Chart 17. Grievance Data

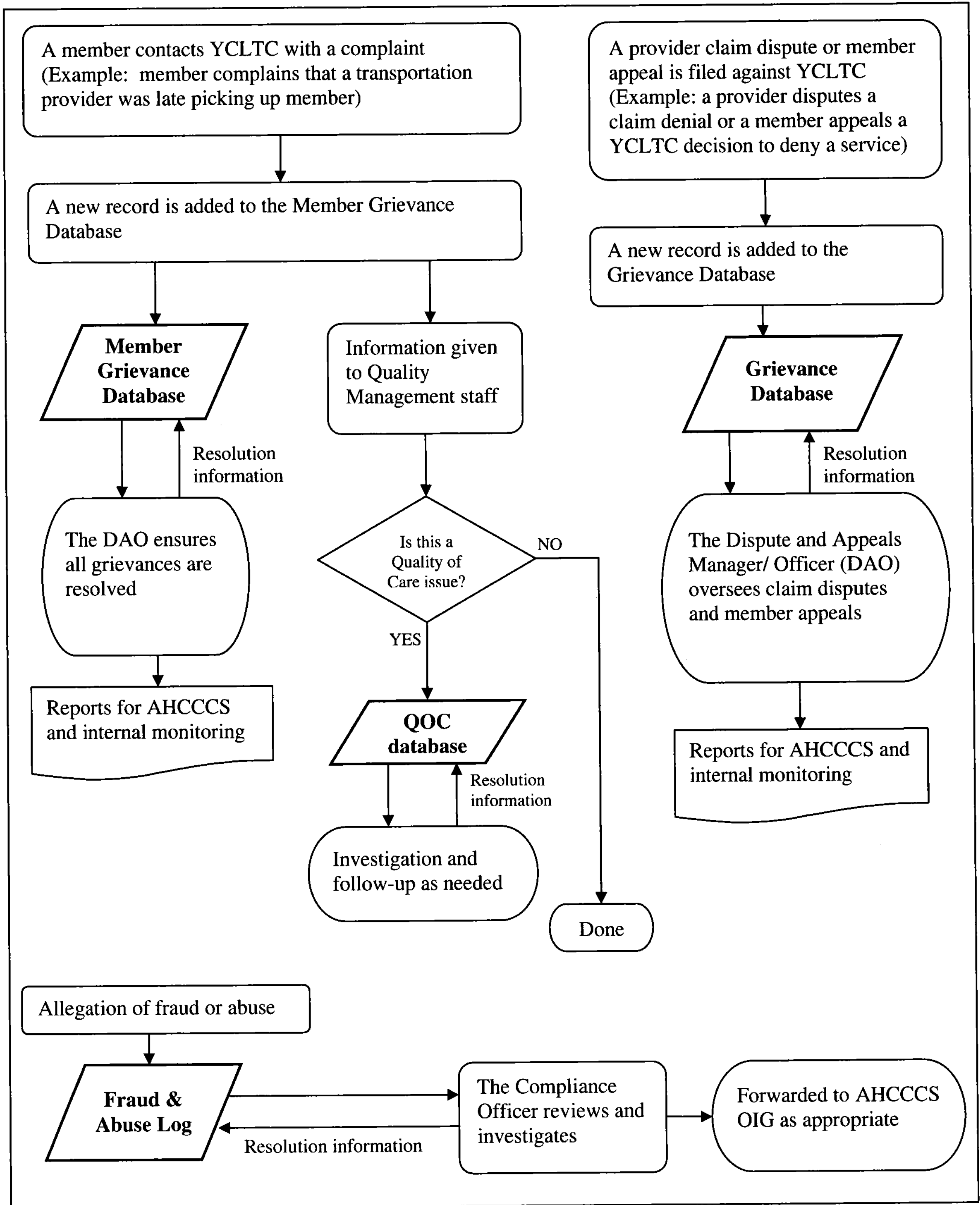


Chart 18. Provider Network

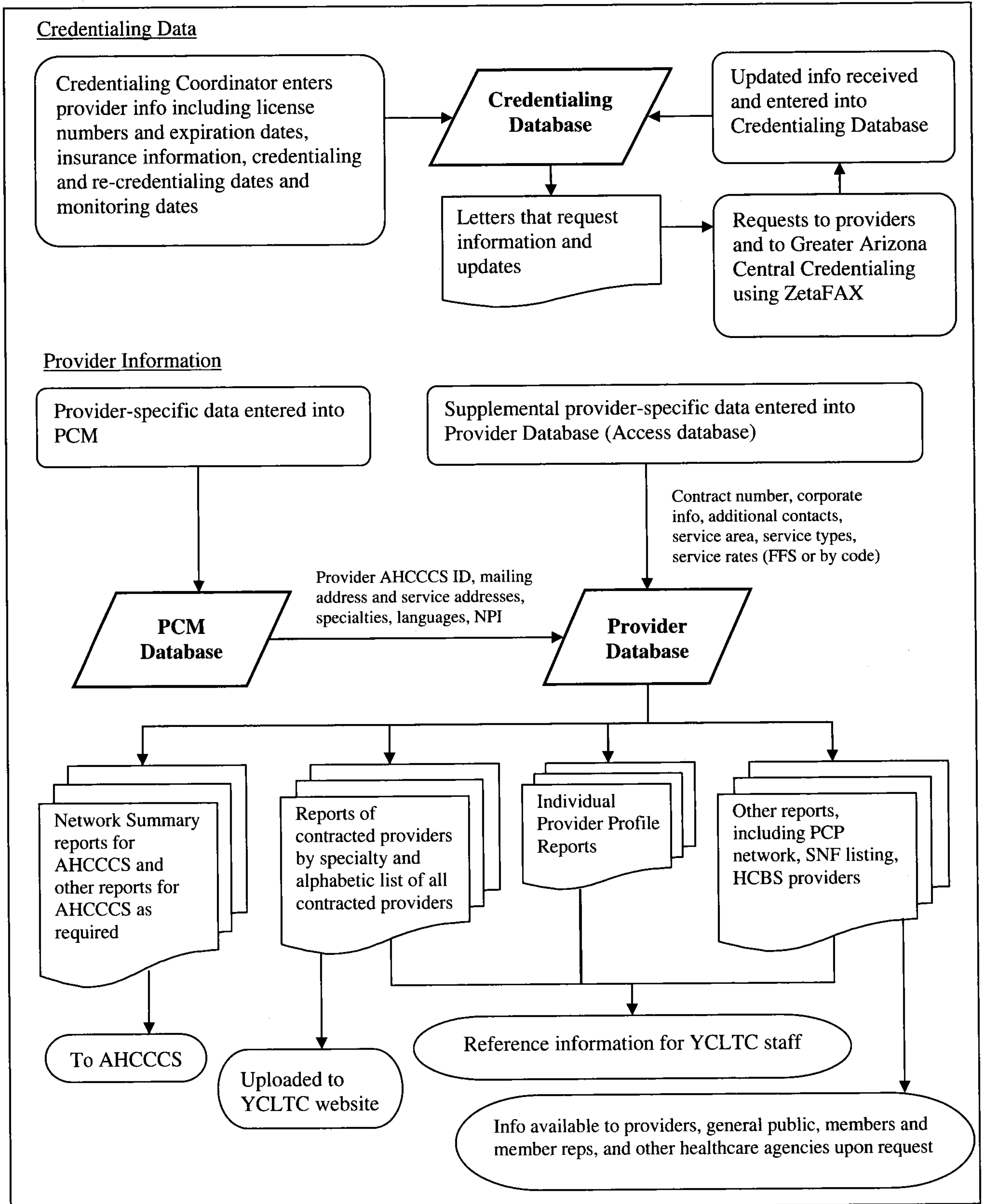
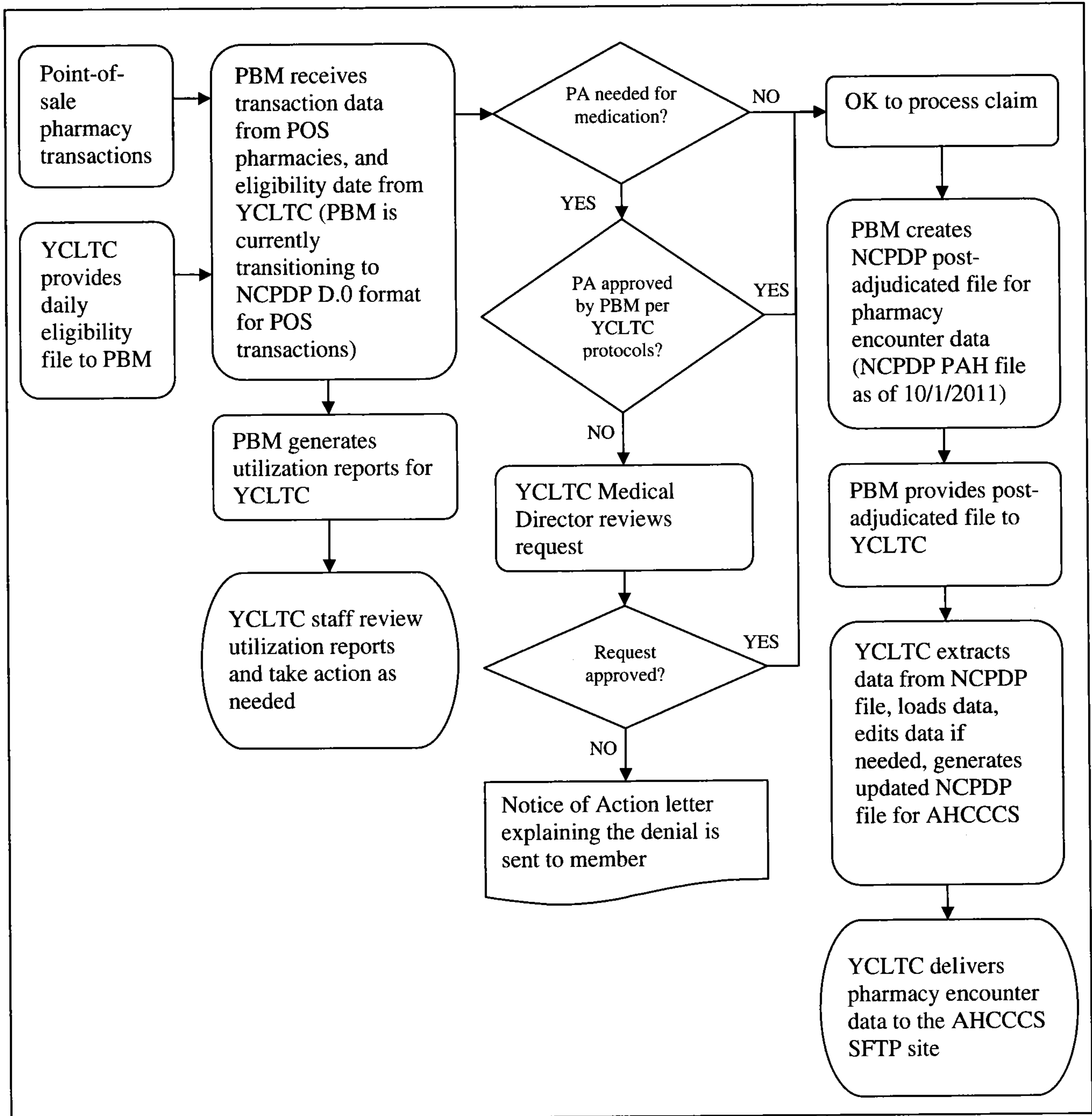


Chart 19. Pharmacy data



Hardware and software upgrades are occasionally needed to maintain current technology and respond to changing data needs. Decisions to upgrade software and hardware are made in collaboration with Yavapai County Management Information Systems (MIS), Plexis Healthcare Systems and CH Mack, Inc.

Many factors are considered prior to a system change. These include a thorough evaluation of:

- Existing program defects
- Enhanced features or capabilities
- Compatibility
- Software support
- Financial impact

Basic Productivity Software

During 2011, Yavapai County MIS Department plans a county-wide migration to Windows 7 and Microsoft Office 2010. Microsoft software upgrades are performed by our MIS Department and are accomplished by re-imaging existing hard drives. The MIS Department performs all hardware and software upgrades for YCLTC. Prior to migration to Windows 7 and Office 2010, YCLTC will verify compatibility with existing Access databases.

Plexis Claims Manager (PCM)

Periodically, Plexis Healthcare Systems offers upgraded versions of PCM or minor updates to address program defects. These are loaded into a PCM Test database which is independent of the Production database. Prior to loading the update, the Production database is copied to the Test database to allow for testing and quality assurance in a current environment.

Upon the request of YCLTC, Yavapai County MIS Database Administrators update stored procedures according to instructions provided by Plexis Healthcare Systems. Any discrepancies or questions which result from testing are reported to Plexis Healthcare Systems Technical Support for guidance, clarification or further analysis. Updates related to claim adjudication are thoroughly tested with all types of claims to ensure expected results. In addition, EDI testing occurs through exporting claim data and submitting to the AHCCCS Test Transaction Insight environment to confirm validity of the file. Once testing has been satisfactorily completed, the production database is updated.

The latest major version upgrade was completed in August 2009 to PCM 8.3. This upgrade required migration from SQL 2000 to SQL 2005 in response to Microsoft's decision to discontinue support for SQL 2000. Use of SQL 2005 also helps optimize PCM performance. This upgrade also enabled YCLTC to utilize a new non-custom coordination of benefits rule to replace a custom rule. The elimination of non-custom rules allows YCLTC to enable future PCM upgrades without the additional cost of customization. A migration plan was developed by our MIS Operations staff which outlined the tasks to complete, the timelines and necessary resources. A new server was purchased with specifications designed by our MIS department. After three months of testing and collaboration with Plexis, we were in production with version 8.3.

In December 2009, YCLTC upgraded from PCM 8.3 to PCM 9.2.0, which is our current production version. This was a minor upgrade to correct a few issues from version 8.3 and to enhance EDI functionality. It is anticipated that YCLTC will upgrade to PCM version 11.0 later this year, which is certified to run under Windows 7. Another PCM upgrade is anticipated prior to October 1, 2013 to support ICD-10-CM diagnostic coding.

Q-Continuum System

Since April 2008, YCLTC has been utilizing Q-Continuum System (a product of C.H. Mack Corporation). This case management software program interfaces with PCM, our claims management system. The most recent version (1.0.4) is Windows 7 compatible. A version upgrade of Q-Continuum is anticipated prior to October 1, 2013 to support ICD-10-CM diagnostic coding.

EDI

Currently, YCLTC uses EDIWorks, an EDI tool developed by Plexis Healthcare Systems. As YCLTC transitions from 4010 versions of EDI transactions to 5010 versions of these transactions, the EDIWorks program will be phased out and gradually replaced by a new Plexis Healthcare Systems tool called QuantumEDI. The new QuantumEDI program is being tested on an ongoing basis as support for each new EDI transaction is made available by Plexis Healthcare Systems.

Plexis Alerts

Yavapai is currently in the process of analyzing the use of a Business Activity Monitoring (BAM) application, Plexis Alerts, which is now offered by Plexis Healthcare Systems. The application has been installed and is currently in use as a test platform.

Plexis Alerts is a "monitor and response" utility that enables users to identify and configure specific data scenarios, and then configure how to present this data once it is harvested. Data is presented in the form of a 'response' which can be provided in an email, export file, page, fax, instant message, dashboard, reports (which can be presented in various formats including MS Word, Excel, CSV, PDF, etc.), and can be scheduled to take place during or after hours to ensure that complex queries do not impact production in a negative way.

The application can monitor and respond to multiple ODBC-compliant databases *simultaneously* (not just the Plexis database), and its unique scheduling and auditing feature ensures that the information is always provided to the right people at the right time, regardless of holidays, lack of staff, retention, etc. Reports can be generated that are *not* run as a result of a data trigger (reports that are run quarterly, weekly, or monthly can be automated). The application will enable YCLTC to focus less effort on day to day reporting and "querying activities", and will enable us to focus more effort on strategic initiatives, such as member satisfaction and improved referral / claim turnaround time. Further evaluation of the application and assistance from Plexis will determine the transition priority, necessary training, and required testing prior to implementation.

Benefits/Claims Management Software

For the past ten years, Yavapai County Long Term Care (YCLTC) has partnered with Plexis Healthcare Systems. Plexis Claims Manager (PCM) software is a claims healthcare information system that supports full claims processing, referral/authorizations, benefit administration, EDI, and encounter tracking functionality for managed care entities.

Current version is Plexis Claims Manager 9.2.0

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Case Management Software

For the past three years, YCLTC has partnered with CH Mack, Inc. The Q-Continuum System is an integrated case management software program. Q-Continuum interfaces directly with Plexis Claims Manager.

Current version is Q-Continuum System 1.0.4

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Fax (513) 936-6006
Cell (513) 252-6105
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Microsoft Office Software

Yavapai County Management Information Systems (MIS) supports and maintains our internal Microsoft Office applications, such as Word, Excel, Access, Outlook, PowerPoint, and Publisher.

Current version is Microsoft Office 2003

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YCLTC is committed to maintaining and developing information technology that addresses current and future Federal IT mandates. New and emerging standards can create unique opportunities for streamlining workflow processes and increasing efficiency and productivity.

Electronic Data Interchange (EDI)

EDI uses pre-defined file formats to transmit information in a uniform and standard format. Since the format is standardized, files can be traded between many different types of organizations, including health care providers and insurers. Using the standard EDI language of X12, new EDI transactions can be developed to respond to changing trends in health care provision and utilization.

HIPAA 5010 introduced new versions of the EDI transactions. Currently, YCLTC is in the process of implementing new EDI transactions that are HIPAA 5010 compliant. Development and trading partner testing have been completed for the 820 transaction (capitation invoices). Live implementation of this transaction is scheduled for April 1, 2011.

The next 5010 version EDI transaction to be implemented is the 834 eligibility file. YCLTC's software vendor, Plexis Healthcare Systems, is currently developing tools to import the new 5010 version of the 834 file. Once the new 834 import is in place, the EDI Analyst, Data Analyst, and other YCLTC staff will collaborate to update and modify work processes that will be affected by changes in the 834 file structure.

The next transactions scheduled for 5010 implementation are the 270/271 (enrollment verification) and the 276/277 (claims status inquiry and response). For current ALTCS contractors, AHCCCS has set an implementation deadline of May 1, 2011 for these transactions. Development of these transactions is underway, and YCLTC is on schedule to meet the May 1, 2011 deadline.

The 837 (claims and encounters), 835 (electronic remittance advice), 277PSI and 277CA (encounter pends), and 278 (prior authorization request) transactions all have an implementation deadline of 10/1/2011. Development is on schedule for YCLTC implementation by that date.

YCLTC's claims clearinghouse (Emdeon Business Services) has already received a letter from the Electronic Healthcare Network Accreditation Commission (EHNAC) verifying that Emdeon has met the requirements of the EHNAC 5010 Readiness Assessment Program. This means that Emdeon's planning and preparation activities are consistent with CMS industry standards for analysis, testing and implementation of the 5010 version of the HIPAA transactions that are mandated for use after 1/1/2012. Per communications directly with Emdeon, they expect to be production-ready by the AHCCCS implementation deadline of 10/1/2011.

AHCCCS has elected to utilize the National Council for Prescription Drug Programs (NCPDP) post adjudication history (PAH) file for pharmacy encounter data. YCLTC is working with our pharmacy benefits manager (PBM), United Drugs, to ensure successful implementation of the PAH file by the 10/1/2011 deadline. United Drugs has obtained and reviewed the PAH file implementation guide from NCPDP.

In 2012, YCLTC expects to begin work on the 5010 version of the 275 transaction (for electronic medical documentation and claims attachments). This transaction complements provider trends in converting from paper health records to electronic health records.

HIPAA and Protected Health Information

Features that help maintain confidentiality of Protected Health Information (PHI) are integrated into many IT applications. For example, Yavapai County MIS limits access to the YCLTC file server via Windows NT authentication using employee-specific network login IDs. Password updates are required at designated intervals, and re-use of passwords is not permitted by the system.

Each employee is granted access to individual folders on the server according to their need to utilize specific types of data. User-specific logins enable YCLTC to implement General Policy & Procedure #14, which states that "member information may only be accessed by authorized personnel and is restricted to the minimum necessary to execute their job responsibilities." Access to highly sensitive data (such as Quality of Care concerns) can be severely restricted while still permitting broader access to other types of data that need to be accessible to all YCLTC employees.

Claims data and case management data is stored in SQL server databases. The open architecture (i.e., ODBC-compliant database structure) is secured through vendor design as well as internal Yavapai County MIS security practices. Remote access to the server is established using Virtual Private Networks.

Internal policies also dictate the rules associated with use of PHI in e-mails. Whenever possible, limited information is transmitted (such as member initials only or initials plus a partial AHCCCS ID). When more detailed PHI must be delivered via email, password protected attachments are used.

Electronic claims and Medicare crossover

YCLTC currently receives 49% of claims electronically in HIPAA compliant formats through Emdeon. We are also in the process of implementing Emdeon's Medicare claims crossover protocol with CMS for secondary claims. This will increase our electronic claims percentage significantly, further reducing our reliance on paper-based systems.

In the interim, we continue to utilize the paper-to-EDI service that is also offered by Emdeon. This service allows most paper claims to be scanned and processed electronically as an alternative to manual data entry. Emdeon uses advanced OCR technology to capture individual data elements from the images. Once the data has been captured, the clearinghouse applies numerous data edits and validation protocols, rejecting claims that fail to conform to the validation rules. Electronic claims are then returned to YCLTC via a standard 837 file.

Electronic Funds Transfer

Yavapai County Long Term Care has been offering payment via electronic funds transfer for the past 4 ½ years. We currently process 89% of payments by EFT. Ongoing communication with providers promotes implementation of EFT for those providers that still receive paper checks.

ICD-10-CM (International Classification of Diseases, 10th revision, Clinical Modification)

One of the primary reasons for updating the EDI transactions from the 4010 to the 5010 format was to accommodate the new ICD-10-CM coding system. The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) have provided ICD-10-CM to replace ICD-9-CM for medical coding and reporting in the United States. (ICD-10-CM is based on the World Health Organization's ICD-10 statistical classification for mortality.) The Department of Health and Human Services has designated an implementation date of October 1, 2013 for ICD-10-CM use for HIPAA transactions. Hospitals will also implement ICD-10-PCS by that date for inpatient procedures. Physician services will still be coded using CPT codes and HCPCS codes.

Preparation for this nationwide transition from ICD-9-CM to ICD-10-CM will begin in 2012. The transition will impact health care providers, hospitals, medical billers, and insurers. YCLTC has already identified resources that will assist in the transition to ICD-10-CM. For example, General Equivalence Mappings (GEM) have been developed by CMS in collaboration with the Centers for Disease Control, the American Health Information Management Association and the American Hospital Association. GEMs provide both forward and backwards mapping between ICD-9-CM and ICD-10-CM. Because there are significant differences between the coding systems, these "crosswalks" also provide useful information to identify situations where no appropriate translation is available between the code sets.

Plexis Healthcare Systems anticipates full support of ICD-10-CM in the first quarter of 2012, well ahead of the federally mandated implementation date.

CH Mack is the software vendor that provides our case management system, Q Continuum. CH Mack is actively designing support for ICD-10-CM at this time, and anticipates ICD-10-CM support later this year. The Q Continuum software will actually support simultaneous use of the ICD-9 and ICD-10 coding systems.

EHRs (electronic health records)

Electronic health records are considered a key component of improving American health systems. EHRs facilitate exchange of health information. Potential benefits include improved patient care and safety, health care cost reductions or stabilization, and greater transparency through the system. In 2005, the Governor of Arizona issued an Executive Order establishing the Arizona Health-e Connection. This organization was tasked with developing a 5 year plan for establishing an e-health infrastructure in Arizona.

As a component of the American Recovery and Reinvestment Act of 2009 (ARRA), the Health Information Technology and Clinical Health Act (HITECH) allocated significant funds for the advancement of electronic use and exchange of health information. Funds from this act were used by the Arizona Health-e Connection to develop a regional health information technology center, the Arizona Regional Extension Center (REC). The REC offers both general and technical assistance to health care providers to assist them in developing electronic health record systems.

YCLTC informs providers about the Arizona REC, and has included information about REC in provider newsletters, provider orientation packets, and at annual provider meetings. Under ARRA, monetary incentive programs are available to providers who demonstrate Meaningful Use of a certified EHR system. REC works closely with AHCCCS to coordinate the EHR incentive programs.

Contracts with YCLTC providers require that providers "cooperate in assisting AHCCCS with developing the Health-e project plan and shall implement required data exchange interfaces as required to meet the goals of the Governor's Executive Order." Contracts with providers also state that "the Agency encourages the provider to participate in the e-Prescribing initiative, EazRx."

Paper reduction technology

The Federal Paperwork Reduction Act (PRA) of 1980 "establishes a broad mandate for agencies to perform their information activities in an efficient, effective, and economical manner"[1]. YCLTC utilizes several tools that promote the goals of the PRA. Department photocopiers have integrated scanning functions, enabling documents to be scanned directly to PDF and TIFF format files for electronic storage. In addition, YCLTC staff use a free printing utility program (CutePDF Writer) that generates electronic PDF documents instead of their printed equivalents.

[1] White House Office of Management and Budget, http://www.whitehouse.gov/omb/circulars_a130_a130appendix_iv

Members and providers have easy access to YCLTC's grievance system. Members can access the system by a phone call to any YCLTC staff member; providers simply send a letter stating they want to file a claim dispute. Members are informed of the grievance system in the Member Handbook, at the initial assessment, on the website, at meetings, and in Notice of Action Letters (NOA). Providers are informed of the system in the Provider Manual, in the claims Explanation of Payment, at provider orientation, on the website, and at meetings. The information is provided as needed and in alternate forms and other languages upon request.

YCLTC's grievance system has three distinct components with three separate processes. The system conforms to BBA, legislative and AHCCCS standards. The grievance and appeal systems allow members to file complaints and appeal actions. The claim dispute system allows providers to dispute any adverse action. Members and providers who disagree with the outcomes of the appeal/dispute can request a State Fair Hearing (SFH) by sending a letter to YCLTC and asking for one. During the Appeal, Dispute and SFH processes YCLTC attempts to negotiate agreements and settle the issues prior to the State Fair Hearing.

Member Grievance System When members enroll with YCLTC, the Care Manager (CM) explains the grievance and appeals processes, member/representative right to file grievances and appeals, availability of member assistance in the filing process, the toll-free and local numbers to use to file grievances and appeals by phone, and the timeframes for filing grievances and appeals. The CM also explains that a provider may file a grievance or an appeal on behalf of a member with the member's written consent. This information is provided in easily understood language and format.

All YCLTC staff are able to accept grievances- member expressions of dissatisfaction with any aspect of their care, other than the appeal of an action - filed by members/representatives in person, orally or in writing, or when forwarded from AHCCCS. There are no time limits for accepting member grievances and each grievance is acknowledged and resolved. If filed in person or verbally, acknowledgement of receipt is understood; if filed in writing, written acknowledgement is sent within 5 business days of receipt. Grievances are typically resolved within 10 business days of receipt, but in no case longer than 90 days from date of receipt. If the CM cannot resolve the complaint, it is processed through the chain of command until it is resolved. Health care professionals who were not involved in any previous level of review or decision making, make decisions regarding a grievance for denial of an expedited resolution of an appeal, or a grievance involving clinical issues. Resolution is communicated to the member in person, in writing or by telephone; written grievances require written notification of resolution. YCLTC does not accept appeals on decisions related to member grievances.

An NOA is sent to the member within three days of denial of a service, within 10 days of the reduction, suspension or termination of a previously authorized service whenever YCLTC completes an action. Members/ representative have the right to file a written or verbal appeal or expedited appeal and do not have to use special forms or specific wording. All YCLTC staff can accept a routine or expedited appeal from a member, member's representative, or a provider acting on behalf of a member and with the member's written consent.

Upon receipt, all requests for appeals are forwarded to the Dispute and Appeals Manager/Officer (DAO) and written requests are date stamped. The DAO ensures that the requests are filed within 60 days after the NOA, and are for a review of an action. She determines if standard appeals need to be expedited by ascertaining if taking the time for a standard resolution would seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The DAO acknowledges receipt of each standard appeal in writing within 5 business days of receipt; of each expedited appeal in writing within one 1 business day of receipt. The DAO uses the same standards to acknowledge receipt of each request not meeting the criteria for an appeal/expedited appeal and explains the standards to the member.

The DAO contacts each person who files an appeal and explains the appeal process. She offers to meet with the parties, to provide the parties the opportunity, before and during the appeal or expedited appeal process, to examine the member's case file or medical records and other documents considered during the appeal or expedited appeal process. The DAO also provides parties a reasonable opportunity to present evidence and

allegations of fact or law, in person or in writing, and tries to understand the member's perspective. She includes, as a party to the appeal, the member, the member's legal representative, or the legal representative of a deceased member's estate. She provides upon request reasonable assistance to members in completing forms and taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

When a member requests an extension of the resolution time-frame, the DAO extends the time-frame up to an additional 14 days. If YCLTC needs additional information and the extension is in the best interest of the member, YCLTC can also extend the time up to an additional 14 days, gives the member written notice of the reason for the time-frame extension, and issues and carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

After completing the investigation, the DAO presents pertinent information from the case file, medical record, AMPM, AAC, ARS, CFR, and all evidence and allegations of fact, law or perception from the member to an appropriate individual to review the appeal or expedited appeal and make a determination. An appropriate individual is one who was not involved in any previous level of review or decision-making. For appeals involving a denial based on lack of medical necessity or grievances regarding denial of expedited resolution of an appeal involving clinical issues, the appropriate individual is a health professional who has the appropriate clinical expertise in treating the member's condition or disease.

The DAO writes a Notice of Appeal Resolution (Notice) that includes the results of the resolution process, the legal citations or authorities supporting the determination, and the date it was completed. For an appeal not resolved wholly in favor of the member, the Notice also contains the member's right to request a SFH no later than 30 days after the date the member receives the notice of appeal resolution; instructions on where to send the request for a SFH; the right to receive continued benefits pending the hearing; and an explanation that the member may be liable for the cost of benefits if the hearing decision upholds YCLTC's decision. The member, member's representative or representative of the deceased member's estate is sent the written Notice by certified mail within 30 days after YCLTC's receipt of the appeal or within 3 business days after YCLTC's receipt of an expedited appeal, unless a 14 day extension has been granted. Then the deadline for the notice is extended up to 14 days. If a Notice is not sent within the required time-frame, YCLTC considers the appeal to be denied on the date the time-frame expired.

Expedited Appeals YCLTC's procedure for expedited appeals is the same as above except: YCLTC accepts a request for an expedited appeal from a member or provider who indicates that the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The DAO makes reasonable efforts to provide prompt oral notice to members regarding an expedited appeal resolution and verbally notifies members of YCLTC's decision within 3 business days of receipt of the expedited appeal. If YCLTC denies a request for expedited resolution, the DAO transfers the appeal to the 30-day timeframe for a standard appeal, and makes reasonable effort to give the member prompt oral notice and follow-up within 2 days with a written notice of the denial of the expedited resolution.

Continued Benefits If members request that benefits continue through the appeal and SFH process, YCLTC continues the benefits until a hearing decision is rendered if the member meets the following: a) the member files the appeal before 10 days from the mailing of the Notice of Action, or the intended date of the action as indicated in the Notice of Action, whichever is later; b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; c) the appeal involves a denial and the physician asserts the requested service is a necessary continuation of a previously authorized service; d) services were ordered by an authorized provider; and e) the member requests a continuation of benefits.

The extended benefits are provided to the member until any of the following occurs: a) the member withdraws the appeal; b) the member has not specifically requested continued benefits pending a hearing decision within 10 days of YCLTC's mailing of the appeal resolution notice; c) AHCCCS issues a SFH decision adverse to the member.

If YCLTC or the SFH decision reverses a decision to deny, limit or delay services not furnished while the appeal was pending, YCLTC authorizes or provides the services promptly and as expeditiously as the member's health condition requires. If YCLTC or the SFH decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, YCLTC pays the provider for the services.

Provider and Subcontractor Disputes Provider Relations Coordinators ensure that providers and subcontractors receive written information about dispute process requirements at the time of contract and as needed or requested. Non-contracted providers are informed of the claim dispute policy in the remittance advice. Providers are given links to ACOM Policy 406, Enrollee Grievance Policy and the YCLTC's Provider Claims Dispute Policy. The Provider Manual includes a description of the right to a SFH, the method for obtaining a SFH, the rules that govern representation at the hearing, the right to file claim disputes, the requirements and timeframes for filing claim disputes, the member grievance and appeal processes, the fact that a provider may file an appeal or grievance on behalf of a member with the member's written consent, and that YCLTC ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

A claim dispute must specify in detail the factual and legal basis for the claim dispute and the relief requested. YCLTC researches claim disputes challenging claim payments, denials or recoupments if the dispute is received no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment denial or recoupment of a timely claim submission, whichever is later. YCLTC denies claim disputes not filed within the above timeframes or filed without stating the factual or legal basis for the claim. YCLTC ensures privacy of records, including transmittal of medical records. YCLTC mails a written Notice of Decision (Decision) of a claim dispute to the provider or subcontractor no later than 30 days after receipt of the provider dispute, unless YCLTC and the provider agree to a longer period. If the claim dispute is overturned by YCLTC or AHCCCS, YCLTC reprocesses and pays the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision. YCLTC pays interest on clean claims, back to the date interest would have started to accrue beyond the applicable 45 day requirement.

Upon receipt of a provider dispute, the DAO or designee: a) ensures that all provider and subcontractor disputes and requests for hearings are received in writing and are date stamped; b) ensures that all documentation mailed by YCLTC during provider dispute resolution process or request for hearing process is dated; c) maintains the provider dispute logs in a database that contains sufficient information to identify complainant, date of receipt, nature of grievance and date of resolution; d) sends an acknowledgment letter within 5 business days of receipt of written claim dispute informing complainant of receipt of provider claim dispute; e) thoroughly investigates each claim dispute using the applicable statutory, regulatory, contractual and policy provisions and ensuring the facts are obtained from all parties. The DAO ensures that the Decision includes and describes in detail: a) date of the decision; b) nature of the claim dispute; c) issues involved; d) reasons supporting the Decision, including facts, references to applicable statute, rule, applicable contractual provisions, policy and procedure; e) whether the request is denied, upheld or partially denied; f) the provider's right to request a hearing regarding the decision by filing a written request for a hearing no later than 30 days after the date the provider receives notification of Decision. A copy of the written decision is mailed, certified with return receipt requested, to all parties.

State Fair Hearing (SFH) Process The Notices of Appeal Resolution for members and of Decision for providers inform the member/provider how to file a request for a SFH on YCLTC's resolution of an appeal/dispute. The Notice of Expedited Appeal Resolution includes additional information on how to file an expedited State Fair Hearing. The DAO accepts requests for standard and expedited State Fair Hearings if the request is in writing and is submitted to and received by YCLTC no later than 30 days after the date the member/provider receives YCLTC's Notice of Appeal Resolution, Expedited Appeal Resolution, or Decision. If accepted, the DAO forwards a written request to AHCCCS, Office of Administrative Legal Services (OALS) within 1 business day for an expedited State Fair Hearing, and within 5 business days of receipt for a standard State Fair Hearing. YCLTC's submission to OALS contains a cover letter that includes the member's/provider's name, member's/provider's AHCCCS ID number, member's/provider's address and phone number (if

applicable), date of receipt of the appeal/dispute, summary of YCLTC's actions undertaken to resolve the appeal/dispute, and summary of the appeal/dispute resolution. The file includes the member's/provider's written request for a hearing, copies of the entire appeal/dispute file which includes all supporting documentation, pertinent findings and medical records, YCLTC's Notice of Appeal Resolution/ Decision, and other information relevant to the resolution of the appeal/dispute.

Denial of a Request for a State Fair Hearing YCLTC denies any request for a SFH under A.R.S. 41-1092, et seq. if: a) the request for a hearing is untimely; b) the request for a hearing is not for an action permitted under A.A.C., Title 9, Chapter 34, Article 2. YCLTC notifies the appellant in writing of the denial and its reason.

YCLTC may make a motion for rehearing if the member's or provider's rights were materially affected by irregularity in the proceedings of a hearing that deprived a member or provider of a fair hearing; misconduct by AHCCCS, OAH, or a party; newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing; a decision that is the result of passion or prejudice; a decision that is not justified by the evidence or is contrary to law; or the nonappearance of a party at the hearing for good cause.

YCLTC maintains separate databases for grievances, appeals, and provider and behavioral health recipient claim disputes. The DAO maintains a file for each appeal/dispute that contains the written request for hearing filed, pertinent records and YCLTC's Decision, and other information relevant to YCLTC's Notice, all notes, documents and correspondence related to the appeal/dispute and its disposition. Files are maintained in a secure, designated area and retained for a period of 5 years following YCLTC's decision, the AHCCCS decision, judicial appeal or close of the claim dispute, whichever is later.

The DAO notifies members and AHCCCS in writing of any significant change in YCLTC's Grievance System policy at least 30 days prior to the intended effective date of change and obtains AHCCCS approval before sending notification of the change to members. The DAO completes and submits monthly grievance reports to AHCCCS and YCLTC management team within 30 days from the end of reporting month, and quarterly reports to YCLTC's QMPI Committee. YCLTC forwards requested information and corrective action plans to AHCCCS within mandated timeframes and is responsible to provide the necessary professional, paraprofessional and clerical services for the representation of YCLTC in all issues relating to the grievance system and other matters which rise to the level of an administrative hearing or a judicial proceeding.

Performance Improvements Identified by Grievance Data Grievance-related actions are reviewed for appropriateness and timeliness, potential for improvement. Per monthly reviews, YCLTC's Grievance System ensures that members, subcontractors, and providers have easy access to YCLTC's grievance system, that grievances are processed fairly in a timely manner, that YCLTC complies with AHCCCS' decisions, and that YCLTC makes and evaluates improvements based on review of Grievance System-related data.

Recent improvements implemented as a result of Member Grievance Data include: 1) including more detail in letters sent to members about Quality of Care concerns so that members could remember what they had reported; 2) change in communication process with the DME provider.

The number of submitted claim disputes has declined due to a change in YCLTC's criteria for timely claims submissions when YCLTC is not the primary payer. The change was made after reviewing the reason for most disputes, evaluating the impact of the change on YCLTC, and determining the benefit of the change.

As a result of an increase in member appeals, YCLTC reviewed the CM assessment process. YCLTC determined that the implementation of a more reliable and valid CM assessment tool decreased some in-home care hours when CMs appropriately applied their training; that CMs sent NOAs; and that members were aware of their right to appeal YCLTC decisions. The review did not reveal needed improvements, confirmed the adequacy of YCLTC protocols, and showed an expected decrease in member appeals. The number of member appeals has since decreased.

Provider Claim Dispute

Dispute and Appeal Manager/Officer (DAO) receives a claim dispute from a provider in writing.

Administrative Support
- Date Stamps the Claim Dispute and related info
- Prepares a Claim Dispute folder
- Enters information in the Grievance Database
- Mails acknowledgement letter to the Provider within 5 business days of receipt of Claim Dispute

Business office receives claim dispute from DAO

Business office
- Researches Claim Dispute information, statutes, and regulations
- Confers with appropriate staff and provider as needed
- Attempts resolution with Provider
- Drafts Claim Dispute Decision Letter

NO

YES

Administrative Support
- Obtains signature for the Claim Dispute Decision Letter
- Sends Claim Dispute Decision Letter to Provider via certified mail within 30 days of receipt
- Enters additional information in the Grievance Database, e.g. completion date, final decision outcome

YES

YCLTC pays claim(s) within 15 days

NO

YCLTC processes claim(s) as denied

NO

No additional action needed

YES

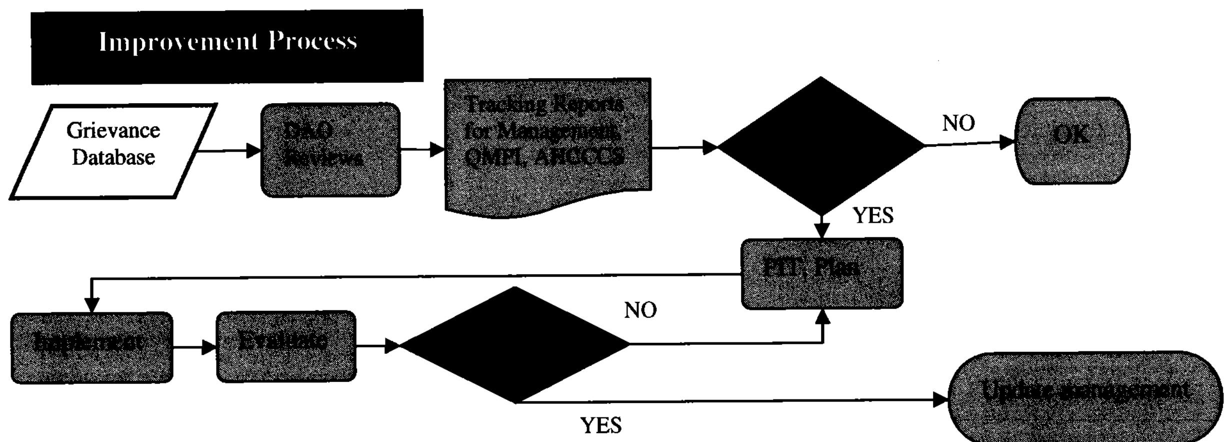
DAO sends SFH request & file to OALS within 5 business days, and enters information in SFH log

YES

SHF log updated

NO

YCLTC pays claim(s) within 15 days



Member Appeals

Member received Notice of action (NOA)

Member/Representative, or Provider with written permission appeals NOA and may request *services to continue while decision is being made

Any staff member receives Appeal information and forwards to DAO

YES

NO

DAO or Designee sends acknowledgment letter within 1 day

DAO or Designee sends acknowledgement letter within 5 days

DAO or designee:
- Logs in Grievance System database
- Calls member
- Meets with member to discuss evidence, review YCLTC medical records, etc
- Reviews Appeal; researches AMPM, AAC, or other regulations
- Requests 14 day extension if in best interest of member

Findings presented to qualified person, who makes decision

DAO sends member a certified decision letter within 30 days of receipt of Appeal (or within 3 days of receipt of expedited Appeal)

YES

NO

YES

NO

No further action needed

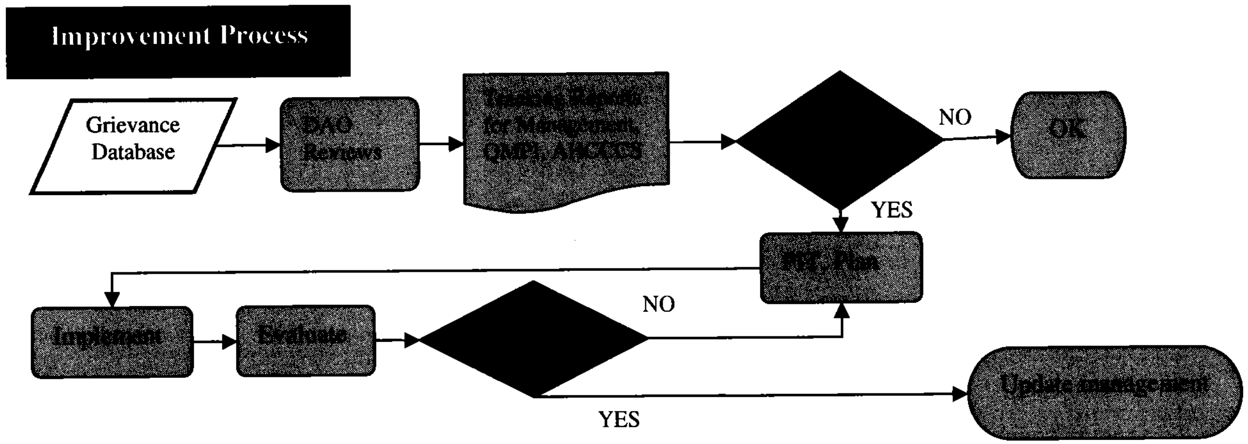
DAO sends request and file to OALS within 3 business days

Decision upheld

Reversal

Services are reinstated or authorized and provider is paid for *services requested

Improvement Process



*Appealed service continued through process at member's request

Member Grievances

Member/Representative or Provider with written permission contacts YCLTC with a complaint.

Any staff member receives Member Grievance and attempts to resolve

Acknowledgement letter is written

Acknowledgement understood

Information is given to CM Supervisor for resolution/training needs

Forwarded to QM

A new record is added to the Member Grievance Database

QM investigates and resolves as needed

DAG ensures that grievances are resolved (including QM investigation, if needed)

Member Grievance Database

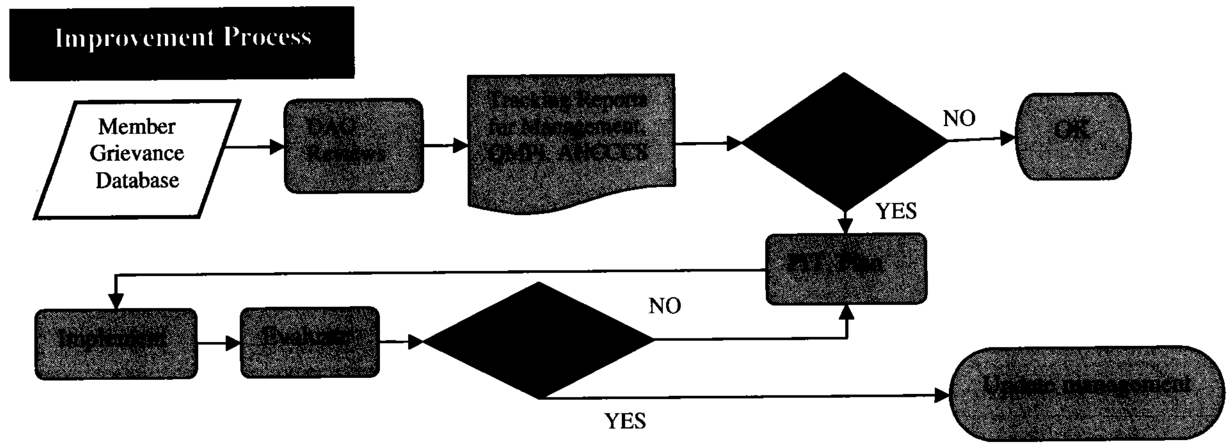
NO

YES

Referred to appropriate staff for resolution within 30 days

DAD or Designee updates Member Grievance Database, and sends follow-up letter if grievance was written

DAG Analyses Trends, Reports Monthly



Compliance Officer YCLTC's fraud and abuse program is administered by its Compliance Officer (CO), Leona Brown. Ms Brown is a highly experienced program manager, possessing over a decade's experience with Medicaid programs in Arizona and New Mexico. Ms Brown is vested with authority to directly report all fraud and abuse issues to AHCCCS-OIG, Office of Civil Rights, Office of Inspector General, Arizona Department of Health Services, Arizona's Attorney General, Drug Enforcement Agency, law enforcement, the Yavapai County Attorney's Office, and other investigatory/regulatory agencies. She is charged with the responsibility to review and assess all documents and interview all persons containing knowledge or information relevant to potential fraud and abuse incidents. She has access to all YCLTC files and documents. She maintains, monitors and trends the fraud and abuse log. She reports identified incidents, trends and interventions to the Compliance Committee, comprised of YCLTC's Director; CFO; CM, Office and Medical Services Managers at monthly Compliance Committee Meetings. She receives all allegations of fraud or abuse identified by or reported by YCLTC staff.

Compliance Program YCLTC creates an environment conducive to preventing fraud and abuse by expecting staff to detect and report fraud and abuse, following established policies and procedures, notifying AHCCCS when aware of potential member or provider fraudulent activities. New staff are required to read YCLTC's fraud and abuse policy. YCLTC provides fraud and abuse training to all staff annually and shortly after hire to new employees. Topics include definitions of fraud and abuse, reporting requirements, Federal False Claims Act, and Citizenship and Immigration. Training provided to staff who interact with providers and members includes scenarios of abuse, neglect or exploitation of an eligible person, the loss, theft, misappropriation, or overpayment of YCLTC funds; mandated reporting requirements; and how to report. YCLTC's CO ensures YCLTC's internal reporting procedure is well defined and made known to all employees.

At YCLTC, prevention, detection and reporting of fraud and abuse is everyone's concern and awareness of the potential for fraud is seen at every level. To that end, all staff are considered to have monitoring responsibilities. Member Services educates members in the Member Handbook and reviews Member Grievance data to identify potential incidents. The Program Development Unit routinely monitors providers for contractual compliance and service delivery; they educate providers through contract provisions, the Provider Manual, trainings, and claims processing requirements. The Credentialing Committee and Medical Director carefully review provider profiling, high or low levels of utilization, credentialing information and check the OIG website for exclusion from participation in federal programs. Staff report anything unusual-Prior Authorization staff focus on prior authorization requests; Nurses identify activities during utilization and quality management processes; Care Managers during conversations with members and at on-site visits. Staff audit claim payments and fee schedules. The financial analyst scrutinizes monthly reports and the Dispute and Appeals Manager conducts monthly reviews of Grievance System Data to identify anomalies and then reports suspected issues.

Care Managers visit members in their homes. They monitor for signs of fraud and abuse, delivery of quality care, and member satisfaction. They build effective relationships with members and encourage members to contact them if problems arise. Members are responsive and report questionable activities to YCLTC staff, who then assess the reports. If the reports indicate possible fraud or abuse, staff make appropriate referrals to Adult Protective Services, Child Protective Services, the Ombudsman, law enforcement, Social Security Administration, and the CO.

The Claims Processing Software generates prior authorizations and processes claims. It verifies member eligibility, needed prior authorization, service coverage. It identifies claims that need retrospective review for medical necessity and appropriateness. It pends claims for excessive or unusual service for sex or age, duplication, invalid procedure codes, excessive cost. Retrospective review of pended claims determines appropriateness of care, level of care and excessive diagnostic testing and ancillary referrals.

Potential issues may be identified by members, representatives/families/friends of members, the public or law enforcement, providers, YCLTC staff, regulatory/government agencies, skilled nursing and assisted living facility reviews, provider monitoring, medical record reviews, or mortality reviews. Issues may have or are likely to lead to physical or emotional harm to a member, place the member at risk for harm, result in inappropriate expenditure

of AHCCCS funds, billing irregularities, or quality of care concerns. Investigative processes consist of on-site reviews, interviews in person and by phone with any person who may have knowledge of the incident or concern, internal and external record reviews, reviews of investigative reports from referral regulatory agencies, and/or review of ADHS nursing facilities survey and tracking system reports, as needed.

Reporting YCLTC is committed to appropriately reporting suspected fraud and abuse to the appropriate agencies. Staff is able to report significant member concerns directly to appropriate Child/Adult Protective Services, law enforcement and the ombudsman. YCLTC Quality Management (QM) may choose to report findings to the CO or directly to AHCCCS CQM, Arizona Department of Health Services, Arizona State Licensure Boards, and QM&PI Committee. The CO makes referrals to other appropriate regulatory agencies such as the Office of Civil Rights, HHS Office of Inspector General, and AHCCCS OIG. Staff inform the CO of their referrals; the CO completes needed preliminary investigations, documents activities, ensures reporting requirements are met.

YCLTC's CO reviews incidents, tracking and trending issues. She plans interventions, allocates resources, evaluates effectiveness and facilitates a monthly Compliance Committee Meeting that reviews incidents, interventions and outcomes. The Committee ensures resources are available, appropriate actions have been taken and reports made. The CO compiles an annual report that identifies trends, substantiated and deterred incidents, reporting sources, and referrals. She presents the report to the Director and QMPI Committee participants.

YCLTC's CO is responsible for YCLTC's comprehensive fraud and abuse prevention, recognition and reporting training that encourage employees, providers, and members to report fraud and abuse without fear of retaliation. Ms Brown participates in AHCCCS Compliance Network Group meetings to better identify and scrutinize prevention and detection of managed care fraud and abuse, to conform to federal requirements, and to discuss the most effective ways to prevent and/or detect fraud and abuse. Promptly following each meeting, she briefs the Director and presents an overview of the meeting to YCLTC's management team.

While YCLTC's employees provide a highly trained core to YCLTC's fraud and abuse program, their effort is reinforced by the YCLTC's provider network as well as YCLTC members and their representatives. YCLTC's CO integrates presentations into meetings with groups of providers or members. Information on fraud and abuse is presented to Member Council, SNF, HCB and ALF meeting participants. It is presented to individual providers as trends are identified and upon request. Fraud and abuse is a required training component of the certification program for new Adult Foster Care (AFC) homes. In addition to extensive coverage of fraud and abuse contained in each YCLTC's Provider Manual and Member Handbook, YCLTC's quarterly provider and semiannual member newsletters regularly communicate its commitment to the prevention, detection, and reporting of fraud and abuse. Each contract addresses fraud and abuse.

YCLTC firmly believes that successful efforts to prevent fraud and abuse must include the community of caregivers, interested parties, agencies and groups that serve the elderly and disabled populations. YCLTC participates in community workgroups such as the Elder Abuse Task Force that address community needs, trends, and resolution to problems. YCLTC requires providers to fingerprint and train their staff who provide direct care to members in any setting. YCLTC offers training to providers that equip them to better serve members as they work within the member's culture, thus reducing stress and frustration and thereby reducing the risk for abuse. Additionally, YCLTC supports adequate pay and respite for caregivers. Intermittent respite includes Adult Day Health Care and paid respite services; continuous respite is offered in-home, in an ALF and in a SNF for a maximum combined total of 720 hours per member per year.

As a County Department, YCLTC's efforts to prevent, detect and report fraud and abuse are supported by Yavapai County. The philosophy of Yavapai County is to conduct all its operations, including its Program Contractor responsibilities, with the highest level of integrity and accountability to taxpayers. As a governmental entity, YCLTC adheres to rigorous financial controls. Those controls include stringent financial accounting practices and policies applicable to governmental entities. Additionally, YCLTC is subject to audits by internal

professionals as well as independent public accountants. Integral to YCLTC's financial controls for fraud and abuse is its Managed Care Revolution software, designed and supported by Plexis Claims Manager. This state-of-the-art managed care computer system provides for the most advanced contract administration, referral management, claims procession and prior authorizations. Yavapai County's compliance program, financial controls, computer system and rigorous audits, ensure accountability for program monies, and performance of program contractor responsibilities.

Following is a partial list of the types of fraud and abuse monitored by YCLTC:

- Administrative / Financial: kickbacks, falsifying credentials, fraudulent enrollment practices, fraudulent TPL reporting and fraudulent recoupment practices
- Denial of Service: denying access to services and benefits, limiting access to services and benefits, failure to refer to a specialist, and underutilization
- Falsifying Services: billing for services and supplies not provided, misrepresentation of services and supplies, substitution of services and providing and billing for unnecessary services
- Falsifying Claims / Encounters: alteration of claims, incorrect coding, double billing, submission of false data or diagnosis, misrepresenting an unallowable service in billing
- Member Fraud / Eligibility Fraud: misrepresentation regarding resources, residency, household composition, citizenship status, income and medical condition, prescription alteration, theft of durable medical equipment and failure to report TPL
- Member Abuse: physical, sexual, mental and emotional abuse, discrimination, neglect, financial abuse or exploitation, provision of substandard care and misdiagnosis

YCLTC seeks continuous quality improvement of this and other programs and systems. Accordingly, YCLTC's CO annually reviews and revises YCLTC's fraud and abuse policies and procedures to meet changing regulations or trends. She facilitates monthly Compliance Meetings, comprised of YCLTC's Director; Business Office, Medical Services, Office, and Care Management Managers. The Business Office Manager is also YCLTC's CFO. These upper level managers assist in monitoring, reviewing, and assessing the effectiveness of the compliance program and timeliness of reporting. They discuss fraud and abuse issues, policy matters, cases, and training. They recommend improvements, discuss possible trends and strategize interventions. YCLTC ensures that an adequate number of staff and resources are available to investigate unusual incidents and to follow up on Corrective Action Plans.

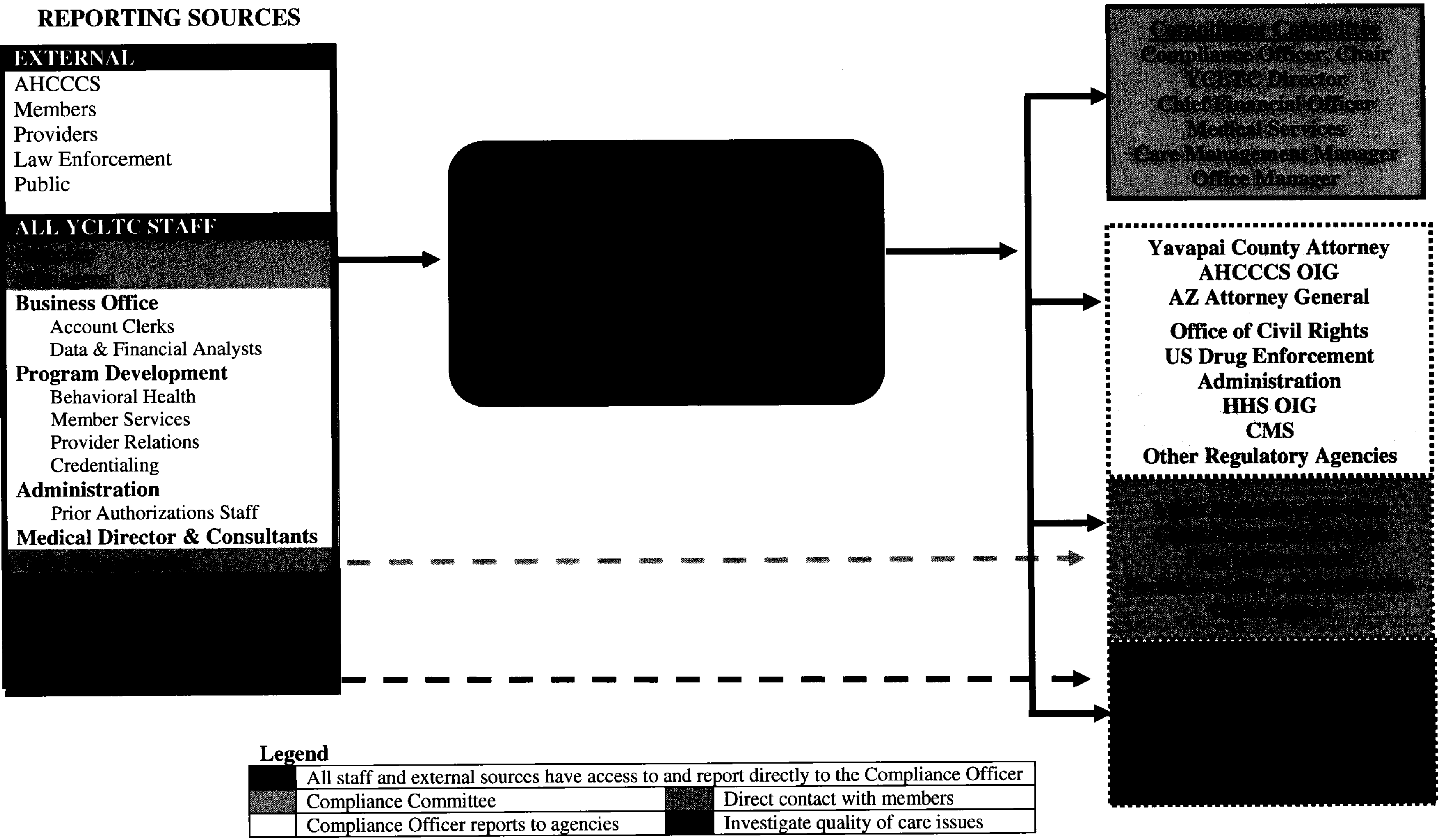
YCLTC staff, providers, and members are expected to report fraud and abuse without fear of retaliation. Failure to report as required in A.R.S. 36-2918.01c could result in staff disciplinary action or contract termination. After review, the CO reports all incidents of suspected fraud or abuse on the confidential AHCCCS Referral for Preliminary Investigation form to AHCCCS, Office of Inspector General (OIG) within 10 business days of discovery. Reported incidents include but are not limited to acts of suspected fraud or abuse that YCLTC was able to resolve, and that involved AHCCCS funds, contractors or providers.

The CO forwards completed forms, attachments, pertinent documentation and/or investigative reports to AHCCCS, DHCM for referrals related to abuse of members, and to AHCCCS, OIG for referrals related to fraud and abuse by providers or members.

YCLTC supports AHCCCS' oversight responsibilities, and cooperates with reviewers by providing, at a minimum, a space to work and access to records, if AHCCCS staff arrives to conducts an on-site review with or without notice to ensure our compliance with reporting standards. YCLTC also responds to electronic, telephonic or written requests for information within the specified timeframe.

Upon notification by AHCCCS OIG, YCLTC researches potential overpayments, conducts cost benefit analyses, and attempts to recover overpayments, if warranted. YCLTC then notifies AHCCCS OIG of the final disposition of the research and any actions taken.

YCLTC Compliance Organization Chart



C. ORGANIZATION – FINANCE AND LIABILITY MANAGEMENT Q.17

YCLTC, as the incumbent ALTCS contractor, has met this submission requirement through current contract requirements and does not need to resubmit the three most recent financial statements.

C. ORGANIZATION – FINANCE AND LIABILITY MANAGEMENT Q.18

Yavapai County Board of Supervisors adopted Resolution No. 897 on June 14, 1993 pledging to provide financial backing as an ALTCS program contractor. A copy of the Resolution is attached.

At the December 6, 2010 Yavapai County Board of Supervisors meeting, YCLTC's request for the support of and permission to submit a response to the ALTCS RFP was unanimously approved.

Please see the next page.

RESOLUTION NO. 897

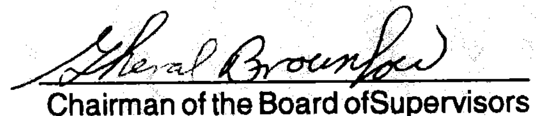
A RESOLUTION OF THE YAVAPAI COUNTY BOARD OF SUPERVISORS PLEDGING TO PROVIDE FINANCIAL BACKING AS AN ALTCS PROGRAM CONTRACTOR

WHEREAS, Yavapai County anticipates its selection as an ALTCS Program Contractor for the service area of Yavapai County, and;

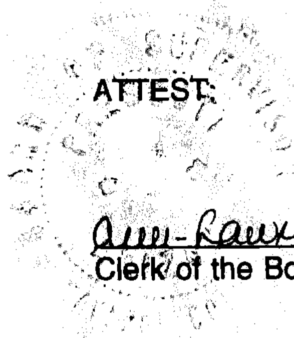
WHEREAS, the proposed contract for ALTCS services includes provisions for financial assurances by the Program Contractor;

NOW THEREFORE, BE IT RESOLVED that Yavapai County as an ALTCS Program Contractor pledges its financial backing, and in the event of default as Program Contractor agrees to pay any damages sustained by the providers by reason of breach of Program Contractor's obligation under its contract, reimburse AHCCCSA for any extraordinary administrative expenses incurrred by reason of a breach of Program Contractor's obligation under its contract, including, but not limited to, expenses incurred after termination.

PASSED AND ADOPTED by the Board of Supervisors of Yavapai County this 14th day June, 1993.



Chairman of the Board ofSupervisors



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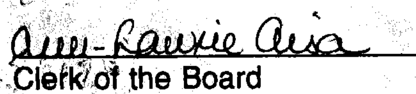

Clerk of the Board

Deputy County Attorney

C. ORGANIZATION – FINANCE AND LIABILITY MANAGEMENT Q.19

Yavapai County Long Term Care (YCLTC) currently meets the Proposed Capitalization Requirement of $1,000,000. Furthermore, YCLTC's history for the past 17 years represents the financial solvency of YCLTC.

As reflected in our October-December 2010 financial statements, YCLTC currently meets the Financial Viability Standards as outlined in Section D, Paragraph 52 of the RFP, as follows:

Requirement	Standard	Actual
Current Ratio	At least 1.00	1.81
Equity Per Member	At least $2,000	$4,070
Medical Expense Ratio	At least 85%	88.4%
Total Administrative Cost Percentage	No greater than 8%	6.4%

YCLTC anticipates continued or improved viability and performance results through sustained efforts and constant focus on process improvement.

[illegible] PROGRAM 124

Case Management
20. Inter-Departmental Coordination 125
21. Monitoring Level of Consistency 128
22. Complex Members 131
23. HCBS Members 134

24. Case Management Scenarios 137
    a. Oscar 137
    b. Magda 140
    c. Wanda 143
    d. Roger 146

Medical Management
25. Process for Utilization Data Gathering and Analysis 149
    a. Utilization Data Sample A 152
    b. Utilization Data Sample B 153
    c. Utilization Data Sample C 154
26. Example of Successful Interventions 155
27. Chronic Care/Disease Management Programs 156
28. Clinical Criteria 159

Quality Management
29. Quality Improvement Opportunity 161
30. Peer Review Committee 163
31. Quality of Care Scenarios 165
    a. Rural Facility 165
    b. Urban SNF 168
32. Improving Quality of Care 171
33. Feedback Drives Changes 174
34. HCBS Monitoring Non-Compliance 176

Oral Presentation
35. Oral Presentation 179

YCLTC acknowledges the value strong inter-departmental communication between case management and other areas of the organization to improve member health or service outcomes. Case Management works closely with Administrative Support, Medical Services, Behavioral Health (BH), Member Services, Provider Relations, Business Office and Management personnel to ensure well coordinated, timely, cost effective service delivery and optimum desired member health outcomes. YCLTC has solid inter-departmental coordination between Case Management and other organizational staff to meets its goal of improved member health and service outcomes through:

Centralized office location

In order to provide inter-departmental coordination between Case Management and other staff, YCLTC maintains its main office in Prescott Valley, Arizona. The centralized location affords Care Managers (CM) the opportunity to interact daily with nurses, a licensed professional counselor and professionals of other disciplines thus ensuring positive member health and service outcomes. The YCLTC Managers, Director and Medical Director are easily accessible and available. Care Managers utilize laptops in the field to ensure member care is continuously coordinated and communication amongst staff is seamless.

HIPAA compliant electronic member records

YCLTC employs a software program that maintains a real time HIPAA compliant electronic member record. The record is utilized by Care Managers, Medical Services, Administrative Support and other staff daily. As documents are received via mail or fax, Administrative Support staff enter them into the record so others can view pertinent information such as ER/hospitalizations or provider communications. Care Managers receive immediate notification that information has been added to the record and can act upon urgent needs and/or requests. Internal staff from each unit has the ability to add documentation and utilize the electronic member record as needed to better coordinate services to meet the needs of YCLTC members and achieve desired outcomes. The member record includes but is not limited to demographics, Uniform Assessment Tool (UAT), assessment data, communications, service authorizations, CATS data and written correspondence.

Policies and Procedures

YCLTC has policies and procedures based on AHCCCS/YCLTC guidelines to assist all staff to recognize and take appropriate action to meet the needs of YCLTC members. YCLTC staff has easy access to policies and procedures via the computer or master paper copies. Examples of policies and procedures that may address immediate actions include: Behavioral Health (BH) Placement, BH Crisis Services, Grievances, Quality of Care, Reporting Abuse/Neglect/Exploitation and Business Continuity.

Meetings: Unit, MDT, Management, Compliance, General Staff

The YCLTC CM Unit meets monthly and as needed. Regular attendees include the Care Management Manager (CMM), Supervisors (CMS), CMs and a Provider Relations Coordinator (PRC). The PRC updates network information and opens a dialogue to discuss concerns, network needs, and new information regarding providers. In addition to a PRC, YCLTC Unit Managers attend at least one CM Unit meeting annually. Staff from other units also attend, especially when there is a presentation that is beneficial to the individual. Meetings with guest speakers, for example a new BH provider, are well-attended by staff outside the CM unit. The fluidity of attendees increases cross-training and improves interdepartmental coordination.

YCLTC schedules Multi-Disciplinary Team (MDT) Meetings bi-weekly and as needed. CMs and other internal staff notify Medical Services staff to schedule the meeting and attendees include the YCLTC Medical Director, CMs, Medical Services RNs and other stakeholders such as the Director, clinicians and unit managers. YCLTC professionals from diverse disciplines come together to provide comprehensive assessment and consultation to help team members resolve difficult cases, provide a "checks and balances" mechanism to ensure that the interests and rights of all stakeholders are addressed, develop and implement interventions to improve member health and service outcomes and identify breakdowns in coordination or communication between the member, internal and/or external staff. They also enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

YCLTC Managers attend Management and Compliance Meetings monthly. Management Meetings provide each unit manager an opportunity to report, discuss and review activities in their units. Items on the agenda include but are not limited to updates regarding AHCCCS, Disease Management, Process Improvements Projects, Network Sufficiency, Site/Service Monitoring, Case Management, Member Reports, Claims and various statistical data. Monthly Compliance Meetings are attended by YCLTC Managers and agenda items include but are not limited to reports on fraud and abuse, service gaps, grievances, quality of care concerns, notice of action letters, appeals and internal audit results. Participants review and discuss agenda items and offer feedback to improve processes for improved member health and service outcomes.

General Staff Meetings are held three times each calendar year. All YCLTC employees attend and receive trainings. The discussion that ensues at these meetings assists YCLTC in improving health and service outcomes through a more thorough understanding by all employees of key program requirements.

Trainings: New Employee Orientation, Quarterly, Ad Hoc

Interdepartmental coordination begins with New Employee Orientation (NEO) which provides foundational information. YCLTC requires all new employees to complete a uniform orientation program that exposes the employee to each YCLTC unit and function and fosters development of relationships with peers and managers. Each session is documented by the training facilitator to validate the employee completed each section of the orientation within the timeframe allotted. The NEO is integrated with the employee's specialized training for the job position and has ten (10) sections; Administration & HIPAA, Care Management, Member Services and Business Continuity, Behavioral Health, Medical Services and Physical Therapy, Assisted Living Facility (ALF) Network and Transition, Program Development, Provider Relations, Cultural Competency, and Business Office. Program Development includes training on Fraud and Abuse, Grievance and Appeals, Deficit Reduction Act, Citizenship and Immigration. In addition, each new employee is required to view the AHCCCS on line training on Fraud and Abuse.

The extensive orientation is particularly important for CMs who must be equipped with a comprehensive understanding of YCLTC's program in order to serve the members as effectively as possible. CMs learn how to interact and communicate with other units within YCLTC and external entities. They are encouraged to take advantage of YCLTC's open door policy of managers to ask questions and solicit information. They may attend meetings held by other units within YCLTC. This increases their understanding of important work completed by these units and familiarizes them with interpersonal dynamics of staff.

Other subjects in which all staff receive on-going training include an overview of AHCCCS, AHCCCS Policy and Procedure Manuals, AHCCCS Contract, State and Federal requirements, Quality of Care Process, HIPAA Compliance, Cultural Competency, Business Continuity, Fraud and Abuse, and Grievances and Appeals. Trainings may be conducted at General Staff meetings, unit meetings, through e-mail, on-line presentations, newsletters or brochures. Employees acknowledge completion of training via the in service attendance form. The forms are maintained in employee personnel files.

YCLTC CMs receive quarterly, refresher and remedial trainings including individualized training if necessary. Last year's training topics included Care Manager Internal Audit Results – Summary and Standards, BH Court Ordered Treatment (COT), Reporting & Tracking, Transfer/Mobility Assessment, Inter-rater Reliability, Medical Record Documentation, Cultural Competency, CM Refresher Training and Transitioning Members. Presentations were provided by CM staff, YCLTC RN, BH Coordinator, Cultural Competency Coordinator, Compliance Officer and Physical Therapist. As a result of the presentations, CMs skill sets were enhanced to better coordinate member care and improve member health and service outcomes.

YCLTC CM staff receives additional ad hoc training as AHCCCS benefits, policies, procedures and program change. YCLTC hosted and attended the Housing, Education and Employment (HEE) training for rural ALTCS program contractors. YCLTC specific training modules were developed and the entire CM unit received comprehensive training on HEE. The training was also attended by YCLTC Member Service and Medical Service

staff. Once again, inter-departmental participation provided non-care management staff with the tools to improve coordination of member health and service desired outcomes.

Example of how YCLTC improved member health or service outcomes because of inter-departmental coordination

A Multi-disciplinary Team Meeting (MDT) was conducted 12/15/2010 with a subsequent follow-up meeting on 1/26/2011 to improve member health and service outcomes for a 57 year old female with a 25 year history of being on a large dose of methadone. She was taking 320mg daily (32 – 10mg tabs) for chronic deforming back pain (severe scoliosis, kyphosis, lumbar flexion to 60 degrees, back brace, walker) and back surgery one year ago that is not evident on a current CT Scan. Attendees included the YCLTC Medical Director, Director, Medical Services RN, CMM/CMS/CM, BH Coordinator and PRC.

Issues

- Complex pain management/methadone habituation/necessary polytherapy with psychiatric medications/related safety issues, including falls.

Desired outcome

- Transition member to pain management and/or methadone clinic for prescribing and reduction of methadone utilization.

Goals

- Less cognitively suppressive opioid regimen, adjunctive medications.
- Good psychiatric pharmacological and cognitive insight work.
- Sort out which is pain management and which is opioid habituation.

Results

- PRC contracted with a new provider to meet member specific complex needs.
- Member is a willing participant in Methadone reduction.
- Member's posture has improved and member now makes eye contact.
- Member verbalizes positive statements.

Dr. Ferenc Nagy, YCLTC Medical Director, states the member is doing well and desired outcomes have been achieved. Case is closed at this time, but will be re-opened if needed.

In conclusion, YCLTC has implemented successful protocols that ensure appropriate inter-departmental coordination between case management and other areas of the organization to improve member health and service outcomes as evidenced above. YCLTC continually examines its protocols and implements changes to its protocol to ensure best practices are utilized and desired outcomes are realized.

The methodology YCLTC utilizes to monitor and improve the level of consistency among care managers (CM) with regard to the assessment of HCBS member needs and service authorizations is a multi-level approach. The tools YCLTC employs include direct supervision of CMs, managerial over sight of the daily operation, comprehensive initial and ongoing training, regularly scheduled and ad hoc unit meetings, multi-disciplinary team (MDT) meetings, quarterly and focus audits and reports created from tracking and trending databases.

Direct Supervision - YCLTC maintains an appropriate ratio of CM to supervisor (8:1). The ratio allows the care management supervisor (CMS) adequate time to review the level of consistency with regard to the assessment of HCBS members and service authorizations, monitor compliance with program requirements, identify CM deficiencies, develop and implement strategies for improvement, as well as support, train and provide the guidance CMs require to successfully provide care management services to YCLTC members. CM protocols require CMS review of CM actions when a CES exceeds 80% or when the number of assessed critical home care hours exceeds 20 per week. In both situations, the CM presents the case and justification to the CMS. They discuss the facts of the case and assessment details, identify alternate plans of care and evaluate how best to meet a member's medically necessary needs most cost-effectively. As necessary, the CMS accompanies the CM on assessment visits. Through these actions, the CM is better prepared to make an accurate and consistent assessment of needs and develop and implement appropriate care/service plans.

Managerial - The Care Management Manager (CMM) oversees the daily operation and provides technical assistance and oversight of the care management function through direct supervision of the CMS and Transition Coordinator. To ensure the level of consistency among CMs with regard to the assessment of HCBS member needs and service authorizations, the CMM develops and implements monitoring systems, utilization standards and policies and procedures in compliance with AHCCCS cost effective and care management requirements.

Comprehensive Training - CMs receive initial orientation and ongoing training according to AHCCCS and YCLTC protocols. YCLTC provides a formal three (3) month training program and orientation with staff from all units for newly hired care managers. The training program consists of eight (8) training modules covering such information as AHCCCS/ALTCS requirements, covered services, internal policies and procedures, agency orientation, the CM's role and philosophy in advocacy, remaining member focused, member needs assessment, member and family involvement, documentation, service and care planning, member rights, member choice and self determination, coordination with stakeholders, cultural awareness, service delivery and YCLTC provider network. Each module provides specific information to develop the skill sets and knowledge CMs need to provide quality long term care services to YCLTC members. On-going trainings are accomplished through training bulletins, quarterly trainings, general staff meetings and ad hoc sessions. Training topics may include, but are not limited to, the following:

- Contingency Plan Form Training
- Direct Care Workers Update
- Behavioral Health
- Acute Care Only Placements
- CM Internal Audit and Routine Paperwork Review
- Children's Rehab Services (CRS) Administrative
- Review and Results of Initiation of Services
- Housing, Education and Employment including
- Freedom to Work
- Community Transition Program
- Self Directed Attendant Care (SDAC)
- Spouse as a Paid Caregiver
- Inter-rater Reliability
- PAS Reassessment Process

Inter-Rater Reliability (IRR) –YCLTC Care Management staff schedule and provide quarterly and ad hoc Inter-Rater Reliability (IRR) Training to ensure the 16 care managers, from very different backgrounds and areas of expertise, achieve consistency in the assessment process, appropriately meet the needs of YCLTC members and adhere to current guidelines and requirements of AHCCCS and YCLTC. In addition, the CMS is available to and intervenes to resolve member issues with service decisions made by the member, family and/or representative. Actions include a review by the CMS of the service unit worksheet and other pertinent member information e.g. CES, on-site reassessment visits, as appropriate, attendance at care and/or discharge planning conferences and

communication with the member, CM, PCP and other interested parties. These interactions help improve consistency among CMs in applying criteria to determine appropriate cost effective necessary services for YCLTC members, identify individual and unit training needs related to inter-rater reliability and increase member satisfaction with the service planning process and its results.

The typical IRR training presents consists of a scenario of an YCLTC member to CM staff in writing and through role play. CMs use assessment tools to complete Uniform Assessment Tools (UAT) and Service Unit Worksheets (SUW) based upon the scenario. The CM results and the expected outcomes are discussed. A report including an analysis of results and strategies for improvement is written and provided to the CM unit and YCLTC management team. YCLTC expects to achieve greater consistency in CM assessments as additional training is developed and provided to individuals and the unit as a result of IRR findings.

Multi-Disciplinary Team (MDT) MDT Meetings provide an additional level of support to CMs to ensure appropriate care coordination for non-collaborative and/or high risk members is achieved. MDT Meetings are attended by YCLTC Medical Services, Behavioral Health, Care Management and other staff, as appropriate. The MDT Meetings provide the CM with the opportunity to collaborate and better coordinate member care with YCLTC clinicians and other staff. Interventions recommended by staff, in attendance at the MDT Meetings, for members identified as displaying complicated or involved medical, social and/or behavioral needs are implemented, documented and completed. MDT meetings are normally held bi-weekly, but can be held ad hoc if developing issues show a need for this support tool. As a result of using the MDT process, CMs are able to gain much greater insight into the possible needs and support options of members with complicated and/or challenging issues. CMs are better able to evaluate sources of concern, mediate and achieve desired member outcomes as a result of the multi disciplinary team process.

Unit Meetings Monthly and ad hoc CM unit meetings are orchestrated to update CMs on AHCCCS program changes and the YCLTC Provider Network, review results of audits to identify deficiencies and inconsistencies with standards and provide education to CMs on improving the level of consistency among CMs in the assessment and service authorization process.

Audits

Care Management Record Review Audit The quarterly Care Management Record Review Audit is an internal audit of CM member case files. The audit meets AHCCCS contractual requirements to monitor compliance with program standards. In addition, the audit evaluates the CM's knowledge of policies and procedures, identifies deficiencies and training needs, reinforces YCLTC priorities and tracks improvement or decline in the overall performance of YCLTC CMs. The Care Management Record Review Audit monitors member record content, accuracy, member contact timelines compliance, mutually agreed upon placement decisions, care plans, with emphasis on the most integrated/least restrictive setting, contingency service plans, accuracy and completeness of documentation, supporting documentation for authorization of attendant care (AC) hours (AC, Spouse AC, SDAC), compliance with completion of assisted living facility (ALF) paperwork; resident single occupancy agreement, room and board agreement and ALF Uniform Assessment Tool (UAT), as well as compliance with behavioral health protocols and timelines. The compiled aggregate results of the audit include analysis, plans of correction (if indicated) strategies for improvement and outcomes of the previous strategies for improvement. The results assist YCLTC to improve the level of consistency among CMs with regard to the assessment of HCBS member needs and service authorizations. An overall summary and analysis of the audit results is distributed to all CMs and reported at unit meetings. CMs receive individual written results; CMS' review individual CM deficiencies and provide training to improve consistency. Compliance deficiencies are further addressed at quarterly CM trainings, unit meetings, in training bulletins, performance appraisals and through the employee disciplinary process as needed. Newly hired CMs are subject to individualized member record case audits in conjunction with their three and six month probationary performance evaluation and quarterly thereafter. The audits focus on process, procedure and documentation. Additional training is provided individually, at meetings and in the field.

Home Modification Audit The Home Modification audit is completed quarterly to determine the level of compliance with AHCCCS standards and YCLTC Policies and Procedures regarding coordination and authorization of home modification projects for HCBS members. Home modification projects are logged and tracked to ensure all appropriate steps are taken within prescribed timeliness guidelines. An overall analysis of the Home Modification Audit is used to determine YCLTC's compliance with AHCCCS standards. Comparison of the current quarterly score to previous quarterly scores is used to show either an increase or decrease in compliance, identify training needs for individuals and the unit and develop and implement strategies for improvement.

Initiation of Services Audit The Quarterly Initiation of Service Audit is designed to determine if HCBS services are started within the 30-day timeline required by AHCCCS with a preference for services to begin within fourteen (14) days of enrollment. The audit also examines if CMs are documenting initiation of services and following up with members as needed. CMS' enter newly enrolled HCBS members into a tracking log, set reminders and notify the CM requesting an update on the new member's services. Start date of the services is entered into the log and at the end of the quarter a written report is completed with the percentage of compliance with the AHCCCS standard. A minimum of 50% of the new members charts are audited at the end of the quarter to follow-up with the requirement for CMs to document the initiation of services. The results are reported at YCLTC QMPI, Compliance and CM Meetings and CMS' address individual compliance issues with the CM. Non-compliance with standards is monitored closely by the CMS and appropriate action steps are taken to ensure future compliance.

Reports

Grievance Report Complaints reported to the CM during the assessment process, via letter, or telephone call are documented on the YCLTC Grievance Form. All written correspondence is acknowledged in writing. The CM attempts to resolve these issues informally, as quickly as possible and documents resolution on the YCLTC Grievance Form. The grievance form is forwarded to the CMS for review, categorization and to monitor compliance with reporting standards. Medical Services staff reviews the grievance to identify, investigate and resolve quality of care issues. Grievances are entered on the grievance database by Administrative Support and evaluated by the Member Services Coordinator who reports findings to her supervisor. The Management Team analyzes results and implements appropriate interventions.

Routine Reports Other mechanisms for monitoring and evaluating CM consistency include the Transitional Program Log and Behavioral Health 90 Day Consult Reports. The Transitional Program Log enables the CMS to ensure CMs monitor skilled nursing facility (SNF) stays for HCBS transitional program eligible members. The Behavioral Health 90 Day Consult database enables the CMS to monitor the CMs timely consistent ongoing completion of behavioral health consults and implement strategies for improvement as needed.

YCLTC uses numerous reports to monitor and improve the level of consistency among CMs with regard to the assessment of HCBS member needs and service authorizations. The reports include:

- The Fourteen (14) Day Authorization Turn-Around Report
- The Member Out-of-County Report
- The Respite/Bed Hold Days Report
- The Limited English Proficiency Report

The reports are reviewed by the CMM and/or CMS to ensure consistent performance among CMs.

In addition to internal mechanisms to monitor and evaluate the Care Management Program, AHCCCS generates reports on a monthly basis that include the Acute Care Only Placement Report, Overdue CM Assessment Review Report and Transitional Member Placement Program Report. The CMM and/or CMS reviews the reports to identify deficiencies, training needs and trends. Training to improve CM consistency in the assessment and service authorization process is accomplished as a result of the reviews.

YCLTC focuses on the member, the member's needs, and the member's preferences when planning services and coordinating care. Effective coordination of care results in medically-necessary, consistent and accessible services provided cost-effectively in the most integrated setting. Effective coordination begins with a comprehensive assessment of the member's needs, discussion of service options and identification of providers. It continues through timely referrals, exchange of information with participating stakeholders, and implementation of a service plan that is mutually agreeable to the member and/or family. Interdepartmental communication among Care Managers (CM), Medical Services RN, Behavioral Health Coordinator (BHC), the Medical Director and Provider Relations Coordinator (PRC) is crucial to the process. Sometimes this occurs through secure email, phone calls, or face to face; at other times a team meeting is convened. PRCs develop and manage a network of providers able to provide quality care to meet member needs

The member's primary contact at YCLTC is their assigned CM. The CM reviews the PAS for new enrollees, makes appropriate contact within seven (7) business days to schedule the assessment and complete an initial on-site assessment within twelve (12) business days of notification of enrollment. Subsequent assessments are completed within 90 days for HCB members and within 180 days for SNF-placed members. Additional assessments are completed as needed and within ten (10) days after a placement change.

Members with complex medical or behavioral health (BH) needs are identified and assessed through the initial PAS review, ongoing member centered care management assessments, collaboration and consultation with Medical Service staff, PCP, specialty providers, discharge planners at a hospital or NF, and other interested parties. Per AHCCCS guidelines the CM completes an on site assessment and interviews the member/family representative, as appropriate, about the member's strengths, medical and functional status and completes a medication review. Components of the medical review include: most recent ER visits, hospitalizations, PCP and specialist appointments, new diagnoses, immunizations, health status as reported by member, diet, weight loss/gain, care plan goals and progress. Barriers to service delivery (i.e. DME, DMS, timeliness issues, non-provision of service) and quality of care concerns are also discussed and documented. Care Managers educate and provide the necessary information to the member/family/representative on the availability and importance of participation in disease management, EPSDT (if applicable) and flu/pneumonia immunization programs. In addition, the self-management of chronic illness/pain management program is discussed and information provided for those interested and able to participate.

Through the assessment process, collaboration and coordination with stakeholders, the CM ensures the member safely resides in the most integrated, member-desired setting with the services the member needs. At each assessment, the CM reviews and documents the member's current status, develops and implements mutually agreed upon Member Service and Care Plans and Contingency Plans for HCB members. Care Plans are goal-driven and address, at a minimum, the member's behavioral health, functional and medical needs, desired outcomes and progress towards meeting goals. Care Plans are documented and updated as needed.

The CM documents all actions and information from the on-site assessment into the Member Case File and:

- Requests orders from the PCP per AHCCCS guidelines
- Completes necessary referrals to appropriate providers (Specialists, HHN, AC, DME, DMS, PT/OT, Respite, Hospice, YCLTC Disease Management, Ashline, Community Resources for non-ALTCS covered services, and transportation)
- Coordinates benefits with Medicare or other insurance entities
- Coordinates member discharge with hospital, ALF or SNF staff
- Completes grievances and/or QOC forms, if applicable
- Completes referrals to the YCLTC Compliance Officer, Adult Protective Services (APS) and other authorities as required by law
- Schedules and attends Multi-Disciplinary Team (MDT) or Individual Treatment (IDT) Meetings
- Develops and implements comprehensive Care, Service and Contingency Plans

- Works ongoing with the member and member's informal support network and providers to achieve desired results

Multi Disciplinary Team (MDT) Inter Disciplinary Team (IDT) YCLTC uses a team approach to ensure members with complex needs are met. Member needs may be medical, behavioral, or environmental. Anyone can convene an MDT or IDT Meeting. The IDT is less formal and usually includes the CM and either the BHC or an RN while the MDT involves more staff members of various disciplines, both convene to discuss member needs and plan of care. The Medical Director, PCP, member or member/representative, and other providers or staff may also be participants at times. The team presents facts of the case, the member's perspective and preferences, the providers' perspective and preferences, and barriers to care. The team develops a written plan that the care manager implements, continues to coordinate and documents outcomes.

The plan contains actions to complete. Common actions are communication with member, PCP and other providers; execution of Managed Care Agreements, intervention with other professionals by our Medical Director or Medical Services Staff, or recruitment of additional providers. The team reconvenes to discuss and document progress and develop and implement interventions, as needed, until the member is stabilized or the plan of care appears effective.

Behavioral Health (BH) Management Assessment of a member's behavioral health is completed at least every 90 days for HCB-placed members and at least every 180 days for members in a Nursing Facility (NF). The CM asks the member questions about their mood and behaviors and reviews medication. The CM may receive information from the PCP, a specialist, provider or member representative. The CM completes a medication review that includes the purpose and effectiveness of the medication and any adverse side effects as reported by the member.

Needed services are offered. If the member agrees, the referral for evaluation is made within one (1) business day and the member is seen within twenty four (24) hours of the referral for emergency appointments or within thirty (30) days for routine appointments. Members can self-refer for BH services or other stakeholders, in conjunction with the CM, can also refer members to a BH provider. Appointment standards are the same, regardless of the referral source. The BH provider submits a treatment plan. The CM authorizes BH services and helps coordinate wrap-around or other services.

The CM coordinates communication between the PCP, the behavioral health provider, and others involved in the member's care. The CM consults with YCLTC's BHC, a BH professional, initially and at least every 90 days for members needing or receiving behavioral health services. Medical and behavioral information from the consultation is documented on the BH Consultation Form. Information includes:

- Member demographics
- Referrals to other agencies
- Medical and behavioral diagnoses
- Medication changes
- Member's Behaviors
- Plan of Treatment and Services
- Member Status
- Recent hospitalizations, ER visits
- Provider information

The BHC reviews and approves the BH Consultation Form, which is then sent to the PCP and BH Provider. The timely involvement of multiple providers and interested parties ensures the development of a comprehensive mutually agreed upon service plan and enhances care coordination to meet the needs of complex medical care members. CMs request and obtain BH provider notes quarterly and as needed to track member progress, verify service delivery and to identify and resolve any member service issues. The case notes are available for review and follow up by the BHC or other YCLTC staff. Case notes include communication between the member, provider(s), other interested parties regarding service delivery, service planning, issues and plans of action to address these issues. The secure record is also available when CMs and medical service staff are in the field.

At times, a member's behaviors may escalate. In coordination with the BHC, PCP and other providers, CMs remove barriers to care through the implementation of the triage program in facilities, consistent communication with PCP, specialist, other providers and the member. The team of YCLTC, providers and representatives work with the member to maintain the current placement. Interventions may include coordination of wrap-around services, additional in-home or BH services, increased NF staffing, or psychiatric hospitalization.

YCLTC strives to provide services in the most integrated setting. The BHC evaluates, approves or denies recommendations for member placements into Residential Treatment Centers, BH units in ALFs and NFs, Level II and Level III alternative residential settings, and traumatic brain injury (TBI) placements. Continued placement is reviewed for appropriateness within thirty (30) days after admission and at least every six months thereafter. The member's length of stay, progress, step-down review, and the facility's step-down and discharge processes are monitored by the CM and BHC. CMs attend regularly scheduled and as needed care plan conferences at BH Facilities to ensure the behavioral heath needs of members are met in the most integrated setting.

YCLTC coordinates crisis intervention services to members identified as unable or unwilling to consent to treatment and in need of intervention due to danger to self or others. The expected outcome is stabilization or prevention of a sudden, unanticipated or potentially deleterious BH condition, episode or behavior. YCLTC assists providers to initiate and complete the processes for Court Ordered Treatment for members, monitors the process to completion and educates the provider throughout the process. YCLTC ensures that court ordered petitions are properly completed, submitted and monitored.

CMs facilitate communication and coordination of care with other agencies (CPS, APS, ADHS) and involved parties (SNF, ALF, School). They ensure the PASRR Level I Screening is completed for members residing in or entering a NF. CMs review PASRR Level II Evaluations and incorporate recommended specialized services into the member's service plan. CMs attend care planning and other meetings as necessary to monitor the members' care. They make referrals, authorize services, and oversee the coordination of care ensuring the member receives care as needed.

<u>**Complex Medical Care Needs**</u> YCLTC identifies members with complex medical care needs through PAS review, member assessments, provider reports, member reports and review of the hospitalization and ER databases. Members with complex medical care needs may have frequent falls, hospitalizations, ER visits or requests for referrals. They may receive care from numerous providers or need to be in Phoenix for an extended period of time to receive needed care.

The CM values and works closely with providers and appropriate internal staff with the clinical and/or area of expertise required to coordinate the complex care needs of members. The Medical Services staff and BHC acts as a resource for CM in determining special health needs and assists the CM to ensure appropriate coordination of care among multiple providers for members with complex care needs. As a result of collaboration with multiple providers and internal staff, appropriate interventions are developed and implemented to ensure the needs of complex care members are met thus ensuring desirable outcomes for the member's health and well being.

YCLTC serves a large rural county and facilities in Yavapai County are unable to meet the needs of all members with complex medical issues. As a result, members with complex care needs are placed in out of county facilities e.g. ventilator dependent YCLTC meets member's needs through an expanded network, specific CM GSA assignment and coordination with Medical Services staff for concurrent review, pharmacy and discharge planning. YCLTC staff ensures the member returns to their residence as soon as safely possible and works closely with the member's family and informal support system to ensure seamless transitions.

The initial and ongoing member focused care management assessments, communication with multiple providers and internal staff as well as the monitoring of quality of care and service delivery develops a well-coordinated plan of service to meet the needs of each member, including those with complex medical needs and/or behavioral needs. YCLTC has found the team approach to be very effective.

The process YCLTC utilizes for the assessment and care planning of members for home based services complies with AHCCCS and YCLTC timeliness, cost effectiveness, medical necessity and documentation standards. The process begins with the Care Management Manager's (CMM) review of the AHCCCS generated daily eligibility report. Assignments are based upon AHCCCS caseload weighted values and the care manager's (CM) assigned GSA or specialty. Once the assignment is made, the CM receives an electronic copy of the PAS and CATS screens for their review and then schedules the initial appointment. For ongoing assessment scheduling, the CM and CM supervisor (CMS) receive a list of assessments due the following month mid-month of the current month.

On Site Assessment Per AHCCCS guidelines, CMs make initial contact with a new member/family and/or representative within seven (7) business days from the date of notification of enrollment. On-site visits are completed within twelve (12) business days and services are implemented within an average of fourteen (14) calendar days but no later than thirty (30) calendar days of enrollment. If a new member is ventilator-dependent, CMs schedule and complete the initial visit within seven (7) business days from the date of enrollment and receive services within twelve (12) business days.

For home and community based (HCB) members the assessment is conducted every 90 days in the member's home, as needed and within ten (10) days of discharge from a facility to the HCB setting. At the initial assessment, the CM provides the member with a Member Handbook and reviews the handbook annually. The CM educates the member, provides informational materials and answers questions on the long term care program, including but not limited to, member rights and responsibilities, covered and non-ALTCS services, approved settings, the grievance and appeal process, the primary care provider (PCP)'s role, self directed attendant care (SDAC), spouse as attendant care, early periodic screening and diagnostic testing (EPSDT) and housing education and employment (HEE). CMs can provide parties interested in becoming paid caregivers with a list of contracted providers and general information about direct care worker (DCW) requirements.

The initial and subsequent on site assessments include a review with the member/family/representative of the member's strengths and needs; medical, functional, behavioral health, psycho-social, informal support, placement, current/proposed services, durable medical equipment/disposable medical supplies (DME/DMS), any barriers or issues to service delivery and level of member satisfaction with providers. CMs identify and accommodate members with cultural, physical and/or knowledge and skill barriers. Oral interpretation services, enlarged print documents, audiotape, sign interpretation, facsimile and translated educational materials are made available upon request to members with limited English proficiency (LEP). PCPs, caregivers and other providers are sought to accommodate those members with LEP.

The results of the on-site assessment should result in a mutually agreed upon, appropriate and cost effective plan of care that meets the member's needs to maintain the member in the least restrictive, most integrated setting. The amount, frequency and type of services the member receives are impacted by the member's placement, cost effectiveness study (CES), service availability, medical necessity and the member's desire.

The CM determines the member's level of care utilizing the Uniform Assessment Tool (UAT) at least annually and more often as indicated by a change in the member's condition. The UAT is completed and maintained in the member file.

Service Plan CMs are responsible for identifying, planning, obtaining, and monitoring appropriate cost-effective medical, medically related social and behavioral health services. These services are based on the member, member's family, and the CM's review of the member's strengths and needs, recommendations of the member's PCP, input from ALTCS service providers as applicable and PAS information. CMs ensure that the member or representative understands that some long term care services require a written order from the PCP. i.e. home health nurse, DME. The service plan is a mutually agreed upon plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated, least restrictive environment. CMs develop and

complete service plans for each enrolled member following AHCCCS/ALTCS guidelines and YCLTC policy and procedures. The service plan explains what services the member will receive through a generalized easy to understand description of the services including proposed frequency and dates of provision. The CM discusses the type, amount, frequency and provider(s) with the member. The plan is developed, signed by, and provided to the member and/or member's representative at the initial assessment interview, subsequent regularly scheduled assessments and as needed. Prior to the member or the member's representative signing the service plan, he/she acknowledges agreement or disagreement with the plan by checking the appropriate box. A Notice of Action (NOA) will be sent to the member if the member indicates he/she disagrees. The service plan is also signed by and provided to the member whenever major revisions are made, for example, when significant increases or decreases are made or the member changes placement. The signed "Member Service Plan" is maintained in the member file.

Service authorizations for in home services that may be approved by the CM are assessed and, if approved, completed by the CM. Members are notified via a Notice of Action letter of denied services. Services that require a PCP order, a Medical Services RN approval or the Medical Director's approval are processed by the CM. Behavioral Health Service authorizations, other than solely medication management are completed in coordination with the PCP and Behavioral Health Coordinator (BHC) and require a quarterly consult completed by the CM. Completed service authorizations are maintained in the member file.

In coordination with assisted living facility (ALF) management, the CM explains, develops and implements the Room and Board (R&B) Agreement for all members residing in assisted living centers (ALC) or homes (ALH) and adult foster care homes (AFC), as well as the "Single Occupancy Residential Agreement" for members residing in ALCs. If amounts are disputed by the member, the CM contacts ALTCS staff to confirm the R&B amount and resolve the dispute.

In conjunction with the Service Plan, the Cost Effectiveness Study (CES) is developed. If the member enrolls onto the plan with HCBS already in place, the CM completes a retrospective assessment, develops the service plan for the prior period coverage (PPC) and completes the CES within twelve (12) business days of enrollment. The cost of HCB services that will be retroactively approved during the PPC can not exceed 100% and is entered in the CATS system within fourteen (14) business days after date of the initial assessment or reassessment or if there is a change that significantly impacts the CES. If any of the services provided during PPC are not approved, the member is provided with a NOA and given an opportunity to file an appeal.

Contingency Plans The member and or member's representative, with assistance of the CM, determines the member service preference level (MSPL) for the development of the "Contingency Plan" to address non-provision of service or gaps in service. The member chooses a MSPL based on how quickly the member feels a break in scheduled service needs to be filled. The member chooses a MSPL number as follows: 1 = needs service within 2 hours, 2 = needs service today, 3 = needs service within 48 hours, 4 = service can wait until next scheduled day. The "Contingency Plan" addresses the actions the member chooses to take if a service provider is unable to deliver critical service(s) as scheduled. MSPL may change as needed.

The CM explains the importance of reporting gaps and/or non-provision of service and the methods to report the gaps. The "Critical Service Gap Report Form" is provided to the member and upon completion can be mailed to YCLTC to report a gap in service. The member and/or member's representative can also report a gap in service by calling the provider of the critical service, YCLTC or AHCCCS. The member or member's representative makes the final decision on how a gap in service is to be delivered (informal versus paid caregiver).

Care Plans CMs develop member focused care plans through mutual collaboration with the member, family, caregiver, representative and recommendations from the BHC, Medical Services staff and other stakeholders, as appropriate. Care planning is based on face-to-face discussion with the member and/or member representative that

includes a systemic approach to the assessment of the member's strengths and needs. CMs facilitate the development of care plans upon initial assessment of newly enrolled members with subsequent review and/or revision at each reassessment focusing on the following areas.

1. Functional abilities
2. Medical conditions
3. Behavioral health
4. Social/environmental/cultural factors
5. Existing support systems

The member and the CM develop goals that address the issues that are identified in the care planning process and are therefore member specific. The goals focus on the member's strengths and include the steps the member will take to achieve the established goals. Goals developed in partnership with the member and/or member's family or their representative, the PCP, caregivers and other available resources enhance member participation and commitment toward mutually established measurable goals. This process ensures a member the opportunity for self-determination, to promote dignity through participation, and to offer on opportunity of choice in care decisions. Member participation in the identification of goals and their perception of goal ownership enhances acceptance of, satisfaction with, and commitment to, established goals. The care plan outlines clear expectations about what is to be achieved through the service delivery and care coordination process. The member's goals are member specific, measurable, specific and attainable. Documentation of progress toward attainment of the goals is completed with each reassessment. New specific measurable goals are developed as needs are identified and goals are met and/or terminated.

CMs assist members to identify their independent living goals and provide members with information about local resources that may help members transition to greater self-sufficiency in the areas of housing, education and employment (HEE). The YCLTC Transition Coordinator is the expert on HEE, available as a resource to CMs and responsible for updating materials related to HEE resources. CMs develop and implement care plans regarding the member's HEE goals, document progress and provide ongoing support to members to achieve the goals.

Member Transition and Coordination of Benefits Members may be transitioned between Health Plans, Program Contractors, Prescription Drug Plans (PDPs) and Medicare Advantage Plans (MAPs). Members may also wish to transfer to a new program contractor as part of a planned or unplanned relocation. The CM is responsible for ensuring a seamless transition and coordinates the transition with the YCLTC Transition Coordinator through the completion of an electronic Member Change Report (MCR), Enrollment Transition Information (ETI) form and communication with the receiving program contractor. CMs inform members of community resources and help members access alternate coverage when they are disenrolled from the ALTCS program and not transitioned to another LTC or acute plan.

Service Plan Monitoring At each reassessment, the CM assesses the member's status, continued appropriateness of the member's status, current placement, services, cost effectiveness of services provided and/or requested, discusses member perception to achievement of goals, develops and revises service plans and care plans as needed. At each assessment, the CM discusses the member's right to receive service as authorized and to be treated with respect. CMs educate members on the importance of reporting service related issues and the methods the member may use to report the issues. The appeal process is also discussed in regard to disputed service plans. CMs act quickly to resolve service issues using the grievance and/or quality of care reporting protocol and ensure the Notice of Action, if applicable, is completed timely.

In conclusion, the process utilized by YCLTC CMs to assess and care plan the needs of members is always a work in progress. YCLTC refines and updates the care management assessment and care planning process as benefit and program changes occur. YCLTC CMs are flexible and adapt to change in order to meet program requirements and the needs of the member.

Assignment of Care Manager – Upon receipt of the daily Eligibility Report, the Care Management Manager reviews new members' PAS and CATS screens to determine Care Manager (CM) assignment. The GSA assignment, current weighted caseload value and facility designation determines which CM the new member(s) will have. The CM receives a HIPAA compliant email that includes the PAS and CATS screens. The CM contacts the new member within seven working days of enrollment and conducts the on-site assessment within twelve working days of enrollment. Review of the member's PAS and CATS screens by the CM reveals the member's demographics, medical, functional and behavioral health (BH) assessments; also, the CM is able to verify insurance coverage for coordination of benefits and identify contacts involved in the members' care.

Initial Interaction – Oscar is a 42 year-old married man with two children under the age of ten living at home with his wife, April. Oscar is quadriplegic and is a newly enrolled YCLTC ALTCS member who currently resides in a skilled nursing facility (SNF). The CM contacts the SNF to confirm the member's residence, enrollment onto long term care and advises staff that he/she will be coming in for the initial assessment. The CM introduces him/herself to Oscar, establishes professional identity with a county-issued badge with photograph and employee number, provides a business card, which includes the local and toll-free telephone numbers to contact YCLTC 24 hours per day, 7 days per week and discusses the purpose of the visit. The CM establishes a dialogue based on mutual respect for Oscar to determine his preferences, interests, needs, culture, language and belief system. April is a contact for Oscar and the CM tells Oscar that he/she contacted April and advised her that, with Oscar's permission, she was welcome to attend any assessment and receive follow up information regarding Oscar's care. The CM explains that the on-site assessment interview assesses Oscar's strengths and needs with the goal of development of a mutually agreed upon appropriate and cost effective service plan that meets his medical, functional, social and behavioral health needs. The CM makes every effort to foster a member-centered approach, while encouraging self-determination and promoting the values of dignity, independence, individuality, privacy and choice. Oscar and the CM review the Member Handbook, including but not limited to Member Rights and Responsibilities, Advance Directives, Notice of Member Privacy Rights, the availability of "free of charge" oral interpretation services, grievance/appeal process, how to report unplanned gaps with service delivery, Self-directed Attendant Care (SDAC), Spouse Attendant Care (AC), Family Planning, Education and Employment. The CM asks Oscar if he has applied for Medicare benefits; if not, the CM encourages him to apply and updates the YCLTC Member Services Coordinator with this information. The CM reaffirms his/her role in the service planning process, emphasizing the importance of Oscar's input in developing a mutually agreed upon plan of service that meets his preferences and needs.

Assessment of Member's Status and Needs – The CM reviews all pertinent information in Oscar's SNF chart including physician and nursing notes, current medications, facility care plan, PASRR, immunizations, Minimum Data Set. The CM completes the UAT to determine the level of assistance required to meet Oscar's needs. The level is determined through chart review, observation, collaboration with SNF staff, and Oscar's responses in the on-site assessment. The Cost Effectiveness Study (CES) and Placement Screen are also completed. The CM uses a holistic approach in facilitating the development of a successful service plan that not only includes ALTCS covered services but also other needed community resources as applicable. The CM enters the information gathered at the interview into the HIPAA compliant electronic Member Record.

Upon contacting April, the CM tells her that he/she will be conducting an initial needs assessment at the facility to determine a plan of care/service to meet Oscar's needs. The CM speaks with April about becoming a paid caregiver through Spouse Attendant Care program; explains the forty (40) hour maximum; possible repercussions to other services and/or Oscar's eligibility with increase household income. The CM provides information about family care giving e.g. Oscar's brother, contracted care giving agencies, getting a wheelchair van, and accessibility obstacles for entry into and out of the home. The CM educates April about AHCCCS covered services and benefits.

The CM refers April to Vocational Rehabilitation regarding obtaining a personal wheel chair van. The CM teaches the member and his wife about home and community based services. The CM educates April about

transportation benefits for medically necessary services when the member's family and/or friends are unable to transport. Oscar and his family, a facility therapist and the YCLTC Physical Therapist evaluate the home for accessibility and safety in preparation for when Oscar is ready for discharge home. YCLTC uses this evaluation to determine equipment needs and/or home modification(s) to enable accessibility and provide safety to the member in the home.

Medical – Oscar is quadriplegic because of a fall from a roof and has limited use of his limbs, only having very spastic control of one arm. He requires bowel care. SNF staff report that the member has become confused and disoriented recently. The CM completes the assessment, notes member's medical status per SNF chart documentation and includes Oscar's comments regarding his medical condition. **Actions** – The CM would speak with SNF staff and if not already done, request referral for PCP evaluation to address Oscar's recent disorientation and confusion. If necessary, Medical Services staff request and review Oscar's medical records.

Functional – Oscar now has limited use of his limbs, only having very spastic control of one arm. He is mostly dependent for all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). He has begun to feed himself with a splint and adaptive utensils although this is very messy. Oscar complains he is not getting enough Physical Therapy (PT) and that his custom wheelchair is hard to maneuver. **Actions** – The CM will obtain orders from the PCP for evaluation by the YCLTC PT regarding the member's power wheelchair (PWC) maneuverability/operation issues. Upon receipt of the order, the CM will complete a referral within 14 days to the YCLTC PT. The PT and CM will coordinate any modifications with the durable medical equipment (DME) provider to enable the member to safely and successfully operate the PWC in the facility and collaborate with facility therapy staff to ensure wheelchair training is a component of Oscar's SNF care plan.

Education/Employment – The CM will discuss Oscar's plan for the future, including educational and employment goals. The CM will educate him about and offer referrals to Vocational Rehabilitation, employment networks (under Freedom to Work) and work incentive/assistance programs such as New Horizons Independent Living Center.

Social – Oscar states all the other residents in the SNF are "too old" so there is nothing for him to do. While Oscar remains in the SNF, April wants to have more home visits to prepare everyone for his homecoming. **Actions** – The CM would ask Oscar about the kinds of activities he would enjoy and collaborate with the SNF Activities Director to develop a plan of care to meet his needs. The CM will also ask Oscar if he desires therapeutic home visits and explain to him the benefit of nine visits each contract year including transportation. To meet Oscar's needs and preferences, the CM will collaborate and follow up with the PCP, SNF staff and Oscar's family and offer Oscar the opportunity for placement in a facility with a younger population mix.

Behavioral Health – SNF Staff state that Oscar presents as "angry" and "depressed". He is never satisfied with whatever they do for him. He occasionally becomes very agitated when caregivers come to give his care and has ordered staff to leave. SNF staff report that Oscar has become confused and disoriented recently.
Actions – Documentation supports that Oscar presents with agitation, isolation, sleeping more and anger. He and the CM discuss his feelings and symptoms. The CM offers and encourages the services of a BH provider. The provider will evaluate Oscar's social, psychological, psychiatric and medical conditions to determine if a behavioral health disorder exists and, if so, to establish a treatment plan for BH services. The member, or any health care professional in coordination with the CM and PCP, can make a direct referral for the BH evaluation. The CM reviews BH requests for appropriateness within three business days of receipt. If established as appropriate, the CM completes a referral within one business day. Initially, and quarterly, the CM will discuss Oscar's BH needs and services with the Behavioral Health Coordinator (BHC). The CM completes the BH consult and sends copies to Oscar's PCP and the BH provider to facilitate communication and coordination of care. Quarterly, the CM will request BH provider notes, review, complete consult and discuss with the BHC, PCP and other appropriate parties. The CM and member will develop a member-specific plan of care and service to address the Oscar's therapeutic goals, achieve desired outcomes and service plan to meet his needs.

Care Plan/Services developed to meet the needs of the member - Oscar has gone home once since admission so that his wife, April, could experience caring for him at home. Identified obstacles and issues include accessibility barriers at home. April would like Oscar to come home but she works part time, worries about money, cares for two children and has concerns about Oscar's ability to control his anger. If Oscar is discharged home, there is a possibility that Oscar's brother may be available to help with his care. Oscar's wife asked for assistance getting a wheelchair accessible van so she could transport Oscar as needed. **Actions** - The CM, Oscar and his family develop member specific care /service plans with objective measurable goals. **Timeframe:** 90 days.

Most Integrated Setting – Goal/Objective: The CM offers to Oscar and his family the opportunity to live in the most integrated setting in which his medical, behavioral and psychosocial needs can be met cost effectively. Oscar currently requires 24-hour care and regularly scheduled rehabilitation therapies. The family home has some barriers to accessibility. His wife is concerned about full time income, the challenges that working part time and caring for Oscar and the children would pose to her and Oscar's anger issues. **Timeframe:** 90 days
Approach: The CM, Oscar, and his family in coordination with the PCP, YCLTC BHC, YCLTC PT, SNF staff, specialists and other appropriate parties will work with Oscar and his family to plan for a safe transition to his home to promote independence. The plan is to work toward achieving this transfer within 180 days. The actions that Oscar, his family, his PCP, the CM and other appropriate parties will take to meet his goals include:

- Attend and participate in care planning and discharge conferences.
- Oscar will continue to work with PCP, staff and follow appropriate treatment plan.
- CM and/or SNF staff will obtain physician orders for ongoing OT and PT therapy, BH evaluation, BH therapy and DME recommended by PT to resolve PWC maneuverability issues.
- Oscar, April and CM will discuss the need for therapeutic leave days (9 per year 10/1-9/30) with PCP and SNF staff; YCLTC will arrange and provide transportation to medically necessary appointments.
- The CM in coordination with PCP and other appropriate parties will provide continued education, referrals, support regarding in-home service options such as SDAC, Spouse AC, AC, HHN, continued therapies and Direct Care Worker (DCW) training.
- Prepare for home modification needs to enable accessibility and safety as determined during the home evaluation.
- SNF therapy staff will provide training to Oscar and his family for situations specific to the home setting prior to discharge.
- CM will coordinate discharge, request physician orders, complete needed referrals and on-site assessment visit within 10 days of member discharge.
- The CM will complete referrals for authorizations within 14 days of receipt of the physician orders.

Behavioral Health Goals and Objectives: Oscar will have reduced feelings of anger and agitation; Oscar is to refuse care no more than twice a week. **Approach**: Member to participate in BH evaluation and treatment; establishment of member-centric goals such as, member will take medications as prescribed, staff will listen to member's concerns and consider his preferences, Oscar and his family will be encouraged to participate actively at facility care plan conferences. The CM will monitor member's progress. The CM will communicate as needed with Oscar and his family, PCP and specialists. The CM will document and revise care/service plans, complete medically necessary cost effective referrals for ALTCS covered services, implement all services within AHCCCS and YCLTC guidelines for timeframes and provide referrals to community resources for non-ALTCS covered services for additional member/family support such as AZ Spinal Cord Injury Association and NACOG. As Oscar approaches discharge, the CM will continue to coordinate his care with the member, his family, PCP, specialists, facility staff, YCLTC internal staff and other appropriate parties to ensure continuity of care and smooth member transitions. **Timeframe:** 90 days

Care Manager Assignment - Upon receipt of the Daily Eligibility Report, the Care Management Manager (CMM) reviews the member's PAS and CATS screens to determine care manager assignment. The assignment determination is based upon the care manager's GSA, current weighted caseload value and facility designation. The Care Manager (CM) receives a HIPAA compliant email that includes the PAS and CATS screens for review and to ensure the CM contacts the member within seven (7) business days of enrollment and conducts the on site assessment within twelve (12) business days of enrollment. Upon receipt of the member's PAS and CATS screens, the CM reviews the member's demographics, medical/functional and BH assessments, verifies insurance coverage for coordination of benefits and identifies contacts involved in member care.

Interaction- Magda is an 83 year old female; has been enrolled with ALTCS for 2 years; is not eligible for Medicare. Her daughter, Raquel, moved Magda into her home from Romania a few years before she became ALTCS eligible. Also in the home are the son-in-law and 4 grandchildren (ages 10–16). If the member has transitioned from another program contractor to YCLTC, the CM would review the Enrollment Transition Report (ETI) Form, document member to update the status of grievances/appeals and/or Notices of Action. The newly assigned CM reviews the Member Record and telephones to schedule an on-site reassessment. Using an interpreter or AT&T's Language Line, the CM asks to speak to Magda and schedules the reassessment visit. If member is legally competent, her preference for family participation determines participants in the reassessment. Otherwise, the CM communicates with the member's legal representative. The CM uses an interpreter at each contact with the member; family members are not relied upon to interpret unless the intervention is formally addressed in a care plan. For clarity in this answer, member is used synonymously throughout this answer for legal representative or to include the daughter or other participants per the member's request.

Assessment of Member's Status and Needs

Through an interpreter, the CM introduces him/her self to the member and other participants, identifies him/her self via the photo county issued ID and provides a business card that includes a toll free number. A dialogue based on mutual respect for Magda is established and member preferences, interests, needs, culture, language, and belief system are determined. The CM makes every effort to foster a member-centered approach, while encouraging self determination and promoting the values of dignity, independence, individuality, privacy and choice. The CM uses a holistic approach in facilitating the development of a successful plan of care that not only includes ALTCS covered services but includes community resources to address non-ALTCS covered service needs. The CM, Magda and her daughter, with member approval, complete the needs assessment:

Assessment Components: Medical - Magda has Diabetes, is on dialysis, and was recently diagnosed with early stage Dementia. Member is confused. The CM reviews the member's current medications, documents changes, name, dosage, frequency, any side effects revealed at the on site assessment; reviews and updates the member's blood sugar information; determines the member's cognitive abilities; records current pneumo/flu vaccine information; ER, hospitalizations, PCP and specialist visits and weight. **Action:** The CM addresses any concerns appropriately; reviews the member's disposable medical supplies (DMS) and durable medical equipment (DME) needs, requests appropriate PCP orders and completes referral authorizations to providers. The CM arranges transportation to medically necessary appointments as needed. CM educates and offers member diabetic nutritional counseling; educates the member about and encourages the member's participation in the YCLTC Disease Management Program and Stanford Chronic Illness Self Management Program. The CM discusses findings regarding disease/chronic illness management, medication review and/or needed education with YCLTC Medical Services staff. Medical Services request medical records, as necessary, to ensure the needs of the high risk member are met.

Functional - Magda is confused and is not always steady on her feet without guidance. She has fallen a few times while walking with her walker and fell in the shower last week. **Action:** The CM determines and documents the types of DME the member has for mobility and transfers. The CM requests orders from the PCP for evaluation by a physical therapist (PT) for home safety and DME needs and then completes appropriate referral authorizations. Upon receipt of the PT evaluation and recommendations, the CM will obtain PCP orders and develop a plan of

care. The plan will include instruction to the member in the use of provided DME and safety precautions, and referral to YCLTC's fall prevention program. Hip protectors will be offered if appropriate.

Social - Daughter has asked about receiving "respite" on Sundays when the family goes to church because member gets too agitated during the service to accompany them any longer. Member says she misses getting out and going to church and says her daughter is just embarrassed that she can't speak English well. **Action:** The CM educates the member about the respite and attendant care service options and develops a mutually agreed upon cost effective service plan. The CM provides community information and recommends that the member's daughter contact the local Romanian Church or other community organizations to see if someone might volunteer, visit with Magda, develop a relationship, and increase her socialization. The CM refers the member to People Who Care as an option to accompany and/or transport her to church. The CM includes medical approaches to member's social needs by recommending contact with the PCP to discuss Magda's agitation, evaluate her current medications and modify her treatment plan to better address the reported agitation. The CM offers Adult Day Care Services for increased socialization.

Behavioral Health (BH) – The CM discusses the member's feelings and informs the member BH services are available as a member benefit. **Action:** If the member or daughter requests BH service, the CM collaborates with the YCLTC BH Coordinator and PCP, makes a decision based on appropriateness within three (3) business days, and completes a referral for authorization within one (1) business day. The CM follows up with the member, consults initially and then quarterly with the BH Coordinator, and obtains treatment notes from the BH provider. Copies of the consult are forwarded to the PCP and BH provider(s).

The CM and Magda complete the **Service Unit Worksheet (SUW)** to determine the amount, frequency and level of assistance needed for the member to safely complete her ADLs/IADLs. The SUW lists ADL and IADL tasks; level of needed assistance - independent, minimum, moderate, and maximum; and guidelines for calculating the amount of time and frequency required to complete the tasks. The CM reviews each task with the member and documents the results. The CM uses information gathered at the needs assessment to complete the Uniform Assessment Tool (**UAT**) and determine the member's current level of care. The CM and member update the written **Contingency Plan** and **Member Service Preference Level (MSPL)** for critical services at least quarterly. CM discusses member right to receive service as scheduled; need to report gap in service; provides Critical Service Gap Report Form. The CM completes the Placement Screen and Cost Effectiveness Study (**CES**) as needed. The CES is updated at least annually and if there is a change in services that would potentially place the member's costs at greater than 80% of institutional cost.

The CM assesses fewer hours of service per week than the prior assessment. The member's daughter disagrees and requests an increase in Attendant Care hours, feels member's confusion has increased and caregiver needs to do more for her. Daughter is also asking about receiving "respite" on Sundays when the family goes to church. **Action:** The CM discusses the daughter's request and attempts to arrive at a mutually agreeable plan. The CM asks the member to review the written service plan, to indicate agreement/disagreement with the type, amount or frequency of authorized services, and to date and sign the plan. The CM explains the respite benefit and decision process. The CM advises the member that she is entitled to up to 720 hours respite services per year beginning 10/1 and ending 9/30 in addition to the care services the CM determined. She explains the decision process - that all authorized services including regularly scheduled respite or additional AC hours are evaluated for cost effectiveness and necessity, that the daughter's request will be reviewed by a CM Supervisor (CMS), that a decision will be made within 14 calendar days unless a 14 day extension is needed and in the member's best interest; that current services will remain in place until a decision is made. The CM states the member will receive written notice of any extensions and of any denials, terminations, reductions or suspensions of services. The CM further notifies the member of her right to submit a grievance appeal (routine or expedited) or request a state fair hearing in accordance with the Arizona Administrative Code Title 9 Chapter 34 and ACOM 414.

Upon return to the office, the CM presents the daughter's request, facts of the case, CM assessment and signed service plan to the CMS. The CMS determines if the CM applied consistent criteria for service authorization and

delivery, completes additional research if needed, and makes a decision based on cost-effectiveness and the member's individual needs. Additional training is provided to the CM as needed. The CMS sends a Notice of Extension or Notice of Action letter(s) as required by the Arizona Administrative Code and ACOM 414.

Grievance – Member's daughter has asked for a new PCP. She says she has difficulty making appointments with the current PCP. **Action:** The CM discusses the issue, explains the grievance procedure, and completes a grievance for investigation and resolution. The CM reviews the list of contracted PCPs and their language capabilities with the member and documents the member's preference. The CM submits a PCP Change Request indicating the member's preference and specifying the member's limited English proficiency. The CM ensures the member's medical records are transferred to the new PCP.

Family Support – The CM refers member's daughter to the local Alzheimer's Association to obtain information about Dementia and support groups. Interaction with group/s may increase members and family's understanding of the disease process and ability to cope with changes.

Care Plan/Services developed to meet the needs of the member – Together the CM and member develop Care Plans that identify issues, specify measurable goals, outline action steps, and include timeframes. Issues are identified during the assessment process; goals begin with the member's strengths and focus on expected outcomes. Action steps detail needed steps to achieve desired outcomes. The member and CM review Care Plans at each assessment visit, document progress towards goals, and revise or terminate goals from the previous assessment. New goals are developed as needed. Possible Care Plans for Magda are:

Most Integrated Setting (MIS) – Goal/Objective: Magda will be able to safely live in her daughter's home. Current placement is desired by member and family, is most integrated setting and is able to cost effectively meet Magda's medical, behavioral and psychosocial needs. **Approach**: The CM, Magda, member's daughter, PCP and other interested parties will take the following actions to meet Magda's goal. **Timeframe:** 90 days

- Complete Physical Therapy evaluation for safety and durable medical equipment needs.
- Instruct member in the use of provided DME and safety precautions
- Provide caregiver and family training on fall prevention.
- Provide disposable medical supplies related to Diabetes per physician order.
- Encourage member participation in Disease Management Program.
- Offer appropriate in-home service options to successfully support member and family.
- Ensure member transports to Dialysis appointments and other medical appointments, as scheduled
- Request and review medical records as needed.
- CM to complete referrals, request physician orders, and coordinate services with member, family, and PCP.

Limited English Proficiency (LEP) - Goal/Objective: Magda will understand and be understood by providers at each contact and participate in the care plan process. **Approach:** The CM, Magda, member's daughter, PCP and other interested parties will take the following actions to meet Magda's goal. **Timeframe:** 90 days

- Offer and provide member and family interpreter services and translated materials upon request.
- Educate member and family about English as a Second Language courses.
- Notify providers about member's and family's LEP; Providers to accommodate member and her family to meet LEP needs.

The proposed service plan could include:

- Attendant Care and Respite
- Home Health Nurse and Physical Therapy- as ordered by PCP
- Transportation to medical appointments.
- Adult Day Care one (1) to (2) times weekly.
- Behavioral Health services

Interaction - Wanda is a 66-year old female who has been on ALTCS for the past 6 months. She is enrolled in a Medicare Advantage Plan (MAP). Her physician is in the MAP's network but not YCLTC's. She is diagnosed with Diabetes, Peripheral Neuropathy, Hypertension and Congestive Heart Failure; Wanda lives with her son and daughter in-law. The Care Manager (CM) telephones Wanda to schedule the onsite reassessment visit; speaks with Wanda's son and discovers the son moved Wanda to an Assisted Living Facility (ALF) near them without the involvement of the CM six weeks ago. Wanda had several falls at home and the son felt she was in need of more care and supervision than the family thought they could handle. Wanda fell for the first time at the ALF four weeks ago with no injury according to her son. She was hospitalized as a result of a second fall two weeks ago that resulted in a broken nose. Wanda was discharged from the hospital back to the same ALF at her son's request. The CM confirms Wanda's current residence and advises Wanda and her son that it is the CM's responsibility to coordinate Wanda's care to ensure she continues to receive cost effective medically necessary service/s and appropriate long term care benefits.

If the facility does not have a contract with YCLTC, the CM completes a referral to a YCLTC Provider Relations Coordinator (PRC) so Wanda can remain in the facility. The PRC discusses the need to have an AHCCCS provider registration number, offers assistance, and works to execute a contract with the ALF. At the same time, YCLTC sends a letter to Wanda that states:

- Member has the right to stay at the facility for seven days from the date of the letter.
- Member will have to move to a contracted facility to receive full long term care services from YCLTC.
- A list of contracted assisted living facilities is enclosed.
- If you are able to move, but choose not to, you will only be eligible to receive acute care services limiting the ways YCLTC can help you.
- Your care manager will help you make plans to move to a facility that has a contract with YCLTC, if you decide to move.

If contracted, the CM and PRC remind the ALF of the need to obtain authorization for payment before admitting a YCLTC member. The CM reviews ALF admission paperwork, Wanda's service plan, and confirms the ALF is licensed by ADHS to provide care at Wanda's service level. The CM intervenes so all admission criteria are met. If Wanda requires directed care and the ALF is not licensed to provide directed care, the CM informs Wanda and her son, discusses and coordinates alternate placement, and asks YCLTC's Transition Coordinator to assist. The CM makes referrals to ADHS, APS, YCLTC Compliance Officer and PRCs.

The CM schedules and completes an on-site assessment with Wanda and, as appropriate, her son, as soon as possible, but no later than 10 (ten) days of notification of Wanda's new placement. The CM encourages Wanda and her son to communicate with the PCP, other service providers, MAP and YCLTC so that Wanda can receive appropriate service coordination and the continuum of care she needs. The CM reinforces Wanda's right to choose her Medicare plan, explains Wanda's options, and verifies her QMB status.

During the assessment visit, the CM evaluates Wanda's strengths and needs. They discuss service and placement options, including hospice. Together they develop mutually agreed upon service and care plans expected to cost-effectively meet Wanda's needs in the most integrated setting. The CM queries Wanda about her satisfaction with YCLTC services, ALF activities and previous home-based services. Wanda explains her dissatisfaction with her previous in-home services. They discuss payment of ALF Room and Board and confirm that Wanda has the ability to pay the $200.00 minimum amount. They complete the Single Occupancy Residency Agreement if Wanda is living in an assisted living center that does not have a waiver.

After the assessment, the CM completes assessment paperwork and follows up on Wanda's service complaints. The CM submits an updated Member Placement Screen, CES and MCR to YCLTC Administrative Staff for entry into CATS. The CM files a grievance about Wanda's previous in-home services; the grievance is forwarded to Quality Management nurses. The CM reminds Wanda's previous home care provider of the need to report issues and informs PRCs of the issue. The CM notifies YCLTC's Compliance Officer of non-provision of service events and the need to compare claims with the NPS log in order for appropriate action to be taken.

Assessment components:

Medical - Wanda is diagnosed with Diabetes, Peripheral Neuropathy, Hypertension and Congestive Heart Failure. She is enrolled in a MAP. Her physician is in the MAP's network but not YCLTC's. Wanda was hospitalized as a result of a fall two weeks ago that resulted in a broken nose. While in the hospital Wanda was diagnosed with pelvic cancer and has begun treatment. **Action:** The CM and YCLTC Medical Services contact the MAP, PCP, and hospital to coordinate care, remove barriers to care and request medical records, as needed. The CM encourages Wanda to participate in YCLTC's Disease Management Program and offers education on chronic illness. The CM provides contact information for Wanda's PCP to a PRC for consideration of a contract.

Functional- Wanda is now non-ambulatory, more confused, sometimes combative, needing near total care for ADLs, including needing to be fed. **Action:** The CM evaluates Wanda's current need for durable medical equipment (DME) based on Wanda's recent history and functional decline. The CM considers a wheelchair, cushion, hospital or low bed, bathroom DME, and hip protectors. The CM verifies the ALF's documentation of frequent falls and receipt of treatment orders. The CM speaks with the YCLTC Physical Therapist for recommendations for caregiver training on member specific handling and fall prevention.

Behavioral Health - Wanda is more confused and sometimes combative. **Action:** The CM educates Wanda and her son on the right to receive behavioral health services, including individual, group and family therapy and counseling. Upon Wanda's request, the CM makes a referral. The CM suggests that Wanda contact her PCP about her increased confusion and combativeness, request a review of her medications and possible referrals.

Social – Although the scenario does not mention any specific socialization needs, the CM talks with Wanda, her family and ALF staff to determine if her needs are being met. **Action**: The CM offers referrals to community service agencies, such as *People Who Care* to Wanda. If Wanda has any activity needs or special interest needs that are not being addressed by the ALF, the CM works with staff to ensure activities or interests of Wanda choice will be offered or considered. CM reviews the facility's activity calendar.

Care Plan/Services developed to meet the needs of Wanda – Together, the CM, Wanda and her family develops goals that address the issues identified in the care planning process. Goals are built upon Wanda's strengths and include steps Wanda will take to achieve her specific, measurable goals. They include actions needed to meet goals, and a timeframe to attain desired outcomes. The CM and Wanda review progress towards goals at each assessment visit and as needed; they revise and develop additional goals as needed. All actions are documented in Wanda's CM file.

Most Integrated Setting (MIS) – Goal/Objective: The CM offers Wanda and her family the opportunity to have Wanda return to the son's home, the most integrated setting, in which Wanda's medical, behavioral and psychosocial needs can be met. Wanda's need for increased supervision and frequent falls are evaluated and appropriate services and equipment is provided to meet Wanda's needs. **Approach**: Wanda, her family, the CM in coordination with her PCP, YCLTC clinicians, specialists and other interested parties will work to plan a safe transition back to the son's home. The plan is to safely discharge Wanda within **90 days**. The actions Wanda, her family, PCP, CM and other interested parties will take to meet her goals include:

- Send BBA letter related to non contracted facilities to Wanda, if facility is non-contracted.
- Pursue a contract with the ALF if non-contracted.
- Complete Physical Therapy evaluation for durable medical equipment needs.
- Provide Caregiver training on fall prevention and member specific-care.
- Request and review medical records requested; follow recommendations.
- Encourage participation in Disease Management Program.
- PCP to address Wanda's combativeness and confusion.
- Offer appropriate in-home service options to successfully support family and Wanda.
- Provide transportation to medically necessary appointments as needed.
- Offer community resources to meet socialization needs.

- ALF staff to meet Wanda's activity preferences and to provide and document meal preferences.
- CM to complete necessary referrals, coordinate discharge, request physician orders.
- Complete on site assessment visit within 10 days of Wanda's discharge home.
- Coordinate benefits with Medicare Advantage Plan.

Medical/Nutritional – Goal/Objective – Wanda's glucose levels to remain within normal limits and nutritional requirements met per PCP orders. **Timeframe:** 90 days Actions:

- Properly trained staff to monitor, document and report glucose levels per PCP order.
- Staff to provide meals, snacks and hydration as prescribed.
- Staff to provide the appropriate level of assistance to meet Wanda's ADL/IADL needs.
- Wanda to take medications as prescribed; Staff to offer medications reminders and supervision.
- Wanda's weight to be taken and documented as ordered by PCP

The proposed service plan could include:

- Assisted Living Facility Placement OR
- Attendant Care
- Respite
- Hospice
- Home Health Nurse per PCP order
- Behavioral Health Services

Assignment of Care Manager - Upon receipt of the Daily Eligibility Report, the Care Management Manager (CMM) reviews the member's PAS and CATS screens to determine care manager (CM) assignment. The GSA assignment, current weighted caseload value and CM specialty determines which CM the new member(s) will have. The CM receives a HIPAA compliant email that includes the PAS and CATS screens for review. The CM contacts the new member within seven (7) working days of enrollment and conducts the on site assessment within twelve (12) working days of enrollment. Review of the member's PAS and CATS screens by the CM reveals the member's demographics, medical/functional and BH assessments; also, the CM is able to verify insurance coverage for coordination of benefits and identify contacts involved in the member's care.

Initial Interaction- Roger is a 39 year old male. His diagnoses include Schizoaffective Disorder and Traumatic Brain Injury. He also has seizures and occasional upper respiratory infections. His sister, Joyce, just moved him here from another state after their mother, Roger's guardian, died. As Roger's new guardian, she struggles to manage Roger on her own. She received some training in behavior management but states his behaviors are escalating. The CM contacts Roger's sister, introduces him/her self, schedules an initial on site assessment visit and answers the sister's questions. Please note, as Roger's guardian, his sister is his legal representative. Roger is included in interactions but the CM relies on the sister for all of Roger's decisions.

Assessment of Member's Status and Needs - The CM introduces him/her self to Roger and his sister, establishes identity with a county-issued badge with photograph & employee ID number, provides a business card which includes the local and toll free telephone numbers to contact YCLTC 24-hours per day, seven (7) days per week and discusses the purpose of the visit. The CM establishes a dialogue based on mutual respect for Roger and his sister to determine his preferences, interests, needs, culture, language, and belief system. The CM explains that the on site assessment interview assesses Roger's strengths and needs with the goal of development of a mutually agreed upon, appropriate and cost effective service plan that meets his medical, functional, social and behavioral health needs. The CM makes every effort to foster a member-centered approach, while encouraging self-determination and promoting the values of dignity, independence, individuality, privacy and choice. The CM uses a holistic approach in facilitating the development of a successful service plan that not only includes ALTCS covered services but also other needed community resources as applicable. Roger, his sister and the CM review the Member Handbook, including but not limited to Member Rights and Responsibilities, Advance Directives, Notice of Member Privacy Rights, the availability of "free of charge" oral interpretation services, grievance/appeal process, how to report unplanned gaps with service delivery, SDAC, Family Planning, Housing, Education and Employment. The CM asks if Roger has applied for Medicare benefits, encourages him to do so if he has not. The CM reaffirms his/her role in the service planning process emphasizing the importance of Roger and his sister's input in developing a mutually agreed upon plan of service that meets his preferences and needs. Attendant Care, SDAC, Respite, and Habilitation are explained and offered. Information gathered at the interview is documented and entered by the CM into the HIPAA compliant electronic Member Record.

Assessment Components: Medical: Roger's diagnoses include Schizoaffective Disorder and Traumatic Brain Injury. He has a seizure disorder and occasional upper respiratory infections. **Action:** CM recommends Roger's sister contact his PCP regarding seizure activity, current medications and appropriateness of referral to neurologist. Upon return to the office, the CM confers with an YCLTC RN. Medical records are obtained if needed and the CM, YCLTC RN, YCLTC Medical Director discuss Roger's plan of care. YCLTC collaborates with Roger's PCP and sister to plan care. The CM completes necessary referrals and authorizations.

Functional: Roger refuses to bathe, change clothes and take meds; uses profanity, throws objects and has taken a swing at Joyce twice since being in her care; and recently attempted to leave home without supervision. Roger needs supervision due to his impaired judgment, need for redirection and cues, and risk of injury. Roger continues to have seizures at least twice a week; his risk of falling during seizures is high. **Action:** The CM discusses the guardian's role and possible in-home services. If the Roger's guardian agrees, the CM contacts the PCP to obtain orders for a physical therapy (PT) evaluation and subsequent PT recommendations. The PT can provide instruction on the use of DME, fall prevention and seizure precautions.

Behavioral Health (BH) – Roger's sister reports that Roger is resistive to care, exhibits some verbal and physical aggression, fabricates stories, and at least once, attempted to leave home without supervision. The sister and the CM discuss Roger's feelings and symptoms. The CM offers and encourages acceptance of individual, group and/or family therapy and counseling services provided by a contracted BH professional. Family counseling may include, but does not require, the presence of the member. If the BH Evaluation determines psychotropic medication is necessary then Roger's treatment plan would include psychotropic medication adjustment and monitoring services which includes prescriptions for psychotropic medications, review of the effects and side effects, and adjustment of the type and dosage of psychotropic medications prescribed that address the therapeutic goals outlined in the service plan.

Roger's sister, or any health care professional in coordination with the CM and PCP, can make a direct referral for the BH evaluation. The CM reviews BH requests for appropriateness within three business days of receipt. If established as appropriate, the CM completes a referral within one business day. Initially, and quarterly, the CM will discuss Roger's BH needs and services with the Behavioral Health Coordinator (BHC). The CM completes the BH consult and sends copies to Roger's PCP and the BH provider to facilitate communication and coordination of care. Quarterly, the CM will request BH provider notes and treatment plan; review, complete consult and discuss with the BHC, PCP and other appropriate parties. The CM and Roger's sister will develop a member-specific plan of care and service to address the Roger's therapeutic goals, achieve desired outcomes and service plan to meet his needs.

At subsequent assessment, the CM reviews and documents the member's psychotropic medications, changes, and any reported side effects in the Member Record. Roger's sister is encouraged to contact the PCP and BH Provider with her concerns regarding side effects. CM follows up with the BHC for recommended interventions and includes the information on the BH Consultation Form. Roger's PCP and the BH providers receive a copy of the BH Consultation Form to ensure good communication between the PCP and the BH providers that are involved in the Roger's care. The CM coordinates care with other agencies and involved parties.

The CM educates Roger and his sister on alternative placement options, including those for members with TBI and BH needs. If of interest to Roger's sister, the CM will make a referral to BH Residential non-IMD alternative settings or ALH –TBI, coordinate authorizations YCLTC BH Coordinator, Medical Services staff, PCP and other stakeholders. Placement options are discussed at each assessment.

Social: Roger spends most of the day in his room. He says he is bored with nothing to do but watch television. Joyce reinforces Roger's positive behavior with cigarettes. **Action:** CM will discuss habilitation day programs and living skills training. Appropriate referral authorizations will be completed in collaboration with YCLTC BH Coordinator, PCP, BH Provider, and other interested parties. AZDHS Ashline will be discussed and referral completed if member expresses interest.

The CM, Roger and his sister complete the **Service Unit Worksheet (SUW)** to determine the amount, frequency and level of assistance needed for the Roger to safely complete his ADLs/IADLs. The SUW includes tasks i.e. bathing, toileting, eating; level of assistance i.e. independent, minimum, moderate, and maximum and guidelines for the average amount of time and frequency required to complete the tasks. The CM reviews each task with Roger and his sister and documents the results. The CM completes the Uniform Assessment Tool **(UAT)** which determines the Roger's current level of care, based upon information gathered at the needs assessment. If the Attendant Care service option is chosen, the CM, Roger and his sister complete the written **Contingency Plan** and **Member Service Preference Level (MSPL)** for critical services. The Contingency Plan, Critical Service Gap Report Forms and reporting service provision issues and Roger's right to receive service/s as scheduled are discussed and updates to the plan are implemented quarterly and as needed. The Cost Effectiveness Study **(CES)** and **Member Placement Screen** are completed and submitted to YCLTC Administrative Support staff for entry into the CATS system and Plexis.

Support Groups - The CM evaluates Roger's and sister's interest in attending support groups for TBI, Mental Health DXs. i.e. NAMI, Spinal Cord and Traumatic Brain Injury. The CM offers Roger's sister the Healthy Living: Self-Management of Chronic Conditions Workshop developed by Stanford University. The workshop is a community service and is provided at no charge to family members and/or individuals who have a chronic illness. CM coordinates care with interested parties, refer and complete appropriate authorizations.

Multi-Disciplinary Team (MDT) Meeting – The CM schedules an initial MDT meeting to ensure appropriate interventions are developed and implemented to reach desired outcomes and stabilize Roger in the most integrated setting.

Care Plan/Services developed to meet the needs of the member –Together the CM, Roger and his guardian develop Care Plans that address issues, specify measurable goals, outline action steps, and include timeframes. Issues are identified during the assessment process; goals begin with the member's strengths and focus on expected outcomes. Action steps detail needed steps to achieve desired outcomes. The member and CM review Care Plans at each assessment visit, document progress towards goals, and revise or terminate goals from the previous assessment. New goals are developed as needed. Possible Care Plans for Roger are:

Most Integrated Setting (MIS) – Goal/Objective: Roger to continue to remain in his sister's home, as appropriate and desired, to cost effectively meet Roger's medical, behavioral and psychosocial needs. Current setting is the least restrictive, most integrated setting. **Approach**: Roger, his sister and the CM, in coordination with the PCP, specialists, YCLTC clinicians and other stakeholders will take the following actions to ensure Roger safely remains in his sister's home. **Timeframe:** 90 days

- Complete Physical Therapy home safety evaluation.
- Provide care giver training on fall prevention, member specific handling and seizure protocol.
- Provide Durable Medical Equipment as prescribed by PCP.
- Encourage Roger to notify caregiver/ or guardian when he wants to go outside; caregiver to provide adequate supervision.
- Offer and provide appropriate in-home service options and support to Roger and his sister.
- Educate and offer referrals to support groups in the community.
- Schedule and complete Multi Disciplinary Team Meetings.
- Request and review medical records as needed.
- Offer habilitation, living skills training, and TBI programs.
- Provide transportation to medical appointments.
- CM to complete referrals, request physician orders and coordinate services with stakeholders.

Behavioral Health – Goal/Objective – Roger will reduce verbal outbursts to no more than three times per week; will not have any episodes of physical aggression such as throwing and hitting. **Approach**: Roger and Guardian to receive requested BH services as scheduled; Roger to take medications as prescribed; behaviors to be documented and addressed with BH Service Provider; caregiver and sister to redirect member as needed. **Timeframe:** 90 days.

Housing, Education and Employment: Once Roger is stabilized, housing, education and employment goals will be discussed. Referrals will be completed; coordinated with PCP and other interested parties. Examples include: New Horizons Independent Living Center, Yavapai Exceptional Industries, NAZCARE, and Vocational Rehabilitation. **Timeframe**: Ongoing

The proposed service plan could include:

- Attendant Care
- SDAC
- Respite
- Habilitation/Living Skill Training
- Behavioral Health Services

Collecting Utilization Data YCLTC gathers/collects data to detect both under and over utilization. YCLTC collects data from claims data, authorization data, provider records and member input. The YCLTC data analyst, Yavapai County's MIS Department and various staff create databases (db) and the methods for querying the db. Below are examples of collected data:

Claims Data

1. Member and provider Utilization by Type of Service (claim #, member, provider, procedure code, procedure description, date(s) of service, type of service, cost by procedure code, units, net cost and total cost).
2. DME Utilization (member, AHCCCS ID #, date of service, net cost, provider, HCPCS codes, modifiers) *(See Sample Report A)*.
3. Emergency and non-emergency transportation (claim #, member, date of service, provider, CPT/HCPCS procedure codes, modifiers, units & net cost).
4. Pharmacy Utilization Data, Monthly
   - Prescription (Rx) Detail by Member by Cost of Claims (member, drug, prescriber, quantity, days supply, ingredient cost, dispensing fee, pharmacy, amount paid).
   - Utilization Summary by Member Ranked by Total Cost (location, member, age, sex, # claims, average ingredient cost, total paid).
5. Pharmacy Utilization Data, Quarterly
   - Benefit Overview (eligible members, paid claims, cost of claims, brand average cost, generic average cost, Rx's PMPM, generic percentage, PMPM broken down into multiple groups with quarterly comparison).
   - Therapy Classes (ranked by cost with quarterly comparisons).
   - Top 50 Drugs and Top 10 Drugs (current quarter utilization compared to prior quarter in total cost, total claims).
   - Specialty Drug Trends (quarterly comparison of # of claims and cost of claims).
   - Pharmacy under utilization (current quarter by diagnosis, identifies members with chronic diseases not filling drugs timely for possible intervention.
   - Drug Utilization Review (DUR) Summary (by issue, number of letters to prescribers, and outcomes).
   - Physician Report Card (current quarter by provider, # Rx's, cost, PMPM, percentage of generics, brand, average cost/brand, controlled drug, and formulary compliance).

Authorization Data

Hospital Admissions, ER Visits and ambulance tracking are reviewed from a monthly, quarterly and annual perspective (member, facility, dates of service, diagnosis, length of stay, setting - HCBS, ALF, or SNF).

Analyzing Utilization Data Data is analyzed by the MM RNs, physical therapist, data analyst, medical director, management team, Pharmacy & Therapeutics (P & T) and Medical Management (MM) Committee for trends in utilization.

Reporting Utilization Data MM data is reported quarterly to the MM Committee and the P & T Committee. The Committees review and analyze the data, interpret variances, and develop or approve interventions based on the findings. Monitoring of interventions implemented and evaluation of measureable outcomes is performed and reported back to the appropriate Committee(s). Strategies are in place to address both over and under utilization for improving the efficient utilization of health care services from an organization wide perspective. A selection of utilization data reports are included below:

Admission & Average Length of Stay (See *Sample Report B*)

This quarterly report is based on notification from hospitals when members are admitted. Quarterly data is compared to the prior quarter and to the same quarter in the prior year. Data is broken out into Medicare and non-Medicare groups. In order to increase the usefulness of the data, it is further broken down by type of acute facility (general hospital, LTAC/Rehab and behavioral health.) Per member per month (PMPM) hospital costs by quarter and year to date are also included.

The following is an example of over utilization and demonstrates when a variance has been identified in the utilization pattern of a provider. When a new acute rehabilitation facility opened locally, there was an increase in admissions within the Rehab/LTAC group. This trend was expected and since previous rehabilitation needs of members had primarily been met by local skilled nursing facilities (SNF), YCLTC implemented the following 3-pronged approach to address the potential over utilization:

1. YCLTC Physical Therapist review of prior authorization requests to acute rehabilitation facilities.
2. YCLTC Physical Therapist on site concurrent review of members admitted to the local acute rehabilitation hospital.
3. Increased communication and collaboration with staff at the local rehabilitation facility. An on site meeting between MM RNs and the facility staff was scheduled which resulted in a greater understanding of YCLTC authorization and concurrent review procedures.

Subsequent monitoring demonstrated that from CYE 2009 to CYE 2010, utilization fell by 42% (from 41 admissions to 24 admission) and in the non-Medicare group by 60% (from 10 admissions to four admissions). The facility is now clearly aware that we will always authorize acute rehab for members when appropriate, but only after determining that the member's needs can be not be meet at a lower lever of care, i.e. in a SNF.

Inpatient Admissions by Diagnosis

This quarterly report is based on notification from hospitals when members are admitted. Each authorization is coded with a diagnosis that is entered into a database. Each quarter a report is generated which shows the top admitting diagnoses. The value of this report is that interventions can be implemented for variances that will have the greatest impact.

ER Utilization – Annual, Quarterly Concurrent, Quarterly by Diagnosis

1. Annual ER Report – This annual report is based on claims data. Each year, claims data is gathered 6 months after the close of the last quarter of the calendar year. Currently we are able to compare 7 years of ER Utilization. In 2008 and 2009, we experienced a significant upward trend in the number of ER visits. Because of this trend, we implemented the Concurrent ER Utilization process in 2009. The 2010 Annual ER Report will be submitted to the MM Committee in July 2011. At that time, the Committee will evaluate the effectiveness of the interventions on the number of ER visits and cost of visits.
2. Concurrent ER Utilization – ER utilization is reviewed on an ongoing, concurrent basis. ER records are reviewed for members with two or more visits per month. When a trend is identified one of the following interventions is implemented: Consultation with Care Manager; Referral to Quality Management; Referral to YCLTC Physical Therapist; Referral to Disease Management; or Multidisciplinary Team Meeting with the Medical Director. The findings are presented quarterly to the MM Committee. The current quarters' data was compared with the prior quarter's data to show the effect of the implementation of interventions specifically showing how many ER visits the member had in after the intervention compared to the prior quarter.
3. ER Utilization by Diagnosis – This quarterly report looks at the most frequent ER admitting diagnoses. Each authorization is coded according to diagnosis, which is then entered into a database. A report is then generated showing the top ER diagnoses. The value of this report is that interventions can be implemented when a trend of diagnoses is identified. For example, fall is repeatedly a top ER diagnosis. The YCLTC Physical Therapist has developed an extensive fall program to address this trend.

Non-Emergency Transportation

MM unit runs quarterly claims based reports. The purpose of the report is to evaluate the utilization and appropriateness of non-emergency transportation. MM first sorts the data by top ten members by cost of service, reason for transport, and then reviews for medical necessity and appropriateness of the transport. The following is an example of over utilization. The top utilizing member in the 1QCYE10 in the category of Non-Emergency Transportation Report was a member who was receiving wound care in Phoenix and required frequent transport by wheelchair van. Investigation revealed that the member could receive similar wound care at the local

hospital's new wound care clinic. This change, which was more convenient for the member, resulted in a cost savings of $5,243 the following quarter and $15,133 savings for the contract year.

Pharmacy – Compliance Drug Utilization Review (DUR)

This report, which is based on pharmacy claims, is run quarterly by YCLTC's pharmacy benefit manager. The process was implemented in 1QCYE10 under the direction of the P & T Committee to detect under utilization of medications used to treat chronic illness. The diagnosis chosen to launch the program was diabetes, due to its prevalence in the long-term care population. The following is an example of under utilization and demonstrates when a variance has been identified in the utilization pattern of a member. After several months of testing, the first compliance DUR data was available for review and analysis for the 6-month period ending in October 2010. Twenty-three cases of potential under utilization were identified. Each case represented an instance where a member was late in refilling a medication. A focused review of each specific case was performed by MM to identify if the member had been hospitalized during the timeframe or if there was any other obvious reason the member was late in refilling the medication. While none of the cases required notification to the prescriber, members with a variance continued to be monitored in the subsequent quarter. When cases were reviewed for the quarter ending in December 2010, a pattern of under utilization was again identified. It was determined at that time to notify the prescribers by letter of the pattern of possible non-compliance. The members will continue to be monitored and utilization data for the quarter ending in March 2011 will be reviewed for variances and reported to MM Committee in May 2011 for discussion and further action.

Fall Program – Hip Protector Program

Looking at data dating back three years, falls have been the top diagnosis for ER visits. As a result, MM has developed an extensive Fall Program under the direction of the YCLTC Physical Therapist and MM Committee. One aspect of the program has been providing hip protectors for members in long-term care facilities who meet one of five specific fall risk criteria (ambulatory and assessed as a fall risk, non-ambulatory with self-transfer and assessed as a fall risk, history of falls, history of hip fracture and diagnosis of osteoporosis). If the member is capable and willing to wear hip protectors 24 hours a day, YCLTC will provide three pairs of hip protectors. The YCLTC Physical Therapist performs monthly audits to determine compliance and collects, analyzes and reports the data each quarter to the MM Committee where the Fall Program is a standing agenda item.

The following is an example of under utilization and demonstrates when a variance has been identified in the utilization pattern of a provider. In 2QCYE10, one skilled nursing facility failed to meet the standard of documented compliance of hip protector use (> 80% across all shifts) on four out of five members in January and three out of six members in February. In March, only one out of ten members did not meet the standard. The improvement in performance followed monthly contact with the facility administrator regarding performance. In subsequent monitoring and evaluation, the facility continued to sustain the improvement with a 91% compliance rate.

Disease and Chronic Illness Management (See Sample Report C)

The Hospital Admissions and ER database is queried weekly, and more often as needed, to compare with a list of active members in the Disease Management (DzM) /Chronic Illness Program. Diagnoses are screened for any related to the disease for which the member is on the DzM program. Discharge summaries (DS) from the facilities are obtained on those members that are on both lists (ER/Hospital and the DzM lists). The information on the DS is then evaluated to determine if the hospitalization was related to their chronic disease. Complete records sets may then be obtained if the DS is not detailed enough to make a determination of what the status of the member was to require hospitalization and the status on discharge. These numbers are maintained to present to the MM Committee for review. Follow-up is conducted with the member and PCP if the admission was related to the chronic illness. Trends are identified with frequent visits to the ER for DzM members and members in general. For example, a member was in the ER multiple times for headache. The ER doctor finally referred the member to a neurologist, as the member had not followed-up with the PCP. This information was forward to the PCP and they were eventually able to get the member in for consistent follow-up with the PCP.

Annual DME Utilization Report

Row	Quarter	Date	Type	Qty	Amount	Vendor	Code	Description
1								
2	1QCYE10							
3		11/2/09	NU	210	$693.00	Alliance	A4351	Intermittant Cath
4		10/23/09	NU	1	$765.00	Alliance	K0007	Extra Heavy Duty WC
5		11/30/09	NU	1	$790.55	Hanger	L5321	Molded Socket-Above Knee
6		12/15/09	NU	2	$971.20	Hanger	L2280	Orthosis-molded inner boot
7		12/15/09	NU	2	$1,008.60	Hanger	L1904	AFO Custom
8		12/23/09	RR	1	$1,190.00	Alliance	E0463	Pressure Support Vent
9		10/23/09	RR	1	$1,190.00	Alliance	E0463	Pressure Support Vent
10		11/23/09	RR	1	$1,190.00	Alliance	E0463	Pressure Support Vent
11		11/12/09	NU	1	$1,893.00	Alliance	E1161	WC with Tilt in Space
12		11/30/09	NU	1	$3,291.37	Hanger	L5858	Addition-LE Prosthesis
13					$12,982.72	Total Top 10		
14					$99,272.52	Total Quarter		
15	2QCYE10							
16		3/1/10	NU	210	$693.00	Alliance	A4351	Intermittant Cath
17		1/4/10	NU	210	$693.00	Alliance	A4351	Intermittant Cath
18		2/1/10	NU	220	$726.00	Alliance	A4351	Intermittant Cath
19		1/12/10	NU	2	$1,167.80	Hanger	L1832	Orthosis-Knee
20		3/23/	[illegible]					
21		2/23/	[illegible]					
22		1/23/	[illegible]					
23		2/24/	[illegible]					
24		3/1/	[illegible]					
25		3/26/	[illegible]					
26								
27								
28	3QCYE10							
29		4/1/	[illegible]					
30		5/3/	[illegible]					
31		5/21/	[illegible]					
32		6/30/	[illegible]					
33		5/21/	[illegible]					
34		4/14/	[illegible]					

Row	Quarter	Date	Type	Qty	Amount	Vendor	Code	Description
1								
35		6/10/10	NU	1	$3,325.00	Ameri - Fab, LLC	S5165	Home Mod-Ramp
36		6/30/10	NU	1	$3,484.75	Alliance	E1002	Power WC Accessory-Power Seating System Tilt Only
37		6/10/10	NU	1	$5,025.00	Ameri - Fab, LLC	S5165	Home Mod-Ramp
38		6/30/10	NU	1	$5,525.52	Alliance	K0856	Power WC
39					$29,082.57	Total Top 10		
40					$107,811.72	Total Quarter		
41	4QCYE10							
42		7/27/10	NU	1	$4,120.00	Ameri - Fab, LLC	S5165	Home Mod-Ramp
43		9/20/10	NU	1	$1,784.19	Hanger	L2036	Knee/Ankle/Foot Orthosis
44		7/1/10	RR	31	$1,190.00	Alliance	E0463	Pressure Support Vent
45		8/1/10	NU	220	$1,412.40	Alliance	A4352	Intermittent Caths
46		7/1/10	NU	220	$1,412.40	Alliance	A4352	Intermittent Caths
47		9/1/10	NU	220	$1,412.40	Alliance	A4352	Intermittent Caths
48		7/1/10	NU	220	$1,412.40	Alliance	A4352	Intermittent Caths
49		8/2/10	NU	220	$1,412.40	Alliance	A4352	Intermittent Caths
50		9/21/10	NU	1	$2,710.58	Alliance	E1399	Misc
51		7/25/10	NU	1	$8,000.00	F and M Builders	S5165	Home Mod-Ramp
52					$24,866.77	Total Top 10		
53					$ 78,302.72	Total Quarter		
54						Annual Total		$361,349.75

Acute Care Admissions, Hospital Days & LOS by Authorization 1st Qtr CYE 2011 [10/1/10 – 12/31/10]

	CYE 2010 1st Qtr 10/09 – 12/09	CYE 2010 2nd Qtr 1/10 – 3/10	CYE 2010 3rd Qtr 4/10 – 6/10	CYE 2010 4th Qtr 7/10 – 9/10	CYE 2011 1st Qtr 10/10 – 12/10
Medicare & Non-Medicare					
Members	1044	1022	1013	995	987
Patient Days	888	708	630	614	703
Average Pt Days per Member *	0.85	0.69	0.62	0.62	0.71
# Total Admissions	148	149	132	105	119
# Acute Admissions	135	143	125	99	108
# Behavioral Health Adm.	4	2	2	0	4
# Acute LTC/Rehab Admissions	9	4	5	6	7
LOS – All Admissions	6.0	5.6	4.5	6.1	5.9
LOS – Acute General Hospital	4.9	5.0	3.8	5.0	4.4
LOS – Acute BH	13.8	18.5	11.0	7.0	14.2
LOS – Acute LTC	20.5	15.8	21.6	22.7	26.8
Non-Medicare					
# Members	141	139	146	146	145
Patient Days	217	66	52	84	82
# Total Admissions	22	12	15	17	15
# Acute Admissions	19	12	14	15	14
# Behavioral Health Adms	1	0	1	0	0
# Acute LTC/Rehab Adms	2	0	0	2	1
LOS –All Non-MC Admissions	9.0	10.9	3.1	5.2	5.5
LOS –Acute General Hosp	5.8	10.9	3.1	4.5	4.9
LOS – Acute BH	33.0	0	0	7.0	0
LOS – Acute LTC	22.0	0	0	9.5	14.0
Medicare					
# Members	903	883	867	849	842
# Patient Days	671	642	578	530	621
# Total Admissions	126	137	117	88	104
# Acute Admissions	116	131	111	84	94
# Behavioral Health Adm.	3	2	1	0	4
# Acute LTC/Rehab Adms	7	4	5	4	6
LOS –All Medicare Admissions	5.4	5.1	4.7	6.3	6.0
LOS – Acute General Hosp	4.8	4.4	3.9	5.1	4.3
LOS – Acute BH	7.3	18.5	11	0	14.2
LOS – Acute LTC	20.0	15.8	21.6	28	29.4
Hospital Costs PMPM per Qtr	188.83	110.55	57.15	135.27	68.00 (est)
Hospital Costs PMPM YTD	188.83	149.70	117.82	122.10	68.00 (est

<u>Year over Year Comparison: 1QCYE10 to 1QCYE11</u>

1. Eligible members
   - ✧ Total members ↓ by 5.5 %
   - ✧ Medicare members ↓ by 6.8 %
   - ✧ Non-Medicare members ↑ 2.8 %
2. Admissions
   - ✧ Total admissions ↓ by 19.6 %
   - ✧ Medicare admissions ↓ 17.5 %
   - ✧ Non-Medicare Admissions ↓ 31.8 %
3. Patient Days
   - ✧ Total days ↓ 20.8 %
   - ✧ Medicare days ↓ 7.5 %
   - ✧ Non-Medicare Days ↓ 62.2 %.
4. LOS Acute General Hospital
   - ✧ For all members, LOS ↓ from 4.9 to 4.4 days
   - ✧ Medicare LOS ↓ from 4.8 to 4.3 days
   - ✧ Non-Medicare LOS ↓ from 5.8 to 4.9 days.
5. LTAC/Rehab Admissions
   - ✧ 7 total admissions ↓ 22.2 %
   - ✧ 6 Medicare admissions & 1 non-Medicare admission
6. Acute Behavioral Health Admissions
   - ✧ 4 admissions, after 3 quarters with 0 – 2 admissions
   - ✧ All BH admissions were for Medicare members
7. Average Patient Days per Member is down year over year, but up from the prior 3 quarters
8. PMPM cost (estimate) is down 64% when compared to the same quarter in CYE10. There were two outliers last year which greatly increase costs. Both members expired.

* Average Patient Days per Member = number of patient days ÷ number of members (lower number is better).

Hospital Admissions by date, with diagnosis and length of service (sorted by patient name)

Last name	First name	AHCCCS ID	Admit date	Disc. date	LOS	Similar dx	Medicare	Fall	Primary diagnosis
			12/6/2010	12/7/2010	1	☐	☑	☐	
			12/25/2010	12/28/2010	3	☐	☑	☐	PNEUMONIA ORGANISM UNSPECIFIED
			12/4/2010	12/13/2010	9	☐	☑	☐	UNSPECIFIED CHEST PAIN
			12/8/2010	12/13/2010	5	☐	☑	☐	SINOATRIAL NODE DYSFUNCTION
			12/15/2010	12/20/2010	5	☐	☑	☑	FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK
			12/17/2010	1/2/2011	16	☐	☑	☐	PNEUMONIA ORGANISM UNSPECIFIED
			12/7/2010	12/9/2010	2	☐	☑	☐	ALTERATION OF CONSCIOUSNESS OTHER
			12/27/2010	1/3/2011	7	☐	☑	☐	CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED
			12/20/2010	12/27/2010	7	☐	☑	☐	HYPOXEMIA
			12/26/2010	12/28/2010	2	☐	☑	☐	UNSPECIFIED CHEST PAIN
			12/1/2010	12/6/2010	5	☐	☑	☐	RESPIRATORY ABNORMALITY OTHER
			12/23/2010	12/27/2010	4	☐	☑	☐	ACUTE OSTEOMYELITIS SITE UNSPECIFIED
			12/19/2010	12/21/2010	2	☐	☑	☐	ALTERED MENTAL STATUS
			12/16/2010	12/17/2010	1	☐	☑	☐	ALTERATION OF CONSCIOUSNESS OTHER

Yavapai County Long Term Care Utilization Management (UM) unit routinely analyzes data to identify patterns of utilization whether over or under, inappropriate or other trends. We gather data regarding emergency room (ER) utilization and review from annual, quarterly and contemporaneous perspectives. The Medical Management Committee reviews and analyzes concurrent ER data on a quarterly basis.

The UM unit identified a trend of increased ER utilization in 4QCYE09 of utilization from 2008 and 2009. The UM unit began monitoring data to determine concurrent ER utilization. The UM staff presented this information to the Medical Management Committee in 1QCYE10. Beginning in 2QCYE10, Medical Management improved the analysis process by adding outcomes data. UM nurses followed all members who had interventions implemented in the prior quarter for two or more visits during a month. During the 2QCYE10 quarter, UM nurses reviewed the data for eleven members who had interventions the prior quarter. The data looked at the number of ER visits the member had in the quarter following the intervention(s). In the group under study, there was a 67% reduction in ER visits from the prior quarter with visits going from 42 to 14. In the data for 3QCYE10, the results again suggested that the interventions had been effective in altering the unfavorable utilization patterns identified with a 37% reduction in ER visits, from 27 to 17.

The interventions used were:

- Interdisciplinary/multidisciplinary meeting with Medical Director, UM Nurses, Disease Management nurses, Care Managers, Care Manager Supervisors, Medical Services Manager, Physical Therapist and Behavioral Health Coordinator.
- Referral to YCLTC Physical Therapist
- Consultation with Care Manager
- Referral to QM Nurses and/or manager for comprehensive investigation
- Faxing the hospital information to the PCP
- Telephone calls to PCP and/or member regarding follow-up visits with the PCP
- Referral to Disease Management nurses for evaluation

This example shows how YCLTC follows its protocols for intervention. YCLTC analyzes data and identifies trends on a routine basis. Staff involves the Medical Director and participants of the Medical Management Committee, including community physicians in the development of strategies. Staff implements the strategies, complete subsequent reviews and analyses and modify strategies until expected results are realized.

D. PROGRAM – MEDICAL MANAGEMENT SUBMISSIONS Q.27

The goal of YCLTC's Disease Management (DzM) Program is to improve the overall health care outcomes for individuals living with chronic diseases by increasing member self management and improving practice patterns of providers. The program which began in 2004 focuses on individuals with Diabetes Mellitus (DM), Congestive Heart Failure (CHF) and/or Chronic Obstructive Pulmonary Disease (COPD).

YCLTC's DzM Program is an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by identifying and monitoring high risk populations; assisting providers in adhering to current evidence based guidelines; promoting care coordination; increasing member self management; optimizing member safety and improving practice patterns of providers. The overall effects of the program are monitored through data analysis and utilizing the results to revise and/or develop components to further improve member outcomes.

The program consists of six (6) components:

1. Population identification process
2. Evidence based practice guidelines
3. Collaborative practice model including physician and support service providers
4. Patient self management education
5. Process and outcome measurement evaluation and management
6. Routine reporting and feedback loop[1]

Population Identification

YCLTC DzM Nurses continuously review every Pre-Admission Screening (PAS) that is received to determine eligibility to participate in the program. All members residing in their homes or assisted living facilities are considered eligible for participation if they have one or more of the selected chronic diseases. These members most likely have the potential to benefit from a concerted intervention plan.

Members can also enter the program through care management referral after the initial assessment and anytime the member develops an eligible diagnosis. Providers may also make referrals. Quarterly reports are generated from encounter data for DzM Nurse review to ensure that newly diagnosed members will be included in the program.

Evidence Based Practice Guidelines

YCLTC has developed practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals in that field. The needs of YCLTC members are considered in the development process. The guidelines reflect the current standard in each practice field and provide a uniform standard for provider reference and education. Evidence based practice guidelines serve as a basis in decision making procedures and for any necessary care evaluations. The CHF guideline was selected from the American Heart Association. The DM guideline was selected from the American Diabetes Association. The COPD guideline was selected from the GOLD/National Heart, Lung and Blood Institute.

The guidelines are reviewed annually by Medical Management staff and approved by the Medical Management Committee. The next review will be in fall 2011. The purpose of this review is to ascertain that the guidelines reflect the current standard of care and represent the best practice standards for each chronic disease. The review, adoption and evaluation of the guidelines will be documented in the Medical Management Meeting minutes. Once approved the guidelines will be distributed to appropriate physicians and uploaded to the YCLTC website. Upon request the guidelines will be distributed to members and other interested parties.

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[1] http://www.carecontinuum.org/dm_definition.asp

Collaborative Practice Model

Assisting members and providers in adhering to established evidence based guidelines is and will continue to be a collaborative effort. The following strategies encourage physician participation and adherence to the practice guidelines, encourage member input and participation and ensure necessary communication and feedback to providers and members:

- Physicians on the Medical Management Committee assist with the analysis of data, provide input, approve and make periodic recommendations for the DzM Program. They also receive ongoing reports of process and outcome measures.
- YCLTC will encourage providers to utilize the practice guidelines by seeking continued input and approval on the development of patient/caregiver education and care management and intervention guidelines.
- Primary and specialty providers will be included in ongoing care management activities and will be provided with ongoing information by telephone and/or in writing on the health status of their members.
- YCLTC DzM Nurses provide outreach to members on a regular basis via telephone and home visits as needed. Family members and/or member representatives are included as appropriate for education and training.
- Within the organization, DzM Nurses consult with Care Managers, Behavioral Health Coordinator, Administrative Support Transportation Specialist(s), Utilization Management, Concurrent Review, and the Physical Therapist to ensure that all interdepartmental communication regarding all aspects of a member's health care situation are being considered in managing and evaluating care.
- Multidisciplinary care conferences are held periodically and include the Medical Director, Care Manager, Care Manager Supervisor and Manager, Medical Services Manager, DzM Nurse, Behavioral Health Coordinator, Member Services Coordinator, Program Development Coordinator, and Physical Therapist, if indicated.

Member Self-Management Education

Self management of chronic diseases is an emerging and significant aspect of health care. YCLTC is anticipating the utilization of the Stanford University Chronic Disease Self-Management Program (CDSMP) by summer 2011. Three staff members – the YCLTC Behavioral Health Coordinator, the YCLTC Transition Coordinator and one DzM Nurse – recently have been certified through the Stanford University Program Leader Chronic Disease Self Management certification class. In collaboration with the Yavapai County Community Health Services Center and other local health care providers we will be offering this program not only to our members but to the community as well. We plan to offer the program in settings that minimize the need for transportation for the member to bypass that obstacle to this very important program.

The CDSMP is helping individuals to manage their chronic conditions and as a result are improving compliance with recommended care. They are learning how to effectively communicate with their health care professionals. The participation in the CDSMP teaches the participant skills that transfer to a confidence and motivation necessary to manage the challenges of living with a chronic health condition.

Process and Outcome Measurement, Evaluation and Management

YCLTC DzM Program includes methodologies to evaluate the effectiveness of the program. Currently, DzM program members are monitored for the number of ER visits for general cause and disease related diagnoses. They are also monitored for the number of general hospital admissions and disease related hospital admissions.

YCLTC also monitors all Diabetic DzM program members for compliance with routine monitoring of glycemic control, lipid management and status of retinopathy and presence of nephropathy. DzM members with CHF are currently being monitored for disease related ER and hospital admissions. YCLTC will begin monitoring CHF members for compliance beginning Quarter 3, CYE 2011 with the current standard of care which includes medications, diet, exercise and nutrition components. Currently DzM members with COPD are being monitored for disease related ER and hospital admissions. YCLTC is monitoring members with COPD for routine spirometry testing as a means of diagnosis and use of medications appropriately based on symptoms and

spirometry results. New monitoring guidelines have been developed which include medications and their proper use, avoidance of smoking/second hand smoke, nutrition, respiratory therapy, and lifestyle changes.

All DzM data is analyzed quarterly to determine efficacy of the program. Recently it was determined that there was a deficit in the number of diabetic members going for dilated retinal eye exams. Staff members met to determine possible causative factors and develop plans to improve outcomes. Several actions were taken. A brochure depicting normal vision and vision with retinopathy was developed and sent to every diabetic in the DzM Program. At the same time each member's PCP was contacted regarding the need for an annual dilated retinal eye exam. After review of those responses the members themselves were called routinely to encourage them to get the needed exam. All of these efforts have proved to be successful. The number of dilated retinal eye exams now exceeds the MPS set by AHCCCS.

Routine Reporting/Feedback Loop

All DzM activities are reported to the Medical Management Committee on a quarterly basis for analysis and recommendation. Outcome measures are specifically reported and analyzed quarterly. An annual evaluation of the program is completed and reported to the Medical Management Committee for recommendations or revisions to the program. Continuous ongoing evaluation of the program is conducted and any areas that need to be adjusted to improve outcomes and delivery of management activities are brought by DzM staff to the Medical Management Committee for approval and recommendations. Member's physicians are an integral part of the feedback loop and are kept up to date with changes in member health status as needed by the DzM Nurses. Physicians are notified annually of their compliance rate regarding outcome measures. If indicated, the Medical Director may contact physicians with recommendations for possible changes in the clinical management of a member.

YCLTC adopts and disseminates clinical criteria for the purpose of ensuring medically appropriate decision making. The criteria are based on valid and reliable clinical evidence and provide a standard for decision making criteria for concurrent and retrospective review in utilization management, disease management, in prior authorization of coverage criteria, in review of discharge criteria and for member and provider education. Criteria are adopted in consultation with the medical director and contracted health care professionals and the Medical Management (MM) Committee; they are based on national standards of care. The below excerpt is characteristic of the criterion we choose:

> *Experts in the subject under consideration are selected ... and charged with examining subject-specific data and writing or updating these guidelines. The process includes additional representatives from other medical practitioner and specialty groups where appropriate. Writing groups are specifically charged to perform a formal literature review, weigh the strength of evidence for or against a particular treatment or procedure and include estimates of expected health outcomes where data exist. Patient-specific modifiers, co-morbidities and issues of patient preference that might influence the choice of particular tests or therapies are considered, as are frequency of follow-up and cost-effectiveness. When available, information from studies on cost will be considered; however, review of data on efficacy and clinical outcomes will constitute the primary basis for preparing recommendations in these guidelines.*

(Excerpt from *Circulation,* American Heart Association on
Guidelines for the Management of Congestive Heart Failure, 2009).

The YCLTC MM Committee approves all criteria for adoption on an annual basis and if a guideline is updated earlier than an annual timeframe, the MM Committee reviews the updated guidelines at the next convening quarterly meeting. The following criterions are used to ensure consistent decision making, for coordination of care activities, monitoring of over and under utilization of services, evaluation of new medical technologies and use of current technologies. The following criteria were approved for adoption on May 19, 2010:

- AHCCCS Medical Policy Manual
- InterQual 2010 Acute Care Criteria
  - Acute Care Adult
  - Acute Care Pediatric
  - Long Term Care Acute
- InterQual 2010 Care Planning Criteria
  - Procedures
  - Imaging
- Medicare national & local coverage determinations
- National clinical practice guidelines (CPGs)
  - American Diabetes Association
  - The American College of Cardiology Foundation
  - The American Heart Association
  - GOLD/National Heart, Lung and Blood Institute
  - Agency for Healthcare Research and Quality
  - National Pressure Ulcer Advisory Panel
- Peer reviewed medical journals articles, when available, published in the United States, when CPGs are not available.
- Peer review. YCLTC maintains contracts with two national peer review organizations
  - AllMed Healthcare Management, Inc.
  - Medical Review Institute of America

Criteria are disseminated to all appropriate providers and, upon request, to members and potential members. Criteria are disseminated via the following methods:

- Active links on the YCLTC website

Clinical Practice Guidelines

Clinical Practice Guidelines are evidence-based tools that help practitioners make decisions about appropriate health care for specific clinical circumstances. Yavapai County Long Term Care has adopted the following guidelines in an effort to improve health care and reduce unnecessary variation in care and to support the Disease Management Program.

- Congestive Heart Failure
- Heart Failure Flowchart - Rev11/2009
- Chronic Obstructive Pulmonary Disease Dec. 2009
- Management of COPD - Rev11/2009
- Depression
- Standards of Medical Care in Diabetes 2010
- Management of Diabetes - Rev11/2009
- National Pressure Ulcer Advisory Panel Resources

Clinical Practice Prior Authorization Decision Criteria

Clinical Practice Prior Authorization decision criteria are based on:

- AHCCCS Medical Policy
- Medicare guidelines
- Nationally recognized clinical support criteria, specifically InterQual

For discussion on the specific criteria used in decision making, please contact the YCLTC Medical Management/Utilization Management Department.

Screen print from YCLTC Website 1

- New Provider Orientation
- Provider Newsletter
- Member Newsletter
- Direct communication with individual providers, such as via mail and fax methods
- Provider Meetings
- Member Meetings

To ensure consistent decision making, inter-rater reliability audits are performed on a regular basis for staff who utilize criteria in the decision making process. Decisions and interventions are analyzed, recommendations for action are made and monitored for effectiveness and reported to the MM Committee.

YCLTC identifies quality improvement opportunities through a variety of avenues. Both staff and providers are encouraged to submit suggestions for quality improvement opportunities as they are identified. In addition, YCLTC proactively seeks out opportunities to develop performance improvement projects through the following methods:

- Review of provider medical record keeping practices for compliance with YCLTC standards
- Review of monthly incident reports submitted by skilled nursing facilities
- Tracking and trending member and provider concerns from grievance system
- Tracking and trending events from Quality of Care (QOC) logs
- Analysis of results from member and provider satisfaction surveys
- Analysis of findings from internal Care Management, Quality Management and Provider Relations audits
- Monitoring and evaluation of service delivery system and provider network
- Tracking and trending of utilization statistics, such as hospital admission diagnoses and length of stay
- Review of findings from clinical practice guideline monitoring

YCLTC also identifies improvement opportunities through discussion at the following regularly scheduled meetings:

- Quarterly Medical Management Team
- Member Council
- Multidisciplinary Team
- Credentialing Committee
- Peer Review Committee
- Quality Management & Performance Improvement (QM/PI) Committee
- Management Team Meetings
- General Staff and Unit Meetings
- Pharmacy and Therapeutics Committee

Selecting a Performance Improvement Project

YCLTC participates in Performance Improvement Projects (PIPs) when areas of improvement have been identified through analysis of clinical and/or operational data that show trends requiring improvement in quality of care or service. Selection of specific monitoring and evaluation activities are appropriate to the specific service or site. A work plan for taking appropriate action to improve care is developed and includes the specific problem that requires corrective action, the person or body responsible for making the final determinations regarding quality issues, the types of member/provider actions to be taken, the assessment of the effectiveness of actions taken, the methods for internal dissemination of findings and resulting work plans to appropriate staff and/or providers and the method for disseminating the information to AHCCCS. YCLTC maintains documentation that confirms the implementation of corrective actions.

YCLTC chooses clinical and non-clinical topics for PIPs. Clinical topics may include primary, secondary, and/or tertiary prevention of acute or chronic conditions, management of acute or chronic conditions, high-risk services, and continuity and coordination of care. Non-clinical topics may include culturally competent delivery of services or interpersonal aspects of care delivery. Regardless of the topic, each PIP includes:

1. Measurement of performance using objective quality indicators
2. Implementation of system interventions to achieve improvements in quality
3. Evaluation of the effectiveness of the interventions
4. Planning and initiation of activities for increasing or sustaining improvement

The QM/PI Committee oversees PIPs as required by AHCCCS and is responsible for making final determinations regarding quality issues. Prior to selection, potential PIPs are reviewed with the Medical Director, Medical Management staff and the QM/PI Committee during scheduled meetings. Topics allow for the use of applicable Health Plan Employer Data and Information Set (HEDIS) measures or the development of performance measures that are objective, realistic, and measurable. YCLTC gives preference to topics that have performance measures

related to outcomes and not process, unless published studies or consensus of relevant providers establish that the process is significantly related to outcomes.

PIPs are based on analysis of data and information that reveals a potential for a positive impact to YCLTC members. Other considerations are member demographic characteristics and health risks, and the interest of members, providers, and staff in the project. Priority is given to PIPs that are expected to achieve the greatest practical member centric benefit for enrolled members. Once a topic is selected, YCLTC documents the project's purpose, justification for choosing the topic, explanation of its importance to YCLTC, and the targeted member need, care or service the PIP will address. YCLTC clearly and concisely states the study question(s) after researching relevant clinical literature and/or other supporting information. The number of questions is limited to ensure the project is meaningful and manageable.

Enhancing Multi-Departmental Interventions

YCLTC uses its excellent channels of communication to notify staff of opportunities to improve care through multi-departmental interventions. QM staff meets with individual units to develop a working partnership and to describe interventions, explain the reasons for the interventions and the expected outcome, generate a spirit of cooperation, and assign activities. Training is provided as needed. Managers and QM staff monitor the implementation of the interventions, praise efforts, offer assistance, and remind staff if interventions are not implemented. Staff is informed of progress at meetings, in memos, in e-mail messages, and in conversations. Throughout projects, QM and management monitor continued efforts. At the end of the project, QM informs staff of the effectiveness of the interventions.

Evaluating Interventions for Effectiveness

YCLTC strives to meet, maintain and/or exceed the benchmark and goal proposed for PIPs. Interventions are recommended and approved by the QM/PI Committee and implemented during the scheduled intervention period. Interventions generally include several approaches involving diverse personnel and methods. For example, a recent PIP intervention included member education, provider education, education of caregivers, and a call-back/reminder system. These interventions were delivered telephonically, electronically, in person and via publications and PowerPoint presentations. The interventions were accomplished by administrative staff, provider relations staff, disease management and care management staff. Once the intervention period is concluded, YCLTC initiates a remeasurement of the indicator to assess for improvement. Findings are presented to the QM/PI Committee and are compared to the baseline measurement, national and state benchmarks and established goals. The committee evaluates whether the interventions had an impact on improvement. The committee may recommend additional interventions and/or delete interventions found not to have an impact on the outcome. The committee may also recommend that a particular intervention be maintained as an ongoing procedure, such as the routine distribution of the Reminder Brochure being integrated into the Disease Management Program. Interventions shown to have a positive impact on outcomes will be continued in order to sustain and/or increase improvement.

YCLTC continues to monitor indicators to ensure the interventions are effective and improvement sustained. A comparison of current findings from the Grievance Databases, Monitoring Reports, Satisfaction Surveys and other reports with the previous findings also demonstrate the success or failure of interventions.

The purpose of YCLTC peer review process is to ensure health care services delivered by contracted practitioners achieve the desired health outcomes for members and are consistent with current standards of practice. It includes review by professionals with similar education, training and/or clinical practice as the practitioner under review, development of recommendations regarding credentialing issues, quality of care issues, including matters of competence, conduct and ethical behavior. In addition, this process may include resolution of issues through development of corrective action plans and practitioner and licensing/regulatory agency notification.

Structure of the Peer Review Committee

The YCLTC Peer Review Committee is a stand alone committee. This Committee is ultimately responsible to the Yavapai County Board of Supervisors. The YCLTC Medical Director is the chair of the Peer Review Committee. Other members of the committee include two contracted providers from the community, YCLTC Director, Medical Services Manager and YCLTC Quality Management (QM) Nurses. A quorum of at least four (4) voting members must be present to convene this Committee. The Peer Review Committee is scheduled to meet quarterly and will meet whenever necessary to determine a case.

If a case involves a specialty that is not represented on the Committee, YCLTC will invite practitioners of the same or similar specialty to participate in review and recommendation of individual peer review cases. If a Behavioral Health specialty is being reviewed, a behavioral health provider will be invited to be part of the peer review process. Yavapai County is a rural community and does not have a large number of each medical specialty. Therefore it may be difficult to obtain a contracted provider in the community to advise the Committee if an unrepresented specialty is involved. YCLTC contracts with two outside Peer Review Organizations (PRO) to consult with in this situation. The Peer Review Committee will consider the recommendations made by the external PRO, however, the final determination will be agreed upon by a majority vote of the Peer Review Committee membership.

Background

All practitioners are aware of the peer review process and grievance procedure. This information is explained in the Provider Manual as well as in the contract. All records of peer review activities are confidential, are maintained for 6 years and are available for consideration during the recredentialing process. YCLTC makes the decision on a course of action based on consideration of information submitted by the PRO and does not delegate the decision-making responsibility.

Peer review is conducted in accordance with Arizona law which ensures that a member of a peer review committee, who in connection with committee functions makes a decision or recommendation, is not subject to liability or civil damages in consequence of that action. The information related to the functions of the committee is confidential and not subject to subpoena or order to produce except as provided by law.

Utilization Procedure

The Peer Review Committee members sign confidentiality statements agreeing to maintain the confidentiality of committee proceedings, and to protect the privacy of both members and practitioners. The committee reviews and makes recommendations regarding quality of care issues, including conduct inconsistent with or harmful to quality patient care, or unethical practice(s) that are unresolved by the QM Unit, Credentialing Committee, QM/PI Committee, and/or the Medical Director. The committee receives referrals for review from YCLTC Medical Director, and also reviews practitioner credentialing issues occurring in the last 5 years. Credentialing issues that may be considered for peer review include, but are not limited to, the following:

- Three or more malpractice suits resulting in settlement against a practitioner
- Adverse licensure action
- Censure by state and/or county medical associations
- Curtailment or suspension of medical staff privileges at the primary admitting facility or any other hospital or medical center
- Federal sanctions imposed by Medicare and/or Medicaid
- Felony conviction

- History of chemical dependency and/or substance abuse
- Invalid/suspended license, DEA certificate or malpractice insurance
- Mental/physical inability to fulfill contractual obligations

The initial peer review process includes investigation and fact finding gleaned from review of medical records or credentialing documents. Based on peer review findings, contracts or contract renewals for practitioner services may be subject to amendment, reduction, suspension, or ultimately termination and notification to the appropriate licensing and regulatory agencies. The Committee's recommendations may include any of the following:

- Recommendations to accept credentialing
- Recommendations to contract/renew contract
- Recommendations to meet with practitioner to determine necessity of further action
- Need for further review

Any non-credentialing related quality of care issue concerning professional competence, conduct or ethics has first been investigated by the QM Coordinator(s) and is subsequently presented for review by the Medical Director. Upon his recommendation the peer review process is initiated. The QM Coordinator gathers all pertinent documents to be reviewed and forwards them to the appropriate physician or Peer Review Organization along with a description of the concerns and/or questions to be considered. Once the findings and recommendations are received from the reviewer(s), the Committee discusses the submitted information and makes recommendations for a plan of action.

The Medical Director supervises peer review activities, and is responsible for notifying the practitioner by letter following the initial review by the Committee of the recommendations, and notifies the practitioner that they may, within 10 days of receipt of letter, request a meeting with the Committee and/or provide documentation explaining the events that are the subject of the Committee's concerns. The practitioner may also choose not to contact YCLTC. Within 10 days of receipt of the practitioner's response, the Peer Review Committee must schedule a meeting to review the response and/or meet with the practitioner in person. The final recommendations of the Peer Review Committee will be submitted to the Deputy County Attorney assigned to YCLTC. The final decision is made by the Peer Review Committee in conjunction with the Deputy County Attorney. Once a decision is made, the practitioner is notified of the results via certified or registered mail, return receipt requested within 10 days of the Committee's decision. This notification will include detailed information about the practitioner's grievance rights as outlined in YCLTC's quality management policy.

In the event of contract reduction, suspension or termination, a 30-day notice will be given to the practitioner by personal delivery, registered; or certified mail. Suspension or termination of a practitioner from the network as a result of serious deficiencies in quality of care will result in automatic reporting to the appropriate licensing and regulatory agencies.

Incorporation into QM Process

All quality of care issues are subject to review by the Quality Management Unit. If it is determined a trend has developed requiring Peer Review, the QM unit will consider addressing the trend as a quality improvement project or process improvement, or a new disease management focus, selecting the most appropriate approach for the situation and continuously evaluating the effects of the selected approach.

YCLTC is responsible for the health and safety of our members. YCLTC's provider contracts include provisions to safeguard members and ensure receipt of medically necessary services. Contracted facilities are required to be licensed and in good standing with state and local entities. In the event that a facility experiences difficulties with licensure, YCLTC Provider Relations Coordinators (PRC) offer assistance and provide problem solving strategies. However, in this scenario, YCLTC has exhausted our efforts to assist the facility to renew its licensure and they remain unlicensed. YCLTC is terminating the contract with cause, effective in 7 days. Since we have been working with this facility for several months in an effort to resolve this problem, we have been aware of the potential for immediate jeopardy. We have assessed the triage level and the urgency to move the member(s), identified possible placements, and notified members or family members of the potential closure. We have looked for grievances or quality of care concerns related to the facility. We have also conducted more on-site visits to ensure member safety since we became aware of the licensure status. Our close monitoring of the facility did not identify any quality of care concerns. Therefore, this plan is developed to move the members as expeditiously and seamlessly as possible. Typically, this can be easily accomplished within a week. Members are prepared, family's questions and concerns are answered, and actions are taken sequentially and issues are addressed promptly.

However, if YCLTC, AHCCCS or ADHS decided members needed to be moved immediately, the timeframes would be shortened. Members would be transitioned as quickly as possible and families would be notified. Some issues would be addressed after the transitions. YCLTC is able and prepared to complete transition plans within 6 to 24 hours as well as within a longer period.

As an ALTCS Program Contractor for the past 17 years, YCLTC has significant experience ensuring member safety and access to care during incidents that occur in a rural county. We have learned to convene our team whenever there is a suspicion that something might be wrong in a contracted facility. We have access to the Yavapai County Department of Emergency Management who can set up temporary shelters. Our providers are required to maintain their own business continuity plans, monitored by PRCs. We help them implement their plan if needed. We partner with several out-of-county contracted facilities and demonstrate competent monitoring and oversight of care provided to members living out-of-county.

In this scenario, YCLTC would be prepared to move our members because we had been working on the licensing situation previously and were already aware of the potential for the result of a 'no license' status, as well as the lack of facilities in the local area. In an immediate jeopardy situation, we follow an established action plan. Upon notification of immediate jeopardy status, the Emergency Response Team would be activated and assembled to meet within 15 minutes. All team members would be expected to be present within 90 minutes. The ERT is composed of the Director, Medical Director, Program Development Coordinator, Care Management (CM) Manager, CM Supervisors, Medical Services Manager, Behavioral Health Coordinator, Provider Relations Coordinator(s), the Business Continuity Coordinator and the Transition Coordinator. Other staff, such as Registered Nurses, the Physical Therapist and Care Managers would also be part of the team.

The team would review the information on the members that are placed in the facility and take steps to begin the process of transferring members to new facilities that would have been previously identified. Since there is no other facility in the area to take the members, YCLTC would have previously arranged for potential short notice transfer to contracted facilities. The process of arranging for safe transportation would also have already been initiated. YCLTC would have talked to the members or families, explained the situation, and offered options. YCLTC would have completed these actions while working on the licensing issue. In the event that the member does not have any family member in area where this immediate jeopardy (IJ) occurred, we would also evaluate the possibility of initiating a PCCR once all of the members were safely transferred.

The following list of steps would be initiated to ensure the safety and well-being of members during their transfer: and to ensure members, family, YCLTC staff, providers and AHCCCS have adequate information.

The person notified of the need to transfer members calls an Emergency Response Team meeting to begin within 15 minutes of notification. Team members are notified via email first and also by phone if off-site and in person if on-site. All participants, including those off-site are to be available within 90 minutes of notification. The Team meeting begins with whoever is available. The ERT team:

- Convenes within 15 minutes of notification.
  - Expects all participants to be available within 90 minutes of notification.
- Assigns an Incident Commander to facilitate the ERT meeting and lead YCLTC efforts.
- Completes the Healthcare Facility Closure/Loss of Major Provider checklist during the ERT meeting to ensure that each component is addressed.
- Reviews and confirms facts of the case.
- Plans a strategy and assigns tasks. Tasks are completed as the Team continues to meet.
- Notifies CM and other staff of need to move members.
- Triages YCLTC members in the facility by risk factors:
  - High: at significant risk for negative incidents, i.e.: weight loss, pressure ulcers, currently unstable or fragile.
  - Moderate: stable but has experienced recent issues.
  - Low: stable with no recent issues.

Tasks that are completed concurrently with the ERT Team meeting are:

- PRCs identify readiness of alternate facilities to receive imminent transfer of YCLTC member(s) within 60 minutes of completion of triage.
- PRCs notify the relinquishing facility in writing of anticipated move date or decision to terminate contract, if appropriate, as soon as this information is known. Verbal communication is confirmed in writing.
- The Transition Coordinator offers information on available facilities to and coordinates with other program contractors within 1 hour of identification of alternate facilities.
- CMs begin to notify members or families of the members of the situation within 15 to 30 minutes of completion of triage.
  - Prepare BBA letters to send to members/families/representatives within 10 business days if they refuse to leave facility.
- CMs contact current PCPs to notify them of the situation and to request transfer/admit orders as soon as the determination to move has been made.
- YCLTC nurses notify ADHS, AHCCCS and Ombudsman of decisions and the expected date and time of transfers.

Upon conclusion of the ERT meeting, in-office ERT members or designees would:

- Assure new facility receives needed tuberculosis clearance/chest x-rays for newly admitted members.
  - Arrange mobile x-ray unit to be on-site for members who need x-rays.
  - Arrange provision of x-ray services at urgent care centers or hospitals if needed.
- Identify DME needs and arrange for new equipment or move of current equipment.
- Identify transportation for each member.
- Identify new PCPs and CMs.

Within 30 minutes of conclusion of the ERT meeting for Immediate Jeopardy or within 1 business day if a longer timeframe would meet YCLTC and member needs, ERT members or designees leave YCLTC and go to the facility:

- Meet with provider to arrange record duplication, medication packaging and/or packing personal belongings.
- Review financial matters including patient personal funds, SOC and room and board.
- Begin moves according to triage information.
- Maintain ongoing assessments of each member for tracking and trending purposes.
- Meet with members, families and representatives to discuss concerns while at the facility and, if needed, once the member(s) arrive at the new facilities.

- Behavioral Health Coordinator meets with any members, families and/or representatives who indicate difficulty with move or request psychological support. In addition to YCLTC Behavioral Health Coordinator, other contracted behavioral health providers may be called upon to assist with support and counseling members and families on site at facility. Many of these activities would be occurring simultaneously. If the move were urgent, this would likely be an initial meeting, followed by another meeting in one to three days if an unexpected move occurred and the member or family had difficulty with the transition.
- Complete transfer.

Within four business hours of the decision to terminate the contract:

- The Director, Medical Services Coordinator, PRC, Program Development Coordinator and CM Manager meet to coordinate efforts.
- The PRC drafts a letter notifying the provider of the termination, its reason, and the effective date. The letter is approved by the County Attorney assigned to YCLTC and then sent via certified letter to the provider. The PRC also the facility administrator by phone and emails the letter.
- The PRC notifies YCLTC staff of the facility's termination and effective date via email.
- The Medical Services Coordinator notifies AHCCCS of the pending contract termination and YCLTC's plan to transition members.

After the transfers:

- YCLTC staff will remain onsite after member transfers are initiated to assist and coordinate information to families/representatives that arrive at the facility with concerns regarding the status and location of their loved ones.
- Medical Services unit will follow the status of the members via ongoing assessments and visits to the facility and member.
- CMs will complete reassessments of transitioned members within 10 business days of the move.

Notification to Stakeholders

- The YCLTC Director meets with Yavapai County Board of Supervisors and Yavapai County Administrator within the next several days to apprise of the events.
- The Director notifies the press and local officials, if necessary.
- AHCCCS, ADHS and the ombudsman are updated of actions.

If the facility obtains a license before the effective date of the contract termination, efforts to transfer the members would continue only if there were other reasons for the termination or if the members desired to move.

This facility is geographically removed from proximity to the offices of YCLTC; therefore, we would coordinate with other program contractors that are already onsite to assist us in communication regarding the status of the situation while our team assembled and responded to the location. Once onsite, we would determine if the other residents' program contractors were onsite. If not, we would make ourselves available to them to assist with their members until they arrived. In an immediate jeopardy involving physical problems such as a lack of heating/cooling, a forest fire or an electrical or water disturbance, YCLTC would also collaborate with other departments in the Yavapai County Government system such as Yavapai County Community Health Services and Yavapai County Emergency Management to identify their counterparts in the other county and enlist their support and cooperation.

Following any incident that requires mobilization of YCLTC ERT and massive coordination efforts to assure the safety and health of our members, we would meet, as a team, for a debriefing. At that time, we would take the opportunity to review our response(s) to the situation, analyzing our strengths and difficulties. Appropriate modifications would then be implemented to YCLTC processes for improvement of our service(s) to our members.

Through regularly scheduled monitoring, YCLTC strives to stay abreast of the status of our contracted facilities. However, emergent, unexpected issues which may result in unanticipated facility closure develop suddenly and require immediate intervention. In this situation, where the air conditioning is out at a Phoenix facility and the outside temperature on a late Friday afternoon is 116°F, YCLTC implements the following strategies:

- The YCLTC Emergency Response Team (ERT) is activated within minutes of notification of the immediate jeopardy.
- The ERT implements the processes for immediate jeopardy situations outlined on the YCLTC *Healthcare Facility Closure/Loss of Major Provider Check-Off List* to ensure the safety and well-being of YCLTC members with an established protocol.
- The ERT contacts program contractors in the Phoenix area within 30 minutes to coordinate efforts, identify potential non-contracted providers that may provide services and to enlist their cooperation in transitioning YCLTC members. They discuss setting an on-site meeting with the facility, other Program Contractors and YCLTC, and if able, Emergency Management Personnel.
- The ERT contacts the facility Administrator within 30 minutes to coordinate efforts, offer support, explain our plan and schedule an on-site meeting with YCLTC, the Administrator and Director of Nursing, other Program Contractors, and if able, Emergency Management personnel.
- The ERT decides what tasks need to be completed on-site and selects specific team members to travel to the facility. Travel begins as expeditiously as possible, but no later than 1 to 2 hours after notification. The travel team carries a laptop and air card to access YCLTC's computer system.
- Other ERT team members remain in Prescott and begin to contact families/representatives by phone, explain the situation and keep them abreast of the member's status throughout the situation.
- Members of the ERT team begin triage assessments of YCLTC members according to risk factors identified in the member file within 60 minutes of notification. Triage is modified by the other on-site program contractors and/or immediately upon YCLTC's arrival at the site. High-risk members are moved first followed by moderate risk and then low risk.
- Concurrent with the above activities, YCLTC immediately contacts the Maricopa County Department of Emergency Management either directly or through Yavapai County's equivalent department. We determine if evacuation has begun and where our members are located if evacuation efforts have already begun. If evacuation has not yet begun, the timeframe for evacuation is most likely imminent due to the extreme outside temperatures.
- The ERT determines from communication with the emergency departments what the extent of the problem is. For instance, is it due to an electrical brown out which may be affecting other facilities as well? This helps us to focus our efforts for relocation.
- With the above information available, Provider Relations (PRC) staff begins immediately to contact facilities and transportation providers. They initiate communication, explain the immediacy of the situation and need to act on limited information, and seek a commitment to assist. They explain that residents with other payer sources may need service and that YCLTC will pay for services rendered to YCLTC members. PRCs offer to identify AHCCCS eligibility for other residents upon request.
- ERT members obtain tuberculosis status/chest x-ray information on YCLTC residents from the relinquishing facility. YCLTC sends current information to the receiving facility.
- ERT members coordinate x-rays needed to transfer members. They verbally authorize use of Phoenix-based urgent care centers, hospitals or mobile x-ray units. If needed, contracted mobile x-ray providers located in Yavapai County are on-site within 3 hours.
- Upon arrival, YCLTC ERT members identify the Designated Coordinator, announce their presence, and offer assistance. They complete requested tasks and ensure YCLTC members' needs are being met.
- On-site ERT members meet with the facility's Administrator, Director of Nursing and other Program Contractors to coordinate efforts, modify the plan of action, and as seamlessly and expeditiously as possible, transfer residents to a safer location. Emergency Management personnel attend as able. This

meeting was scheduled within 30 minutes of initial notification and is held as soon as possible, preferably within four to six hours.

- On-site ERT members update AHCCCS, ADHS and Ombudsmen – who are already onsite in this scenario – and other appropriate agencies.
- On-site and office-based ERT members communicate frequently and coordinate efforts.
- CMs and other staff, with facility representatives, discuss conditions/issues with members and/or representatives to inform them of the potential for closure and possible relocation.
- Since the air conditioning will be out for four days and the outside temperature is an extreme 116°, it is apparent that all members will need to be relocated. Some members may be able to go home with their families during this time, and others will need to be transferred. YCLTC will authorize in-home services for members able to go home.
- YCLTC coordinates with other program contractors to work together to affect quick transfers to other facilities.
  - Contact current PCPs or their on-call service to notify and request transfer/admit orders concurrently with other activities.
  - Identify DME needs and arrange for moving equipment or obtaining new equipment to be delivered as soon as possible.
  - Arrange record duplication, packaging of medications and/or packing personal belongings prior to the arranged time of transfer. Assist with packing, copying, reassuring members as needed.
  - Offer to have Psychologist/Behavioral Health Coordinator meet with any members, family and representatives who indicate difficulty with move.
  - Identify transportation for each member and begin moves according to triage information.
  - Identify PCP assignment and pharmacy for each member or facility.
  - Ensure continuity in and access to other scheduled services such as dialysis, therapies, hospice and specialists.
  - Complete the transfers.
  - Make on-site visits the day of arrival with the members at the new facilities to ensure the members are transitioning well.
- Within 3 days of transfer, YCLTC will:
  - Review financial matters including patient trust funds and SOC
  - Request other information that may be needed to determine the facility's viability for the planned return of the members. BBA letters to members/families/representatives will be prepared in Prescott and faxed to the facility for the CMs to give to members refusing to leave the facility; though it is likely that the City of Phoenix will not allow the member to stay, even if they want to, due to imminent safety risk.
  - Maintain current assessment of each member for tracking and trending purposes until permanent placement is achieved.
  - Identify new PCPs and CMs, if transfer is permanent.
- Within 7 days of transfer, YCLTC will debrief and identify improvement opportunities.

It is YCLTC's philosophy to assist facilities, when appropriate, to remain open and to permit members to remain in the SNF or ALF if that is their choice. In this situation of extreme temperatures, life safety issues would arise and the local fire officials and city officials may determine that immediate evacuation will occur. YCLTC would send a team to the facility to investigate and discuss the problem with facility staff and administration, members and their representatives. YCLTC would work closely with the facility, ADHS and the State Fire Marshal to problem-solve and find, if possible, a temporary solution to the cooling problem. In this scenario, the cooling problem is going to last for four days; therefore, transfer would be required with the extreme temperatures. When the problem is rectified, onsite monitoring would continue until the cooling systems were repaired and approved by The State Fire Marshal and ADHS.

In this situation, the only option is to assist members in relocating to another SNF or to home with family, if possible. When this occurs, every effort is made to locate a facility which most closely meets the medical/level of

care needs and personal desires of the member. If possible, a choice of locations is provided. Members' families and representatives play a key role in assisting members during the transition.

Providers are required to have a contingency plan for providing medically necessary services to YCLTC members in the event of an emergency or disaster, where the usual means for delivery or service provision is unavailable. Facilities are required to have evacuation procedures and documentation of drills performed. The provider is required to have a copy of the plan on-site and available for inspection by YCLTC at any time, and this is monitored by Provider Relations staff.

Finally, YCLTC is an advocate for training providers and staff about the importance of emergency preparedness. SNF and ALF providers receive training at provider meetings, through articles in the Provider Newsletter, and through individual meetings with Provider Relations staff during contracting and monitoring.

Overview of Quality Improvement at YCLTC

YCLTC has been providing quality healthcare services as a contractor for AHCCCS since 1993 to the elderly and physically disabled Medicaid population in Yavapai County. During these last 17 years we have attained great outcomes which validate our commitment to quality. Our work includes measuring performance and developing reports to share our performance results. Our Quality Management (QM) Unit regularly reviews for information on the websites and/or participates in e-mail notification from the Centers for Medicaid and Medicare, Institute for Healthcare Improvement, National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set tool, the Arizona Department of Health Services, individual membership in the Arizona Association for Healthcare Quality, the Agency for Healthcare Research and Quality for such information as mortality measures, hip fracture data, facility reviews and quality issues. We research the current clinical practice guidelines, professional studies, attend seminars and review the literature to learn how we can improve the quality measures for our membership, discussing, brainstorming and searching for alternative methods to incorporate into our processes. We regularly evaluate the impact of any new and established methods and assess steps needed to improve care. We authorize quality medical care without regard to payor source or eligibility category. We have established processes reflected in policy and procedure documents, specifically QM: 01 – entitled "QM Program" to assess, plan, implement, evaluate and report QM activities. Our policies and quality processes are based on Chapter 900 of the AHCCCS Medical Policy Manual.

Example of a Quality Initiative

Our diabetic members were not obtaining diabetic retinal exams as desired to meet the benchmark. The problem was how to get more members in for these assessments. Several internal unit meetings were convened to identify barriers to meeting the AHCCCS benchmark and to ensure our members received needed care that would enhance their quality of life while maintaining cost effectiveness. We began by modifying an existing Disease Management (DzM) database; added fields and created a follow-up report that gives summarized information on when labs and retinal exams are next due. We initiated our improvement efforts through education and created a brochure that was specific to the member. The brochure included information on the member's most recent exam dates for lipid profiles, HbA1c and dilated retinal exams. YCLTC DzM nurses conducted follow-up telephone surveys to evaluate the effectiveness of our efforts by asking the member if they had taken any action regarding the retinal eye exams and other tests related to their diabetes. Prior to calling the members, we began data collection efforts two months after distribution of the brochures to narrow down the number of telephone calls that needed to be made. First, we reviewed claims on those members to see if any new claims data for the examinations was available. Second, in the absence of claim data, we checked our transportation services logs to look for trips to the eye doctor. Next, we faxed the PCP to see if any results were available from those who were still without eye exams in the recommended period. We gave the most recent ADA Clinical Practice Guidelines to the PCP's office. In addition to these Guidelines, the DzM nurses created a "quick desk reference" to be used by the PCP staff explaining what labs and eye examinations are required for YCLTC diabetic members. The DzM nurses went the extra mile in trying to gather the data by calling the individual members if it was noted that the member did not receive the needed eye examination or the lab work. During the conversations with the members, it became clear that there was confusion regarding the type of eye examination that they needed. Many members did not realize that an eye examination solely for the purpose of getting eyeglasses was not the same as a dilated eye examination which is necessary for the detection of retinopathy. The nurses took this opportunity to educate the members on what retinopathy is, how it is detected and how it can be prevented or treated.

YCLTC conducted further brainstorming sessions and decided to continue the use of repeated telephone calls with the members and faxes to the PCP offices to see if a more personal interaction would help. These efforts were successful. We began seeing our numbers improve and to this day we send the brochure annually, print off reports from our database weekly and use a simple method of a telephone call and a fax to the PCP reminding them of what examinations the member needs for health maintenance of their diabetes. The Minimum Performance Standard (MPS) of 60% for retinal exams was not met in 2007 at which time YCLTC scored a 57%. We were able to raise the dilated retinal eye exam rate to 62.4% for 2008 and again another increase to 67.8% for 2009.

Collaboration within YCLTC

Our results are based on the coordination and cooperation of team members in all YCLTC departments. For example, the data analyst from the Business Office updates our databases, conducts queries for requested information and performs quality control testing on the databases used by the Medical Services Unit. The Business Office also provides claims data to the DzM nurses – usually the same day and often within an hour or two of the request. The Transportation Coordinator from the Administrative Services Unit creates reports for us so we can determine utilization of services. We work closely with the Care Management Unit to remind our members of the need for follow-up with their PCPs. When the Care Manager is meeting with the member quarterly, we realized that this is another great opportunity to remind the members to follow up with their PCPs.

Our pharmacy nurse runs reports on medications and our Utilization Management (UM) nurse notifies the DzM nurses when our members are in the ER or admitted to the hospital. We fax the face sheet from the hospital to the PCP to be sure the PCP is aware of the visit or admission. Our Provider Relations Coordinators (PRC) are consulted whenever there is an issue with a provider in an effort to promote provider satisfaction while also promoting regulatory and contractual compliance.

YCLTC believes that if we can positively impact our members' health, we can help them to achieve and maintain the maximum level of independence possible; often this will translate into their ability to stay in their own homes and maintain a more independent approach in activities of daily living. Through education and encouragement, our members will be empowered to obtain a better control over their Diabetes. This self-empowerment will help minimize emergency room (ER) utilization and inpatient hospital stays. The members will also have the satisfaction of knowing that they can make a difference in their health status.

Continuous Education of our Members and Providers

Our DzM nurses and staff Physical Therapist conduct many training sessions throughout the year at the Assisted Living Facilities (ALF), Skilled Nursing Facilities (SNF), member council meetings and individually with members in their home. One of the DzM nurses; Transition Coordinator and the Behavior Health Coordinator have received training in the Stanford Chronic Disease Self-Management Program (CDSMP). This training will facilitate workshops in our community in alliance with Yavapai County Community Health Services to promote self-management for our membership and community. This program has a proven success record for the attendees, and facilitates formation of techniques to deal with a multitude of areas such as frustration, fatigue, pain and isolation; flexibility exercises; appropriate use of medications, effective communication skills with their family, friends and healthcare providers. We are looking forward to analyzing and collecting data after the implementation of this program to determine it's effectiveness in the long term care population and our community in general.

Transparency

Our Performance Measure results are available to the public via the Yavapai County website and on the AHCCCS website. We publish quarterly provider newsletters that report on the results of our improvement strategies. We also report this data to the Quality Management and Performance Improvement Committee (QMPI) quarterly. The semi-annual member newsletter educates our members about the YCLTC website, self-management of chronic illnesses and of taking appropriate preventative measures. Annually we report to the YCLTC QMPI Committee which is chaired by our Medical Director on the evaluation of the QMPI program activities. After review and approval by the committee, the report is sent to the Yavapai County Board of Supervisors for review and approval. Once approved, the report is submitted to AHCCCS by December 15th annually.

Performance Measures

Performance measures are drawn from nationally accepted standard measure sets. These numbers are meaningful to both providers and patients as benchmarks of how their provider is performing on their behalf. The data is reviewed by the QM nurses to ensure accuracy and reliability as well as by the YCLTC Data Analyst. Providers are given information in the provider newsletters, member council meetings, group and individual provider meetings and during internal committee meetings on provider performance. During onsite visits, the QM nurses

discuss with the provider their findings of the monitoring review; the nurses offer resources and support to the providers to help support the members to achieve the best possible outcomes. Each visit to a facility or a provider is followed up with a letter from the QM staff explaining in detail the results of the visit. The providers are encouraged to contact YCLTC QM staff with any questions or comments. YCLTC promotes an environment of open communication with all the providers.

Sources of Quality Information

Routine reports are run from our internal databases and analyzed. Scrutiny of this data, and correlated research, will prompt a new quality initiative, such as the question of why pneumonia is routinely the primary diagnosis for ER and in-patient admissions.

Multidisciplinary and Individual Team Meetings

When a member is identified from analysis of the data and review of decision criteria (AMPM, Medicare guidelines, InterQual Evidenced Based Clinical Decision Support) to be increasing utilization inappropriately or not utilizing services appropriately, the nurses, care managers, supervisors, and the medical director meet to discuss these findings. A team approach with discussion from various members of the staff review each case and come up with ways that can help our member to achieve the best health outcomes with the most cost effective methods. For an example, we have a member that was going to the ER almost every week for the last 22 weeks. This member was extremely ill and appropriately transported to the local ER. Despite several attempts by the DzM nurses to educate her regarding her illness, these ER visits continued. A review of her medical records, consults with her CM, discussions with this member's significant other all revealed that this member had very pronounced short term memory loss. She was unable to retain any instructions given to her by nurses, doctors, etc. She refused to live in an ALF and felt that she was managing quite well on her own, in her own home. To ensure her safety, YCLTC provided a Home Health nurse (HHN) to visit her three (3) times weekly, and we also consulted with the County Public Fiduciary. The Public Fiduciary, who had previously been involved with this member, agreed to make a visit to her home to evaluate the situation.. The YCLTC multidisciplinary team, being respectful of honoring her desire for self-determination, reviewed the data to ascertain how she was responding to the HHN visits. At this point, since the HHN has been placed, the member has been to the ER only once in the last month. We continue to closely monitor this member for the most desired outcomes.

Quality of Care Investigations

Each staff member of YCLTC is charged with reporting any potential Quality of Care (QOC) issues that they are aware of to the QM nurses. The nurses investigate these issues through medical record review, interviews with CMs, discussions with the PCP, family members and the member as appropriate. Interventions are put into place to correct any deficiencies or system issues as identified during the investigation. If a trend is identified, further investigation, data collection and analyses are initiated and conducted. Some of the reports reviewed include the following: database entries regarding ER visits, inpatient hospitalizations, drug utilization review related to over/under utilization, narcotic usage, new medications, polypharmacy issues such as Tylenol aggregate in multidrug prescriptions for a single member, multiple hospitalizations in a 30 day period, hospitalizations related to a chronic illness that is exacerbating, CM notification of potential issues at facilities, incident reports received from providers, fall reports, and transportation costs – especially for refusal of scheduled transports – to identify any potential problems with the member not keeping a scheduled appointment. Occasionally a QOC requires review by the Peer Review Committee, which is chaired by the Medical Director.

Conclusion

YCLTC has made a commitment to seek and identify barriers to healthcare, over/under utilization of healthcare, inappropriate use of benefits, strategies to improve the delivery system, identification of the most cost effective services, the potential for new medical technology, provider satisfaction issues, provider education opportunities, and filling voids in the network. We diligently maintain patient confidentiality in our processes in accordance with Federal and State requirements. We continue to promote and improve quality of care and positive patient experiences.

YCLTC is committed to provide quality care and service to our members and to provide excellent support and resources to our providers. Member satisfaction is very important to us. Our goal is to improve quality of care for our members that is cost-effective and meets the standards of clinical practice guidelines. Whenever an opportunity is identified, whether a trend is identified from review and analysis of data, from a grievance, or from an incident report, we take action. We encourage our members, employees and providers to immediately inform us of questions, concerns, or problems related to long term care services. We encourage this notification and communication via care manager assessments, member/provider council meetings, newsletters to members and providers, mandated AHCCCS member satisfaction surveys including the quarterly verification of services received survey, at staff meetings, at external training with ALFs and SNFs, during monitoring, and other appropriate intervals concerning quality of care.

All complaints/grievances are taken seriously and thoroughly investigated upon receipt regardless of time of day so that matters of dissatisfaction can be promptly resolved. We have often sent nurses to facilities in the evening or early morning hours to observe the quality of care our members receive. Our members are a vulnerable population and we understand their dependence on our efforts to maintain quality of care services. If a facility or a provider has had any recent issues, they are closely monitored for as long as deemed necessary. We continue to closely monitor a facility that had a corrective action plan from early 2009.

Other sources of quality of care concerns include:

- Incident reports
- PCP change requests
- Contractor change requests
- Care Management audit results
- Quality Management and Provider Relations audit results
- Appeals and Claim Disputes

During an investigation of a complaint/grievance the first review is completed to determine if a Quality of Care Concern (QOC) exists. If during the investigation, quality issues other than the original one are identified, it is determined if the issue is systemic or an isolated incident. Data gathering begins immediately through discussion with the originator of the complaint/grievance, review of the medical records, discussion with the provider and other team members as appropriate, including the medical director to determine if a trend is present, if immediate jeopardy exists, if there is a need for immediate action or if there is no immediate risk. Various database (db) reports are analyzed to identify any adverse trends that require investigation, such as the QOC db, Incident db, Fall Tracking db, PCP change request db.

Notifying the care manager of an issue is typically the first step for a member. Occasionally, a complaint will come from family or friends. Complaints received from a community member are processed the same and are taken as serious as any received from all other previously mentioned sources.

A member example

We received a complaint from a concerned citizen in the community that the food was being rationed at one of our contracted SNF facilities and that they had knowledge that the amount of food was decreased and source of the food was changed to save money. We immediately discussed this with the care manager assigned to that facility who was not aware of any problems. We became aware of this complaint around 2:00 pm and determined a site visit during the dinner hour was necessary. A Care Manager and a Quality Management Nurse observed the residents eating their food and asked questions regarding how the food tasted and if they usually get enough to eat, etc. The nurse toured the kitchen and looked through the cabinets. She spoke with the cooks who felt they had appropriate food for the residents. We found the complaint to be unsubstantiated. If this complaint was substantiated, we would have looked at it from several perspectives, including our own internal operations. We would have put into place some processes to check the quality of the food at random intervals and incorporate those monitoring efforts into our routine. The Care Manager would have been advised to visit regularly during

meal hours to identify any issues. We also would have conducted a survey of our members and their perspective on the quality of the food and the food proportions.

A provider example

We have a commitment to our providers and our members that services offered by our providers are safe, medically and financially effective, member centered, efficient and also equitable to the provider. YCLTC staff is comprised of highly experienced and qualified professionals. We have strong problem solving techniques primarily based on excellent interdepartmental communication routines.

Most publicly reported quality indicators are process measures. Processes are the place we look to make changes to improve outcomes. Our providers are encouraged to communicate with us and we provide rapid response to any complaints, suggestions, survey results or other assessment process. When we receive information from a provider we analyze the process components and compare what we are doing with regulatory requirements to ensure that they are appropriate. Next, we determine if any process change will result in improved outcomes. For example, at a SNF meeting, providers asked that the number of reports required by contract be reduced. They explained their perspective, discussed the value of the reports and described their processes for documentation. After the meeting, QM and PR staff assessed the request, reviewed regulatory requirements and changed the contractual reporting requirements. The improvement reduced the provider's administrative burden without diminishing quality of care to members.

YCLTC modified its prior authorization (PA) process in response to provider complaints. Our PA requirements were perceived as onerous and a barrier to care. At least one provider cited the PA process as the reason for their contract termination. YCLTC responded to these complaints by convening a Process Improvement Team (PIT) comprised of individuals from each unit. The Team reviewed comprehensive utilization reports, denial rates, payer sources and potential for fraud. It discussed PA requirements by service category, beginning with PCPs and specialists, and by payer source. The Team discussed the impact a change would have on member care, allocation of provider and YCLTC resources, financial forecasting and coordination of care. It evaluated how changes would impact each unit's processes and collaborated on systemic changes. The Team thoughtfully and carefully made changes. At first, the changes were minimal. As the results were evaluated and found to be positive, additional modifications were made. The PA PIT worked together for about 18 months, eventually publishing a "CPT Code Summary for Prior Authorization" and "PA Guidelines". YCLTC continues to formally review its PA process at least once a year.

YCLTC implements an integrated, multi-disciplinary approach to monitor and evaluate HCB services and sites, members' access to services, receipt of appropriate care, availability of services and timely delivery of services. YCLTC identifies service-related issues through contacts with members and providers, the Quality of Care (QOC) report process, Member Council meetings, Multidisciplinary Team (MDT) meetings, member and provider satisfaction surveys, provider monitoring and member satisfaction noted during the reassessment process. Care Managers (CM), Quality Management (QM) nurses, Provider Relations Coordinators (PRC) and others collaborate to perform various monitoring activities. Such activities include identifying member care issues, investigating quality of care concerns, monitoring contractual compliance, and analyzing data.

HCB services and service sites, including home-based, behavioral health, acute care and assisted living facility (ALF) services, are monitored through various reports. YCLTC tracks, trends, and analyzes service issues identified in verification of receipt of services surveys, service gap logs, compliance reports, member grievances, member appeals and provider disputes. At times, caregiver timesheets are compared with authorization information to determine if services were provided. CMs request behavioral health provider notes to track members' progress, verify service delivery, and identify service issues. PRCs ensure home care providers conduct on-site caregiver supervision at five, 30, and 90 day intervals as required by AHCCCS. The YCLTC financial analyst monitors over/under utilization through claims analysis and quarterly financial analysis.

YCLTC monitors routine, urgent, and emergent appointment schedules for primary care providers (PCPs), specialists, and behavioral health providers to ensure service availability. YCLTC monitors wait times, after hour care and required back up coverage through on-call contacts, member grievances, staff communications and provider self-reports.

YCLTC's MDT monitors and addresses complicated care issues. Referrals to the team may come from any YCLTC employee through their supervisor. The Medical Director leads the team, reviewing current care and standards, identifying the unique needs of the elderly or disabled member, and determining recommendations for continuing care and follow-up. The team reviews appropriateness of care based on member needs, availability of and access to services, cultural preference, program limitations, and medical necessity. PRCs ensure providers meet ADA requirements, provide care as scheduled, and that members have easy access to service sites.

Monitoring Assisted Living Facility Sites and Services In conjunction with QM nurses, CMs and PRCs are responsible to monitor ALF sites and services. YCLTC has the authority to train ALF managers and caregivers and to certify Adult Foster Care (AFC) homes through a delegation agreement with ADHS. As part of this agreement, YCLTC also monitors AFCs on behalf of ADHS. Staff reviews compliance with State and Federal Regulations and contractual obligations at regular intervals throughout the year to ensure continuous compliance with certification, licensure, contract requirements, and regulations as defined by ADHS, State, Yavapai County standards and regulations. ALFs are monitored according to approved standards and indicators that include, but are not limited to:

- Member satisfaction
- Compliance with ADHS standards
- Infection control
- Menu planning
- Current ADHS licensure
- Member appearance/hygiene
- Proper medication monitoring
- Quality of care issues
- Medication and treatment issues
- Monthly wellness checks
- Accurate documentation
- Single Occupancy in ALCs
- Incident reporting, safety, and facility issues
- Service plans
- Environmental standards
- Activities/socialization planning

Care Management Care Management actively monitors HCB services and service sites. CMs monitor service delivery, timeliness, quality and member satisfaction at each 90 day visit and through daily interactions with members. A Care Management Supervisor (CMS) completes routine audits to monitor CM actions and YCLTC

processes. Issues are addressed and results monitored; additional interventions are implemented as needed and then reviewed until expected outcomes are achieved. Routine audits review timely delivery of initial services, completion of home modifications, and wheelchair/repairs activities. Other audits ensure receipt of services, timely processing of service requests and access to care. A CMS also monitors timely delivery of behavioral health services in the quarterly CM audit to determine if routine BH services were provided within 30 days of referral and emergency BH services were provided within 24 hours of referral.

The CM informs members of their right to receive services as scheduled, encourages them to contact YCLTC or the provider if a service gap occurs, and provides them with forms to complete and mail to YCLTC in the event of a service gap. When a member or provider notifies YCLTC of a gap, YCLTC ensures the gap is resolved, and enters the gap information into a database. CMS and PRCs track reported service gaps on a monthly and as needed basis. If a trend is identified, the PRC requires the provider to submit a written corrective action plan, monitors compliance with the plan, and intervenes until the plan sufficiently corrects the problem.

Quality Management QM nurses monitor home health, hospice, out patient services such as dialysis centers, transportation providers, Assisted Living Facilities (ALF), pharmacy services, DME and medical care providers such as PCPs, specialists, hospitals as scheduled and through investigation of quality of care concerns. Monitoring is completed through desktop reviews, on-site reviews, and interviews. On site reviews are completed for ALFs and as needed for hospice, hospitals, out-patient center providers. Desktop reviews are commonly performed for hospitals, home health agencies, transportation providers, out-patient centers and services, DME, pharmacy services, and hospice.

QM nurses are informed of potential issues through the QOC process. As QM nurses investigate and resolve QOCs, they identify systemic trends, and communicate issues to the management team and PRCs. On-site reviews of the PCPs and specialists are completed triennially in coordination with the credentialing process and can also occur as a result of an investigation of an active QOC. ALFs are monitored annually in coordination with PRCs.

In the monitoring process QM nurses use AHCCCS Medical Policy Manual (AMPM), federal and state regulatory agencies, professional associations, such as American Diabetes Association, National Comprehensive Cancer Network, Agency for Healthcare Research and Quality, our own internal monitoring tools and the peer review process. The monitoring process usually begins with requesting medical records, speaking with providers, researching prior QOCs to identify any trends, talking with YCLTC staff and Medical Director, researching peer-reviewed journals and regulatory agency findings and applying InterQual Criteria.

Provider Relations Coordinators PRCs ensure HCB services are accessible and available during the contracting process with providers. They address individual concerns as they arise and coordinate care between providers as needed.

Prior to annual HCB service monitoring, PRCs review the AMPM, solicit input from internal references and prior years findings, and review contractual requirements to determine what items to include in their monitoring. PRCs expect consistent and clear documentation of service delivery, and are vigilant for inconsistent or contradictory information regarding service delivery. YCLTC anticipates it will add further program integrity measures in future HCB service monitoring, such as; OIG website verification for personnel selected for review, direct care worker (DCW) training compliance, cross match between hospitalized members and their NPS log entries and HCB claim records.

Arrangements are made with the Provider for routine contract audits. YCLTC sends the audit tool to the Provider prior to the monitoring appointment. YCLTC randomly selects records for review and completes independently verifiable items prior to appointment. At the appointment, the PRC reviews Provider records for contract compliance. Upon completion of review the PRC provides oral preliminary findings to the Provider, requesting clarification of items discovered during the review when necessary.

YCLTC PRCs include the following in HCBS monitors:

- Verify Provider supplied required information and documents to meet credentialing requirements including current licenses and adequate insurance coverage;
- Solicit YCLTC internal references regarding incidents of grievances, fraud, abuse, QOCs, including responsiveness to Care Management and claim processing;
- Research of member or family-initiated grievances and QOCs;
- Verify Organizational qualifications, including the qualifications of staff – various health and background clearances, education and experience requirements;
- Observe compliance with authorization requirements;
- Audit accuracy of claim submissions – review service delivery documents and time sheets to ensure accurate support of Provider's claim submissions;
- Ask open-ended questions regarding Provider relationship with YCLTC to identify potential issues before they become grievances;
- Review other requirements specifically delineated in the AMPM for specific service categories including Attendant Care, Personal Care and Homemaker services; Self-Directed Attendant Care and Direct Care Worker requirements.

Addressing Non-Compliance YCLTC's highest priority is member safety. If provider non-compliance is assessed to jeopardize member safety and well-being, YCLTC intervenes immediately and takes necessary actions to safeguard the member(s). Then, YCLTC formally addresses the systemic issues.

Although the QOC process and other monitoring processes are completely distinct and separate, the resolution processes are very similar. The QOC process is highly confidential, actions are only completed by the Medical Director or Medical Services unit and actions are documented in a secured QOC database. Medical Services staff includes QM nurses. All QOC-related letters maintain confidentiality of the findings according to state statutes. If a QOC meets severity criteria, appropriate state agencies and regulatory boards are notified, as well as AHCCCS and ADHS. Occasionally federal agencies are also notified. By contrast, monitoring activities are completed by all levels of YCLTC staff and findings are documented in provider files.

Providers are notified when investigation of a QOC or monitoring activities reveals a deficiency. If the provider is a physician or PCP, YCLTC's Medical Director writes a letter requesting a response to the identified issues. Otherwise, the QM Coordinator or PRC communicates with the provider and gathers additional information.

QM nurses or PRCs analyze the data and determine if the issue is substantiated, unsubstantiated or unable to be substantiated. Substantiated issues are addressed and other issues are closed; all are documented. A letter is sent to the provider that states the deficiency; cites supporting regulations, rules, standards and/or contract provisions; and specifies a due date and response, usually a corrective action plan (CAP). The CAP describes how the provider will address the issue on a systemic and individual basis, and specifies actions and implementation dates.

Once received, the CAP is reviewed and either accepted, rejected or partially accepted. The provider is given the opportunity to modify the CAP so that it adequately addresses the deficiencies. Upon acceptance of a CAP related to a QOC investigation, QM nurses follow up at six months and as needed for assurance of continued compliance. PRCs and other staff may use different timelines in their follow- up plans for other CAPs. YCLTC reports CAPS related to significant issues to AHCCCS CQM.

The provider receives written notification of the requirements to correct the issue throughout the process until the issue is completely resolved. YCLTC works with the provider, offering technical support and suggesting resources. Providers can dispute YCLTC findings and explain their perspectives. Most providers collaborate with YCLTC in the resolution process and demonstrate a commitment to provision of quality care to members. Occasionally, providers are non-responsive. YCLTC intervenes by limiting referrals, communicating via certified mail, and, when needed, by terminating the contract.

D. PROGRAM – ORAL PRESENTATION Q.35

YCLTC is available to participate in a scheduled oral presentation.

[illegible] PROVIDER NETWORK

[illegible] PROVIDER NETWORK....180

36. Network Development and Management Plan....181
    a. Current Status of the Network....181
    b. Network Development....196
    c. Internal and External Coordination....205
    d. Network Design....209
    e. Network Management....220
    f. Evaluation of Previous Year's Plan....234
37. [illegible] Exemption....242
38. Provider Communication....243
39. Provider Issues....246
40. Provider Inquiries....249
41. Provider Staff Training....252
42. Provider Staffing Levels....255
43. Loss of SNF, ALF....258
44. Provider Performance....261
45. List of Providers....264

YAVAPAI COUNTY LONG TERM CARE'S NETWORK PLAN
CYE 2012

INTRODUCTION

Yavapai County Long Term Care's (YCLTC's) Network Development and Management Plan is written to effectively meet the immediate and long range needs of its ALTCS population, to sufficiently provide diverse, flexible, timely and accessible covered services to YCLTC members as dictated by member needs. It ensures that member needs dictate the amount and schedule of Home and Community Based Services (HCBS) and that services are provided 7 days a week, at extended hours. It implements safeguards to ensure members are able to access the same amount and duration of services with the same ease and timeliness as community members. The plan outlines YCLTC practices that address use of out of network providers and resolve network gaps. It describes YCLTC's involvement with Work Force Development and external organizations. The plan is evaluated each year to identify accomplishments and areas of needed improvement. It is then modified to reinforce strengths and to address areas of needed improvement.

The Plan promotes member placement in their own home rather than a skilled nursing or assisted living facility, encourages family caregivers and other informal support systems through the provision of respite services and adult day health programs, supports member-centered care, ensures development of services that can meet the needs of members with cognitive impairments, behavioral health needs and other special medical needs, and supports provision of care to members by paid family members or their friends through the Self-Directed Care or Attendant Care programs.

Additionally, the Plan describes the process YCLTC uses to analyze its network, describes services by type included in the network, and outlines processes used to respond to gaps in critical services as well as those related to newly identified needs. It is implemented and supported by YCLTC's Director, Medical Director, CFO, Provider Services Manager and staff, Provider Claims Educator, Dispute and Appeals Manager, Compliance Officer, Behavioral Health Coordinator and Credentialing Coordinator.

The CYE 2012 Plan addresses accessibility of services to YCLTC members; prompt and reasonably accessible services in terms of location and hours of operation; sufficiency of personnel for provision of all covered services including emergency care on a 24 hour a day, 7 day a week basis; and places a priority on allowing members, when appropriate, to reside in or return to their own home and receive services as the member needs them, even if 7 days a week and at extended hours.

1. CURRENT STATUS OF THE NETWORK BY SERVICE TYPES

YCLTC has assigned the Program Development Unit the primary responsibility of managing the provider network. The unit ensures the member-centric provider network will adequately meet member needs in the provision of timely, accessible services that are as accessible to YCLTC members as to non-YCLTC persons in the same service area. It identifies service needs, identifies and recruits potential providers, negotiates and writes contracts, educates and supports providers, monitors contractual compliance, addresses provider concerns, manages credentialing activities, and facilitates the contracting process for appropriate providers.

YCLTC has a well-developed network consisting of approximately 500 providers, many of whom have been partnered with YCLTC over 10 years, have multiple locations or offer more than one type of service. The number of new contracts was expected to decrease in CYE 2011, and this was realized as YCLTC executed approximately 20 contracts with new providers to date in CYE 2011. Seventeen were for PCP and specialist services. YCLTC expects to continue to maintain a stable network throughout the term of the AHCCCS contract.

YCLTC does not discriminate against providers based on type of licensure or certification, on provision of services to a high-risk population, on specialization in conditions that require costly treatments, or on advocacy for members. YCLTC limits the network based on member needs and has established cost-saving, quality-ensuring measures to ensure the network meets program requirements. YCLTC uses different reimbursement

amounts for different providers within the same specialty, if appropriate. YCLTC gives written notice to affected providers if YCLTC does not include them in the network, giving the practitioner reasons for the action. YCLTC's network does not include providers who have been excluded from participating in federal health care programs.

YCLTC's network is sufficient in the amount, duration and scope to reasonably be expected to meet individual member needs. YCLTC does not arbitrarily base a decision to deny or reduce the amount, duration or scope of a service for a member solely on the member's diagnosis, type of illness or condition. However, YCLTC does appropriately place limits on a service based on medical necessity or utilization criteria, if the provided services are expected to achieve their purpose.

Yavapai County's rural geography presents a unique challenge to service delivery due to the limited number of qualified providers in the area. Oftentimes, YCLTC must recruit providers from other counties, such as Maricopa and Coconino in order to meet member needs. Specialty physicians and behavioral health services are often obtained from these neighboring areas. Only one skilled nursing facility in Yavapai County has the ability to admit members with significant disruptive behaviors, however, it requires those behaviors to be stable. One Yavapai County-based assisted living facility offers high staff-to patient ratios to provide care to members who wander or exhibit problematic behaviors.

YCLTC has obtained contracts with four assisted living facilities in Maricopa County with high staff-to-patient ratios, two residential treatment agencies, four skilled nursing facilities with behavior units in Maricopa County, and one facility each in Pima, Mohave and Pinal Counties in order to meet the behavioral health needs of our members. YCLTC has also contracted with one pediatric skilled nursing home, one wandering dementia facility, two hemodialysis and two ventilator care nursing facility and three subacute facilities in Maricopa County, as well as two subacute and two wandering dementia facilities in Gila County.

Acute Care

YCLTC's network for acute care services includes 4 hospice agencies with service provided state-wide, 2 urgent care centers, 4 dialysis centers with services provided state-wide, dietitians available through the outpatient services of 5 hospitals, 2 infusion companies, and 8 providers of laboratory, radiology, medical imaging or interpretive services with additional services available through hospital outpatient services. YCLTC contracts with 4 surgical centers, two urgent care centers and three outpatient eye surgical centers with 6 locations. The network also includes community health centers. All services are available county-wide.

YCLTC is contracted with 5 hospitals, one of which is a rehabilitation facility and another provides care to children. The business model of the two hospitals in the Prescott area is to offer cardiac services at one site and OB/GYN and neonatal services at the other. Transportation is available to transport members to the appropriate site after they have been stabilized.

YCLTC's contracts with providers of acute care services, such as rehabilitation therapy, dialysis, durable medical equipment and supplies, urgent care, infusion and ventilator management, are sufficient to meet the needs of YCLTC members. YCLTC uses AHCCCS' specialty contracts for transplant services and anti-hemophiliac agents and pharmaceutical related services.

YCLTC reviews Medicare Advantage Plans that serve Yavapai County as a preliminary step to formalizing relationships. At this time, YCLTC does not have a formal agreement with a Medicare Advantage Special Needs Plan (MA-SNP) and in 2011 only one MA-SNP was available to Yavapai County residents. YCLTC is committed to pursuing a contract with a Medicare Advantage Plan and continuing the discussions that began in CYE 2011.

Members have access to non-emergency services provided by non-contracted MAP providers through the prior authorization process. Medicare-covered services provided to dual-QMB members do not require prior authorization.

YCLTC has explored the possibility of partnering with other stakeholders within Yavapai County to develop an accountable care organization (ACO). Participation by several larger entities, including the community health center, and established electronic health systems are requisite to a viable ACO. To date, the community health center has not expressed interest in collaborating with others to create a new delivery system and the infrastructure for an electronic health system has not been developed. Therefore, YCLTC will continue to participate in community conversations with interest in the development of an ACO as a long-term goal.

Alternative Residential Settings

YCLTC is currently contracted with 32 Assisted Living Facilities (ALF), 28 of which are located within the boundaries of Yavapai County. Although this meets the AHCCCS mandated requirement of 20 contracted ALFs within Yavapai County, YCLTC, based on historical events, expects the number to fluctuate. Three contracted ALFs in Yavapai County and several contracted ALFs in the Phoenix area provide services to members with specialized needs. YCLTC recently negotiated a contract to provide specialized services in an ALF located in the eastern portion of the county.

Over the past year, YCLTC's census of assisted living facility placements averaged about 112, 11% of our total enrollment. The average number and percent of ALF placements is slightly lower than last year; however, the overall HCBS placement is higher. YCLTC contracted facilities have capacity to accept more members and YCLTC does not have a waiting list for ALF placement. The current network of ALFs is sufficient to meet the needs of our members.

YCLTC will continue its efforts to recruit home-like, quality ALFs into its network through staff and community outreach. YCLTC is committed to recruit new ALFs that can provide directed care, negotiate contracts, maintain relationships and monitor ALFs. YCLTC has one staff who is responsible for appropriate placement of YCLTC members into contracted ALFs. Another staff provides significant support to the ALFs, educating on State Statutes, Rules, Regulations and contract provisions; claim submissions; and facility and manager licensing issues. YCLTC expects to assist ALFs transition from roster billing to HIPAA-compliant billing in CYE 2012.

YCLTC will continue to support ALF sponsors through individual training, provision of at least 12 hours of continuing education per year, appropriate placements, discussion of issues, and assistance with problem solving. In the past, this support motivated facilities to remain contracted with YCLTC.

YCLTC has no plans to proactively expand the adult foster care network. However, YCLTC will continue to discuss service requirements with potential AFC sponsors. YCLTC's experience has been that most AFC sponsors do not realize the impact of incorporating elders into their families despite bi-weekly respite, and terminate their contracts after a short time.

YCLTC is additionally contracted with Level 2 and Level 3 alternative residential treatment homes for adults, Level 2 and Level 3 alternative residential treatment homes for adolescent girls and adolescent boys, and is pursuing a contract with a group home for the developmentally disabled.

Ancillary Services

One provider is contracted for custom, non-custom durable medical equipment (DME), and disposable medical supplies; another 2 providers provide specialized DME and 3 provide prosthetics and orthotics. One immunization clinic providing county-wide services is contracted.

YCLTC contracts with allied professionals: 4 individual occupational therapists, 25 physical therapists and 4 speech language therapists; 5 home health agencies to provide in-home therapies; and 5 facilities to provide out-patient therapy.

YCLTC has a contract with a pharmacy benefit management company that subcontracts with local pharmacies. Members are able to choose among 66 retail and mail-order pharmacies. An additional 7 specialty pharmacies are located out of state. YCLTC is also contracted with an immunization clinic.

All services are available county-wide.

Behavioral Health Services

YCLTC's network for behavioral health services includes contracts with one Level 1 sub acute behavioral health facility and three outpatient facilities, two located in Yavapai County and one with locations in Williams and Flagstaff. YCLTC's network also includes contracts with five psychiatrists; twelve psychologists, two of whom are neurological specialists; five licensed clinical social workers; one licensed family and marriage therapist; one licensed professional counselor, and one licensed independent substance abuse counselor. The network also includes contracts with a health clinic in Flagstaff that provides BH services in northern Arizona, a practice group that is willing to travel to Yavapai County if someone will provide them with a full day's schedule, and a practice group in Phoenix that offers services in the Phoenix metro area. The network also includes two Community Service Agencies, one Level 2 RTA and one Level 3 RTA admitting adults, and two Level 3 RTAs with several locations that serve children.

Based on trends, YCLTC expects to see a continued increase in the utilization of behavioral health services and in the need for more specialized services. Although its current network is expected to be sufficient to meet future needs of most members, some services are only available outside Yavapai County. There are not a sufficient number of psychiatrists in Yavapai County to meet the needs of the general public. YCLTC is contracted with the RBHA provider in the Verde Valley area and with another non-RBHA behavioral health outpatient clinic in the Prescott area. Members may also receive service from contracted psychiatrists outside Yavapai County.

YCLTC worked with a provider who modified an assisted living center to meet the needs of members with problematic or wandering behaviors. Addition of this provider gave YCLTC members the opportunity to receive these services within their own county and in a more integrated setting. YCLTC also expanded a contract to include a Level 2 behavioral health residential group home for adolescent girls. Although there is no immediate need for this service, it diversified and strengthened the network. YCLTC will continue to pursue contracts with additional providers, residential treatment centers, and assisted living facilities, if willing and available, that provide behavioral health services as part of their per diem.

Members requiring inpatient psychiatric care are able to receive these services from their choice of two providers within Yavapai County, be stabilized, and then discharged to the most integrated setting. YCLTC's network also includes assisted living facilities that care for members with traumatic brain injuries, dementia, challenging behaviors, or end-of-life conditions.

Since 2007, YCLTC has collaborated with an Alcoholic Anonymous' subgroup, Cooperation with the Elderly Community, to bring support groups for substance abuse and alcoholism into skilled nursing homes. These services are available to any interested nursing facility and open to people who live in or outside the facility. Although few members utilize this support, YCLTC will continue collaboration efforts.

YCLTC will continue networking for behavioral health services as part of an ongoing process of evaluation, recruitment and assessment. YCLTC will also continue to contract with assisted living and skilled nursing facilities that deal specifically with members exhibiting difficult behaviors or with behaviors that could cause harm to the member or others. YCLTC will continue the triage program that is designed to reduce the number of placements in behavioral health facilities and to support the buddy-up program designed to facilitate a stress-reduced move of members to an assisted living environment.

YCLTC's network of behavioral health service providers is reasonably expected to be sufficient to meet member needs.

Emergency Services
YCLTC is contracted with all hospitals located within Yavapai County and Flagstaff. There are 3 hospitals in western Yavapai County, 1 in eastern Yavapai County and 1 in Flagstaff. The YCLTC network also includes Phoenix Children's Hospital in Maricopa County. Members are able to receive care in non-contracted hospitals as reimbursement rates are set in statute and hospitals are willing to work with YCLTC. Emergency and hospital care provided by qualified medical professionals to provide pre-hospital, emergency care is available to YCLTC members 24 hours a day, 7 days a week.

YCLTC's network includes urgent care and surgical centers, PCPs and specialists, labs and testing services and other medical services necessary to rule out emergency conditions.

YCLTC does not contract with ambulances, however has working relationships with 22 ambulance companies throughout the state of Arizona and pays according to state regulations. The absence of contracts is not a barrier to provision of care to members.

Home and Community Based Services
YCLTC currently has contracts with 11 home care agencies that provide attendant care, homemaking, and personal care; 6 that provide home health services, 10 that provide respite care, 4 that provide habilitation services and 2 that provide self-directed attendant care-related services. Critical services are available 7 days a week and for extended hours.

YCLTC currently has a sufficient number of contracts to provide critical services, habilitation, home health, emergency alert, home modification, adult day health care, group and individual respite and home delivered meal services to members as needed. One contracted provider delivers pre-ordered meals to members' homes via UPS or FedEx. This allows members who reside in outlying areas to receive daily meals and others to choose their own menus. Nursing services for members who require more individual and continuous care is available through contracted home health agencies. YCLTC does not employ independent nurses to provide private duty nursing. The current network is more than sufficient to be able to meet member needs, even as the number and acuity of members at home increase.

YCLTC has contracts with two providers to assist members with Self-Directed Attendant Care. One provides fiscal employment services; the other training. We also have contracts with six home health agencies that can provide training to SDAC caregivers to perform limited skilled tasks.

New in CYE 2012, is our contract with an Independent Living Center to provide Community Transition Services. This service will enable members with limited resources to return to a home-setting. The provider is excited to partner with us in the provision of this service.

YCLTC routinely reviews network sufficiency and acts to maintain a network of quality providers to meet member and program needs. YCLTC has determined that six providers of critical home care services can reasonably be expected to provide care to YCLTC home based members. Therefore, YCLTC tentatively plans to reduce the number of home care providers when the next contracts are awarded in August 2012. The plan is in response to utilization review, program review, and provider request. It is subject to further evaluation before the RFP is released.

Institutional
YCLTC contracts with all 8 Medicare certified skilled nursing facilities located within Yavapai County and exceeds the minimum network requirements. One in-county facility provides a secured behavioral unit and two provide wandering/dementia units. YCLTC contracts with an additional 13 skilled nursing facilities located in neighboring counties, such as Maricopa, Gila and Mohave, to ensure that specialty units, such as behavioral, wandering, subacute, rehabilitation, ventilator, and pediatric, will be available to members as needed. The current network is sufficient to meet member needs at this time and has the capacity for increased utilization. YCLTC's goal is to provide services that enable members to remain at home if appropriate.

Non-Emergent Transportation (NEMT)
YCLTC meets the AHCCCS requirement to provide county-wide transportation services. The current network has seven providers, one of which has a very limited service area. The current NEMT network is sufficient to meet member needs. YCLTC is also able to reimburse skilled nursing and assisted living facilities as well as adult day health care providers for the provision of transportation services to members.

OB/GYN
YCLTC's network includes 4 OB/GYN specialists who are located throughout the county. Female members can self-refer to a contracted OB/GYN. They may also receive services from qualified non-contracted providers if YCLTC network is unable to meet the member's needs.

Oral Health
YCLTC's network includes 5 dentists, three of whom provide care to children; 1 denturist and one dental consultant. Oral health care is available throughout the county and the network is overly sufficient to meet member needs. YCLTC does not require prior authorization for routine EPSDT dental services and provides EPSDT members direct access to dental providers. However, the dental provider must have an AHCCCS provider identification number for payment purposes.

Primary Care and Specialty Providers
YCLTC currently contracts with 97 PCPs for the EPD population and with 16 pediatric PCPs. Although the number appears more than sufficient to serve 1000 members, the network of PCPs for EPD members in the Prescott area is only adequate. About half of contracted PCPs accept new members and about half accept members who meet certain criteria. Four practices are not accepting new patients. The twelve pediatricians provide care to 21 EPSDT members.

YCLTC continues to work to negotiate contracts with additional PCPs. As in previous years, several PCPs changed or closed their practices. Others limited their practices to established patients. Almost all PCPs carefully screen new patients before accepting a very limited number. Others refuse to care for patients who need narcotics or pain management, or who are Medicare recipients. The providers cite administrative requirements, proposed reimbursement cuts by Medicare, and increased oversight activities as reasons for declining to serve Medicare patients. YCLTC works with physician office management companies, recruits new PCPs, discusses reimbursement issues with contracted PCPs, facilitates community discussion, and researches and addresses any other issues that affect PCPs.

Hospitals in the Prescott and Verde Valley areas use differing models to support recruitment efforts. Yavapai Regional Medical Center (YRMC) helped open a for-profit clinic independent of YRMC that offers PCP and cardiac care. Northern Arizona Health Care and YRMC are purchasing existing primary and specialty care practices and incorporating them into their organizations. NAHC openly states they desire to serve all residents in east Yavapai County and to provide needed primary care and specialty services.

YCLTC contracts with approximately 170 specialists, the majority of whom are board certified, and with 33 allied professionals. The current network includes group contracts with ophthalmologists, nephrologists, and allied professionals, resulting in greater member choice. Individual practitioners in corresponding specialties are also contracted in order to ensure provision of care if the group contracts are terminated. YCLTC contracts with DMG for additional specialists in the Phoenix area. The network also includes a podiatrist to provide foot care services to members under the age of 21. Table 2012.1 reflects the current specialties.

YCLTC will continue to meet all the minimum contract requirements for this category. PCPs and specialists new to the area will continue to be recruited in efforts to provide members with choice and to meet the demands of physician panel capacity. YCLTC will continue its support of the relocation of new providers to Yavapai County and will contract with newly licensed PCPs who open new practices in Yavapai County and are willing to contract. YCLTC will offer training in managed care principles and assistance in billing practices upon request. YCLTC will continue to use its knowledge of health care in the County to encourage providers to expand their

practices into underserved areas, and to encourage new providers to locate into these communities. YCLTC will also support J-1 Visa waivers for new physicians willing to serve Yavapai County.

Number and Type of Contracted Specialists					
15	Cardiologists	8	Oncologists, Medical	14	Retinal Specialists
5	Dentists	5	Oncologists, Radiation	1	Rheumatologist
6	Dermatologists	20	Ophthalmologists	7	Surgeons, General
1	Endocrinologists	12	Optometrists	18	Surgeons, Orthopedic
6	Gastroenterologists	2	Pain Management Specialists	1	Surgeon, Plastic/Wound
1	HIV Specialist	16	Pediatricians	1	Surgeon, Transplant
1	Infectious Disease Specialist	1	Podiatrist	3	Surgeons, Vascular
22	Nephrologists	3	Physical Medicine/Rehabilitation	5	Urologists
3	Neurologists				
4	Obstetricians/Gynecologists	5	Pulmonologists	3	Wound Care Specialists

Table E36.1

Studies show that rural areas have a lower number of physicians, specialists, nurse practitioners and physician assistants per capita than urban areas and that there are an inadequate number of providers in urban areas. This continues to apply to Yavapai County, especially in the western portion of the county. This is despite development of primary care practices and recruitment of additional providers by two hospitals and the collaboration of the local hospital and county health services in recruitment efforts. The expectation of the health care community is that Yavapai County will experience a greater shortage of practitioners in the near future. YCLTC continues to assign new enrollees in a timely manner; however, this takes great effort.

Not all physician specialties, such as endocrinology, are available in Yavapai County; others are closed or have limited capacity. The composition of the community of health providers is reflected in YCLTC's network. YCLTC's network is adequate for the provision of services to members who are able to travel to contracted providers in other parts of the county, to Phoenix or to Flagstaff. YCLTC approves the use of qualified, non-contracted specialists, if available, for members who are unable to travel a long distance. Member accessibility to these physician specialists is the same as individuals in the community.

YCLTC has identified five (5) specialties that are either not available or have limited availability in Yavapai County: otolaryngology, gastroenterology, dermatology, endocrinology, and neurology. YCLTC is interested in strengthening its network in these areas and continues to seek contracts, address issues as we are able, and ask for help from local hospitals. One other specialty, pain management, may also not have sufficient presence in Yavapai County due to the unexpected death of one provider.

YCLTC will maintain its recruitment efforts to practitioners in Yavapai County and in Phoenix, Flagstaff, Williams, Seligman, Wickenburg and Payson. YCLTC will participate in community efforts to address local and state-wide issues related to health care, and will continue to evaluate YCLTC's customer service to providers. YCLTC supports the community health center in Flagstaff that has a graduate educational program supporting medical residencies in rural Arizona, which increases the likelihood that the residents will not relocate after graduation. YCLTC is willing to partner with new graduates, authorize services provided by medical residents in a Graduate Medical Education in Yavapai County and to ask the residents to participate in QMPI or other committees.

The majority of physicians within YCLTC's network have hospital privileges and practice in hospitals. However, both hospitals within Yavapai County have hospitalist programs and assign patients to a hospitalist upon admission, as needed. Therefore, the fact that a physician does or does not have hospital privileges does not impact service delivery to YCLTC members.
YCLTC will monitor accessibility to specialists. Because the YCLTC network includes most providers within the health care community, members and YCLTC staff utilize the same network. Based on current findings, YCLTC

expects to find that members will continue to have the same access to specialists as the general population in CYE 2012.

YCLTC will provide female members with direct access to obstetric or gynecological specialists within the network and will pay for second opinions from qualified health care professionals. Preference will be given to contracted providers, but non-contracted providers will be used when needed.

YCLTC assigns specialists as PCPs if the member has a specialized health care need and the provider accepts the PCP role. Examples of members who may be assigned a specialist as a PCP are members who are pregnant, are ventilator-dependent, or are on hospice. Most specialists do not accept the PCP role.

a. Member Access to the System

YCLTC has protocols in place to ensure that members know how to access the system and information. As CMs develop a plan of care with the member, they respectfully focus on the member. CMs listen to members and collaborate with them to arrange services and community resources that will enable the member to remain at home or in the most integrated setting. CMs explain service provider restrictions, limitations or assignment criteria to the member and family/significant others. Members are made aware that they can access www.myhealthandwellness and www.myahcccs for information.

CMs explain the program to members and give them a handbook as a reference at the time of their initial visit and upon request. Members can ask to receive this information in alternate forms. Member Services notifies members in writing if their provider is no longer contracted with YCLTC and all members are notified of material changes to the network. Members have access to a list of pharmacies, specialists and PCPs with language capabilities in their Member Handbook and on YCLTC's web page. Members are able to self-refer and make appointments directly with their PCPs, obstetricians and gynecologists, behavioral health providers, specialists when part of a treatment plan, and with dentists if member is enrolled in the EPSDT plan. PCPs and specialists coordinate needed referrals and medical care. If a member calls a specialist without being referred by a PCP, the specialist coordinates the service with YCLTC and the PCP.

Member Services contacts new members who are assigned to a new PCP to ensure an appointment has been made. Members who make their own appointments have a low no-show rate as evidenced by a lack of reports of no shows from providers. CMs assist members in removing barriers to access, and, as necessary, ask the ordering provider for orders and documentation to provide a service. CMs and Medical Services Management coordinate care delivered by a Medicare Advantage Plan, when notified in advance.

All members are educated by the CM and via the Member Handbook on the availability of same day PCP appointments and after-hour services. Unnecessary utilization of emergency services by members is identified by Medical Services Management during routine reviews. Interventions are increasingly formal, but begin with the CM explaining options to individual members and increasing member's health literacy. YCLTC implements other interventions as needed, including but not limited to verbal reminders, evaluation of service hours to determine sufficiency, one-to-one instruction, involvement of the PCP, discussion of alternate plans at inter- and multi-disciplinary team meetings, managed care agreements between the CM and member, and letters from the YCLTC Medical Director. Most YCLTC members use emergency services appropriately.

CMs advocate on behalf of members as issues arise and PRCs educate providers on member rights and YCLTC processes. Members receive Notices of Action (NOA) letters when YCLTC takes an adverse action as defined by the Arizona Administrative Code. YCLTC provides reasonable assistance to members filing grievances, appeals, and requesting state fair hearings; informs members of the availability of services during these processes; and does not take punitive action against providers who assist members.

CMs advocate for members so members can remain in their homes. They arrange for services, such as respite, adult day health care and behavioral health services, to support members' formal and informal support systems so

that members can remain in a home setting. They work with providers to ensure services meet members' individual needs, inform family members of available support groups, and solicit their input in the plan of care. They make referrals to community organizations for non-covered services. They offer themselves as advocates and resources, advising members and representatives to contact them if issues arise. They educate members and their representatives on how to file a grievance or appeal an adverse action. They inform members of the option to have family members or neighbors provide care through the self-directed attendant care or traditional attendant care programs.

YCLTC Care Managers, Utilization Nurses and Provider Relations Coordinators partner with providers and members to ensure members with high medical needs receive timely, quality care. They work together to creatively meet member needs, asking contracted providers to go above and beyond. Recently, an YCLTC member needed to receive out-patient care in Phoenix for an extended period time. YCLTC staff intervened; contracted providers were able to provide transportation and in-home care out of their usual service areas. The member was unable to coordinate her own care; YCLTC's partnership with providers effectively provided seamless care to the member.

YCLTC's member-centric network has been developed to meet general and specific needs of members and its service system is designed to ensure that members can rely on services being provided as agreed to by the member, the provider and YCLTC. YCLTC's system is accessible to its members, is flexible and diversified, and services can be modified to meet the needs of individual members. PRCs recruit and contract with providers who are able to meet diverse member needs in a way that respects the member and allows the member to be an active participant in their plan of care. Providers cite good customer service and fast payment of claims as reasons for renewing their contracts. YCLTC's network offers services that are as available and accessible as the community norm and transportation to providers inside and outside Yavapai County is available. Members are able to arrange emergency, urgent and routine appointments for most modalities within the specified appointment standards, during normal working hours and at locations close their home. For other modalities, members are able to arrange appointments within the same timeframes as the general public. PRCs ensure provider compliance with ADA requirements so that members do not face physical barriers to care. YCLTC tracks data from mystery shopping exercises to confirm member accessibility is the same or better than the community's.

Although YCLTC's network allows members the same access to providers as the community norm, the community norm has changed. YCLTC staff and providers report that many PCP practices screen new patients, selectively choosing those they will serve. Other offices no longer accept Medicare rates. These changes affect both YCLTC and community members. Although YCLTC still assigns new members to PCPs within the mandated timeframes, it remains difficult to find new PCPs for members who request changes.

YCLTC's network includes contracts with several professional providers to go into the home of house-bound members to provide PCP services, behavioral health services and therapy services. Without professional in-home services, the member would be at a higher risk of nursing home placement. Members in nursing or assisted living facilities may benefit from in-facility optometry or behavioral health services.

YCLTC has a dynamic relationship with members, providers, internal staff, Yavapai County Board of Supervisors, and people in the community. YCLTC uses the Member Council to explore barriers to service, unmet needs, and improvements to the program with members, community members and advocates. YCLTC educates the community about YCLTC at public forums, health fairs, workgroup meetings and association meetings. In turn, members, providers, internal staff, the Board of Supervisors, and people in the community initiate conversations with YCLTC to resolve community issues and barriers. This collaboration with stakeholders results in improved member access to the system.

YCLTC ensures member access to the network is not limited by health, literacy, language, national origin, culture, race, sex, age, mental or physical disability, sexual orientation, genetic information, ethnic, or religious factors. YCLTC educates providers on the need to be culturally aware, to build a treatment plan that reflects the member's lifestyle and belief system, and to communicate the treatment plan in ways the member can understand.

PRCs encourage providers to take into account a member's culture when addressing members and their concerns. They educate providers of the need to make interpreters available to members to ensure appropriate delivery of service. YCLTC educates members and providers on cultural awareness at meetings, in newsletters and in person. YCLTC incorporates information from "Ask Me Three" when addressing health literacy issues. YCLTC's network delivers culturally competent services as evidenced by a lack of grievances and quality of care concerns related to language, culture, race, ethnicity, disability, or religion.

These protocols support provision of consistent, accessible services.

b. **Relationship Between Levels of the Network for the General Population**

The culture of Yavapai County's health care community impacts relationships between levels of the network. Yavapai County's population is changing; the health care arena is also changing. Yavapai County's overall culture is one of independence. Neither Yavapai Regional Medical Center nor Verde Valley Medical Center is credentialed by JCAHO. Several parts of the county have been designated as underserved by the health care system. Some PCPs elect to serve limited populations; some charge non-AHCCCS patients an annual administrative fee. Most Medicare Advantage Plans (MAP) are available to Yavapai County residents for only a year or two. Many providers are privately owned and not part of a larger corporation that is able to allocate administrative costs across several lines of business.

Provider to Provider

YCLTC promotes effective relationships between various levels of the network through systemic and individual interactions. YCLTC staff support providers through dissemination of information, assistance in designing and managing plans of care, and problem resolution. The Medical and Dental Directors are available as resources to other providers, and contact providers to discuss options, covered services, coordination with other providers, and other professional concerns. YCLTC's Director is also available to meet with or intervene on behalf of providers.

Some YCLTC organizational processes are structured to build relationships between providers. Forwarding copies of the member's medical record to the new PCP helps the new PCP understand the member's medical history. Forwarding behavioral health consults to the member's behavioral health provider and PCP updates both providers with medical and treatment information. Requiring specialists to communicate and coordinate patient care with the PCP and to provide comprehensive reports to the PCP builds the relationship between the PCP and specialist. Receiving treatment plans and notes from behavioral health providers allows care managers to coordinate wrap-around services that focus on a common goal. Other processes that build relationships include: 1) the triage program in which a behavioral health professional trains facility staff on member-specific behavior management techniques and 2) creating educational opportunities for providers to explain their services to interested providers and YCLTC staff.

YCLTC serves as an intermediary between providers when needed. Recently, YCLTC intervened to resolve issues between a PCP and a nursing facility. YCLTC listened to both providers, provided education, obtained information from a third party and interacted with both providers so that members received the care they needed.

In other situations, YCLTC explores options for service delivery with providers, attempting to understand not only the process but also the rationale for perceived barriers. At times, YCLTC will facilitate meetings between providers, especially if the providers need to partner together. At other times, YCLTC will conduct research and then provide education, seeking improved service delivery or better understanding.

By posting the network on the website, providers are able to refer to in-network providers and coordinate care with other providers. This is especially important when referring to a specialist or transportation provider. Information on the website was critical to a recent safe and timely hospital discharge for a member who required durable medical equipment (DME) and transportation. The discharge planner, transportation and DME providers collaborated on a complex situation, resulting in a smooth, effective discharge. By disseminating information through mass emails, providers are able to contact each other about industry events or trends.

YCLTC convenes routine provider meetings in which information is disseminated, preferred modes of communication are identified and questions are answered. Practices are discussed and evaluated; providers network and build relationships. At times YCLTC facilitates provider to provider meetings to resolve issues; other times, individual provider meetings are held. Recently, YCLTC asked a hospital with a relationship with a clinic to intervene with the clinic on our behalf. The hospital did so, the clinic corrected their misconception of YCLTC and the relationship improved. In another instance, two providers met with YCLTC to question actions of another provider. YCLTC listened, explained contract requirements, and offered strategies for intervention. Since all three providers offer the same type of service, member care did not improve was not affected. However, conflict among network providers was minimized.

YCLTC also involves providers in Quality Management/Process Improvement Committee and Member Council Meetings. Involved providers are exposed to other categories of service, service issues and systems. They are better able to communicate and serve members due to their increased understanding.

YCLTC supports the development of an electronic health information data exchange (HIE) of personal health information between providers, payers and members and the deployment of necessary health information technology to facilitate electronic health records in provider offices. YCLTC cooperates with AHCCCS in the development of the Health-E project plan by participating in meetings and providing information to providers as needed. At this time, the electronic network in Northern Arizona is not sufficient to implement deployment of an HIE.

YCLTC is contracted with one RBHA ensuring a smooth transition for members from the RBHA to the ALTCS system. The transition is usually seamless for members living in the eastern section of the county. The RBHA provider in the western portion of the county is not contracted due to capacity issues. This necessitates YCLTC intervention to ensure members continue to receive prescribed psychotropics during the transition to a new psychiatrist. Fortunately, YCLTC is contracted with another behavioral health clinic that has capacity for new members and offers a full array of behavioral health services.

One challenge in coordinating relationships between providers is with hospitalists. Although the hospitalist program was designed to provide better quality of care to hospitalized patients and then to communicate with PCPs, the program does not adequately address conformity to formulary limitations and care for people without a PCP. It appears that hospitalists do not have access to patients' Medicare Part D insurance information. YCLTC frequently intervenes on behalf of dual-eligible members who present a script to a pharmacy for a drug requiring prior authorization by the Part D Plan. Since hospitalists are unavailable for follow up to a discharge patient, YCLTC, when notified by the pharmacy benefit management company or the member, contacts the member's PCP for needed information or for a script for a different medication.

Another challenge is building relationships between nurse practitioners (NPs) and home health, infusion and hospice providers. Although NPs are able to write orders and willing to work with the identified providers, federal regulations prohibit the identified providers from accepting the NP's orders. This resulted in conflicted relationships. YCLTC discussed the issues with the various parties and created a list of interventions. Providers accepted some of the interventions, continued their discussions and implemented other strategies.

To address the need for physician follow-up to people without a PCP, hospitals in both the western and eastern sections of the county recently established relationships with PCP clinics. Their intent is to provide care to patients who do not have a PCP. Another option for people without a PCP is the local health department whose mission is to provide care to people without PCPs. Most YCLTC members have an assigned PCP; however, some new enrollees, members who just relocated, members recently assigned to a PCP and members who have been discharged from numerous PCP practices may need to receive care from one of the clinics.

YCLTC also promotes collaborative relationships between providers attempting to meet the same member's needs. YCLTC formally coordinates the relationship between PCPs and behavioral health professionals by providing a completed Behavioral Health Consultation form to each practitioner. The member's Care Manager

documents the member's name, diagnosis, placement, medications, recent emergency room visits and hospitalizations, and behavioral health needs, treatment and status. The completed form is reviewed and updated as needed by administrative staff and the Behavioral Health Coordinator and then sent to both the PCP and the behavioral health professional.

YCLTC convenes multi-disciplinary meetings and invites providers and members as appropriate. Meetings focus on providing member needs, drafting a comprehensive plan of care and improving member care. YCLTC also attends care plan meetings at facilities and will help coordinate care as needed. YCLTC is careful to protect member privacy during these interactions.

Some YCLTC members misuse services or medications. For medication issues, YCLTC works with the pharmacy benefit manager, individual pharmacy, various prescribers, the member and YCLTC's Medical Director. The usual outcome is acceptance by one prescriber to be the sole prescriber; other parties are notified of the outcome and limits are entered into the system.

YCLTC also fosters relations between network levels through training on common or member-specific issues. Recently, YCLTC attended a training provided by the Helen Keller Institute on how to best communicate with a specific member who has mental, vision and hearing deficits. Attendees included nursing facility staff, transportation staff, member representatives and YCLTC.

YCLTC staff members provide training to providers on various topics but primarily administrative requirements and member-care issues. Guest speakers may be experts in their field or providers who could regularly interact with the providers. Last year, Arizona Association of Physical Therapy presented information on documentation requirements to a group of contracted physical therapists. YCLTC's physical therapist provides fall prevention training to facilities and home care providers; nurses developed Training-on-a-Disk that providers can use for staff training.

YCLTC staff attend provider meetings and address billing and claim issues, update providers on relevant topics such as HIPAA, electronic claim submissions and electronic health records, and community initiatives. They educate about resources, including other providers, and discuss the referral process. They also facilitate conversations among providers, hoping to increase awareness of a health care team that benefits participants and members.

YCLTC maintains open communication between all levels through community involvement, regularly scheduled provider meetings, general and individual communications, dissemination of information through the website, newsletters, provider manual, blast email messages, trainings and individual interactions. Levels of the network include YCLTC staff and management, provider staff and management, members, AHCCCS, the local community and the health care community within Arizona. Efforts are made to include all levels of the network in the assessment and review of the services offered, resulting in alignment with identified member needs and preferences. Changes to the service system are planned, implemented and evaluated for continuous improvement and enhancement.

Provider to YCLTC

YCLTC is committed to being a valuable partner with our providers and has found that communication and efficient processes are integral to effective partnerships. YCLTC focuses on listening to providers and trying to understand the provider's perspective. YCLTC applies this to understanding the providers' business model, limitations, expectations, values, barriers and perception of AHCCCS and YCLTC. YCLTC strives to clearly communicate reasons for YCLTC requirements and to find a value-add for the provider. Provider Relations Coordinators maintain ongoing relationships with providers and bring feedback to the management team. Follow up on issues happens quickly- generally the same day.

YCLTC documents requests for information, provider complaints, and other provider-initiated issues in a database. The database's monthly review looks at response time, topics, and interventions. A summary of

database findings, identified trends and interventions is reported to the quarterly Quality Management Performance Improvement committee. Interventions are evaluated and modified as needed; often utilizing suggestions from the providers.

YCLTC has identified two key processes to maintaining productive relationships with providers- payment and prior authorization. YCLTC pays 98% of claims within 30 days of receipt. Although our perspective is that we are just meeting contract requirements, providers praise us for prompt payment.

YCLTC continues to evaluate prior authorization requirements and processes and has simplified most processes. Prior authorization is not required for most services from contracted providers when Medicare is the primary payer source. If the provider has reasonable expectations that Medicare will pay and then receives a denial from Medicare, the provider can submit the Medicare denial and supporting documentation and ask YCLTC to complete a retrospective review.

YCLTC requires prior authorization for most non-Medicare services, for items and services provided by non-contracted providers and for the following Medicare-covered items: behavioral health, capped rentals, custom or specialized DME or DMS, DME provided to SNF-placed members, lift chairs, specialty support surfaces, nutritional supplements, wound supplies and all DME and DMS with quantities or features that exceed the Medicare allowable. Non-contracted providers must meet YCLTC criteria and after the initial authorization, can submit requests for authorization of services that are included in a treatment plan for specific members.

Prior authorization is not required for Medicare-covered services provided to dual-QMB members and for some services provided to EPSDT members.

The Provider Manual is given to each new provider and is available on the YCLTC website. When issues arise, PRCs first attempt to informally resolve them with the identified contact person. If the issue involves a serious breach of contract, fraud or abuse, or a general practice, the PRC involves the provider's representative who signed the contract. Provider issues are documented in a database and data is routinely evaluated. No significant trends were identified and all issues were addressed within established timelines.

YCLTC coordinates authorizations and addresses payment issues with contracted and non-contracted providers, encouraging electronic billing practices. Each Explanation of Payment (EOP) describes the claim dispute process and YCLTC's provider relations coordinators work closely with providers, educating them on claims processes and requirements, and advocating on their behalf.

YCLTC's routine meetings with providers continue to be the venue to discuss substantial changes or issues related to care management, department policy, federal or state requirements, claims, and prior authorizations. YCLTC also facilitates additional meetings as required by AHCCCS. Non-provision of services is reported by providers and some members and is addressed by YCLTC. The importance of providing critical in-home services is discussed at least annually with HCBS providers and as gaps occur.

YCLTC continues to partner with contracted providers to meet the medical needs of members. YCLTC seeks to understand member and provider needs and perceptions before suggesting solutions to issues. The CM is integral to maintaining an open, successful relationship with the member; the PRC is integral to the relationship with the provider; and the Program Development Coordinator and YCLTC Director are integral to the relationship with AHCCCS.

YCLTC continues to participate in community forums and work groups to encourage work force development, identify member needs, community trends and potential gaps. The need for caregiver training and AHCCCS Benefit Changes were common topics in recent meetings.

YCLTC to AHCCCS

YCLTC notifies AHCCCS of proposed material changes to policies or processes 30 days in advance. YCLTC

also asks AHCCCS to approve in advance all material changes in its provider network and notifies AHCCCS within one business day of any unexpected change that would impair the YCLTC provider network. The notification includes information on how the change will affect service delivery and the plan for maintaining quality care. YCLTC submits timely deliverables and ad hoc reports, seeking clarification as needed. YCLTC also informs AHCCCS of problematic issues, at times as a heads-up; at other times for resolution.

YCLTC is committed to maintaining a productive and positive relationship with AHCCCS.

2. CURRENT NETWORK GAPS and the METHODOLOGY USED TO IDENTIFY THEM

YCLTC proactively addresses potential and actual gaps in the network so that diverse member needs are met. It is imperative that the sufficiency of the YCLTC network is regularly evaluated as YCLTC members live in a largely rural county that has a limited number of service providers. YCLTC's network for services for special populations is comprised of local providers and providers in adjacent counties. At times, YCLTC members must travel to see a specialist, and this can be burdensome. However, YCLTC members have the same access to providers as community members and there are no unmet needs at this time. YCLTC authorizes use of non-contracted providers for member-specific care. YCLTC is unaware of any current unmet needs.

Current Gaps

YCLTC does not have any gaps in its network and meets AHCCCS' minimum network requirements.

Implementation of the methods described below confirms that the YCLTC network meets AHCCCS' minimum network requirements. However, it also confirms a limitation of the network –limited accessibility to network neurologists, otolaryngologists, gastroenterologists, endocrinologists and dermatologists.

Gaps in Critical Services

YCLTC is committed to maintaining a network that enables members to remain in their own home, if that is their desire and it is appropriate. To that end, YCLTC maintains a network of contracted providers adequate to ensure that critical services, inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to and from bed or wheelchair, are provided without gaps. A gap in critical service is defined as the difference between the number of hours of critical service scheduled in each home-based member's care plan and the scheduled hours of critical service that are actually delivered to the member. YCLTC resolves gaps in critical services within two hours of a reported gap. CMs attempt to fulfill this court-ordered mandate by informing members of their right to receive services as authorized and how to contact YCLTC or the authorized home care service agency when a gap in critical service occurs. CMs also assess a member's needs and service preference level if a gap in critical services were to occur, and develops, with the member, a contingency plan to follow in the event of a gap in a member's services.

PRCs educate providers of critical services about the requirement that all critical service gaps need to be filled within two hours of notification. They will encourage subcontractors to work together to provide services to members. Agencies are available 24/7 and most ask their supervisors to provide care if caregivers are unavailable. The providers impart valuable service to YCLTC members and are integral to a comprehensive network. Care Management Supervisors and PRCs track reported service gaps on a monthly and as needed basis. If a trend is identified, the PRC requires the providing agency to submit a written corrective action plan, monitors compliance with the plan, and intervenes if the plan insufficiently corrects the problem. Providing agencies are surveyed to ensure prompt responses to member calls received outside regularly scheduled office hours.

YCLTC staff is available 24 hours a day, 7 days a week. Members and providers can contact a "live" person after hours by calling the local or toll-free phone numbers for YCLTC. YCLTC's on-call person contacts other contracted agencies to provide the scheduled services. Contracted providers are also encouraged to contact other providers to help them out so members receive their needed service.

Methodology Used to Identify Network Gaps

The Program Development Unit reviews, assesses and evaluates the YCLTC network on a regular basis through the following avenues:

- Monthly Review of databases and logs
  - Service Gap and Non-Provision of Service Logs to determine need for additional home care providers
  - Provider Communication Log
  - Member Grievance database
  - Verification of Service database
  - Dispute and Appeals database
  - Emergency and Hospitalization database
  - Non-Contracted Provider Report
  - Fraud and Abuse log
  - Quality of Care Reports database
- Discussion at Meetings
  - Care Management Meetings, usually monthly
  - Inter- and Multi-Disciplinary Team Meetings, as needed
  - Medical Services Unit Meetings
  - Medical/Utilization Meetings
  - Provider Relations Meetings, usually bi-weekly
  - Program Development Meetings, quarterly
  - Member Council Meetings, quarterly
  - Provider Meetings, usually quarterly
  - Process Improvement Team Meetings, as needed
  - Quality Improvement and Process Improvement Committee Meetings, quarterly
- Discussions with Members, Providers, Staff, Community Members
  - Suggestions and requests received from community members and groups
  - Suggestions and requests received directly from members and providers
  - Suggestions and requests received directly from any YCLTC staff member
  - Other provider, member and staff communications forwarded to Program Development
  - Review of monitoring results

Through these approaches, information regarding the network is regularly communicated and proactively addressed. At times, PRCs initiate discussions; at other times, participants raise issues or needs, or affirm that the current network is sufficient. Recommendations about the network are communicated through each of these processes, including recommendations to recruit new providers, troubleshoot service issues, hone recruiting efforts, and identify service or geographic gaps. Each meeting's facilitator communicates needs with the Program Development Unit.

Additionally, through the management and compliance meetings, internal systemic problems that may affect service delivery are identified, addressed, and resolved. The meetings also address any change in services, covered benefits or geographic service area, payment issues and needs of a new population. The use of non-contracted providers is reviewed to determine the necessity to pursue new contracts, to monitor out-of-network utilization, and to identify the need to assist a provider with billing or other issues.

PRCs interact regularly with other YCLTC staff. They discuss over-utilization of hospital emergency departments, the need for specialty providers and placements, and other issues with medical management nurses. They determine service standards by talking with quality management staff. Care management identify service gaps as reported by members; member services raise issues related to the termination of contracts. The assisted living unit is instrumental in identifying new homes with which to contract, and the behavioral health coordinator recommends dynamic development of the behavioral health service network to meet the ever-changing behavioral health needs of members.

PRCs interact daily with providers through emails, phone conversations, faxed messages, and meetings. They identify and address network issues and implement strategies to ensure services are provided as needed.

Ultimately, all network recommendations and issues brought forth from these processes are communicated at routine PRC meetings. Strategies for addressing service or geographic gaps are developed and implemented. Evaluations occur until the recommendation or issue is thoroughly resolved. Open communication continues between the program development unit, care management, medical management, quality management, behavioral health coordinator, and/or YCLTC's management team.

Strategies to Address Gaps

YCLTC diligently strives to prevent network gaps by maintaining a strong provider network and good communication with members and providers. If YCLTC is unable to provide medically necessary services within its contracted network, YCLTC will ensure timely, adequate coverage through out-of-network providers until a provider is contracted. When a gap, potential or actual, is identified, YCLTC will use creative and proactive approaches to resolve problems to deter network gaps and deficiencies. Strategies include:

- Address barriers to contracting
- Assist potential providers to obtain AHCCCS provider registration and/or licensure
- Coordinate authorization and payment issues with the non-contracted providers
- Establish contracts with providers outside the geographic area for needed services when local providers are unavailable
- Establish relationships with non-contracted providers, as necessary
- Identify and establish contracts with local providers, if available
- Participate in community efforts to resolve gaps
- Partner with local providers and agencies to identify and resolve barriers to service delivery
- Partner with current providers in the expansion of services
- Solicit recommendations from members and their representatives
- Solicit recommendations from other providers
- Solicit recommendations from participants at Member Council meetings
- Solicit recommendations from participants at Quality Management and Performance Improvement meetings
- Review on-line networks of health plans serving Yavapai County for potential providers
- Review newspaper articles and advertisements for potential providers

NETWORK DEVELOPMENT

3. IMMEDIATE SHORT-TERM INTERVENTIONS WHEN A GAP OCCURS INCLUDING TEMPORARY CREDENTIALING

Yavapai County, like most of the United States, would benefit from additional PCPs and specialists. YCLTC PRCs diligently strive to develop and maintain a provider network adequate to meet member needs. They contact practitioners in the area to recruit them to become YCLTC providers. However, despite their continuing efforts, gaps can occur.

YCLTC ensures members, providers, staff and AHCCCS are aware when there is a temporary network gap. Upon notification of a gap, PRCs review the network to verify that a gap does exist and then determine if the gap is expected to be short-term. They also, in collaboration with other units, determine if the gap is expected to meet the entire YCLTC membership, a subpopulation or an individual. They consult with the Medical Director and speak with the exiting provider. PRCs ask the exiting provider's practice group to provide interim coverage of a short-term gap. They also ask other contracted providers who provide the same service to provide interim care. PRCs expand their efforts as they work with other YCLTC staff, the member via the Care Manager, other

providers and the referring provider to identify an appropriate provider. They may conduct a provider search on the internet or phone book, seek information from other Contractors, hospitals or providers. Once a provider is identified who is willing to see the member and meet AHCCCS appointment standards, provider qualifications are reviewed, an appointment is made and prior authorization is processed if needed.

YCLTC communicates network gaps to stakeholders. Member Services sends letters to members who are assigned to an exiting PCP or routinely receive services from the exiting provider. The standard letter informs members of effective dates, of actions YCLTC is taking to fill the gap, and to call their Care Manager with questions and concerns. PRCs notify YCLTC staff of the plans to meet member needs. CMs and other YCLTC staff may meet to generate ideas for alternate service delivery that may be able to meet member needs resulting from the gap.

If the gap is due to a contract termination that meets the definition of a material network change, YCLTC completes additional steps and communicates with AHCCCS, providers and all members. AHCCCS notification includes expected impact on members and the plan and timeline to resolve the gap. YCLTC notifies providers and members when there are material changes in its network with the expectation that the communication will result in smooth transition of care with minimum negative impact to members. YCLTC provides at least 30 days notice when possible. However, some providers do not notify YCLTC 30 days in advance of termination. YCLTC then provides notification as expeditiously as possible and implements the "loss of a major provider" section of our Business Continuity and Recovery Plan. The Plan includes triage of members by risk factors, identification of alternate providers, implementation of a contingency plan, notification to affected parties, coordination of paperwork and other ancillary services, completion of transfer to new provider, evaluation of success of transfer, revision of plan if needed.

If the provider is willing to contract, YCLTC negotiates a short-term contract, facilitates the provisional credentialing process, and follows up by initiating the initial credentialing application. Upon approval of the initial credentialing application and process, the contract is extended by amendment to full-term. All actions are reported to YCLTC's Credentialing and QMPI Committees and providers are notified.

At times, YCLTC is unable to negotiate a contract with a provider before services are needed and the provider is then able to see the member on a non-contracted basis. YCLTC uses comprehensive measures to ensure that non-contracted providers can be expected to provide quality care. The first step is a review of the YCLTC network for an appropriate provider. If member needs cannot be met by network providers, the Care Manager Supervisors justify the use of a non-contracted provider. Then a non-contracted provider is identified and the non-contracted provider database is checked to verify that YCLTC has not previously denied use of the provider. The YCLTC Medical Director or his designee reviews provider and quality of care information and approves or denies use of the provider. If approved, services are authorized, the non-contracted provider database is updated, and the provider is entered into the claims payment system.

If the provider is interested in contracting and is a physician, nurse practitioner, physician assistant or certified nurse midwife, dentist or affiliated practice dental hygienist, psychologist or independent behavioral health professional, provider in a federally qualified health center (FQHC), FQHC look-alike, or a hospital-employed physician, the provisional credentialing process is completed. Information reviewed for provisional credentialing includes a signed, dated and completed written application; curriculum vitae; copies of current DEA certificate, license and liability insurance; the Arizona Medical Board Provider Profile or equivalent; the National Practitioner Data Bank or equivalent; Medicare/Medicaid sanctions or limitation of licensure; and transcripts as needed. Care is taken to ensure the process does not discriminate on the basis of license, certification, service to high-risk populations or specialty in the treatment of costly conditions. Information is reviewed and use of the provider is either approved or denied within 14 days of receipt of the completed application. Expedited requests can be facilitated if it is in the member's best interest to be seen immediately.

Reviewed information for non-contracted providers includes AHCCCS provider registration and NPI numbers, current licensure or certification in the provider's respective field; proof of Yavapai County minimum

requirements for liability insurance; Arizona Board of Medical Examiners (BOMEX) or similar report; Medicare/Medicaid sanctions; YCLTC non-contracted database; and grievance and quality of care reports.
Some providers, despite YCLTC efforts, provide more than 25 services a year on a non-contracted basis. YCLTC informs AHCCCS of these providers. YCLTC asks the provider to complete an application that captures information similar to provisional credentialing and also reviews information from the NPDB. YCLTC updates application information every three years.

Sometimes members need to see a provider before the provider approval process is complete. At other times, the non-contracted provider contacts us when the member identifies YCLTC as their payer source at the time of the appointment. If it is in the best interest of the member, the YCLTC Medical Director or designee will review the reason for the service and approve use of the provider for that appointment only. Afterwards, YCLTC completes the process described above.

Throughout these interventions, YCLTC is mindful of the expectation of the provision of quality care by all providers seeing YCLTC members. YCLTC's processes require research of reported quality of care issues. The Arizona Administrative Code A.A.C. R9-22-512 authorizes YCLTC to obtain safeguarded information from contracted and non-contracted providers. Research is completed and corrective action plans are requested as needed. Findings are reviewed by the Medical Director. Decisions to deny use of a provider for quality issues can be made by the Medical Director, QMPI or the Peer Review Committee. If the provider is contracted, the contract is terminated with cause. If the provider is not contracted, the non-contracted provider database is updated with a notation of "Do not use". Both contracted and non-contracted providers are informed of their grievance rights.

After or during the completion of short-term interventions, PRCs seek to fill network gaps on a permanent basis.

4. INTERVENTIONS TO FILL NETWORK GAPS and BARRIERS TO THOSE INTERVENTIONS

YCLTC uses routine and creative interventions when working to fill network gaps. Interventions are situation-specific but always focus on member needs and begin with determining the cause of the gap and the immediacy of the need. Interventions include:

- Determine cause or reason for the gap. Ask questions such as: Is it member-specific? Systemic? Temporary? Permanent? Service highly utilized? What is the required skill level? Access to care? Limited member choice? TPL insufficiency?
- Determine the immediacy of the need and create a timeline.
- Resolve at lowest level possible and involve management team immediately if needed.
- Personal contact by Medical Director to providers to explain member need, program requirements and reimbursement.
- Collaborate with providers in identifying a possible provider.
- Discuss and respond to barriers with providers.
- Ask contracted providers in other areas to travel to Yavapai County and provide service in a temporary office, in SNFs, ALFs or in member's homes.
- Identify alternate services such as group respite when ADC is unavailable.
- Contact a provider who exceeds the minimum qualifications of the service and ask to provide the service on a temporary basis. An example is asking a home health aide to perform personal care or homemaking tasks.
- Combine various services to meet member needs, such as group respite on some days and in-home respite on others.
- Ask different providers to partner together to provide to one member, such as several home care providers covering different shifts of attendant care for one member.
- Identify alternate schedules of care, such as members who choose to receive service from a specific caregiver from a specific home care provider and do not choose self-directed attendant care may be asked to schedule care when the caregiver is not already scheduled to provide care to another member.

- Offer alternate services such as homemaking in lieu of home delivered meals.
- Discuss expansion of services/delivery with currently contracted providers, such as asking the DME provider to order a portable INR machine.
- Discuss modification of compensation and prior authorization requirements.
- Discuss capacity issues and offer to limit the number of referrals.
- Discuss care issues and offer to intervene. An example is the ENT who did not want to see members who only needed their wax removed. The ENT wanted to provide care for more complex issues.
- Assist potential providers to obtain NPI and AHCCCS provider registration numbers.
- Visit providers at their office and educate, emphasize community responsibility.
- Offer to reduce utilization once the network becomes sufficient.
- Determine cause of the gap and address the issue. If, for example, the cause of the gap is reimbursement, YCLTC's Director, CFO, PRC and Program Development Coordinator would meet to evaluate the need for higher compensation, the impact on the program and discuss findings with the provider. YCLTC would use the same process, although with different staff members, to address other causes.
- Provide accurate information about the ALTCS program, YCLTC systems and member, using positive recommendations from other providers in the community.
- Provide good customer service and prompt responses to provider, staff, and member inquiries.
- Continuously evaluate interventions and modify plan if gap continues and strategies prove ineffective.

Barriers to Interventions

YCLTC has identified the following significant barriers to interventions:

- Small per capita number of PCPs, specialists and subspecialties in the GSA, resulting in a lack of capacity.
- Provider's inability or unwillingness to accept payment from or bill other payers, including Medicare.
- Provider's perception of inadequate reimbursement.
- Ineffective communication between health care providers and their billing companies. At times, one of the parties will refuse to provide services to YCLTC members even thought the other party agreed to do so.
- Misunderstanding of the Arizona Medicaid system and YCLTC's place within the system. YCLTC routinely addresses allegations that AHCCCS plans do not pay and must convince potential providers that YCLTC wants to pay them for services rendered and pays 98% of claims within 30 days of receipt.
- Confusion about the difference between acute and long term care contractors.
- Provider's perception that YCLTC members' medical conditions are more complex than most patients, and therefore YCLTC members will require more time, placing a strain on an already full practice.

Some Strengths of YCLTC Network Providers

- YCLTC network providers want to provide quality service.
- Providers want to fulfill their community responsibility.
- Providers want to be unfettered by bureaucracy but want to serve those in need.
- Providers want to do whatever they can to help.
- Providers want to comply with expectations and regulations but do not want to burdened with non-patient care activities.
- Providers have good relationships with YCLTC staff.
- Providers care.

YCLTC addresses barriers as they arise, building on provider strengths when appropriate.

5. OUTCOME MEASURES/ EVALUATION OF INTERVENTIONS

YCLTC uses several outcome measures and processes to evaluate the effectiveness of interventions. Some key measures of the effectiveness of general network development strategies are: