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Offeror's Signature Page.....N/A  
Offeror's Checklist.....N/A  
Completion of all items in Section G of the RFP .....N/A

**Offeror's  
Signature Page**

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

**OFFER**

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

Arizona Transaction (Sales) Privilege Tax License No.:  
02-015998-C

Federal Employer Identification No.:  
86-6000398

E-Mail Address: mgomez@cochise.az.gov  
Cochise Health Systems

Company Name  
1415 Melody Lane, Bldg A  
 Address  
Bisbee, AZ 85603  
 City State Zip

For clarification of this offer, contact:  
 Name: Mary Gomez, RN, MN

Phone: (520) 432-9609

Fax: (520) 432-9698

Mary Gomez, RN, MN  
 Signature of Person Authorized to Sign Offer

Mary Gomez, RN, MN  
 Printed Name

Director  
 Title

**CERTIFICATION**

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

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

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

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



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


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

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

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

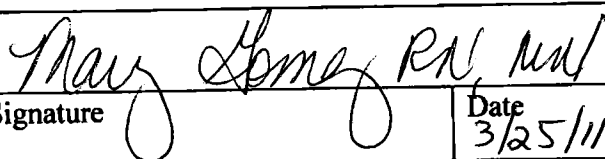
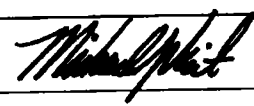
Awarded this \_\_\_\_\_ day of \_\_\_\_\_, 2011


Michael Veit, as AHCCCS Contracting Officer and not personally

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 24 <sup>th</sup> day of February, 2011, in Phoenix, Arizona.	
			
Signature	Date 3/25/11		
Mary Gomez, R.N., M.N.		Michael Veit	
Typed Name and Title		Contracts and Purchasing Administrator	
Cochise Health Systems, Inc.			
Name of Company			

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

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

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

Offeror hereby acknowledges receipt and understanding of this Solicitation Amendment.		This Solicitation Amendment is hereby executed this the 11 <sup>th</sup> day of March, 2011, in Phoenix, Arizona.	
<i>Mary Gomez, RN, MN</i>		<i>Michael Veit</i>	
Signature	Date 3/25/11		
Mary Gomez, R.N., M.N.		Michael Veit	
Typed Name and Title		Contracts and Purchasing Administrator	
Cochise Health Systems, Inc.			
Name of Company			



**Offeror's  
Checklist**

**OFFEROR'S CHECKLIST**

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

**A. GENERAL MATTERS**

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

**B. CAPITATION**

<i>Subject</i>	<i>Reqmt. #</i>	<i>Offeror's Page #</i>
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**C. ORGANIZATION**

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	31-B	112-114
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**E. PROVIDER NETWORK**

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Network Summary via EFT/SFTP	45	N/A

**Completion of all items  
in Section G  
of the RFP**

SECTION G. REPRESENTATIONS AND CERTIFICATIONS OF OFFEROR

The Offeror must complete all information requested below.

1. CERTIFICATION OF ACCURACY OF INFORMATION PROVIDED

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

2. CERTIFICATION OF NON-COERCION

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

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

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

4. AUTHORIZED SIGNATORY

Authorized Signatory for Cochise Health Systems
[OFFEROR'S Name]

Mary Gomez, RN, MN Director, Cochise Health Systems
[INDIVIDUAL'S Name] [Title]

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

5. OFFEROR'S MAILING ADDRESS

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

Table with 2 columns: Offeror Information and Contact Information. Rows include Name, Title, Address, Telephone Number, City, and State/ZIP.

6. OFFEROR GENERAL INFORMATION

a. If other than a government agency, when was your organization formed? N/A

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

Have any licenses been denied, revoked or suspended within the past 10 years? Yes [ ] No [X]

**SECTION G. REPRESENTATIONS**

**Contract/RFP No. YH12-0001**

If yes, please explain.

N/A

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

N/A

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

Accessibility Assurance is a contractual requirement for all CHS subcontractors and is verified at site surveys conducted by CHS staff. All CHS facilities are required by law to be accessible and are routinely inspected by the County's Facilities staff and Fire Marshall to verify compliance.

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

None.

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

N/A

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

Thomas D. Snook, FSA, MAAA and Jon Hendrickson, FSA, MAAA, Milliman

Name	City	State
15333 N. Pima Road, Suite 375	Scottsdale	AZ 85260

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

N/A

Name	City	State

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

N/A

**7. FINANCIAL DISCLOSURE STATEMENT**

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

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

Name	Address	Percent of Ownership or Control
N/A – County Government		

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

Name	Address	Percent of Ownership or Control
N/A – County Government		

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

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

None

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

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
None		

**SECTION G. REPRESENTATIONS**

**Contract/RFP No. YH12-0001**

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

Name	Address	Title
None		

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

Name	Address	Description of Debt	Amount of Security
N/A			

**g. Outstanding Legal Actions:**

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

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

N/A

**8. RELATED PARTY TRANSACTIONS**

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

Name/Title	Address
Patrick Call, Chairman, County Board of Supervisors	1415 Melody Lane, Bldg G, Bisbee, AZ 85603
Ann English, Vice Chairman	1415 Melody Lane, Bldg G, Bisbee, AZ 85603
Richard Searle, Supervisor	1415 Melody Lane, Bldg G, Bisbee, AZ 85603

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

**SECTION G. REPRESENTATIONS**

**Contract/RFP No. YH12-0001**

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

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
N/A		

Justification:  
N/A

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

Name	Address	Owner Or Controller	Has Controlling Interest? Yes / No
N/A			

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

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

Cochise Health Systems does not now have or anticipate having any offshore services in the proposal.

END OF SECTION

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**B. CAPITATION**

1 Capitation Rate Bid (via EFT/SFTP and hard copy) ..... 1



**Capitation  
Rate Bid**

<b>AHCCCS Capitation Calculation For Rates for CYE12 EPD RFP Bid Submission <sup>1</sup></b>			
<b>Service Category</b>	<b>Cochise Health Systems / GSA 46</b>		
	<b>Gross</b>	<b>MIX</b>	<b>Net</b>
Nursing Facility Share of Cost <b>Net Nursing Facility</b>	\$ 4,672.15		\$ (348.32)
HCBS Home and Community <b>Net HCBS</b>	\$ 1,061.44	60.95%	
Acute Care Prior to Reinsurance Reinsurance Offset <b>Net Acute Care</b>			\$ 493.02 \$ (120.27)
<b>Medical Component <sup>2</sup></b>			
<b>Case Management <sup>3</sup></b>			\$ 120.00
<b>Administration <sup>4</sup></b>		8.00%	
<b>Sub-Total of Scored Components</b>			
<b>Risk/Contingency at 1%</b>			
<b>Net Capitation</b>			
<b>Premium Tax (98% of Final Cap)</b>			
<b>Net Cap w/ Premium Tax</b>			

**Key**

user input

user input using AHCCCS provided numbers

**Notes**

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



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

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

milliman.com

March 22, 2011

**Actuarial Certification  
Cochise Health Systems  
ALTCS Elderly & Physically Disabled Capitation Bids: GSA 46  
October 1, 2011 – September 30, 2012**

I, Jonathan M. Hendrickson, am a Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries. I am also a Member of the American Academy of Actuaries and meet its Qualification Standards for Prescribed Statements of Actuarial Opinion. I have been retained by Cochise Health Systems to provide a certification of the actuarial soundness of its proposed capitation rate for Elderly & Physically Disabled Services in GSA 46 under the Arizona Long Term Care System (ALTCS).

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

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

**Cochise Health Systems  
Proposed Capitation Rate for GSA 46**

**Net Capitation with Premium Tax  
\$2,928.31**

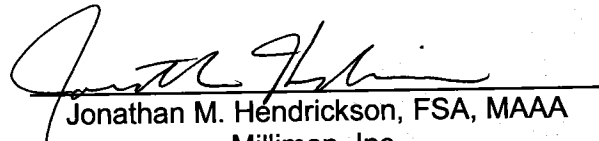
It is my opinion that the above rate is adequate to fund claims and administrative expenses for an average elderly & physically disabled population for GSA 46 during the time period for which it are intended.



My determination is based on a review of the claim experience and other information provided by ALTCS, experience data and descriptions of provider contracts provided by Cochise Health Systems, and my judgment. In performing my analysis, I relied on data and other information provided by ALTCS and by Cochise Health Systems. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

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

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



Jonathan M. Hendrickson, FSA, MAAA  
Milliman, Inc.  
15333 N. Pima Road, Suite 375  
Scottsdale, AZ 85260

March 22, 2011

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**Moral and Religious  
Objection**



**COCHISE HEALTH SYSTEMS (CHS) MORAL AND RELIGIOUS OBJECTIONS # C2**

CHS has no moral or religious objections to providing any services covered under Section D, Program Requirements of the ALTCS RFP.



**Organizing  
and Staffing**





## COCHISE HEALTH SYSTEMS (CHS) ORGANIZATION AND STAFFING # C3

CHS has in place the organization, operational, managerial and administrative systems capable of fulfilling all ALTCS contract requirements. CHS does not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under Executive Order 12549 or the guidelines implementing that Order. CHS screens all its employees and contractors through the HHS-OIG website to determine whether any of them have been excluded from participation in Federal health care programs.

CHS employs sufficient staffing and utilizes appropriate resources to achieve contractual compliance. CHS' resource allocation adequately achieves outcomes in all functional areas within CHS. Adequacy of staff and resources is evaluated at least annually by the CEO based upon outcomes and timely compliance with all contractual and AHCCCS policy requirements, including the requirement for providing culturally competent services.

One of CHS' strong points is our local staff available 24 hours/day, seven days/week to work with AHCCCS and/or other State agencies on urgent issue resolutions. This local staff has access to the information necessary to identify members who may be at risk, their current health/service status, ability to initiate new placements/services, and are available to perform status checks at affected facilities and potentially ongoing monitoring, if necessary. CHS is in the process of creating electronic copies of all documentation so that any data can be remotely accessed by staff at any time through the County's Virtual Private Network (VPN). We began this project by scanning in the Case Management records for our members in the Graham/Greenlee county areas of our GSA and no obstacles have been encountered. Due to the labor intensive nature of scanning all of the documents, CHS is meeting with a firm who is in the business of creating digital copies of documentation. This firm brings in their own equipment and staff and in a relatively short period of time creates the electronic copies of any documents we request. One of our local physicians' groups employed this firm when they converted to Electronic Health Records as a way to get historic patient information from the paper charts into the new electronic files. These Providers were very satisfied with the results and CHS is hoping to have the same results and put the digitalization of our records on a fast-track toward completion. Once the paper records are all scanned, then staff will be required to complete all documentation electronically. Most staff are doing this already.

CHS supplied to AHCCCS DHCM in May 2010 specific phone numbers and email addresses of all Key Staff positions. CHS utilizes an answering service and an 800 telephone number for all stakeholders to reach CHS staff after regular working hours. The answering service then calls the M/UM RN on call to handle any urgent requests. The CHS Medical Director is also available 24 hrs, 7 days/week for the M/UM RN on call to consult if needed. The CHS COO, Paula Saroff, a member of the CHS Leadership Team, is the employee designated to work with AHCCCS and/or other state agencies on urgent issue resolutions and is available 24 hrs/day 7 days/week by cell phone. All CHS staff, except for the Medical Director, Dental Coordinator, and PBM Manager, live in the GSA we serve. This proximity to members, providers, and contracted facilities is invaluable as evidenced by CHS actions during a recent winter storm and hard freeze that covered our GSA. CHS staff members living in all major population centers throughout the GSA were experiencing issues with heating, plumbing, water, and broken or frozen pipes in their own homes. This intimate knowledge of the environment and special challenges in our rural GSA make CHS staff uniquely qualified to anticipate, understand, and deal with the issues affecting our members. Since all of our Administrative, CM, Provider Relations/Contracts, and M/UM staff reside in the GSA, CHS is able to respond very quickly to homes or facilities for onsite welfare checks when necessary. In addition, CHS has contracted providers that also assist our organization when there are urgent situations to conduct welfare checks to ensure the safety and health of our membership.

CHS has never and does not anticipate ever having functions located outside of Arizona. CHS understands that approval from AHCCCS DHCM would need to be obtained at least sixty days prior to moving any functions outside of Arizona. This notification would include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance in this event.

## **CHS Key Staff Positions – All Currently Filled**

Due to the relatively small size of our member population, there are some CHS staff who occupy more than two of the Key Staff positions listed. This listing was sent to AHCCCS DHCM in May 2010 and was approved. CHS will notify AHCCCS DHCM in writing within seven days if any of the Key Staff positions below become vacant. The name of the interim contact person would be included with this notification. If this occurs, CHS will notify AHCCCS DHCM as soon as the permanent replacement is hired and submit that individual's resume and a revised Organizational Chart with time allocation noted. In addition, on October 15<sup>th</sup> of each year, CHS submits the name, Social Security Number and date of birth of the CHS CEO, CFO, CMO, and COO to AHCCCS. The purpose of this submission is so that AHCCCS can verify the information previously screened by CHS against federal databases to confirm that those individuals are not banned from participating in Federal programs as described in 42 CFR 455.104. Key Staff resumes follow this document.

**CEO:** Mary Gomez, RN, MN since 2005 - more than 33 years of LTC experience.

**Medical Director/CMO:** Rhema Sayers, MD since 1994 - more than 30 years of LTC experience.

**CFO:** Chuck Smith since 2007 - more than 27 years of LTC experience.

**Pharmacy Coordinator/Director:** Darla Bodnar, RPh., employed as clinical director of United Drugs, CHS' PBM since 1994. Mrs. Bodnar has 17+ years of LTC experience.

**Dental Director/Coordinator:** Mark Curtis, DDS since 2009. Dr. Curtis has 40+ years of LTC experience, including experience in consulting with other ALTCS program contractors.

**Compliance Officer:** this position is filled by two CHS staff members, Rebecca Laliberte, RN since January 2010 and Paula Saroff, COO employed since August 1998 to May 2003 then July 2006 to Present. CHS has designated two individuals to fill this position to ensure that all stakeholders have immediate access to our Compliance Officers to report issues when necessary. Mrs. Laliberte has 14 years of LTC experience and Ms. Saroff has almost 10 years of experience with the ALTCS program.

**Dispute and Appeal Manager/COO:** Paula Saroff, COO, employed since August 1998 to May 2003 then July 2006 to present with almost 10 years of experience with the ALTCS Program.

**Business Continuity Planning and Recovery Coordinator:** Mary Gomez, RN, MN since 2005 - more than 33 years of LTC experience.

**Contract Compliance Officer:** Paula Saroff, COO, employed since August 1998 to May 2003 then July 2006 to present. Ms. Saroff has almost 10 years of experience with the ALTCS Program.

**Quality Management Coordinator:** Rebecca Laliberte, RN since 2010 - 14 years of LTC experience.

**Performance/Quality Improvement Coordinator:** Rebecca Laliberte, RN since 2010 - 14 years of LTC experience.

**Maternal Health/EPSTD (child health) Coordinator:** Geri Bressinck, RN since 2007 - years of LTC experience.

**Medical Management Coordinator:** Rebecca Laliberte, RN since 2010 - 14 years of LTC experience.

**Behavioral Health Coordinator:** Cindy Sawinski, RN since 2007 - 17 years of LTC experience.

**Provider Services Manager/COO:** Paula Saroff, COO, employed since August 1998 to May 2003 then July 2006 to present with almost 10 years of experience with the ALTCS Program.

**Claims Administrator:** Chuck Smith since 2007 - more than 27 years of LTC experience.

**Provider Claims Educator:** Chuck Smith since 2007 - more than 27 years of LTC experience.

**Case Management Administrator/Manager:** Cindy Sawinski, RN since 2007 - 17 years of LTC experience.

CHS has been a Program Contractor for ALTCS since November 1993. In December 1999, CHS successfully transitioned the ALTCS members in Graham County when the previous AHCCCS PC there terminated its contract. In 2001, CHS further expanded its program and began providing services for Greenlee County as part of the GSA. CHS has developed and expanded an extensive health care network and contracted with most available medical providers within our GSA. Many CHS staff members have come to this organization after years of employment in our medical community with our contracted providers. This previous affiliation is invaluable to CHS in building and working with our provider network. Mutual respect and trust among our provider network and staff has been developed over many years and continues to strengthen as we continue to collaborate with these stakeholders.

Since Cochise County is a border county, CHS staff members are sensitive to diverse cultural needs. A number of staff, including senior management, speak Spanish and CHS strives to ensure cultural sensitivity throughout this organization and network. CHS has developed a staff of competent, caring individuals who continually strive to

improve the services offered to the members. Senior management staff represents all aspects of service delivery and offer a rich heritage of experience in the areas noted above.

CHS, as a division of Cochise County, has developed strong, collaborative relationships with other service organizations in our GSA who are not necessarily part of our network. Along with CHS, the Public Fiduciary Division (the court-appointed guardian and/or conservator of last resort) also operates within the Cochise Aging and Social Services (CASS) Department. Some of the Public Fiduciary wards are CHS members. The Public Fiduciary Division serves to add additional expertise to the department as it serves the elderly and disabled.

Also operated within CASS, the Area Agency on Aging (AAA) Case Management program provides limited in-home services to approximately 600 clients throughout Cochise County. Funded by federal funds under the Older Americans Act, through a contract with Southeastern Arizona Governments Organization, this program offers a variety of services to elderly and disabled individuals. These clients are not eligible for ALTCS due to financial or physical abilities, but many eventually become eligible for ALTCS services. AAA CMs work with individuals, their families, and support systems to help find resources and delay or avoid ALTCS eligibility whenever possible. AAA CMs initially investigate and assess requests for assistance to determine eligibility for services. They also provide Information and Referral services and assist individuals to attain services from a number of other programs or agencies. AAA CMs work closely with CHS CMs to ensure continuity of care as members transition through various programs within CASS.

Since its inception, CHS has worked to promote AHCCCS' vision of supporting the least restrictive environment for members with long-term care needs. The percentage of members in a home setting has risen from approximately 22% in 1993 for Cochise County to over 60% today. CHS has achieved this goal by ensuring that the network of providers from this large rural area continues to thrive and meets the culturally diverse needs of our members. CHS continues to support the viability of rural health care providers by contracting locally whenever the service is available. For example, CHS has continually excelled in the development and maintenance of in-home personal care agencies and transportation providers, two services that are extremely difficult to secure in this vast rural GSA of 11,000 square miles. CHS and our contracted HCBS providers have also taken a very active role in the Direct Care Workforce development efforts in our GSA.

In summary, the CHS executive management/Leadership Team has a wealth of experience specifically related to the elderly and physically disabled population. Staff members have also brought to CHS experience and expertise from other private and public programs. CHS has undergone annual program reviews by AHCCCS since 1993, receiving a high level of compliance each year. Since its inception, CHS has conducted annual Provider and Member Satisfaction Surveys. Overall satisfaction from both members and providers has resulted in a satisfaction levels that have generally exceeded 90% throughout its history as a program contractor and currently exceed 95%. CHS staff has excelled in our role as the ALTCS Program Contractor for Cochise, Graham and Greenlee Counties and has worked to be sensitive and informed on issues related to the needs of our elderly and physically disabled population, developing and delivering quality services to this population. In the Case Management division, the average length of service is twelve years for each CM. The eight RNs employed by CHS on the Leadership Team and in M/UM bring a combined total of **223 years of nursing experience** to their roles here! CHS, as a division and as a part of Cochise Aging and Social Services, has solid experience in providing quality long-term care services to this particularly vulnerable population. CHS is second to none in the level of quality, experience, expertise, and local commitment that it offers in these rural areas for our ALTCS members.

# **RHEMA ELIZABETH SAYERS, M.D., F.A.A.F.P.**

## **Curriculum Vitae**

**March 2011**

- Licensed in Arizona
- Board Certified in Family Medicine 1980; Recertified in 1986, 1992, 1998, and 2004
- Certificate of Added Qualifications in Geriatric Medicine 1994; Recertified 2003
  
- Fellow of the American Academy of Family Physicians since 1992
  
- Medical Director, Cochise Health Systems, ALTCS Program, Cochise and Graham Counties since October 1994
  
- El Dorado Urgent Care Clinic - Tucson, Arizona. Contract Physician October 2008 - present
  
- NextCare Urgent Care - Tucson, Arizona. Contract Physician September 2006 - September 2008
  
- Emergency Department, El Dorado Hospital, Tucson, Arizona. Contract Physician, January 1995 - August 2006
  
- Emergency Department, Kino Community Hospital, Tucson, Arizona  
Contract Physician part-time April 1993 - April 2000  
(included supervision and teaching of residents, interns and medical students).
  
- Emergency Department, Tucson General Hospital, Tucson, Arizona  
Contract Physician part-time November 1993 - December 1996.
  
- Primus Clinic for military dependents and retirees, Tucson, Arizona  
Contract Physician part-time November 1993 - August 1995.
  
- Emergency Department Naval Hospital Lemoore, Lemoore, California.  
Contract Physician full-time October 1990 - September 1993.  
Alternate Medical Director October 1990 - June 1991  
Medical Director June 1991 - August 1992.
  
- Private Practice in Douglas, Arizona

August 1980 - June 1991

**Hospital Admitting Privileges:**

Southeast Arizona Medical Center, Douglas, Arizona

- Chief of Medicine, July 1987 - September 1990
- Chief of Intensive Care Unit July 1987 - September 1990
- Chief of Emergency Department 1982 - 1986
- Chief of Staff 1987
- Vice-Chief of Staff 1988 - 1989
- Member Hospital Board 1984 - 1985; 1986 - 1987
- Supervisor Laboratory Services July 1987 - September 1990
- Chairman Professional Activities Committee 1982 - 1990
- Member Strategic Planning Committee
- Member Ethics Committee

**Residency:**

Monsour Medical Center Family Practice Residency

Jeannette, Pennsylvania 1977 - 1980

Chief Resident July 1979 - June 1980

**Medical School:**

University of Connecticut School of Medicine

Farmington, Connecticut; 1973 - 1977

**Additional Activities:**

- Consulting Physician - Cochise County Department of Health Services; 1985 - September 1990.
- Member of Board, Cochise County Woman's Shelter; 1985 - 1990.
- D.E.S. Disability Determination Consultant District VI; 1985 - 1990.
- Member Governor's Task Force on Malpractice; 1988 - 1990.
- Senior Aviation Medical Examiner; 1985 - 1987.
- City Physician Douglas, Arizona; 1980 - 1990.
- University of Arizona Rural Health Conference 1984 Practitioner of the Year.
- Arizona Area Health Education Center Board; 1984 - 1990.
- Lady of the Year, Douglas, Arizona; 1987.
- Member - Tucson Women Physicians' Society: 1994 to present.

**Special Certifications:**

- ACLS certification 1983 - present. Recertified November 2009.
- PALS certification September 1993. Recertified February 2011.

## Mary Gomez, RN, MN

Date of Birth: 5/3/55      Marital Status: Married, no children

### Personal

### Education

1969-1973 Morenci High School, Morenci, AZ **College Preparatory Courses**

1973-1977 University of Arizona, Tucson **Bachelor of Science in Nursing**

1994-1996 University of Phoenix, Tucson **Master of Nursing Administration**

*May – August, 1974*

***Clerk Typist – Phelps Dodge Corporation – Morenci, AZ***

Worked with 8 geologists in Geology Department. Secretarial duties included typing, filing, receptionist duties, labeling ore slides, etc.

*1979 – 1980*

***Part-Time Clinical Instructor – Cochise College – Douglas, AZ***

Clinical supervision/instruction of 10-12 first or second semester nursing students in rotations at hospitals through Cochise County. Clinical areas: Pediatrics, Psychiatric, Medical-Surgical, Operating Room, Geriatrics, ICU, SNF, OB. Presented seminars on cardiovascular assessment, abdominal assessment, EKG interpretation, S.O.A.P. charting, cardio-pulmonary resuscitation. Wrote and presented clinical performance appraisals. (Concurrent employment at Benson Hospital)

*1978 – 1981*

***Associate Director of Nursing – Benson Hospital – Benson, AZ***

Planned, developed, and implemented in-service education programs, orientation of new employees, functioned as Operating Room Supervisor, Utilization Review Coordinator, Infection Control Nurse, and supervised shift charge nurses in this 22 bed, rural acute care facility.

*1981 – 1985*

***Director of Nursing – Copper Queen Hospital – Bisbee, AZ***

Directed, supervised nursing services concerned with all aspects of patient care in this 49 bed, rural acute care facility, which included 22 licensed SNF beds. Implemented nursing department budget, formulated and defined departmental policies, coordinated nursing service activities with other departments, hired, promoted, staffed, disciplined all staff in nursing departments, negotiated contracts with collective bargaining units. Functioned as liaison to Medical Staff and to Cochise College Nursing Department.

*1985 – 1998*

***Asst Administrator, Home & Community-Based Services (HCBS)***

***Southeast Arizona Medical Center (SAMC) – Douglas, AZ***

Responsible for direction and coordination of all home and community based services, which included Home Health, Hospice, Homemaker Program, and three Rural Health Clinics. Directed, supervised all staff and clinical activities, evaluated performance of clinical managers and ancillary staff, provided oversight for the development, State Licensure and Medicare Certification for the Hospice Program in April, 1996, for the Homemaker Program in 1994, and for the Rural Health Clinics beginning in 1995. Developed and implemented program for Home Health Case Management to deal with capitated population of Medicare and commercial members in first risk-sharing contract entered into by SAMC. Responsible for planning and implementation of departmental budgets, staffing, performance appraisals, strategic planning. Functioned as liaison between HCBS and other hospital departments, Medical Staff, and regulatory bodies.

*Jan – Oct, 1998*

***Assistant Administrator, Patient Care Services – SAMC***

Organizational restructuring resulted in combining above responsibilities with those of former Director of Nursing. Responsible for all HCBS and patient care services at SAMC: duties as described above expanded to include management of inpatient services, hospital outpatient services, Environmental Services Department, Rehab Department and Pharmacy.

- 10/98 – 7/03** *Chief Executive Officer/Partner – Copper Cities Physicians – Bisbee/Douglas, AZ*  
Recruited to organize and oversee operations of newly formed physicians' group as department of SAMC until 12/1/98, at which time became independent entity. Reported to Board of Directors. Responsible for management of operations of physicians' offices in Bisbee and Douglas. Duties included those which are traditionally accomplished by CFO, COO, Human Resources Manager, IS Manager, and Business Officer Manager for this small organization. Responsible for supervision of staff, contract negotiations with insurance carriers, marketing and public relations, policy initiation and implementation, fiscal control, purchasing, management of AR and AP, claims processing, practice management, and strategic planning.
- 7/03 – 5/05** *Administrator Rural Health Clinic – Copper Queen Medical Associates – Bisbee/Douglas, AZ*  
Employed by Copper Queen Community Hospital (CQCH) to manage transition of Copper Cities Physicians into a department of CQCH. Also responsible for transition of private practice into two state licensed outpatient treatment centers and Medicare certification as Rural Health Clinics. Continued with same duties listed above with Copper Cities Physicians in addition to new duties at CQCH until 6/04 when entire practice was merged with CQCH. No longer responsible for AR or Human Resources. Responsible for implementation of electronic practice management and electronic medical record system and coordination of IT activities within the hospital, participation on grant-writing team with duties to report grant expenditures to federal government.
- 5/05 - Present** *Director – Cochise Aging and Social Services – Bisbee, AZ*  
Directs Cochise Health Systems, the Program Contractor for the Arizona Long Term Care System, a division of AHCCCS. Duties include: programmatic oversight of a managed care organization which provides long-term, acute, and mental health services for elderly and physically disabled clients; planning for and negotiating the capitated contract rate, to include analysis and strategic presentation to AHCCCS of program costs and overall operations; developing/maintaining acute and long-term care networks by analyzing client and provider needs and formulating capitated or risk-taking strategies for various medical providers and facilities; negotiating, as necessary, with doctor's groups, nursing homes, home care providers, or other medical providers; oversight of development and implementation of programmatic requirements and policies for administration, network development, contracts monitoring, claims payment and financial reporting, case management, quality assurance, prior authorization, utilization review, and grievance and appeals; interpretation and analysis of Arizona Revised Statutes, Administrative Code, and pertinent federal regulations for contractual or appeal issues related to AHCCCS and long term care; interpretation and analysis of financial data on an ongoing basis to ensure that costs for various components remain within appropriate levels; take corrective action, as necessary; oversight of budget development for CASS; attendance at CHS Quality Improvement Committee meetings quarterly, and assist the CHS Medical Director in resolving administrative issues related to Quality of Care concerns; represent the Division at Board of Supervisors' hearings related to CHS administrative or contractual issues, at the legislature, with regard to long-term care or managed care issues, at inter- or intra-departmental meetings; management and supervision, directly or indirectly, approximately 100 professional and administrative staff; acting as governmental liaison with other agencies within the State and County.

**LANGUAGES** Fluent in English, Conversational ability in Spanish.

**SKILLS** Excellent word processing skills, Microsoft Word, Excel, Power Point, Lotus SmartSuite, Medisoft EPM, CPSI Practice Management and NextGen Practice Management software, dotNet, Wells, and QuickBooks. Working knowledge of computer networking and very comfortable with data entry and electronic communications.

Experience and confidence in public speaking, preparation of formal presentations.

**REFERENCES** Available upon request.

## Charles Smith III

1180 Exeter Drive • Sierra Vista, AZ 85635 • (520) 459-2954 • Email: csmith@cochise.az.gov

### Objective

To apply my Accounting, Finance, Business Management experience and education for developing, implementing, and servicing financial management goals and objectives.

### Profile

Exceptional expertise in the following:

Accounting / Finance	B.S.B.A. MGT
Financial / Variance Analysis	Contract Negotiation/Administration
Project Management / Leadership	Cost / Financial / Governmental Accounting
Budget Formulation / Analysis	Leadership
Auditing	Business Process Analysis

- Strong leadership, motivational, problem solving and communication skills.
- Proven ability to plan, implement, direct and complete projects.
- Ability to communicate effectively to all levels of management and senior executives.
- Skilled in framing and communicating financial projections and internal audit results.
- Experienced manager in corporate and local government.

### Education

Northern Arizona University, Bachelor of Science in Business Administration / Management, 1983

### Professional Experience

**COCHISE AGING AND SOCIAL SERVICES (COCHISE COUNTY), Bisbee, AZ**  
***Chief Financial Officer / Administrative Services Manager*, 2007 to Present**

- Direct the financial function of the organization to ensure effective and appropriate use of taxpayer funds and achieve sustainable growth.
- Ensure fair presentation, in all material respects, the financial position of Cochise Health Systems, and the changes in its financial position and cash flows in conformity with U.S. Generally Accepted Accounting Principles (GAAP).
- Financial Controller overseeing accounting operations and monitoring internal controls of the Department's \$46M budget.
- Report on financial statements to senior management, state and local government officials including: financial performance and analysis; budget variance and trend analysis; the impact of business activities on financial statements, and other metrics as required.
- Utilize complex cost estimation / statistical analysis techniques to formulate accurate estimates of future liabilities.
- Develop and maintain the organization's accounting information system.
- Conduct comparison analysis and ratio analysis in order to assess organizational financial statements, evaluate current operations, ascertain performance trending, and determine operational efficiency.
- Partner with internal departments to establish operating standards and measures of performance.
- Formulate and recommend policies on the receipt and disbursement of funds, fiscal, and accounting matters.
- Formulate budgets for multiple grant and county fund lines based on state, county, and grant regulations and budget requirements. Assessed departmental needs, potential funding shortfalls and developed alternative solutions involving the resolution of conflicting goals and objectives.
- Analyze budget estimates and advised managers of trends, deficiencies, and potential unfunded requirements and the potential impact on the current budget.
- Provide justification, analysis, and presentation of the department's operating budget to senior staff.
- Design procedures and tools to improve internal control, cash flow management and GAAP interim reporting.



**Professional Experience** (Continued)...

- Implement resource management initiatives to ensure most effective use of governmental resources.
- Hire, discipline, and evaluate staff as required.
- Direct the work of 10 employees in achieving goals, adhering to organizational and government compliance, and meet required training and developmental needs.
- Motivate and train staff as required and instill a team approach to reaching individual and departmental goals.

**WALGREENS**, Tucson and Sierra Vista Arizona

**Manager**, 1984-2007

- Directed the work of 30 employees in achieving goals, adhering to organizational and government compliance, and meeting required training and developmental needs.
- Led risk mitigation activities, including the analysis of reports to make operating decisions and improve business processes.
- Developed and implemented action plans to improve loss prevention and maximize efficiency within the organization.
- Motivated and trained staff as required and instilled a team approach to reaching individual and company goals. Recognizing strengths and weaknesses of individual performances led to successful team oriented goal setting.
- Managed staff in all phases of operations to ensure the most effective use of resources.
- Formulated and analyzed annual budget.
- Maintained accurate financial records ensuring the store met or exceeded all operational/financial compliance guidelines.
- Hired, disciplined, and evaluated staff as needed.
- Implemented performance management strategies (coaching and mentoring) in order to improve organizational retention, meet individual and business goals, and develop bench strength within the company.
- Partnered with company affiliates in order to bridge corporate gaps and exceed organizational goals.
- Utilized inventory management techniques to maximize resources and maintain corporate inventory standards.

**Community Activities**

- Relay for Life Since 2004 / Habitat for Humanity, since 1999

**Computer Skills**

- Accounting/Financial Management: Peachtree, Quick Books Pro, PeopleSoft, and AS400/3270.
- Other: Microsoft Excel, Word, PowerPoint, PMMIS (AHCCCS).

## DARLA BODNAR, R.Ph. Permit No. S010106

Phone: (602) 648-6252

Email: dbodnar@uniteddrugs.com

### SUMMARY:

B.S. Pharmacy degree with a total of 18 years experience in the pharmaceutical industry including consulting, managed care, Long Term Care, hospital pharmacy and retail. Clinical Director for United Drugs Pharmacy Benefit Management (PBM) since 2004.

EDUCATION	1989-1992	B.S. Pharmacy, University of Oklahoma
	1986-1989	Northeastern State Univ., Tahlequah, OK

### EMPLOYMENT

- |              |   |
|--------------|---|
| 2004-present | Clinical Director, United Drugs, Phoenix, AZ<br>Provide pharmacy consulting services to 4 Medicaid PBM clients covering 9500 lives and over \$7.6 million annual revenue. Provide consulting services to PBM clients including the evaluation, assessment and reporting of interventions based on data. Participate in Pharmaceutical and Therapeutic Committees, report on formulary adherence, suggest formulary changes and cost containment strategies. Oversees the clinical department of United Drugs PBM, including: developing and managing formularies, developing and instituting client cost savings programs, managing the prior authorization department, managing system edits for DUR, quantity limits, Step Therapies, and other system requirements that relate to processing claims. |
| 2003-2004    | Pharmacist, Pharmerica Long Term Care Pharmacy/<br>Chief Pharmacist, Goot United Drug, Glendale, AZ<br>Chief pharmacist in a long-term care/retail/compounding pharmacy located in a medical building which provides close contact with patients and physicians. Responsible for servicing individuals, group homes, and other long-term care facilities where major emphasis is on customer care. Supervisor of 3 employees and Midwestern Univ. College of Pharmacy student preceptor. Staff pharmacist for Pharmerica Long Term Care—responsible for filling prescriptions, I.V. preparation, and general oversight for daily pharmacy functions in a busy long term care setting.   |
| 2001-2003    | Pharmacist, WalMart Pharmacy, Phoenix, AZ<br>Retail pharmacist excelling in customer service and patient counseling. Responsible for filling medications, narcotic inventory, supervising 4 technicians, Daily contact with physicians regarding third party formularies. Trained multiple store locations on new pharmacy input software.  |
| 1997-2001    | Lieutenant Commander—USPHS, Phoenix Indian Medical Center, Phoenix, AZ<br>Clinical pharmacist in 180-bed facility responsible for extensive patient counseling, filling prescriptions, IV's, chart reviews, checking blood pressure/blood sugar, and working in conjunction with physicians regarding patient's drug therapy. Gained knowledge of government hospital formulary with face-to-face interactions with physicians regarding formulary-based med changes. Heavy emphasis on patient counseling.   |
| 1995-1997    | Pharmacist, K-Mart Pharmacy, Nashville, TN<br>Retail pharmacist responsible for daily retail pharmacy operations excelling in customer care.  |

1994-1995      Pharmacist, Safeway Pharmacy, Honolulu, HI  
Retail pharmacist in a multi-cultural setting responsible for daily retail operations and  
again excelling in customer service. Received numerous awards for customer care.

1992-1994      Pharmacist, Osco Pharmacy, Phoenix, AZ  
Retail pharmacist responsible for daily retail pharmacy operations.

**Awards/Organizations**

1992. 1993      Pharmacy Communications Award—University of Ok College of Pharmacy  
Member—AMCP, AZPIN, CHADD

146 Thoroughbred Drive, Prescott, AZ  
8159

(H) 928-778-3326 (C) 480-240-

**CURRICULUM VITAE**

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- Weber State College - Ogden, Utah 1962-1964
- Case Western Reserve University School Of Dentistry 1964-1968 DDS Degree
- University of Arizona 1994-1996 Master of Public Health Degree
- Current Active Dental License in Arizona, Utah and Illinois

**DENTAL CONSULTANT – COCHISE COUNTY HEALTH CARE SYSTEMS**

**DENTAL CONSULTANT - YAVAPAI COUNTY DEPARTMENT OF MEDICAL ASSISTANCE  
LONG TERM CARE.**

**COMBAT READINESS HEALTHCARE SYSTEMS – Currently contracted**

- Dental care for Illinois National Guard. Primarily weekend work, 2-3 weekends a month plus travel days.

**@HOME DENTAL CARE - Currently contracted**

- Dental care in nursing homes in Arizona through a mobile unit, 3-9 days a month.

**REACHOUT HEALTHCARE AMERICA – Currently contracted**

- Az. Schools and US Army National Guard. Not active at this time.

**PRIVATE DENTAL PRACTICE – Mesa, Arizona, 1970 – 2008**

**OTHER**

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- MILITARY SERVICE
- USAF Dental Corp 1968 – 1970

**PAULA SAROFF**  
620 Santa Cruz Drive  
Bisbee, AZ 85603  
(520) 249-4545, [psaroff@cochise.az.gov](mailto:psaroff@cochise.az.gov)

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**Objective:** To apply my years of experience and expertise as a Chief Operating Officer for a leading HealthCare Organization.

## **Work Summary**

### **Chief Operating Officer for Cochise Health Systems, 2006 to Present**

#### **Responsibilities**

Contract Compliance Officer-Serve as primary point of contact for all Program Contractor Operational issues. This includes, but not limited to submission and tracking of contract deliverables; field and coordinating responses to AHCCCS inquiries, coordination of preparation and execution of CHSAHCCCS contract requirements such as operational and financial reviews etc.

Dispute and Appeals Manager-manage and adjudicate member and provider disputes arising under the Grievance System such as grievances, member appeals, provider claim disputes and request for hearing.

Compliance Officer- responsible for oversight of the CHS Compliance Program in accordance with AHCCCS policy- Shared duty between the Medical Utilization Manager and the COO.

Provider Services Manager- responsible for coordination/facilitation of communications between CHS and Provider Network. Promptly resolve provider problems, respond to inquires and provide provider education about AHCCS program. Develop and maintain a healthcare network of Providers for Cochise Graham and Greenlee Counties to ensure quality of care to membership.

Post Payment Recoveries and Cost Avoidance Program-responsible for the management of the post payment recoveries program in accordance with state/federal regulations and AHCCCS policy.

AHCCCS Deliverables-responsible for multiple reporting requirements set forth by contract with AHCCCS to include Grievance System Report, Network Plan and Development Report, Ball vs Betlach report, Financial reporting for the provider network (Unit cost report), Quarterly verification of services and cultural competency plan and other reports as required by AHCCCS.

Cultural Competency Coordinator- THE CCC reports to the CEO/Director and is available to all CHS staff to assist in the oversight of culturally sensitive provision of services throughout the organization. The CCC assists all Sections of CHS to ensure that policies/procedures include cultural competency provisions, ensure staff education on cultural competency. The CCC assesses the language needs of CHS members and makes recommendations for translation services for the members or for translating materials as needed.

Member and Provider Communications-Responsible for the oversight of member and providers communications in accordance with AHCCCS policy to include; member handbooks, member newsletters and provider manual including quarterly updates and newsletters and website oversight and .maintenance

## **Work Summary Continued**

### **Cochise Health Systems (CHS), Contracts Coordinator, 2001 to 2003** 1415 Melody Lane Bldg A, Bisbee AZ

Developed, Supervised and managed the Healthcare Network for covered services and contracting functions for CHS in accordance with Federal, State, County Procurement Codes and AHCCCS requirements. Interpreted contractual terms for providers and CHS staff, monitored providers to ensure compliance with contract terms and was a Provider liaison for CHS. Evaluated Sub-Contractor proposals, Wrote and maintained policies/procedures for CHS in accordance with federal, state, county and AHCCCS regulations. Supervisory role: supervised two employees, Contracts Specialist and Contracts Support Specialist.

### **Cochise Health Systems, Contracts Specialist 1998 to 2001 Promoted to Contracts Coordinator for CHS**

1415 Melody Lane Bldg A, Bisbee AZ 85603

Description of Duties: Assist the Contracts Coordinator in the administration of contracts for client services pertaining to healthcare services. Prepare bids and/or contracts. Format and maintain the CHS Provider Manual. Conducted On-site monitoring for contracted providers to ensure compliance with contractual requirements per AHCCS guidelines. Wrote and updated contract section policy. Acted as liaison for CHS staff members and Providers including responded to requests for information from providers and staff members. Responsibility to perform research to aid/assist CHS departments in the interpretation of contractual clauses, and/or federal and state laws when managing provider inquiries, concerns and/or complaints in a timely manner. Assisted the Supervisor in the development and maintenance of contracts for covered services available to CHS members. Managed data input in the CHS Health Information Systems, and Access to the AHCCCS PMMIS system for provider and member inquiries. Assist the Supervisor in the development of employee standards, goals and employee monitoring/evaluations.

Imaginat International Inc., Customer Service Representative 1993 to 1998  
304 Arizona Street, Bisbee AZ, 85603—now out of business/sold to another business  
Secured the Contracts Specialist position with Cochise Health Systems in 1998.

Duties includes: Customer service representative for mail order Company that specialized in health care products. Duties included: receiving and processing orders, maintenance of mailing lists, accounts receivable/accounts payable, processing orders. Addition duties included participation in the hiring and training process of employees, represented the company at state and national conventions-which included educating potential customers on products to negotiating with potential distributors both domestic and foreign. Product advisor for customers and staff members including biannual training sessions

### **EDUCATION (College/University):**

Cochise College, Bisbee AZ (through Cochise County) 2000-2001 Certified Public Manager Levels 1-3  
University of Arizona, Sierra Vista AZ 1996-1997, 97 Credit Hours (Combined Hours), Psychology  
Cochise College, Sierra Vista AZ 1993-1995, credit hours listed under U of A, General Studies and Psychology  
Arizona State University 1992-1993, 12 credit hours, General Studies, Psychology

**Other Skills-** Spanish, Some proficiency, Management Courses Levels 1-3, Supervisory Trainings by Cochise Co  
**Nine and half years of experience with the Arizona Long Term Program (ALTCS)**

Computer Skills Proficient with Microsoft Office including word, access and excel  
AHCCCS Database-PMMIS  
SFTP (Secure File Transfers of electronic data  
HIPAA including technical experience such as 4010 834 and 837 file transactions  
Some experience with Microsoft SQL Server Management Express running queries/scripts.

# REBECCA L. LALIBERTE

## OBJECTIVE

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To utilize my military, medical professional and leadership experience to develop strategic direction for the Medical Utilization Management Department.

## EXPERIENCE

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**Jan 2010 - present Cochise Health Systems** **Bisbee, Az**  
***Medical/Utilization Management Manager***

- Coordinates the Medical/Utilization Management process and supervises the M/UM Nurses and admin staff consisting of 9 personnel.
- Responsible for the Quality Management process by the ongoing monitoring of services, development of QM studies, compiling and analyzing data, and reporting trends.
- Responsible for the Utilization Management process by the collection, tabulation and analyzing of utilization data. Identify and analyze over/under utilization data or trends and make recommendations for improvement.

**Oct 2008 – Jan 2009 Las Palmas Medical Center** **El Paso, Tx**  
***Clinical Staff Nurse, Medical-Surgical Unit***

- Responsible for the primary care of up to 5 patients with complex surgical and medical diagnoses.
- Served as resource for new staff members and new graduate RN's.

**Jun 2008 – Sep 2008 Akron General Medical Center** **Akron, Oh**  
***Clinical Staff Nurse, Neuroscience/Cardiac Telemetry Unit***

- Responsible for the primary care of up to 6 patients with complex neurological and neurosurgical diagnoses.
- Night Shift Charge Nurse; oriented new RN's and float staff.

**Jul 2007- Jul 2008 Brooke Army Medical Center** **San Antonio, Tx**  
***Nurse Manager, Medical-Surgical Unit***

- Responsible for managing 40+ personnel and the provision of nursing care on a 29-bed inpatient unit.
- Integral team member for facility Performance Improvement initiatives, projects and Quality Management oversight.

**Aug 2005 – Jul 2007 RWB Army Health Center** **Sierra Vista, Az**  
***Head Nurse, Dept of Military Medicine***

- Supervised health care services to a Soldier population of apr 8,000 in

four separate clinical areas.

- Responsible for leadership and management of all department services provided by 27 assigned nursing personnel.
- Served on Functional Management Teams (Medication Management, Medical Records) with a focus on Performance Improvement for the organization.

**Mar 2004 – Jul 2005    RWB Army Health Center    Sierra Vista, Az**  
***Head Nurse, Ambulatory Procedure Unit***

- Responsible for supervision of nursing care and services in the Preadmission Unit and Post-Anesthesia Care Unit.
- Initiated and managed a Performance Improvement project on anesthesia recall and PTSD in post-operative patients.

**Feb 2001 – Feb 2004    61<sup>st</sup> Area Spt Med Battalion    Killeen, Tx**  
***Head Nurse, Area Support Medical Company***

- Served as Battalion Chief Nurse and medical liaison to corp level units.
- Planned, implemented and evaluated medical training for 150+ Army medical personnel.

**Jan 2000 – Jan 2001    121<sup>st</sup> General Hospital    Seoul, Korea**  
***Clinical Staff Nurse, Multi-Care Unit***

- Senior Clinical Staff Nurse on a 30-bed Med-Surg Unit.
- Responsible for direct patient care for medical, surgical, orthopedic and pediatric patients.

**Dec 96 – Dec 99    William Beaumont Army Med Center    El Paso, Tx**  
***Clinical Staff Nurse, Ambulatory Surgery Unit***

- Provided preadmission nursing assessments, pre-op teaching, discharge planning and post-procedure follow up.
- Dec 96 – Jun 97, Clinical Staff Nurse on a 43-bed multi-service surgical ward.

EDUCATION

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BSN                      The Ohio State University                      Columbus, Oh

LICENSURE

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RN                      Arizona                      Exp Jun 2013

Email: [RLaliberte2011@live.com](mailto:RLaliberte2011@live.com)  
3722 E. Mandan Dr, Sierra Vista, Az 85650  
(520) 678-4962



**GERI BRESSINCK, RN**  
**9545 South Swiss Court**  
**Tel: 520-803-1634**  
**Email: gands5062@msn.com**

## **PROFESSIONAL EXPERIENCE**

**8/08 –Present Cochise Health Systems**  
***Medical/Utilization Management Nurse (M/UM)***  
***Maternity/EPSTD Coordinator***

Trained to identify, monitor, evaluate, and respond to member/provider care issues that impact members' health, safety, and/or well being. Provide oversight and coordination for delivery of primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems to eligible CHS members including those members under 21 years of age which would include all health screenings, developmental/behavioral health screening in accordance with the AHCCCS EPSTD Periodicity Schedules. Includes programmatic oversight of maternity care services such as, preconception counseling, identification of pregnancy, and medically necessary services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. Determine the member's medical or medical-social needs through risk assessment; coordinating referrals for the member to appropriate service providers. Monitoring to ensure delivery of appropriate services for collaborating with revisions of plan of care as indicated. Report program and compliance to AHCCCS and MUM/PIC on a quarterly basis. Participates in monitoring, evaluation and oversight of covered health related services for CHS eligible members including, concurrent review of medical records, pharmacy utilization, medical claims review, cost containment projects, medical review of referrals, medical on-site chart review of SE AZ facilities, on-site facility review of SE AZ facilities, quality of care investigations and direct face to face response to members/providers.

**10/05 - 6/08 Sierra Vista Regional Health Care Sierra Vista Ambulatory Center**  
***Circulating Nurse***

Responsible for managing the nursing care within the operating room by observing the surgical team from a broad perspective and assisting the team in creating and maintaining a safe, comfortable environment. Surgical services include: trauma, pediatrics, oncology, general surgery, urology, otorhinolaryngology, reconstructive, and orthopedic.

**10/94 - 10/04 Wallow County Health Care LTC/Acute Hospital**  
***Nursing Supervisor***

Evaluate and assess residents' needs, including physical and mental health, family and community resources, physical environment, and finances. Developed a plan of care for residents based on a close assessment of resident's requirements. Carried out the arrangements needed to implement the plan. Coordinated all services of a resident's health, safety, and general well being. Periodic reevaluation to make changes in plan of care as needed. Other responsibilities are as follows: Resident Case Manager, Head Nurse Supervisor, worked closely with nursing team, MD's, family and ancillary services, scheduled medical appointment/follow up care. Attended team conferences, utilized MDS, emergency department, OB/GYN, Med/Surg.

**10/94 -10/95    Adult and Family Services**  
***Community Care Nurse***

Completed assessments, medical evaluation, plan of care, teaching, skin care and nutrition. Self Employed. Certified in Gerontological Nursing 1995-2001.

**EDUCATION**

Peninsula College, Port Angeles Washington  
Associate Degree in Nursing 1994

**SOFTWARE/SYSTEM SKILLS**

Excel, Windows, Outlook, State Utilization Programs

**LANGUAGE SKILLS**

Primary English

Cindy Sawinski  
3373 Dirksen Draw  
Tombstone, AZ 85638  
520-559-3568  
[toddsawinski@msn.com](mailto:toddsawinski@msn.com)

**Professional Experience**

**Cochise Health Systems / Case Management**

**1415 Melody Lane Bld A**

**Bisbee, AZ**

**520-432-9600**

Case Management supervisor/Behavioral Health Coordinator/ RN 10-08 to present

- Provide professional oversight of case management staff & management of client placement & services
- Review and analyze monthly reports
- Develop, revise, and implement Case Management Policies and Procedures
- Develop and revise the Case Management Plan on an annual basis
- Facilitate quality Case Management to Cochise Health Systems' clients
- Collaborate with Utilization Management and Quality Management to ensure timeliness of services
- Conduct monthly Case Management staff meetings
- Review PCCRs for determination of appropriate and cost-effective transfer to & from CHS
- Collaborate with Director, Case Managers, and RBHA provider on Behavioral Health issues
- Member placement, staffing, and clinical recommendations, High acuity BH members- Guardianship and secured placement, Monitor BH consult data base to ensure timeliness of service
- Attend Case Management/Behavioral Health meetings at AHCCCS
- Develop, revise, and implement Case Management office procedures

**Cochise Health Systems / Case Management**

**1415 Melody Lane Bld A**

**Bisbee, AZ**

**520-432-9600**

Assistant Case Management Supervisor/Behavioral Health Coordinator/RN 10-07 to 10-08

- Provide professional oversight of case management staff & management of client placement & services
- Assist Case Management Supervisor in reviewing and analyzing monthly reports
- Develop, revise, and implement Case Management Policies and Procedures
- Assist in development and revision of the yearly Case Management Plan
- Facilitate quality Case Management to Cochise Health Systems' clients
- Collaborate with Utilization Management and Quality Management to ensure timeliness of services
- Participate in monthly staff meetings
- Review PCCRs for determination of appropriate and cost-effective transfer to & from CHS
- Collaborate with Supervisor, Case Managers, and RBHA provider on Behavioral Health issues
- Input member and CM information in Plexis system
- Attend Case Management/Behavioral Health meetings at AHCCCS
- Develop, revise, and implement Case Management office procedures

**Correctional Medical Services/Pima County Adult Detention Center**

**1270 West Silverlake Rd**

**Tucson, AZ 85713**

**520-351-8139**

Director of Nursing 6/07 to 10/07

**Health South Rehabilitation Institute of Tucson**

**2650 N Wyatt Drive**

**Tucson, AZ 85712**

**520-325-1300**

Charge Nurse/Staff RN 8/06 to 6/07

**Wisconsin Department of Corrections**

**Wisconsin Secure Program Facility**

**1101 Morrison Dr.**

**Boscobel, WI 53805**

608-375-5656

Health Services Administrator 1/03 to 8/06

**Prison Health Services**

**Supermax Correctional Institution**

**1101 Morrison Dr.**

**Boscobel, WI 53805**

608-375-5656

Health Services Administrator 7/02 – 12/02

**Prison Health Services**

**Supermax Correctional Institution**

**1101 Morrison Dr**

**Boscobel, WI 53805**

608-375-5656

Registered Nurse: 5/02 – 7/02 Staff Nurse

**St. Joseph's Community Health Services** 11/00 – 5/02

**400 Water Ave**

**Hillsboro, WI 54634**

608-489-8000

**Acute Care General Hospital**

**Critical Access Hospital**

Registered Nurse: Charge Nurse; Med/Surg ER

**Orchard Manor** 9/99-11/00

**8800 US Hwy 61 S**

**Lancaster, WI 53813**

608-723-2113

**Long Term Care**

Registered Nurse: Nurse Manager, Developmentally Disabled Unit

**Lancaster Care Center** 8/99-11/00

**1350 S Madison**

**Lancaster, WI 53813**

608-723-4143

**Long Term Care/Rehab**

Registered Nurse Staff Nurse

**Wisconsin Veterans Home** 8/98-6/99

**King, WI 54946**

715-258-5586

**Long Term Care**

Registered Nurse: Nurse Clinician 2

**Manawa Community Nursing Center** 12/97-6/99

**400 E 4<sup>th</sup>**

**Manawa, WI 54949**

715-596-2566

**Long Term Care/rehab**

Registered Nurse: Night Charge Nurse

**Riverside Medical Center** 4/91-12/97

**800 Riverside Dr.**

**Waupaca, WI 54981**

715-245-1000

**Acute Care General Hospital**

**Critical Access Hospital**

Registered Nurse: Staff Nurse, Med/Surg, ER, Specialized Care Unit

**Certifications:** CPR-AED (AHA), Train the Trainer, Primary Instructor for Certified Nursing Assistants,

Wisconsin Department of Corrections Supervisory Development Program,

2004 Wisconsin Nursing Law

Previous certifications: ACLS, PALS, TNCC

Associate Degree: Registered Nurse, Fox Valley Technical College, Appleton, WI 1994



## COCHISE HEALTH SYSTEMS (CHS) ORGANIZATION AND STAFFING # C4

All CHS Key Staff positions are filled and the following positions are not full time: Medical Director/CMO, Dental Coordinator, and Pharmacy Coordinator. Justification for these less than full-time positions follows.

### **MEDICAL DIRECTOR/CMO**

The Medical Director (CMO) for CHS, Rhema Sayers, MD, is a part-time employee at 14 hours per week (or .35 FTE) and has worked with CHS since 1994. The position is not full time because of the relatively small size of our membership. As a small plan, the number of hours that the CMO needs to accomplish her necessary duties does not justify a full-time physician. In fact, CHS membership has decreased over the years to a low of 871 currently. The Medical Director is available and willing to work more time if needed.

The CHS CMO works part time as an Urgent Care physician in the Tucson area. She is available to CHS staff or members 24 hours per day, seven days/week via cell phone. The CHS CMO, a Board Certified in Family Medicine with a specialty in Geriatrics, is a dynamic, involved team member. The CMO maintained a private practice in Douglas for many years before moving to Tucson. Dr. Sayers knows many of our contracted providers on a first name basis and has worked with or referred to them for many years. Those relationships, as well as her experience and current involvement in the provision of direct patient care, greatly enhances her effectiveness and credibility with our contracted providers and other medical professionals. She also has developed collaborative relationships with many providers in the Tucson area. This rapport is a very valuable asset when one of CHS' members requires placement outside of our GSA and/or with a non-contracted provider. Dr. Sayers plays an integral role in network development, is involved in creation of policy and protocol, and in the medical/utilization/quality management of CHS members. She communicates regularly (at least daily) with CHS staff and Leadership Team to discuss quality of care concerns, prior authorization requests, medical review of claims, and other issues. The CMO is the Chair of the Medical/Utilization Management and Process Improvement and Peer Review/Credentialing Committees. Dr. Sayers is dedicated to the continued excellence of CHS and brings to us a wealth of hands-on patient care experience and expertise in managed care, particularly with ALTCS members.

When issues are referred to our CMO that she is not comfortable in evaluating or managing, CHS contracts with several specialty consultants with whom she can confer. These specialists include an internal medicine physician, a pediatrician, a geriatrician, the Medical Director of another ALTCS PC (for secondary review on appeals), and we are currently pursuing an agreement with an ophthalmologist. CHS also contracts with Parag Patel, MD who acts as a secondary reviewer in the Grievance Process for Member Appeals and Claims Disputes. Since Dr. Patel is not involved in any previous level of review or decision-making, this ensures that decisions rendered are objective and independent. The involvement of Dr. Patel and the other specialists with whom CHS contracts ensure that decisions involving clinical issues include a provider who has the appropriate clinical expertise per federal requirements. These specialty consultants are also involved in the development of CHS Clinical Practice Guidelines. Our CMO also participates regularly in the AHCCCS meetings for Medical Directors and considers this group, and our PBM, as other resources for her in clinical management decisions.

### **DENTAL COORDINATOR**

The Dental Coordinator for CHS, Mark Curtis, DDS, is an on-call employee and has worked with CHS since 2009. As with our CMO position, the Dental Coordinator position is not full time because of the relatively small size of our membership. As a small plan, the number of hours that the Dental Coordinator needs to accomplish his necessary duties does not justify a full-time position. These duties have been further decreased with the recent changes in ALTCS benefits relating to covered dental services. Dr. Curtis is a licensed dentist in the state of Arizona who is available and willing to work more time if needed and is available to CHS staff by phone at all times.

## KEY STAFF POSITIONS WHICH ARE NOT FULL-TIME

Due to the relatively small size of our member population, all CHS Executive Management/Leadership Team members occupy more than two of the Key Staff positions listed. This listing was sent to AHCCCS DHCM in May 2010 and was approved. In addition, the nature of the duties in relation to each of these positions, as well as the size of our network, allows for these individuals to wear "multiple hats". At least annually, the CEO evaluates the adequacy of these staffing assignments by reviewing Member and Provider survey results, Quality of Care Concerns, Expressions of Dissatisfaction, and timely compliance with contractual compliance organization-wide. The CHS Leadership Team meets bi-monthly and works collaboratively to resolve any issues that may arise. Each team member is willing and able to provide assistance to another team member should any individual workload become unmanageable. The approximate time allocation for each role varies throughout the year based on that role and duties. Line staff in all divisions can also be depended upon to offer support and assistance to the Leadership Team at all times.

An example of how wearing "multiple hats" is advantageous at times is Ms. Saroff's position as COO. In addition to her role as Cultural Competency Coordinator, Ms. Saroff also performs the duties of the co-Compliance Officer, Contracts Compliance Officer and Claims Dispute and Appeals Manager, and Provider Services Manager thus ensuring that Subcontractors are aware of the importance of providing services in a cultural competent manner and that the Grievance process is culturally and linguistically sensitive to members' needs

A list of CHS staff holding more than one Key Staff Position follows. All are employed full time by CHS and the approximate time allocation to each role is indicated in parentheses following the titles.

**Mary Gomez, RN, CEO (95%) and Business Continuity Planning and Recovery Coordinator (5%).** Mrs. Gomez has one full-time Administrative Coordinator to assist in the accomplishment of these roles.

**Chuck Smith, CFO (50%), Claims Administrator (45%), and Provider Claims Educator (5%).** Mr. Smith supervises a Financial Manager and three Senior Claims Processors (4.0 FTE) who assist in the accomplishment of his duties. The average number of years of experience among the Claims Processors is seven years.

**Paula Saroff, as COO, responsibilities include: Contract Compliance Officer (30%), Provider Services Manager (30%) Dispute and Appeal Manager (30%), and co-Compliance Officer (10%).** Ms Saroff supervises three administrative support staff to assist in the accomplishment of her duties, especially in Provider Services and Dispute and Appeals. Collectively, Ms. Saroff and the Program Coordinator in this division have over 20 years of LTC experience, specifically with this ALTCS health plan.

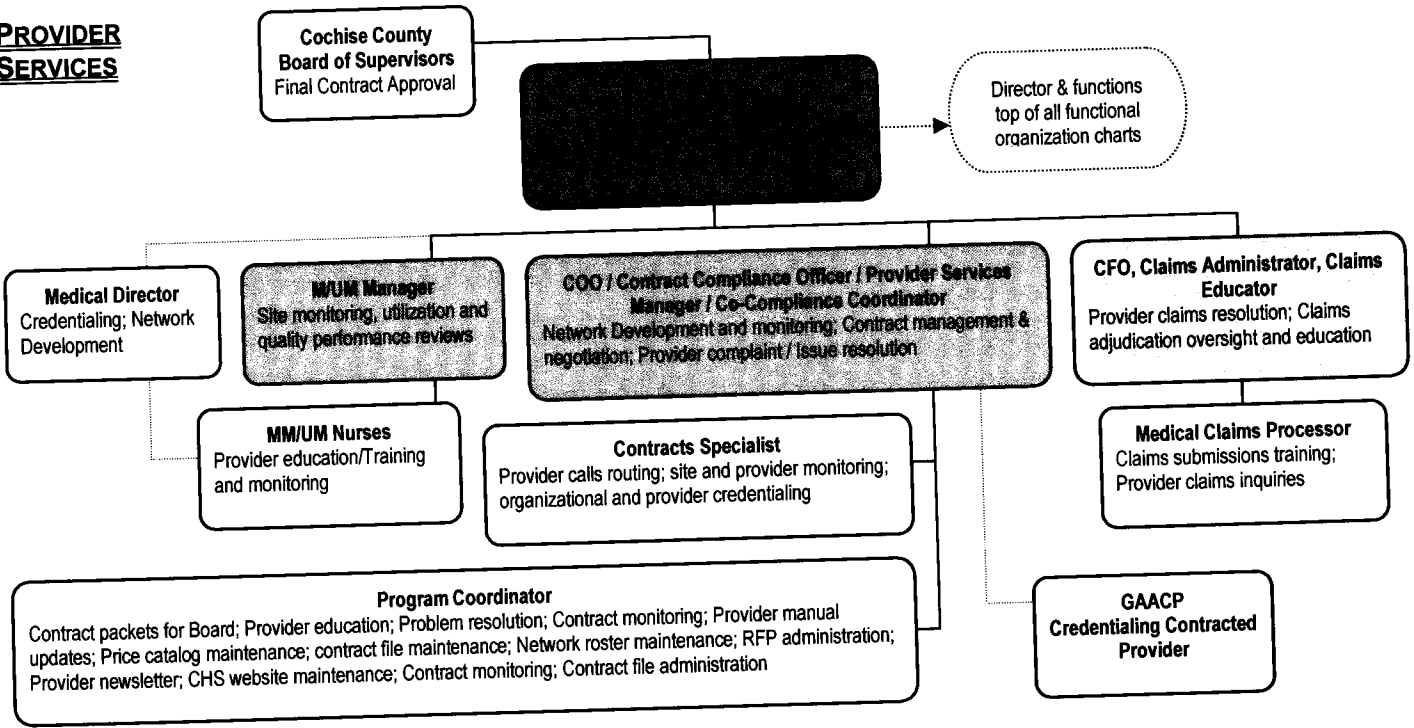
**Cindy Sawinski, RN, Behavioral Health Coordinator (35%) and Case Management Manager (65%).** Mrs. Sawinski supervises four full-time Lead Case Managers and a 0.75 FTE RN whose role is CM-M/UM Liaison. These five CM staff members assist Mrs. Sawinski in her dual role as BH Coordinator and CM Manager. The average number of years of experience of the CHS Case Management team is 12 years per Case Manager.

**Rebecca Laliberte, RN, co-Compliance Officer (10%), Quality Management Coordinator (30%), Performance/Quality Improvement Coordinator (30%), and Medical Management Coordinator (30%).** Mrs. Laliberte supervises four other highly experienced RNs (3.75 FTEs) and four administrative support staff to assist in the management of her duties. The combined number of years of RN experience in CHS Leadership Team and M/UM is 223 years! One of those RNs has been a certified professional coder for three years and there are very few certified professional coders on the payer side in the AHCCCS arena. This RN is hoping that Dr. Lieb will offer the national certification course again in the future – she was unable to take it the last time it was offered because she did not have the pre-requisite three years experience at that time. This RN has been doing medical claims review pre and post payment, as well as for prior authorization requests, at CHS for over ten years. She has saved CHS/AHCCCS thousands of dollars by scrutinizing claims for unbundling and incorrect coding as a part of CHS' Fraud and Abuse prevention efforts.

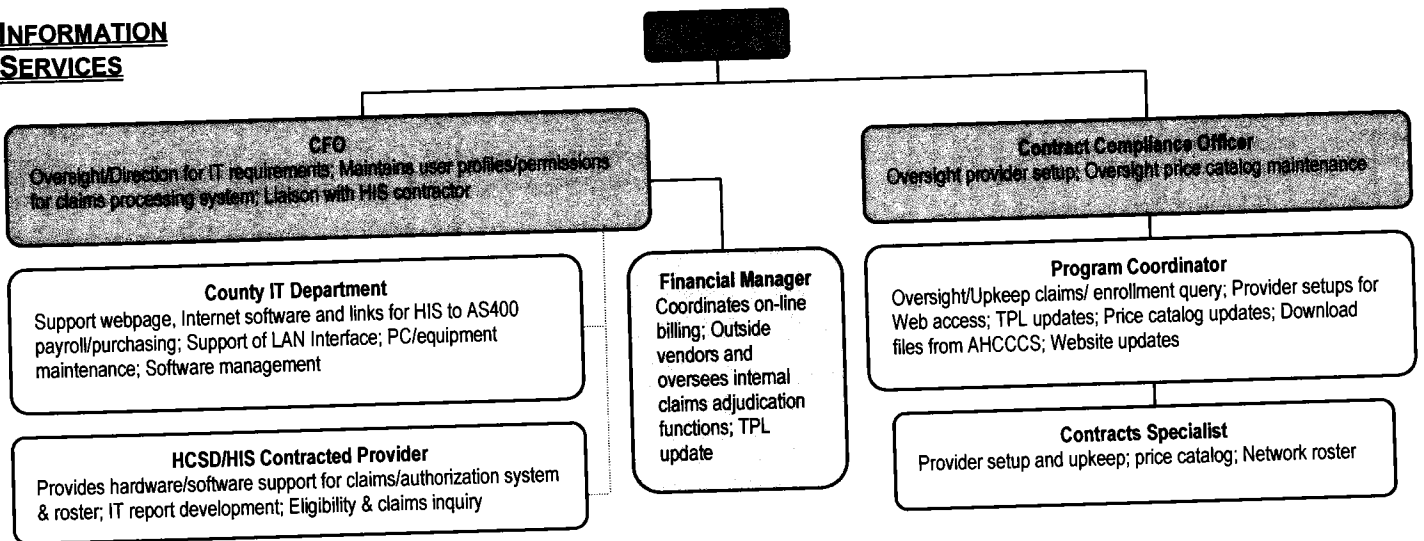
# COCHISE HEALTH SYSTEMS FUNCTIONAL ORGANIZATION CHART

#C5

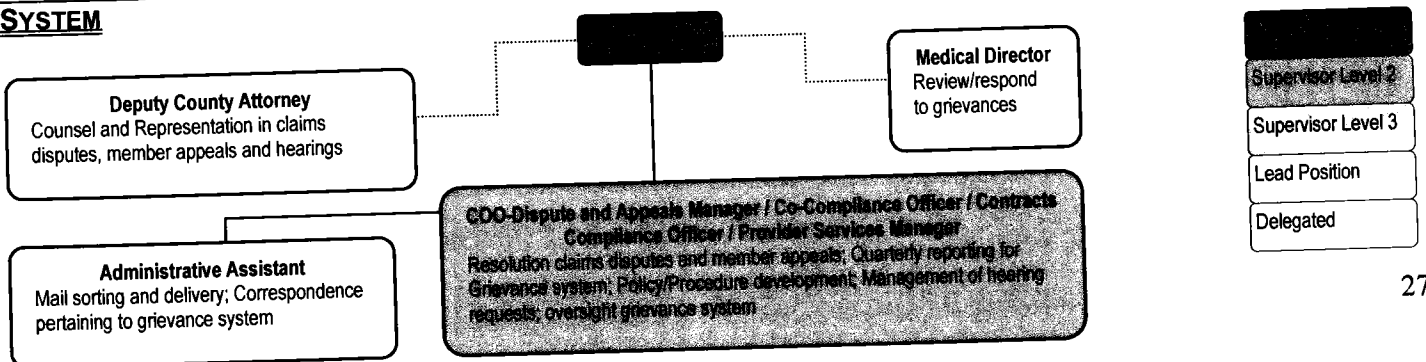
## PROVIDER SERVICES



## INFORMATION SERVICES

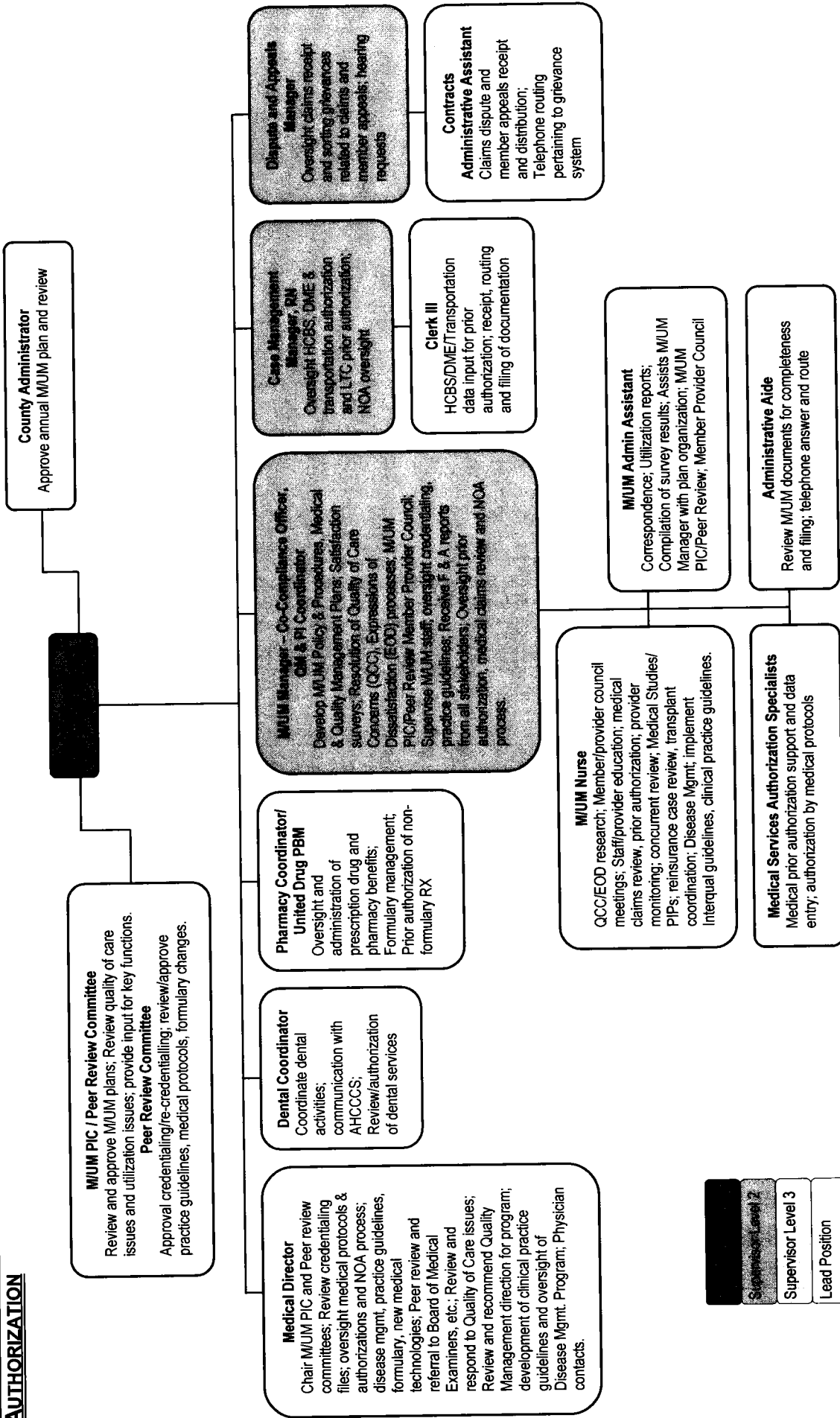


## GRIEVANCE SYSTEM



**COCHISE HEALTH SYSTEMS FUNCTIONAL ORGANIZATION CHART**

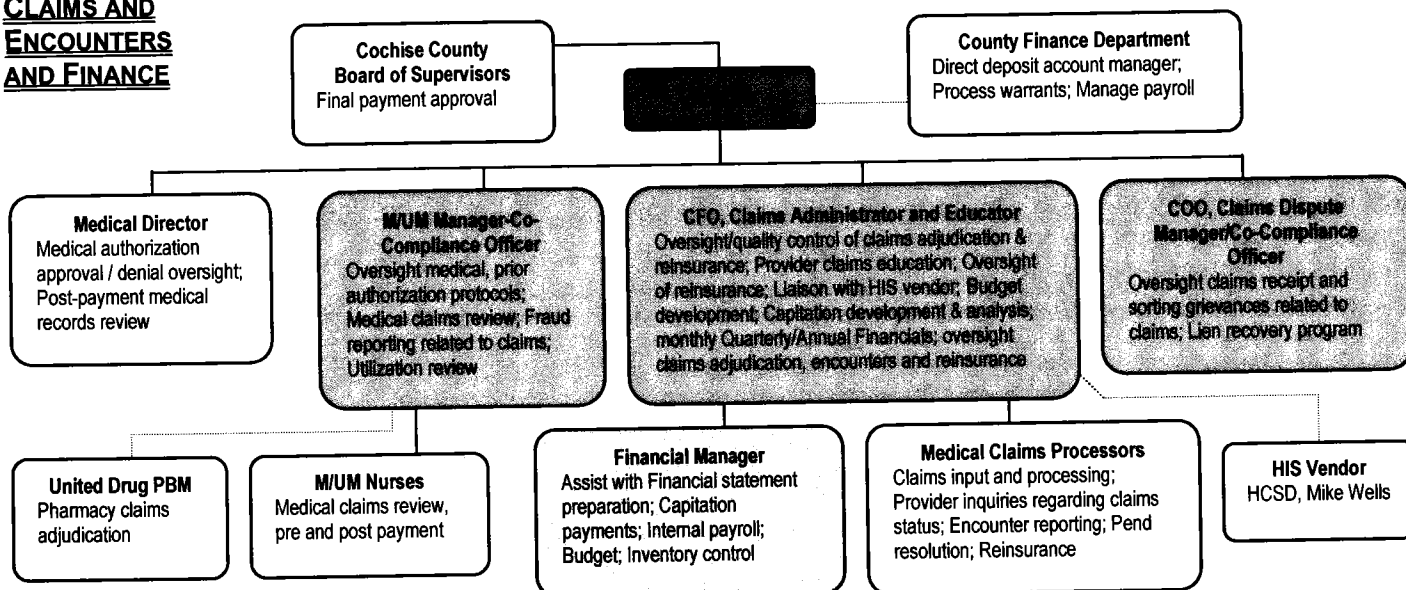
**MEDICAL/QUALITY  
MANAGEMENT AND PRIOR  
AUTHORIZATION**



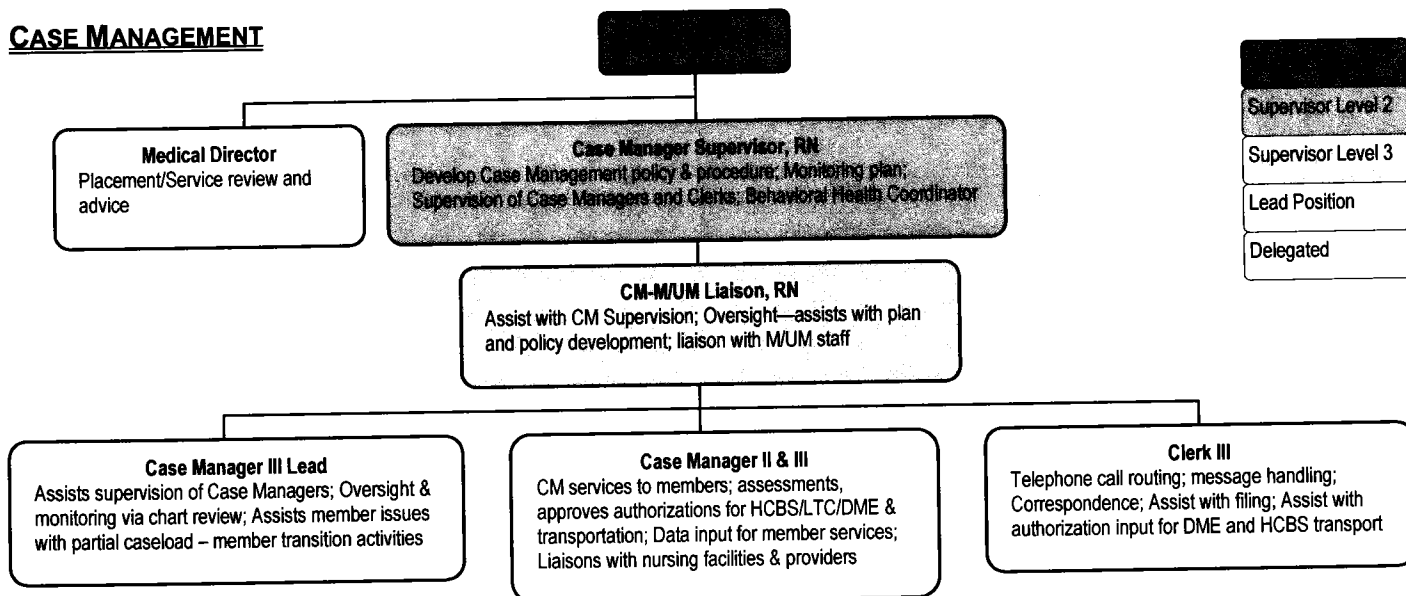


## COCHISE HEALTH SYSTEMS FUNCTIONAL ORGANIZATION CHART

### CLAIMS AND ENCOUNTERS AND FINANCE



### CASE MANAGEMENT



There are three key program areas at CHS in which a portion of the services provided are subcontracted in Delegated Agreements. These are Pharmacy Benefit Management to United Drugs, Health Information Systems to HealthCare Systems Development, and Provider Credentialing to Greater Arizona Central Credentialing Program. Functional organizational charts for all program areas follow and the delegated functions are clearly identified. CHS remains legally responsible for contract performance of all delegated entities and will ensure that all activities carried out by the delegated subcontractor conform to the provisions of the AHCCCS contract. All CHS subcontracts are in writing, have been in place for several years, and have been reviewed and approved by AHCCCS, Contracts and Purchasing Division. All subcontracts incorporate by reference the applicable terms and condition of CHS' contract with AHCCCS. In the event that any other key program function is delegated/subcontracted in the future, CHS will request prior review and approval from AHCCCS DHCM at least sixty days prior to the beginning date of the subcontract.

Before entering into any agreement with a subcontractor, CHS evaluates the prospective subcontractor's ability to perform the activities to be delegated. CHS monitors the subcontractor's performance on an ongoing basis and conducts a formal review at least annually or more frequently if requested by AHCCCS. Any performance deficiencies identified in this review process are communicated to the subcontractor in order to establish a corrective action plan (CAP) if needed. The results of the performance review and the CAP are also communicated to AHCCCS upon completion. CHS is compliant with all requirements in Section D, Paragraph 33 Subcontracts relating to delegated agreements.

**Sanctions**



## COCHISE HEALTH SYSTEMS (CHS) SANCTIONS # C6

Since January 1, 2008, AHCCCS has sent CHS letters reporting the Final Aged Pended Encounter Sanctions for each quarter. All pended encounter sanctions for CHS were waived by AHCCCS. The most recent notice received was 3/3/11 for the quarter ending December 2010. Again, sanctions were waived; however, as always, CHS is working diligently to correct the pended encounters in a timely manner. CHS understands that in the event the encounters in question are not corrected timely, AHCCCS reserves the right to levy sanctions retroactively. CHS staff meets by telephone quarterly with AHCCCS Encounter and Reinsurance staff for our 1:1 meetings. CHS has found these meetings to be extremely helpful and informative and the exchange of information with AHCCCS staff during the meetings and in between meetings has helped CHS to correct pended encounters timely and to reduce or prevent errors that are causing the pended encounters. CHS, along with our claims processing systems administrator, have recently implemented some changes that should result in a reduction of the number of pended encounters. CHS is one of few PCs who have in part converted to the 5010 file format and are testing with AHCCCS. To date, CHS has not identified any major issues with the 5010 file format and continues to report monthly progression toward the goals for integration of all the required HIPAA 5010 file Formats. CHS does not anticipate any problems with the 5010 conversion.

CHS did have one other issue in CYE 2010 to note in this response regarding Notices of Action (NOA) and possible sanctions. CHS staff participated in a telephone conference with AHCCCS DHCM staff to discuss two NOA letters in which CHS incorrectly utilized samples from the NOA Language Guide in NOA letters sent to two separate members. At the time of this discussion, the issues were considered "sanctionable" and a monetary amount was discussed. However, as of this date, CHS has not identified any sanctions imposed for this occurrence. While CHS did not receive a formal sanction notice and no monetary penalty was assessed, CHS includes this information in the interest of full disclosure.

**Claims**



## COCHISE HEALTH SYSTEMS (CHS) CLAIMS SUBMISSIONS # C7

CHS uses Health Care Systems Development's (HCSD) proprietary computer system for the software to adjudicate claims and encounters. The HCSD system collects, analyzes, integrates, and reports data. It provides information on areas including, but not limited to, service utilization by member and provider, authorizations, claim disputes and appeals. HCSD integrates member demographic data, case management information, provider information, contract terms, service provision, claims submission, coding edits, and reimbursement. It collects, stores, and provides information for the purposes of financial, medical, and operational management. HCSD is a HIPAA compliant claims processing and payment system capable of processing, cost avoiding, and paying claims in accordance with all AHCCCS and federal claims processing requirements. HCSD is adaptable to updates in order to support future AHCCCS claims related requirements as needed.

CHS currently has a staff of nine (9) full-time medical claims processor positions with an average of seven years experience. The Financial Services Manager/CFO oversees the processes of this section. In addition to initial training, each medical claims processor has access to desktop procedures, which contain thorough step-by-step instructions for each type of claim and provider type, as well as reference files. The claims section conducts monthly meetings/training sessions and uses all published information made available by AHCCCS, such as Claims Clues, Encounter Keys, etc. Issues addressed in the staff meetings are documented for easy reference by staff.

CHS is currently processing approximately 6,000 claims each month on average and processes 100% of claims within 30 days of receipt. The current staff is adequate to maintain this timeframe. Should there be an increase in volume or other circumstance that could potentially slow adjudication time, CHS has two staff members primarily assigned to work pended encounters but can assist in processing claims until permanent staff can be hired and trained or until work volume returns to normal levels. CHS currently meets and exceeds all AHCCCS contractual requirements for timely claims adjudication, as shown by our monthly dashboard statistics. This process is reviewed weekly by the CFO and reported monthly to AHCCCS on the Claims Dashboard report. CHS has already met the AHCCCS requirement to eliminate roster billing for dates of service (DOS) on or after October 1, 2011, since CHS discontinued this process in March 2010. CHS will continue to work with other providers to eliminate roster billing and submit standardized claims for DOS on or after October, 1, 2012.

CHS is currently in the process of contracting with Gateway EDI to process all AHCCCS required Electronic Claims, including electronic submission and electronic remittance in compliance with all HIPAA, AHCCCS, and Federal regulations. All electronic claims will be received through a secure HIPAA compliant site and downloaded into HCDS as shown on the flow chart below. Once in HCDS, the claims will be processed in the same manner as paper claims passing through all required edits. All claims are reviewed and verified weekly prior to release for payment. This contract with Gateway will ensure that CHS reaches the electronic transaction standards set forth in its contract with AHCCCS.

Some service providers currently use an electronic remote entry system that allows them to enter claims directly into the CHS system. These providers are primarily non-emergent transportation providers who do not usually bill Medicare. This process allows for electronic entry for providers who may never have the capability to otherwise submit electronic claims. The claims from these providers constitute approximately 5% of the total claims adjudicated. Once the claim is in the system, it must pass all edits and the electronic entries are checked by the claims processing staff weekly prior to release for payment. In order to ensure that all procedures set forth in the contracts are met, quarterly audits of the backup documents are conducted.

CHS requires back-up documentation for HCBS claims that include a signature from the member or authorized representative confirming that the member received the authorized service. This back-up is checked at time of submission with a paper claim. Due to this process, CHS was recognized by AHCCCS for its efforts in identifying and reporting several providers for suspected fraudulent documentation to the Office of Inspector General. Another tool in CHS efforts to detect fraud and abuse is post-payment medical review of claims by RNs in the Medical/Utilization Management (M/UM) division. This manual process is initiated when any automatic claims edit "pends" a claim for review, or for any claims that have been identified as problematic in general, i.e., dialysis claims.

One of the more experienced RNs in the M/UM division has been performing medical claims review for over ten years. Backup documentation reviewed includes, but is not limited to, medical records, home health visits notes, authorizations, transportation trip tickets, attendant care notes, etc. This RN is a certified, professional coder and has saved CHS and AHCCCS thousands of dollars over the years by reviewing claims for unbundling, inappropriate coding, and overcharging. It is interesting to note that in 2010, AHCCCS had developed two new jobs for medical claims auditors. It appeared that AHCCCS identified the internal need for a coder with medical experience to review claims for appropriateness identification of potential cases of fraud. This is precisely the method CHS has been using for several years with our M/UM RNs. There are two other individuals in the M/UM division who have taken the professional coding classes but have not yet passed the exam. The one RN who is certified provides coding and claims review classes internally to teach the other medical reviewers (M/UM RNs) and claims processors about the current ICD-9 and CPT codes, the correct coding principles, etc. CHS also uses a software application called Encoder, which is an excellent reference for coding and claims review.

Paper claim submissions are controlled throughout the process. The M/UM Section staff receives the claims from the county mail room staff. All claims are date stamped. The claims are then delivered to the CFO where they are sorted by type and queued by date prior to data entry into the system. AHCCCS guidelines and provider contract timelines are considered to ensure that all claims are processed within the prescribed timeframes as per A.R.S. 36-2904H. If a claim is adjudicated past the contract deadline, the HCSD software assesses any late penalty and adds it to the amount due the provider in accordance with A.R.S. 36-2903.01 and 36-2943.D. If the claim is processed prior to the deadline, the system applies the quick pay discount in accordance to the provider's contract with CHS in accordance with A.R.S. 36-2. Non-contracted emergent and non-emergent claims are processed in accordance with A.R.S. 36-2903, 36-2904, and the Deficit Reduction Act of 2005.

Once the claims processor gets the claim from the queue, the claim is checked for such things as eligibility on date of service, timeliness of filing, and other insurance coverage including Medicare and TPL. If there is other insurance, the EOB is reviewed to ensure the billing matches the billing to CHS. If the claim has been submitted in accordance with CHS and AHCCCS guidelines, the appropriate category of service is then determined and the claim is entered into the processing system, HCSD.

HCSD has edits established which are based on various factors, including the edits that are used by the AHCCCS encounter system. AHCCCS FFS rates, including hospital tiers and outpatient methodology, are downloaded into HCSD as well as modifiers and all other appropriate AHCCCS reference files. The CHS Contracts Department staff enters all contracted provider information into the price catalog, or the system defaults to the AHCCCS FFS rates if there is no contracted rate. Quarterly Data Integrity Reports from HCSDS are reviewed by the Contracts Section staff. Original data regarding first party insurers is entered into the HCSD system by the CFO. In order to ensure that any potential outside insurance coverage is kept up to date in the HCSD system, the CFO researches the specific coverage provided by other carriers and enters the updated information in the HCSD system. The information regarding insurance coverage is provided to the CFO by the case managers and AHCCCS via the monthly TPL file on the SFTP. If a TPL is discovered that is not in the AHCCCS System, AHCCCS is notified immediately by using the AHCCCS electronic TPL referral form. The claims adjudicators act as a check and balance by ensuring that the additional insurance coverage is in the system at the time of adjudication. Once the existence of TPL is discovered by the CFO through any means, the CFO updates a TPL log which is maintained in CHS network files. This log can be accessed by all CHS divisions for consideration with prior authorizations, placement, referrals, or any service for which the existence of TPL plays a role in the decision-making process.

Because of the significant volume of claims, the nursing facility and HCBS community setting provider claims are separated to ensure that they are paid within the current or following week's payment cycle. The case managers provide a census report to the claims section that shows the days, level of care authorized and share of cost assigned to each member. Any discrepancy in the share of cost is further verified by checking the monthly report from AHCCCS and the PMMIS.

Authorizations for claim payment are processed by the case management section for transportation, HCBS and counseling services. The authorizations for acute medical services are generated through the M/UM section and authorizations are entered into HCSD system.

Pharmacy claims are received electronically in a file sent by United Drugs, CHS' Pharmacy Benefits Manager to the CHS FTP server. United also sends a remittance file from which the providers are paid semi-monthly. The encounter file is balanced against the remittance file prior to processing. Quarterly audits of the backup documentation are conducted to ensure that there is a record of the member receiving the prescriptions.

Claims that are edited from the system because the authorization does not match the claim are pended in HCSD and forwarded to the appropriate section for medical or case management review. The appropriate action is taken and either the approval is noted on the claim, or a letter is sent returning the claim and detailing the additional information that is needed. The claim may be denied for untimely receipt or lack of authorization and in those cases, a letter is also sent to the provider explaining the reason for the denial and giving the provider their appeal rights.

Once the claims for the weekly cycle have been entered and disposition has been entered into HCSD system, the claims are sorted by provider with a HCSD report attached which details the claim and its disposition. Senior staff and the CFO review all batches. The HCSD printout is used to check entries and payments. Returns and denials are also reviewed to ensure accuracy. Any errors are noted and reviewed with the claim processor and a record is maintained of the number of errors as well as the number of claims processed by each processor.

A file is generated by HCSD that is downloaded into the county's accounts payable system. Any manual adjustments are made and the files are balanced. Cochise County's finance department generates the provider checks. The checks are delivered by the county's finance department to the CHS administration section. The remittance advice generated through HCSD, including grievance rights letters and return or denial letters, are attached to the check and mailed to the provider. Some CHS providers receive electronic payment for their claims. The documentation that would otherwise accompany their check is sent to them following the same schedule as the other claims processed during the cycle.

### **Provider Education and Training:**

New providers receive a provider manual that gives instructions for claim submission, as well as training in claims processing prior to submission of their first claim. Additional training and training materials are provided as needed. Depending on the needs of the provider, ongoing training can sometimes be achieved via phone all the way up to detailed written instructions and a site visit by an experienced medical claims processor.

Provider queries usually begin with a phone call. The call is logged in the call tracking system, or on manual logs, and routed based on the availability of the appropriate claims section staff. Queries are generally answered within one business day or less. Over the last 18 years, CHS claims staff has built a very close relationship with provider billing staff and know many of them on a first name basis. Provider questions are analyzed by senior staff to determine if there is a deficiency in our system. If a deficiency is identified, adequate action is taken to correct the problem and/or additional training or communication with the provider is warranted, this will also be accomplished.

Another resource for claims and eligibility queries is the CHS website. Providers may register with CHS to enter claims and eligibility queries into the CHS website to obtain a summary of the status of the claim. In addition, provider newsletters often address claims issues to help the providers.

### **Monitoring Process and Resolution of Claim Adjudication Deficiencies:**

Deficiencies in the claim adjudication process are internally monitored as part of the weekly cycle. After the claims have been processed through the claims processing system (HCSD), a report is generated by the system that details the claim and payment. The entries are then audited by a senior medical claims processor and the CFO. Generally, 100% of the claims are checked in detail to ensure that the claim has been entered correctly and that the correct amount has been paid. Claims that have no other payer source are given particular attention during the review process, since the primary payer often edits many parts of the claims prior to submission to CHS with the EOB. Errors identified through this review system are addressed as follows:

If any errors are revealed in the entry, the error is detailed in a log and corrective action is initiated. Simple data entry errors are brought to the attention of the individual claim processor and corrected. Ongoing claims processing

errors which show no improvement are subject to formal employee corrective action or retraining for the staff if more than one processor is making the same error.

If a file within the HCSD system is the cause of the error and needs to be updated (such as a change in the price catalog), the information is given to the CHS Contracts Section and the correction is made. If there is a system error, the problem is noted on a log and HCSD is contacted and directed to rectify the problem. A manual adjustment in payment is processed, if required, to ensure that the claim payment to the provider is correct.

Claim deficiencies may also be identified from sources outside CHS. The most common identification sources are phone calls from providers, resubmission of a claim, a claims dispute that has been found to be an error by CHS, or monitoring by other sections of CHS, such as authorization input or price catalog maintenance. CHS encourages its providers to make contact if there are any questions or concerns regarding the claims adjudication process and/or claim payment. Any issues identified by providers are researched and the provider receives a resolution to the problem, usually within 24 hours.

Even though CHS offers claims submission training at the inception of the contract, and the CHS Provider Manual gives specific instructions for claims submissions, the source of the problem may lie with the provider to submit the claim accurately. If CHS identifies a provider deficiency in claim submissions during an internal monitoring, or the provider seeks advice or help, CHS offers assistance. Depending upon the needs of the provider, training can sometimes be achieved via phone, or the process may include a detailed written instruction to the provider, and a site visit by an experienced medical claims processor for training.

### **Cost Avoidance and TPL:**

For Cost Avoidance and TPL activities, CHS uses a series of edits in HCDS that ensure we are payers of last resort. The CFO verifies member eligibility and TPL status prior to claims being received by the processors for adjudication. The processor again verifies eligibility and TPL status along with member Share of Cost on Nursing Facility claims. This process ensures that CHS is payer of last resort on a day-to-day basis. Everything from eligibility to possible TPL is verified during claims processing. HCDS does have the capability to "pend" any claims for a limited period of time where the possibility of another liable party exists in order to further review any potential coverage prior to adjudication. The processing system is also set up to follow the "lesser of" rule as described in the current contract. There is a post-payment review process in place that facilitates any post payment recoveries that need to take place. HCSD, as well as the CHS prior authorization and concurrent review processes, minimize the likelihood of having to recoup already paid claims.

If a recoupment or reimbursement is required, CHS follows all policies set forth by AHCCCS in the current contract. HCDS also identifies potentially liable parties through the use of Trauma Code Edits so that CHS may research for potential Liens that may be enforced.

CHS also conducts an internal claims audit function through the Contracts division. This internal audit conducts member services verification and data validation studies with provider contracts and checks the accuracy of payments against provider contract terms on a quarterly basis. This process also contributes to CHS cost avoidance efforts.

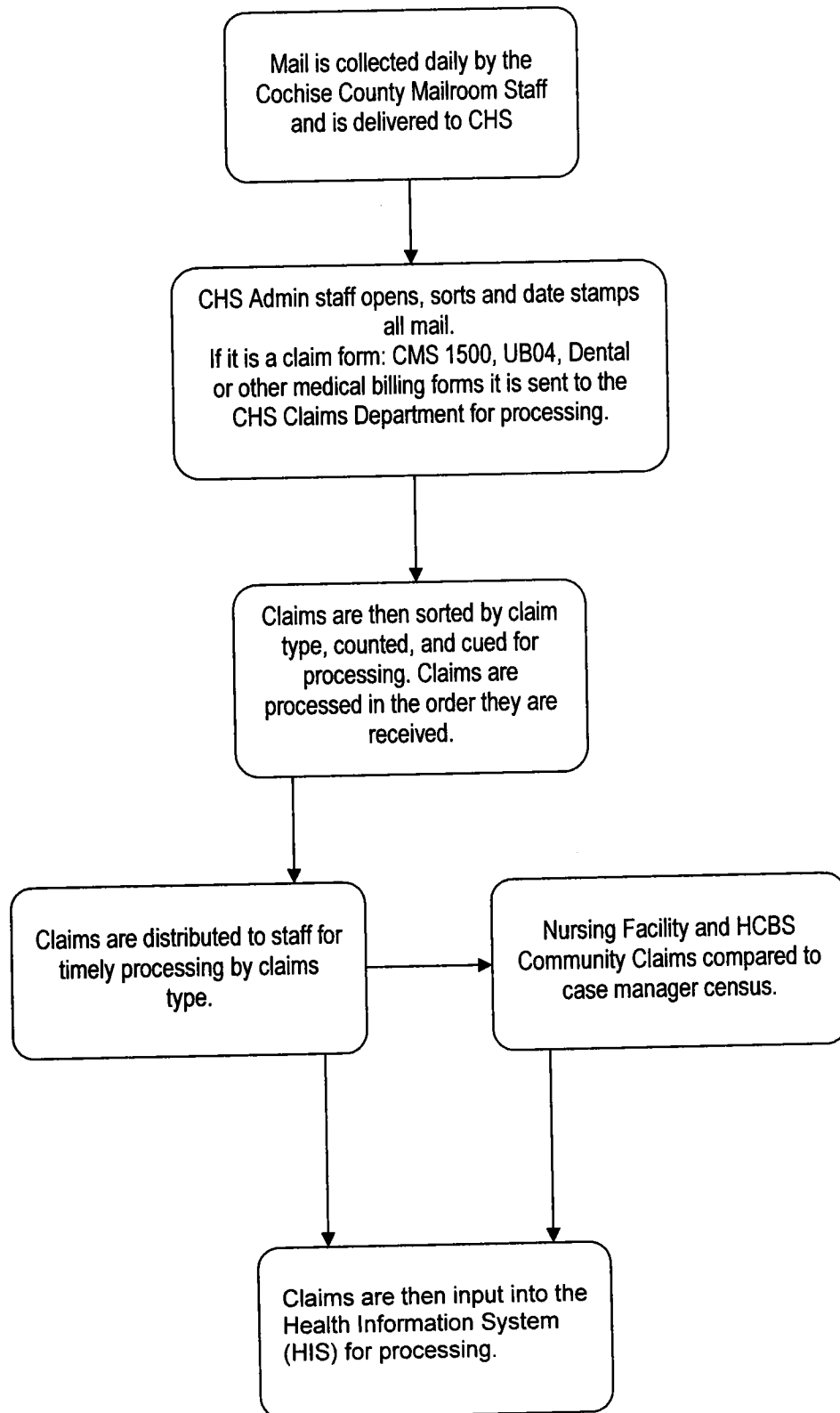
CHS is committed to ensuring that they have adequate resources to maintain its reputation as an accurate and timely payer. CHS looks forward to participating in any AHCCCS workgroup activities to develop uniform billing guidelines for all of our stakeholders. CHS will also continue to review claims requirements, including billing rules and documentation requirements, and report the results of this review to AHCCCS as requested. CHS understands that AHCCCS may require an independent audit of our HIS in future contract years, or in the event of a system change or upgrade, and will comply with this request when directed to do so.

### **Appeals:**

If CHS or a Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, CHS will process the claim for payment from the provider in a manner consistent with CHS' or the Director's Decision and all applicable statutes, rules, policies, and contract terms.

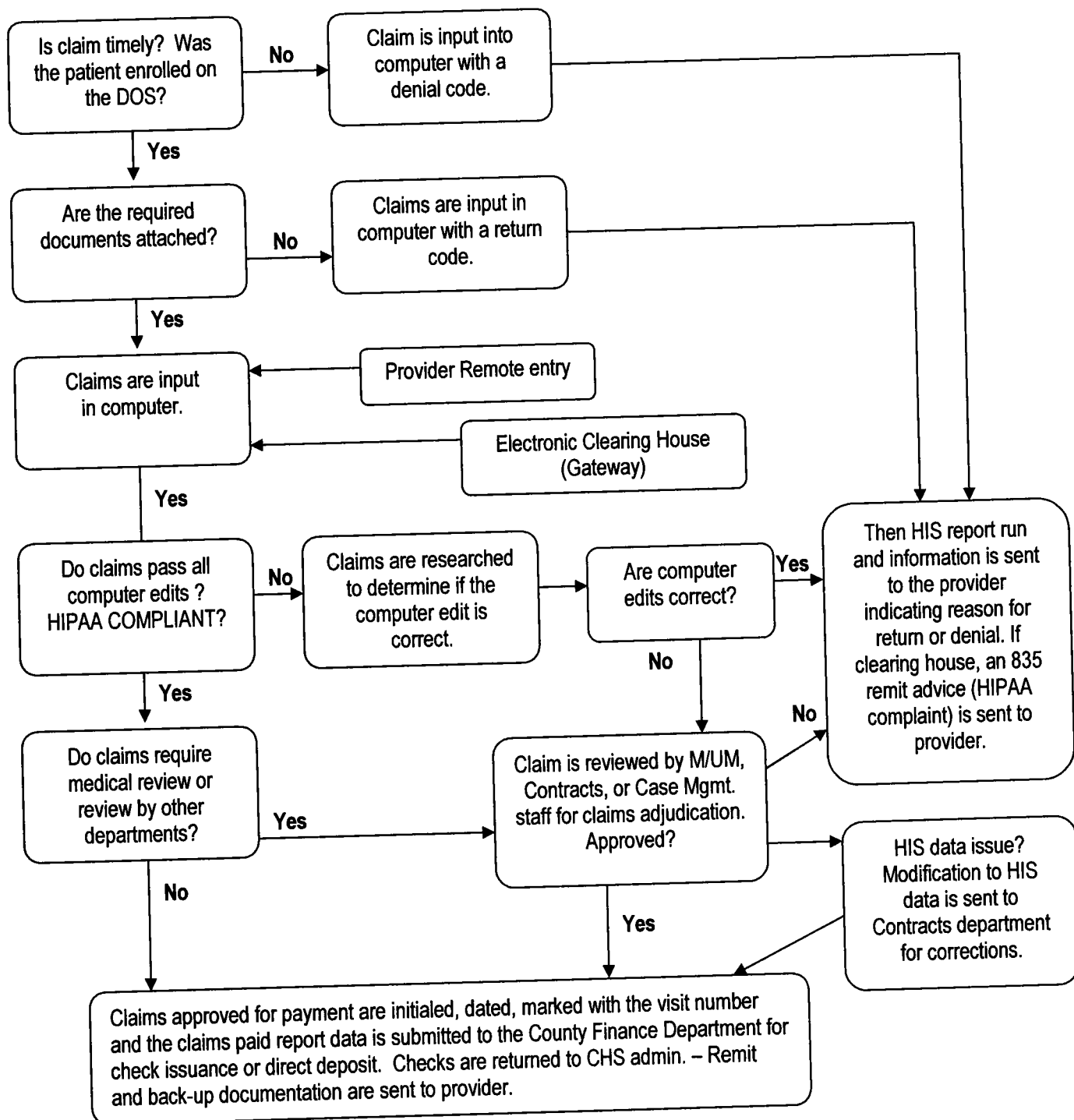


# Cochise Health Systems (CHS) Claims Adjudication Process Flow Chart #C7



# CHS Flow Chart 1 (Continued) #C7

## Health Information System Process/Adjudication



COCHISE HEALTH SYSTEMS FOR DELUCA JR, LAWRENCE A. MD 01/13/2011  
PAYMENT CYCLE JANUARY 20, 2011 PAYMENT TO: DELUCA JR, LAWRENCE A. MD PAGE 62

BILLING NUMBER	PATIENT NAME	DATE OF SERVICE	PROCEDURE CODE	UNITS	AMOUNT BILLED	AMOUNT PAID	HOW PAID
		11/17/10	036556	1	1,014.00	20.12	FFS
			MEDICARE PAYMENT		98.10		
			DIFF BETWEEN MEDICARE/AHCCCS		891.38		
			MEDICARE APPROVED AMOUNT		122.62		
			AMOUNT REDUCED BY FEE SCHEDULE		4.40		
		11/17/10	09929125	1	997.00	19.49	FFS
			MEDICARE PAYMENT		174.62		
			DIFF BETWEEN MEDICARE/AHCCCS		802.89		
			MEDICARE APPROVED AMOUNT		194.11		
		11/17/10	09301059	1	35.00	1.49	FFS
			MEDICARE PAYMENT		7.28		
			DIFF BETWEEN MEDICARE/AHCCCS		25.90		
			MEDICARE APPROVED AMOUNT		9.10		
			AMOUNT REDUCED BY FEE SCHEDULE		.33		

CLAIM CAPITATED TOTALS

CLAIM FEE FOR SERVICE TOTALS

AMOUNT BILLED	.00	AMOUNT BILLED	2,046.00
ADJUSTMENTS	.00	ADJUSTMENTS	2,330.73
TOTAL AMOUNT CAPPED	.00	PAYMENT	3 41.10

Should you have any questions regarding the payment of medical claims submitted to Cochise Health Systems, please contact our claims processing unit at (520) 432-9600.

DENIED CLAIMS

The items listed below have been denied for payment. If you disagree with our denial for payment, you may file a dispute or grievance with Cochise Health Systems. Cochise Health Systems has established a grievance and appeal program for service providers to ensure the operational integrity of the residential and community based service programs and the quality of medical and health care. Please refer to your contract for more details or contact Cochise Health Systems at (520) 432-9481. Your claims with additional information will be returned to you under separate cover.

Please submit all claim resubmissions and claim disputes or grievances to:  
Cochise Health Systems  
PO Box 4249  
Bisbee, AZ 85603

BILLING ID#	PATIENT NAME	SERV DATE	REASON	CHARGES
		11/17/10	CHARGES DENIED BY MEDICARE	451.00

## COCHISE HEALTH SYSTEMS PROVIDER CLAIM DISPUTE RIGHTS (Excerpt from CHS Provider Manual)

### XIII. CLAIM DISPUTES / COMPLAINTS-ISSUES RESOLUTION PROCESS

#### 13.1 RIGHTS AND RESPONSIBILITIES

All providers of services and items to Cochise Health Systems (CHS) members have the right to submit a claim dispute involving a payment or denial of a claim by CHS in accordance with Arizona Administrative Code, R9-34, Article 4 and Arizona Revised Statutes § 36-2903.01.B.4.

Complaints-issues related to contractual matters will be resolved as outlined in the County's Procurement Code and Provider Contracts.

All providers must comply with policies and procedures related to the claim dispute / complaints-issues resolution process in accordance with Federal and State laws, regulations and policies, including, but not limited to, 42 CFR Part 438 Subpart F.

All providers must ensure that member care is not compromised or impacted by the providers pursuing the claim dispute or complaints-issues resolution process. Refer to Policies GRV001B and GRV002 in the Policy Section (pink) of the Manual.

#### 13.2 CLAIM DISPUTES

- a. Prior to submitting a claim dispute, a provider must take reasonable steps to (1) understand the underlying basis of a claim denial or adjudication, and (2) correct any defects in the initial claim submission and resubmit the claim.
- b. CHS encourages providers to seek information/relief prior to initiating a claim dispute, if time allows.

The following steps are recommended:

**STEP ONE:** Contact the CHS Finance Section to help clarify any denials or other actions relevant to the claim and to help with a possible resubmission of a claim with modifications. Allow the CHS Finance Section a reasonable amount of time (30 days) to respond to your request.

**STEP TWO:** If the provider still has a dispute with the resolution of the claim after CHS assistance, the provider may challenge the claim denial or adjudication by filing a formal written claim dispute with the CHS Grievance Manager in compliance with this policy and applicable Federal and State laws.

- a. Prior to submitting a claim dispute regarding a claim not yet adjudicated, a provider is encouraged to contact the CHS Finance Section to determine whether the claim was received and processed by the CHS Finance Section.
- b. The provider should indicate (1) the steps taken to locate any claim (claims tracer) or obtain any explanation; and (2) the date and person contacted.
- c. The provider must institute in writing to the CHS Grievance Manager any claim dispute challenging a claim denial or adjudication. The Grievance Manager must receive the written claim dispute WITHIN TWELVE (12) MONTHS AFTER THE DATE OF SERVICE (FOR A HOSPITAL INPATIENT, FROM THE DATE OF DISCHARGE) FOR WHICH PAYMENT IS CLAIMED, TWELVE (12) MONTHS AFTER THE DATE THAT ELIGIBILITY IS POSTED OR WITHIN SIXTY (60) DAYS AFTER THE DATE OF THE DENIAL OF A TIMELY CLAIM SUBMISSION, WHICHEVER IS LATER.
- d. The claim dispute shall specify in detail the factual and legal basis for the grievance and the relief requested, along with any documents (i.e. claim, claim denial form, remit, medical review sheet, medical records, correspondence, etc.) in support of the factual and legal basis of the claim dispute. Failure of a provider to detail the factual or legal basis may result in the denial of the claim dispute.
- e. A provider shall, as requested by CHS Grievance Manager, supply additional information necessary to document and/or resolve the claim dispute. Failure of a provider to supply requested information in a timely manner may result in adjudication of the claim dispute based upon existing documentation alone.
- f. CHS will make a final decision within thirty (30) days of receipt of the claim dispute and advise you of your appeal rights and procedures if you do not agree with the decision. You must let CHS know you wish to request a hearing WITHIN THIRTY (30) DAYS OF THE DATE YOU RECEIVE THE DECISION LETTER.

(Also see Policy GRV001B in the pink section of the Provider Manual. Please review with all billing staff.)



## COCHISE HEALTH SYSTEMS (CHS) CLAIMS # C8

Cochise Health Systems has been including information regarding electronic fund transfer registration with the payment and remit to providers, notifying them that this benefit is available. Since May 2010, this process has resulted in a 29% increase of providers signing up for electronic fund transfers. Cochise Health Systems is currently undertaking the task of contacting all providers by phone to offer the benefit of electronic fund transfers. In addition, during any future site visits to providers, CHS staff will address EFT payment availability with provider billing staff and strongly encourage their participation. Cochise Health Systems also has a link on our website for providers to access the form they need to complete to initiate Electronic Fund Transfers.

Cochise Health Systems is also currently in the process of contracting with Gateway EDI. Gateway has signed a letter of intent describing an implementation schedule of six weeks. At the end of that period, CHS will have the ability to accept electronic claims and send electronic remits to accompany the electronic fund transfers. At the time the implementation is complete, Cochise Health Systems and Gateway EDI will work together to promote electronic claims, electronic remit, and electronic fund transfers to even more of our network providers. Cochise Health Systems will closely monitor the results of the current efforts from now until it is time for contract renewal – October 1, 2011. If at that time Cochise Health Systems does not meet AHCCCS standards set forth in the current contract for electronic fund transfers, CHS will then make electronic fund transfers a contractual requirement.

With the above efforts in place, Cochise Health Systems expects to meet the AHCCCS Requirement for both electronic claims submission and electronic fund transfers as described in Section D, Paragraph 44 of our Contract with AHCCCS. However, if either electronic claims submission or payment volume is below 60%, CHS shall submit a report to the ALTCS Operations staff on December 15<sup>th</sup> of each contract year. This annual report will at a minimum include measurable goals, the success of previous interventions, barriers to goals, the action/tasks CHS will take to facilitate meeting goals, and the anticipated timeframe to accomplish goals.



## COCHISE HEALTH SYSTEMS (CHS) CLAIMS SUBMISSIONS # C9

Cochise Health System currently has and maintains a HIPAA compliant claims processing and payment system capable of processing, cost avoiding, and paying claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules R9-28 Article 7. This system is adaptable to updates in order to support all future AHCCCS claims related policy requirements as needed. CHS was among the first group of contractors to meet the 5010 requirement for the 820 and 834 file conversions and testing and is confident in meeting the remaining requirements for 5010 as well as ICD10.

Cochise Health System's Claims Process includes, but is not limited to, the following nationally recognized clinical and data related edits:

- Correct Coding Initiative for Professional and Outpatient Services
- Multiple Surgical Reductions
- Global Day E & M Bundling
- Benefit Package Variations
- Timeliness Standards
- Data Accuracy
- Adherence to AHCCCS Policy
- Provider Qualifications
- Member Eligibility and Enrollment
- Over-Utilization Standards

Cochise Health System's Claims Processing system currently produces a remittance advice related to the providers' payments and/or denials that includes, but is not limited to:

- An adequate description of all denials and adjustments
- The reason for such denial and adjustments
- The amount billed
- The amount paid
- Application of COB and SOC amounts
- Provider rights for claims disputes

The related remittance advice is sent with the payment, unless the payment is made by EFT. In that case, the remittance advice is mailed the same day as the EFT is processed.



**Encounters**



## COCHISE HEALTH SYSTEMS (CHS) ENCOUNTERS # C10

Cochise Health Systems is authorized to exchange data with AHCCCS relating to the information requirements of the current contract. CHS through its HIS (HCSD) supports the data elements to be provided to AHCCCS in the formats prescribed by AHCCCS that include formats prescribed by HIPAA. CHS and HCSD follow the formats specified in the HIPAA Transaction Companion Documents and Trading Partner Agreements, the AHCCCS Encounter Reporting User Manual, and in the AHCCCS Technical Interface Guidelines.

CHS, through HCSD, records and submits data to AHCCCS in accordance with all procedures, policies, rules, and statutes in effect during the term of their agreement. If any of these procedures, policies, rules, regulations or statutes are changed, CHS agrees to conform to these changes following appropriate notification by AHCCCS. CHS through HCSD is responsible any incorrect data, delayed submission problems, or payment to CHS or its subcontractors, and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CHS-submitted data. CHS understands that any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS. CHS is also responsible for identifying any inconsistencies immediately upon receipt of the data from AHCCCS. CHS understands that any unreported inconsistencies are subsequently discovered, CHS shall be responsible for the necessary adjustments to correct its records at its own expense. CHS shall also provide to AHCCCS updated date-sensitive PCP assignments in a form appropriate for electronic data exchange upon request.

All data transmissions to AHCCCS are made using the specific security code provided by AHCCCS in accordance with contract requirements. CHS agrees that by use of its security code, it certifies that any data transmitted is accurate and truthful, to the best of CHS' CEO, CFO or designee's knowledge as per 42 CFR 438.606. CHS complies with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 and all Federal regulations implementing that Subpart that are applicable to the operations of CHS by the dates required by the implementing Federal regulations, as well as all subsequent requirements and regulations as published.

CHS Finance uses Health Care Systems Development's (HCSD) proprietary computer software system for adjudicating claims and encounters and subsequently reporting the encounters in the HIPAA compliant format required by AHCCCS as outlined in the X12 and NCPDP Transaction Companion Documents and Trading Partner Agreements as well as the Encounter Manual. Encounters should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered or the effective date of the enrollment with CHS, whichever date is later. CHS follows all requirements for Encounter data as described in the AHCCCS Encounter Manual and the Encounter Companion Documents. The HCSD system edits, which include duplicate billings, valid provider AHCCCS Identification numbers, member eligibility, authorization of services, rate catalog, and reporting capabilities. CHS downloads all reference files containing provider and medical coding information made available by AHCCCS to ensure accurate encounter reporting. Accuracy, timeliness, and completeness of encounter reporting are controlled by CHS policies and procedures, which have been in place since 1993. These policies have been updated to accommodate new procedures as appropriate.

Accurate encounter reporting requires quality control from the time the claim is produced to the time the encounter is successfully adjudicated at AHCCCS. However, if any revision is made to a provider's claim after it has been encountered, a replacement or voided encounter must be submitted. CHS strives to ensure the claims or encounters received from the provider provide the correct level of care, place of service and provider of service. To aid the providers in accurate reporting, CHS provides a comprehensive provider manual, updated quarterly, a semi-annual provider newsletter, and special mailings when requirements change. Individual training is also conducted for providers identified as having excessive errors in billings, or who request such training. On-site visits from our Contracts and Medical Management/Medical Management (M/UM) and Finance divisions are used to identify problem areas and offer support for providers. Because the CHS reporting requirements are based on payment for services, CHS' M/UM Nurses assess the accurate submission of claims by capitated providers since these providers are paid monthly based on members assigned and not on individual encounters. These case file reviews allow CHS to check a sample of encounters reported versus services rendered to ensure complete reporting of encounters by providers, including capitated providers.

On a weekly basis, CHS runs a report of paid encounters through the HCSD system. All edits and any errors detected are corrected. This includes making sure that all Medicare and Third Party Liability payment information is



accounted for in the appropriate fields. The file is balanced against the claims paid report for the same cycle period. The file is dropped into the AHCCCS Community Manager and all errors corrected prior to being loaded on the SFTP to AHCCCS. The file is certified by the CFO and AHCCCS responds upon receipt.

The day after the transfer, CHS begins checking the status of the files in PMMIS. The successful file transfer is logged to ensure timeliness, and a copy of the PMMIS screen is printed for CHS records. If the file was not received or if it failed, the cause is researched and, if necessary, the file is resent. Encounter data must be submitted within 240 days of the end of the month of service or the date of enrollment, whichever is later. To support federal drug rebate processing, pharmacy related encounter data must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. CHS currently partners with United Drug Company to process our pharmacy claims and help ensure that we meet this requirement. Drug rebates are tracked by the CHS Financial Manager.

Following the encounter adjudication edit and audit processing cycle, AHCCCS generates Status and Pend files that are posted on the SFTP for CHS to download and process. The 277U report provides CHS with all finalized encounters and their assigned CRN numbers. This file is directly downloaded into HCDS which results in the CRN numbers being assigned to the correct claim information in the HCDS processing system. The 277S provides CHS with the denied encounters that need to be replaced. This process involves modifying or correcting the data and linking it to the previous submissions for timeliness. The Pend file contains all encounters that need to be corrected. Depending on the type of error, some can be corrected online in the PMMIS system and HCDS system directly, while the majority requires using the void and replacement process. If the correction involves a recoupment, the encounter is voided. The voided encounters are recorded in a database with the reason for recoupment documented. A provider notification is prepared detailing the amount and reason for the recoupment, with a copy of the claim and any appropriate documentation attached. The adjustment is queued for recoupment for the next payment to the provider. If there are no payments to the provider after four weeks, progressive collection commences. For recoupments requiring AHCCCS approval, replacements must be submitted within 120 days of approval.

Reinsurance pended encounters are downloaded monthly when available from AHCCCS. Pended encounters that can be corrected are generally processed the month received. For those pended encounters that require additional documentation, the requested documentation is collected and sent monthly to the AHCCCS reinsurance department. CHS compares data via a program that records the amount of the reinsurance payment from the remittance advice provided by AHCCCS on a monthly basis to the encounters recorded in the HCSD system.

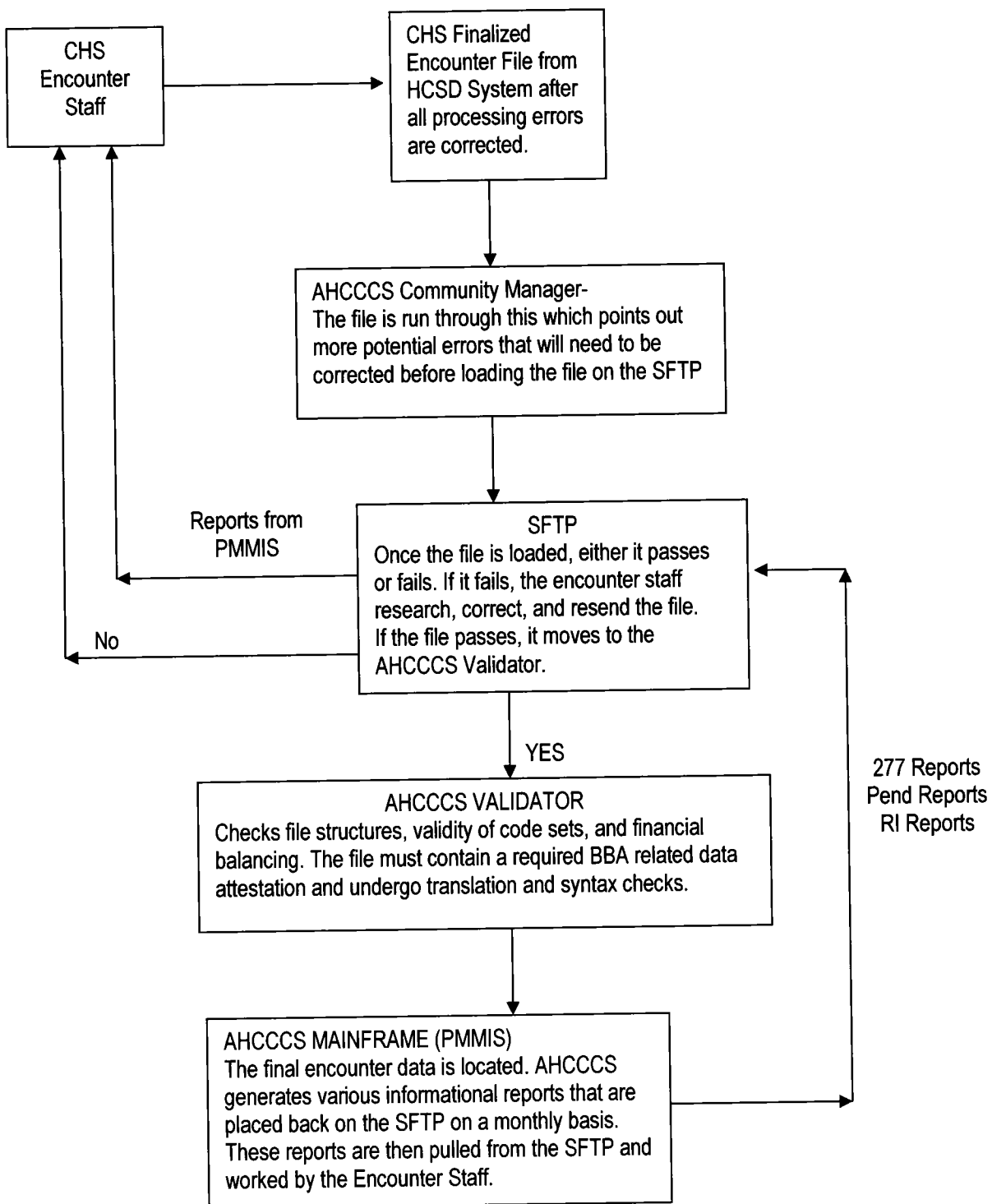
Pended encounters are reviewed within 30 days of the first reporting. The small percentage of items requiring additional research is usually resolved within 90 days. CHS has already implemented the use of the new Encounter Submission and Revision Tracking Report beginning January 2011. This is not an AHCCCS requirement until May 2011. This report serves the purposes of tracking, trending, reporting process improvement and monitoring submission of encounters and encounter revisions. CHS also uses the adjudicated and pended reports provided by AHCCCS via the SFTP on a monthly basis. These reports are listed in the Encounter Manual starting on the bottom of page 3-7. All data is reviewed and researched for any possible issues that need to be corrected, including but not limited to: low submissions, missed target rates, aged pends, etc. CHS understands that it must meet the established encounter performance standards as detailed in the AHCCCS Encounter Manual. Rating below the standards (pended encounters that have pended for more than 120 days), or poor encounter performance overall, may result in corrective action plans and/or sanctions imposed by AHCCCS.

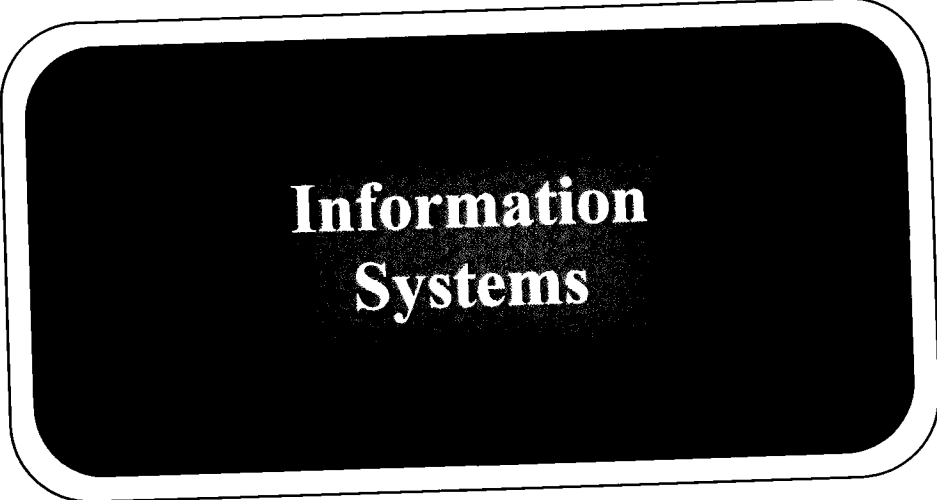
Another feedback mechanism is the data validation process required yearly by AHCCCS. This study compares recorded utilization information to our submitted encounter data. Criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. CHS has scored high on these studies in previous years. Using these reports helps ensure the completeness of the encounter reporting process. CHS also uses the approved encounter reports by month when made available by AHCCCS, AHCCCS Encounter Keys, as well as Quarterly One-on-One Meetings, and continuous email and phone communication with the AHCCCS Encounter Staff to assist with tracking, trending, and improving the overall performance with encounter submissions. CHS uses all of these processes and tools to strive for a goal of 100% pend avoidance.

CHS understands that AHCCCS may also perform special reviews of encounter data, such as comparing encounter reports to CHS' claims files. Any findings of incomplete or inaccurate encounter data may result in the imposition of sanctions or requirement of a corrective action plan from CHS.

# Encounter Submission Flowchart

# C10





**Information  
Systems**



## COCHISE HEALTH SYSTEMS (CHS) INFORMATION SERVICES # C11

Healthcare Systems Development (HCSD), an Arizona partnership, specializes in the development, implementation and support of health care related application software systems. In 1982, HCSD contracted with Comprehensive AHCCCS Plan of Flagstaff to develop systems for AHCCCS claims processing and has been working ever since then with AHCCCS lines of business. HCSD has been providing claims authorization, processing, and encounter reporting software and services to CHS since 1993 when CHS was first awarded an ALTCS contract.

HCSD provides a server-based system that co-exists on Cochise County's IT structure. HCSD uses Hewlett-Packard hardware and operating systems. Database design and support is based upon HP's Turbo Image/XL. Image provides support of design and generation of the database (schema, data dictionary and capacity management), access to the database (read/write, query and report generation), and security of the database to the data item level in compliance with all HIPAA standards.

### **Overall Program Elements and Processes:**

**Eligibility:** Member eligibility with historical eligibility and rate codes are downloaded into HCSD from AHCCCS electronic files. Twelve screens in this section of the program track member demographic information, case management information, primary care providers, transportation limitations, primary caregiver information, and interact with CHS web site for enrollment verification. Daily eligibility information is transferred to HCSD and is processed to enroll a new member, disenroll a member, or update basic demographic information. Case manager is assigned to a member and updates placement for Home and Community Based Services (HCBS) or institutional placement and primary physician information.

**Capitation Management:** HCSD manages this aspect of data processing by recognizing various risk pools according to provider set up information contained in the system. Capitated providers are easily identified and claims are adjudicated according to contract terms. HCSD ensures that all claims from capitated providers are submitted as encounters to AHCCCS. Data from HCSD also allows CHS staff to respond to provider inquiries about how their reimbursement differs as a capitated provider from those providers who are not capitated. This has been very helpful to CHS over the years in contract review and negotiations.

**Prior Authorization and Referral Processing:** are received by CHS via phone conversations or faxed requests. HCSD is currently developing the functions for prior authorization from the CHS web site and/or the HIPAA 278 transaction. Data for IBNR reporting and identification of reinsurance claims is managed by this section of the program. Reporting of all authorizations per member is given to the case manager or other authorization staff. Claims information sent by providers is verified against the prior authorization data in the system prior to adjudication. Claims processors can "pend" any claims on which the prior authorization information on the claim does not match what is in HCSD for further medical review as needed, or the claim is returned to the provider.

**Claims/Encounter Processing:** is accomplished in HCSD through interactive validation and adjudication. Automatic tracking of capitated vs. FFS reimbursement is also accomplished. Claims/encounters, whether using direct entry, dialup entry, data files or batch entry, all use the same adjudication function verifying eligibility, proper coding, and CCI editing, prior authorization of units, days, type of service, duplicate checking prior to payment determination. HCSD generates detailed remittance advice statements for each claim processed and provides clear information to the provider about the claims dispute and appeal rights.

**Medical/Utilization Management (M/UM):** M/UM functions are supported in HCSD through census/placement reporting by case manager and facility, authorizations by case manager or other authorization staff, review and reassessment reporting, repeat use of service report, service lag reporting, inpatient days reporting, provider satisfaction reporting, disease management reporting and monitoring of members with major disease classifications. HCSD data is also utilized in research for Claims Disputes and Member Appeals, and in identifying potential lien recovery cases. The data management in HCSD allows CHS staff throughout the organization to collect, analyze, integrate, report, and share information with providers, AHCCCS, internal workgroups, and authorized stakeholders to improve CHS operations.

EPSDT Processing and Tracking: AHCCCS contractual requirements are met in this area by HCSD, including letter and label generation for member/guardian reminders, and periodic reporting and notifications to AHCCCS and providers.

Reference and Provider File Processing: this section of the software maintains or provider demographic data, including provider profiles and pricing information from AHCCCS.

Interfacing to Cochise County Finance: data is transferred electronically from CHS to Cochise County's Finance department for accounts payable and general ledger interface for claims, provider capitation, operating expense payments, as well as for weekly provider remittance advice generation. The data sent from HCSD is used by the County Finance department to issue provider checks and allows a check and balance of CHS reimbursement processes through the involvement of this outside department.

Interfacing to Cochise County / CHS Website: data is used from HCSD for eligibility verification, claims status, provider inquiries made via the CHS website. All reports requested through online screens allow user control of reporting requirements.

Creation of Data Files for Interfacing to External Agencies: this functionality in HCDS allows for secure electronic claims submission and provider payments. HCSD is intimately involved with CHS implementation of Gateway EDI to increase the number of claims that CHS received electronically, as well as promote Electronic Fund Transfers to CHS providers.

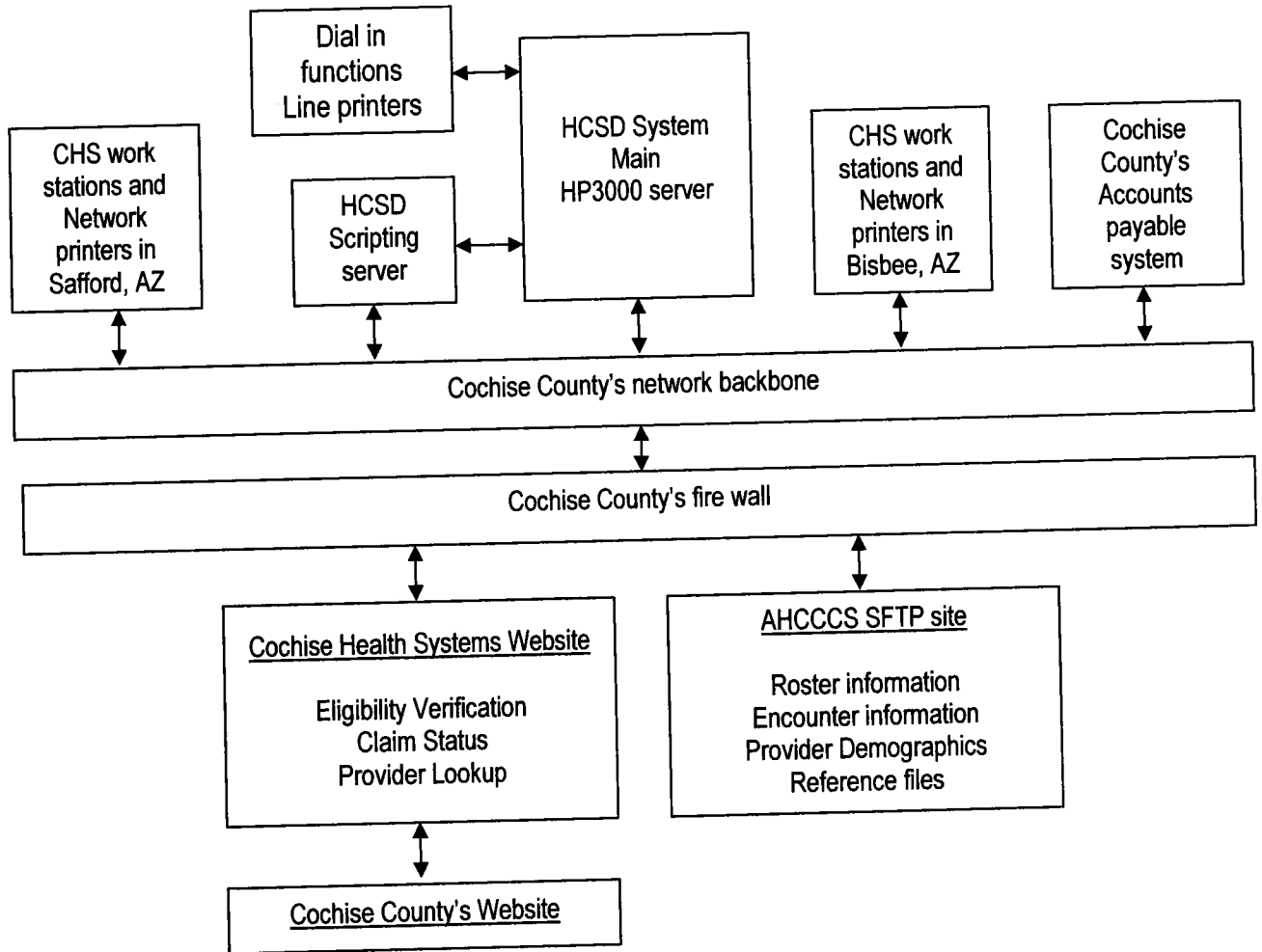
Reinsurance and Deferred Liability Monitoring: this functionality ensures that CHS is the payer of last resort and that claims are paid using the "lesser of" billed amount or contracted rates. Data in this area includes details of claims submitted and reimbursement made.

As described above, the HCSD system collects, analyzes, integrates, and reports data. It provides information on areas including, but not limited to: service utilization and claim disputes and appeals in accordance with all AHCCCS contractual requirements and Federal and State mandates. HCSD integrates member demographic data, case management information, provider information, service provision, claims submission, and reimbursement amounts. HCSD collects, stores, and provides information for the purposes of financial, medical, and operational management. HCSD is a HIPPA compliant claims processing and payment system capable of processing, cost avoiding, and paying claims in accordance with all AHCCCS and federal claims processing requirements. HCSD is quickly adaptable to updates in order to support future AHCCCS claims related requirements as needed.

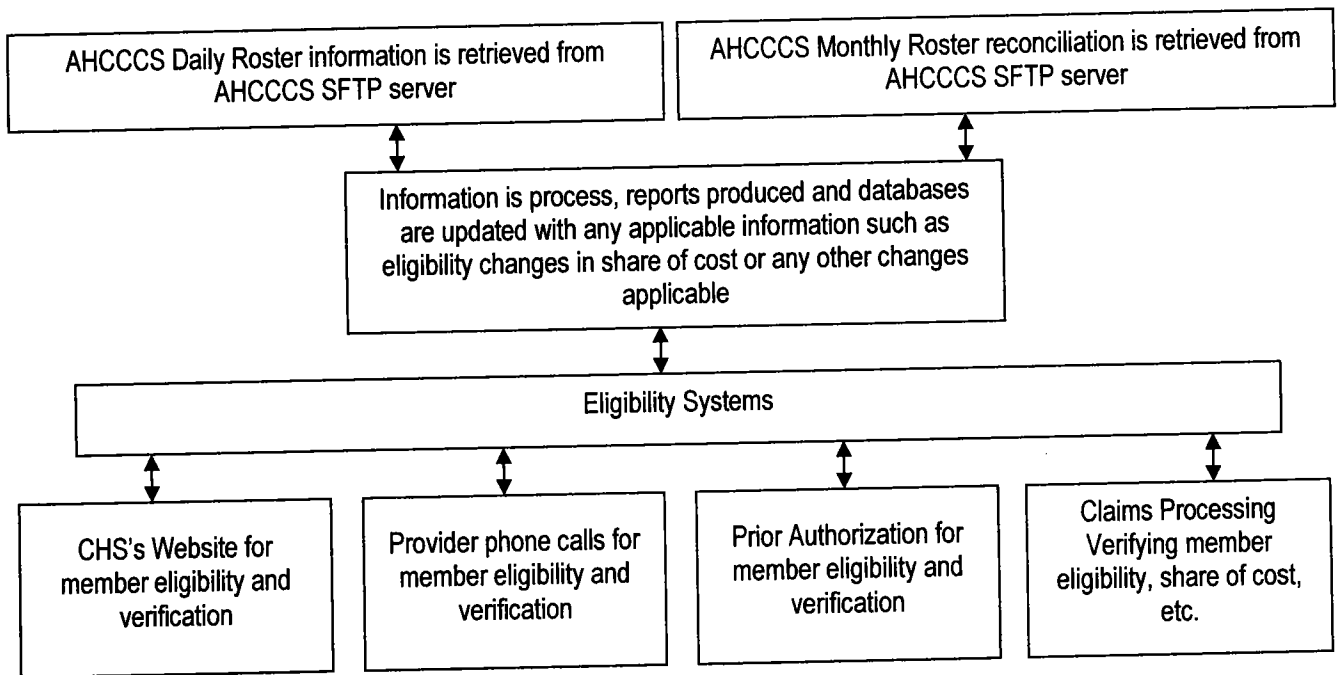
CHS is currently authorized to exchange data with AHCCCS relating to the information requirements of the current contract. Through HCSD, CHS provides these data elements to AHCCCS in the formats prescribed by AHCCCS adhering to all HIPPA standards. CHS and HCSD follow the formats specified in the HIPPA Transaction Companion Documents, the AHCCCS Encounter Reporting User Manual and the AHCCCS Technical Interface Guidelines. CHS and HCSD submit data to AHCCCS in accordance with all procedures, policies, rules, and statutes during the course of their agreement and beyond termination of the agreement as described in contracts.

Upon receipt of data from AHCCCS, CHS using HCSD is responsible for correcting any incorrect data, delayed submission or payment to CHS or its subcontractors, and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CHS-submitted data. CHS is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCS. CHS understands that if any inconsistencies are subsequently discovered, CHS shall be responsible for the necessary adjustments to correct its records at its own expense.

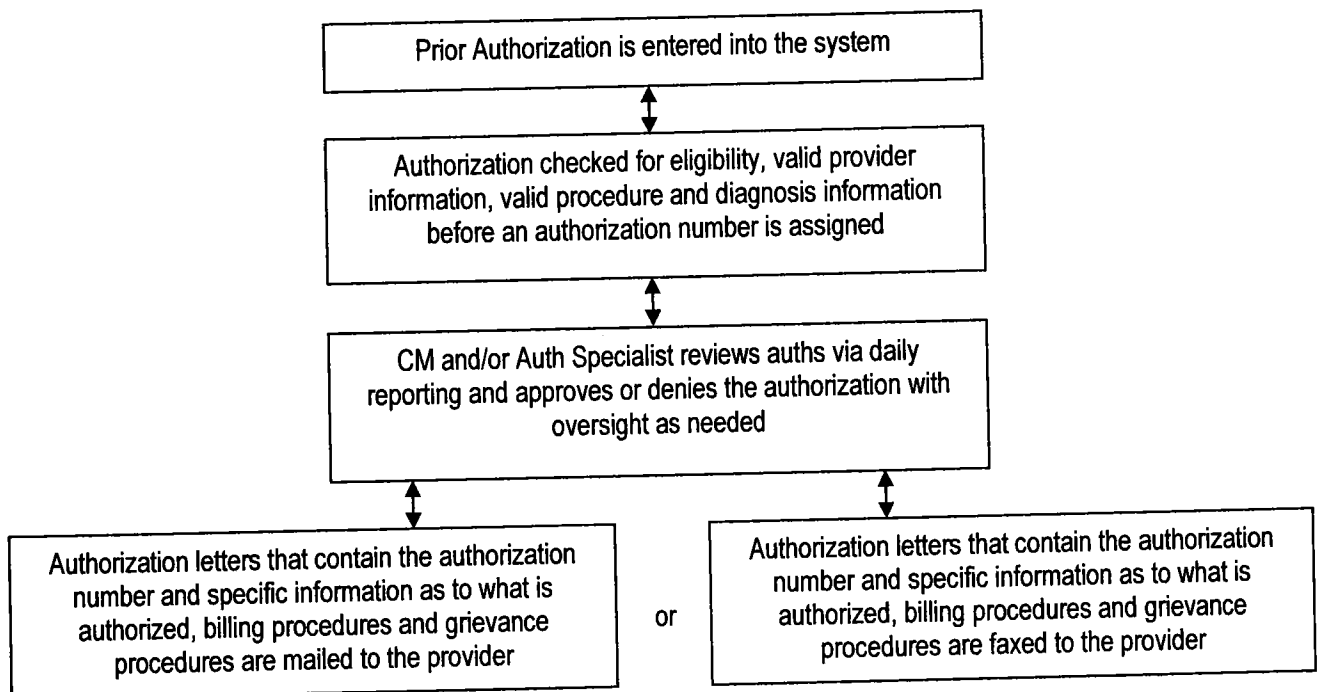
# HCSO OVERALL NETWORK



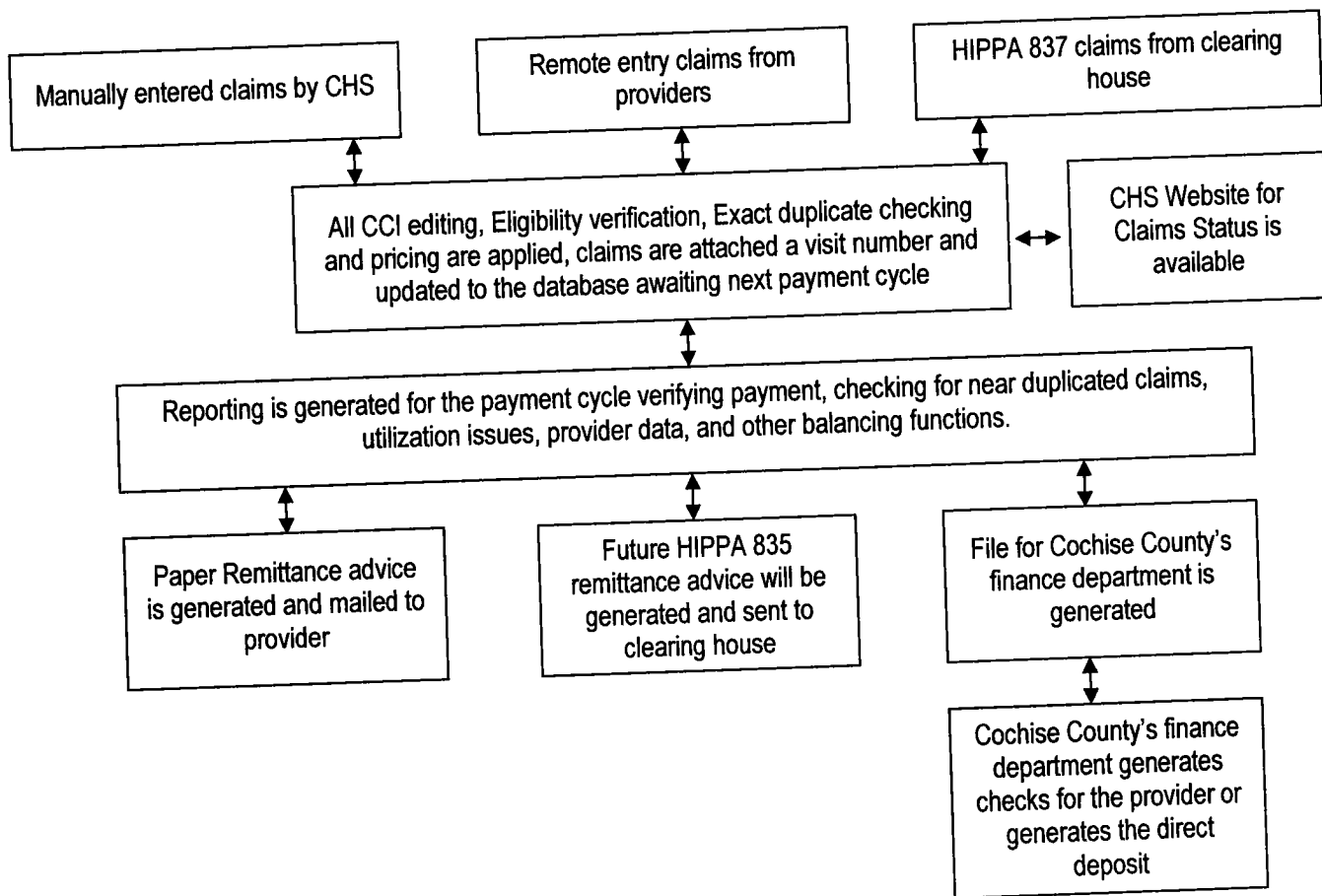
## HCSD MEMBER ELIGIBILITY DATA PROCESSING FLOW



## PRIOR AUTHORIZATION DATA PROCESSING FLOW

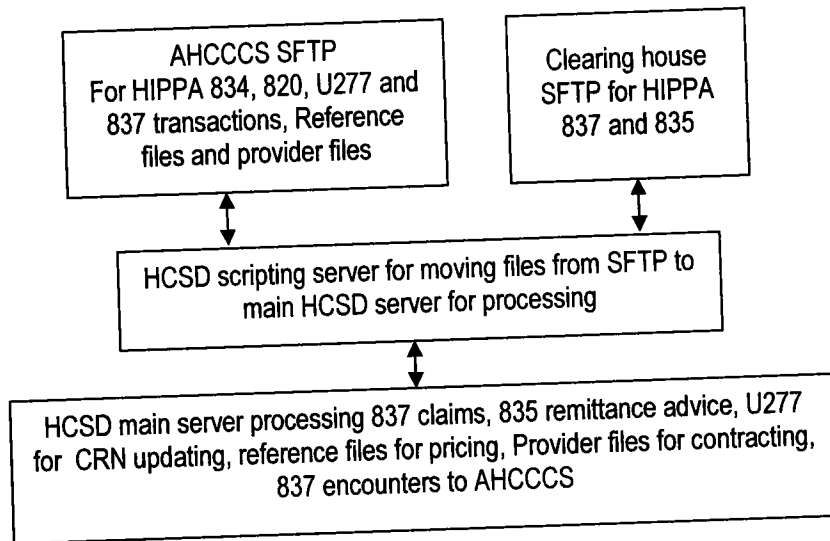


# HCSD CLAIMS PROCESSING DATA FLOW

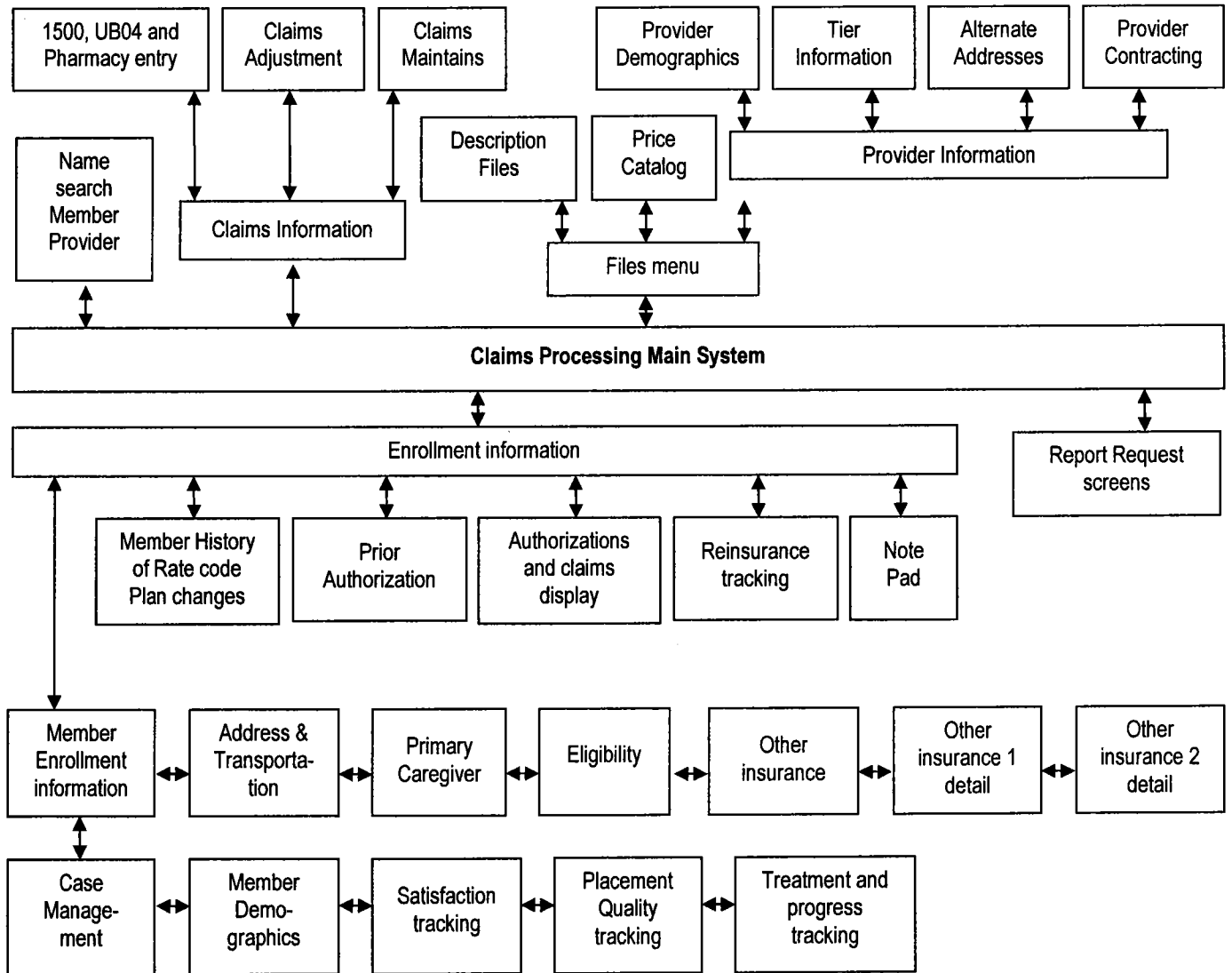




## HCSD ELECTRONIC FILE PROCESSING FLOW



## HCSD SYSTEM MENUS





## COCHISE HEALTH SYSTEMS (CHS) INFORMATION SERVICES # C12

HealthCare Systems Development (HCSD) has never controlled system updates by releasing a new version of the software. Instead, HCSD provides software changes and implementation in one process.

HCSD provides ongoing support, not just major version updates. All change requests are documented by CHS as mandated by AHCCCS and/or requested for internal purposes. HCSD then makes the appropriate changes and CHS verifies the changes are compliant with request.

Both HCSD and CHS have many planned updates and modifications that will occur over the next five years that include AHCCCS mandated changes. None of the changes will require, nor do we plan, a full system conversion.

Computer software that is serviced by the County IT department is updated as the hardware is replaced. Currently the replacement schedule is every four years. Most computers are currently operating on Windows XP. The County IT department is available for any day-to-day change orders as needed through staff at the Help Desk available to CHS on any working day. County IT staff is also available after hours on-call as needed for emergency trouble-shooting.

CHS is currently operating a Virtual Office pilot program recently approved by the County Board of Supervisors. The goal is to have all documentation in an electronic format with staff able to work from any remote location through secure connections to the County's Virtual Private Network. The County IT department is in the process of expanding the broadband capabilities to support this additional remote traffic and CHS is experimenting with different mobile devices. Policies and procedures are being developed to support this new Virtual Office environment to ensure that staff supervision and productivity standards are not compromised. If CHS is successful in this implementation, we anticipate a significant cost-savings to the program as well as streamlined operations and increased flexibility for staff. CHS will update AHCCCS on the status of this project as it progresses. The HCSD system already supports this remote access so will not pose an obstacle to the advancement of this project.



## COCHISE HEALTH SYSTEMS (CHS) INFORMATION SERVICES # C13

CHS' IT vendor is HealthCare Systems Development (HCSD). HCSD has twenty nine (29) years of experience in managing AHCCCS claims and authorizations and has been contracted with Cochise Health Systems for over eighteen years. The HCSD version currently in use is C.60.00 and the contact person for HCSD is Mike Wells at:

**HealthCare Systems Development  
1600 W. University Avenue #215  
Flagstaff, AZ 86001**



## COCHISE HEALTH SYSTEMS (CHS) INFORMATION SERVICES # C14

Cochise Health Systems currently maintains a HIPAA compliant claims processing and payment system (HCSD) capable of processing, cost avoiding, and paying claims in accordance with ARS 36-2903, 2904, AHCCCS Rules R9-28, Article 7, and all Federal and AHCCCS rules and regulations. CHS is confident in the ability of HCSD to adapt to any current or future AHCCCS requirements or Federal mandates. This is evident by CHS' ability to be one of the first contractors to meet the 5010 conversion timeline for the 820 and 834 files and CHS remains on track for the remainder of the 5010 conversion.

HCSD is also prepared to work with Gateway EDI for all of our electronic transaction functions. CHS currently has a signed letter of intent with Gateway EDI and the interface programs are already prepared and awaiting testing. Based upon the past performance of HCSD, CHS does not anticipate any problems with meeting all of the AHCCCS requirements for electronic transaction functions.

Cochise Health Systems and HCSD have a long-standing relationship and, working together, have always adhered to all Federal and AHCCCS IT guidelines and mandates. CHS and HCSD are in constant communication and always looking for ways to improve information services technology and processes. HCSD participates in all workgroups conducted by AHCCCS or CHS pertaining to technological advancements. HCSD also uses the AHCCCS web page as a resource to remain informed of all IT requirements. HCSD has been able to support 5010 file transmission through testing to date and is currently involved in researching ICD10, NCCI, and MUE requirements. Due to HCSD's vast knowledge and experience in the healthcare industry with particular expertise in AHCCCS claims, as well as past performance with CHS, CHS is confident that HCSD can support any current and/or future Federal or AHCCCS mandates. CHS will continue to report 5010 Milestone progress on the 15<sup>th</sup> of each month in the format required by AHCCCS.

CHS will ensure that if there is a need to change or make major upgrades to HCSD, these will be reported to AHCCCS immediately. This report would be accompanied by a plan including timelines, milestones, and adequate testing before implementation is begun. At least six months prior to any anticipated implementation date, CHS will provide this system change plan to AHCCCS for review and comment.

CHS understands that the costs of software changes are included in administrative costs paid by AHCCCS to Program Contractors. There is no separate payment for software changes.



**Grievance  
System**



## COCHISE HEALTH SYSTEMS (CHS) GRIEVANCE SYSTEM & FLOW CHARTS # C15

**Purpose:** CHS has appointed a Dispute and Appeals Manager (DAM), who currently administers the Enrollee Grievance System and Provider Claims Dispute System. The purpose of this process is to ensure the operational integrity of CHS. It also provides a Dispute and Appeals Process as a formal resolution for member appeals and claim disputes for all affected parties in accordance with the applicable federal/state laws, and AHCCCS Contract and applicable policy.

**Overview:** The DAM is responsible for the adjudication of member and provider disputes arising under the AHCCCS Grievance System including member grievances, appeals, claim disputes and requests for fair hearing. The DAM facilitates the process through various personnel within the organization. CHS staff are initially trained on the Grievance System Process at the time of hire and annually thereafter. Upon receipt of an appeal or dispute, the Manager is assisted by support staff with clerical duties, such as the date stamping of all claim disputes and appeals upon receipt, copying, filing, and sending out the initial acknowledgment letters and other correspondence. The DAM is assisted by the Medical Director with the review of medical records and medical opinions as needed in disputes and appeals. The DAM ensures that individuals who make decisions regarding claims disputes and member appeals are not involved in any previous level of review or decision making in accordance with AHCCCS policy. The Behavioral Health Coordinator, or contracted Behavioral Health Consultants, assists the DAM with opinions regarding behavioral health matters. The DAM has authority to independently make final decisions with regard to all member appeals and/or provider claim disputes received; however, the DAM works closely with, and receives input from, pertinent staff (e.g., Finance, M/UM, Provider Relations/Contracts, Case Management) during the investigative process. The DAM reports directly to the Director of CHS and may consult with the Director prior to the final decision on various issues/aspects of this process. Each appeal or claim dispute is reviewed after final determination by the Director, the M/UM Manager and/or the Administrative Services Manager. This functions as a check and balance system to ensure the adequacy of the systems in place, to track/trend any issues and also serves as a process improvement mechanism. The decision of the DAM is considered final upon the expiration of the time frames in which to request a hearing as outlined by AHCCCS policy. If a member or a provider requests a fair hearing or submits an expedited request for hearing following a decision, the request is forwarded timely to the AHCCCS Office of Administrative Legal Services (OALS) including all required material in accordance with AHCCCS policy. The Cochise County Attorneys Office (CAO) is also notified, and the DAM assists the Cochise County Civil Deputy who is assigned to CHS to prepare for hearings at the Office of Administrative Hearings. All disputes and appeals documentation is maintained in the Dispute/Appeals department, in a secure, designated area and are retained for six years following the final decision, judicial appeal or close of a dispute and/or appeal.

**Enrollee Grievance System Process:** As an established Program Contractor, CHS maintains an enrollee grievance and appeal process through written policies that are in accordance with all applicable federal and state law and AHCCCS Rules and policies. CHS has a process in place to notify a member through formal written notice of any action taken by CHS to deny or limit a new service that has been requested, or a current service being provided is reduced, suspended or terminated. This letter is a Notice of Action (NOA) that informs the member of the action being taken by CHS. NOA content and timelines are in strict accordance with AHCCCS policy. This aspect of the grievance system is shared and managed by both Medical and Case Management Departments. This process ensures that members receive medically necessary, ALTCS covered services, and to ensure that members are notified of a denial, reduction, suspension, or termination of covered services and their grievance, appeal, and State Fair Hearing rights in a timely manner as set forth by applicable rules and regulations. Notice of Action (NOA) letters are required for the following actions: a denial or limited authorization of a requested service, including the type and level of service; a reduction, suspension or termination of a previously authorized service; a denial, in whole or in part, or payment for a service; failure to provide a service in a timely manner; failure of CHS to act within the time-frames set forth by AHCCCS policy; and denial of rural enrollee's request to obtain services outside the network (CFR 438.52(b)(2)(ii) when the contractor is the only Contractor in the rural area. A standard authorization request is an enrollee's request for the provision of a service. For standard authorization decisions, CHS will provide an NOA to the Member, as expeditiously as the Member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. An extension of up to 14 calendar days is allowed if the member or provider requests an extension or if CHS establishes a need for additional information and the delay is in the member's best interest [42CFR 438.210(d)(1)]. When a CHS requires an extension, a written Notice of Extension (NOE) letter is sent to the member. This notice (as all notices) is sent in easily understood language, tells the member why the extension is needed and also tells a member how to grieve the NOE. The definition of an expedited authorization request is a request that CHS determines or the provider (in making the request in the Member's behalf) indicates that the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. For an expedited authorization decision, CHS will provide an NOA to the

Member as expeditiously as the Member's health condition requires, but no later than three (3) business days following the receipt of the authorization. An extension of up to 14 calendar days is allowed if the Member or provider requests an extension or if CHS establishes a need for additional information and the delay is in the Member's best interest [42 CFR 438.210(d)(2)]. In this event, an NOE is sent to the member. Also, CHS informs the member that they have the right to complain to CHS about inadequate NOA and their right to complain to AHCCCS if CHS does not resolve the complaint to their satisfaction. All actions as stated in this document shall be in compliance with AHCCCS policy including (but not limited to) pre-defined templates and notice content.

**Member Appeals**-An appeal is the request for review of an action as defined above. CHS offer assistance in the filing process and a toll-free number to member to file a grievance or appeal by phone if requested. When an appeal is received, CHS sends a notice of acknowledgement to the member within five business days from receipt of the appeal or one business day for expedited appeals. Members may file oral or written appeals and grievances. Appeals are defined and processed in accordance with 42 CFR 438 Subpart F. Expedited appeals, which meet the criteria, are handled within three (3) working days from the date CHS receives the appeal (unless a 14 day extension is in effect). CHS provides oral notice to Members regarding expedited resolutions. If CHS denies a request for expedited appeal resolution, CHS will provide a decision within the 30 day timeframe for a standard appeal. Members have 60 days from the NOA to file an appeal. NOA is provided to Members at least ten (10) days before the date of a termination, suspension, or reduction of a previously authorized service, with exceptions, including member's request or death as stated in policy. Benefits are continued during the appeal and request for hearing process, if the member requests this, within ten (10) days from the mailing of the NOA or the Notice of Appeal Resolution, for the time for which the services were authorized. The member has the right to request in writing no later than 30 days after the date the member receives the Notice of Appeal Resolution a State Fair Hearing. CHS provides the member or his/her representative, a reasonable opportunity, before and during the appeals process, to examine the case file including medical records and other documents considered during the appeals process. The member or his/her representative is provided reasonable opportunity to present evidence and allegations of fact or law in person and in writing and CHS informs the member of the limited time available in cases involving expedited resolution.

**Provider and Enrollee Informal Grievance (Complaint) Process:** CHS has in place a system and process to respond to and resolve Member Grievances and Provider Complaints-Issues. Enrollees may submit a grievance orally or in writing. All CHS staff are responsible for reporting/documenting Member Grievances and Provider Complaints-Issues. It is CHS' philosophy that Member and Provider concerns can and should be resolved at that first level whenever possible. CHS Members are encouraged to contact their Case Manager and CHS Providers are encouraged to contact Contracts' staff, who will act as a liaison to resolve any complaints or issues unrelated to Claim Disputes. This process helps ensure that CHS follows established guidelines and timeframes (set forth in state/federal rules AHCCCS policy) for the receipt, resolution and tracking of grievances from Members and complaints-issues from Providers. Through this system, CHS monitors services provided, strives for excellence of care provision and ensures that trends are analyzed and process improvement plans are set forth whenever deemed necessary. If an enrollee files a grievance orally, acknowledgment of receipt is understood. Most informal complaint decisions are relayed verbally to the member or provider within ten (10) days of receipt. CHS attempts to resolve all grievances as expeditiously as possible but within 90 days. There is no time limit for filing an enrollee grievance. The enrollee grievance decision made by CHS is considered final. The informal complaint process is tracked by the M/UM Manager, who trends all complaints and reviews them for Quality of Care Concerns (QCC). If a QCC issue is identified, the informal complaint is investigated further through the quality review process. The M/UM Manager maintains a log of all complaints received on a monthly basis, identifies any trends, and submits a report to the Process Improvement Committee on a quarterly basis. As an integral part of administering the informal complaint process, it is CHS' philosophy that all concerns, complaints, problems should be resolved quickly and at the lowest level possible. Therefore, all Administrative, Case Management, Finance, Contracts, and Medical/Utilization Management (M/UM) staff strive diligently to resolve all matters within the informal complaint process and have been very successful in this regard.

**Trending of Member Issues;** M/UM staff monitors the member grievances via the Member Expressions of Dissatisfaction (EOD) & Provider Complaint-Issue Log and performs periodic trending analysis to identify problems and issues. Findings from this analysis will be used to improve quality of care and services. A trend is defined as the receipt of problems/complaints regarding the same member that number three (3) or more in a one (1) month period or five (5) or more within a three (3) month period. If a trend is identified, the QCC process is begun to investigate the member situation. All trends will be discussed with the Medical Director for review and recommendations. If there are trends substantiated through the complaint process which continue to be a concern, discussion will be held with the respective CHS supervisor for review and input into development of a resolution. All pertinent information will be documented and forwarded to the supervisor for the section involved.



All trends will be kept for reference in the involved provider's profile for review upon re-credentialing and/or during contract renewal. All trends will also be discussed at the M/UM Performance Improvement Committee (M/UM PIC) meetings.

**Provider Claim Dispute Process for Providers:** As an experienced Program contractor, CHS has an established Claim Dispute Process for Providers in compliance with all applicable state/federal rules and AHCCCS policy (as evident through successful performance audits conducted by AHCCCS). Providers are required to submit their Claim Disputes in writing no later than twelve (12) months from the date of service (for a hospital inpatient claim, from the date of discharge), twelve (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. Providers must specify in detail the factual and legal basis for the claim dispute and the relief requested. Each claim dispute is thoroughly investigated and facts are obtained from all parties. A Claims Dispute resolution is mailed, certified/return receipt requested, within 30 days of filing. The resolution timeline is extended only by mutual agreement of both parties and is documented. The Provider is advised of their appeal rights to AHCCCS, which must be filed in writing no later than 30 days after the date they receive the decision letter. If a hearing is requested, CHS shall provide all required documentation to AHCCCS OALS within 5 business days. If a Claim Dispute Decision is overturned in favor of the Complainant, CHS shall reprocessed and paid in a manner consistent with the Decision within 15 working days.

**Workflow/Process summary:** Upon receipt, all appeals and claim dispute letters from Members and Providers are date-stamped on each page. The DAM or support staff then initiate the process on the appeal or claim dispute. This includes, but is not limited to: verification of the Provider's AHCCCS ID, the Member's AHCCCS ID, the date of adverse action and/or the date of service. This information is verified via the CHS Health Information System (HIS) and the AHCCCS PMMIS System. A letter is sent to the Member or Provider acknowledging receipt of the appeal or claim dispute, within five (5) business days and sent certified/return receipt. The appeal or claim dispute is logged upon verification of the data. Following this, the Dispute/Appeals department researches the case and once a decision is reached a Notice of Resolution letter is mailed to the member or provider within the 30 day time limit (unless expedited or an extension is in effect as outlined in AHCCCS policy) by the DAM (sent certified/return receipt requested). Timelines for responses to the Notice of Resolution Letters are tracked by the DAM and support staff. The return receipt is filed in the individual appeal or claim dispute file upon receipt by staff. Oral Grievances and Appeals are available to members and are handled by the DAM. Assistance in the filing process including a toll free number is available to members. Following the conversation, the DAM writes a statement documenting the oral conversation as stated by the Member. If the oral matter is an appeal, it is handled as stated in this document. If the oral matter is a grievance, the matter will be handled informally (in accordance with AHCCCS policy) within 10 days and the member will be provided oral or written notice of the decision.

Members are informed of their grievance and appeal rights through the CHS Member Handbook that is updated annually and are educated through member newsletters sent out twice per year. Member communications are in compliance with AHCCCS policy. Contracted providers are informed of the grievance and claim dispute process through their contracts, claims dispute policy distributed with remittance statements, newsletter, and the CHS Provider Manual. Information regarding the grievance system process is also available to both members and providers via the CHS website. All providers, contracted or non-contracted, are informed of the grievance and claim dispute process via the remittance advice, which is provided within 45 days of receipt of a claim. Records on all grievances, appeals and requests for hearing are maintained by the Dispute and Appeals Department (DAD) and are available upon request. The DAM is responsible for submitting the Monthly Grievance Report to AHCCCS within the specified timelines. Upon completion and submission, the report is routed to the Director and CHS leadership team for review. The DAM participates as a member of the M/UM Process Improvement Committee (MUMPIC) and quarterly present reports to the committee regarding Grievances, Member Appeals and Provider Claim Dispute activity, as well as reporting of any Trends and Plans of Correction, as applicable. The MUMPIC may also act in an advisory capacity. The DAM also participates as a member of the Member/Provider Council and attends at least one meeting per year.

Separate logs are maintained for grievances, appeals, and claims disputes by contract year. The logs contain all data elements as specified by AHCCCS. Policies are summarized in this document and are available for review upon request. Logs are available upon request and are reviewed by AHCCCS during each Audit and are also reviewed by CHS management for trend analysis and process improvement.

**Grievance System-Operational Improvement Forums-**As an established Program Contractor with 18 years of experience, CHS has an operational performance improvement system to ensure quality care is provided to our membership. Grievance data is shared and utilized by CHS through a variety of reporting mechanisms and is incorporated through CHS Annual Plans, as well as Policies and Procedures. A positive outcome of this process is reflected in the continued high rating of satisfaction from our membership and provider network via CHS survey results. By responding to opportunities for process improvement identified through Grievances, the organization operates more efficiently and with higher satisfaction expressed by members and providers.

**Administration/Grievance:** Grievances, Appeals and Claims Disputes are reported by the DAM at Bi-Monthly CHS Leadership Meetings, quarterly staff meetings, and quarterly MUMPIC meetings. Specific supervisors bring issues to meetings with their staff and provide education regarding grievance system issues as needed. The Member Handbook and Newsletters are used to keep members updated on the most recent updates to covered services and their grievance rights. Treatment of members in a culturally competent manner is incorporated in all grievance situations, as well as respect for the members' privacy rights in accordance with HIPAA standards. All member communications are in accordance with AHCCCS policy.

**Case Management:** Case managers are an invaluable tool used to monitor the efficacy and quality of the services provided by CHS. If specific member issues are identified through the Grievance System process, they are discussed with the specific Case Manager and/or the Case Management Supervisor. Depending on the nature of the issue identified, education is provided to the Case Manager or education may be provided to members by the case manager or the Notice of Resolution decision letter regarding the specific issue/trend and may include education regarding the rules of the program.

**Provider Relations/Contracts:** Specific provider issues identified through claims disputes are discussed with the Provider during the grievance system process. Education is provided to the Provider via the Claims Disputes Resolution Letter regarding applicable rules specific to the issue. If applicable, Contracts staff follows up with Provider, via the Site Review & Monitoring process or, as a last resort, sanctions are imposed or provider contract may be terminated. Information obtained through the Grievance process also results in improvements to the Provider Manual, network development, provider training and the contract language.

Case Management is also responsible for a data validation study that is conducted quarterly to assess the integrity of the HIS data that in turn helps reduce the number of claims disputes and streamlines the adjudication process.

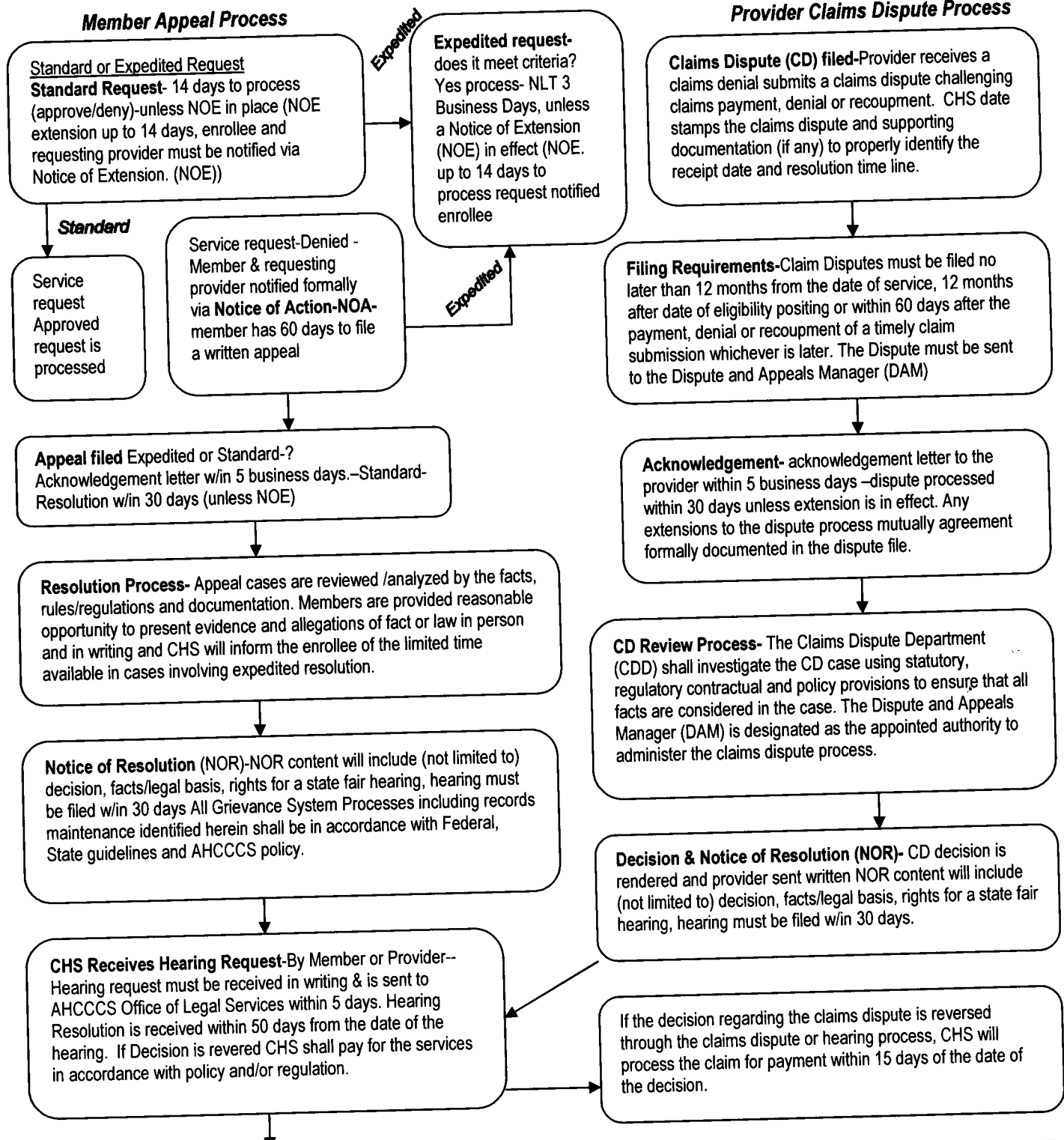
**Finance/Claims adjudication:** Specific claims issues are discussed with the Administrative Services Manager. Problems/issues with claims are corrected and the specific Medical Claims Processor is educated via the Decision Letter. Information gained from Grievance Process helps the Finance Division in implementing claims edits and authorization processes that better serve the providers. In addition, this process also helps CHS monitor the integrity of the data in the HIS utilized for claims adjudication.

**M/UM:** The department overall serves as a tool for CHS to help identify opportunities for improvement through the various services conducted by the departments. This includes the oversight of (but is not limited to): EOD and QCCs—these tools help identify problems within the organization both internal and externally. The information gathered from these processes is evaluated by the M/UM dept. and from here the CHS Leadership team focuses on CAP or process improvement. The M/UM PIC is a committee that is used as a forum to relay information regarding CHS performance and offers participants a means to vocalize their thoughts and ways to improve our operations. The Member/Provider Council – also part of M/UM is forum for reporting issues/trends and soliciting input for process improvement (PI) from providers and members and CHS staff to collectively identify with ways to improve. Member and Provider Satisfaction Surveys –the information gathered from surveys is used to improve upon any part of the organization, including the Grievance System. The M/UM dept may track and trend the information and present to the Leadership team for CAP or PI. Provider Profiling –is a process used during the credentialing/re-credentialing of a provider to review any data collected within the M/UM dept (such as EOD, QCCs, etc.) that may be used to determine if a provider is suitable for appointment/reappointment. This serves as a process improvement mechanism by ensuring that CHS offers quality care to our membership. Monitoring is shared by Provider Relations and M/UM—information gathered during site visits also helps CHS ensure a high quality of care is rendered to members. Monitoring tools include a segment for the evaluation of a provider's performance through the grievance system such as claims disputes, EODs and QCCs. Fraud & Abuse – Potential Fraud & Abuse issues may be identified via Grievance process. For example, the identification of a provider with inappropriate billing practices that results in training for CHS staff and Providers to improve the process and reduce the number of returns, denials or claim disputes. Other forums include the CHS quality circle process, inter-rater reliability committee and interdepartmental cooperation. Each of these groups/processes serves as an opportunity to discuss issues/trends and improve processes for CHS.

**Grievance Trending:** Grievances, appeals and claim disputes are analyzed on a quarterly basis. A formal report is presented to the M/UM PIC and the Member/Provider Council for recommendations. As an example, CHS was able to identify cases of suspected HCBS fraud/abuse through the claims adjudication and claims disputes process that resulted in a study that was presented to AHCCCS. This project resulted in the development of a provider sanction policy and provider re-education based on poor billing practices—Study available upon request. This has improved CHS' ability to identify cases of suspected fraud, reduced the number of instances/occurrences of fraud through provider education which in turn helps to avoid the administrative time of returning claims and adjudicating complaints or disputes.



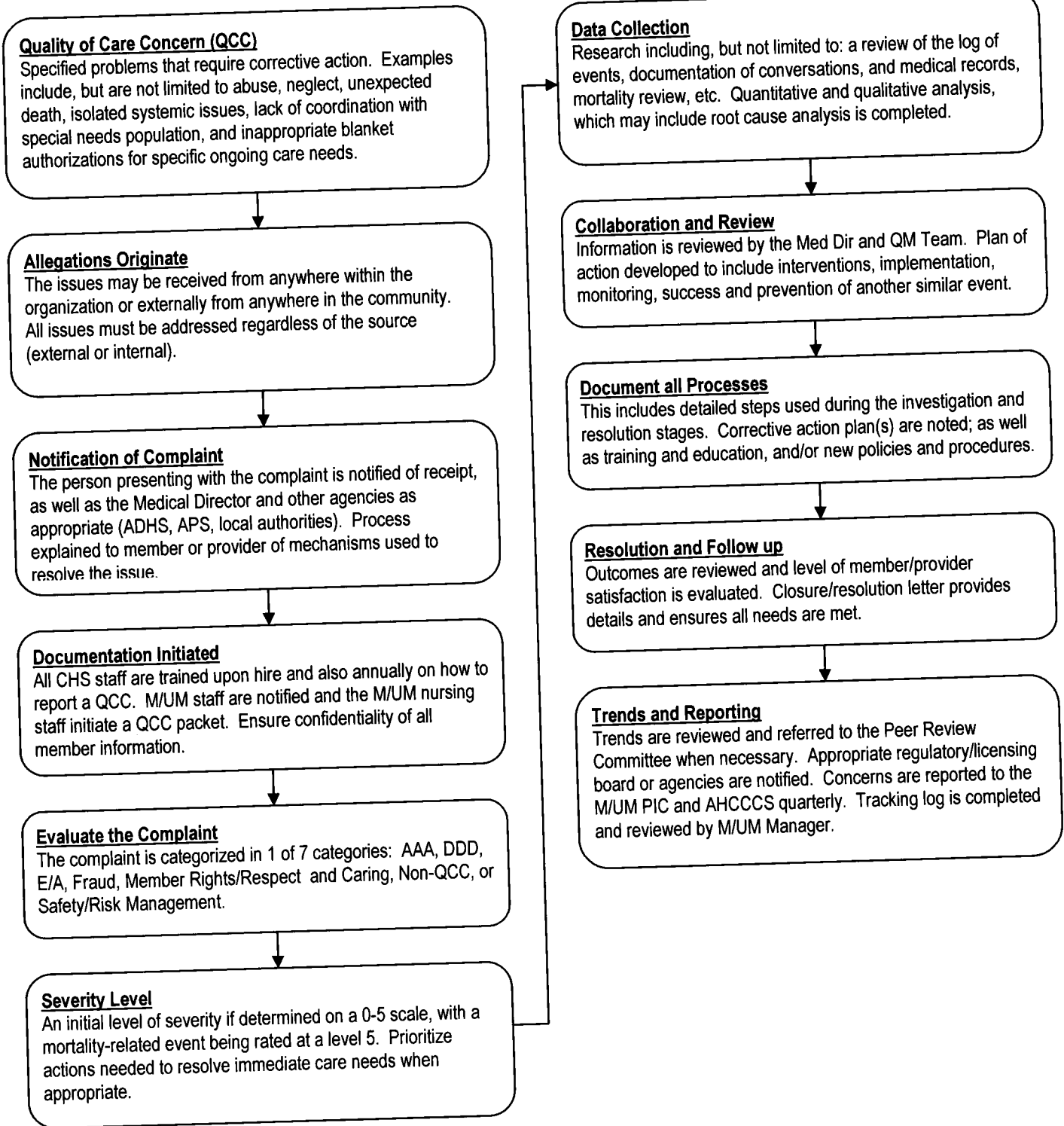
**COCHISE HEALTH SYSTEMS (CHS) Member Appeals and Claims Dispute Flow Chart**  
*CHS authorization service request- Standard and/ or Expedited*



The information provided in this flow chart is a brief summary of the Grievance System Process-CHS adheres to all Federal and State rules and regulations including AHCCCS Policy including records maintenance identified herein shall be in accordance with Federal, State guidelines and AHCCCS policy. All documentation sent through the Grievance System Process shall be sent certified return receipt requested.



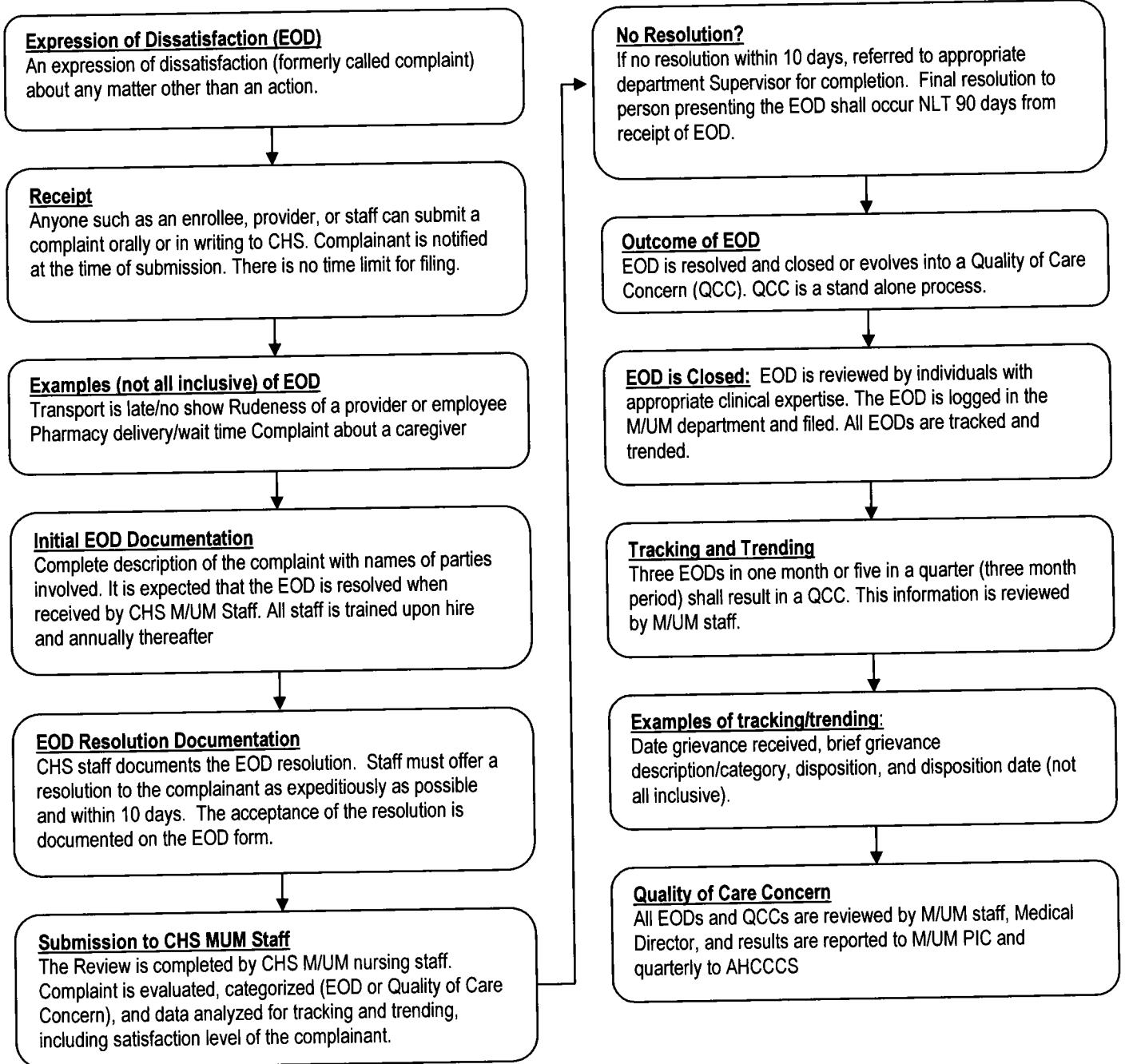
# COCHISE HEALTH SYSTEMS (CHS) Quality of Care Concern Flow Chart



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# COCHISE HEALTH SYSTEMS (CHS) Expressions of Dissatisfaction Flow Chart



The information provided in this flow chart is a representation of the Cochise Health Systems' Expressions of Dissatisfaction (EOD) process. It is not intended to be a substitute for the actual process. All EODs are tracked and trended. All EODs are tracked and trended through the CHS Health System Process and are reported to the Medical Director.



**Corporate  
Compliance**



## COCHISE HEALTH SYSTEMS (CHS) CORPORATE COMPLIANCE PROGRAM # C16

CHS maintains a Corporate Compliance Program (CCP) committed to detecting, preventing and reporting suspected fraud and abuse as defined in A.R.S. Section 36-2918.01 and compliant with applicable Federal, State regulations and AHCCCS policy. As stated in A.R.S. Section 13-2310, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material is guilty of a class 2 felony. The components of our CCP are described below.

**Goals and Objectives of Plan:** the goals of our CCP are to elevate staff, provider, and member awareness of fraud and abuse prevention, recognition, and reporting, and to encourage all CHS stakeholders to report fraud and abuse without fear of retaliation. CHS promptly reports, in writing within ten business days of discovery, instances of suspected fraud or abuse in accordance with federal law. CHS provides all stakeholders with the knowledge necessary to detect, prevent and report fraud or abuse, exploitation, neglect, misappropriation and/or overpayment.

**Compliance Officer(s):** CHS has designated two employees to implement, oversee and administer the CCP program, including fraud and abuse control. Both employees work full-time onsite and are readily available to all stakeholders. CHS Compliance Officers have the designated independent authority to access and provide records and make independent referrals to AHCCCS Office of Inspector General (OIG). The role of the compliance officers is to oversee, track, and monitor the CCP and have direct access to the CEO, legal counsel, and/or the OIG. These Officers ensure that staff are adequately educated upon hire about the internal reporting procedures for fraud and abuse and receive training annually thereafter (or more frequently as deemed necessary).

**Compliance Committee:** CHS Compliance Committee includes the Compliance Officer(s), the Chief Financial Officer, the Chief Operating Officer, and includes additional members of the CHS Leadership Team. The purpose of the Committee is to ensure compliance with the CCP and assist in the monitoring, reviewing, and assessing the effectiveness of the CCP and timeliness of reporting. The Committee meets at least monthly to review reported cases of suspected fraud and/or abuse. Any concerns are first referred to the Compliance Officers.

**Training/Education:** all CHS staff attends Fraud and Abuse training at least annually. CHS Administration ensures all employees, providers, and members receive adequate education and training through a comprehensive training program. This program addresses fraud and abuse prevention, recognition and reporting, and encourages all stakeholders to report fraud and abuse without fear of retaliation. During CHS orientation, all new employees are required to complete the Deficit Reduction Act power point presentation on the AHCCCS web page. Documentation of education and training is maintained in the employee's personnel file.

**Provider Education:** provider manuals include information regarding the reporting of alleged fraud, abuse or exploitation. Providers are given the opportunity to express concerns relating to alleged fraud, abuse or exploitation through the informal complaint process, Quality of Care concerns process and the annual Provider Satisfaction Survey. Also, a Provider Newsletter is sent to all contracted providers at least annually offering current information relating to our CCP and all Provider issues. All providers are monitored for compliance with contract terms, licensure requirements, and ability to provide contracted services. Incidents of compliance program violations or exploitation of members or providers are reported to the AHCCCS OIG. All Subcontracts contain the Federal False Claims Act Provision, including provisions for any state law relating to civil or criminal penalties for false claims and statements. (Sample contracts are available upon request.) All Subcontracts require the provider ensure that employees receive adequate education and training through a comprehensive training program about Corporate Compliance. Providers are subsequently monitored through the Provider Relations/Contracts Department and any deficiencies relating to CCP are noted. Corrective action plans are requested of the provider as needed. All providers are informed of the Deficit Reduction Act educational power point on the AHCCCS website via monitoring and through provider correspondence, such as newsletters, notice of claim dispute resolution notices when deemed necessary and other means/information avenues within the organization. In addition, CHS educates providers through provider manual, periodic updates, and newsletters sent out annually.

**Member Education:** CHS ensures that all members are informed regarding their rights, responsibilities, and CCP processes when there are changes to the CCP. CHS staff is culturally sensitive and responds appropriately and in a

timely manner to concerns or requests for information. This is accomplished through a bi-annual Member Newsletter printed in English and Spanish and a Member Handbook printed in English and Spanish that contain information about what fraud and abuse means. This educational material also provides examples and explains how to report suspected fraud, abuse, or exploitation. Members are also sent annual surveys for satisfaction with services and providers, and may at that time express any concerns relating to fraud, abuse or exploitation. If any suspected fraudulent or abusive situations are identified, the matter is referred to one or both of the CHS Compliance Officers for follow-up investigation and timely reporting to AHCCCS, OIG or other authorities as required.

## PREVENTION AND DETECTION OF FRAUD AND ABUSE

**Medical Utilization Management (M/UM) - Prior Authorization Processes:** prevention and detection begin at the initiation of a service. When prior authorization is requested for specific services, provider requests are reviewed by the Medical Director, M/UM Manager, and Nursing staff. The review ensures that the members are eligible, that the services are AHCCCS defined covered benefits, are to be provided at the most appropriate level and within the Network, and are medically necessary. This review is generally accomplished at the time of the authorization request. If additional medical information is required, an information request is sent to the requesting provider. CHS may request additional time and/or information to make this decision if it is in the best interest of the member to do so. This process is compliant with the AHCCCS guidelines for service authorization requests. Criteria utilized to evaluate medical appropriateness are based on information sources including CHS' developed Clinical Practice and Interqual Guidelines. Interqual intensity of service and severity of illness (IS/SI) criteria may be applied to inpatient admissions

**Credentialing/Re-credentialing and Provider Profiling:** to ensure compliance with local, state, and federal laws, and to ensure that providers who render services to CHS members are competent and qualified as defined in AHCCCS policies and procedures, all providers are initially credentialed and re-credentialed on a prescribed/scheduled basis. All credentialing and re-credentialing activities are reviewed and acted upon by the Credentialing and Peer Review Committee (CPRC) under the direct supervision of the CHS Medical Director, or designee. The CPRC is comprised of a panel of physicians and CHS staff members who make the final credentialing and re-credentialing decisions based upon the recommendations of the committee members. Provider profiles are maintained on each provider. These files contain information relating to utilization, Expressions of Dissatisfaction, Quality of Care concerns, member and provider survey information, and monitoring results. The file contents are reviewed at the time providers are re-credentialed and considered when contract renewal is requested.

**Health Information System (HIS)/Claims Edits:** CHS maintains a HIPAA compliant system designed to collect, analyze, integrate, and report data. The system is designed for claims processing and payments, includes nationally recognized methodologies to correctly pay claims, and is capable of cost avoidance editing to ensure that all claims are reimbursed in accordance with state and federal regulations. This HIS is critical for detecting, preventing and reporting suspected fraud. Pre-adjudication claims edits, code edits, and clinical rules help CHS pay claims efficiently and maintain program integrity.

Another aspect of the HIS is Pharmacy Benefit Management (PBM) Claims Adjudication system. Claims adjudication technology is available to ensure that prescription claims are properly authorized and edited for price, drug interactions, dosage, and quantity supplied. The system is also designed to reject any duplicate claims, claims submitted which exceed authorized amounts, or claims submitted for a non-eligible member or provider. The PBM provides CHS staff with various Drug Utilization Reports which are reviewed monthly or quarterly, and corrective action taken if necessary.

Any CMS compliance issues related to HIPAA transactions and code set, complaints, and/or sanctions are immediately reported to AHCCCS per guidelines.

**Medical Review of Claims:** the M/UM staff conduct Prospective, Concurrent and Retrospective Reviews on claims to ensure that CHS members receive health care services in a timely, appropriate, and cost effective manner and are provided in accordance with the ALTCS program requirements. These tools are also used as a means of determining inappropriate use of services. M/UM staff conducts a Medical Review of claims to identify potentially over-utilization, questionable medical necessity, or to identify procedures performed that differ from those authorized. If the documentation is insufficient to support the medical necessity of the services, the claim is pended for additional information. All denials are reviewed/approved by the Medical Director. Post claim payment medical reviews are



conducted on specific services as deemed appropriate based upon utilization, trends, or identified areas of concerns. Any indication of fraudulent or abuse in service delivery identified by M/UM through any review process is reported to one of the CHS Corporate Compliance Officers for review and reporting to AHCCCS OIG or other enforcement agencies as appropriate.

**Expressions of Dissatisfaction (EOD):** EODs from members/providers/other sources are received and/or documented by CHS staff and sent to the M/UM Department. Any fraudulent or abusive situations noted on the EOD Form are forwarded immediately to one of the CHS Compliance Officers for follow-up investigation and reporting to AHCCCS, OIG or other authorities as required. All forms are logged and reviewed on a monthly basis for trending. In addition, these forms and logs are periodically analyzed by the M/UM Manager, and if any the possible fraudulent or abusive situations are noted that were not previously identified or reported, the matter is investigated and timely reported to AHCCCS. The M/UM Manager will also notify the involved Section Supervisor of the reported deficiency and provide staff education as needed.

**Quality of Care (QOC) Concerns:** CHS identifies, investigates, and evaluates alleged QOC issues that are reported by members, providers, staff, or any stakeholder. All QOC concerns are investigated by M/UM staff in conjunction with the Medical Director. If any possible fraudulent or abusive situations are identified, the matter is further investigated by one of the CHS Compliance Officers for follow-up investigation and timely reporting to AHCCCS, OIG or other authorities as required.

**Grievances:** all members and providers of services/items to CHS members are advised of their right to grieve any adverse action by CHS and are advised of this right through the Member Handbook, the Provider Manual, and through CM, M/UM, and Finance processes. The information is also identified in all provider contracts. If upon investigation of a grievance, any possible fraudulent or abusive situations are identified the matter is further investigated by one of the CHS Compliance Officers for follow-up investigation and timely reporting to AHCCCS, OIG or other authorities as required.

If applicable, a statement will be included in the Grievance Decision Letter of the possibility of a violation of the compliance program requirements.

## REPORTING OF INCIDENTS

Incidents of CCP violations or exploitation of members or providers will be reported to AHCCCS OIG. Member eligibility issues are reported to the AHCCCS Office of Eligibility, Member Fraud Investigations. Reporting is done within ten (10) business days of discovery. The AHCCCS Fraud and Abuse Referral Form is initiated by any CHS employee or subcontractor and forwarded to a CHS CCP Officer for review and reporting to AHCCCS. Reporting will be completed in accordance with Federal, State regulations and AHCCCS policy. The CCP Officer(s) will include all pertinent documentation regarding the incident, including QOC concern investigation, utilization reports, member records, provider records and other documentation relevant to the situation. Reports are forwarded to the appropriate AHCCCS section on receipt of the report of fraud or abuse.

Suspected member or provider fraud is referred to:

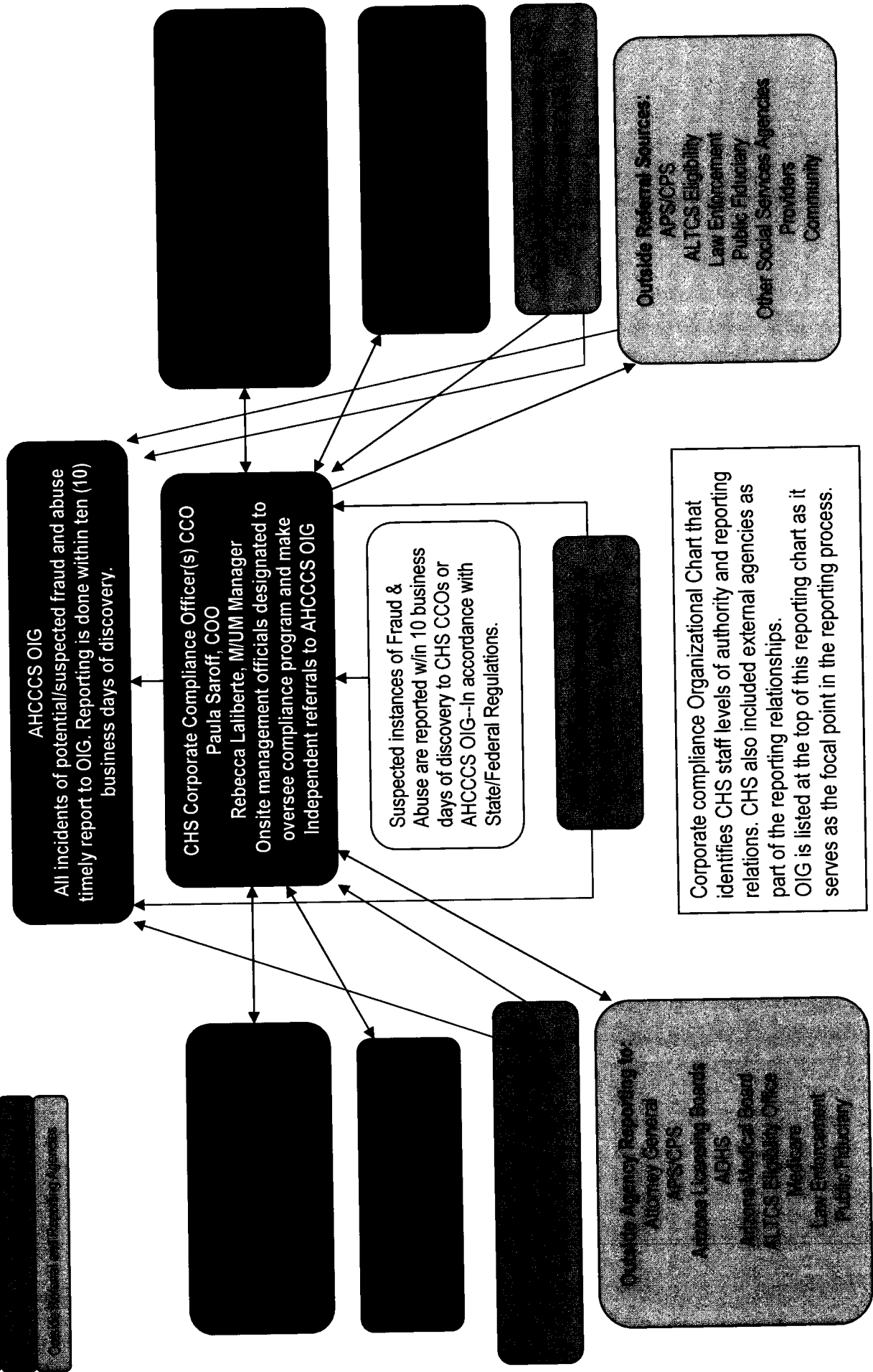
Arizona Health Care Cost Containment System (AHCCCS) Inspector General  
Office of Inspector General  
701 E. Jefferson St., Mail Drop 4500  
Phoenix, AZ, 85034  
OR by FAX: 602-417-4102

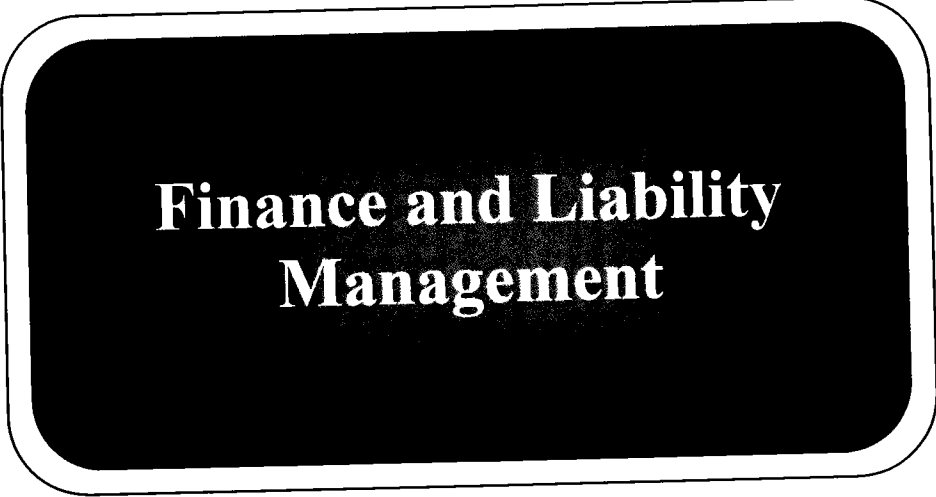
Member, Provider, CHS or any stakeholder may also contact and /or report directly to AHCCCS OIG  
Email: [AHCCCSFraud@azahcccs.gov](mailto:AHCCCSFraud@azahcccs.gov) or report through the AHCCCS website:  
<http://www.azahcccs.gov/fraud/Default.aspx>

**Confidentiality:** voluntary disclosure of member-specific clinical and non-clinical information will not be made, except to person(s) authorized by Arizona Administrative Code or AHCCCS Rules to receive such information. All information is marked strictly confidential and HIPPA guidelines are strictly enforced relating to the release of any Protected Health Information.

**COCHISE HEALTH SYSTEMS  
CORPORATE COMPLIANCE ORGANIZATION CHART C-16**

CCOs-Highest reporting authority for CHS





**Finance and Liability  
Management**



## **COCHISE HEALTH SYSTEMS (CHS) FINANCE AND LIABILITY MANAGEMENT # C17**

CHS has met this submission requirement through current contract requirements as an existing ALTCS Program Contractor for the last eighteen years. AHCCCS has received copies CHS' three most recent audited financial statements.



## **COCHISE HEALTH SYSTEMS (CHS) FINANCE AND LIABILITY MANAGEMENT # C18**

### **BOND SUBSTITUTE REQUIREMENT**

CHS is a division of Cochise County. On September 20, 1993, the Cochise County Board of Supervisors adopted Resolution 93-99 pledging to provide financial support as an ALTCS program contractor. On November 22, 1999, the Cochise County Board of Supervisors adopted Resolution 99-80 amending Resolution 93-99 to include the addition of Graham County in the Cochise County ALTCS Program service area. Effective October 1, 2001 Resolution 01-61 was adopted by the Cochise County Board of Supervisors amending the previous resolutions to include Greenlee County.



## COCHISE HEALTH SYSTEMS (CHS) FINANCE AND LIABILITY MANAGEMENT # C19

### CAPITALIZATION REQUIREMENTS

As of September 30, 2010, CHS had cash of \$13,101,027 and total liabilities of \$3,863,583 for a net capitalization in excess of \$9.9 Million. CHS plans to maintain capitalization of at least \$2,000,000. Projected cash flows to CYE11 show a further increase in capitalization. Therefore, CHS will far exceed the proposed capitalization of \$900,000 as required by Section D, Paragraph 45.

CHS has been in compliance with all AHCCCS financial viability standards for all of the eighteen years that we have been a Program Contractor. AHCCCS, on a quarterly basis, has monitored the following ratios: Current Ratio (at least 1.00), Equity per Member (at least \$2,000), Medical Expense Ratio (at least 85%), and the Administrative Cost Percentage (no greater than 8%). CHS has historically met or exceeded these minimum financial viability standards in reviews conducted by AHCCCS, as well as in the reviews conducted by our Independent Auditor, and anticipates no change in this track record of performance and strong financial viability.

CHS complies, in a timely manner, with all financial reporting requirements contained in Attachment D, Chart of Deliverables and the ALTCS Financial Reporting Guide and will continue to do so as described in our contract with AHCCCS.

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35	.....	N/A
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## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT # D20

Inter-departmental coordination and communication between Case Management (CM) and other areas of CHS is a frequent occurrence. In fact, by virtue of the fact that CHS is a relatively small organization, staff has the privilege of daily interaction among all CHS departments. Each department within CHS is very aware that any changes and/or concerns in one department have an impact on another. Inter-departmental coordination happens informally by staff just speaking with each other and more formally through scheduled meetings or work groups.

Inter-departmental coordination is a component of every CHS Leadership Team meeting. One example of how this coordination improved member outcomes involved a concern identified by Finance and CM staff independently regarding HCBS claims. Discussion at several Leadership Team meetings clarified the scope of the problem and was the genesis of its resolution. The Claims Processors noted that the HCBS authorized by the CMs did not correlate with the documentation submitted by some of the provider agencies. The backup documentation submitted in several cases showed the member was not receiving the HCBS or hours as authorized by the CM. Typically, the CM staff would not see the agency backup documentation attached with their claims. Claims processors used these backup documents during the adjudication process to note the accuracy of hours billed. The documentation submitted by the agencies showed services provided when the member was not home, i.e., member was in the hospital or away on a visit. Once the claims processors shared the backup documentation in question with the CM assigned to the member, it was also revealed that some members were receiving services not authorized or needed by the member at all. For example, the documentation showed member was receiving assistance with grooming and dressing when the member was independent and did not require assistance. The total number of hours of attendant care services billed matched the authorization, but the specific tasks used to calculate those hours by the CM based on member need were not always accomplished. These inconsistencies raised such concern that the CM team decided it was necessary to verify each member was receiving the specific HCBS the CM had authorized. The CMs contacted by phone or by visit each member receiving HCBS to survey them about the services they were currently receiving. CHS created a team to complete an internal review of these findings. This led to an in-depth review of services the CMs were authorizing, variances in the time assessed for service completion, and data used by CMs to make authorization decisions. CHS identified a trend of over-authorization of HCBS by the CMs, especially in tasks not related to direct personal care, i.e., authorizing excessive time for cleaning of common areas in the member's home shared with the entire family. CMs were also allowing excessive time for shopping and laundry when the caregiver was a family member living with the member. The inconsistency in the authorization of HCBS was ultimately providing services to members who did not require these services, thereby expending resources inappropriately. The CM Supervisor and Lead CMs conducted re-training with all CMs regarding the authorization of attendant care services and a new process was implemented establishing an Assessment Review Team. The Assessment Review Team consists of two or three CMs with more than ten years experience, the CM M/UM RN Liaison, and the CM Supervisor. These meetings are held weekly to discuss initial assessments on HCBS members, members requesting an increase in HCBS hours, or when the CM has determined an increase or decrease of hours is needed. The CM comes to the meeting prepared with the UAT, HCBS Member Needs Assessment Tool, and CHS Assessment form completed and presents the case to the team. Each team member documents his/her assessment of services needed. A consensus is reached after all information has been presented. This has resulted in more consistent and appropriate authorization of HCBS services for members. This team approach has also been very beneficial for use as a teaching tool for CMs in assessing a member's needs. What began as a billing issue in the Finance department, resulted in an improvement in service outcomes in the CM department. This is an example of how close inter-departmental communication and cooperation resulted not only in member outcome improvements, but in internal process improvements as well.

Another example of this type of cooperation: CHS identified a need for greater communication between all staff department-wide at the line staff level. The Leadership Team members were meeting and communicating on a regular basis, and each department was holding regular staff meetings within their respective departments, but line staff was hesitant to communicate concerns to other departments within CHS. To address this situation, the CHS Quality Circles were established. The Quality Circles were set up as an avenue for staff members from different departments of CHS to meet monthly to discuss member issues and concerns. The Circles also discuss how any

changes within their individual departments may affect other departments. There is a set agenda for each meeting and each team member is afforded the opportunity to provide input in a roundtable format. Many opportunities for improvement have been identified through these inter-departmental meetings.

An example of an issue identified at a Quality Circle meeting was the DME authorization process. CMs and the Medical Services Authorization Specialists (MSAS) identified issues regarding untimely delivery of DME supplies to members, authorizations for DME not being processed timely, and the inability to track supplies. These DME issues identified the need to form a DME workgroup consisting of staff from CM, Medical/Utilization Management (M/UM), and Administration. A complete re-organization of the DME process resulted, from the moment a prescription from a PCP arrives in CHS, to the delivery of the DME to the member. This process achieved the streamlining of internal functions; however, this process improvement was not enough to resolve the many problems still attached to the DME authorization process. Ultimately, the MSAS who is responsible was physically moved from the M/UM department to the CM department. CMs now have better accessibility and greater communication with the DME MSAS so that issues are addressed sooner and more effectively. Weekly meetings are held between the DME MSAS, CM/MUM RN Liaison, and the CM Supervisor to review DME authorizations and to discuss any DME concerns. This combination of changes has resulted in a significant decline in untimely authorizations, improved tracking of DME, improved communications with the DME providers, and most importantly, more timely delivery of DME to members thereby improving service outcomes for our members.

Home modifications are another specific collaborative effort between M/UM, CM, CHS Medical Director, and Contracts departments. Each has an important role in contributing to this process and making it possible for a member to remain in their home. On several occasions, this one service alone has meant the difference of members remaining in their own home or having to be placed in a facility.

Collaboration between CM and M/UM is a critical component of CHS' Disease Management program. CMs refer members with certain medical conditions to M/UM. CMs and M/UM nurses jointly review the member's medical condition and assess appropriateness for inclusion in the formal Disease Management program. Even for members not appropriate for inclusion in the formal program, M/UM and CM staff still educates, monitor, and provide those members with resources deal with their medical condition.

Another inter-departmental workgroup recently initiated in CHS is the Behavioral Health Review Team. This team consists of the M/UM Supervisor, CM Supervisor, Behavioral Health (BH) Specialist CM, and M/UM RNs along with the member's CM. The team meets at least monthly to reviewing the member's BH needs to ensure the current services are appropriate, as well as identify other options available to ensure the member's BH needs are being met.

Meeting the needs of medically complex members with BH is a collaborative effort involving every department in CHS. An example of this is a member with a diagnosis of MS who was adamant in her desire to remain in her home even though she was unable to perform any of her ADLs and was making poor decisions. She had been declared competent by her PCP and her psychiatrist. She lived alone with no support system in the immediate area and had alienated her friends and family. She was able to use her emergency alert system. It took a collaborative effort from all departments to meet her needs. Many brainstorming sessions were held to offer solutions and suggestions to keep her in her home. Multiple caregiver agencies were authorized to provide attendant care services in different shifts. Weekend rates were authorized for the agencies providing late evening services. Medical and psychiatric care was provided in her home. DME providers made home visits to evaluate her needs for specialized equipment. Eventually this member did receive a court-appointed guardian. Finding proper placement for this member required collaboration between CM and Contracts. Most facilities were either unable to meet her complex medical needs or her BH needs. After the CM had exhausted all placement options within the CHS network, Contracts was able to find a facility appropriate to meet her needs and willing to accept her. This member has since been stepped down to a lower level of care and is adjusting to her surroundings remarkably well. This case describes how inter-departmental coordination improved health and service outcomes for an individual member and is offered as just one example of how this process is used continually within CHS.

Inter-departmental coordination is almost always needed for members with extreme BH needs. If there is not a network provider for a specific BH Service a member needs, the Contracts Department is notified. The Contracts Department will work on obtaining a Letter of Agreement with a non-contracted Provider, or will assist in finding a suitable alternative within the existing network.

An area outside of CHS, but equally important, is the close collaboration between CM and caregiver agencies. Besides daily telephone communications, CMs and caregiver agency representatives meet monthly in person to discuss issues and/or concerns regarding services provided to members. Updates are given regarding members' physical and mental condition. These meetings have led to brainstorming sessions instrumental in developing, providing, and exploring the different options available for difficult members, medically complex members, and members with BH issues. These meetings have also led to shared communication of concerns for our vulnerable members and the actions needed or taken to ensure member safety.



## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT # D21

Case Management has implemented a quarterly inter-rater reliability review process that evaluates the consistent application of service assessment and authorization criteria among case managers. The purpose of this inter-rater review process is to improve Case Management assessment and review procedures, with particular emphasis on coordinated approaches for member assessment and consistent authorization of in-home HCBS among case managers (CMs).

To achieve this purpose, a live scenario is presented at each monthly Case Management meeting for a total of three (3) scenarios per quarter, but not less than one (1) scenario per quarter. These scenarios are presented by a CM representing one of their own members. This live role play scenario presents a more realistic representation of an actual interview with a "member", thereby allowing the CMs to be more interactive with the "member" to clarify needs. Providing the CMs an opportunity to ask detailed questions to the member during the scenario will assist the CMs in obtaining the appropriate information required to complete the member's assessment and in the determination of the HCBS needs of the member. This group interview technique also allows the less experienced CMs to observe the types of questions the more experienced CMs ask the "member" during the assessment "visit". The ultimate goal in the completion of these scenarios is to determine the level of consistency among CMs in the authorization of HCBS while continuing to meet the medical needs and desires of the member in the most cost effective manner.

To determine the HCBS needs of the member, the CMs will utilize the Uniform Assessment Tool (UAT), the HCBS Needs Assessment Tool, and/or the CHS Assessment Form. The tool utilized will be changed periodically throughout the year, targeting different areas of the assessment process. All CMs will utilize the same tool at the same time with the goal of determining which tool supports the most consistent assessment of need. Each CM will independently assess and identify the HCBS needs of the member and "authorize" the HCBS he/she determined through the assessment / interview process. Identification of individual CMs' assessments will play an important role in this process so all CMs are required to place their names on the tool used. This identifies an individual CM who may need specialized training and/or re-education in a specific area of assessment and authorization of HCBS. Additionally, this will help in identifying weaknesses and strengths CMs have as a whole in the assessment and authorization of HCBS, thereby reinforcing positive results as well as identifying trends or other opportunities for process improvement.

CMs presenting scenarios are rotated through the Case Management meetings allowing each CM to either role play a "member" or to be the Case Manager assigned. A control group consisting of the CM Supervisor, Lead CMs, CM M/UM RN Liaison, and at least one CM with more than ten years experience complete an assessment of their own to set the benchmark for the determination of services and service hours to be authorized for each scenario presented.

A written analysis of the findings, along with any identified corrective action to be taken, is produced each quarter and sent to AHCCCS for review. Training and/or re-education in deficient areas in the assessment and authorization of HCBS identified in the analysis will be presented at Case Management meetings or to an individual CM as needed. It will be equally important to identify and stress the positive results, building upon the non-deficient areas. The combination of building on the positive results, and providing training and/or re-education in deficient areas, will ensure coordinated approaches for member assessment and authorization of HCBS. Comparing each CM's assessment against the benchmark set by the control group is also used for re-education purposes.

Another tool utilized by CM to improve consistency is the CM Assessment Team. This Team consists of the control group described above who meets weekly, or as often as needed. The purpose of these meetings is to hear all CMs present member cases in real time and recommend to the control team the HCBS to be authorized. All new member assessments must be presented to the Team, as well as any interim assessment or member request for a change in authorized hours prior to the next regular assessment visit. The Team members individually assess the case presented and suggest service authorization levels with the Team and with the CM. The group then together makes the final authorization determination for the member. The Team's efforts and this entire process are documented on an Assessment Team Review form in a network file by meeting date and name of members discussed for future reference and/or educational efforts as needed.

One other tool used by CHS to monitor CM inter-rater reliability is a spreadsheet completed by the CFO at the beginning and end of each month. The CFO sends this report to the Director and the CM Manager. The spreadsheet reports average attendant care hours authorized by each CM at the beginning of the month compared to the end of the month. The CM Manager can easily compare the average number of attendant care hours among all of the CMs and address any areas that seem to be outliers or inconsistencies. The CM Manager also compares the current monthly report with previous months' data to identify trends. This information is shared with CMs individually as needed, as well as at monthly CM staff meetings for educational purposes and is stored in a network file that can be accessed at any time by any CM staff for reference.

CMs work closely with ALF providers in determining level of care assignments and in providing any equipment or supplies the residents there may need. CHS will be including HCBS members residing in ALFs in this inter-rater review process starting next month. The inter-rater tool currently being used in the inter-rater process, the HCBS Member Needs tool, is not appropriate for members residing in an ALF. A revised UAT form will be utilized as the inter-rater tool for members residing in an ALF. Members who are currently residing in an ALF are being currently being reviewed in the Assessment Team meetings as with the in-home HCBS members. The member is reviewed every six months for appropriate placement and to verify the member/family/significant other wishes the member to remain in their current setting. Attention is given to the possibility of a less restrictive placement in all cases and transition plans are started when appropriate as a result of the Team's recommendations. If discrepancies are noted, an inter-rater review process will be developed to monitor this population. CHS does not anticipate that there will be any issues discovered in this type of service authorization.

CHS will continue efforts to improve all of the assessment tools currently in use, streamline the process of inter-rater reliability evaluations, and share findings with AHCCCS DHCM as needed.



## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT # D22

### **Needs Assessment/Service Planning for Members with Behavior Management Needs and Multiple Providers:**

CHS' overall goal is to provide member-centered, cost-effective, quality care for members in the least restrictive environment possible. This cannot be accomplished without a strong team effort involving all CHS staff, Provider network, and community resources. CHS delivers services to members with varying degrees of medical need, from simple needs to medically complex or behavior management needs. When members needing behavioral health (BH) services are identified, they are assigned to a Case Manager (CM) with expertise in BH management. At the initial assessment, the CM completes the Screening for Referral for BH Services form, the BH section of the Initial Assessment form, & the Psychotropic Medication Monitoring form. These tools aid the CM in gathering information to identify any BH needs the member may have. The CM also completes a BH Consult for those members who have been identified as having a BH need. A BH consult outlining the current treatment plan and future needs is completed, in conjunction with the BH Coordinator (BHC) every 3 months until the member is stable and the consult has been closed by the BHC. BH consults for members receiving counseling services along with other behavioral services cannot be closed. BH consults for members receiving medication management may not be closed unless it is confirmed that the member is stable on medications and is only receiving medication management. Members who reside in a BH facility may not be closed to consults even if they are stable and only receiving medication management.

Identified needs and care are coordinated and discussed with the PCP. The member family/legal guardian/MPOA are active participants in identifying the member's needs and in the planning/coordination of care. After contacting the PCP to determine medical necessity, the CM contacts the BH provider(s), supplies member history, and completes referral within two days of identifying a need. BH referrals are routed to the Medical/Utilization Management (M/UM) department and are approved within one day. Referrals are routed to the CHS Medical Services Authorization Specialist (MSAS). The MSAS will verify member's insurance and verify the provider is a contracted CHS provider. If the referral is for counseling services, an authorization for evaluation is given. If after evaluation the counselor determines that services are needed, the counselor must submit the evaluation to the M/UM Department. If the request is approved, authorization is issued for one month at a time, subject to submission of the counselor's notes. M/UM notifies CM of the frequency and duration of the authorization for purposes of service coordination. M/UM monitors utilization of BH services for appropriateness and necessity. If concerns are identified, M/UM may do any or all of the following: request additional information, speak to the provider about concerns, request secondary review from the Medical Director, or request review from the BH Consultant/specialist. CHS recently enlisted the services of a BH Nurse Practitioner to assist with BH concerns that may be beyond the scope of the Medical Director and/or the M/UM nurses. This Nurse Practitioner works in conjunction with M/UM department, Medical Director, PCP, and the BH Provider.

Members not exhibiting behaviors that make them a danger to themselves or others (DTS/O) are offered in home or outpatient services. This would include members with behaviors controlled by medication, behavior modification, counseling and treatment programs, and/or members who have a strong support system. Members who qualify can receive one-on-one counseling services in the home that may or may not include the family/support system, medication monitoring through Home Health Agency (HHA) to ensure member is receiving proper dose and maintaining medication schedule, and in-home habilitation services. Members may also be referred to an outpatient clinic for the same services, as well as group counseling services. Members receiving psychotropic medications are referred to a psychiatrist for medication monitoring every three months or more often if needed. Members may be referred for psychiatric evaluations at any time it is determined to be medically necessary. Many members also receive anti-depressants and other psychotropic medications from their PCP. The member's PCP continues to monitor the effectiveness and any adverse reactions of these medications. Because this is such a rural area, there is a shortage of psychiatric providers. Members may be given the option of traveling out of town to obtain services. All necessary referrals and transportation are provided by CHS and coordinated by the CM. There are Providers in this GSA who utilize telemedicine services - a member can go to a local clinic and "meet" with the Provider via televised sessions. Coordination with available community resources is also achieved by the CM. When appropriate, the CM may make referrals to Adult Protective Services, Child Protective Services, the Public Fiduciary, Habilitation providers, adult day programs for individuals with an SMI diagnosis, and any other social agencies or community groups the CM feels may benefit the member. If there is not a contracted Provider for a specific BH Service that a member needs, the Contracts Department will be notified. Contracts staff will obtain Letters of Agreement (LOA) with a non-contracted Provider, or assist in finding a suitable alternative, if needed. BH staffings are also held each

month with M/UM and CM to review members receiving BH services. These staffings ensure services are still appropriate and identify any additional member needs.

When it is determined by the PCP, BH Professionals, and the judicial system, members may be placed in an inpatient BH setting. Members who are PAD, GD, have psychotic episodes, exhibit behaviors making them DTS/O, and/or members who have an acute episode, may be petitioned under Title 36 for court ordered treatment. If the member has a legal guardian or a Mental Health Power of Attorney with powers to place the member in a Level I facility, this could be accomplished without the court order. The Judicial Review process is followed and monitored by the BH CM for members who are court ordered for inpatient treatment. Inpatient placement is facilitated by the CM, in conjunction with other professionals and the member/family/legal representative. The facility is determined by type of treatment needed and availability of a bed in the selected facility. If no bed is available in a contracted facility, CM contacts the Contracts Department to see whether a LOA can be written for placement in a non-contracted facility. CHS has expanded its BH network to include BH facilities and providers statewide due to the limited availability of BH providers in this GSA.

To ensure that members remain in the least restrictive environment possible, CM is very involved in coordinating and providing education for CHS staff and providers. The BH Specialist CM coordinated an educational pro-active program to help facilities in dealing with situations before they arise. The Positive Behavior Support and Behavioral Interventions training developed by Counseling and Consulting is a unique six hour course developed for CHS and aimed at identifying triggers that have the potential to set in motion a person's adverse behavior pattern. After identifying triggers, a plan of care is developed and all staff is trained in the use of this care plan for the member. It is felt by recognizing certain triggers or what response/reward the member is seeking from certain behaviors, interventions to fulfill these rewards can be implemented without escalating the behaviors. The BH Specialist CM also provided education to our contracted providers on how to handle crisis intervention when a member is exhibiting behaviors that are DTS/O. CMs are required to attend BH training on an annual basis. Other educational training resources available to CMs are filed in computer network folders including trainings on the BH process, BH quiz, BH process cheat sheet, and BH Policies and Procedures. Training is provided on an annual basis or more frequently as policy and procedures and /or AHCCCS mandates change. These educational efforts have equipped CHS and facility staff to manage behaviors in the least restrictive environment possible and have prevented or at least delayed the need to a higher BH level of placement.

**Needs Assessment/Service Planning for Members with Complex Medical Care Needs and Multiple Providers:**

As stated previously, CHS' overall goal is to provide member-centered, cost-effective, quality care for members in the least restrictive environment possible. This cannot be accomplished without a strong team effort involving all CHS staff, Provider network, and community resources. CHS delivers services to members with varying degrees of medical need, from simple needs to medically complex or behavior management needs. All members have the right to reside in the least restrictive environment able to meet those needs, even if complex. Complex members can have many needs including, but not limited to, therapies/rehab, ventilators, extensive wound care, or secure and behavioral placement. If at any time a member needs a service that is not available with the CHS Network, the Contracts department is contacted. Contracts staff assist Case Management with exploring all options, including inpatient services, LOA with a non-contracted provider, or a combination of services to achieve the desired result.

Placement determination begins with the CM assessment of the member's living environment, physical and mental condition, support system, current medical needs, and member preferences. A determination can then be made of the most appropriate level of care and placement, from remaining in their home, to an assisted living facility, a skilled nursing facility (SNF), a BH unit, or other setting. The member's placement is ultimately decided by the member and/or family/legal guardian. Once a determination has been made with input from all stakeholders, the CM will contact the PCP to discuss the identified options and coordinate care.

Providing care in the home to members who have medically complex conditions can be a challenge. It requires coordination between the member and/or family/legal representative if appropriate, the PCP, social agencies, HCBS providers, and CHS staff. Safety is a prime concern for HCBS members. Oftentimes safety is simply a matter of acquiring the necessary equipment for the home, such as toilet risers, grab bars, or personal emergency response units. When equipment needs are identified, the CM will contact the PCP and request prescriptions and documentation for that equipment. A DME request is completed and forwarded to the DME MSAS. The DME MSAS will review insurances for the member and ensure that all supporting documentation is included with the request. Requests are reviewed daily by the CM Supervisor, the CM-M/UM RN Liaison, and the DME MSAS. If it is unclear that criteria

have been met, the information will be forwarded to the Medical Director and/or M/UM staff for further review. The approved request and required information is forwarded to an appropriate DME Provider. CHS maintains a close relationship with contracted DME providers. There is constant communication to ensure requests are filled timely. Many times arrangements can be made to deliver key pieces of equipment to the member's home if the member is currently at a facility to expedite discharge plans.

Members requiring assistance with ADLs have the option of using a contracted provider, spousal or family attendant care, SDAC, or a combination of these. A service plan is developed and signed by the member or representative to indicate that all parties have agreed with the plan. For members with complex needs, a meeting of CM, member, attendant caregiver, and usually a supervisory level person from the agency is held at the member's home to develop a member-centered plan of care. This could mean setting up different, staggered blocks of time for services. It could mean involvement of more than one agency to provide those services. The attendant care agencies also formally meet with CM on a monthly basis to discuss complex cases. Members with complex needs may also require skilled nursing services. The services available include, but are not limited to, medication set up, wound care, teaching/monitoring, and/or infusion therapy. The PCP orders skilled nursing services then CM authorizes and arranges the services. The Home Health Agency (HHA) provides copies of their notes to the CM for review. Wound care supplies are coordinated by CM, DME MSAS, and the agency providing the wound care. If the wound care supplies are extensive and indicate high utilization, the M/UM department may be asked to review the agency's documentation, speak to the agency RN, and/or review wound care supplies for appropriateness. In some complex cases, the CM and M/UM RN make a joint home visit to assess the situation. The Medical Director is consulted and asked to review documentation when necessary.

Home modification (HM) may also allow a medically complex member remain in his/her own home. The CM will assess the need for a HM. This may include widening a doorway, roll-in shower, a ramp to ensure accessibility of the home, or safer steps and railings. If a need is identified, an order will be obtained from the PCP. The order may also include a physical or occupational therapy evaluation to provide a more comprehensive assessment of member needs. A prior authorization and/or DME request is completed. The home modification order is then transferred to M/UM and Contracts departments for further assessment, including on-site assessment and photographs. The Medical Director will be involved in the final decision. If the requested HM is not approved, other alternatives will be discussed, and/or an NOA is issued. CM and M/UM collaborate in the NOA process following AHCCCS guidelines.

Arranging infusion therapy involves several disciplines including, but not limited to: PCP, M/UM, DME MSAS, CM, HHA, pharmacy, and/or facilities. If it is determined that the member can self-administer the infusion, or has a support system that can assist, the CM receives the order for infusion, completes a request for the necessary supplies and submits all the documentation to the M/UM department. The CM contacts the HHA and the DME MSAS if DME needed (i.e., IV pole). M/UM reviews the documentation and submits the request, authorization for the infusion, and name of the HHA to the contracted pharmacy. Because CHS operates in very rural areas, we have developed a unique system for delivery of infusions. The contracted pharmacy cannot deliver the medications to the member's home due to Medicare certification status. Therefore, the delivery is typically made to a nearby contracted SNF. The facility is notified of the date and time of an impending shipment. The facility will let CHS know who will be responsible for accepting the delivery. The delivering pharmacy and HHA are provided this information. The HHA arranges to pick up the medication from the facility prior to seeing the member. If a member is not suitable for home infusion, there may be an option to transport to a nearby clinic or hospital for the infusions. CHS arranges and provides necessary transportation. This is accomplished by CM in cooperation with M/UM department, member, and PCP. The CM also coordinates in-home therapy services, including physical, speech, and occupational therapies when needed. CMs also provide members resource information and assistance regarding housing, education, and employment. The information includes housing options, educational and employment opportunities, as well as resource contacts. The CM can facilitate the initial contact with resources and assist during the process as needed.

When a medically complex member's needs are unable to be met in the home due to an inadequate support system, safety reasons, economic reasons, or other issues, a SNF may be the only option. The ultimate goal is for the member return home as soon as possible, but sometimes this is not feasible. If it appears that placement is the only option, the CM discusses this with the member, family and/or legal representative, and the PCP. Once all agree on placement, the CM researches what is available in the CHS network that meets the member's needs most appropriately. If there is not a facility in the network that meets the needs of the member, the CM will look outside of the network with the assistance of the Contracts department. When suitable facility is found, Contracts will negotiate a LOA prior to placement.





## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT # D23

Home and Community Based members are assessed every ninety days or more frequently if the member's placement is changed or if there is a change in the member's mental or physical condition. To track member re-assessment due dates, CHS Case Managers (CMs) utilize the CATS CA 225 screen and assessments are completed on or before the due dates. The CM contacts the member and/or family representative to arrange a visit time convenient for them. The CM conducts an onsite review at the member's place of residence. This is to assess the appropriateness of services already in place. A visit to a site other than the member's place of residence may occur but must be at the request of the member or representative. If an alternate site is used, the rationale is documented in the member's file.

Home based services for members are developed and determined through a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the member's health needs and to promote member-centered, quality, cost-effective outcomes. The CM conducts the assessment by interviewing and observing the member. The CM utilizes the CHS Assessment Form, UAT, and HCBS Member Assessment tool to obtain information to determine the member's level of care and the member's home based service needs. The CHS Assessment Form, along with the other tools used by the CM, aid in obtaining and updating such information as member demographics, sensory, neurological, physical and functional status, along with behavioral health needs, member's learning ability, and DME needs. The CM also obtains information about the member's support system, need for general supervision, evaluates the member's need for assistance in performing household tasks, and any home modification needs. The member's medications are reviewed as well as the Authorization for Use or Sharing of Health Information Form. The Service Plan is also reviewed at each assessment and updated at least yearly or with any change. The CM discusses any Housing, Employment, or Education needs the member may have as well as any other unmet needs. A booklet containing information regarding Housing, Employment, and Education is left with the member, along with an updated County Resources Directory. Once yearly, an updated Member Handbook is reviewed with the member in addition to the Important Member's Rights Notice.

The member and family/significant others are active participants in the planning for and evaluation of home-based services. The CM discusses the different home-based service options available to the member and informs the member he/she may request a change in services at any time in meeting those needs. The CM explains the different service options available, such as SDAC and family/spousal attendant care. The CM also explains services provided by a caregiver agency, regular attendant care, housekeeping, personal and respite care, habilitation services, and home delivered meals. Home-based services that require collaboration/facilitation with the member's PCP are identified. These include skilled nursing services, Therapy service (PT, OT, ST, and Respiratory), DME, home modifications, and Personal Emergency Response Systems. Behavioral Health service options are also discussed with the member. Service provider restrictions, limitations, or assignment criteria are clearly explained and identified to the member and family/significant other. Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining the highest level of self-sufficiency possible. The CM explains that she/he makes a preliminary determination of home-based services meeting the member's medical needs in the most cost-effective manner. The CM updates any changes in contact information for the CM and leaves a business card with the member.

All information is then reviewed with the Assessment Review Team to determine the home-based service authorizations. The Assessment Review Team process is explained and who is involved. The Assessment Review Team consists of two or three CMs with more than ten years experience, the CM-MUM RN Liaison, and the CM Supervisor. This team along with the CM discusses the information gathered during the assessment visit and other previous assessment information if any. The team discusses the member's situation, identifies the member's needs, and makes a determination of services based on the assessment information provided. The member is informed that CHS CMs follow this process for any new CHS members who require home-based services and for any member identified as needing and/or requesting a change in current services whether for an increase or decrease. The CM explains the member will receive a phone call from him/her with in two days of the Assessment Review Team meeting informing him/her of the services that are authorized. The CM documents this phone conversation in the member's file. The CM also explains that the Service Plan will be mailed for the member's or family/significant other's signature. The CM explains the importance of the member to signature on the Service Plan whether they

agree or disagree with the services authorized. The member and family/significant other is informed that if they disagree with the services authorized, the services will be reviewed by the CM Supervisor and CHS Medical Director. The NOA process and member appeal rights are also discussed with the member and family/significant other. The Cost Effectiveness Study (CES) is also completed and discussed with the member.

Goals that are member-specific and measurable are developed in collaboration with the member and family/significant other and the CM. The member and family/significant other assists in developing the member's Contingency Plan. The CM discusses gaps in service and how to report should they occur. The Contingency Plan is reviewed at each assessment visit and a copy is left with the member. A copy of the Plan is also sent to the caregiver agency and a copy is kept in the member's file.

Members are maintained in the least restrictive setting possible, but members are given the choice of remaining in their own home or choosing an alternative residential setting. Member placement in a residential setting is reviewed by the CM at each assessment visit or with any change in mental or physical condition. Members in alternative residential settings are reviewed yearly by the Assessment Review Team to determine appropriateness of continued placement.

As soon as service level determinations are made, the CM contacts all providers, including notification of the PCP, if a change has occurred in the member's condition or needs, and coordinates all care through the member's PCP. The CM places the assessment/re-assessment form and all other applicable documentation in the member's record. He/she also completes a progress note documenting the onsite assessment visit and any other pertinent information not already contained in the body of the assessment. The CA160, CA161, and CA165 are updated for current services. Authorizations are entered into health information system and sent to providers. The member's file is updated and completed within seven working days of the assessment.

All CMs participate in the quarterly inter-rater reliability review process to evaluate the consistent application of service assessment and authorization criteria among CMs. The purpose of this inter-rater review process is to improve CM assessment and review procedures, with particular emphasis on coordinated approaches for member assessment and consistent authorization of HCBS among CMs. This process involves a live scenario presentation at each monthly CM meeting for a total of three (3) scenarios per quarter, but not less than one (1) scenario per quarter. These scenarios are presented by a CM representing one of their own members. This live role-play scenario presents a more realistic representation of an actual interview with a "member", thereby allowing the CMs to be more interactive with the "member" to clarify needs. Providing the CMs an opportunity to ask detailed questions to the member during the scenario will assist the CMs in obtaining the appropriate information required to complete the member's assessment and in the determination of the HCBS needs of the member. This group interview technique also allows the less experienced CMs to observe the types of questions the more experienced CMs ask the "member" during the assessment "visit". The ultimate goals in the completion of these scenarios is to strengthen the member-centered approach to home-based service authorizations by all CMs, and to determine the level of consistency among CMs in the authorization of HCBS while continuing to meet the medical needs and desires of the member in the most cost-effective manner.



## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT SCENARIO # D24A

### 1) INTERACTION OF THE CASE MANAGER (CM) WITH THE MEMBER AND OTHERS AS APPLICABLE

PAS information was reviewed after daily enrollment report was received by CM showing that member had rolled on to CHS roster. Initial telephone contact was made with the member and facility staff within three working days of receipt of the enrollment roster. The CM assigned scheduled the initial assessment within seven working days of receipt of the roster at a time convenient for Oscar and his wife, April. The CM reviewed the Oscar's medical chart and met with staff to receive a verbal report on his status. The CM was then introduced to Oscar and April. The CM welcomed them to the program and set the stage for a sound working relationship based on mutual respect and trust. The CM explained that the role of the CM is to help Oscar get the best health care possible within program guidelines, based on medical necessity. She explained that CMs work with doctors and providers to coordinate care, and are readily available to answer questions and address Oscars' day-to-day concerns as well as provide support needed for the family.

The CM provided Oscar with the CHS Member Handbook, business card, list of CHS contracted physicians, specialists and pharmacies. The CM ascertained that Oscar was slightly confused and not able to remember the few details presented so far. The CM confirmed his wishes to include April, and other family members or friends, in all decision-making, including care planning and establishing goals. The Notice of Privacy Practices was provided and explained. The Authorization to Share Health Information was completed, with April identified as the MPOA. April said the facility has a copy of his Power of Attorney, which the CM copied for his chart. April expressed concern over Oscar's increased anger and confusion which is unlike him. Oscar said he was dissatisfied with the care he was receiving. He said the caregivers are not as responsive as at the "last place," and they handle him "roughly." He also said there is nothing to do so he sleeps all the time, and the other residents are "too old." The CM assured them that she would discuss their concerns with the Director of Nursing and Social Services at the SNF, and inform them of the resolution. The CM also told them CHS had an internal mechanism for investigating complaints and concerns voiced by members and families called an Expression of Dissatisfaction (EOD) which she would be completing upon her return to the office. The CM explained that CHS will respond to their EOD within ten (10) days and if the resolution presented is not acceptable, CM explained their right to grieve and the process for doing so. The CM asked if April had access to a computer and found that she did. The CM encouraged April to visit the CHS Website and the AHCCCS Website for additional information about the program and to feel free to contact the CM at any time to discuss issues or concerns.

The CM continued with program orientation, explaining covered services. Oscar and April said they were unaware of community resources, at which time the CM provided a copy of the County Resource Directory. The CM inquired if Oscar had any other insurance, noting a carrier through his previous employer. Advanced Directives were discussed and an informational booklet was provided. April said he did not have a living will. CM explained how to put one in place if he chose to do so. The CM explained Oscar's rights and responsibilities. She explained that he had the right to determine his services, and together they would develop a service plan to meet his needs. Oscar said he wanted to return home. The CM explained what home-based services were available, including the Self-Directed Attendant Care (SDAC) program and Spousal/Family Attendant option. The CM explained that if April chose to be Oscar's spousal attendant caregiver part-time, his brother could also be a family attendant caregiver part-time. This would provide April the opportunity to still continue with her part-time job. Oscar and April were very receptive to this idea as childcare was not an issue because both children were in school full-time. The CM established a goal with Oscar and April, outlining the steps needed to facilitate a safe return home. The CM explained that CHS' overall goal is for him to regain as much independence as possible and return home as he has expressed the desire to do. April voiced her willingness to support this decision. April also requested assistance in obtaining a wheel chair accessible van. The CM informed her that CHS does contract with transportation providers enabling CHS to offer this service to members. The CM explained transportation services are limited to provide transportation to medical appointments or other medically-related appointments, such as dialysis or PT appointments. She explained transportation could not be provided to take Oscar shopping or to visit a friend. The CM informed Oscar and April she would research other sources for assistance with a van and provide her with the information. April told the CM that as long as there was a way for Oscar to receive transportation to his medical appointments, they would wait on pursuing a van until they knew the extent of Oscar's recovery and what his limitations would be. No particular cultural or linguistic needs were identified. The CM completed the Behavioral Health Screening form, identifying a possible need for counseling and

medications due to symptoms of depression and anger management issues. They discussed placement options and the cost effectiveness of placement. The CM pointed out areas in Oscar's life that had proven to be problematic for him and made suggestions for services that would help him reach the goal of living independently in the community. The CM also discussed the possibility of vocational rehabilitative services and informed both Oscar and April she would provide them with contact information. He became more receptive to suggestions knowing he had choices. The CM asked about his medications and allergies. April accurately listed his medications, which matched those documented in the facility chart. A Contingency Plan for critical care services was discussed, but not implemented at this time.

## 2) ASSESSMENT OF THE MEMBER'S STATUS AND NEEDS

### **Physical status assessed as follows:**

Transfer/mobility: According to the PAS, facility MDS and Oscar, he has limited use of his limbs, with only very spastic control of one arm. Oscar owns a customized power wheelchair.

Bathing, Dressing & Grooming: Oscar requires total assistance.

Eating: Oscar has started to feed himself with use of splint and adaptive utensils, but will require standby assist while eating and total assist with meal preparation and clean up.

Toileting: requires bowel care, with facility bowel care program in place.

Change in ADL function: no further decline at this time, with improved ability to feed self.

Communication: no problems making his needs known.

### Summary of physical needs assessed:

- Needs PT, OT and home safety evaluations.
- Needs continued strengthening and exercise program.
- Needs increase in ability to perform ADLs & IADLs.
- Needs bowel program set up to facilitate regular elimination and maintain skin integrity.
- Needs assist with transfers, bathing, dressing, grooming and toileting.
- Needs durable medical equipment, including Hoyer lift with commode sling, hospital bed, egg crate mattress, shower chair, handheld shower, grab bars and reusable bed pads.
- Needs medically necessary transportation.
- Needs therapeutic home visits to evaluate HCBS challenges.
- Needs tentative Contingency (Back up) Plan developed.
- Needs medical evaluation to rule out UTI or other medical conditions causing disorientation including review of medications.
- CHS Medical Director to discuss rehab potential with Oscar's PCP
- CHS PBM to review medications for possible interactions that could be causing behaviors.

### **Psychological status assessed as follows:**

Oscar is presenting with increased anger, agitation, depression, confusion and disorientation.

### Summary of psychological needs assessed:

-Needs psychiatric evaluation for medications and counseling to address loss of independence, employment, and income. Evaluation should include possible benefit of family, as well as individual, counseling.

### **Environmental status assessed as follows:**

Oscar has own home. During one visit home, barriers to access were discovered at the home's main entrance and master bathroom, possibly requiring environmental modifications

### Summary of Environmental needs assessed:

-Needs home modification evaluation to provide Oscar access to his home and master bathroom.

### **Socialization status assessed as follows:**

Oscar is able to interact, but self-isolates because placement is not age-appropriate.

### Summary of socialization needs assessed:

- Encourage visitations by family, friends and co-workers.
- Encourage interactions with his children.
- Arrange for therapeutic home visits as often as possible and increasing in duration.
- Individual and family counseling, as indicated by psychiatric evaluation.
- Encourage participation in age-appropriate activities per member preference.
- Seek age-appropriate facility until able to return home; involve CHS Contracts department to look outside of network if needed for possible Letter of Agreement with more age-appropriate facility.

### **Community supports and public assistance programs**

Oscar has support from family and friends, but needs information on other resources and benefits available to him and family.

Summary of community supports and public assistance needs assessed:

- Needs contact information for public assistance programs, including DES Vocational Rehabilitation Services, and Social Security.
- Needs a list of contracted caregiver agencies for possible spousal and family attendant care and/or SDAC.
- Needs referral to Area Agency on Aging Family Caregiver Support Program.
- Needs list of options and schedules for local support groups.
- Needs referrals to other programs that could possibly assist with non-covered services as identified following enrollment.
- Needs HEE (housing, education and employment) booklet, including social security work incentive programs.

3) CARE PLAN/SERVICES DEVELOPED TO MEET THE NEEDS OF THE MEMBER, INCLUDING IMMEDIATE AND LONG TERM OUTCOMES THAT ARE MEMBER-SPECIFIC AND MEASURABLE

**Physical:**

Schedule a care conference within one week with facility staff, Oscar and April to facilitate discharge planning for possible discharge home. Ask Oscar and April if, and to what degree, they wish to involve their two children in care planning. CM will advise PCP that coordination is needed between home health nursing agency, behavioral health provider, and PCP. A prescription request was completed for a home safety evaluation, home modification evaluation, PT/OT evaluation for a home strengthening and exercise program, durable medical equipment and supplies, and adaptive aids. Prior to discharge, an order for home health nursing will be requested, to include a bowel program. Home health nurse will teach bowel care, as well as assess skin integrity; family teaching to be completed within thirty days. HHN will determine frequency of visits after intake. Oscar will be able to identify signs and symptoms requiring medical attention and follow up with medical professionals timely and appropriately. A tentative Contingency plan will be developed at the discharge planning meeting. Caregiver(s) will assist with personal care, meal prep and general supervision. An attendant with BH training will be requested to provide positive reinforcement and minimize risk of losing caregivers. The CM requested that facility nursing staff provide additional training/return demonstration of daily care, such as bowel and skin care prior to discharge. CM will contact CHS Medical Director to consult with Oscar's PCP to determine rehab potential.

**Behavioral Health:**

CM will contact PCP to determine medical necessity within two days of identifying needs. CM will contact the behavioral health providers within two days, providing member history, and complete referral documentation for a psychiatric evaluation to determine diagnosis, need for medications, and individual/family counseling. Since the goal is to return to own home, counseling may improve both member's and family's coping skills to manage loss of independence and other environmental stressors. The CM completed the initial BH Consultation for review and recommendations by the BH Coordinator. The BH professional will recommend frequency of visits after intake, and submit monthly progress reports to the CHS Medical/Utilization Management division and CM.

**Housing/home modifications:**

Home modification needs are to be determined according to the PT/OT and home safety evaluations. Pictures of the current living environment will be taken by CM and forwarded to Contracts division to solicit bids. These modifications will allow Oscar to access the home and master bathroom. Home modifications to be completed within ninety days of home modification request.

**Socialization:**

Encourage 1:1 visits with family, friends and co-workers and encourage participation with his children's activities. Being socially involved with others, Oscar may report fewer feelings of isolation.

**Community Supports/Public Assistance:**

CM provided a Directory of County Resources, including information on volunteer groups, food banks, commodity distribution sites, as well as assistance with utilities and telephone. Also provided was the booklet information on Housing, Education and Employment (HEE), Social Security Disability, facility Ombudsman, public assistance programs through DES, and appropriate support groups. April and Oscar's brother were provided additional information regarding CHS and its program and providers to assist them in making informed decisions. If HCBS placement fails, then CM, Oscar, and family will seek age-appropriate long term placement.

The ALTCS Service Plan was completed and mailed to Oscar. A tentative Contingency Plan was developed. Authorizations were entered into health information system and sent to providers. CHS Administration was notified of a potential for possible lien recovery and for research into benefits provided by other insurance carrier to ensure that CHS is payor of last resort. CM updated the CA160, CA161 and CA165 in CATS for current services.



## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT SCENARIO # D24B

### 1) INTERACTION OF THE CM (CM) WITH THE MEMBER AND OTHERS AS APPLICABLE

The new CM scheduled a ninety-day assessment with Magda's daughter Raquel. Magda does not speak English and requires Raquel or another family member to interpret for her. The visit was arranged to meet the Raquel's work schedule. The CM introduced himself to Magda and Raquel and provided a business card. He set the stage for a sound working relationship based on mutual respect and trust. He reviewed the Authorization to Share Health Information, already on file. He reviewed Magda's health insurance coverage, noting no changes. The CM began the assessment by informing Raquel that CHS has an account with Language Services Associates for InterpreTalk, a phone service that facilitates communication with non-English speakers 24 hours a day, 7 days a week. CHS also has access to tools through a company called viaLanguage for assistance in translation of up to 150 languages. The CM informed Raquel this service could be utilized by Magda and caregiver when she was not at home to provide interpretive services for her mother. After discussing Magda's language barrier, Raquel reported that Magda was recently diagnosed with early stage Dementia, has increased confusion, but is still able to make her own decisions, and go to dialysis by herself. The CM discussed the possibility of Raquel pursuing guardianship of her mother in the near future or MPOA due to the recent diagnosis of Dementia and the increased confusion. Raquel declined to pursue that option at this time.

Raquel requested an increase in weekly Attendant Care hours and respite care on Sundays. The CM noted that the Attendant Caregiver was providing housecleaning and laundry for the family. He explained that Attendant Care services are only authorized for Magda's specific area: her bedroom, her laundry, cleaning the bathroom after her shower and do not include housecleaning and laundry for the entire family. He also discussed the different service options available, such as SDAC and family attendant care services. Magda informed the CM these would not be viable options as both her and her husband work outside the home. The CM explained that a HCBS Member Needs Assessment Tool, a Uniform Assessment Tool, and the CHS Assessment Form would be completed during the assessment. These tools aid the CM in gathering information about Magda's needs and identifying what home based services Magda requires in order to remain safely in the home setting. The CM explained he makes a preliminary determination of services and then all information is reviewed with the Assessment Review Team to determine the home based services to be authorized. He explained the Assessment Review Team process and who is involved. The Assessment Review Team consists of two or three CMs with more than ten years' experience, the CM/MUM RN Liaison, and the CM RN Supervisor. This team, along with the CM, discusses the information that was gathered during the assessment and other previous assessment information if any. The team discusses the member's situation, identifies the member's needs and makes a determination of service needs based on the CM's assessment information provided. The CM informed Magda and Raquel that CHS CMs follow this process for any new CHS members who require HCBS and for any member identified as needing and/or requesting a change in current service levels whether for an increase or decrease. He told Raquel she would be receiving a phone call from him within two days of the meeting, informing her of the services authorized and that the Service Plan would be mailed for Magda's signature. He informed Raquel that if they disagreed with the services authorized, they may note that on the Service Plan, and the services would be reviewed by the CM Supervisor and CHS Medical Director. The NOA process and grievance rights were also discussed with Magda and Raquel.

The Cost Effectiveness Study was explained to Magda and Raquel and that services are based on medical necessity. The Contingency Plan was reviewed for gaps in service and member preference. The CM asked if Magda and Raquel were satisfied with the performance of the caregiver(s), including being on time. Raquel said the caregiver is often tardy, making her late for work. The CM told Raquel he would contact the agency, discuss the caregiver's tardiness, and let her know the outcome of that discussion within twenty-four hours. He also reviewed how and when to report gaps in service, including the 800# at AHCCCS dedicated for this purpose. Raquel asked for a new PCP because it was difficult to make appointments with him. The CM told Raquel he would discuss this with the PCP's office. The CM provided a list of CHS contracted PCPs to Magda and Raquel. The CM informed them he would contact the PCP of their choice to inquire whether they were accepting new patients at this time. If the new PCP was accepting new patients, the CM would send a new enrollment letter to the PCP, including Magda's enrollment date, DOB, address, phone number, and any other insurance information. The CM informed Raquel that her mother would also receive a letter informing her of the change in PCPs once this had been done. She would be instructed to request the medical records from her previous PCP to be sent to the new PCP and to schedule an appointment with the new PCP within

seven to ten days of receipt of the letter. Raquel is interested in getting information on community supports available to member and family. She said current supports include church, friends and neighbors. Magda stated that Raquel is embarrassed by her lack of English and no longer wants to take her to church. The CM completed the Screening for Referral for BH Services form and assessed for other BH concerns. The CM discussed the resources available to Magda and provided her with the County Resource Directory. Alternative placement options were discussed, including SOC, in case Raquel and family found they are unable to meet Magda's needs at home.

The CM presented Magda's assessment to the Assessment Review Team. It was noted the new CM had suggested a decrease in Attendant Care services from what had previously been authorized and Raquel was requesting an increase in services plus respite for Sundays when the family attends church. The team, along with the CM, reviewed this member utilizing the UAT, HCBS Member Needs Assessment Tool, the CHS assessment form, and previous assessment information. The consensus of the team was the amount of service hours already in place could meet Magda's needs with additional time given on Sunday. Housecleaning and laundry would be limited to Magda's needs only. The extra hours that had been dedicated to housecleaning and laundry for the family will now be used for general supervision for Magda. Through the Assessment Review Team process, the CM was re-educated on a member's general supervision needs and how to determine those services. The CM notified Raquel of the home based services that had been authorized. Raquel verbally disagreed with the decision. He informed Raquel the NOA process would now be enacted. He explained that CHS has fourteen days to review the information and make a decision to deny the request for additional service hours or to authorize them. He informed her if CHS denied her request, she would be receiving a letter notifying her of that decision. He also told her services currently in place would not change until ten days after the date of the letter. He explained the letter will contain information that will explain Magda's right to appeal the decision and how to go about that process. He explained that they can choose to keep services at current level during the appeal process, but they could be held responsible for the hours provided above what the CM was authorizing if the appeal did not end in their favor.

## 2) ASSESSMENT OF THE MEMBER'S STATUS AND NEEDS

### **Physical status assessed as follows:**

Transfer/Mobility: Member is falling and unsteady on her feet, requiring standby assist with transfers and supervision when ambulating.

Bathing, Dressing and Grooming: Member has a shower bench and requires supervision with bathing, dressing and grooming.

Eating: Member needs prompts to finish eating and drinking, and cueing to take medications.

Toileting: No changes reported.

Change in ADL function: Increased risk of falls due to poor safety awareness, unsteady gait and increased confusion. She needs prompts to eat, drink and take medications. She needs assistance with bathing due to a recent fall in the shower. She needs durable medical equipment for safe bathing. She is unsafe to be left alone.

Communication: Member is usually able to make needs known to her daughter, but has episodes of confusion. She speaks very little English. Her native language is Romanian.

General Supervision: Member now requires general supervision due to increased confusion and recent falls.

### Summary of physical needs assessed:

-Needs PT evaluation for unsteady gait, increased falls.

-Needs durable medical equipment to make transferring and personal care safer, including grab bars, safety poles, raised toilet seat, and hand held shower.

-Needs assistance with transfers, bathing, grooming, and dressing.

-Needs prompting for eating and drinking, and cueing for taking medications.

-Needs supervision when ambulating and general supervision due to increased confusion, is unsafe to be left alone.

-Continues to need medically necessary transportation.

-Needs interpretive services when daughter is not home to facilitate communication between member and caregiver.

-Address diabetes with PCP – possible dietary evaluation and family education on diabetic/renal diet.

-Refer Magda and family to M/UM for disease management program.

-CM to contact dialysis staff to discuss possible relation between increased confusion and dialysis/electrolyte issues.

**Psychological status assessed as follows:** Address low self-esteem issues family involvement as preferred.

### Summary of psychological needs assessed:

Needs counseling to address low self-esteem issues. Evaluation should include possible benefit of family, as well as individual, counseling.

**Environmental status assessed as follows:** No needs assessed at this time. Home is fully accessible.

**Socialization status assessed as follows:** Magda receives socialization from daughter and family, including taking member to restaurants, shopping, family gatherings, and other outings. Raquel wants to know what other socialization opportunities are available.

Summary of socialization needs assessed:

-Needs information on other age-appropriate community activities and events for socialization opportunities.

**Community supports and public assistance needs assessed as follows:** Member is newly diagnosed with Dementia. Daughter is requesting information on community supports.

Summary of community supports and public assistance needs assessed:

-Needs County Resource Directory

**3) CARE PLAN/SERVICES DEVELOPED TO MEET THE NEEDS OF THE MEMBER, INCLUDING IMMEDIATE AND LONG TERM OUTCOMES THAT ARE MEMBER-SPECIFIC AND MEASURABLE.**

**Physical:**

-CM contacted attendant care agency to report caregiver tardiness immediately upon return to office and counseled agency on not providing extra family care services. Agency replaced the tardy caregiver immediately. CM completed an EOD and submitted the form to M/UM the next day. MUM verbalized that on annual provider review the MUM nurse would assess compliance of Agency supervisor visits and oversight of the employee. CM notified Raquel immediately of change in caregiver and informed her agency would be in contact with her the next day. Daughter to report to CM any further issues regarding caregivers.

-CM to contact current PCP's office within 24 hours to discuss appointment scheduling issues reported by member. CM to complete EOD regarding scheduling difficulties after discussing with PCP's office and submit to M/UM. May be referred to Provider Relations Manager if appropriate to research previous results of Physician Accessibility Surveys.

-Magda and Raquel will choose a new CHS contracted PCP within three days and report to CM.

-Raquel will make appointment with the new PCP within seven to ten days of receipt of letter informing her of new PCP.

-CM will request prescription for DME from new PCP to include grab bars, safety poles, raised toilet seat, handheld shower and diabetic supplies.

-Raquel will request, at first visit with new PCP, a referral for a PT/OT evaluation after discussing Magda's balance problems and recent falls and a dietary consult for renal and diabetic diet teaching.

-Enact NOA process for disagreement of attendant care services authorized; CHS has fourteen days to review the information and make a decision to deny or authorize additional service hours. If CHS denies Magda's request, a letter will be sent notifying her of that decision. Services currently in place will remain until ten days after the date of the letter. The letter will contain information that will explain Magda's right to appeal the decision and how to go about that process. Authorization will be sent to provider agency with new service hours and effective date, depending on member's decision about keeping at current levels until appeal is completed.

-CM did an annual review of the Member Handbook, including specific information on the grievance/appeal process, which process is also included on the NOA.

- CM to authorize Language Services Associates to set up InterpreTalk in Magda's home to facilitate communication between Magda and caregiver. Member will be able to communicate with caregiver when daughter is away from the home within the first day.

**Behavioral health:** Contact PCP to determine medical necessity and coordinate behavioral health services, counseling for low self-esteem issues. Complete referrals within two days of identifying need.

**Housing/home modifications:** No needs reported or assessed at this time; will re-evaluate in ninety days.

**Socialization:** CM provided information on local volunteer groups, including in-home church services/prayer groups. He will research availability of opportunities for socialization with volunteers/groups that have Romanian speaking members. Member will continue involvement with church without increased agitation within the first home based church service. Family members encouraged to speak Romanian in home whenever possible to decrease Magda's feelings of isolation.

**Community supports/Public Assistance:** CM provided updated County Resource Directory.

-CM provided a list and schedule of local support groups for Alzheimer's/Dementia, as well as on-line websites and phone numbers for the National Alzheimer's/Dementia Associations.

-CM will find out if there are any Romanian communities or native speakers in the area.

-CM will refer Raquel to the Area Agency on Aging Family Caregiver Support Program.

-CM referred Raquel to local Adult Day Programs to investigate suitability for Magda.

The ALTCS Service Plan and Contingency Plan were mailed to member. Contingency Plan was faxed to the agency. CM updated the CA160, CA161 and CA165 for current services. Authorizations were entered into HIS and sent to providers.





## COCHISE HEALTH SYSTEMS (CHS) CASE MANAGEMENT SCENARIO # D24C

### 1) INTERACTION OF THE CM (CM) WITH THE MEMBER AND OTHERS AS APPLICABLE

The CM received notification that Wanda was discharged from the hospital to an ALF, unbeknownst to the CM. The CM reviewed the program contractor's network to verify that the ALF is a contracted provider, and confirmed that member's income met Room and Board eligibility criteria. The CM scheduled an onsite change of placement assessment with staff, Wanda and her son. The CM advised the ALF owner that a Residency Agreement is required per contract prior to admitting CHS members. The owner provided Wanda's room and board amount, which turned out to be close to what CHS requires. The CM completed the Room and Board Setup form and forwarded it to the Provider Relations/Contracts department, with a request for follow up with the ALF to review the contract. The CM completed a MCR, noting change in placement.

Prior to meeting with Wanda and her son, the CM reviewed the Residency Agreement with the owner, and obtained her signature. The CM reviewed the facility chart and met with staff, who reported that Wanda was now almost total care, more confused and at times combative. The CM requested that staff contact the PCP to rule out medical causes of confusion and behaviors. Staff said they were able to meet member's needs, although it appeared they were struggling.

The CM then met with Wanda and her son. Wanda appeared confused and mostly deferred to her son during the assessment. The CM explained to Wanda and her son that in order for CHS to assist with the cost of placement, the CM needs to be notified to confirm the facility is contracted with CHS and to coordinate admission. The CM reviewed the Residency Agreement, explaining the Room and Board requirement and cost effectiveness of placement. The CM reviewed Wanda's insurance and found that it had been switched to a MAP and a non-contracted PCP. The CM explained that in order to coordinate care between the MAP and CHS, Wanda needed a physician that was contracted with both. The CM provided a list of CHS contracted PCPs and specialists, requesting that Wanda and her son choose a PCP within five days. The CM informed them she would contact the PCP of their choice to inquire whether they were accepting new patients at this time. If the new PCP was accepting new patients, the CM would send a new enrollment letter to the PCP including Wanda's enrollment date, DOB, address, phone number, and any other insurance information. The CM informed the son that his mother would also be receiving a letter informing her of the change in PCPs. Wanda would be instructed to request the medical records from her previous PCP to be sent to the new PCP and to schedule an appointment with the new PCP within seven to ten days of receipt of the letter. The CM advised the son to schedule the appointment with the PCP to evaluate medical, physical and behavioral changes, including continuity of treatment for cancer. The CM completed the UAT, noting a much higher level of care in all categories due to significant changes in ADL functioning. The CM completed the Medication and Psychotropic Medication Monitoring Record. The CM completed the BH Screening form, noting altered mental status and changes in behaviors. Wanda said she would like to meet with a counselor to cope with diagnosis of cancer and loss of functioning, which the CM noted on the BH screening form.

The CM reviewed and discussed changes in Wanda's level of care and functioning. The son said he wanted his mother to stay at the ALF if possible, and was not interested in SDAC, the family attendant program or trying to meet Wanda's needs at home. The CM asked Wanda what her preference would be. Wanda explained that while she would like to live at home, she has accepted that her son can no longer care for her in the home. The CM went on to explain that Wanda's LOC was higher than the ALF could provide, and she would need a facility where she could receive skilled nursing care. Wanda and her son verbalized their understanding. The CM provided a list of contracted nursing facilities and urged Wanda and her son to tour the facilities and interview staff. The CM explained that if Wanda's level of functioning improves, she always has the opportunity to return to a lower level of care at any time. The CM assured both Wanda and her son that they just need to contact her at any time if a change in condition did occur and she would re-evaluate for placement in a lower level of care. The CM stressed that ultimately the decision would be Wanda's as long as she was competent to make her own decisions. The CM discussed with Wanda and her son the importance of designating a MPOA as soon as possible. Wanda and her son agreed to consider a move into a SNF as well as the MPOA. The CM reviewed Advanced Directives and found that they were in place and in the chart. The CM addressed medically necessary transportation needs, providing the transportation flyer/telephone

number. The son said he and his wife preferred to take Wanda to appointments, and were usually available to do so. The CM reviewed the current ALTCS Service Plan, indicating placement at the ALF. The CM advised the son and Wanda that she would contact the new PCP regarding level of care, continuity of cancer treatment, altered mental status and behavioral changes.

## 2) ASSESSMENT OF THE MEMBER'S STATUS AND NEEDS

### **Physical status assessed as follows:**

Transfer/mobility: Wanda was able to ambulate at home with a walker, but is now wheelchair bound. She is a high fall risk, with falls at home and at the ALF, one leading to hospitalization.

Bathing/Dressing/Grooming: Wanda used to require verbal prompting, but now is near total care.

Eating: Wanda used to require verbal prompting, but now needs to be fed.

Toileting: Wanda is incontinent of bowel/bladder and requires near total care.

Change in ADL function: Wanda's level of functioning has declined significantly, now requiring near total care with all ADLs and a LOC higher than the ALF can provide.

Communication: Wanda is usually able to make her needs known, but is experiencing increased confusion.

### Summary of physical needs assessed:

- Needs medical evaluation to determine cause of increased confusion and behavioral changes
- Needs placement in a skilled nursing facility to receive skilled medical care and monitoring, including monitoring effects of cancer treatment.
- Needs Physical and Occupational therapy
- Needs Fall Risk program including call light, bed and chair alarms, and any additional equipment identified to address confusion and neuropathy.
- Needs possible Hospice involvement depending if PCP determines a 6 month prognosis
- Needs DME while transitioning to a Skilled Nursing Facility: request for rental - wheel chair, semi-electric hospital bed w/trapeze, and Hoyer lift. Request for purchase - gait belt and/or transfer board, reacher, high-rise toilet seat, incontinent pads, bed and chair alarms, and diabetic supplies.

### **Psychological status assessed as follows:**

Wanda is experiencing increased confusion and at times is combative with care. She was recently diagnosed with pelvic cancer.

### Summary of psychological needs assessed:

- Needs a psychiatric/psychological evaluation to determine cause of confusion and behavioral changes.
- Needs psychiatric/psychological evaluation to receive individual and family counseling/support for coping with diagnosis of cancer.
- Needs possible Hospice involvement, which can also provide emotional support; depending on prognosis (see physical needs).

### **Environmental status assessed as follows:**

No needs; lives in ALF and will transition to SNF. Wanda and family are requesting placement out of home. Re-evaluate placement needs at next assessment or sooner if a change in condition is noted.

### **Socialization status assessed as follows:**

Wanda is able to communicate and interact with others, including participating in activities of choice. Family visits often. No needs identified - will re-evaluate at next assessment.

### **Community support and public assistance programs**

Wanda is receiving Social Security income, Medicare and AHCCCS/ALTCS assistance with placement and services. She has a new diagnosis of cancer and needs information on diagnosis and community supports.

### Summary of community support and public assistance need assessed:

- Needs list of community cancer support groups.
- Needs website address for the National Cancer Association.

3) CARE PLAN/SERVICES DEVELOPED TO MEET THE NEEDS OF THE MEMBER, INCLUDING IMMEDIATE AND LONG TERM OUTCOMES THAT ARE MEMBER-SPECIFIC AND MEASURABLE

**Physical:**

Wanda and her son will choose a PCP from the list provided by the CM within five days, notifying the CM of their choice. The CM will contact the PCP of their choice to inquire whether they were accepting new patients at this time. If the new PCP is accepting new patients, the CM will send a new enrollment letter to the PCP including Wanda's enrollment date, DOB, address, phone number, and any other insurance information. The CM will send a letter to Wanda informing Wanda and her son of the change in PCPs. Wanda or her son will request the medical records from Wanda's previous PCP to be sent to the new PCP and to schedule an appointment with the new PCP within seven to ten days of receipt of the letter. Wanda, as able, and her son will contact, tour, and interview skilled nursing facilities contracted with CHS and MAP. CM will contact Wanda's CM from her MAP to coordinate care and ensure that CHS is payor of last resort. Wanda and/or her son will contact the CM with the LTC facility of their choice as soon as possible. Coordination of care will be facilitated between the ALF, LTC facility, Wanda and her son, and PCP to transition Wanda to a higher level of care as soon as possible but within thirty days. The CM will explain to Wanda and her son that even though Wanda is placed inappropriately due to her higher level of care needs they do have 30 days in which to make their choice of an appropriate placement. The CM will also inform them that it would be to Wanda's benefit to be placed in an appropriate facility as soon as possible. The CM will contact the SNF chosen by Wanda and her son immediately upon notification and will coordinate the transition with CM from MAP. Until appropriate placement is found, Wanda will need a wheelchair, Hoyer lift, gait belt and/or transfer board, reacher, semi-electric hospital bed w/trapeze, high-rise toilet seat, incontinent pads, and diabetic supplies. CM will make arrangements to provide as much of this DME as possible through rental arrangements while awaiting placement. The CM will contact the physician for prescriptions and place orders, first coordinating with the primary MAP regarding covered services. Wanda and her son will speak with the PCP at the first appointment about Wanda's decline in functioning, cancer diagnosis and treatment, increased confusion and behavioral changes, and medically necessary PT/OT. The CM together with Wanda, her son, and the ALF will develop a fall risk program immediately to prevent any further falls.

**Psychological:**

The CM will contact the PCP to determine the medical necessity of behavioral health services to address confusion, behavioral changes and coping with cancer. Once medical necessity is determined, the CM will contact the BH providers, providing member history, and complete the referrals within two days of identifying need. The CM will complete the initial BH Consultation and meet with the Behavioral Health Coordinator. The CM will contact Wanda and her son and update them regarding behavioral health services. If Hospice services are indicated by the PCP, the CM will contact and authorize Hospice to initiate services as soon as possible.

**Socialization:**

Wanda will continue to socialize with staff and peers, attending preferred activities at present level and will not show a decline in socialization. Family will continue to visit Wanda and take her on outings, as able.

**Community supports:**

The CM will provide information/schedules of local support groups for cancer patients, as well as providing websites for the National Cancer Association. Wanda and/or her son will contact the local cancer support groups of their choice within one week.

Authorizations were entered into the health information system and sent to providers. CM updated the CA160, CA161 and CA165 in CATS for current services.