a timely and consistent manner, reducing misinterpretation of program information.

39. Describe how data and information obtained from throughout the organization are used to manage the network and identify how provider issues are communicated within the organization. Provide an example of how this process has been used in your organization.

Evercare Select incorporates information from throughout our organization to manage our network. As we identify gaps in our network, we **initiate recruitment activities** that target the needed provider types. When new members with unique needs enroll in our plan, we **make changes to our network to accommodate the needs of special populations** that fall outside the realm of the needs of typical ALTCS members. We monitor **capacity limits** and research capacity limits prior to initiating network recruitment activities. Established policies, procedures and processes are in place to:

- Ensure **issues regarding provider availability are communicated appropriately** to ensure effective and efficient resolutions to the appropriate internal area
- Ensure our Provider Relations and Network Development teams are given/receive regular information and **feedback from all departments within Evercare Select**
- Close provider panels to assignment due to **non-compliance with appointment standards.**

Obtaining Information to Manage the Network

Evercare Select is committed to providing our members with medically necessary care through a comprehensive provider network that meets AHCCCS and Evercare Select standards. We use a comprehensive and cooperative interdepartmental approach to monitoring all provider types and care provided. This information is **reported up through our Quality Management Committee (QMC)**. This process identifies geographic areas and provider types that may require enhancement in response to results from monitoring activities. Provider Services and our Dental and Pharmacy directors have the primary responsibility for the management of the provider network, coordinating the network monitoring results from various departments and internal sources, to ensure the maintenance of a qualified provider network. **Results from monitoring activities are addressed by our Provider Services Manager, Larry O'Connor. Network Management includes processes to address any adverse findings that have been identified through the monitoring activities and coordinates with Quality Management on quality of care issues.** These processes allow efforts to be focused, ensuring prompt response to network deficiencies and inadequacies.

- ***Network Accessibility*:** Results of the quarterly GeoAccess reports, which analyze the adequacy of the PCP, assisted living facilities (ALFs), skilled nursing facilities and pharmacy networks are used to identify potential gaps in our network. These reports are shared with the Senior Leadership Team.
- ***Network Availability*:** We use the **results of the appointment standards monitoring to evaluate the sufficiency of the network to provide covered services within appropriate timeframes**. We track and trend appointment standards (emergency, urgent and routine care appointments) for primary care physicians (PCPs), specialists and transportation providers. The results of monitoring efforts to determine that a member's wait time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes (except when the provider is unavailable due to an emergency) are also used to determine the sufficiency of the provider network. Findings regarding providers who are found to be non-compliant with appointment or wait time standards are communicated to Provider Services staff, who offer educational material and technical assistance to the non-compliant provider. If it is determined that the provider's panel size is prohibiting compliance with standards, Provider Services evaluates the accessibility of other providers and takes appropriate action, which may include: capping a PCP's panel and enrolling new members with a different PCP; **notifying the Case Management Department that referrals to non-compliant specialists should be suspended and referred to other specialists**; or recruiting additional providers to ensure appointment availability and wait time standards are met.

- ***Panel Size*:** We routinely monitor PCP panel size in a number of ways, including reviews of member-to-PCP ratios, the AHCCCS PCP report of panels over 1,800, and open or closed panel status. As a result of such reviews, or gaps identified in our bi-weekly meetings with case managers, we recruit additional PCPs or reassign members to another PCP to ensure member access to care.
- ***Referral Rates*:** Information regarding referral rates is disseminated to Provider Services and Case Management. Working together, the departments analyze information regarding specialty referral rates and volume. PCPs are analyzed to ensure appropriate coordination of care and initiation of referrals for medically necessary services beyond the scope of their practice. If utilization patterns indicate a PCP is inappropriately referring members to specialists for contracted services, a Provider Services representative meets with the provider to discuss non-compliance and offer technical assistance. The provider is monitored on a monthly basis and any trends of non-compliance with standards are submitted to the Service Quality Improvement Subcommittee (SQIS) for review and disposition. The SQIS reports at least quarterly to the Quality Management Committee (QMC), which has responsibility for ensuring that our quality management processes are implemented and monitored. We conduct an analysis of members' access to specialty services, ensuring our membership has access at least equal to community norms. The analysis includes tracking the time between approval of a specialty referral and the actual appointment.
- ***Provider and Member Input*:** We obtain feedback from providers and members through a variety of mechanisms including but not limited to: analysis of satisfaction surveys; complaints, grievances, provider call center and appeals; and meetings with providers or members (including Member Provider Council meetings). In addition to the feedback and corresponding reports being reviewed by the applicable department within Evercare Select, the feedback is regularly reported to the SQIS for review and disposition of any identified problems or trends.

Communication of Provider Issues

We use an integrated, cross-functional approach in developing, maintaining and monitoring the provider network. We consider this critical activity a health plan-wide endeavor, integrated by interdepartmental monitoring processes and activities, business application systems that are accessible to all areas and oversight committees structured with representatives from across the health plan. As stated in the introduction, Provider Services has primary responsibility for developing, managing and monitoring our provider network, and works continuously to maintain a network of providers capable of providing care in compliance with all ALTCS guidelines and requirements. **Provider Services monitors the status of our network, projecting future needs and identifying any network deficiencies or gaps**. The Provider Services Department works closely with our Dental and Pharmacy Department staff to ensure an adequate network. Additionally, Mr. O'Connor oversees provider education and training, our high-touch provider service programs, as well as monitoring of provider satisfaction. **Provider Services routinely communicates and coordinates with other internal departments regarding provider issues**, including Case Management, Claims and Quality Management in a variety of ways including the following:

- Provider Services attends a bi-weekly meeting, which includes the contracting Pharmacy and Dental contract staff, where there is an open and cross-functional discussion of network information. Network issues and strategies are discussed at these meetings. Provider issues are also tracked and trended through the Provider Advocate Resource Tool as well as the review of provider acknowledgement and resolution data from our provider call center.
- Mr. O'Connor and Kelly Kreiselmeier, Compliance Officer, communicate with the provider call center on a regular basis to ensure appropriate oversight and that the staff is familiar with the Provider Services and Management Plan and all applicable work plans including education on ALTCS program changes.
- Our **directors, including our Chief Medical Director, meet monthly to review operations reports including provider call center reports, claims dashboard reports, medical management reports**

and member and provider grievance reports to identify best practice opportunities for improvement and to develop appropriate action plans, if needed

- Representatives from Member Services, Case Management, Quality Management, Prior Authorization and other departments may identify a network issue or potential provider to be included in the network and inform Provider Services. Due to their knowledge of local communities and providers, these internal sources often assist Provider Services with provider recruitment.

Bi-Weekly Network Management Meetings

In addition to the various methods detailed above, Provider Services communicates provider issues within the organization through bi-weekly Network Management meetings comprised of staff from key departments (including but not limited to Contracting, Case Management, Claims, and Database Management and Quality Management) to review provider/network issues and concerns, both global and provider-specific, and engage in an appropriate course of action. **Provider issues are identified through multiple sources including feedback from Contracting, Provider Services and Case Management.** We also discuss provider concerns received through member feedback.

Use of Information to Improve and Manage the Network

One recent example of provider information used to manage/improve the network is when our Non-Provision of Service (NPS) Coordinator Joanne Helmer identified an agency specific pattern through her review of the monthly NPS logs. The provider had an increase in NPS and gaps in a particular month due to weather conditions affecting access to members in our rural regions. Joanne arranged a meeting with the management of the provider to discuss the reasons for the gaps and why they were unable to provide a back up caregiver for some but not all members that had service delivery affected due the weather. They reported that they had identified a breakdown in communication and adherence to company policy by some of their staff. They revised their back up caregiver policy and educated staff. In addition, they made a change in specific staff responsibilities in order to improve performance. In essence they self-imposed a corrective action plan.

This event prompted the start of a *bi-monthly* joint operations committee (JOC) meeting. Several positive outcomes can be attributed to the JOC meetings. Issues identified included:

- Evercare Select collaborated with the provider to deliver immunizations to members who were willing to obtain their preventative immunizations but not willing to leave their home to get them.
- The provider will assist us in obtaining blood draws for diabetic screenings for non-compliant members.

In collaboration with this provider, a tool to log the member's preventative care history was developed. This tool is a magnetic white board that can be placed on the member's refrigerator. The member, their family, the case manager, or a member's attendant who is in the home several days per week, can log the member's preventative care information in the document. In addition, each of these parties can review the log to identify when a needed screening or test has not been completed. The member, family or attendant will contact the case manager for assistance with obtaining the necessary screenings/tests.

These collaborations resulted from the implementation of the JOC. The collaborative initiatives will lead to better service to and improved clinical/health outcomes for ECS members.

40. Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the claims dispute process.

The primary process for providers to communicate issues to Evercare Select is via our Provider Call Center. All provider inquiries, complaints and request for information are acknowledged within three days of receipt. In keeping with our contract requirements, our provider call center responds to all inquiries, complaints and requests for information within 3 business days and resolves them within 30 business days of receipt. Providers are given periodic updates on the status of inquiries until resolution is achieved. All inquiries entered into our tracking system and tracked through resolution and closure. Providers are able to track the progress of their inquiries via our provider portal on our website.

Accepting and Managing Provider Inquiries/Complaints/Requests Received Outside the Claims Dispute Process

Our provider call center, which is staffed Monday through Friday from 8 a.m. to 5 p.m. Arizona time, is our providers' point of contact for making inquiries, registering complaints or requesting information. The call center's toll-free number is prominently displayed in our provider manual, provider newsletters, provider web portal and ad hoc provider communications, and is reinforced verbally at provider orientation sessions, provider forums, and other face-to-face provider meetings. Providers are instructed to call this number for assistance with any issue, including but not limited to: provider notifications, covered services, eligibility, clarification of regulatory or programmatic changes, claims resolution, contracting and credentialing issues, forms required to report specific services, and billing questions. The call center also is also an additional point of contact for PCPs who require assistance in referring members to specialists. Our educational efforts emphasize the ALTCS contract requirements that all provider calls coming through our toll-free provider call center be acknowledged within three business days of receipt and resolved with the result communicated to the provider within 30 business days of receipt (notice of call resolution). We are committed to handling any provider complaint we hear of, whether in writing, through personal contact, or through calls received outside of the call center, in a timely manner.

We adhere to ALTCS' telephone standards for provider call center interactions. We have exceeded ALTCS' standards for each measure in 2010.

2010 Provider Call Center Performance Results		
Key Metric	***ALTCS Standards***	***2010 Results***
Maximum Allowable Speed of Answer	60 seconds	14 seconds
Monthly Average % Abandonment Rate	5.0% or less	1.11%
Monthly Average % Service Level	80.0%	93.06 %

Our performance against these standards is monitored on a monthly basis to ensure compliance. The call center adjusts staff size or staff schedules to ensure continuous coverage and consistent compliance with standards.

Acknowledging Provider Calls Using Call-Tracking

Provider calls are answered by call center staff, having received training on the ALTCS program and understanding the geography and needs of our market. An additional, back-up call center is available to handle overflow and disaster recovery. Staff assigned to handle overflow receive appropriate training. Call center staff use our IDT **call-tracking system** to acknowledge all calls. For the small percentage of instances in which the provider call is not answered promptly, the provider is able to leave a message requesting a callback. Thus, the large majority of calls are acknowledged immediately, and all calls are

acknowledged within three business days. Calls that cannot be resolved immediately by provider call center staff, including claims issues, are triaged and routed via our online routing system (ORS) to other areas within the company as appropriate for additional research, investigation and resolution.

All triaged calls are **assigned a case number** by call center staff, entered into our **tracking system** and communicated to the provider. Our provider service call model has an owner for each provider issue. If the issue cannot be resolved within the initial call, the call routes to an expert for resolution, with the issue owner tracking the issue to resolution and closure. When there is a requested claims adjustment, the issue owner will ensure the provider has provided or sent in all requested information. The issue owner will coordinate this information, providing it to the adjustment team for expedited handling. Communication is sent to or verbally communicated to the provider, notifying them of the outcome of the adjustment. Our provider service call model has an owner for each provider issue. If the issue cannot be resolved within the initial call, the call routes to an expert for resolution, with the issue owner tracking the issue to resolution and closure. When there is a requested claims adjustment, the issue owner will ensure the provider has provided or sent in all requested information. The issue owner will coordinate this information, providing it to the adjustment team for expedited handling. Communication is sent to or verbally communicated to the provider, notifying them of the outcome of the adjustment.

Provider issues are also **tracked and trended** through the Advocate Resource Tool, a database used by our Provider Services team, to log contacts with providers. The Advocate Resource Tool includes data fields documenting provider issues as well as tracks Provider Services activity.

Facilitating Timely Resolution of Provider Inquiries

Evercare Select has procedures in place to address and analyze feedback and determine resolution. Feedback can be received from a variety of sources. Provider Services is the lead for supporting the resolution of provider issues and ensuring open communications. On a daily basis, telephone, email and face-to-face inquiries, complaints and requests for information received from providers or internal and external partners related to providers are logged in a Provider Contact Log tracking system. This system tracks the original inquiry, complaint or request for information, the resolution and the date closed.

As issues are worked by internal departments (which may include, for instance, medical management services, contracting, or a team that addresses specialized claims issues), progress is documented in our tracking system to facilitate timely resolution. We **notify** providers of resolution via phone, email, written communication or web-enabled process, referring to the case number within 30 business days. Our Provider Services Manager manages and monitors the communication and resolution process and timelines. He is also responsible for managing call tracking, trending, and analysis for identification of any systemic issues and for ensuring that corrective action plans are developed, implemented and evaluated as appropriate to improve the quality of our operations. All of this information flows into our regular reporting package for review at our monthly management meetings. Our Provider Services staff also log and track provider contacts in the Advocate Resource Tool. We ensure all issues are responded to within 3 days and at least 90 percent are resolved within 30 days. If the issue cannot be resolved in 30 days, **we keep in communication with the provider** and ensure the issue is resolved within 90 days.

Calibrating and Improving our Communication with Providers

All Evercare Select directors meet monthly to review operations reports including provider call center reports, claims dashboard reports, medical management reports (ER Utilization/Access to Care), and member and provider grievance reports to identify best practice opportunities for improvement and to develop appropriate action plans, if needed.

High-Touch Provider Service Programs and Initiatives

Evercare Select realizes the unique characteristics of an ALTCS provider, particularly the home and community-based providers. We have established a high-touch service model for retaining provider trust and building and sustaining a successful partnership with our providers. We continue to proactively work alongside our providers to identify and anticipate provider issues and needs, address them before they become problems, and collaboratively develop improvement projects. For example, our Provider Services representative visited all assisted living facilities (ALFs) with members last year to educate them on how to access online billing through the provider portal. This greatly improved provider billing accuracy as well as our EDI claim submission percentages.

Provider Complaint Escalation

The Provider Call Center is generally the first point of contact in resolving provider issues. If the Provider Call Center is not able to resolve the issues to the provider's satisfaction, providers may reach out to local provider advocates. Provider advocates serve as the external and internal point of contact to respond to provider questions, resolve outstanding issues and educate providers on process changes. Should the provider advocate be unable to resolve the provider's issue to his/her satisfaction, providers may reach out to the Provider Services Manager for assistance. After these measures have been exhausted, providers may ultimately escalate the issue to the Evercare Select Chief Executive Officer Karen Brach, if needed. It is important to note that providers may escalate their issues to middle and senior management at any time. Our goal is to ensure the highest level of service to our providers.

Provider Account Management (PAM) Program

To support Provider Services in general and the call center in particular, the Provider Account Management (PAM) program was implemented as a mechanism to address immediate and significant complaints around claims payment, focusing on hospital providers. The PAM program was employed to provide a dedicated resource to act as a single point of contact for escalated claim issues. The PAM program focuses on end-to-end root cause analysis as well as appropriate and complete issue resolution. As part of this program, we created the new position of Network Service Agent, now called Network Account Manager (NAM), to drive service initiatives, resulting in positive service experiences for hospital providers. Our provider services advocates and the PAM staff continue to hold regular meetings with the designated hospital providers to work specific service agendas/issues and participate in quarterly Joint Operating Committee meetings to maintain a desired level of service.

The success of the PAM program is measured by provider satisfaction surveys, an increase in auto-adjudication rates, a reduction in claim adjustments, and a reduction in provider accounts receivable (A/R) balances for our partner hospitals.

Bi-Weekly Network Management Meetings

We communicate provider issues within the organization through bi-weekly Network Management meetings conducted to review provider/network issues and concerns, both global and provider-specific, and engage in an appropriate course of action. Provider issues are identified through multiple sources including feedback from Quality Management, Medical Management, and Compliance and Case Management staff. We also discuss provider concerns received through member feedback.

In summary, we are committed to cultivating our relationships with providers and to fostering their enhanced and active participation as partners in our health plan. We are acutely aware that contracting with providers is simply the first step in creating a network that meets the needs of our members. We have developed a variety of mechanisms to address provider inquiries and concerns and effective processes to respond and resolve issues expeditiously.

41. Describe the process for ensuring that provider services staff receive adequate training.

Provider Services Employee Training

Under the leadership of the Provider Services Manager, Larry O'Connor, Evercare Select has an employee training program to fully prepare staff to provide exceptional services for our members and providers. A key first step in developing a strong workforce is hiring qualified, experienced staff that are passionate about serving our members. These staff also have experience working with chronic care and special needs groups. Our training includes initial and ongoing efforts to educate staff about ALTCS' requirements and individual job requirements. Courses include policies and procedures pertaining to corporate compliance, internal auditing, fraud and abuse; progressive discipline; cultural competency; and regulations such as the Health Insurance Portability and Accountability Act (HIPAA). Employees are required to attend training on "Valuing Diversity and Inclusion" as part of our corporate commitment to integrity and ethics. This includes compliance with the prohibitions on discrimination and equal access to benefits in government programs required by applicable laws and the Americans with Disabilities Act.

- ***Provider Services Curriculum*:** Every department within Evercare Select has a unique training regimen tailored to specific job functions with each department focusing on policies, procedures, process, and understanding of the ALTCS contract requirements. Following the Local Immersion program, Provider Services employees join their functional units and begin departmental training. On-the-job training begins with cross-training and shadowing to address specific ALTCS program requirements including:
  - Detailed training on the AHCCCS Contractor Operations Manual (ACOM) and AHCCCS Medical Policy Manual (AMPM)
  - Detailed review of the ALTCS contract

Topics in the Provider Services curriculum include but are not limited to:

- ***Member Services and Eligibility*:** AHCCCS Enrollment Choice Policy, ALTCS Eligibility, ID Cards, Member Enrollment and Eligibility, Member Welcome Packets, Member Rights, ALTCS Enrollee Responsibilities, Enrollee Grievance and Complaints, Mail Order Pharmacy, Primary Care Provider (PCP) assignment and how to reassign a member to another PCP
- ***Physician or Healthcare Provider Responsibilities*:** Responsibilities and Expectations, Confidentiality and Release of Medical Records, Appointment Standards, Waiting Times, Ball vs. Biedess–Service Gap Contingency Plan, Interpreter Services, Cultural Competency, Member/Provider Advisory Councils and Provider Responsibility During Termination of Provider Agreement, the Provider Portal Website Functionality
- ***Covered Services*:** Evercare Select Covered Services, Acute Care Health Services, Behavioral Health Services, Long Term Care (LTC) Services, HCBS Alternative Residential Settings, Therapeutic Leave and Bed Hold, Medical/Acute Care Only Services, Emergency Services, Non-Covered Services and Medical Supplies included in FFS Home Health Nursing Visits
- ***Behavioral Health Services*:** Behavioral Health Services Referrals, Role of the Evercare Select Case Manager in Behavioral Health, Role of the Non Behavioral Health Care Provider, Initial Behavioral Health Evaluation, Ongoing Behavioral Health Evaluations, Behavioral Health Services Appointment Availability Standards and Specialized Behavioral Health Case Management
- ***Utilization Management*:** Concurrent Review, Discharge Planning Coordination and Physician Medical Review, and Preferred Drug List
- ***Case Management*:** Overview and Field-Based Training
- ***Prior Notification*:** Who to Contact for Prior Notification, Deadlines for Requesting Notifications for Evercare Select, Evercare's Timeframes for Responding to Notification Requests, Approved

Requests, Denied Requests and Evercare Select Prior Notification Request Forms

- ***Claims Disputes and Appeals*:** Claims Research, Claims Disputes, Time Limits for Filing a Claim Dispute, Dispute Process, Dispute Resolution/Decision Letter, Hearing Process and Dispute Submission Suggestions/Reminders
- ***Fraud and Abuse*:** Definitions, Examples of Fraud, Evercare Select Responsibilities, Provider Responsibilities, Self-reporting to Evercare Select, Self-reporting to External Agencies and Provider Training and Awareness
- ***Deficit Reduction Act, Advanced Directives* and *How to Obtain Clinical Practice Guidelines***
- ***Credentialing/Re-credentialing*:** Physician and Health Care Providers, Skilled Nursing Facility, Medical Record Review, Office Visits for PCPs and High Volume Specialists and Adverse Credentialing Determination Appeals
- ***Provider Services and Network Development*:** Network Development, Utilizing Your Provider Representative, Network Management, Provider Agreements, Contract Concerns or Complaints and Arbitration, GeoAccess and EDI
- ***AHCCCS Enrollment Choice Policy***
- ***Evercare Select Dental*:** DBP Contact Information, DBP Claims and Dental Coverage
- ***Responding to Provider Inquiries*:** All inquiries, complaints or request for information must be acknowledged within three days and resolved within 30 days
- ***Network Access Standards*:** Appointment access requirements and travel distance standards
- ***Pharmacy*:** Policies, procedures and processes

Provider Call Center Departmental Training

Customer service training is especially important when communicating with providers. Provider Call Center staff receive the same provider service curriculum training. Call center new hire training typically takes between six to eight weeks. Training for our provider call center includes call center and plan-specific policies and procedures; phone system training; ALTCS requirements, benefits and technology; HIPAA; enrollment/disenrollment; grievances and appeals; and claims payment processes and procedures.

New Employee Orientation

All new employees, including Provider Services staff, participate in an on-boarding process through New Employee Orientation (NEO), where they receive introductory mandatory training on Evercare Select, administrative processes, and other important topics such as “Redefining Our State Partners’ Experience.” The process is overseen by the employee’s supervisor, with support from experienced staff members in the department. This pre-immersion training period varies in duration, depending on the employee’s hire date, and ends when the employee begins our regularly scheduled orientation for new hires called the Arizona and National Immersion program. The pre-immersion training may include:

- Overview of Medicaid and AHCCCS programs, including the goals and objectives of the programs
- Introduction to Evercare Select and our parent company, UnitedHealthcare Community & State, including general information about the company, a discussion of our mission, vision and values, and how the employee is expected to contribute to our mission
- Introduction to special needs populations, including behavioral health and CRS program.

During this preliminary phase, employees are introduced to the ULearn learning management system, an all-inclusive catalog of online learning. It is the primary resource for all learning management, including required training. It is designed to provide all end users—learners, managers and administrators—with a slimmed-down process for quickly initiating their learning-related tasks. Managers use a variety of training modules like compliance training, job skills training, professional development and technology

skills to complete required training and build professional development through more targeted modules. The business book catalog contains more than 5,000 summaries, of which new employees . ULearn tracks the lessons completed by each staff member, ensuring that employees complete required training within targeted timeframes.

Local Immersion Program

Each new employee, regardless of their experience or position, undergoes Evercare Select's Local Immersion program, which lasts one to three days. We provide a general view of Evercare Select, ALTCS and UnitedHealthcare Community & State. The local immersion program includes:

- ***Introduction to Evercare Select*:** During this initial discussion, new staff is given an overview and history of Evercare Select, including a description of our mission, vision, and operating principles. We also provide each staff person with organization charts to help them understand the breadth of the organization and how they fit in, and discuss the various "products" of Evercare Select, such as our participation in the Medicare program and ALTCS programs.
- ***ALTCS, AHCCCS and Other Partners*:** Employees receive an overview of Evercare Select's role as a partner of the program, populations eligible for the program, and ALTCS and AHCCCS missions, visions, and values. They are also introduced to our ALTCS contract and counseled on the importance of adhering to contract requirements. Staff also receives an overview of the Children's Rehabilitative Services (CRS), Regional Behavioral Health Authorities (RBHA), ALTCS and the Centers for Medicare and Medicaid Services (CMS).
- ***Human Resources and Compliance*:** During this module, employees are introduced to UnitedHealthcare Community & State and UnitedHealth Group, the corporate parents of Evercare Select. In addition, Kelly Kreiselmeier, our Compliance Officer, provides training on key compliance issues, such as HIPAA, Sarbanes-Oxley regulations, fraud and abuse and "commonsense" tips for compliance. This session also gives staff the chance to review Evercare Select's contract with ALTCS again, as Ms. Kreiselmeier stresses the importance of adhering to operational expectations, performance standards, and reporting requirements. Compliance training is required and is a condition of employment. New employees are required to acknowledge receipt of a copy of the "Principles of Integrity and Compliance" brochure and an agreement to review within 30 days.

Provider Relations - Ongoing Training

Within our commitment to employee engagement, we maintain a training program that is designed to maintain Provider Services staff competence while also cultivating skills for growth and improvement. Program training goals include:

- Refresh understanding of the components of the organization and employee position, including but not limited to: corporate compliance mandates, job function, cultural competency, and understanding of state and federal requirements; additionally, provide ongoing feedback on employee's performance and developmental needs
- Assure knowledge of process for referral of Quality of Care and Quality of Service concerns and provide manager and leadership tailored training
- Assure knowledge of fraud, waste and abuse controls as required by the Deficit Reduction Act of 2005 to meet the ever-evolving program integrity standards that govern Medicaid programs.

Evercare Select continuously administers ad hoc training as contractual changes occur. Our Compliance Department, led by Kelly Kreiselmeier, interprets the change, assesses the impact, and communicates the new contractual requirements to applicable department heads. Department leaders are responsible for training current employees on the new contractual requirement within 30 days of the contract change. The Compliance Department holds an audit to ensure that all applicable departments implement methods to satisfy the new contractual requirement within the 30-day period.

42. Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

Provider Services Staffing

As an ALTCS Program Contractor for more than 20 years, Evercare Select recognizes the need to adequately staff the Provider Services department to effectively develop, maintain and monitor the provider network in accordance with ALTCS service and quality of care standards.

Provider Services Staffing Model

The Evercare Select Provider Services local staffing model is based on staff ratio to providers. The needs of each provider vary based upon size, practice sophistication, managed care experience and population requirements leading to adjustments to provide quality service and support to our provider community. Our current staffing equates to one provider service/provider advocate/contractor per 237 contracted providers. This model has proven reliable based on previous experience and with supplemental support services from regional and national resources.

Larry O'Connor, Provider Services Manager, evaluates the Provider Services staffing model at least annually, and more often as needed, to ensure timely provider education and training of the provider network and timely resolution of provider issues.

To ensure proper staffing levels, Evercare Select monitors prescribed performance measures. The performance measures employed are:

- One hundred percent new provider orientation training sessions conducted within 30 days of contract execution
- One hundred percent of quarterly site visits of providers with significant membership utilization
- Ninety percent provider issue resolution within 30 days
- Provider Call Center response standards
  - Maximum allowable speed to answer: less than 60 seconds
  - Monthly average abandonment rate: less than 5 percent
  - Monthly average percent abandonment rate: 80 percent of calls answered within 60 seconds.

The Provider Services Manager, Larry O'Connor, routinely monitors adherence to these performance indicators. If a measurement falls below the prescribed target, the manager will identify causative factor(s), and after all operational remedies have been exhausted, will redeploy personnel or employ temporary or permanent staffing as deemed appropriate to attain and sustain standards.

Should staffing levels be deemed inadequate based on the above criteria, Mr. O'Connor discusses the assessment results with Chief Executive Officer, Karen Brach and requests additional staff accordingly. The addition of personnel will trigger a detailed analysis of the current staffing model to ascertain whether the staff to provider ratio needs to be revised. As a result of this process, we identified a need for additional staffing to support our rural counties. In November 2010, we added another full-time provider advocate, Jennifer McCoy, based in Flagstaff, to fill this deficiency. Our current Provider Services staffing level is reflected in the following organizational chart.

If awarded a contract in Pima and Santa Cruz counties (GSA 50), Evercare Select plans to use the current staffing model used in Maricopa County. GSAs contiguous to both Maricopa and Pima will be supported by Provider Services staff in Phoenix and Tucson. It is our intent that non-contiguous GSAs will have a Provider Service Representative within each GSA. Staff will be recruited and hired prior to August 01 to ensure the completion of required training.

Call Center Staffing and Management

In addition to monitoring Provider Services staffing levels, we also monitor and record all provider call information through our Virtual Call Center (VCC) technology, to ensure an adequate number of lines for the ALTCS call center. The VCC system allows for extremely high service availability and captures data and generates reports on call availability, answering speed, on-hold time and abandonment rates for the ALTCS program. Supervisors review performance results hourly and daily and meet each morning with representatives to review the previous day's results. They also review weekly performance in staff meetings and report results monthly on business segment scorecards. Supervisors use load-balancing analytics to balance workload and employ a variety of variable staffing techniques in order to accommodate anticipated volume.

To monitor service levels, we generate a Customer Care Daily MIS Report, which is reviewed by Mr. O'Connor. This report provides daily, week-to-date, and month-to-date information and statistics on call availability, answering speed, on-hold time and abandonment rates for the ALTCS program.

If deficiencies are identified related to capacity in our call center, we take such actions as immediately installing additional lines or transferring calls to another call center. Any other call-handling deficiencies identified by our system reports or audit processes are corrected through staff training or system enhancements.

Our provider call center staffing levels reflect our commitment to meeting and exceeding ALTCS program standards. Our 2010 provider call center results are well above the minimum AHCCCS requirements as reflected in the table below. The 2010 data below represents ALTCS-specific results for overall service level, average speed of answer and the telephone abandonment rate.

2010 Call Center Performance Results		
	AHCCCS Target	***2010 Results***
Average Speed of Answer	Less than 60 seconds	14 seconds
Telephone Response Time	80% of calls answered within 60 seconds	93.26%
Telephone Abandonment Rate	Less than 5%	1.11 %

In the event that the response time measurements fall below target and remedial action (e.g., additional lines) are proven ineffective over time, Mr. O'Connor will determine the need for additional personnel, whether temporary or permanent is required and seek necessary authorization. Performance measures will continue to be evaluated to determine impact on performance standards. If standards are achieved due to additional staffing, the Provider Services Manager will conduct a thorough review to ascertain whether the staff–to-provider ratio needs to be adjusted accordingly in a near or future review.

Provider Account Management (PAM) Program

An excellent example of supplemental support services provided through a related entity is the Provider Account Management (PAM). PAM is a mechanism to address immediate and significant complaints around claims payment, focusing on institutional providers. The PAM program provides a dedicated resource to act as a single point of contact for escalated service issues. The PAM program focuses on end-to-end root cause analysis as well as appropriate and complete issue resolution. We currently use existing FTE resources to cover our hospital servicing needs for our PAM program and we have staff deployed across hospitals within the western region markets. We will evaluate the need for additional staffing if service levels decrease but we do not anticipate the need for additional staffing based on our current model.

The success of the PAM program is measured by provider satisfaction surveys, an increase in auto-adjudication rates, a reduction in claim adjustments, and a reduction in provider accounts receivable (A/R) balances for our partner hospitals. The PAM program staff continues to work with the hospitals to maintain an aggregate A/R over 60 days and 90 days of 15 percent or less. As of October 2010, the aggregate A/R over 60 days and 90 days was at 17.72 percent. We continue to work with the hospitals participating in the PAM program to bring their A/R down to the established level.

The PAM program enhances Evercare Select's hospital relationships while alleviating the plan from the time-consuming burden of managing large, complex account receivables – thus allowing Evercare Select to maintain a reasonable Provider Services staffing level while providing quality service to the remaining provider network.

43. The Offeror must describe how their organization will handle the potential loss …..

Upon notification of the potential loss of a nursing facility, Evercare Select reviews the nursing facilities financial data, licensing reports, ownership changes and trends of quality of care (QOC) concern findings. We investigate providers with known issues that may result in a closure that included contact with the provider prior to closure. The transition of displaced members is done by following our documented transition plan. Terminating providers are contacted and surveyed to determine their reason for terminating their Evercare Select contract. Reasons for provider turnover are tracked and trended.

Monitoring Providers with Known Viability Problems or Potential for Closure

The ability to recognize and respond to potential critical gaps in service in a timely manner occurs through interdepartmental coordination between Provider Services, Case Management (CM), Medical Management (MM) and Quality Management (QM). Communication between is critical in the process of developing immediate interventions that ensure that members receive medically necessary care within an appropriate length of time. We maintain policies and procedures designed to ensure that:

- Ongoing monitoring of the potential for network disruption occurs so that, whenever possible, the disruption can be averted or its impact minimized.
- **Members receive adequate and timely care during periods of temporary network disruption**, including facility closure(s) or loss of major provider(s).
- Post-disruption processes, payment of claims are addressed; and operational, financial reconciliation, member reconciliation and claims payment issues are minimized as the network returns to normal.

These policies and procedures are incorporated in our business continuity plan (BCP), which is approved by AHCCCS, along with instructions for handling emergencies and disasters affecting Evercare Select's facilities and internal operations. Our most recent BCP test was completed in January 2011. We modify and test our procedures on a minimum of an annual basis. A summary of our policies and procedures relating to monitoring and potential for handling network disruption follows.

Evercare Select closely monitors nursing facilities and assisted living facilities (ALFs) with **known viability problems**. Several areas can indicate problems:

- Notification from AHCCCS or CMS of sanctions or potential sanctions
- Failure to obtain or maintain required insurance
- Complaints raised by members, family members, or facility employees
- ***Financial triggers*** – requests for cash advances, filing of bankruptcy, etc.

Evercare Select takes the following steps when suspecting a potential closure:

- Send a case manager to the facility to assess and make observations and have Provider Services contact the facility to discuss the concerns.
- Request a corrective action plan, if warranted.
- Cease new member placement to the facility, if warranted.
- Possibly terminate the agreement.

Handling Potential Provider Loss

Provider Services works closely with CM in the event of a nursing facility or ALF closure. We have procedures in place for handling the loss of a nursing facility and ALF due to immediate termination or unexpected closure as described below. Our Provider Services team **tracks provider licensure, certification** and **other QOC data and trends** that may potentially lead to contract termination for cause.

Internal departments, such as MM, CM and QM, work directly with and monitor various aspects of our provider network, providing us ongoing information about our network. This allows us to monitor the potential for loss of a nursing facility or ALF due to closure/contract termination. For instance:

- Provider Services routinely monitors contract facility terminations, trend reason for turnover, and if possible, initiates remedial measures to reverse trends.
- MM routinely evaluates, tracks, documents and reports facility QOC issues.
- MM routinely conducts and reports on medical chart reviews.

Loss of Nursing Facility or Assisted Living Facility Due To Contract Termination

In the event of a contract termination by a nursing facility or ALF, we generally have significant advance notice prior to the effective date of the termination. We adhere to the requirement that we provide facilities and provider groups **90 days notice** prior to a contract termination without cause. Evercare Select manages the loss of a facility by assessing the impact on both the member and provider communities through a cross-functional approach. We use an established rapid response team, which can be convened within 15 minutes and includes senior leaders including the Chief Executive Officer, Medical Director, CM Administrator, QM Coordinator, Pharmacy Director, Provider Services Manager and Compliance Officer. The team assesses the situation and determines the steps to be taken to arrange access to medically necessary services with minimal disruption to the members. Resources are identified and deployed to ensure the timely execution of the action plan. Common to all loss of service types is a core set of activities vital to a successful transfer, including:

- Identification of all members who will be relocated, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs
- Coordination with the member, the member's family and the caregiver to arrange for the transfer of the member to another facility with the appropriate level of care
- Identification of all available facilities, both contracted and non-contracted; if Evercare Select contracted facilities are not available, we will arrange for placement in non-contracted facilities
- Detailed documentation relating to each member and his/her transfer (e.g., when, where)
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medications, charts, medical equipment and personal belongings of the member are transferred with the member to the new facility
- Monitoring of the new facility(ies) on a daily basis initially (including nights and weekends) to ensure the availability and QOC is appropriate for each member.

Loss of Nursing Facility or Assisted Living Facility Due to Unexpected Closure

In the event of an unanticipated loss of access to an inpatient facility, Chief Executive Officer, Karen Brach and Chief Medical Officer, Timothy J. Peterson, MD, convene the Evercare Select leadership team to develop and execute a situation specific plan of action. As we do for a contract termination, we assess the impact of the closure on both the member and provider communities through the cross-functional approach. The core set of activities vital to a successful transfer of members includes:

- Identification of all members who will be relocated, including a roster with the assigned PCP and family/legal representative contact information
- Assessment of any special needs the members may have
- Triage of members according to medical, social and behavioral health issues and needs

- Coordination with the member, the member's family and the caregiver to arrange for the transfer of the member to another facility with the appropriate level of care
- Identification of all available facilities, both contracted and non-contracted; if Evercare Select contracted facilities are not available, we will arrange for placement in non-contracted facilities
- Detailed documentation relating to each member and his/her transfer including when and where the member was transferred
- Notification of AHCCCS throughout the process including initial notification, developed plan of action, regular updates and transition completion
- Ascertaining that all medications, charts, medical equipment and personal belongings of the member are transferred with the member to the new facility
- Monitoring of the new facility on a daily basis initially (including nights and weekends) to ensure the availability and QOC is appropriate for each member.

If our members experience a loss of service due to a natural disaster affecting a hospital or nursing facility, the redundancy of our network is sufficient to compensate for the loss. We make provisions to move residents to the nearest contracted facility that can accommodate them. For rural areas, this may require moving the members out of their county of residence. All hospitals and nursing facilities are required by the Arizona Department of Health Services to have a written disaster plan that includes a written transfer agreement with another facility in the event that members must be moved. In the event that an Evercare Select-contracted facility is not available, we authorize the use of non-contracted facilities. Depending on the severity of the event, support may include crisis counselors and federal, state, county and city first responders. Members' safety during the evacuation/transfer process is the highest priority.

Ensuring that Members Receive Medically Necessary Services

When a network gap occurs, we take immediate steps to address the gap so that a member's care is not compromised. Our Provider Services team, in collaboration with MM, Dr. Peterson and other involved parties, immediately assesses the availability of other providers in the community. The preferred intervention strategy is to refer the member to another qualified, contracted provider. If a contracted provider is not available, the following short-term interventions are taken:

- ***Referral to a non-contracted provider*:** Special provisions, such as a letter of agreement, are made with non-contracted providers to accommodate the member's needs until an equivalent provider is located, or if possible, a contract with the non-participating provider is secured.
- ***Recruitment of a new provider*:** To expedite the contracting process, providers recruited to fill a network gap are processed quickly through use of a provisional and expedited credentialing process pending completion of the standard credentialing process. Dr. Peterson approves provisional credentialing applications within 14 days of receipt of the provider's completed application. Upon the final credentialing approval, Evercare Select executes the provider agreement.
- ***Transportation of a member to a provider outside the member's community*:** If a provider is not available in the member's immediate community, we make arrangements for the member to temporarily receive care from a provider located in another community. This solution is generally used until an appropriate provider is available within the member's immediate community.

For members in active treatment, we ensure members' care is not disrupted during the transition process. If necessary, the case manager maintains care with the member's current provider to ensure continuity of care and the member's care is transitioned after his/her medical condition is stable. The case manager and MM team work collaboratively with the Provider Services team to secure letters of agreement if the member's current provider is not a contracted Evercare Select provider. Our comprehensive continuity of care policies serve to reinforce our position that our members' needs come first.

44. Describe the process for addressing provider performance issues, up to and including contract...

Addressing Provider Performance

Our Provider Services team, working in collaboration with other departments, has organizational responsibility for gathering, evaluating and trending provider input, prioritizing provider-identified issues, and developing effective intervention strategies to address them. These multiple data points of provider information operate as a clearinghouse and an early warning system to identify issues as early as possible and avoid escalation.

- ***Member Satisfaction Survey Data*:** Member satisfaction may be assessed surveys as conducted by AHCCCS or internally, as well as member complaint/grievance and quality of care data. When a member survey is done the results are used to:
  - Measure health plan performance and establish benchmarks and monitor performance
  - Assess overall levels of member satisfaction with providers and Evercare Select
  - Assess service performance
  - Create action plan to create opportunities for improvement

  An in-depth analysis is conducted to identify barriers, prioritize opportunities for improvement and implement improvement actions. Action plans to address opportunities for improvement based on survey results are reviewed by the Quality Management Committee (QMC).
- ***Quality of Care Feedback*:** Quality of care issues are investigated by QM specialists in order to take proper action and timely resolution to ensure patient care remains safe, effective and appropriate. Quality of care issues are tracked and trended to identify issues impacting the effectiveness and safety of care for our members. For quality of care issues, Member Services and Quality Management work in conjunction in leading our efforts for tracking and trending feedback related to care issues. Member Services presents trends and potential action plans related to quality of services to the Service Quality Improvement Subcommittee. Quality Management presents trend related to quality of care to the Healthcare Quality Utilization Management (HQUM) Subcommittee. Each committee finalizes action plans and designates project leads for operational improvements when appropriate. These plans are approved at the Quality Management Committee (QMC), which oversees performance improvement efforts.
- ***Chart Audits*:** Evercare Select QM nurses conduct onsite chart reviews. Medical records are reviewed using standardized criteria and audit tools to evaluate compliance with Evercare Select and ALTCS requirements. After each review, findings and identified trends are discussed with the provider along with education on the areas of deficiency. Corrective action plans are required for those providers who did not achieve the required score of 85 percent, or when critical quality issues are identified. A repeat audit may be conducted by QM staff within 3-6 months after the corrective action plan has been approved by Evercare Select to evaluate the effectiveness of the actions taken. The effectiveness of the performance improvement actions taken by the provider is determined during subsequent monitoring visits by Evercare Select staff. It is the goal of the QM staff in conjunction with Provider Service staff to provide education and technical support to providers to develop changes in policies, procedures and internal monitoring to effect lasting improvement in areas found deficient.
- ***Reporting*:** We use a comprehensive database that stores all medical and pharmacy encounter data. On a quarterly basis, reports are generated from the database to monitor the expected and actual services provided, as well as the appropriateness of these services. Examples of these reports include but are not limited to the following:
  - Prescriber Activity Report: Specific prescriptions can be associated with a prevalent, high-risk disease category. We monitor prescriber activity to measure associated office visits and follow-up

care. If encounters are not submitted by the prescriber, we conduct physician outreach to ensure members receive appropriate care.

- Diagnosis Reports: Historical diagnosis data for members is compared to encounter data for the current period. If a historical diagnosis is not evident in the current period, our care management unit conducts outreach to the member to ensure they are receiving all necessary services for their historic diagnosis.
- Peer Group Reports: We conduct peer group comparisons by provider specialty type. The peer group's data establishes a benchmark that is used for individual physician comparison. If a physician is reporting a lower than expected number of encounters, the physician is identified for outreach which may include corrective actions.

The scorecard trends and intervention outcomes are also reported at least three times per year to our Quality Management Committee.

- ***Other Evaluative Tools*:** We continue to monitor provider performance against standards through the collection and analysis of member grievances, appointment wait time surveys, and quality management review, and non-provision of services as described in the Network Development Plan. Our overall goal is to offer a provider network of the highest quality and to ensure that all ALTCS and Evercare Select standards are met. We use regular communication, education and ongoing monitoring of the network to measure performance.

Contract Termination

Termination for Cause

Providers are first given the opportunity to comply with a corrective action plan, if appropriate. If the findings of an investigation indicate that a provider has potentially provided substandard or inappropriate care, or has exhibited inappropriate professional conduct, the case will be referred to the Provider Advisory Subcommittee (PAS) for peer review.

The PAS, Evercare Select's peer review committee, meets at least monthly and is chaired by our Medical Director, Dr. Tim Peterson. In addition to Dr. Peterson, members of the PAS include the Director of Quality Management, Myra Kingsley, network primary care and subspecialty physicians, other providers (for example mid-level providers,) as designated by the Chair, ad hoc health plan staff as needed (for example, quality specialist RNs) and ad hoc specialty physicians as needed. The peer review process ensures that providers of the same or similar specialty participate in both the review of documentation to ensure that the standard of care was met and recommendation on individual peer review cases. We use external consultation, if the specialty is not represented on the committee.

This PAS subcommittee reviews all cases presented, evaluates findings and make recommendations including: the outcome of the investigation, closure categories, interventions to improve processes and meet member specific needs, and further investigation or intervention as needed to ensure resolution. Dr. Peterson refers the case for peer review as indicated.

When cases are referred to PAS for peer review, there must be a majority of votes to approve the final determination and recommendation for actions. The committee may make recommendations to our Medical Director, Dr. Tim Peterson, to request additional information; assign or adjust the severity level; or request an outside peer review consultation prior to decision. The scope of actions that may be recommended by the PAS include, but are not limited to: 1) development of an improvement action plan with time frames for improvement; 2) education; 3) counseling, monitoring and trending of data; 4) reducing, restricting, suspending, terminating or not renewing the providers credentials necessary to treat our members; and 5) referral to the appropriate state, federal or regulatory agencies. Our Medical Director, Dr. Tim Peterson, reports the final recommendations of the PAS to the QM Committee and to our Board of Directors. Prior to informing the provider of the recommended action, the Board of

Directors must approve or modify any action to reduce, restrict, suspend or terminate for clinical reasons a provider's Evercare Select credentials or contract. A provider may request a fair hearing appeal for certain recommendations that adversely affect their credentials or contract with Evercare Select. The Board of Directors has ultimate responsibility for making the final decision to uphold, modify, or reverse a proposed action. The final decision by the Board of Directors is reported in writing by Dr. Peterson to the applicable regulatory/licensing board, agency and AHCCCS as required by law. Dr. Peterson also informs the member of the final resolution to the QOC issue in writing. Upon completion of the investigation, the findings are documented in the QOC file, including:

- If the issue was substantiated, unsubstantiated, or unable to be substantiated
- The main category and subcategory
- A summary of findings and if applicable a plan to reduce or eliminate the likelihood of reoccurrence
- Interventions taken and supporting documentation of occurrence and success of intervention
- Summary of external/internal referrals and copies of all agency reports and correspondence
- Closing severity level
- Closure letter.

Evercare Select has written policies and procedures governing provider contract suspension and termination. Evercare Select reserves the right to immediately terminate a provider's participation in the network due to the following occurrences:

- Failure to maintain contractually required licenses, certifications, including Medicare and Medicaid, or accreditations
- Indictment, arrest, or felony conviction on a criminal charge related to a provider's practice
- Determination that action is in the best interest of the Evercare Select membership
- Determination of fraud and abuse
- Breech of contract of failure to comply with contract requirements
- Issues relating to the Quality Management/Utilization Management program (i.e., repeated failures to obtain a passing Medical Record Review score, quality of care issues, imminent harm to a member)
- Non-compliance with Evercare Select quality standards.

Terminations due to professional misconduct are reported to the appropriate federal and state agencies.

Evercare Select has written policies and procedures governing written notification and provider hearing requests. We notify Compliance, Member Services, Case Management, Claims, Medical Management and Prior Authorization/Utilization Management of the termination with the effective date and a request to notify all members impacted by the termination. We also notify AHCCCS of any material changes that may cause potential network disruption 60 days before the termination takes effect. We notify AHCCCS of unexpected material changes that would impair the provider network within one working day.

45. Offerors shall develop and maintain a provider network, supported by written agreements…..

Evercare Select's Network Summary template and Network Attestation Statement have been completed and uploaded to the AHCCCS Secure Enhanced File Transfer site, as required.