under the category of loss of essential provider. The contingency plan was developed with the assumption that licensure would be obtained. The potential of moving member(s) to other residential sites is the last option exercised. Upon notification of the IJ status, the contingency plan is implemented. Assignments are distributed, and the PWC members begin executing the plan.

Urgent Interventions - The P/GLTC CMO, DQMM, and DCM call the other Medicaid Program Contractor (PC) with the two members in the facility to discuss the licensure issue. P/GLTC had been collaborating with the other PC on how to assist the facility in licensure. Both PCs agree that despite both their attempts to assist, the facility failed to comply, and now needs to be on a corrective action plan. The two PCs also agree P/GLTC must complete a Network and Quality audit immediately to ensure no health and safety issues exist and report their findings to the other PC. The tools for the survey are standardized, having been previously agreed upon. Both PCs agree to leave members in the facility with the expectations that licensure will be completed. If the facility fails to resolve its IJ status within 14 days, the PCs meet again.

The local Case Manager (CM) is dispatched to the facility to assess the status of the members and communicate with the facility staff pending the arrival of the QM nurse and Provider Representative. The CM also updates the P/GLTC PWC members regarding the facility's efforts to immediately implement correct actions and expedite licensure. The CM Supervisor is assigned as the liaison to families and representative of the members residing in the facility. (S)he contacts each authorized representative to notify them of the IJ status and of actions being taken to ensure that the members continue to receive quality care and services. The CM Supervisor offers residents alternative placement. If alternative placement in requested, the CM Supervisor or designee arranges transfer to an available, contracted facility with approval of the member.

Upon arrival to the facility, the QM nurse and Provider Representative communicate with the on-site CM for updates. The QM nurse and the Provider Representative contact the facility owner/manager to discuss status and confirm implementation of the corrective action. The QM nurse then assesses the current quality of care, including discussions with and assessment of the residents as indicated. The Provider Representative performs a site survey to ensure the facility continues to meet contracting requirements.

A conference call is held with the PWC members, the P/GLTC staff on-site, and the facility owner/manager to review status, discuss the development of the required action plan, and agree to an aggressive timeline in which to complete licensure and address any other concerns identified by the survey team. In addition, a communication plan is agreed upon, including the requirement for daily updates from the facility owner/manager on the status of the licensure.

Next Steps
P/GLTC is committed to partnering with our providers to ensure consistent, high quality care and services. Based on that commitment, a facility that receives a critical regulatory finding with associated action plans is placed on Provider Watch status. Provider Watch serves to heighten the intensity of surveillance for the provider/facility. For example, QM nurses may perform scheduled and ad hoc chart reviews. In this scenario, Provider Watch related interventions include: 1) required daily reports on licensure status; 2) expectations of expedited CAP implementation; 3) monthly on site audits throughout the period of CAP implementation' and 4) quarterly reviews of contractual elements. The provider is expected to remain on Provider Watch status until successful completion of its next ADHS survey and subsequent Organizational Credentialing approval.

Summary: Resolution Timeline

DATE	ACTION	RESPONSIBILITY
Prior to IJ Notification	• Ongoing collaboration to facilitate licensure	DNDM
	• Referral to Provider Watch Committee due to licensure issue.	DNDM
	• Provider Watch Committee meeting held to discuss immediate and contingency planning	DQMM
	• Quality of Care surveys performed by Quality Management (QM) Nurse	DQMM
Receipt of IJ Notification ["0" Hour and Day "0"]	• Notification of P/GLTC of IJ Status	AHCCCS
Day 0 Within 30 minutes of IJ notification	• Initial notification to Director of CM (DCM) and DNDM of IJ status. Confirmation of notification to CEO and CMO	DQMM
Day 0 Hour +1 s/p Notification	• Provider Watch Committee Convened and Contingency Plan implemented • Local Case Manager is notified arrives on scene at facility	DQMM/CMO DCM
Day 0 Hour +1-2 s/p Notification	• Contact made with other Program Contractor. Plan developed • C M Supervisor begins contacting member representative to communicate finding and plan	DQMM/CMO DCM
Day 0 Hour + 2 - 3 s/p Notification	• Arrival of QM RN and Provider Representative at facility • Discussion of findings with Facility owner/manager • Begin QOC reviews	DQMM PWC QM Nurse
Day 0 Hour + 4 s/p Notification	• Discussion of status and expectations between PWC and Facility owner / manager	CEO/DNDM/DQMM/CMO
Day 1	• Facility owner/manager submits status report re: CAP • PWC meeting to review status and evaluate effectiveness of interventions	Facility owner / manager PWC
Day 2, 3, 4, 5, 6 +	• Facility owner / manager submits status of CAP implementation daily until licensure confirmed	Facility owner / manager DQMM
Day 7	• PWC meeting to review status and evaluate effectiveness of interventions	DQMM, PWC
Day 14	• Completed licensure application submitted? o Yes – continue with monitoring o No – discuss options with other PC, including potential for moving members, develop basic plan if moving required.	PWC
Day 30, 60, 90 6, 12 months s/p	• PWC meeting to review status and evaluate effectiveness of interventions	PWC

31B. The Offeror is notified of an immediate jeopardy at 4:15 P.M., on a Friday, before a holiday weekend, that a nursing facility in the Phoenix area will not have air conditioning/cooling available for approximately four days. Arizona Department of Health Services licensing staff, local city staff, and the Ombudsman are on site. Reporters are on the way. It is July and currently 116 degrees outside. There are 48 Medicaid members in the facility spread out across several AHCCCS Contractors.

As an ALTCS contractor in rural Arizona, we are well versed in addressing and facilitating joint resolution of issues with our individual and organizational providers. P/GLTC remains aware of provider contracting, credentialing, and associated problems through the Organizational Credentialing and Provider Watch Committees. In addition, our business continuity plan is developed and tested at least annually, with one of the scenarios including loss of a facility due to weather conditions. As such, we are able to respond promptly and with adequate human and physical resources when urgent and emergent needs arise. Based on our knowledge of the scenario cited above and considering our existing processes, the following describes our approach.

Notification of Immediate Jeopardy Status
The Director of Quality and Medical Management (DQMM), the Chief Medical Officer (CMO) and Chief Executive Officer (CEO) are identified as recipients of information from AHCCCS. As such, they receive the email from AHCCCS of the notification of Immediate Jeopardy (IJ). Immediately, the DQMM informs the Director of Case Management (DCM) and the Director of Network Management and Development (DNMD) of the notification and status of the facility. An urgent Provider Watch Committee is convened to discuss the issue and develop a plan of action. The PWC consists of the Directors, the Quality Management (QM) Nurse, and the Supervisor of Providers Services. The Case Management Supervisor is included in the meeting to facilitate implementation of the interventions.

Planning and Urgent Interventions
Site-Based Facility Support-P/GLTC considers our responses to this IJ as emergent due to the potential impact of the weather on our vulnerable members. Recognizing the need for staff on site, several Medical Management Nurses, Case Managers, Behavioral Health Coordinators and Network Development staff

are dispatched to the facility. The nurses collaborate with the facility staff to provide triage assessments identifying members in need of urgent services. The nurses contact the P/GLTC CMO for support as needed. Urgent and emergent transportation services are secured to transport the members needing a high level of care to treat their reaction to the heat and AC failure. CMs have face-to-face contact with all residents and collaborate with members and the facility staff to implement safety measures, and coordinate members' relocation if needed.

The CM Supervisor is assigned as the liaison with the families and representative of the members residing in the facility. (S)he contacts each authorized representative to notify them of the IJ status and of actions being taken to ensure that the members continued to receive quality care and services.

Behavioral health staff assists members, staff, and others with coping skills training and counseling to optimize effectiveness. Network Development is on-site to facilitate single case agreements if members need to be moved to non-contracted facilities.

P/GLTC Office-Based Operations - The PWC members and core staff remain in the P/GLTC office to facilitate processes from there. Three Case Management Supervisors remain at P/GLTC to act as liaisons to members' families and representatives. Supervisors work with facility-based staff to contact authorized representatives to offer residents and representatives alternative placement. If alternative placement is requested, the CM Supervisor arranges the transfer to an available, contracted facility of the member's or representative's choice.

The Directors establish contact with the other AHCCCS and ALTCS program contractor (PCs) to develop identify a lead PC and establish a

response plan. The CMO directs clinical support and advises level of care placement. The CMO also contacts the CMO of the lead PC to discuss the situation and provides input in the development of the joint PC response. The CMO of the lead PC schedules a teleconference among the PCs to discuss the response. The Chief Executive Officer (CEO) contacts the Pinal County Assistant County Manager to provide a short report on the activities, then notifies the Public Relation Spokesperson to inform him of the situation.

As part of the P/GLTC's business continuity plan, we contract with a company to provide air conditioners and generators on an emergent basis, 24 hours a day, seven days a week. The vendor estimates response to initiate service at urban area facilities in less than two hours. The provider is called immediately to allow him time to collect the equipment needed. Generators and AC units are requested, with the knowledge that the additional generators are needed to supplement electricity needs such as additional loads from mobile equipment.

The P/GLTC Leadership team, the leadership from other involved PCs, and the facility administrator/designee hold a teleconference to discuss the situation, options and potential interventions, and confirm the response plan which reflects a staged response. The ADHS licensing staff, city staff, and ombudsmen are included in the meeting to get input into the plan and ADHS approval of the IJ response. Noting that the emergent component of the plan is well underway, the plan is to continue to relocate those members requiring an emergent or urgent clinical response to the heat. The PC's and facility administrator agree to the strategy, including use of the mobile AC and generators

to limit the disruption to the residents and staff. The PCs agree to pay for the AC units and generators until the facility's AC is functional. Noting that the AC and generators are not routine equipment, ADHS licensing and city fire prevention staff require implementation of a 24-hour fire watch, which the Administrator agrees to provide. To support transparency and ensure consistent messaging, the plan is then communicated to the site-based staff, assignments made, and implementation of the staged response continues. Concurrently, the reporters are informed of the plan and the commitment to the residents is reaffirmed.

Once the ACs and generators are functioning, the facility administrator agrees to provide frequent, scheduled reports to the lead PC staff contact, who then has agreed to follow up with the other PCs as changes occur. Twice daily reports to the PC's are provided throughout the weekend and continue until the AC system is fully functional. They are followed by daily actions followed by confirmation of resolution.

Next Steps
A facility that receives a critical regulatory finding with associated action plans is placed on Provider Watch status. Provider Watch serves to heighten the intensity of surveillance for the provider. Provider Watch related interventions include required daily reports on status related to the air conditioning, expectations of expedited CAP implementation to address the IJ, routine preventive maintenance of the HVAC, annual and ad hoc reviews of contractual and credentialing elements. The provider remains on Provider Watch status until successful installation and full functionality of the electric and air conditioning systems are confirmed.

Summary: Resolution Timeline

DATE	ACTION	RESPONSIBILITY
Prior to IJ Notification	• Business Continuity Planning • Testing of Business Continuity Plan • Organizational Credentialing / Re-Credentialing including medical records, regulatory compliance, quality and site surveys	CEO DQMM CMO

Friday, 1615	• Notification of P/GLTC of IJ Status	AHCCCS
Friday, 1615-1645	• Initial notification to Director of Case Management (DCM) and DNMD of IJ status and confirm notification to CEO and CMO • Notify Provider Watch Committee (PWC) of urgent meeting • Assign applicable staff to respond to NF (RN, CM, BH, NDM) • Initial notification of Mobile Air Conditioning vendor • Contact CMOs of other Program Contractors to discuss situation • CMOs identify lead PC • Collaborate with all PC leadership to schedule urgent multi-plan teleconference to include the facility administrator	DQMM DQMM DQMM, DCM, DNMD MM Admin Asst. CMO CMO CMO and CEO
Friday, 1715	• PWC meeting, Contingency Plan developed and implementation • Notify Assistant County Manager and Public Relations representative of event, status and plan • P/GLTC staff arrive on location of NF and begin assessing situation, triaging and calling back to CMO to update status • Members suffering complications from heat transferred to higher level of care for emergent/urgent evaluation and treatment	DQMM/CMO CEO On site staff CMO/MM RNs (clinical) and NMD staff (contractual as needed)
Friday, 1745	• Multi-plan teleconference held including all Plan CMOs, P/GLTC PWC, NF Administrator, ADHS / regulatory representatives Corrective action plan developed and agreed upon ○ Decision made to use mobile AC and generators to minimize disruption to stable residents and PCs will split costs. • Mobile AC vendor arrives with AC and generators and sets up • Triage of residents in progress • Contact made with other Program Contractor. Plan developed • Contact member rep. to communicate findings and plan	PWC NDM staff with vendor On site CMs, Nurses, BH Coordinator. CMO CM Supervisors
Friday, 1900-1930	• Mobile ACs working with generator support. Initiate Fire Watch • Immediate triage complete. • Begin site and quality survey • Discussion of status and findings with Facility administrator	DQMM PWC QM Nurse PWC and other PC
Friday, 2030	• Teleconference of Facility administrator, CMOs, PC leadership and regulatory rep. for status updates, intermediate planning/ identification, discussion, and resolution of remaining barriers • On site staff round on members to address any needs then leave the facility after giving contact information to staff and members.	CEO/DNMD/ DQMM /CMO On site staff and associated Directors
Saturday, 0800 & 2000	• Facility administrator submits status report r/t CAP execution • PWC members notified of additional concerns as indicated	Administrator on Call
Sun, Mon, Tues 0800 & 1700	• Facility administrator submits status of CAP implementation to all PCs daily until air conditioning units fully installed /functional	Administrator on Call / PWC
Wednesday Day 5	• PWC meeting, review CAP status and evaluate intervention	DQMM, PWC
Annually/ad hoc	• Progress reports and final completed CAP submitted? ○ Yes – continue monitoring. ○ No– discuss options with other PCs including potential for moving members, develop basic plan should moving be required.	DQMM and PWC

Requirement 32: Describe and provide an example of the Offeror's experience and commitment to improving quality of care and performance in specific measures of health care services. Describe how this commitment is spread throughout the Offeror's program.

P/GLTC actively participates in AHCCCS mandated and internally identified initiatives aimed at improving the quality of care and services our members receive. Our participation, commitment, and resulting improvement are achieved through communication and collaboration with our stakeholders. Pinal County's Managing for Results Program (MFR) requires all departments to publicly report key indicators. Our key healthcare indicators are reflected in the MFR findings. For example, P/GLTC's MFR data sets include diabetes care, advance directives, and referral management metrics. Stakeholders include P/GLTC clinical and non-clinical services, members, individual and organizational providers, social and behavioral health service partners, and the communities which we serve.

We participate in formal quality improvement monitoring using the AHCCCS Performance Measures (PMs) and Performance Improvement Projects (PIPs). Evidence-based chronic condition health services, on which the performance measures are based, are an integral part of the Medical Home model. The Medical Home relies on the primary care physician to provide comprehensive, preventive care based on patient needs.

Interventions for improving or sustaining gains in performance measures can also be associated with the Wagner Chronic Care Model. Our health system promotes wellness of patients by reimbursing providers for providing evidenced-based care. The performance measures also promote prevention and early detection, which can prevent complications, ED visits and hospitalizations. Self-Management promotes a better physician/patient relationship, which can lead to better outcomes. P/GLTC case management and medical management staff collaborate with physicians, rural service delivery systems, community services, home

health services, and provide outreach to members to encourage preventive services.

Standardized performance improvement metrics and associated interventions benefit members and providers in addition to benefiting AHCCCS and P/GLTC. Our members benefit with improved health outcomes. Providers have better information regarding the member's health which supports continuity of care and ongoing communication between the provider, health plan staff, the member, and family. Evidence-based care is designed to support a population's health status and well being. People who control their chronic conditions, avoid co-morbidity, and receive home-based services in a timely manner are healthier and utilize fewer resources, resulting in long-term cost savings for P/GLTC and AHCCCS.

AHCCCS Performance indicators measure the utilization of standardized health services provided to members enrolled in a long term care plan. There are a total of four measures in two areas of access to care and use of evidence-based disease-specific health services. The performance measure rates are calculated using HEDIS specifications, developed by NCQA. HEDIS is the most widely-used set of performance measures in the managed care industry. Results are compared with standards specified by contract, and trends are identified. Performance improvement projects also are reviewed and analyzed by P/GLTC. Appropriate actions, such as requiring implementation of corrective action plans or technical assistance from AHCCCS, follow findings. P/GTLC has been a top performer among ALTCS health plans over the last two years. AHCCCS reports performance measure data at the aggregate, regional, service area and plan levels, and by ethnicity and urban versus rural.

Organizational Commitment to Quality

P/GLTC strategies for and success in continual improvement in health services delivery as well as PM and PIP performance, rely on our commitment to performance improvement throughout the P/GLTC program. This includes coordination of member's care by an interdisciplinary Care Team. This team approach leads to multi-dimensional problem-solving, member specific interventions, resolution of identified issues, and removal of barriers to care. In addition, P/GLTC is developing an integrated Primary Care and Behavioral Health Services Medical Home with Mountain Health and Wellness to address depression and other mental health issues that often co-exist as chronic conditions. Our second medical home partnership is our Sun Life Family Health Center in Casa Grande. This FQHC Medical Home has a diabetes program that provides a full spectrum of care Diabetic Educators, Self Management Courses, access to a comprehensive set of health promotion resources, Focus Groups, Nurse Case Management and additional Community Case Management services.

P/GLTC CMs evaluate their members' abilities to self-manage and implement interventions aimed at addressing individualized needs, paying particular attention to ensure that members receive behavioral health services as needed to behavior modification. CM or care team nurses follow-up by phone to advise patients that they are due for tests provided as part of a disease management program. Finally, P/GLTC uses culturally relevant patient education materials, such as guides on preparing healthy meals, particularly those that incorporate traditional foods for specific ethnic and racial populations.

The Quality Task Force (QTF) serves as the operational team to improve PM and PIP related performance. The QTF consists of representatives from all the P/GLTC areas. The QTF meets to establish the work plan, including goals, measurable, objective performance indicators, responsible parties, the methodologies used to implement and evaluate

the project and timelines. The length of the project is determined, and both one-year and long-term goals are developed. AHCCCS benchmarks are incorporated into the PM or PIP. Many improvement initiatives involve staff from multiple sections of P/GLTC as well as providers so it is vital that everyone has a clear understanding of roles and responsibilities.

In general, CMs, Care Team nurses, the PI nurse and QM staff spearhead interventions. Data Analysts collaborate with the QTF and Quality and Medical Management leadership to develop and produce the reports needed to track performance data. The progress of the QTF is reported and reviewed quarterly by the QM Committee.

Evaluating the Effectiveness of Interventions

The effectiveness of strategies and interventions is evaluated over time. While data are reported to AHCCCS annually, internal reports are generated quarterly to monitor outcomes of interventions more frequently. Initially, data are analyzed to determine baselines. Then results are compared to annual goals, AHCCCS determined benchmarks, or national standards. Each quarter a summary report, including outcome data and progress toward reaching the annual goal, is completed and presented to the QM Committee. The committee analyzes the results, discusses barriers, and makes suggestions for modifications in interventions or approach. We expect that sustained and demonstrated improvement can be shown for at least a year after improvement is first achieved.

Progress in reaching goals for each PM and PIP is reviewed and reported in an annual report. The report identifies trends, suggests changes or modifications to goals, interventions or methodologies, including recommendations whether or not a plan-designated PIP should be continued the next year. This information is reported to the QM Committee at the end of the fourth quarter for review. Once the existing PIPs are accepted for continuation, the modified methodologies and work plans are

developed and approved. P/GLTC continues to measure the Performance Measures using the AHCCCS prescribed process. In addition, the P/GLTC Quality Task Force meets every other week, reviewing internal performance, provider and member specific interventions and issues, and brainstorming additional opportunities for continued improvement.

AHCCCS requires monitoring of PMs for Diabetes, with metrics related to rates for Hemoglobin A1c Testing, Biennial Fasting Lipid Profile, and Biennial Retinal Screening. For the purposes of this response, Performance Measures related to Diabetes Care serves as an example of success in the planning, development, and execution of strategies aimed at improving care to our diabetics, as demonstrated by significant gains in PM results. The gains are reflected in the table below.

performance improvement initiatives, P/GLTC has implemented a pay-for-performance (P4P) program Physician P4P initiatives provide additional compensation for those providers that administer or refer members for evidence-based testing and document the results of the testing in the medical record. P/GLTC improved its diabetes care PM through improving access to care for lab and retinal screenings. For example, home health nurses were able to draw lab samples, and transportation to lab and PCP services were arranged and facilitated. Additional testing and immunizations may be provided at any of the Pinal and Gila Public Health clinics through a collaborative relationship with our sister department. Our gain in retinal screening is in part due to partnerships with traveling ophthalmologic services. The utilization of ophthalmologists who travel throughout the

Performance Measure - CYE 2010	% Receiving HbA1c Blood Tests MPS 80%	% Receiving Lipid Screening MPS 80%	% Receiving Retinal Exams MPS 80%
Pinal / Gila Long Term Care	91.1%	90.4%	78.3%
Bridgeway Health Solutions	83.3%	74.1%	59.9%
Cochise Health Systems	74.5%	65.7%	57.8%
Evercare Select	84.4%	76.9%	57.5%
Mercy Care Plan	90%	88%	75.4%
Pima Health Systems	92.4%	69.7%	61.3%
SCAN Long Term Care	85.6%	75.2%	45.1%
Yavapai County Long Term Care	75.9%	71.3%	67.8%
Overall Average	86.5%	77.9%	63.9%

The object of the Diabetic Performance Measures is to ensure that members receive regular evidence-based services through their PCP. The health plan promotes and encourages the utilization of these services through outreach, targeted interventions and incentives. The end goal is to foster a relationship between patient and provider that supports health maintenance, and early detection of co-morbid conditions that require on-going management.

The interventions to improve diabetic care measures rely on the provider, member, P/GLTC nurses and case management interface. To support the providers' adherence to our

counties providing retinal screenings improved access to care to those members with barriers to care in a regular opthamology office. These services have been provided in homes, nursing facilities, and the P/GLTC office complex.

Requirement 33: Describe how feedback (complaints, survey results etc.) from members and providers is or will be used to drive changes and/or improvements to the Offeror's operations. Provide a member and a provider example of how feedback was used by the Offeror to drive change.

Feedback

The feedback P/GLTC receives from its members and providers is an essential element in our ongoing efforts to improve the quality of care and services for our members.

P/GLTC receives formal and informal feedback from members and providers through multiple avenues. These sources include, but are not limited to, member satisfaction surveys, joint operations committee meetings held between P/GLTC and network providers, grievances, appeals, claims disputes, quality of care and service concerns, and outreach activities such as our member / provider council meetings. These processes are tools to gain feedback and assess the quality of services provided by P/GLTC and contracted providers. They provide the data that is then analyzed by the sponsoring department, interpreted by our executive team overseen by Marlene Bluestein, our Chief Medical Officer (CMO) and Donna Beedle our Chief Executive Officer (CEO), and used to drive changes or improvement to P/GLTC operations.

The Quality, Dispute, and Appeals team tracks and trends member and provider issues. Under the leadership of the Director of Quality and Medical Management (DQMM), 2.5 FTEs investigate and analyze quality of care issues, abuse, neglect and unexpected deaths. Lynne Braatz, Dispute and Appeals Coordinator, manages administrative processes, including issue acknowledgement, documentation, data entry and reporting. All implemented corrective action plan(s) or action(s) taken to resolve the concern are documented and analyzed to assess the effectiveness of the interventions taken.

Member Satisfaction Surveys – Members are asked about their satisfaction with all the services they receive. The data is summarized, analyzed, and reported to the P/GLTC

Executive Team to be used as an assessment of our care and services. Resulting data and analyses are included as part of the Provider Profiling and re-credentialing processes. In addition, the surveys are used to identify network gaps and evaluate Case Manager effectiveness. Significant trends in member survey responses may suggest the need for a focused study or performance improvement (PI) initiative.

Member Councils - P/GLTC has a Member Council in both Pinal and Gila counties. The two councils are made up of members who are concerned about healthcare and services. These councils advise P/GLTC on issues that are important to members. Providers are welcome to attend meetings. Council members are volunteers. P/GLTC provides training, lunch and transportation to the meetings, scheduled four times a year.

Joint Operations Committees (JOCs) – The Joint Operations Committee meetings serve as a traditional method of reviewing topics of interest to P/GLTC and its vendors. P/GLTC has long hosted JOC's with our high volume providers on a regular basis. Feedback from providers on the value of the JOC venue has led to increase use of the JOC process. Ad hoc, provider type based, issue based, and new contractor JOCs now are used to enhance our communication with providers. Ad hoc JOCs may be held with a provider type when special information or benefit changes needs to be shared or discussed.

Driving Change

A provider type, issue based JOC for all Assisted Living Facilities (ALFs) was held to provide wound care education and allow for discussion of how wound management monitoring could be implemented in the ALF environment. The latest enhancement to the JOC process involves newly contracted organizational providers.

The JOC is held within six months of contact execution. The JOC provides an opportunity to review contractual requirements and clarify expectations for partnering with P/GLTC to provide care to our members. Feedback from these JOCs has been positive and has resulted in improved communication between the provider and P/GLTC, improved quality of care to our members, and support for the new provider for any identified issues.

Member Grievances – P/GLTC's commitment to quality care and service drives its member grievance processes. P/GLTC defines a grievance as an expression of dissatisfaction about any manner other than an action. Examples of a grievance include but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights. The orientation of all P/GLTC staff includes information on the grievance process. Specifically, the new hire and annual orientation programs include what constitutes a grievance, how to report a grievance, and the role of P/GLTC's Quality Management staff in grievance resolution.

Driving Change
A review of member grievances revealed an increasing trend in gaps in service concerns related to attendant care and transportation. An analysis of root causes identified process barriers related to scheduling and communication. Interventions were implemented that included electronic notification of gaps in service, scheduled back-up providers, and a timeliness standard of two hours for resolution.

Quality of Care and Service (QOC/S) Concerns – Members and their representatives submit grievances that, after review and application of severity criteria, reflect potential Quality of Care issues. In addition, concerns are written when staff is aware of issues with a potential negative impact to the member's health outcomes. Individual QOC/S submissions to the Quality Management Department are assigned
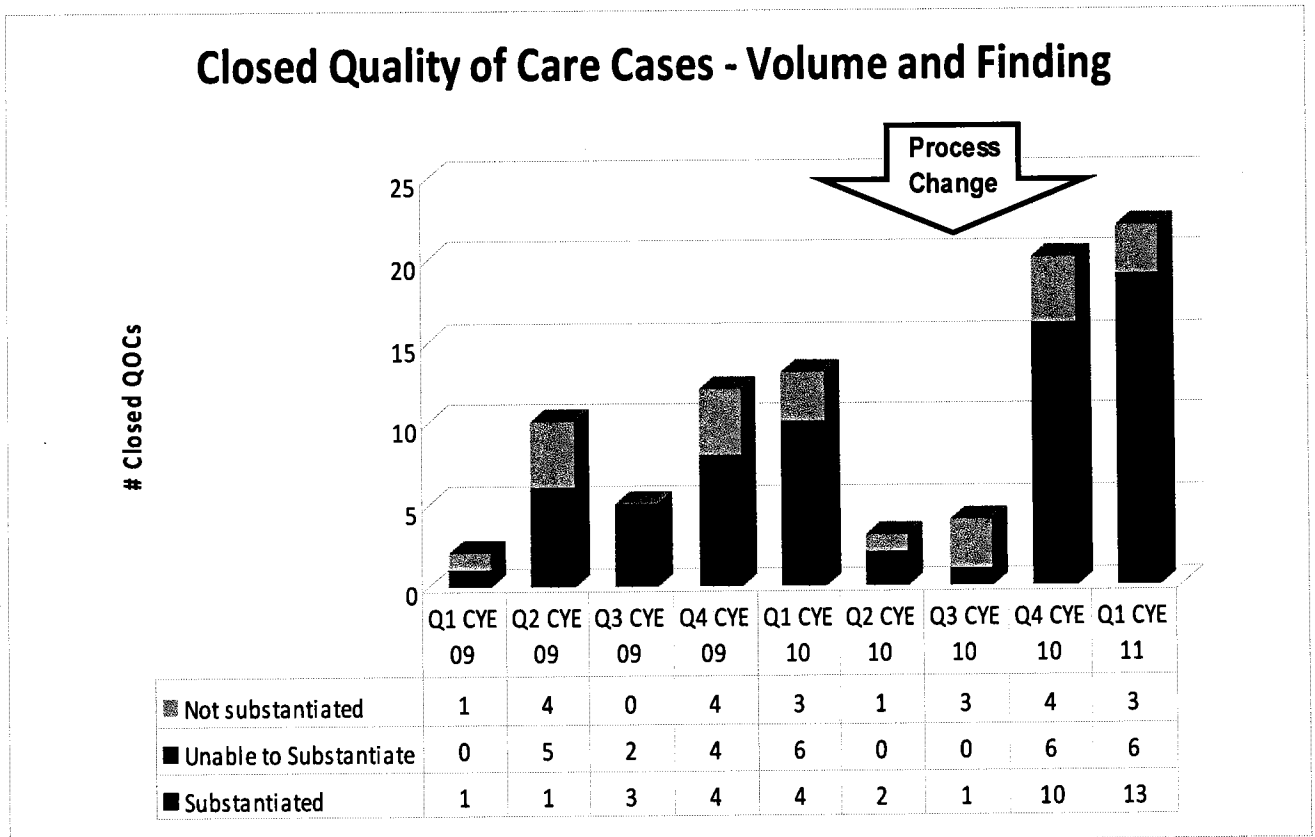
an initial severity level, logged in a secure database, acknowledged, investigated, and substantiated as appropriate with corrective action plans required as indicated. Closure letter are sent to those initiating the concerns. Collectively, data from concerns are aggregated, analyzed, tracked, and trended. Quarterly reports for both complaints and concerns are evaluated by the Grievance Committee and reported to the Quality Management Committee on a quarterly basis.

Driving Change
Based on tracking and trending of closed and open QOC case, we noted that the turn-around time from receipt to closure of the potential QOC required process improvement. Trends from quarterly QOC data reported from October 2008–June 2010 indicated significant quarterly variation with an average of seven cases closed per quarter and a range from two to thirteen cases. The number of received cases did not reflect the same degree of variation. Given that the report includes only closed QOC cases, the variation was thought to reflect the QOC review process more than the number of QOC concerns that were submitted. A review of the data from the QOC data base confirmed the hypothesis. An opportunity for improvement was identified in the QOC investigation and case closure aspects of the process.

As part of the QOC process review, quality of care and service concerns and complaints data were reviewed to identify if opportunities for improvement existed. Specifically, the volume of potential QOC concerns received, the throughput time from receipt to resolution, potential barriers to submission and investigation of potential QOC's, potential process variance related to initial leveling, investigation and closure. Findings of the review indicated process improvements could be achieved by reviewing existing policies and procedures and revise as indicated, combining the concerns and complaints form into a single report form, clarifying the submission and review processes, ongoing monitoring of throughput times, aligning QOC, grievance, appeals, and credentialing to improve capture,

review, analysis, trending, and resolution of issues, and designating specific P/GLTC staff and application of the PDSA rapid cycle improvement process in this area. The findings from the review were implemented, resulting in a standardized review process and a decreased throughput time from receipt to substantiation.

Closed Quality of Care Cases - Volume and Finding

Process Change

Closed QOCs

	Q1 CYE 09	Q2 CYE 09	Q3 CYE 09	Q4 CYE 09	Q1 CYE 10	Q2 CYE 10	Q3 CYE 10	Q4 CYE 10	Q1 CYE 11
Not substantiated	1	4	0	4	3	1	3	4	3
Unable to Substantiate	0	5	2	4	6	0	0	6	6
Substantiated	1	1	3	4	4	2	1	10	13

Requirement 34: Describe the process that will be utilized by the Offeror to monitor services and service sites of members that reside in their own home. Describe what steps will be utilized if non-compliance is identified.

P/GLTC's success in keeping our members as independent as possible in the least restrictive setting is reflected in the percent of our members living in home and community based settings. We have the highest percent of member receiving HCBS of all ALTCS Program Contractors in Arizona. Our improvement continues with 74.41% of our members receiving HCBS as of January 2011.

In January 2011, almost 75 % of our members received HCBS

The ultimate goal of our HCBS services is to provide high quality care and services while the member remains in his or her own home. With the highest level in the state, we continue to strive to improve our HCBS care through daily communication with our providers and our 24 / 7 availability for our members.

Quality monitoring and evaluation activities are carried out by a variety of P/GLTC staff. Quality review of home based care and services are overseen by the organizational credentialing process. Organizational credentialing applies to those contracted entities providing direct, indirect care, or supervisory services in the home or alternative residential settings. In addition to regulatory requirements, quality and performance measures are included in the organizational credentialing files and considered during the credentialing process. Organizational provider files are kept separately from contract files.

The P/GLTC Organizational Credentialing Committee ensures our members have access to a comprehensive network of qualified organizational healthcare providers by performing credentialing and re-credentialing functions. The Committee consists of the Chief Medical officer, Director of Quality and Medical Management, Director of Network Management and Development, the Chief Executive Officer, and the Credentialing Coordinator. The Committee reviews P/GLTC contracted organizational providers for quality issues, member concerns that include grievances (complaints) and appeals, utilization management information, performance improvement, and results of network management visits and medical record audits.

P/GLTC coordinates with other ALTCS program contractors on mandatory routine quality monitoring and oversight activities for facilities and alternative housing options when they are contracted with more than one plan. Should an immediate jeopardy situation arise, we consult with each involved contractor, identify the lead plan, collectively work to address deficiencies, and if the members must be moved, join forces to minimize the impact on all members.

P/GLTC ensures that the credentialing and re-credentialing process does not discriminate against healthcare professionals based on their license or certification. In addition, it does not discriminate against practitioners who serve high-risk populations or who specialize in the treatment of costly conditions. Finally, we ensure that the process complies with Federal requirements that prohibit employment or contracts with practitioners excluded from participation under Medicare or Medicaid.

P/GLTC utilizes an extensive set of tools to monitor the delivery of care and services in the home setting. They range from experiential satisfaction to objective process and outcome audits. We solicit feedback from surveys, grievances, care team interactions, providers, and caregivers. We review licensure, direct and indirect care provider competency, care planning, integration of services, untoward events, hospitalizations, and provider records. Whenever possible, outcome goals and standards of care are aligned with those of AHCCCS, ADHS and CMS.

Monitoring Frequency

The organizational re-credentialing process may occur on an annual basis, but no less than every three years. For home-based services, P/GLTC provides annual monitoring of attendant care, homemakers services, and personal care service as defined by our policies and procedures. P/GLTC performs monitoring of durable medical equipment (DME), medical supplies, respite care, respiratory therapy, occupational, speech, and physical therapies, transportation, home delivered meals, home health nursing, and hospice services at least once every three years. If deficiencies or potential deficiencies are identified, we address them from a member and system perspective.

For contracted home health agencies, we validate at least every three years that the agency is licensed to operate in the State. In addition, we assure compliance with any other applicable State or Federal requirements, including AHCCCS requirements. If not accredited, CMS certification or State licensure review may substitute for accreditation. If CMS certification or AZ State licensure review is being used as a substitute for accreditation, P/GLTC verifies that compliance was achieved by obtaining a copy of the report. The P/GLTC Organizational Credentialing Committee must review and approve the agency. In addition, P/GLTC must review and monitor additional organizational providers in accordance with their contract.

Data Sources

Organizational Surveys – P/GLTC reviews several types of records from the monitored organization. These include corporate site surveys of human resource files and surveys from regulatory agencies (e.g. ADHS or CMS). Additional monitoring is based on the type of services provided, with randomized sampling methodology used for the selection of documentation and review of workers' files to ensure all provider agencies and direct care workers have an equal opportunity to be included in the samples. For example, attendant care monitoring includes verification of the monitoring and documentation of

applicant interviews within 14 days of contacting the agency, annual and ad hoc continuing education and training sessions for certified attendant care workers (ACWs). Personal care monitoring includes but is not limited to the verification of supervisory coverage and visits, competency, and the necessity of duties specified on the member's individualized care plan. Homemaker monitoring includes documentation of successful completion of tasks designated on the member's care plan such as cleaning, laundry, meal planning and preparation, and appropriate supervision.

Member Satisfaction Surveys - Member satisfaction surveys provide subjective data that can be used to evaluate the member's perceptions of their needs and the care delivered to meet those needs. The annual Member Satisfaction Survey explores the member's feelings related to their CM, primary care provider, provider office practices, timeliness of service provision, and transportation services.

Grievances, Claims Disputes, and Incorrect Claims Submission - Grievance or complaints from home based members are received, reviewed, and every effort made to resolve the issue related to the grievance. Grievances are entered into a database as they occur. They are aggregated quarterly and reviewed by the Grievance Committee and reported to the Quality Management (QM) Committee.

Claims disputes are received from organizational providers disagreeing with the amount, timeliness, or level of payment received after their claims have been adjudicated. Organizations that submit claims disputes on a regular basis receive coding and claims submission support from the P/GLTC Claims Staff. If organizations submit claims that include reimbursement for services not rendered, the organization is referred to the Compliance Officer.

Quality Care Concerns - Potential QOC Concerns often involve more serious issues and are

generated by CMs or any person aware of the issue. They are forwarded to the QM staff as problems are identified, investigated, and substantiated as indicated. Corrective action plans may be required from the provider to ensure the causative factors have been addressed.

Disease Management Compliance Reports - This monitoring activity reports on condition-specific or risk-based elements of care. The condition-specific programs monitor comprehensive diabetic care, congestive heart failure treatment, smoking cessation, and weight management. The risk-based programs focus on fall prevention and medication safety.

Performance Improvement Projects (PIPs) - PIPs are designed to address aspects of care that impact entire populations. Currently, PIPs address annual influenza immunization, exploring the motives behind those refusing the vaccine. The Advance Directives PIP focuses on timely completion of documents and explores decisions not to engage in the Advance Directive process. Guideline adherence and timeliness of responses by an organization for information related to these PIPs are included in the organizational review.

Steps to be Taken for Non-Compliance
If problems are identified with the care and services provided to our home-based members, P/GLTC develops work plans and takes appropriate actions to address the issues. The improvement initiatives are the work of P/GLTC QM, NDM, and Case Management sections in collaboration with the involved provider. The investigation process is used to examine the issue from the member and system perspectives, identify causative factors, and identify potential opportunities for improvement. Corrective action plans (CAPs) serve as the map to achieve the improvement.

A full investigation and mandatory CAP are required in cases where significant harm or the risk exists. Examples include abuse, neglect, unexpected death, isolated systemic issues, lack of coordination with special needs population, and inappropriate blanket authorizations for specific ongoing care.

P/GLTC requires that CAPs include the action to be taken, the person responsible, a timeline for achievement, and measures of effectiveness to validate the improvement. All reasonable efforts are made to support successful implementation of the CAP by the organizational provider. For example, we have partnered with our preferred home care provider to insure CAP compliance through bi-weekly communication meetings, monitoring established performance metrics, and audits of provided services. Actions required as part of a CAP include but are not limited to organizational planning, staff training, focused staff remediation, and revisions to processes, structures, or forms. We may terminate our affiliation with a provider. We issue appropriate referrals to regulatory agencies. P/GLTC retains all documentation regarding the evaluation, collaboration, CAP development, and validation of its implementation.

Any contracted organization may be placed on "Provider Watch" for closer monitoring if it determined that members' safety and health are potentially at risk. Provider Watch Committee (PWC) members include the senior Executive Management team representing the CMO, DQMM, Plan Director, Director of Case Management, the Chief Financial Officer, and the Contract Compliance Officer. The PWC meets monthly or ad hoc to address urgent issues. The Committee's purpose is to determine the continued suitability of the service organization for our members through the review and evaluation of all available data from Quality of Care concerns, ADHS licensure reports if appropriate, grievances, appeals, and any information regarding potential financial instability. The review determines whether the organization should be placed on an administrative hold, whether to withhold recredentialing or contract renewal, or whether to immediately terminate a contract. Provider Watch Committee actions are tracked and trended by the DQMM, with results included in the organizations' credentialing files.

Requirement 35: Oral Presentation

P/GLTC shall submit the names and resumes of participating individuals via the EFT/SFTP server by 3pm MST on April 8.

E. PROVIDER NETWORK

Subject Requirement:	Reqmt. Page #	Offeror's Page #
Provider Network	36	224
	37	290
	38	291
	39	294
	40	297
	41	300
	42	303
	43	306
	44	309
Network Summary	45	Via EFT/SFTP
	Attestation Sheet	313

Requirement 36: *Provider Network Development and Management Plan*

P/GLTC Provider Network Development and
Management Plan follows - pages 225 through
288.

Network Development and Management Plan

Pinal/Gila Long Term Care Plan

Table of Contents

Executive Summary

The purpose of the Pinal/Gila Long Term Care Network Development and Management Plan is to document the process of development, maintenance and continuous monitoring of an adequate provider network. The network is currently sufficient to provide member access to all Arizona Health Care Cost Containment System (AHCCCS) Arizona Long Term Care System (ALTCS) covered services. P/GLTC assures ALTCS member access is commensurate with commercial insurance coverage in terms of timeliness, amount, duration and scope of service in the same service area.

P/GLTC continues to engage an analytical approach to applying our Network Development Model. The model is instrumental in triggering quick intervention when necessary. The main components of the Network Development Model are:

- Access to Care
- Trend Projections
- Demand Forecast
- Needs Based Forecasts
- Review of current capacity and utilization data
- Network requirements by provider type
- Community health status
- Assessing local health care resources including workforce
- Integration of medical, social, and community services

Trends, Patterns and Vital Statistics

The P/GLTC geographic service area covers all cities of Pinal and Gila counties that are home to approximately 400,000 people. Gila County's population remains relatively constant. Growth in Pinal County over the last ten years has been 109%.

Currently, one in four people in the two-county area are 60 years or older. The 80 plus year old population is the fastest growing in both counties and is expected to triple by 2020.

In addition to these factors, increasing life spans, changes in ethnic and racial diversity and personal behaviors all have an impact on future health.

The number of available health care services in both counties remains inadequate. This large geographic service area, rich in diversity and unique characteristics, requires innovative and effectives solutions to the challenge of providing high quality health care services.

Pinal County Health Care Delivery System

P/GLTC is in a unique position to continue planning, delivering, monitoring and reinvesting into the local health care system. P/GLTC, in partnership with local health care providers and social service agencies has established the "Building Healthy Communities" health care delivery model below. The components are already in place and ripe for expansion through collaborative community based efforts.

Health Care Delivery System

Wellness & Prevention	Outpatient Providers	Community Care	Institutional Care
• Healthy Lifestyle	• Well People Care	• Home Health	• Skilled Nursing
• Healthy Mind & Body	• Primary Care Providers	• Intensive Therapies	• Rehabilitation
• Control of Communicable Disease	• Specialists	• Partial Day	• Residential Care
• Nutritious Safe Food	• Allied Professional	• Attendant Care	• Hospitals
• Clean Air	• Therapies	• Alternative Living Facilities	• Trauma Centers
• Exercise/ Recreation	• Imaging/ Lab	• Hospice	
• Housing	• Pharmacy		
• Prevention	• Urgent Care		
• Education	• Ambulance Ground & Air		

PINAL·COUNTY

In addition, health care has been identified by county leadership as a strategic priority:

Pinal County will provide residents with quality, accessible healthcare as evidenced by:

- By 2012, there will be an increase of 7% in physicians from 42 to 45.
- By 2012, there will be an increase in the number of licensed healthcare facilities:

Facility	From	To
Hospitals	1	2
Skilled Nursing Homes	1	2
Outpatient Clinics	46	51

An exciting opportunity for true innovation is imminent when P/GLTC is designated a Medicare Special Needs Plan (SNP) beginning in January, 2012.

It is with a great deal of pride, P/GLTC presents the following Network Development Plan.

Background

Pinal/Gila Long Term Care (P/GLTC) is a community based, publicly-run, non-profit organization that provides member-centered, high quality services to the frail, elderly, and disabled through comprehensive networks that are accessible to members who reside within the Geographic Service Area (GSA).

Comprehensive and coordinated healthcare services are delivered through progressive practices and innovative thinking that results in measurable positive health outcomes. Our capable proactive leadership direct dedicated and integrated teams that deliver personalized care which ensure member's access to medical and long term care services while enhancing each individual's quality of life.

P/GLTC takes great pride in the way it partners with providers to deliver personalized and customized attention to care for our members. Believing that independent living in one's home or an alternative community setting is a worthwhile goal, we have achieved and maintained one of the highest Home and Community Based Service (HCBS) percentages in the state of nearly 75%. To ensure professional and business integrity, P/GLTC receives strong oversight by a publicly-elected body that is accountable to taxpayers, local members and providers who operate businesses in our communities.

Membership Demographic Description

P/GLTC serves elderly and physically disabled persons who are enrolled in the Arizona Health Care Cost Containment System (AHCCCS)/Arizona Long Term Care System (ALTCS) program and reside in Geographic Service Area (GSA) 40 that includes Pinal County and Gila County. The majority (83%) of P/GLTC's membership lives in Pinal County. See Graph A below.

Graph A

P/GLTC Membership by County
published 09/28/2010

Gila County
254 Members
17%
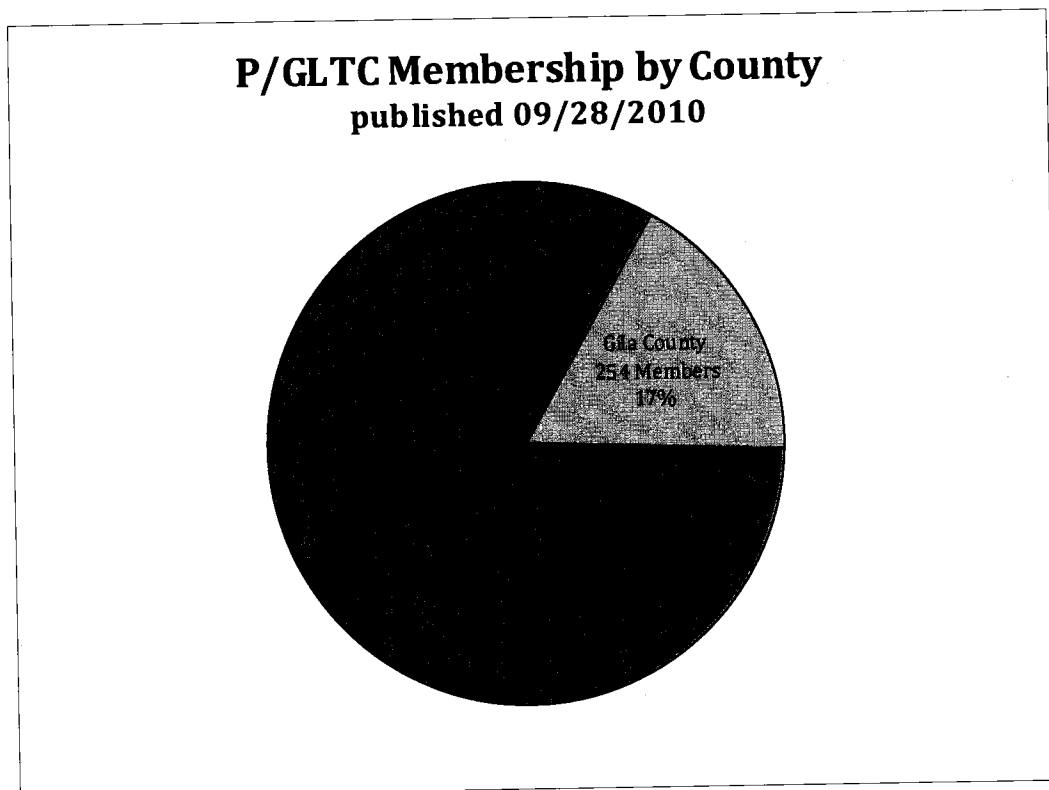
Graph B depicts total membership by gender which illustrates a similar pattern that is found among the ALTCS population, in general, wherein female enrollees outnumber males (63% vs. 37%).

Graph B

Pinal & Gila County Members by Gender
n = 1,475
published 9/28/2010
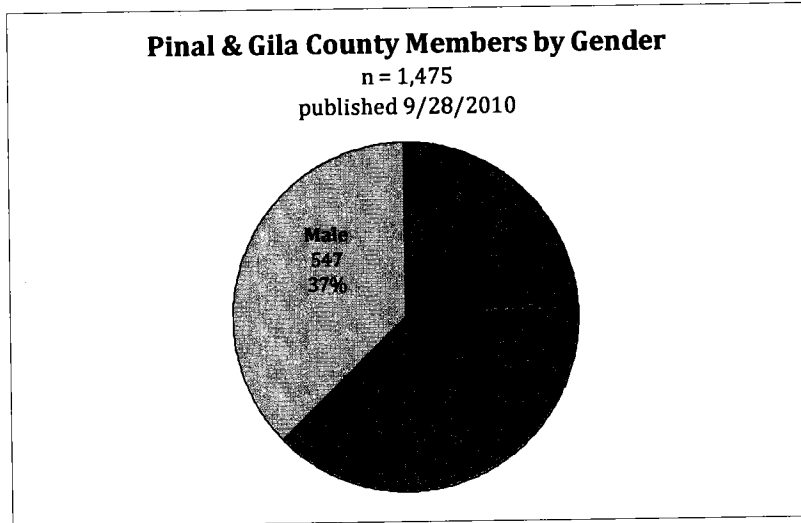
A breakdown analysis of membership by age group in Graph C shows 54% of membership that is 65 years or older.. Over 35% of P/GLTC's total membership is 80 years old and above. A young disabled population below age 45 comprises 12% of the population. Ten members are centenarians.

Graph C

Pinal & Gila County Members by Age
n= 1,475
published 9/28/2010

Age 100+
10
1%

Age Under 21
37
3%

Age 21 to 45
112
8%

Age 90 to 99
153
10%

Age 46 to 65
357
24%

Age 80 to 89
363
25%

Age 66 to 79
443
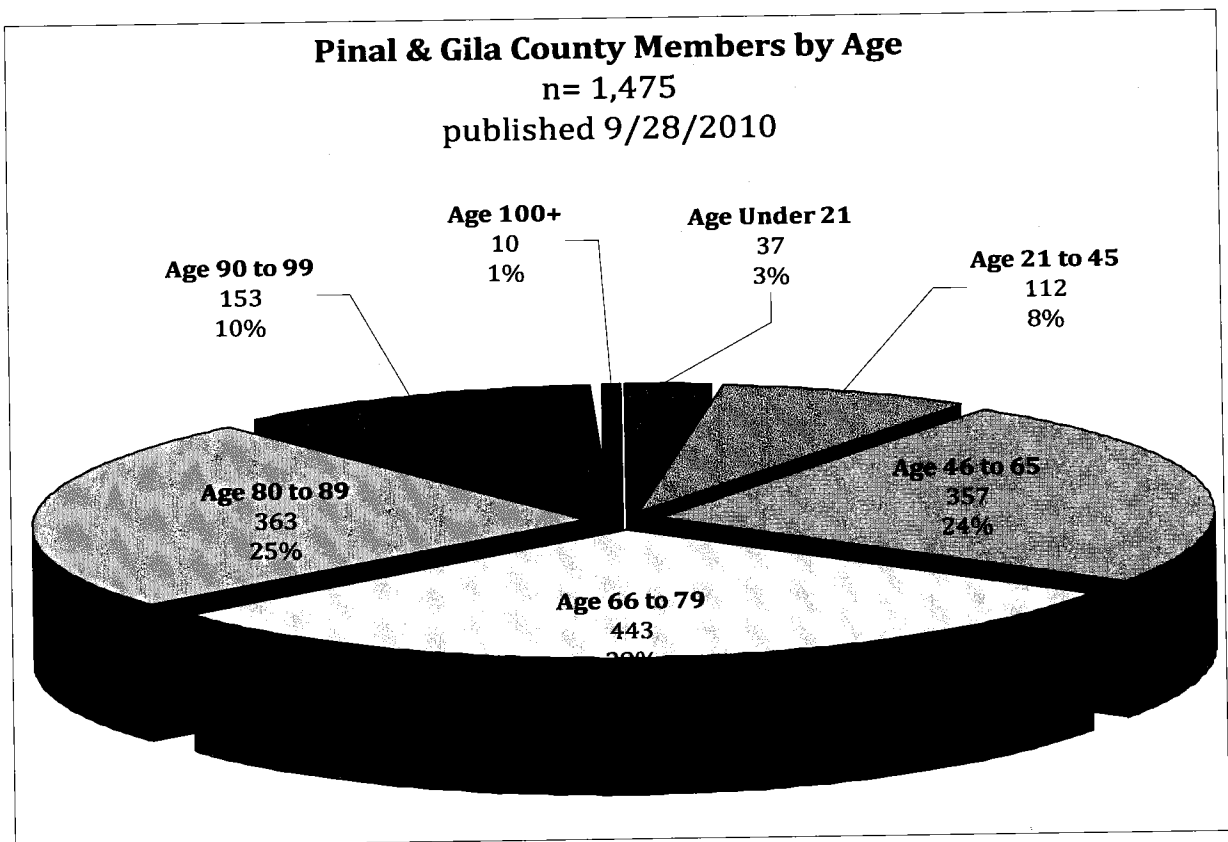
A comparison of population demographics between two counties show that Gila County is predominantly Caucasian (80%) but less so in Pinal County (58%) where Hispanics comprise approximately 30% of the population. See Graphs D and E.

Graph D

Pinal County
Member Ethnicity
n = 1,221
published 9/28/2010

Caucasian 700 58%
African-American 103 8%
Asian/Pacific 17 1%
Hispanic 360 30%
American Indian/Native Alaskan 25 2%
I Prefer Not to Answer 16 1%

Graph E

Gila County
Member Ethnicity
n = 254
published 9/28/2010

Caucasian 202 80%
African-American 1 0%
Asian/Pacific 1 0%
Hispanic 40 16%
American Indian/Native Alaskan 3 1%
I Prefer Not to Answer 7 3%

Of the total population of 1496 members (December 2010), Spanish is reported as the most common language spoken (10.6 %) in addition to English. However, this exists in greater frequency within Pinal County (12.3%) than in Gila County (2%) as displayed in Graphs F and G. Among those

Pinal County members who report their ethnicity as Hispanic, 71% speak Spanish whereas in Gila County only 1.4% of those who classify themselves as Hispanic speak Spanish.

Graph F

Pinal County Members Language by Ethnicity
n = 1,221
published 9/28/2010

	American Indian/Native Alaskan	Hispanic	Caucasian	African-American	Asian/Pacific	I Prefer Not to Answer
▨ English Pinal	22	211	692	102	11	16
■ Spanish Pinal	0	149	2	0	0	0
▢ Other Language Pinal	3	0	6	1	6	0

Graph G

Gila County Members Language by Ethnicity
n = 254
published 9/28/2010

	American Indian/Native Alaskan	Hispanic	Caucasian	African-American	Asian/Pacific	I Prefer Not to Answer
▨ English Gila	3	35	202	1	1	7
■ Spanish Gila	0	5	0	0	0	0

Payor Sources

Among P/GLTC members, a majority (86 %) are dually enrolled in both Medicare and Medicaid (AHCCCS/ALTCS) while 12% have Medicaid (P/GLTC) as their sole payor and 2% have a commercial plan as their primary payor. See Graph H.

Graph H

Pinal & Gila County Primary Payor
n=1,480
published 10/01/2010

AHCCCS
179
12%

TPL
25
2%

Medicare with
(TPL or Medicare
Advantage Plan)
1229
83%
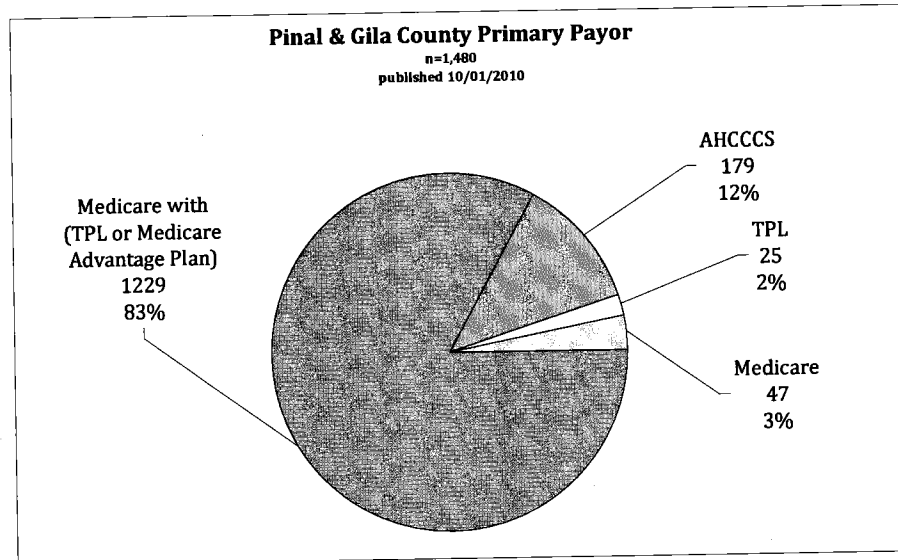
Medicare
47
3%

In the world of payment coordination rules, commercial insurance pays first, Medicare pays second and Medicaid is the payor of last resort. In most cases (86% of P/GLTC membership) Medicare is the primary payor. This means that Medicare FFS pays 80% of a member's medical costs for Medicare-covered services that are also covered by Medicaid. The remaining 20% of the medical cost becomes the financial responsibility of Medicaid (P/GLTC), which pays on behalf of the member. This results in the dually enrolled member paying a $0 cost share for services that are covered by both Medicare and Medicaid.

Graph I

Medicare with TPL or Medicare Advantage Plan

Top 5 Other Payors
n=1,390 policies
published 10/01/2010

Humana
82
10%

Secure Horizons
97
12%

Health Net
405
50%

United Healthcare
106
13%

Sierra Rx
118
15%
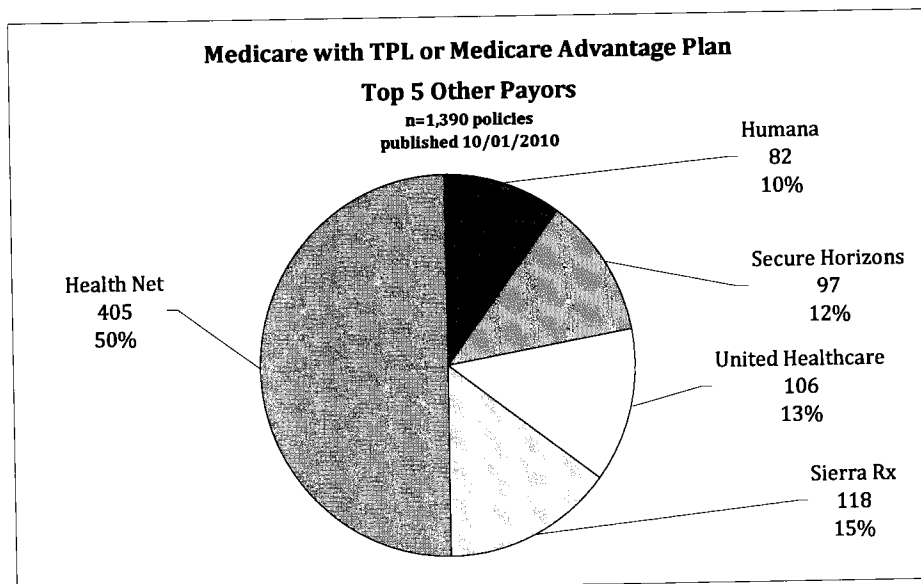
For those P/GLTC members with a Medicare Advantage Plan (MAPD) as their Medicare primary payor, the MAPD plan assesses a co-pay or coinsurance for MAPD-covered services. For P/GLTC members who are dually enrolled, these co-payments or coinsurances also become the financial responsibility of Medicaid (P/GLTC) because dual members always pay $0 cost share.

The top four MAPD plans that P/GLTC members belong to are: Health Net (50%), United HealthCare/Secure Horizons (25%), Humana (10%) and Sierra Rx (15%). See Graph I.

Vision for the Future and Network Gap Intervention Plan

Network Vision for the Future

P/GLTC's 5-year strategy is to further develop and expand its network of physicians and long term care services within its service areas. This strategy will reduce reliance on medical providers and long term care services that are located far from members' residences within the two counties.

This process began with the mining of the AHCCCS provider database in December 2010 to identify AHCCCS providers not yet contracted with P/GLTC. As of March 1, 2011 we have added an additional 1,045 PCPs and 1,816 specialists to serve current P/GLTC's Medicaid members and anticipated Medicare SNP members beginning 2012.

In order to continue to innovate for the future while solidly intervening with known service gaps, P/GLTC has launched the following innovative projects to develop and expand home and community-based settings, offer additional member benefits that are not currently enjoyed and strengthen our plan to continue to care for the elderly, frail and disabled population.

- HCBS Strategy and Action Plan
- Assisted Living Facility (ALF) Expansion Plan
- Adult Foster Care (AFC) Development Plan
- Workforce Development Plan
- Health Care Reform Plan
- Special Needs Plan

HCBS Strategy and Action Plan

Background

The Arizona Long Term Care (ALTCS) Program encourages the placement of eligible long-term care populations in the least restrictive environment in order to enable the frail elderly and disabled populations the highest level of independence as they "age in place". It has been P/GLTC's priority to allow members to return home when appropriate.

Based on need, ALTCS members can be placed in one of two settings: an institutional setting or a Home and Community-Based setting (such as a member's home or an ALF).

Home-based services include direct care provision in member's natural home and usually include assistance with activities of daily living such as eating, bathing, dressing and toileting or intermediate activities of daily living such as shopping or transportation to medical appointments. The array of home-based services which support the member's goal for independent living in the least restrictive environment are typically authorized and arranged by the member's Case Manager. ALTCS-covered home-based services include:

- Attendant Care
- Personal Care
- Homemaking
- Respite Care
- Companion Care
- Home Health
- Home-Delivered Meals
- Adult Day Health Care Center

Barriers/Issues

P/GLTC prides itself in being an ALTCS contractor in the state of Arizona with the highest percentage of members residing in a home or community based setting (75%) as of September 2010. Pinal County displays an impressive 83% of members residing in a home or community

based setting. This phenomenon is not repeated in nearby Gila County where only 44% of members reside in an HCBS setting. See HCBS Placement charts for details.

Graph J

Gila County
Member Placement
n = 254
published 9/28/2010

Home Based
106
42%

Community Based
6
2%

Skilled Nursing
Facility
142
56%

Graph K

Pinal County
Member Placement
n = 1,221
published 9/28/2010

Home Based
862
71%

Community
Based
146
12%

Skilled Nursing
Facility
213
17%

Graph L

Pinal & Gila County Long Term Care
Member Placement
n = 1,475
published 9/28/2010

Community
Based
152
10%
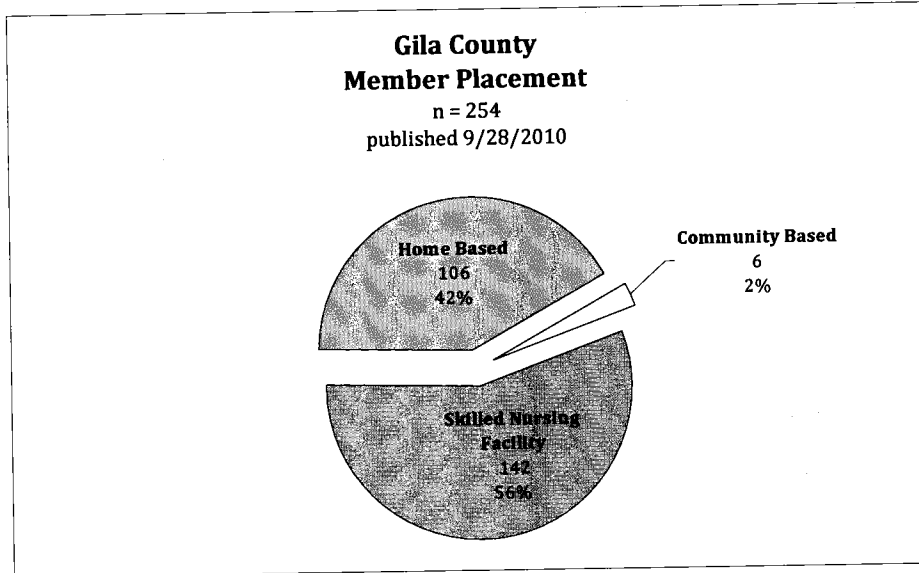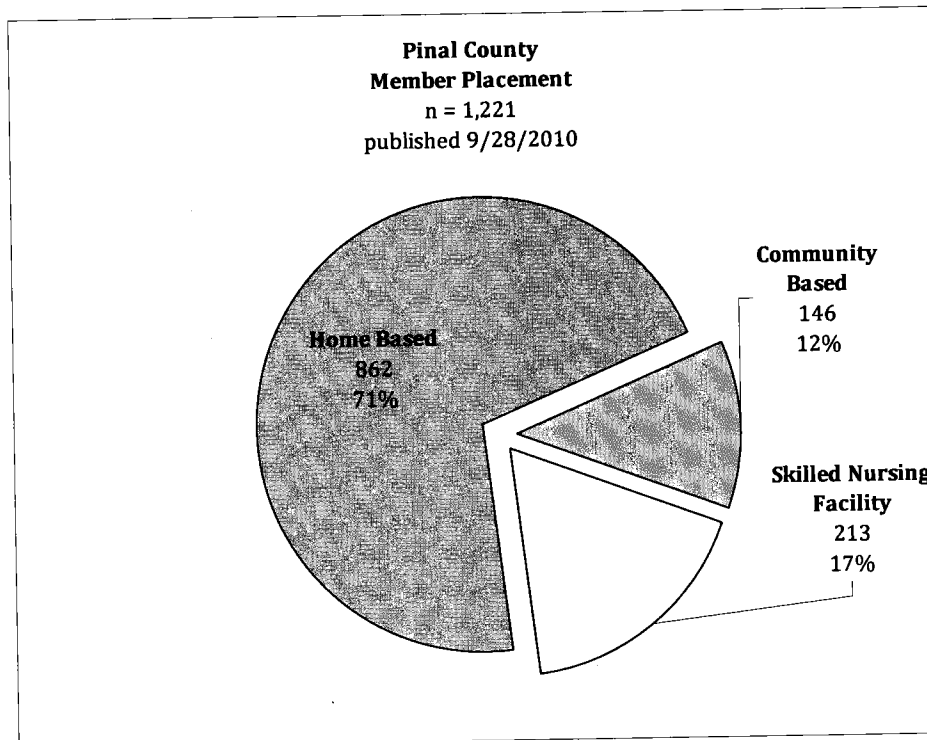
A situational analysis of HCBS placement patterns in Gila County reveals that the aggressive marketing presence of four dominant nursing homes (*Payson Care Center, Rim Country, Heritage and Copper Mountain*) in the hospitals of Payson and Globe has created a natural feeding system for Skilled Nursing Facility (SNF) placement over the years. This pattern is supported by family and community expectations which perceive nursing homes as the natural and logical setting for individuals who can no longer care for themselves in their own home. There appears to be widespread lack of knowledge within the community of other alternate home and community-based options.

In Pinal County, there remain opportunities for members who can no longer live in their own home due to their frail condition but have no ALF alternatives that are close to their family and friends. Such members are placed in ALFs located outside of Pinal County.

Gila County Strategy
P/GLTC's dual strategy is to aggressively expand limited home-based services and community-based facilities in Gila County while systematically interrupting the hospital discharge planning and SNF connection. An additional long term strategy is to impact the underlying knowledge and cultural attitudes in the hospital/provider community and local community away from the perception of nursing homes being the ultimate solution for "aging" residents.

Pinal County Strategy
P/GLTC's dual strategy in Pinal County is to focus on reducing reliance on Assisted Living Facilities in Maricopa County by expanding ALFs and AFCs within Pinal County and bending the cost curve for home-based services through more favorable negotiated unit rates.

Goal
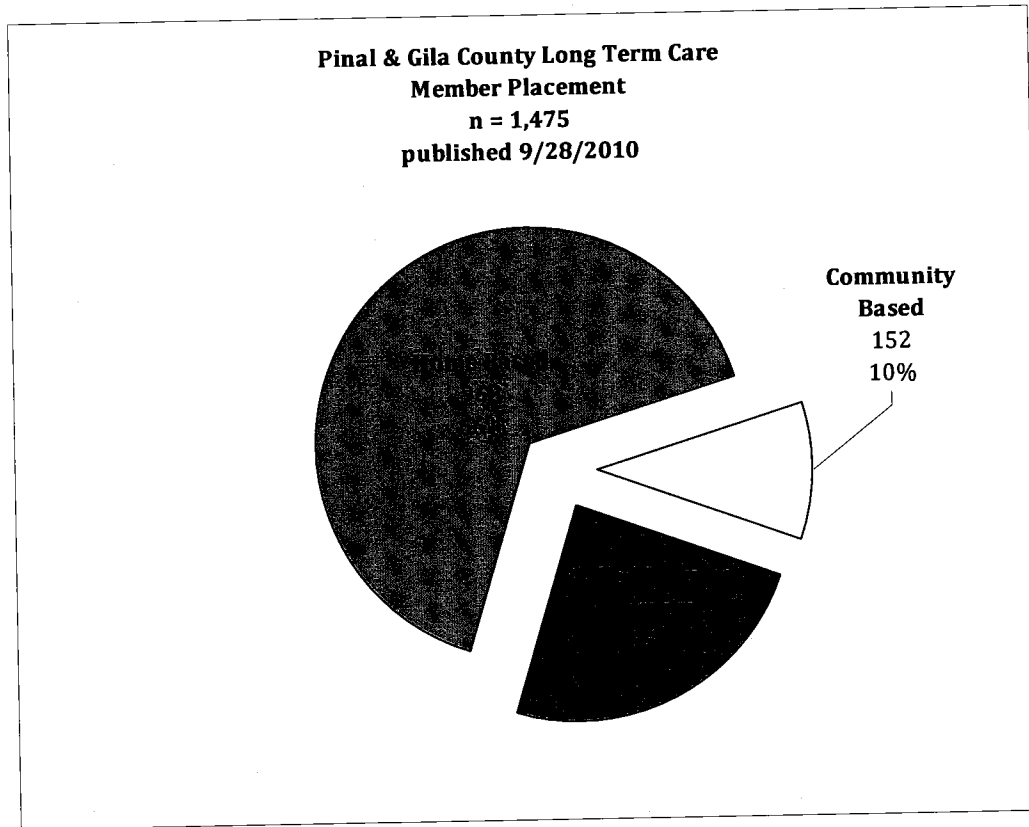To maintain P/GLTC ranking as the top ALTCS plan in Arizona with the highest percentage (nearly 75%) of members residing in a Home or Community-Based setting.

Objectives
- To maintain 83% of Pinal County members residing in an HCBS setting by December 2011 and increase to 85% by December 2015.
- To increase the percentage of Gila County members residing in an HCBS setting from 44% to 54% by December 2011 and to 74% by December 2015.
- Target recruitment and contracting for additional services that support a member's return to a home setting after a hospitalization such as home health nursing, outpatient therapy, adult day health care center and home-delivered meals while maintaining P/GLTC's robust Attendant Care Program.

Methods

Methods	Responsible Department/Staff	Initiation Date
Pinal and Gila Counties		
Implement the P/GLTC *Assisted Living Facility Expansion Plan* which is designed to increase the number of ALFs in Pinal County by six and in Gila County by two.	• Provider Representatives • Community Outreach Coordinator	11/01/2010
Aggressively implement P/GLTC's new *Adult Foster Care Development Plan* designed to stimulate and encourage the new development of at least four Adult Foster Care Homes in Pinal County and two in Gila County.	• Provider Representatives • Community Outreach Coordinator	11/01/2010
Recruit and contract with at least two psychiatrists for Pinal County and at least one for Gila County to serve members through a "traveling clinic".	• Provider Representatives • Contract Specialists • Behavioral Health Case Mgr.	11/01/2010
Expand P/GLTC's use of its telemedicine program to allow increased member access to psychiatric care.	• Provider Representatives • Contract Specialists • Behavioral Health Case Mgr.	11/01/2010
Gila County Only		
Fully implement the results of the September 2010 Attendant Care, Personal Care, Homemaking and Respite Care Request for Proposal (RFP) which increased access for Gila County members to an increased pool of direct care workers through four exclusively-contracted private sector agencies (Prileo; Lutheran Social Services; Soreo; At Home Solutions) in addition to the County-operated Attendant Care Program (Horizon).	• Case Management	10/01/2010

Methods	Responsible Department/Staff	Initiation Date
Target recruitment of at least one additional Home Health Agency in Payson, one Outpatient Physical Therapy provider in the Globe/Miami area, and one Occupational Therapist in Gila County	• Provider Representatives • Contract Specialists	01/2011
Develop and implement an aggressive *Hospital Intervention Program* that targets the discharge practices of hospital discharge nurses and incentivize the referral of potential eligible members to P/GLTC to achieve a successful return home. This can be accomplished through daily rounds performed by a local P/GLTC Case Manager.	• Case Managers/Provider Representatives • Community Relations and Outreach Coordinator	12/01/2010
Institute a *Nursing Home Review process* whereby multiple levels of internal management reviews and approvals are conducted prior to the placement of new enrollees into a Skilled Nursing Facility. Similarly, intensify systematic review of nursing home members utilizing additional levels of review to achieve a successful return to their own home.	• Case Management • Medical Management	12/01/2010
Develop and distribute Community Awareness and Education materials and media messages designed to dispel myths about nursing homes as the ultimate choice for family members in need of long term care.	• Community Relations and Outreach Coordinator.	01/2010
Extend the Provider Education Program to educate PCPs about the availability of a robust array of home-based services and/or assisted living community-based facility in order to encourage the promotion of these HCBS choices among families who consult PCPs about long term care placement.	• Case Managers/Provider Representatives • Community Relations and Outreach Coordinator	01/2011

Assisted Living Facility (ALF) Expansion Plan

Background
Since it is P/GLTC's philosophy and policy to maintain its members in the least restrictive and most cost effective environment, the ideal setting for P/GLTC members is often the member's own home. However, there are enrollees who are unable to direct their own care, or are simply no longer able to live independently even with significant direct care assistance and/or whose care needs require a more structured environment with closer 24-hour supervision. Such individuals become ideal candidates for a community-based setting such as an ALF.

An ALF is a residential care institution that provides or contracts to provide supervisory care services, personal care services or direct care services on a continuing basis. ALFs are licensed and

regulated by the Arizona Department of Health Services, Assisted Living Licensing Division. There are three basic types of assisted living facilities based on their licensed capacity.

- An assisted living center provides resident rooms or residential units to eleven or more clients.
- An assisted living home provides resident rooms or residential units for up to ten residents.
- An adult foster care home provides room and board for no more than 4 adults with at least one who is an ALTCS enrollee and in which the sponsor or manager resides with the residents around the clock thereby integrating residents into that sponsor/manager's family.

Furthermore, ALFs provide, or contract to provide, supervisory care services, personal care services or direct care services on a continuing basis. ALFs provide three levels of care:

- Supervisory Care: provides general supervision including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and provide assistance in the self-administration of prescribed medications.
- Personal Care: provides assistance with activities of daily living that can be performed without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medications and treatments by a nurse who is licensed.
- Direct Care: provides programs and services including personal care services to persons who are incapable of recognizing danger, summoning assistance, expressing need and making basic care decisions.

Barrier/Issue
Missed opportunities exist as Gila County members can no longer live in their own home due to their frail condition but have no ALF alternatives to move to that are close to their family and friends.

Based on the licensure database maintained by the Arizona Department of Health Services, there are four ALF contracting opportunities in Gila County and an additional 15 in Pinal County. Expanding the network of ALFs in both Pinal and Gila Counties will increase availability of community-based settings which allows Pinal County to maintain its long term care population in an HCBS setting while enabling Gila County to improve its HCBS penetration levels above the rate of 45.49%.

Strategy
Expand P/GLTC's ALF network in selected cities/towns of Pinal County and expand in all areas of Gila County while decreasing reliance on Maricopa County ALFs in the short term. In the long-term, the full development AFCs will further increase the availability of community-based facilities within Pinal and Gila Counties at a lower unit cost associated with ALHs and ALCs. This strategy will allow P/GLTC to respond to the anticipated decrease in capitation revenues from ALTCS in 2011 and beyond. (See AFC Development Plan for further details.)

Goal
Expand P/GLTC's ALF network within Pinal and Gila Counties while reducing reliance on ALFs located outside of these counties.

Objectives
Increase by six the number of Assisted Living Centers or Assisted Living Homes contracted to serve members in selected geographic areas of Pinal County by September 30 2011 and increase by another eight by September 30, 2015.

Increase by 2 the number of contracted Assisted Living Centers and Assisted Living Homes contracted to serve members in Gila County by September 30, 2011 and increase by another 4 by September 30, 2015.

Methods

Methods	Responsible Department/Staff	Initiation Date
Pinal and Gila Counties		
Using the Arizona Department of Health Services statewide database of licensed ALFs, identify Assisted Living Centers and Assisted Living Homes currently licensed to operate within Pinal and Gila counties.	• Network Director	08/2010
Investigate the identified ALFs most-recent ADHS monitoring visit to screen out those ALFs whose scores are significantly below established P/GLTC contract standards.	• Network Director	08/2010
Deploy P/GLTC's Provider Representatives to Recruit potential ALF contractors, simultaneously conduct a pre-contracting site-visit assessment and educate ALF operators to the ROQ process.	• Provider Relations Representatives	09/2010
Institute a systematic ALF Replacement Plan wherein a Maricopa-County ALF with a zero census is terminated when a Pinal County-based ALF or AFC with similar capacity is added to the network.	• Provider Relations Representatives	09/2010
Compress contracting cycle by directing Provider Representatives to proactively work with potential ALF owners to apply for an AHCCCS provider identification number, collect copies of licensure, proof of current insurance and W-9 form, fax number, phone number and email address.	• Provider Relations Representatives	09/2010
Expedite the contracting process by utilizing the provisional credentialing process for institutions and holding more frequent Credentialing Committee meetings.	• Credentialing Specialist	On-going
Profile cultural and linguistic capabilities of ALF staff and document these in PIMS or on a report for case manager use.	• Provider Relations Representatives	On-going

Conduct an orientation meeting for newly-contracted ALFs to discuss:
 • Contract service requirements
 	
 • Effective coordination and communication with
     o Case managers
     o Billing procedures
     o Contract Monitoring system
     o Medication Management
     o Transportation arrangement
     o Assistance with achievement of clinical
	• Provider Relations Representatives	On-going upon contracting

Methods	Responsible Department/Staff	Initiation Date

      o Indicators related to:

- Diabetes
- Influenza
- Pneumonia
- Advanced directives
- EPSDT
- Pressure ulcers.

Evaluation

Measure the increase in number of contracted ALFs and compare against stated network expansion objectives of six ALFs in Pinal County and two ALFs in Gila County by September 2011 and expansion objectives of eight ALFS in Pinal County and four ALFs in Gila County by September 30, 2015.

Adult Foster Care (AFC) Development Plan

Background

Although there are two identified Adult Foster Care Homes (AFCs) licensed in Pinal County and one licensed in Gila County according to the ADHS licensure database published July 2010, today, there are no AFCs in either Pinal or Gila County contracted with P/GLTC

The relative absence of AFCs, as a supplement to assisted living homes and assisted living centers can be attributed to two factors. The first barrier has been the ADHS requirement that an AFC sponsor/owner obtains a contract with P/GLTC as a precondition of licensure and similarly, P/GLTC's requirement for AFC sponsors/owners to show proof of ADHS licensure prior to contracting. The "Catch 22" nature of contracting appeared insurmountable at the time and the path of least resistance was taken which was to contract with the more readily-available assisted living centers and assisted living homes. Secondly, the cost of general liability insurance became unfeasible for some sole proprietors and entrepreneurs who ventured into the business of operating AFCs.

Barrier/Issue

The availability of community-based long term care facilities or homes serving P/GLTC members is inadequate. Although there are 36 ALFs in Pinal County, as of August 2010, the vacancy rate is low according to case management experience. This inadequacy is particularly evident in Gila County where there is only 1 ALF as of August 1, 2010. Given P/GLTC's enrollment trends, it is estimated that the supply will be outstripped by demand in a matter of a few years.

P/GLTC has filled this gap, over the years, by contracting with ALFs that are located in Maricopa and Pima Counties – the two largest metropolitan areas in Arizona. The cities that benefit from this phenomenon include Queen Creek, Gilbert, Mesa, Apache Junction and Tucson. ALFs in these locales have met the placement needs of many P/GLTC members including those with highly specialized care needs such as behavioral health problems, traumatic brain injury or wandering dementia. This natural business solution has had the undesirable effect of placing members at great distances from their families and natural communities.

Although there are a total of 56 contracted ALFs serving approximately 1064 HCBS members which equates to a ratio of one ALF per 20 members, the data otherwise suggests a misleading picture

because of ALF geographic distribution outside of the inner concentric circle of member's home County.

Distribution of P/GLTC Contracted ALFs by County

ALF Levels of Care	Gila County	Pinal County	Pima County	Maricopa County	All Counties
Level I, II, III Only	0	1	0	0	1
Level I, II,III and Wandering Dementia (WD)	3	14	1	7	25
Level I, II, III and Behavioral Health (BH)	0	0	0	1	1
Level I, II, III, BH and Traumatic Brain Injury (TBI) Level I	0	0	1	0	1
Level I, II, III, WD, TBI Level I & II	0	0	0	1	1
TBI Level I & II only	0	1	0	4	5
Adult Foster Care (AFC)	0	0	0	0	0
Behavioral Health Only (BH)	0	5	4	7	6
Wandering Dementia Only (WD)	0	0	0	6	6
Adult Foster Care Home (AFC)	0	0	0	0	0

Unlike Pinal County, Gila County does not have the close proximity to nearby Maricopa and Pima counties. The historical business response to this problem in Gila County has been to place members in institutionalized settings (Skilled Nursing Facilities) as the only available alternative. Knowing that institutionalized care is far more expensive than home and community based settings, the expansion of ALFs, development of AFCs and increased member referral to attendant care services becomes P/GLTC's more urgent mission in Gila County.

Business Solution
P/GLTC's Network Management Team plans to promote establishment of AFC homes as an alternative community-based living placement for P/GLTC enrollees whose more intimate family environments may be appealing to rural members. In pursuit of this goal, P/GLTC plans to stimulate the local economies of Pinal and Gila Counties and resurrect the AFC residential care setting as a cost effective alternative to skilled nursing facilities, assisted living centers, assisted living homes and even to attendant care service-utilizing members who average greater than 30 hours per week. The introduction of this ALF type may also increase the availability of homes that are operated by owners/sponsors who are culturally and linguistically more diverse such as Hispanics, African Americans and Asians.

The advantages of focusing on AFC development over further enhancement of other types of assisted living facilities are enumerated below. An AFC:

- Fosters care of long term care clients in a more intimate, home and family-like environment due to requirement for owner/sponsor to also reside in the home.
- Promotes economic opportunity for sole proprietors and local entrepreneurs who reside in Pinal and Gila counties requiring lower capital requirements.
- Represents a cost-effective strategy for P/GLTC in response to an increasingly challenging financial environment as it allows Network Management to establish its contracting price points to be set at a percentage less than the lowest ALF Tier payment levels.

Payment Level Comparisons for New Contracts by ALF Type

Payment Level (Effective Contract date of 10/01/10)	AL Center or Home (Effective 10/01/2010)	AFC Proposed (New Contracts in 2011)	Estimated Annualized Savings (assuming ALCs at full capacity)
Levels I and II	$76.10- $78.39	$68.49-$70.55	$ 1, 483.20
Level III	$95.49 -$98.35	$85.94-$88.52	$1, 860.48
Wandering Dementia	$95.49 - $125.00	$85.94-$112.50	$2,116.80
Behavioral Health	$133.68-$207.83	$120.32-$187.05	$3,277.44
Traumatic brain Injury	$144.90-$163.83	$130.41-$147.45	$2,963.52

Strategy
Build a culturally diverse AFC network through targeted recruitment in cities, communities and neighborhoods of Pinal and Gila counties whose AFC ownership profile matches the racial/ethnic composition of P/GLTC's membership population.

Goal
Develop and implement a business model that establishes a new network of Adult Foster Care homes within Pinal and Gila counties that can accommodate membership growth while decreasing reliance on assisted living facilities outside of these counties.

Objectives
- Increase from zero to 4 the number of contracted AFCs in Pinal County by September 30, 2011 and increase up to a total of 12 by September 30, 2015.
- Increase from zero to 2 the number of contracted AFCs in Gila County by September 30, 2011 and increase up to a total of 8 by September 30, 2015.
- Increase from zero to 2 the number of newly contracted AFCs in either Pinal or Gila Counties whose owners/sponsors are ethnically diverse and/or bilingual in English and another language spoken by enrolled members by September 30, 2011 and up to a total of 6 by September 30, 2015.

Methods

AFC Development Plan

Methods	Responsible Department/Staff	Initiation Date
Collaborate with the Arizona Department of Health Services, Office of Assisted Living Licensing and the Pinal County/Gila County Departments of Building and Safety to facilitate and expedite the application and approval of Adult Foster Care Homes in Pinal and Gila Counties.	• Network Director	09/10
Request the Arizona Department of Health Services to accept P/GLTC's model letter of agreement which formally states its intent to contract with potential AFC sponsors in order to meet ADHS licensure preconditions.	• Network Director	09/10
Identify additional barriers throughout development and implementation phases and create solutions to overcome barriers or mitigate its effects. (Barriers identified to date include general liability insurance policy costs, need for additional business incentives, speed-to-market abilities)	• Network Director	09/10

Contract with an appropriate DCW training entity to provide training for AFC owners following approved training curriculum currently utilized for direct care workers. This training should be completed prior to member placement in AFC.	• Network Director	10/10
Develop, and implement a public information and community-wide awareness effort targeted at Pinal County and Gila County homeowners to consider becoming an AFC sponsor/operator while specifically targeting bilingual, minority home-owning sponsors who can meet the unique cultural and linguistic needs of our ethnically diverse member population.	• Community Relations & Outreach Coordinator	10/10
In collaboration with Pinal County Public Information Officer and local Pinal and Gila newspapers, host public education forums to inform the community about the economic opportunity presented by AFCs and to receive technical assistance and consultation about the AFC application requirements. Alternatively, contract with an appropriate entity that can provide "speed-to-market" program promotion and technical assistance, at the individual and community grassroots level.	• Community Relations & Outreach Coordinator	09/10
Designate the Provider Relations Representative as the single point of contact for the AFC Development initiative within their assigned geographic areas of responsibility whose role is to provide technical assistance and consultation to facilitate and expedite the application process with potential AFC applicants.	• Provider Relations Representative	09/10
Delegate to the Contract Specialists and Credentialing Coordinator the task of identifying and addressing AFC credentialing and contracting process barriers in order to achieve a faster turnaround time for AFC contracts.	• Contract Specialists • Credentialing Coordinator	On-going
Assign a special committee to review and modify ALF work statement to include unique service requirements for AFCs.	• Contract Specialists	09/10
Conduct a comprehensive orientation for AFC providers to ensure business success as well as service performance. Training topics will be aligned with P/GLTC's program goals, customer satisfaction objectives and clinical outcome goals to include at a minimum: • Maintaining effective relationships with Case Managers • Understanding and achieving clinical goals pertaining to diabetes, influenza, pneumonia, pressure ulcers, osteoporosis, EPSDT, childhood immunizations and advanced directives • Promoting Individual and environmental Safety • Transportation arrangements and "best practice tips" • Availability of other complementary services such as	• Provider Services Manager	12/10

respite care

- Improving nutritional meal-planning and preparation

- Integrating Cultural competence into direct care delivery

Develop and institute an annual Award for the "Best Performing AFC" and "Best Performing ALF" encourage others to aspire towards excellence in service, member satisfaction and quality.	• Provider Services Manager	01/11
Schedule and conduct periodic Joint Operations Committee Meetings with AFC operators as well as other ALF Managers/owners to: • improve understanding of their contractual responsibilities, • increase care giving knowledge and skills and • align clinical initiatives with operators' care giving priorities	• Provider Relations Representative	01/11
Perform annual contract monitoring audit utilizing revamped audit tool to meet AHCCCS requirement for annual contracts monitoring. This revamped monitoring system relies on an analysis of ADHS deficiency scores, internal concern reports and Site monitoring scores.	• Provider Services Manager	Per annual Schedule
Continue to implement P/GLTC's Cultural Diversity Plan designed to encourage recruitment and nurturing of bilingual/bicultural long term care providers.	• Community Relations and Outreach Coordinator	Per Cultural Diversity Plan timelines

<u>Evaluation</u>
Measure the increase in the total number of contracted AFCs against stated objectives of 4 new AFCs in Pinal County and 2 new AFCs in Gila County by September 2011 and 12 new AFCs in Pinal County and 8 new AFCs in Gila County by September 2015.

Workforce Development Plan

<u>Background</u>
The US Bureau of Labor Statistics reports that there will be a 56% increase in the demand for direct care workers in the next 10 years. Although there are over 30,000 direct care workers in Arizona, the demand for these workers is rising.

Direct care workers are people who care for individuals of all ages who have disabilities or a chronic illness and need their assistance. They are sometimes referred to as:

- Caregiver
- Home Care Aide
- Attendant Care Worker
- Personal Assistant
- Personal Care Attendant
- Direct Support Professional
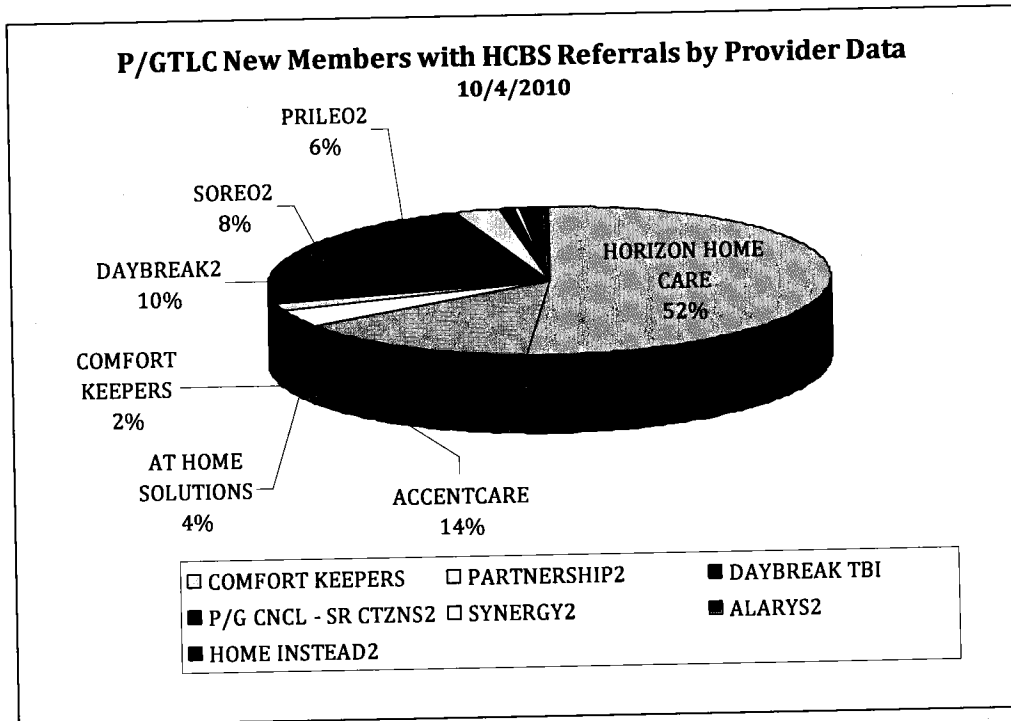
- Habilitation Technician
- Respite Care Worker

Direct care workers provide essential help with daily activities. This allows the elderly and people with disabilities or chronic illness to live with as much dignity and independence as possible, regardless of their age or condition. P/GLTC members typically receive direct assistance with bathing, dressing, eating, getting in and out of bed/wheelchair and going to the toilet. They also help members with medications and may accompany them to medical appointments.

The most common type of direct care workers who provide services to P/GLTC members include:

- Home Care Aide/Caregiver: Home care aides or caregivers provide a range of basic services in the home, including help with bathing, dressing and grooming. Some may help with home management tasks such as grocery shopping and preparing meals.
- Personal Care Attendant/Attendant Care Worker/Personal Assistant: Personal care attendants assist people with basic tasks such as bathing, dressing, grooming, and eating. They provide for safety and comfort of members, providing companionship, and assist with activities of daily living.
- Habilitation Technician: Habilitation technicians provide a range of services from personal care to behavioral modification in a variety of settings to help people who have developmental disabilities or problems with substance abuse.
- Respite Care Worker: Respite care workers provide care and companionship to people with a disability or health condition to ease the burden of family members who usually provide those services.

P/GLTC delivers direct care services to members in their homes with the deployment of 5 contracted Attendant Care Providers and five non-contracted providers as of 10/1/2010. (As a result of an RFP, the number of Attendant Care agencies has been consolidated into 5. The non-contracted providers, however, continue to serve existing members but will no longer receive any new member referrals.) Graph M illustrates the distribution of members served by provider.

Graph M

P/GTLC New Members with HCBS Referrals by Provider Data
10/4/2010

PRILEO2
6%

SORE02
8%

DAYBREAK2
10%

COMFORT
KEEPERS
2%

AT HOME
SOLUTIONS
4%

ACCENTCARE
14%

HORIZON HOME
CARE
52%

☐ COMFORT KEEPERS   ☐ PARTNERSHIP2   ■ DAYBREAK TBI
■ P/G CNCL - SR CTZNS2 ☐ SYNERGY2   ■ ALARYS2
■ HOME INSTEAD2

Barrier/Issue

With the aging of residents in both Pinal and Gila Counties, P/GLTC is faced with the challenge of assuring a steady and competent pool of direct care workers, who can meet the growing demands of the program.

Goal

To achieve a steady, constant, and competent direct care workforce designed to meet the demands of an aging Pinal and Gila County population while providing support for P/GLTC families in their efforts to maintain loved ones at home and in the community.

Objective

By December 2011, develop and implement a comprehensive Work Force Development Plan (see Table O) designed to increase the number of direct care workers available to work in attendant care agencies, assisted living facilities and skilled nursing facilities in order to meet future care needs of P/GLTC members.

By December 2015, demonstrate a minimum of 20% increase in the number of direct care workers from current baseline employment levels.

5-year Work Force Development Plan

Activity	Responsible Department/Staff	Initiation Date
Collaborate with selected attendant care providers, and other Direct Care Worker training programs to develop and implement strategies that achieve the stated objective of creating a steady source of direct care workers who will be prepared to care for P/GLTC members in their homes.	• ACP • Agencies	01/11
Partner with Central Arizona Community College located in	• Network	01/11

Pinal County, to design and offer a Caregivers certificate following the training guidelines developed through the Direct Care Workforce Initiative.	Director	
Coordinate with Horizon Home Care and the Pinal County Human Resources Department to streamline promotion, recruitment, and hiring practices for direct care workers employed in the County's internally-operated Attendant Care Program while reviewing and addressing market compensation.	• Human Resources Director • Horizon Program Director.	11/10
Promote economic opportunities within Pinal County and Gila County through community awareness outreach activities that educate the unemployed about a direct care worker career path.	• Community Relations and Outreach Coordinator	01/11
Participate in the auditing of DCW training programs to ensure adherence to established care-giving standards.	• Provider Relations Representatives	Upon requirement

Evaluation
Measure the increase of Direct Care Workers employed by contracted Attendant Care Providers against stated objective of a 20% increase from its current 2011 employment levels.

Health Care Reform

Health Care Reform presents a unique opportunity for P/GLTC that will be fully explored and mined as part of a comprehensive plan to offer innovative ideas that increases the plan's value to AHCCCS/ALTCS.

The Patient Protection and Affordable Care Act (ACA) signed into law by President Obama on March 23, 2010, improves access to health care coverage for Americans through an expansion of Medicaid to a national floor level of 133% FPL, and through a state-based *"American Health Benefit Exchange"* system where individuals can purchase coverage beginning 2014. It is estimated that an additional 32 million individuals will be covered though these two mechanisms. In this system of care there are provisions for:

- Populations with incomes between 133%-400% to receive subsidies to pay for premiums and cost share.
- Small employers to create separate health benefit exchange called Small Business Health Options Program (SHOP).
- Employers to pay penalties if their employees participate in the exchange.
- New health plan regulations to achieve cost savings and improve health care.
- A simple, seamless eligibility and enrollment system that is technology-supported across Medicaid and health exchange.

Implications for Health Plan Under the Health Benefit Exchange:
P/GLTC will explore the possibility of becoming a "qualified health plan" to participate in an Arizona-based health benefit exchange and/or in a Small Business Health Options Program (SHOP) that cover the Pinal/Gila geographic areas, once such entities are created. There can be more than one exchange in a given state as long as it defines geographic areas of coverage and solely depends on how a state structures its system.

Although Arizona's direction is not as clear with respect to the entity that will fill this role, it appears that AHCCCS may not become Arizona's health benefit exchange or SHOP even though the state Medicaid agency is the natural candidate in other Medicaid states. This leaves the field wide open for a commercial entity, or a consortium of health and/or business interests, to form such an exchange. Within the law, states that do not offer a Health Benefit Exchange will be administered at the federal level, though details of this are still under development.

Regardless of the resulting health benefit exchange entity, P/GLTC will consider participating as a "qualified health plan". Pinal/Gila LTC has the requisite structure and systems to meet the following minimum requirements:

- Offer at a minimum the "essential health benefits package";
- Adhere to marketing requirements and use a uniform enrollment form;
- Provide outreach and enrollment assistance using "navigators";
- Demonstrate adequate networks including contracts with "essential community providers";
- Be accredited with respect to "performance quality measures";
- Maintain medical loss ratio of 80% (individual and small group market) or 85% (large group market);
- Adhere to new insurance market rules (i.e. no lifetime limits, dependent coverage to age 26, prohibition on prior-existing condition exclusion for children, prohibition on coverage rescissions) and consumer protections (standard benefit materials etc.); and
- Present written policies and submit reports on :
  - o Marketing.
  - o Enrollment/disenrollment.
  - o Claims.
  - o Claims denied.
  - o Cost sharing.
  - o Out of network.
  - o Comprehensible, written enrollee rights.

The only remaining basic requirement that may need to be further explored is whether P/GLTC needs to seek separate approval as a risk-bearing entity under the Arizona Department of Insurance. Currently, P/GLTC is waived from this state requirement as part of the AHCCCS Medicaid system which currently imposes its own financial solvency standards and requirements.

Implications for ALTCS/ P/GLTC under Medicaid Expansion
The Patient Protection and Affordable Care Act (ACA) increases access to affordable coverage by extending eligibility to a national floor of 133% FPL. According to an analysis by the Kaiser Family Foundation, this significantly reduces the number of uninsured. The Federal government will pay a very high share of new Medicaid costs and increases in state spending are relatively small compared to increases in federal revenues and to what states would have spent if reform had not been enacted. This same analysis on Medicaid and the Uninsured (Medicaid Coverage and Spending in Health Reform: May 2010) has estimated that approximately 81,095 previously uninsured Arizonans will have access to Medicaid/AHCCCS under the new law, with an associated additional state spending of only 0.2% and federal spending of 4.2% for the period 2014-2019 should the state choose to receive the matching dollars.

Although the prospect of AHCCCS/ALTCS expanding its existing ALTCS program is very low, given the state budget crisis, there are new opportunities for program expansion under ACA. P/GLTC is well positioned and prepared to participate in any of the following Long Term Care demonstration and pilot programs in cooperation with, or under the direction of, AHCCCS pending availability of program funds:

- Medicaid Money Follows the Person Rebalancing Demonstration program (thru 2016)
- New HCBS options through state Medicaid plan (effective Oct. 2010)
- Community First Choice Option to provide attendant care to disabled needing institutionalized care using increased federal match (effective October 1, 2011)
- State Balancing Incentive Program to increases HCBS percentage through increased federal match (effective October 1, 2011-Sept. 30, 2015)

The downstream effect on ALTCS contractors will be that opportunities for revenue expansion through ACA are few, if any. It is even possible, if not highly probable, that revenues will decrease with corresponding decreases in capitation rates in 2011 and beyond. This is why PGLTC intends to seek alternative revenues associated with the enactment of the law through the Arizona Health Benefits Exchange beginning 2014. In order to support this vision, PGLTC will continue to build its network to increase access for members.

Special Needs Plan
In an effort to improve both member care and payment coordination, P/GLTC prepared an application to become a Medicare Advantage Special Needs Plan beginning January 1, 2012. P/GLTC's SNP application was submitted to the Center for Medicare and Medicaid Services (CMS) on February 24, 2011, with full approval from AHCCCS. Our preliminary product and benefit offerings include those services that were eliminated or reduced by AHCCCS effective 10/1/2010 such as:

- Well exams;
- Podiatry;
- Emergency dental ;
- Physical therapy;
- Insulin pumps; and
- Physical therapy beyond 15 visits.

We also plan to cover supplemental services not covered by Medicare Fee for Service or Medicaid/AHCCCS such as:

- Vision;
- Hearing aids;
- Adult preventive dental; and
- Incontinent supplies.

It is P/GLTC's goal to significantly increase market share in Pinal and Gila County and become the major Medicare Advantage SNP in our service areas. We intend to compete vigorously with the private sector which currently dominates the SNP landscape in our own backyard. Our major competitors in Pinal County are:

- Evercare
- Health Net of AZ
- CIGNA
- Health Choice
- University Physicians Healthcare

There is no Special Needs Plan in Gila County. P/GLTC will be the first SNP to offer dual members an alternative plan to Medicare Fee for Service including additional medical, pharmacy and supplemental   benefits.

Current Network Design and Monitoring

Network Monitoring

All ALTCS-covered services are accessible to P/GLTC members in terms of timeliness, amount, and duration and scope as described in the annually-updated member handbook and as explained by the case manager during assessment visits. This includes access to emergency care on a 24 hour, 7 day a week basis. To ensure that members do not face any barriers to accessing care, P/GLTC has instituted a robust provider education, monitoring and auditing system that is largely effectuated by three FTE Provider Relations Representatives and 1.0 FTE Provider Services Supervisor, all under the direction of the Network Management and Development Director.

The main role of the Provider Relations Representative is to function as the official liaison between the provider and P/GLTC. P/GLTC Provider Relations Representatives perform educational, consultative, and monitoring roles for the purpose of developing and maintaining effective relationships with contracted providers. They are relied upon by the Department to help achieve a mutual goal of delivering quality care and service to our members.

P/GLTC utilizes the managed care industry's "best practice" of providing highly-personalized, face-to-face interaction with key providers while equipping them with updated information through website applications. The Network Development and Management section of P/GLTC believes in a strong, practical focus on interpersonal communication that builds collaborative relationships, minimizes provider concerns and creates an atmosphere of cooperation toward member and provider issue resolution. The secondary role of the Provider Relations Representative is to help identify network gaps and recruit additional providers and provider/types to fill those gaps.

There are five major methods employed by P/GLTC's Network Development and Management Section to effectuate "best practice". They include:

- Face-To-Face Site Visits - A year round schedule is created to allow the informal, personal visit onsite of high-volume providers by Provider Representatives. During this visit a standardized site-visit tool available on individual laptops is used to guide the Provider Representative in assessing provider adherence and educating the provider, on matters of great importance to providers and the plan alike including accurate billing, provider standards, appointment availability/wait time, performance measures, EPSDT visit frequency, HIPAA, fraud and abuse, no show requirements, covered services, Cultural Competency and ALF (ALF) surveys for example. Site visit scoring and written results are produced then discussed with the provider during this same visit. In 2010, 721 face-to-face site visits were completed.
- Focused Investigative Visit- Upon request by the Quality Management (QM) Department or Case Management (CM) Department, a focused visit may be conducted announced or unannounced for the purpose of investigating allegations of neglect or service quality and determine areas in need of immediate correction or improvement. This visit is often a supplement to a visit also conducted by a QM nurse, CM, ADHS Licensure, Law Enforcement or Adult Protective Services. In 2010, twelve (12) focused investigative visits were completed.
- Contract Auditing - An annual formal visit conducted by the Provider Relations Representative for the explicit purpose of conducting an official audit of the provider onsite to determine level of compliance with the most salient requirements of the provider's P/GLTC contract. The contract audit tool varies on the provider type being audited. In 2010, 65 contract audits were completed. In 2010, of 65 contracts audited, 78.5% scored 100% on all audit elements. The remaining 21.5% scored between 95%-99% and were cited for a deficiency requiring a corrective action plan.
- Joint Operations Committee (JOC) Meeting – A periodic meeting facilitated by the Provider Relations Representative and attended by selected P/GLTC Management Team members and selected providers or provider groups such as hospitals, attendant care providers, skilled

nursing facilities (SNFs) or durable medical equipment (DME) companies for a specific problem-solving or issue resolution purpose. In 2010, eleven (11) JOCs were completed.

- Focused Training Sessions – A special training session convened specifically to achieve specific training objectives that are aligned with the Department's quality, performance or service objectives. In 2010, four (4) focused training sessions were conducted. An example of this is the training conducted in October 2010 on "timely and accurate service gaps reporting".

As part of a continuous effort to strengthen provider monitoring and enhance relations with contracted providers these "best practice" methods were recently redesigned and implemented beginning July 1, 2010 as depicted below.

Summary of P/GLTC "Best Practice" Methods

Provider Type	AHCCCS Monitoring Requirement	P/GLTC Monitoring Frequency	Best Practice Method
High Volume Providers (PCPs, Specialists)	Once every three years	• Every four months and more often as needed for special initiatives	• Face-to-face Site Visit • Focused Training • Focused Investigative Visit
Other Providers (Low volume Providers, Dentists, DME, Therapists/Others)	Once every three years	• Once every three years	• Contracts Audit (DME)
Assisted Living Facilities including TBI	Annually	• At least biannually	• Face-to-face Site Visit
Assisted Living Facilities including TBI	Annually	• At least biannually as needed	• Focused Training Focused Investigative Visit
Assisted Living Facilities including TBI	Annually	• Annually Onsite	• Contracts Auditing
Hospitals, Behavioral Health Facilities, Home Health, Transportation	Once every three years	• Annually Onsite • Quarterly (Transportation, DME)	• Contracts Auditing Joint Operations Committee as needed
Attendant Care, Homemaker, Personal care, Adult day health Care Providers (HCBS)	Annually	• Annually Onsite	• Contracts Auditing
Skilled Nursing Facilities, Hospice (SNF)	Annually	• Annually Onsite	• Contracts Auditing Focused • Investigative Visit as needed

In order to fully comply with the AHCCCS requirement to monitor all contracted providers at least once every three years for certain providers and at least once a year for other providers such as Attendant Care Providers, Assisted Living Facilities and Skilled Nursing Facilities, P/GLTC adheres to systematic contract monitoring. In contract year ending (CYE) 2010, 100% of 69 P/GLTC providers scheduled for an annual contract audit have been audited (see Contracts Audit Schedule CYE2010 below). In this audit, providers scored at least 95%. Contract audits were completed using a 16-page contract audit tool. This tool has been recently streamlined and improved for use in 2011.

All providers with deficiencies discovered during a formal annual contracts audit or a focused investigative site visit, are required to prepare and submit a Corrective Action Plan (CAP). Each CAP describes the corrective measures to be taken to address deficiencies. For example, in the 2010 Contracts audit cycle, 14 providers were requested to submit a Corrective Action Plan. A follow-up call by the Provider Relations Representative is typically required to ensure performance improvement, adequate application of corrective actions and systematic compliance. A future enhancement will be to conduct a return visit to providers that scored below 95% to ascertain consistent adherence to submitted corrective action plans.

Contract Audit Results -2010

Contract Audit (2010)	Numbers	Percentage
Total Monitor	65	
100% scored	51	78.5%
95-99% scored	14	21.5%
ACP Total	9	
100% scored	6	66.7%
95-99% scored	3	33.3%
SNF	26	
100% scored	18	69.2%
95-99% scored	8	30.8%
ALF	30	
100% scored	27	90.0%
95-99% scored	3	10.0%

Contracts Audit Schedule Q1 & 2 CYE2010

Provider Type	Total # Prov	1st Q CYE2010 Oct Due	Oct Comp	Nov Due	Nov Comp	Dec Due	Dec Comp	2nd Q CYE2010 Jan Due	Jan Comp	Feb Due	Feb Comp	Mar Due	Mar Comp	TOT MON DUE	TOT MON COMP	% COMP
Adult Day Health														0	0	#DIV/0!
Behavior Health														0	0	#DIV/0!
Dental														0	0	#DIV/0!
DME/Medical Supply														0	0	#DIV/0!
Emergency Alert														0	0	#DIV/0!
Environmental Mod														0	0	#DIV/0!
Home Del Meals														0	0	#DIV/0!
Home Health														0	0	#DIV/0!
Hospice																
Therapies (PT, ST, OT)														0	0	#DIV/0!
Transportation	30											30	30	30	30	100.0%
ALF														0	0	#DIV/0!
Hospitals	26							15	15	11	11			26	26	100.0%
Nursing Facilities*														0	0	#DIV/0!
PCP*														0	0	#DIV/0!
OB/GYN*																
High Volume Specialist*														0	0	#DIV/0!
AC/PC/HMK (annual)	9							5	5	4	4			9	9	100.0%
Total	65	0	0	0	0	5	5	20	20	15	15	30	30	65	65	100.0%

Pinal/Gila Long Term Care

The Representatives use a proprietary database called the Provider Information Management Systems (PIMS) that enables P/GLTC Representatives to track, trend and analyze incoming and outgoing provider communications. This system stores data utilized for several purposes including provider education documentation, provider demographic updates, provider inquiry trend analysis and troubleshooting of concerns and complaints. Additionally, PIMS is used for storing contract monitoring and site visit documentation on physicians, attendant care, SNFs and assisted living homes and centers.

Representatives utilize the Provider Manual, Quick Reference Guide and the provider's individual contract to educate providers on key program and service components, use of P/GLTC website functionalities such as provider lookup, contract applications process, and provide information on links to additional important web sites such as AHCCCS, Arizona Department of Health Services and Centers for Medicare and Medicaid Services. Under supervision of the Provider Relations Supervisor and overall direction of the Network Director, the Representatives form a cohesive team that continues to examine opportunities to enhance processes and improve efficiencies.

Representatives are knowledgeable of the P/GLTC's network needs and growth goals. Armed with this knowledge, Representatives take every opportunity to address these requirements. For example, as they interact with providers in their assigned territories, Representatives often identify additional potential contracted providers. The Representatives recruit prospective providers and provide hands-on technical assistance and consultation with the P/GLTC Review of Qualifications (ROQ) contract application process. For example, recently, they were instrumental in recruiting potential applicants to become Adult Foster Care Home providers in rural areas of Pinal and Gila counties through presentations at public forums in Casa Grande, Maricopa, Globe, Payson and Apache Junction.

<u>Appointment Waiting Times</u>
Representatives measure provider adherence to appointment waiting time standards using two methods. The first method is through the Site Visit Tool during on-site, face-to-face visits with physicians and specialists. The current Site Visit Tool documents self-reports to determine the next available appointment then the Representative educates the provider on appointment availability standards as reflected in the Provider Manual and the provider's contract.

The second method measures adherence to appointment waiting standards through a telephonic appointment availability survey which is conducted annually. The 2010 appointment availability telephone survey conducted determined whether the next available appointment met "routine and urgent" timeliness established by AHCCCS. The telephone survey revealed that 100% of the 61 providers surveyed met appointment waiting standards for routine and urgent care appointments. This methodology will be revised in 2011 to allow this telephone survey to be conducted as part of "mystery shopping" without identifying surveyor as a P/GLTC Representative. This will replace the current method of office staff being queried by a self-identified Representative as to the availability of the next Routine, Urgent and Emergent appointments to determine if they meet AHCCCS requirements.

As a process improvement initiative, an enhancement has been added to the Site Visit Tool to allow the proactive collection of appointment availability data from provider offices. The enhancement specifically directs the Representative to ascertain from the provider's office appointment records/logs onsite what the next available appointment is for "Routine, Urgent and Emergent" appointments. Providers are found to be non-compliant will be required to delineate reasons for non-compliance and submit a corrective action plan. Corrective action plan progress will be monitored during subsequent visits.

"No Show" Rates

In 2009, an intervention was implemented to collect information on "no show rates". This was initiated because no data has been voluntarily reported by physicians. Rather than assuming that "no shows" was not a problem among P/GLTC members, a different data collection method was initiated. The intervention was a website-based reporting system where physicians could report member "no shows" online. An article was included in the summer 2010 newsletter, "Missed Appointments" to educate providers on this methodology and included detailed instructions for online submission of "no-shows".

In addition, during face-to-face visits made by Representatives, providers were educated regarding the on-line reporting availability. The Site Visit Tool documented that this subject was specifically covered during a face-to-face visit and that provider office staff have reviewed the web site and understand the reporting steps. Documentation was in the form of a provider's signature on the Representative's Provider Visit Log as attestation of understanding.

To date there have been zero (0) reports from providers. This appears to be supported by the absence of provider telephone complaints about member "no shows". P/GLTC can only deduce that, although this may be a problem for other plans, it does not appear to be a problem for P/GLTC providers. None the less, member education on the importance of canceling appointments 24 hours in advance will continue.

Member Access to System

Upon enrollment, members are sent a Member Handbook which describes covered services, benefits and programs and clear instruction on how to access routine medical care, urgent care and emergency care. Access instructions are reinforced by the member's Case Manager during the initial assessment visit and subsequent visits. Members are educated that for home and community-based services, the Member Services and Case Management staff become the first point of contact for members to identify a need for services that must be prior authorized prior to arrangement. Members with other insurance coverage remain with that provider to ensure continuity of care. If the provider is not currently contracted with P/GLTC, all attempts are made to contract with that provider. Case Managers assist members in the selection of a PCP and specialists, selection of an assisted living center or selection of their home-based service providers utilizing a hard copy Provider Directory or the searchable website.

PCP Assignment for Special Populations

P/GLTC supports member choice in selection of the Primary Care Provider (PCP) who will direct member's overall care. Upon enrollment members may choose a contracted PCP. Selection is left entirely up to members unless they request assistance from the Case Manager who will takes into consideration medical condition and proximity to members residence as a factor in selection. Depending on members' specific medical condition or needs, some specialists may act as PCPs. For example, pediatricians become PCPs for children, obstetricians become PCPs for pregnant females and members with HIV or AIDS may select an infectious specialist as their PCP.

Reducing Unnecessary ER Visits

P/GLTC ensures access to emergency care on a 24 hour a day, 7 day a week basis through its contracted network of hospitals for those members experiencing a health emergency. Recognizing the value of facilitated rapid emergency department (ED) access, members are encouraged to use the ED for emergent care. P/GLTC defines emergent conditions as those that include, but are not limited to, medical and/or behavioral conditions that manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the member's health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

Emergency services do not require prior authorization (PA).

While the appropriate use of the ED is beneficial to our members, we believe that Primary Care Physicians (PCPs) provide the best care and coordination. Urgent Care Centers may be used for non-emergent care if the member's PCP is not available, after office hours and/or on weekends. Members are expected to use the PCP or Urgent Care for non-emergent needs.

P/GLTC supports member use of appropriate level of care through prospective and retrospective strategies. Prospective strategies focus on member education, timely treatment and resolution of non-emergent needs, and health promotion activities. These strategies include but are not limited to the following.

- Resources cited in the P/GLTC Member Handbook, including documentation of member expectations associated with appropriate ED access, providing a readily available resource for the member/representative.
- P/GLTC case managers (CMs) review the Member Handbook content on a one-to-one basis with their assigned members/representatives. The CMs respond to any questions the member/representative may have to support member/representative comprehension and understanding of the Member Handbook content related to service utilization.
- Case Managers address member needs and proactively seek support for those needs during regularly scheduled member visits. These visits minimize ED use by dealing with non-emergent health needs, to minimize potential escalation.
- Each P/GLTC member is provided with the name of his/her P/GLTC CM and contact information for the CM and/or back-up services.
- Multi-disciplinary Care Teams review and problem-solve to address actual and potential needs on an ongoing basis.
- Member newsletters include information regarding ED utilization, and remind members of the availability and appropriate use of ED services.
- P/GLTC encourages the use of preventive and disease management services, to provide core resources to the member and avoid ED utilization through disease prevention and/or clinical management.

Retrospective strategies to avoid future inappropriate ED utilization by P/GLTC members include but are not limited to:

- Routine monitoring of ED use, including evaluation and trending of ED visit volume and presenting chief complaints. This strategy has resulted in the development of disease/condition management and member safety initiatives.
- Identification of members who frequently use the ED for non-emergent conditions. Identified members are contacted by CM and/or clinical staff for education on appropriate ED use and support in seeking care at more appropriate locations.
- PCP/Care Team/Member/Representative collaboration to identify member specific alternatives for care, e.g. routinely scheduled visits for the member, additional testing and or appropriate treatments.
- Home visits by CM and clinical staff for members who continue to access the ED for non-emergent conditions. During these home visits, the CM and clinical staff conference with the member/representative to develop an individualized action plan for the member/representative to use in lieu of the ED visit.

Relationships among Providers

PCPs assume primary responsibility for the initial medical evaluation of each member and continuing care. As a result of this assessment, PCPs are

- responsible for initiating all referrals to specialty, ancillary, inpatient and outpatient services,
- approving all home-delivered medical services such as DME and home health for coordinating the continuity of care,
- communicating and collaborating with various providers who provide care to members.
  - o All attempts are made to ensure that P/GLTC networks mirror those of the member's primary insurance plans to ensure successful coordination of care. This coordination will be further enhanced in 2012 when P/GLTC becomes a Special Needs Plan, pending Medicare approval.

A member's case manager plays a key role in facilitating communication among the member's providers, always encouraging each provider to exchange assessment and treatment information with member's PCP. Special coordination efforts are also carried out by P/GLTC's Qualified Behavioral Health Professional (QBHP) or EPSDT Coordinator as described sections below. Moreover, Medical Management nurses, under the CMO's direction coordinate and facilitate PCP and specialist interaction to communicate progress notes, lab/radiology reports, consultation documents needed to manage member's health.

Case Managers work very closely with the CMO and Medical Management/Disease Management Nurses to ensure comprehensive management of member's special conditions through member's medical providers, skilled nursing facilities and providers that deliver services directly to member's homes such as home health, physical therapy/occupational therapy/speech therapy, attendant care, and DME.

Special Populations: Members with Behavioral Health Needs

The P/GLTC Network of Behavioral Health (BH) Providers was purposefully designed and created utilizing the ADHS/DBHS Covered Behavioral Health Services Guide of type of services allowed under law. They include:

- Behavioral Management (personal care, family support/home care training, and self-help/peer support),
- Psychiatric care (evaluation/assessment and monitoring),
- Counseling (individual, group, family) and case management (limited) ,
- Crisis, stabilization unit and inpatient services, detox,
- Rehabilitation (living skills training, health promotion, and supportive employment services), and
- Behavioral Health placement options (SNFs with BH units, ALFs licensed as BH Level II or III, and those specializing in the care of the Traumatic Brain Injured).

The Behavioral Health Network Summary on the following page depicts the comprehensive behavioral health providers contracted to deliver the full gamut of behavioral services to meet member needs. Medically-necessary BH services are provided to all P/GLTC members in accordance with AHCCCS policies.

Behavioral Health Network Summary

Type of Service	Payson	Globe	Casa Grande Area	Apache Junction	Southern Pinal	Phoenix Area (including East Valley)	Tucson Area
Behavioral Mgmt, includes BH PC, family support/home care training, self-help/peer support	Horizon Human Services	Horizon Human Services	Horizon Human Services, CPES, Empact	SMMHC			
Psychiatric care, includes evaluation/assessment and monitoring	Horizon Human Services	Horizon Human Services, Dr. Diamond, PhD (no meds)	Horizon Human Services, Empact, Pinal Hispanic Council	SMMH, Dr. Jarek Opechowski	SMMHC	Bayless, DMG, Dr. Jarek Opechowski	Aleph Center
Counseling, includes individual, family, group and CM	Horizon Human Services, Christine Tetzloff	Horizon Human Services	Horizon Human Services, Empact, Suzy Najera, Liz Faulkner,PhD, Helping Assoc, CPES, Corazon, Pinal Hispanic Council	SMMH, Suzy Najera, CPES, Dr. Fred VanHoose, PhD	Suzy Najera, Karen Lombardi	Bayless, CPES, Dr. Fred VanHoose, PhD	CPES
Crisis	Nursewise	Nursewise	Nursewise	Nursewise	Nursewise	Empact	SAMHC
Stabilization unit and inpatient services				SMMHC (non-Medicare)		Haven Senior Horizons, St. Lukes, Aurora	Kino, Sonora
Detox unit	Community Bridges	Community Bridges				Community Bridges, Aurora	
Rehabilitation, includes living skills training, health promotion and supportive employment services	Horizon Human Services	Horizon Human Services	Empact, Horizon Human Services, Suzy Najera	CPES		CPES	
BH placements	Rim Country (SNF)		AZ Mentor (Level II ALF)	AZ Mentor (Level II ALF), Supreme Care Home (TBI ALF), House of Change, (Level III ALF)		AZ Mentor (Level II ALF), Freedom Manor (TBI), Assisted Living by Sholt (TBI), Comfort Haven (BH/TBI ALF), EMCC (SNF), Maravilla (SNF), Desert Haven (SNF), Scottsdale Village Square (SNF), Maryland Gardens (ALF/SNF), Desert Sky (SNF), Ridgecrest (SNF)	Santa Rosa (SNF), Devon Gables (SNF)

Providers utilized on a "single case agreement" contractual basis due to the low volumes.

Pinal/Gila Long Term Care

The BH network reflects the distribution of members throughout the rural areas of Pinal and Gila Counties, and members who live adjacent to Maricopa and Pima Counties. Since a large part of P/GLTC's service area is rural in nature and generally underserved, P/GLTC has used the successful strategy of utilizing providers who are willing to travel to these areas, use modern technology such as telemedicine, and locally accessible, though fewer in numbers.

P/GLTC focuses attention on services that meet the needs of the majority of members, i.e. psychiatric care and counseling. As there is not a significant number of members in need of other behavioral services such as detoxification services or stabilization/inpatient services, the department utilizes a "single case agreement" contracting methodology which allows greater speed and flexibility to secure an appropriate facility/treatment center in a timely manner.

P/GLTC strives to keep members at home or in their community by providing a variety of services, including BH services. All new members are informed about the type of services available and how to access them at intake with the case manager. The Member Handbook which gives them the same information about the BH services. Members have several BH services options including:

- Care startup and coordination by their assigned case manager,
- Care startup through member's PCP, or
- Direct access to a list of BH providers through the provider directory or P/GLTC's website.

New members, who enroll with P/GLTC and are receiving BH services through a Regional Behavioral Health Authority (RBHA), are transitioned via a process by which the Behavioral Health Coordinator coordinates with the RBHA representative, the current BH provider and the P/GLTC Case Manager. For example, if the current BH provider is not contracted with P/GLTC, the CM works with the member to identify a contracted provider. This process ensures member access to comprehensive behavioral services to ensure continuity of care as the member transitions from one behavioral health system to another. The smooth transition is ensured through the oversight of the QBHP who coaches or assists Case Managers in this complex process.

The Case Manager sends a referral information sheet to the BH provider on every member for whom BH services are being initiated. The referral includes information about the member's medical conditions, functional abilities and contact information for the PCP and the case manager. A letter containing information about the service and the behavioral health provider's contact information is sent to the member's PCP along with a copy of the quarterly staffing form so the PCP is apprised of the member's treatment goals, and progress. To ensure members are receiving quality care, an annual survey is administered to members who receive BH services to obtain feedback to be used to improve availability, access and quality of care received.

P/GLTC's BH network and services are administered by the QBHP who works closely with the NMD Section to:

- assist in identification of provider gaps,
- identification of providers available to meet those gaps ,
- measuring members' satisfaction with their provider and treatment plan, and,
- ensuring closely-coordinated care for members in collaboration with Medical Management staff and Case Managers.

The QBHP is a critical asset to the NDM Section in the assessment of BH gaps and in the articulation of the Department's CYE 2011 goal of increasing its network of psychiatrists available to see members and prescribe psychiatric medications. (See Network Needs Section)

Special Populations: EPSDT Children and Young Adults

The Early Periodic Screening and Diagnostic Treatment (EPSDT) Program is focused on promoting optimal health outcomes for all members under 21 years old. This includes covering comprehensive healthcare services such as Well Child visits, dental and vision appointments as well as the amelioration of defects, illnesses, and conditions identified through EPSDT screening. There are currently 37 P/GLTC members in the EPSDT program who are disabled. Of these, 89% reside in Pinal County with the remaining 11% living in Gila County.

Because the population of EPSDT children is small and manageable, P/GLTC provides close program monitoring and a high level of personalized care to the special population of disabled children. Compliance with EPSDT-required periodic visits is assured through the EPSDT Coordinator's outreach and education activities conducted with members to remind them of upcoming EPSDT visits and the Coordinator's close coordination with the member's case manager. Together, they ensure that the children and their parents access their PCP to receive age-appropriate EPSDT services. A member may choose a pediatrician as a PCP. This close coordination and aggressive outreach has resulted in the attainment of 71% EPSDT participation rate.

The EPSDT Coordinator works closely with the Representatives to ensure that all EPSDT providers are meeting the requirements of the EPSDT program. In addition to adherence to periodicity schedules and utilization/completion of appropriate well child visit forms, the EPSDT Coordinator regularly reviews member newsletters, member educational materials, Provider Manual, provider audit monitoring tools and other provider materials for accuracy of information. If the need arises, the EPSDT Coordinator also works with the NDM Section to notify PCPs when an NICU-discharged member is assigned to their panel. It should be noted that such has not occurred with a P/GTLC member to date.

Another important aspect of P/GLTC's program for children is its service coordination with state funded programs such as the Children's Rehabilitative Services (CRS) and Arizona Early Intervention Program (AzEIP) to ensure that eligible EPSDT members receive comprehensive and appropriate care through those agencies. Coordination with community-based programs and services that serve children is also achieved through collaboration with P/GLTC Community Relations and Outreach Coordinator who continuously identifies economic, social and recreational resources. She compiles a resource directory that families rely on to locate additional support services for children in their local community. A resource library is also maintained that includes additional local and state resources that case managers access in order to ensure the most comprehensive set of services available to this special population.

The Community Relations and Outreach Coordinator also develops and disseminates informational materials to alert and promote a calendar of community events and activities that may be beneficial to the children and their families including diabetic fairs, nutrition programs.

Coordination with Outside Organizations

P/GLTC, is a county-operated program and is enmeshed in the community. The Community Relations and Outreach Coordinator is a standing member of many organizations. This position is viewed as a resource and expert on senior issues in general, and long term care services in particular.

As a result of community-building efforts, P/GLTC has consistent representation at the following community organization meetings where issues and concerns pertaining to the elderly and disabled are addressed:

- Pinal-Gila Council for Senior Citizens (PGCSC) Area Agency on Aging - P/GLTC has a close collaborative relationship with this agency that has served both Pinal and Gila Counties in the during the last 15 years. P/GLTC contracts with this entity to prepare and deliver home-delivered meals to members. Outside of this contractual relationship, both agencies have worked together to meet the social needs of P/GLTC members. One specific example is the Santa Cruz Village Apartments, located in Eloy and owned by PGCSC. A number of P/GLTC members reside in this apartment community. It is estimated that at least 50 percent of the residents in this community are Latino. Every year during the holidays, a variety of events are scheduled for the residents. There is Thanksgiving dinner, Christmas gift giveaway, and a special New Year's Eve meal. P/GLTC staff help facilitate these events. Often times the residents are hesitant to participate in these events, but the P/GLTC case managers encourage participation, thus fostering a greater sense of community in this complex. The working rapport between these two organizations, developed over a period of over 15 years, continues to benefit the community at large.
- Casa Grande Mayor's Task Force on Disabilities – a panel of advocates, service providers, and consumers appointed by the Mayor who advise the city and county on issues that affect people with disabilities in the region. Committee members include city employees, disabled citizens, and health care service providers. Issues that specifically relate to the disabled are addressed with resolution sought within the group. There are two main events hosted by committee members that bring about community awareness and involvement for those with disabilities. P/GLTC has been successful in recruiting new committee members and assisting in the coordination and production of the events.
- Pinal County Social Service Network Group – a networking group where service providers meet to discuss programs, learn about new initiatives, and share information that relates to the underserved within Pinal County. P/GLTC has arranged for speakers such as the director of the new skilled nursing facility, Oasis Pavilion in Casa Grande.
- Southern Gila Networking Group – this is the only health care networking group in the Globe/Miami area. It is comprised of housing, education, and health care providers who collaborate with faith-based organizations to discuss and work to meet the needs of the community. P/GLTC has supported the annual event by providing an informational table, as well as providing information about program updates and changes at the meetings. This group has provided feedback and guidance on local resources.
- Pinal County Triads – consists of local citizens, volunteers, and service providers for the purpose of providing telephone reassurance calls to homebound seniors, home alone units, 9-1-1 cell phones, and referrals. P/GLTC regularly attends monthly meetings at five separate Triad groups, and assists in the coordination and set up of a senior expo, as well as working to create a new group in the Casa Grande area.
- Pinal County Domestic Violence Coalition – a countywide organization made up of law enforcement, legal advocates, service providers and volunteers that works to increase public awareness about the issue of domestic violence, enhance the safety and services of domestic violence victims, and reduce incidence of domestic violence in Pinal County families. The members of this grassroots group are key individuals within the community who represent a wide variety of organizations. P/GLTC is the only health care related agency member as other health care agencies have been difficult to recruit. In addition to regular attendance and participation at monthly meetings, P/GLTC has played an active role in arranging speakers at the annual conference. This group provides opportunities to develop and maintain relationships with high-profile, key members of the community.

- Sizzling Seniors – a monthly morning meeting made up of seniors and service providers from San Tan Valley. The purpose is to provide local citizens with information about resources and to provide opportunities for socialization.
- Elder Abuse Task Force – this group represents Pinal and Gila Counties and is a collaborative of law enforcement, legal advocates, and public health to increase public awareness of abuse specific to seniors. There is specific case analysis and guidance provided at the quarterly meetings with the main focus on the annual conference. This group provides opportunities to develop relationships with high-profile, key members of the community.
- Pinal County Diabetes Coalition – a committee of Pinal County diabetes educators and others committed to public education about and of prevention of diabetes. P/GLTC has participated in coordination of the annual health fair. This group provides the most up-to-date diabetes education and information to case managers.
- Payson Inter-Agency/Continuum of Care Group – this is the only health care networking group in the Payson area. It is comprised of housing, education, and health care providers who collaborate with faith-based organizations to discuss and work to meet the needs of the community. This group has provided feedback and advice on local resources.
- Pinal Hispanic Council – a monthly meeting of service providers and businesses that assists in meeting the mission of creating a full and integrated continuum of behavioral health care. This allows for placing individuals in the most appropriate level of treatment for their needs, and allowing them to step down to other services depending on their specific needs.
- Eastern Arizona Health Education Center – P/GLTC collaborated with the Center to plan and deliver a Caregivers Conference for caregivers in Pinal and Gila Counties in December 2010 in Gila County. Planning is underway for future annual conferences.

Through the active involvement of the Community Relations and Outreach Coordinator with these and other community organizations, P/GLTC staff is often invited to speaker or exhibitor at community health fairs, public awareness-raising events and community organization meetings in Pinal and Gila counties where information on aging issues and aging resources are disseminated.

Coordination with other Pinal County Government Programs/Departments
The following Pinal County Programs support and enhance services to the elderly and disabled in Pinal County:

SMILE Program - funded by the Older Americans Act through the Pinal-Gila Council for Senior Citizens Area Agency on Aging Region V and Pinal Gil along Term Care. This program provides in-home case management services and in-home services such as, home delivered meals, personal care, group respite, in-home respite and housekeeping services to low-income elderly and disabled populations who are not yet eligible for ALTCS. A very close coordination with this program ensures the smooth transition of SMILE members into the P/GLTC plan upon qualification for ALTCS.

Family Caregiver Support Program - works with the caregivers of elderly and physically disabled adults, including family caregivers to ALTCS members. Staff provides information and advocacy on additional long-term care resources in the community. Services are similarly funded through The Older Americans Act, Pinal-Gila Council for Senior Citizens Area Agency on Aging Region V and Pinal/Gila Long Term Care.

Other departments within Pinal County government cooperate to the benefit of P/GLTC members are described below:

- Pinal County Public Health Department – In 2009 the Health Department was charged with performing a mass H1N1 immunization along with the seasonal flu vaccine. Three clinics were set up throughout Pinal County that required additional staff. A number of P/GLTC staff

volunteered to work a Saturday for these events that were open to the public. P/GLTC members have also taken advantage of these free clinics which helped P/GLTC achieve one of the highest influenza vaccination rates among ALTCS contractors in the state of Arizona.

- Pinal County Sheriff's Office – In 2009 the Sheriff's Office served an eviction notice on a senior who had limited mobility and was unable to facilitate a move. Sheriff's office staff contacted P/GLTC staff find resources to assist the elderly woman in transitioning to a satisfactory residential placement. This avoided temporary homelessness which would have occurred had Case Managers not been informed by the Sheriff's Office.

- Pinal County Public Fiduciary (PCPF) – PCPF acts as guardian/conservator while P/GLTC provides case management and appropriate services. P/GLTC works closely with the PCPF office during review and annual reassessments to ensure member information is communicated between the two agencies. In one example, P/GLTC staff identified several care concerns with a particular BH Level II group home. The case manager notified the PCPF guardian and the departments worked together to assess the members current status, his needs (both short and long term), and the options available under the ALTCS program. The guardian participated in the transitioning process by attending meetings with the P/GLTC case manager and by visiting two BH Level II group homes with the P/GLTC case manager in order to make an informed decision for placement.

- Pinal County Animal Care and Control - P/GLTC and Animal Control collaborated in 2010 to assist a dog-owner/member who was taken to the hospital unexpectedly. Animal Control staff and P/GLTC's case manager collaborated to care for the dog. He was given food, water and shelter until the member was released from the hospital two weeks later. The member had no family or friends to assist with taking care of the dog. Without this collaboration, the dog could have died.

- Pinal County Housing Authority - P/GLTC and the Housing Authority collaborate to ensure P/GLTC members are given priority for housing when a member needs assistance. The Director of Housing also works with P/GLTC case managers to ensure assistance with physical moves if needed.

Coordination with Internal Departments
Formal coordination occurs at several levels within P/GLTC. Overall coordination formally occurs first and foremost at the Senior Management Team level where the Assistant County Manager, CEO, CFO, CMO, Director of Quality Management/Utilization Management, Director of Case Management, and Director of Network Management/Development exercise their responsibility to set the overall priorities and direction of the organization through priority and goal-setting and collaborative problem-solving on both organizational as well as operational issues.

The second level of coordination occurs at various committees where focused issues and concerns are addressed and results of interventions are reported. These formal committees involve managers and directors from several departments and attended by the P/GLTC CEO. These committees include:

- Corporate Compliance Committee
- Quality Management Committee
- Provider Watch Committee
- Peer Review Committee
- Credentialing Committee
- Organizational Credentialing Committee
- UM/Medical Mgmt. Committee
- Pharmacy Utilization Committee

- Pharmacy and Therapeutics Committee
- Network Planning Committee
- Diversity Committee

In addition, network issues are coordinated at the Inter-disciplinary Care Team held regularly and facilitated by Case Management. The team consists of Case Managers, Case Management Supervisors, and representatives from Medical Management and Provider Services. Each Representative attends an assigned Care Team meeting where member-staffing issues, provider issues and perceived network gaps are discussed. A general Case Management meeting, with all Case Managers present, is also held periodically to discuss program and policy changes. At these meetings, a Representative gives updates on new additions/terminations to the provider network, newly created policies and procedures, and Network process changes. Likewise, case managers will identify providers who require further education in order to accommodate members' special access needs or sometimes identify a need for additional providers. Furthermore, semi-annual "Ideas Together" meetings are held allowing entire staff to contribute innovative ideas designed to improve or enhance any program or activity within the organization.

The third level of coordination occurs at Joint Operations Meetings (JOCs) which are issue-focused problem-solving meetings that are held with a selected provider and participated in by representatives of many departments. An example of this is the Transportation Joint Operations Committee meeting where the transportation provider, Network Development and Management section, Case Management, and Quality Management come together to discuss, analyze and resolve individual and system barriers that keep members from arriving at their scheduled medical appointments in a timely manner. As a result of this coordination, MTBA, the transportation vendor reported a performance improvement in the August 2010 report, which shows 97% of P/GLTC members who utilized service have arrived at their destination on time.

Graph I

P/GLTC Timelines August 2010

Late 3%

On Time 97%
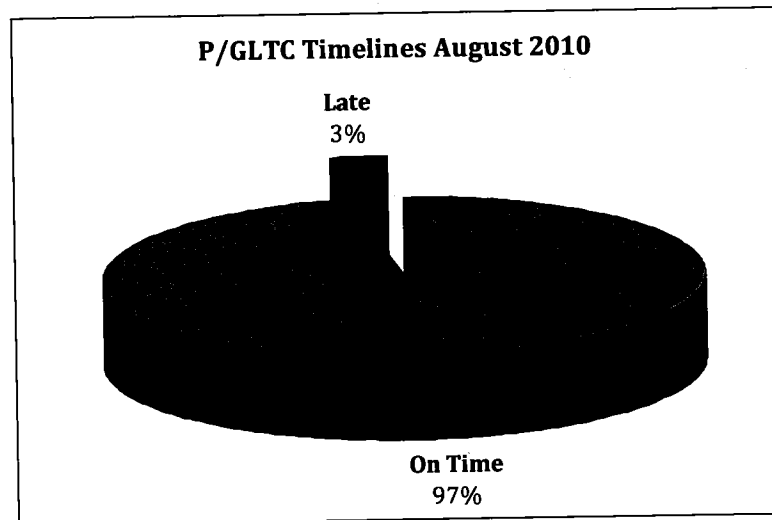
Another example of the Department's effective use of JOC is the Attendant Care Joint Operations Committee meeting where providers were recently trained on the accurate and timely reporting of non-provision of service (NPS) and on the importance of responding to after-hours member calls within 15 minutes.

The fourth level of coordination which occurs rarely in large organizations but is commonplace within P/GLTC, is the natural coordination, troubleshooting and problem-solving that occurs among case managers, NDM, information systems, claims and prior authorization, QM or UM on

day-to-day member issues and operational concerns on a drop-in basis and/or in small informal, unscheduled meetings. Such meetings occur across all departments as well as across position levels. There is a philosophy and atmosphere within P/GLTC that encourages and welcomes natural communication and coordination outside the milieu of formal meetings. More complex issues that could not be easily resolved at these levels are escalated to the highest level of coordination. All-staff meetings also become forums for additional communication and training on matters of importance to the organization.

Disaster Response Plans
As part of Pinal County Government, P/GLTC is required to complete a Continuity of Operations Plan (COOP), which adheres to Federal Emergency Management Agency standards. The purpose of our 58-page COOP is to establish operational guidelines in the event of a disaster or emergency so that there is never an interruption of service delivery. A possible planning scenario is one that would affect our main facility. In this case our plan identifies alternate facilities for designated staff relocation, supplies, and technology. These efforts have been established to ensure seamless continuation of services for our members as well as the public at large. Another portion of our plan outlines how we respond when the emergency occurs in an area where our members reside. The response plan varies according to the emergency as fires are more prevalent in the mountain areas where we are not allowed to send in staff to check on members, versus flooding in the lower geographic regions where we can send in staff to check on individual members. Many members of our staff have completed advanced training in the National Incident Management System so that they are equipped to lead our staff in an appropriate response to an emergency. P/GLTC also receives ongoing assistance from Pinal County's Emergency Management Department in revising our plan as needed.

P/GLTC also maintains a Business Continuity Plan as required by the AHCCCS ACOM. This plan complements the COOP plan and provides steps to follow in the event of a computer, communication and/or electrical system emergency or in the loss of a major provider either through quality issues or acts of God.

Pinal/Gila Member Councils
To meet the AHCCCS requirement to create, develop and maintain a Member Council that's purpose is to provide input on P/GLTC policy, programs and network adequacy, two councils were formed to serve each of the counties of Pinal and Gila.

Each council is unique and comprised of members who reside in the particular county and providers who serve them. Both members and providers are handpicked for their willingness to identify and express member concerns and brainstorm potential program and system solutions. Communication and feedback result in program and policy enhancements that improve member quality of care and satisfaction.

Past Accomplishments
Successful completion of all training topics as assigned. Presentation topics include:

- Emergency Management Plan
- Fraud & Abuse/Compliance/False Claims Act
- Flu and Pneumonia Prevention and Vaccinations
- Osteoporosis
- Elder Abuse
- Medicare Changes and Updates
- Cultural Competency
- Behavioral Health
- Advance Directives

- Clinical Indicators
- Significant increase in attendance by members and providers at both councils

Identified Barriers

- Inconsistent attendance by providers
- Inconsistent attendance by members due to illness and travel distances
- Lack of understanding of role within the Council

Council Goals

The councils have been redesigned in order to achieve the following new goals for CYE 2011:

- Redefine the purpose of the Council, in clear and simple terms, so that roles and expectations are easily understood by all Council members.
- Create two Member/Provider Councils in each county where members / families/significant others, caregivers, represent at least 50% of Council membership.
- Cement commitment by obtaining a signed letter of commitment from each member.
- Identify system issues and opportunities for improvement to be addressed by the Council.
- Establish timeframes for addressing these issues and opportunities.
- Ensure issues surfaced by this Council are presented to Pinal/Gila Long Term Care Executive Management Team for input and implementation.
- Restructure format so that the Council meetings are more interactive and effective in facilitating above objectives.
- Assist in meeting members' and caregivers' cultural and linguistic needs through education and feedback.

Interventions Currently Implemented

- Formalize Council composition and elicit more consistent attendance by a committed group by sending a formal invitation accompanied by a commitment agreement to be signed.
- Consolidate meetings into fewer sites within each to allow more time for membership pre-meeting reminder and arrangement of transportation and companions for members.
- Invite more members to participate knowing that member's frailty and medical conditions will naturally result in unplanned absences among even the most committed members.
- Hold meetings at central locations within each county to help reduce member absences due to vast distances traveled.
- Reeducate all members to the role and responsibilities of the Council as an advisory entity, which provides important feedback on service issues (such as transportation) programs, policies and initiatives such as flu campaigns.
- Initiate more follow-up reminders and e-mails to all Council members as well as providers after meeting invitations are mailed one week in advance of the meeting date.

Evaluation of Prior Year's

Network Management Plan

In County FY 2010, Pinal County Government established 'health care' as one of its Strategic Priorities. In response to this county-wide direction, P/GLTC established four (4) corresponding network development goals to be achieved within three (3) years beginning July 2010.

Four network development goals established by P/GLTC support Pinal County Government's Strategic Priorities surrounding its "Building Healthy Communities" model. These county strategic priorities include:

Strategic Priority 1: By 2012, there will be an increase in the number of physicians from 75 per 100,000 to 82 per 100,000; an increase of 10%. *(Linked to P/GLTC Goal 4)*

Strategic Priority 2: By 2012, there will be an increase in the number of licensed *health care facilities. (Linked to Goal 1 and Goal 2)*

Status Report on Three-Year Network Development Goals
Goal 1: To increase the number of contracted inpatient hospitals serving P/GLTC members, from one (1) hospital to two (2) hospitals by 2012.

Goal 1 Status: This goal has been exceeded with the opening of Florence Community Hospital, Mountain Vista Medical Center, Arizona Regional Medical Center and Banner Ironwood Hospital in San Tan. Two of these hospitals are now contracted with the third going through the contracting process. The opening of Florence Hospital of Anthem, however has been delayer due to the sudden turn of the economy beginning in 2009 and continuing through 2010.

The Status Report on Planned Hospital Opening Dates Table compares the initial expected hospital opening dates against actual or forecasted opening dates and summarized the contracting status on each of these five hospitals that were previously targeted for contracting.

Status Report on Planned Hospital Opening Dates

Planned Hospital	Location (City/County)	Planned Opening Date	Actual/Projected Opening Date
Florence Community Hospital	Florence – Pinal County	Spring 2010	Opened July 23, 2010 Contracted with P/GLTC effective February 1, 2011
Banner Ironwood	San Tan Valley – Pinal County	Spring 2010	Opened November 1, 2010 Banner deferring contracting until 2012
Florence Hospital of Anthem	Gilbert – Maricopa County (Borders Pinal County)	Fall 2010	Projected Spring 2011 Initiated contracting process in March 2011 with anticipated effective date of May 2011.
Arizona Regional Medical Center- Apache Junction	Apache Junction – Maricopa County (Borders Pinal County)	January 2010	Opened February 2010 Undergoing P/GLTC contracting with anticipated effective date of April 1, 2011
Mountain Vista Medical Center	Chandler – Maricopa County (Borders Pinal County)	July, 2010	Opened July 2010 P/GLTC Contracted as part of the IASIS Integrated Health Care System effective January 2011.

Goal 2: To increase the number of SNFs located in Pinal County serving P/GLTC members, from one (1) SNF to two (2) SNFs by 2012.

Goal 2 Status: The goal of increasing the number of SNFs within Pinal County has been met through the building of Oasis Pavilion in Casa Grande. This Medicare-certified SNF currently serves P/GLTC members as a contracted provider effective December 1, 2010.

Goal 3: To increase the number of outpatient clinics serving P/GLTC members, from 45 outpatient clinics to 46 outpatient clinics by 2012.

Goal 3 Status: This goal has been exceeded with 58 clinics operating to serve Pinal and Gila counties as of February 1, 2011.

Goal 4: To increase by 10% the number of PCPs serving P/GLTC members by 2012.

Goal 4 Status: This goal has been exceeded with two more years remaining. In 2009 there were 25 P/GLTC physicians in Pinal County functioning as PCPs. As of March 1, 2011, there are 123 PCPs in Pinal County. In 2009 there were 19 P/GLTC PCPs in Gila County. As of March 1, 2011, there are 40 PCPs in Gila County.

Evaluation of Prior Year's Network Gaps and Interventions

In the 2009-2010 Network Development and Management Plan, the following provider networks were identified as network gaps. It is important to note that these gaps represent a perennial provider need that has long been associated with underserved populations.

Specifically, the Arizona Department of Health Services Office of Health Systems Development has designated all of Gila County as a federal medically underserved area. Likewise, the northern part of Pinal County including the towns/cities of Apache Junction, Queen Creek, San Tan, Superior and the Gila River Indian Community as well as the central portion of Pinal County that includes Casa Grande, Maricopa, Stanfield, Florence, Coolidge, Eloy, Arizona City and Picacho are also designated as federal medically underserved areas.

Identified needs in CYE 2010 included institutions/facilities and individual practitioners:

- In-patient Hospitals
- Psychiatric inpatient Hospitals
- Skilled Nursing Facilities
- PCPs

In addition, identified needs also existed in Home and Community-Based services including:

- Assisted Living Facilities
- Home Health Nursing
- Adult Day Health Centers

Gap Methodology and Gap Interventions

P/GLTC identifies network gaps or needs through a comprehensive gap (needs) assessment and analysis utilizing multiple methods. This process starts with a routine review and comparison of P/GLTC provider availability and access reports against AHCCCS network requirements:

Network Monitoring and Analysis:
- Network Availability reports by provider type
- Geo-mapping by provider type by location
- Member Grievance Reports related to provider adequacy and accessibility

- Member Appointment Waiting Time reports
- Network Utilization reports
- CLAS standard reports
- Case Management, Member Services and Prior Auth/Medical Management staff feedback
- Bi-annual Network Planning Committee representing all functional areas of P/GLTC

Network Data Mining and Analysis:
- Comparison of networks available through licensing agencies such as Medical/Nursing Boards, AHCCCS provider files, third party health plan networks (TPL), and ADHS.
- Analysis of non-contracted providers who have rendered services to members

Once gaps are identified, interventions are put in place to identify providers for recruitment and contracting opportunities following P/GLTC's formal contracting process.

Due to the Pinal County Procurement Code and credentialing requirements, the entire contracting cycle could take as long as 90-150 days. In recognition of this unique barrier, P/GLTC expedites contracting for providers to fill a critical and urgent gap. This is done by employing the provisional credentialing process for both individual practitioners and organizations. In addition, a new expedited contracting method - "Single Case Agreement" – allows non-contracted medical or HCBS providers to serve an individual member for a period of up to 30 days upon meeting established criteria and upon agreement on a negotiated amount.

In addition, beginning October 2010, P/GLTC received approval from the Board of Supervisors to execute five-year contracts with an option to amend contract by either party as needed.

The table below summarizes last year's identified gaps (needs) and the results of interventions applied in 2010. It is important to note that these services listed below are not "true gaps". P/GLTC met all minimum network requirements last year as it does this year.

Prior Year's Network Gaps (Needs) and Intervention Status

County	Provider Type or Service	Need Description	Shortage or lack	Rural Locations
Pinal	Skilled Nursing Facilities	Nursing facility increased by one (1) in Pinal County. Two were in development: (1) Florence and (1) Casa Grande with both expected to open in 2010 but only Casa Grande Oasis came to fruition. **Intervention Status:** Need filled with Casa Grande Facility (Oasis) contracted with P/GLTC effective December 1, 2010.	X	
Pinal Gila	ALFs	Due to the AZ economy, many ALFs have difficulty maintaining their business with a mix of ALTCS and private pay clients. Nevertheless, Pinal County has gained (12) additional ALFs since 2009, while Gila County added (1) ALF in Globe since 2009 for a total of 3 in Gila county: (1) in Payson, (2) in Globe. **Intervention Status:** Need filled with increased ALFs (total of 21) in Pinal County and Gila County (total of 3). An over reliance on Maricopa County-based ALFs has created a member distribution challenge. See ALF and AFC Action Plans created to proactively address this.		X
Pinal Gila	PCP	The PCP network in both counties has remained constant from previous years. However, in 2010 Right Way physician practice opened adding 3 PCPs in Casa Grande and (1) PCP in Kearny. In addition, Mountain Mental Health Center in Apache Junction has submitted its application to become an FQHC with P/GLTC support. Gila County has not experienced any PCP increase. **Intervention Status:** Need Partially Filled with the addition of [4] PCPs in Pinal County.	X	X
Pinal	Hospitals	Five hospitals were targeted for 2010. All have opened in 2010 except for Florence Hospital of Anthem in Gilbert. See Table D for summary on hospital openings. **Intervention Status:** Need Filled with opening of Florence Community Hospital, Banner SanTan, Mountain Vista Center and Arizona Regional Medical center. Three of these hospitals are contracted or in process	X	

Pinal/Gila Long Term Care

				X
Gila		towards contracting.		
	Home Health Nursing	P/GLTC's provider network reflected a gap in Medicare-certified home health in the Globe/Payson area. Horizon Home Care now covers Globe area. However, Payson continues to have no coverage except from a home health agency that is not Medicare-certified. Intervention Status: Need Partially Filled in Gila County	X	X
Pinal Gila	Psychiatric Hospitals	Only 14 in-patient beds exist within Pinal County, however, multiple contracts are held for these services with facilities in Pima, Maricopa and Coconino counties. **Intervention Status:** Need Partially Filled in Pinal and Gila Counties due to the lack of an economic incentive to build an additional psych hospital in rural areas. However, member needs are met through use of telemedicine and facilities in Maricopa, Pima and Coconino counties.	X	X
Pinal Gila	Adult Day Health	Discussions have continued with Payson Care Center and Lutheran Social Services to encourage development of Adult Day Health Centers within P/GLTC's service area. **Intervention Status:** Need Partially Filled for Gila & Pinal Counties. ADHC services are currently provided through a facility located in Mesa. Lutheran Social Services has recently partnered with P/GLTC, AAA and a local church to begin planning for an ADCHC in Arizona City.	X	X

Current Network Gap Needs Assessment

Network Design and Network Gap

The network design for the 20-year old P/GLTC program is largely based on the availability of medical and long term care providers to contract with in its service areas that encompass Pinal County and Gila County, collectively referred to as GSA 40. Overall, minimum network requirements are met as illustrated by the geomaps at the end of this section that show where key providers are geographically located.

HCBS Community

A review of the AHCCCS/ALTCS minimum network standards in GSA 40 shows that P/GLTC exceeds minimum network standards for community-based services. As of October 15, 2010, P/GLTC contracts with 56 Assisted Living Facilities versus AHCCCS-required minimum standard of 17 ALFs in Pinal County and 2 ALFs in Gila County. Of the total number of 56 contracted ALFs, 21 are located in Pinal County while 3 are in Gila County. The remaining 32 ALFs are located in communities that border Maricopa or Pima County. Thirteen (13) ALFs were added in the past year.

HCBS Home

Likewise, the minimum network standards for Home-Based Services in both Gila County and Pinal County are also exceeded for Attendant Care, Personal Care, Respite and Homemaker Services. The services are available 7 days a week and for extended hours as determined by Case Managers. In fact, an RFP was issued in August 2010 in an effort to consolidate the myriad of contracted Attendant Care Providers (ACP) from ten (10) to five (5). These five agencies are now required to serve both counties. P/GLTC's "preferred provider", county-operated Horizon Home Care, will receive the majority of new enrollment referrals. The minimum requirements are also met for all other home-based services such as environmental home modifications, emergency alert, home-delivered meals, and habilitation.

Institutionalized

AHCCCS-required minimum standards for nursing facilities are met in Gila County which requires two SNFs in Globe and 2 SNFs in Payson. In Pinal County, the minimum standard is to contract with one skilled nursing facility (SNF) in Casa Grande, one SNF in Apache Junction, 5 SNFs in the East Valley, and 3 SNFs in Tucson. P/GLTC exceeds minimum requirements for the East Valley and Apache Junction with 2 SNF contracts in Apache Junction, 6 SNF contracts in East Valley and 6 contracted facilities in Tucson. The AHCCCS requirement has been met in Casa Grande with the current contract with Oasis Pavilion.

Hospitals

The minimum standard for inpatient care in GSA 40 according to AHCCCS is one contracted hospital in Casa Grande, Globe, and Payson respectively. This standard has been exceeded with 10 contracted hospitals serving P/GLTC members, two in Gila County and one in Pinal County. There is now a ratio of one hospital per 150 members. The planned addition of at least two more hospitals in CYE 2011 will provide members with a greater accessibility. Hospitals include:

- Casa Grande Regional Medical Hospital
- Cobre Valley Community Hospital
- Mountain Vista Medical Center - Iasis
- St. Luke's Medical Center - Iasis
- Tempe St. Luke's Hospital - Iasis
- Northwest Medical Center
- University Medical Center
- Payson Regional Medical Center
- Florence Community Healthcare
- Oro Valley Hospital

PCPs/Specialists
The AHCCCS requirement for Primary Care Physicians (PCP) in Pinal County is the presence of contracted PCPs in Apache Junction, Casa Grande, Coolidge, Eloy, Florence, Kearny and the Mammoth/Oracle area. In Gila County, PCP availability is required countywide. Both of these standards in GSA 40 are exceeded. As of November 1, 2010 there are approximately 409 PCPs serving 1500 members resulting in a PCP: member ratio of about 1: 4.

Currently, there are 123 PCPs located in Pinal County and 40 are in Gila County. Four delegated entities furnish more than 85% of PCPs. There is also an abundance of specialists totaling 2,694. Of these, 136 specialists are located in Pinal County and 61 are located in Gila County.

Behavioral Health
P/GLTC has built a comprehensive network of inpatient and outpatient behavioral health providers. P/GLTC currently contracts with six (6) psychiatrists. Although providers are readily available, psychiatrists are not readily accessible due to vast travel distances that pose a barrier to care for members requiring monthly medication monitoring visits. See the summary table below of network needs and CYE 2011 plans to meet these identified needs including a special need for psychiatrists.

Other Acute Services
The minimum standards required for all other acute services such as Urgent Care Centers, Specialists, Durable Medical Equipment, Dentists, Laboratory, Therapies and Transportation have been met. However, P/GLTC plans to expand access to a Physical Therapist and an Occupational Therapist in the Globe/Miami area (Gila County). This effort supports 2010-2011 HCBS objectives to increase the percentage of members in an HCBS setting by 10% in Gila County. *See HCBS Strategy and Action Plan.*

Conclusion
In summary, there is no network gap per se in GSA 40 for medical, long term care or home and community-based services due to a robust network and a responsive transportation provider that received high member satisfaction ratings in a recent member survey.
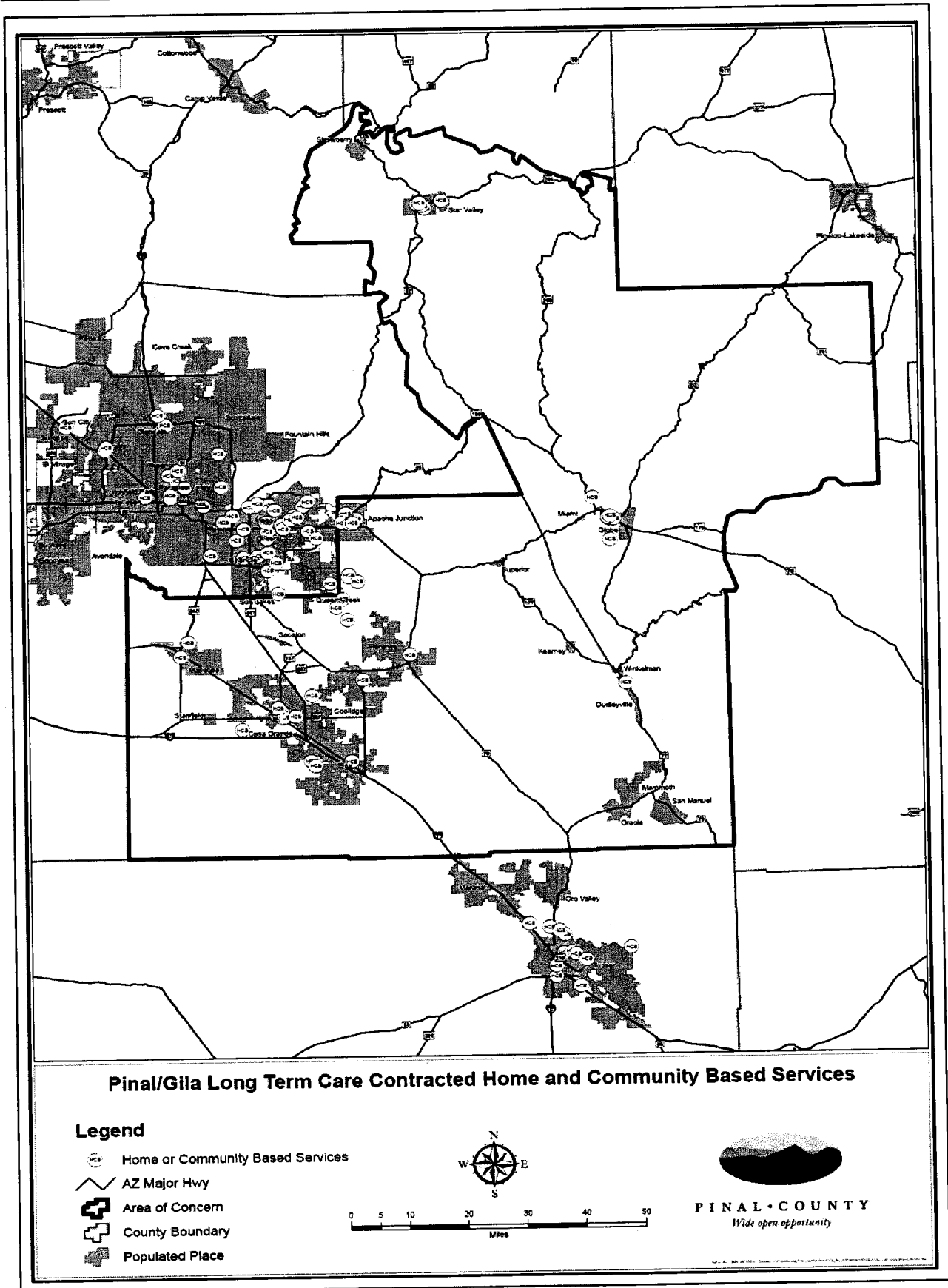
Although the network is available and adequate, the vast distances required to travel to sites of service represent a member barrier. The operational challenge from a network management and program operations perspective is the biggest challenge faced by P/GLTC with regards to network deployment. Partnering with health care systems, rural health networks, and the University of Arizona Medical School to develop a long term plan to incentivize medical graduates to establish or join practices in underserved, rural areas of Pinal and Gila County is being explored
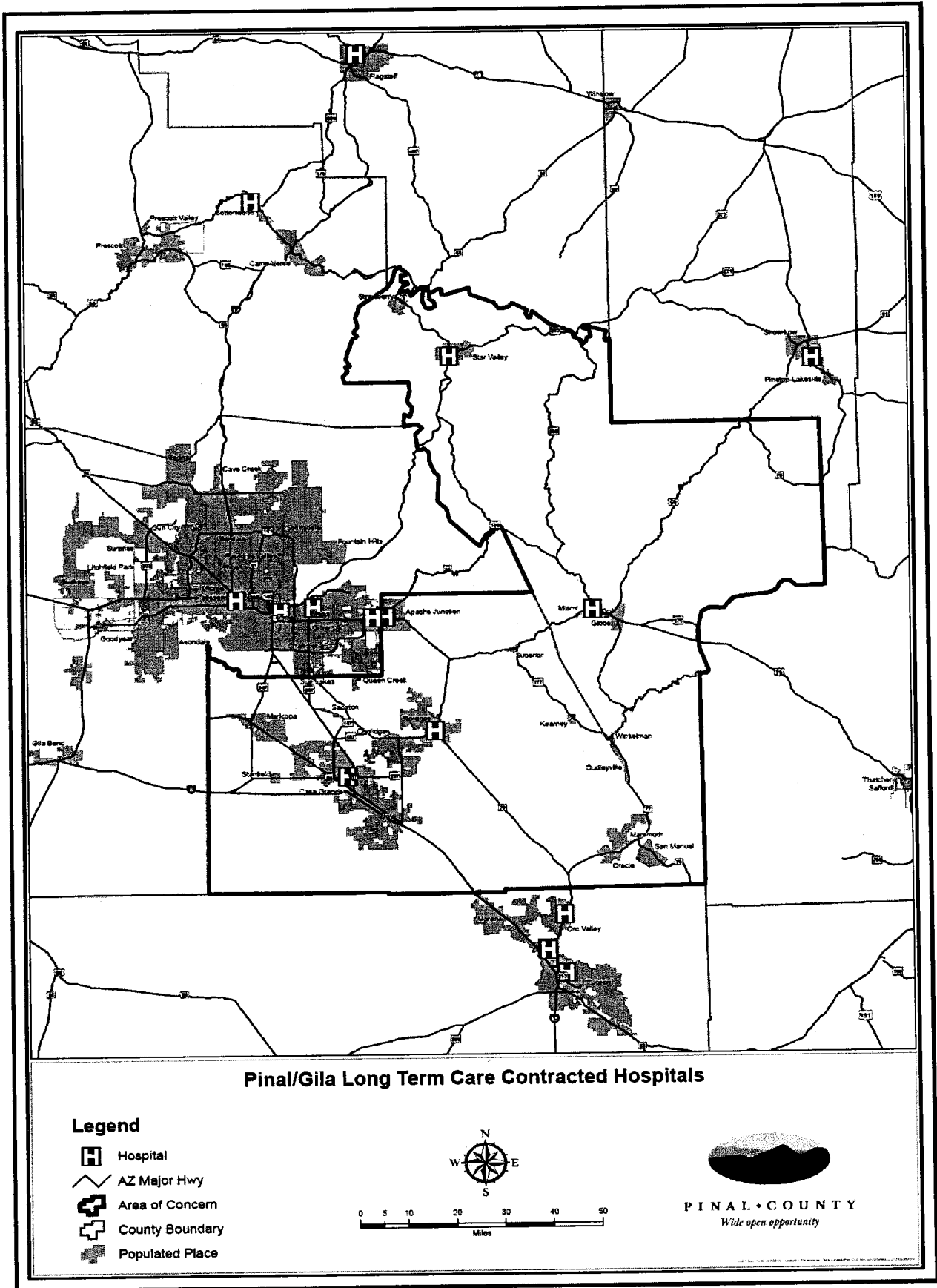
P/GLTC has determined the need for greater consolidation of its overall network; away from an unwieldy, sprawling network design that extends deep into Maricopa County, to a smaller, tighter network that is more accessible in serving members. This identified need requires a strategy to recruit selected providers that are strategically clustered around areas where members live or access services. The strategy will be complemented by the deployment of a traveling network that is offered on a rotation basis and increased use of telemedicine, especially for psychiatric services.

Therefore, although there is no "network gap" in the classic sense there is a definite need to "bring services closer to home". Our goal is to decrease reliance on community-based services such as ALFs, PCPs and specialists outside of Pinal and Gila Counties over time while retaining providers within GSA 40. *A strategy of how to achieve this is described in the HCBS Services Strategy and Action Plan, AFC Expansion Plan and ALF Expansion Plan.* The following table summarizes identified network needs that are targeted for development or recruitment for the sole purpose of enhancing member access to care.

CYE 2010-2011 P/GLTC Network Needs

Service Type	Min. Goal	City (Pinal County)	Min. Goal	City (Gila County)	Service Need Description
Psychiatrists (see HCBS Strategy and Action Plan)	2	Casa Grande Maricopa Coolidge Apache Junction Eloy Arizona City	1	Payson, Globe	Traveling Provider who offers a once- a-month clinic at selected sites Increased access to telemedicine services
Adult Day Health Care Center (see HCBS Strategy and Action Plan)	1	Casa Grande	NA	NA	Low member volumes have failed to attract business interest in ADHC in prior years
Adult Foster Care Homes (see AFC Development Plan)	4	Casa Grande Maricopa Coolidge Apache Junction Eloy Arizona City Mammoth/Kearny/San Manuel	2	Payson, Globe, Superior	New AFC development will gradually replace Maricopa County-based ALFs ; New AFCs will help prevent or reduce nursing home placement in Gila County SNFs
ALF (see ALF Expansion Plan)	6	Casa Grande Eloy Arizona City Coolidge	2	Payson, Globe	Need to add Already-licensed ALFs operating within Pinal and Gila Counties
Home Health	Not a Gap	NA	1	Payson and surrounding area	Complements existing home-based services (attendant care, personal care, homemaking)
PT/OT (see HCBS Strategy and Action Plan)			1	Globe	

Pinal/Gila Long Term Care Contracted Home and Community Based Services

Legend

- Home or Community Based Services
- AZ Major Hwy
- Area of Concern
- County Boundary
- Populated Place

P I N A L • C O U N T Y
Wide open opportunity

Pinal/Gila Long Term Care Contracted Hospitals

Legend

H	Hospital
/\/	AZ Major Hwy
	Area of Concern
	County Boundary
	Populated Place

N
W — E
S

0   5   10   20   30   40   50
Miles

PINAL•COUNTY
Wide open opportunity

Pinal/Gila Long Term Care Contracted Skilled Nursing Facilities

Legend
- Skilled Nursing Facility
- AZ Major Hwy
- Area of Concern
- County Boundary
- Populated Place

P I N A L · C O U N T Y
Wide open opportunity

Pinal/Gila Long Term Care Contracted Acute Care Services

Legend
- Acute Care Services
- AZ Major Hwy
- Area of Concern
- County Boundary
- Populated Place

P I N A L • C O U N T Y
Wide open opportunity

Pinal/Gila Long Term Care Contracted Specialist Services

Legend

- Specialist
- AZ Major Hwy
- Area of Concern
- County Boundary
- Populated Place

Pinal/Gila Long Term Care Contracted Behavioral Health Services

Legend

- BH Behavioral Health Services
- /\/ AZ Major Hwy
- Area of Concern
- County Boundary
- Populated Place

N
W — E
S

0   5   10   20   30   40   50
Miles

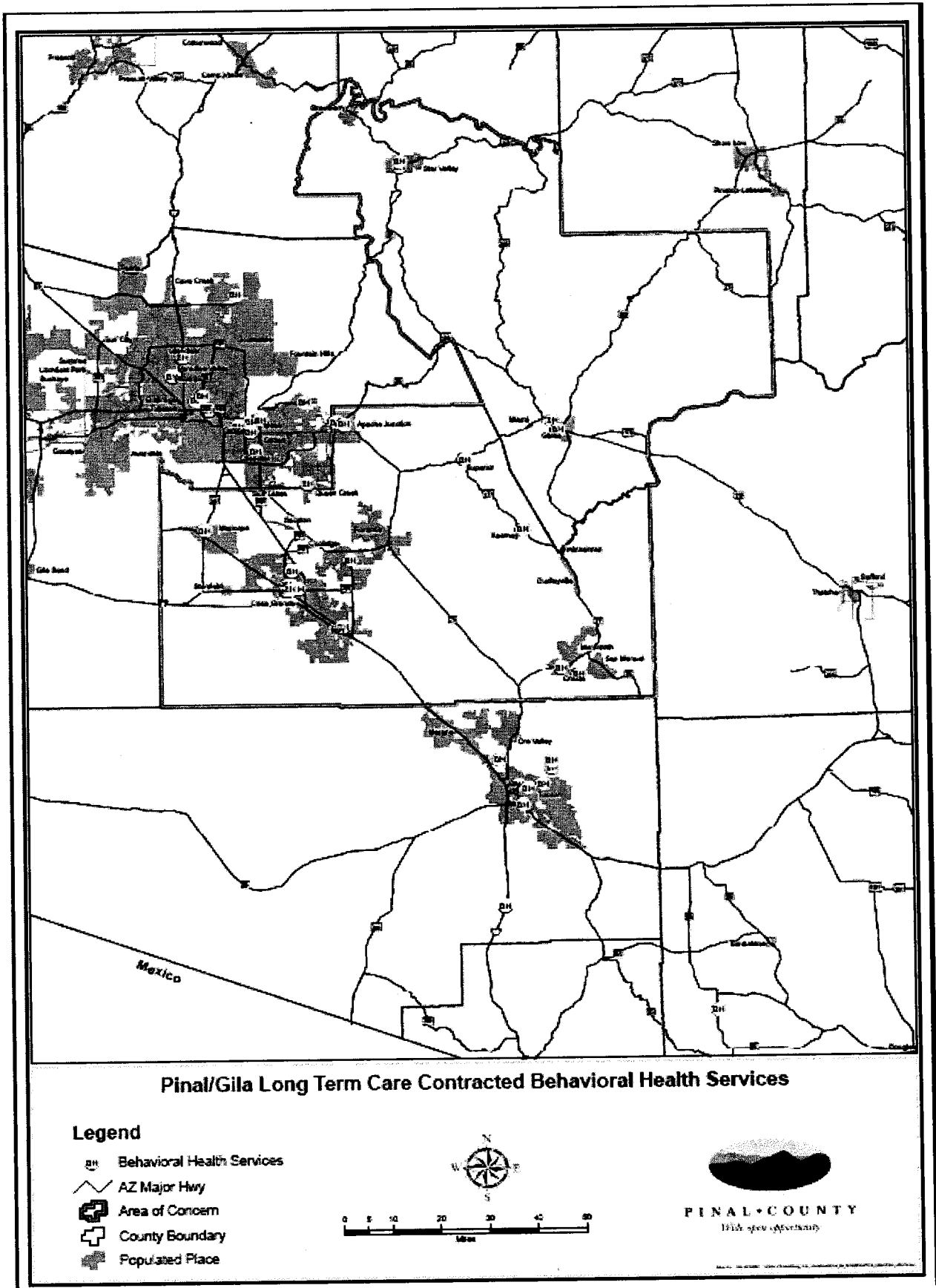P I N A L • C O U N T Y
Wide open opportunity

Requirement 37: Any Offeror who is new to a GSA must submit a description of how it will launch a network capable of supporting its membership by October 1, 2011. Incumbent Contractors that are not new to a GSA are exempt from this requirement.

Pinal/Gila Long Term Care (P/GLTC), an incumbent contractor, is exempt from this requirement.

Requirement 38: Describe how the Offeror will communicate with its provider network in explaining the standards for the program, changes in laws and regulations, and changes in subcontract requirements.

Pinal/Gila Long Term Care (P/GLTC) is committed to preserving its provider network and maintaining ongoing open communications with its providers. Maintaining a robust provider network in two rural counties provides some unique challenges. Each provider within our network is highly valued in our organization as we strive to ensure a consistent continuum of care for our members as well as to maintain a solid network.

P/GLTC believes in maintaining strong and personal communications with our network providers. Unlike other plans that rely on a telephonic or electronic methodology for communicating with providers, our Provider Services staff conducts weekly face-to-face, on-site meetings with providers on a systematic schedule. All provider network encounters are documented in a P/GLTC provider database called Provider Information Management System (PIMS) for tracking and trending. From this system we compile our monthly gap report, which was recently praised and acknowledged by ALTCS in January 2011.

To effectuate this system, each provider is assigned a provider relations representative (PRR) who is their primary point of contact for all issues and concerns. Each PRR is provided a Blackberry and laptop to ensure their availability 24-hours per day, 7-days a week to respond to questions or concerns by providers. It is not uncommon for a provider to have a need at 5:30 p.m. on a Friday, or even over the weekend. The provider's ability to contact their PRR at all times ensures that they receive an immediate response to any need, issue, or concern.

Network Development and Management (NDM) staff participates in several internal meetings in order to understand program standards and implementation. These include weekly interdisciplinary care team meetings, monthly cross-functional task force meetings, and bi-monthly case management section meetings. Changes in program standards, rules, and regulations are then communicated by to the Provider network.

Program Standards
Review of Qualifications (ROQ)
The communication process begins when a provider requests to join our network or when NDM staff approaches the provider to contract their services. The application materials can be accessed online at www.pinalcountyaz.gov. A PRR is assigned to a provider based upon their geographic location and remains available to assist the new provider with any questions during the ROQ process. The ROQ process clearly communicates the requirements and expectations of joining the P/GLTC network and participation in the AHCCCS Plan (AHCCCS Minimum Subcontract Provision). The PRR guides, assists, and answers any questions for the assigned non-contracted provider/facility. This approach permits the provider and P/GLTC staff to begin establishing a relationship, which ultimately affects the member's future success. Education about P/GLTC contract language, AHCCCS contract language, and requirements and credentialing requirements are also provided. The desired outcome is a new provider/facility that knows and understands our expectations prior to signing a contract. This process sets the stage for a more successful and integrated relationship.

Orientation
Our network providers receive an initial orientation within 30 days of the effective date of the contract and before receiving member assignments. The orientation reviews the contents of our provider manual (which is available online or by hard copy) that meets and exceeds the elements required by AHCCCS Contractors Operations Manual (ACOM). The elements address, accessing behavioral health services, prior authorization requirements,

EPSDT forms and reporting, reporting non-provision of services, appointment standards, eligibility verification, etc. During orientation, our provider relations representatives share their Blackberry contact information, e-mail address, and office phone number. The provider is instructed to contact their assigned PRR with any questions or concerns at any time of the day or night. The immediate access to an assigned provider relations representative establishes trust and consistency in the relationship.

Audits and Reviews
Our provider relations representatives exceed AHCCCS requirements by visiting 95% of their assigned network providers on a quarterly basis. During these visits, the representative reviews program standards, any changes in the laws and regulations, as well as changes in subcontract requirements. Providers have an opportunity to bring up issues for immediate response. These ongoing visits are most important due to the frequent turnover in staff at providers' offices. This regular contact enables the representative to serve reminders to the established staff and to educate new staff members of AHCCCS requirements. Additionally, PRRs provide other communication/educational tools such as web age tools and specialized education materials at these meetings. Yearly audits, performed by provider relations representatives for skilled nursing facilities, assisted living facilities, adult day health, attendant care agencies, and behavioral health providers provide essential information for our organizational credentialing process. These audits also offer us the opportunity to communicate with our facility partners regarding AHCCCS requirements and any changes in laws, regulations or subcontract agreements.

Provider Forums, Member Councils
Every year we invite our network providers to participate in a public forum. The agenda for these meetings are based on input received from our network including reminders of AHCCCS program requirements, recent AHCCCS program changes, recent changes in law, and

discussion of trends identified via P/GLTC's integrated system. All changes in AHCCCS requirements or subcontract requirements are communicated, at a minimum, 60 days prior to the effective date of the change. P/GLTC also takes this opportunity to receive input from our providers for continuous process improvement.

Specialized Educational Training
We also provide specialized training for certain groups of providers/facilities who have been identified as needing additional education. These meetings are on an ad-hoc basis. For example, when we rolled out P/GLTC's Assisted Living Facilities (ALF) Billing Manual in June 2010, all the contracted ALFs gathered to meet with NDM in conjunction with our claims unit to provide specialized training on claims billing. An example of ALF training aimed at improving member care occurred in October 2010 when all ALF representatives were in-serviced on skin assessment.

Changes in Laws and Regulations and Subcontract Requirements
P/GLTC has a formal communication plan that uses the same methods for communicating program standards as well as changes in subcontract requirements. Prior to implementation, NDM follows the 60-day provider notification requirement for such changes. P/GLTC initially uses electronic technology methods such as blast faxes, and sends emails to key personnel within the provider network. Future endeavors include posting these items on the P/GLTC website under "What's New."

Website Tools
P/GLTC is supported by the Pinal County Government's information system, which provides us with communication tools via our website. The web-based portal facilitates provider communication by enabling providers to check the status of their claims, view the provider manual and provider directory, obtain referral forms, provides links to check AHCCCS eligibility, cultural competency provider survey, EPSDT forms/EPSDT periodicity schedule, formulary, no show submission, provider and

member newsletters, non-provision of services/nothing to report, provider surveys, clinical quality performances measures for diabetes, and tobacco cessation. Future enhancements to our website include web-based service authorization request submissions.

Newsletters/Flyers/Blast Fax
P/GLTC utilizes provider newsletters, flyers added to claims payments, and blast fax memos to communicate any material changes in our network, changes in AHCCCS requirements/laws and changes in subcontract requirements. The flyers and blast fax memos are instrumental in ensuring communication of material changes within the required 30-day time frame.

JOC/One-on-Ones/Ongoing Telephone and Email Communication
P/GLTC staff members use every opportunity to communicate on a personal level with our providers by use of Joint Operations Committee (JOC) meetings and problem solving via phone calls and emails. JOC is another opportunity for providers to bring issues to our attention for resolution by receiving collaborative input with P/GLTC staff. We have experienced great success via e-mail communication, which ensures that changes in AHCCCS requirements and laws or subcontract requirements are timely communicated to our provider network.

Requirement 39: Explain how data and information is received throughout the organization, how it is used to manage network, identify provider issues, and how it is communicated back to the organization.

Philosophy

Because Pinal/Gila Long Term Care (P/GLTC) is a community-based health plan, data and information from every section within the organization is shared in a rapid and timely manner through established mechanisms, both formal and informal. This system of data gathering, analysis, communication, and resolution embodies a multi-disciplinary approach that successfully brings together all sections for the purpose of identifying and resolving provider issues.

Because our 9.0 FTE Network Development and Management (NDM) staff is constantly in communication with providers, they serve as the "eyes and ears" of the organization in identifying network gaps and recruiting additional providers and provider/types to fill those gaps.

Network Data Collection and Receipt

There are four major methods employed by P/GLTC's Network Development and Management Section to effectuate "best practices" in network data collection capacity assessment and management:

Face-To-Face Site Visits
A year round schedule is created to allow the informal, onsite personal visit to high-volume providers by Provider Representatives. This schedule exceeds AHCCCS standards for visit frequency. During this visit a standardized site-visit tool, available on individual laptops, is used to guide the Provider Representative in assessing provider capacity, provider adherence and educating the provider on matters of importance. This plan includes reviews accurate billing, appointment availability/wait time, performance measures, EPSDT visit frequency, fraud and abuse, "no show" requirements, covered services, Cultural Competency, and assisted living facility (ALF) surveys. Site visit results are discussed onsite with the provider during this same visit.

In 2010, 721 face-to-face site visits were completed.

Focused Investigative Visit
Upon request by the Quality Management (QM) Section or Case Management (CM) Section, a focused visit may be conducted, announced or unannounced, for the purpose of supporting a quality of care investigation or performing a quality of service review. This visit is often supplemental to visits conducted by a QM nurse, CM, ADHS Licensure, Law Enforcement or Adult Protective Services staff member. In 2010, 12 focused investigative visits were completed.

Contract Audits
Provider Relations Representatives conduct onsite annual formal visits to determine level of compliance with the most salient requirements of the provider's contract. The contract audit tool varies on the provider type being audited.

In 2010, 65 contract audits were completed. Of these 65 contracts audited, 78.5% scored 100% on all audit elements. The remaining 21.5% scored between 95%-99% and were cited for a deficiency requiring a corrective action plan.

Joint Operations Committee (JOC) Meeting
These are periodic meetings facilitated by Provider Relations Representatives for a specific problem-solving or issue resolution purpose. These are attended by selected P/GLTC Management Team members and appropriate providers or provider groups such as hospitals, attendant care providers, skilled nursing facilities (SNFs), or durable medical equipment (DME) companies. In 2010, 11 JOCs were completed.

Member and Provider Satisfaction Surveys and Member Council
P/GLTC also seeks input from members regarding adequacy of network through quarterly Member Council meetings and

annual member surveys conducted by the Case Management Section. Provider input is similarly solicited through an annual provider satisfaction survey, which seeks to ascertain provider satisfaction with the claims turnaround times, responsiveness of Provider Representatives to provider inquiries and complaints and to determine satisfaction with mass communications on program benefits, provider participation rules and expectations and significant program changes. Survey data collected are analyzed to determine process improvements that can be implemented across the organization to improve satisfaction at both the member and provider levels.

Provider Information Systems
P/GLTC uses a proprietary database called the Provider Information Management Systems (PIMS) that enables P/GLTC Representatives to track, trend, and analyze both incoming and outgoing provider inquiries and complaints, appointment waiting times, and 'no show reports'. This system stores data that is utilized for several purposes including provider education documentation, provider demographic updates, provider inquiry trend analysis and troubleshooting of concerns and complaints. Additionally, PIMS is used for storing contract monitoring and site visit documentation on physicians, attendant care, SNFs and assisted living homes and centers. A database of formal provider claims disputes is maintained. The data are trended, analyzed, and reported to the UM committee for process improvement discussion and intervention ideation. Results of interventions are communicated back to the providers through Provider Relations Representatives.

Network Recruitment
As a result of gap and capacity analysis which includes communications feedback from members, providers and staff, network recruitment is conducted specifically to close a gap. For example, a recent gap analysis revealed the need to improve community-based setting capacity and as a result an AFC development initiative and collaboration with

Lutheran Social services to build an adult day care center in Pinal County was started in 2010. Network recruitment occurs on an ongoing basis for network gaps that pose a challenge in the rural areas such as behavioral health providers and services that serve special populations such as members with TBI, disabled children and adults and members with multiple behavioral issues.

Formal communication back to the organization occurs at four levels within P/GLTC. Overall coordination formally occurs at the Senior Management Team level where the Assistant County Manager, CEO, CFO, CMO, Director of QM/UM, Director of Case Management, and Director of Network Management/Development exercise their responsibility to manage the network and resolve provider issues presented to it.

The second level of communication occurs at various committees and cross-functional team meetings where issues and concerns are addressed and results of interventions are reported. These formal committees involve managers and directors from several sections and attended by the P/GLTC CEO. These committees include the:
• Corporate Compliance Committee
• Quality Management Committee
• Provider Watch Committee
• Peer Review Committee
• Credentialing Committee
• Organizational Credentialing Committee
• UM/Medical Management Committee
• Pharmacy Utilization Committee
• Pharmacy and Therapeutics Committee
• Network Planning Committee
• Diversity Committee.

Inter-disciplinary Care Team meetings, co-facilitated by the CM Supervisor and the MM RN, are held regularly. Team members include Case Managers, Case Management Supervisors, and representatives from Medical Management and NDM Services to obtain informal data on provider issues that impact member care. Furthermore, a cross functional workgroup
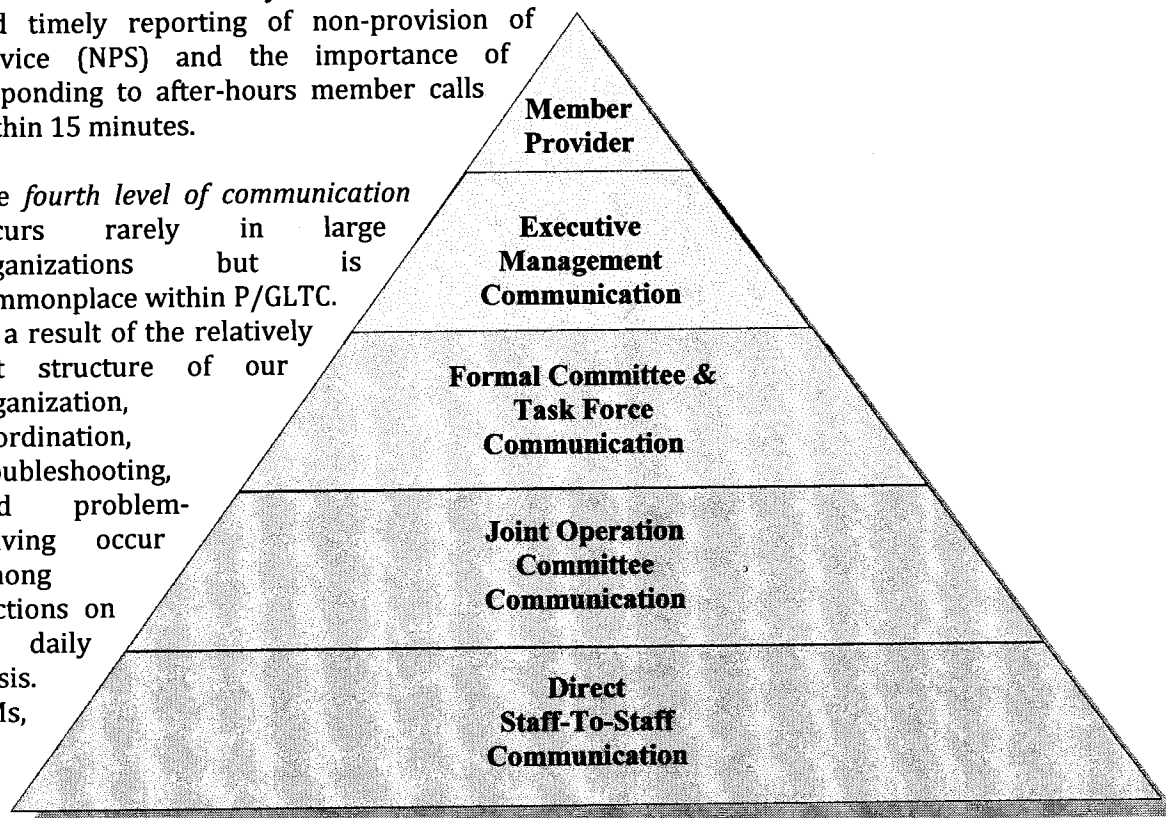
facilitated by Claims Section is held monthly to discuss claims setup issues that require intersectional resolution.

The third level of communication occurs at Joint Operations Meetings (JOCs) which are issue-focused problem-solving meetings held with a selected provider. An example of this is the Transportation Joint Operations Committee. Using feedback from 33 member complaints, a meeting was held with the transportation provider, NMD, CM and QM to discuss, analyze and resolve individual and system barriers that keep members from arriving at their scheduled medical appointments in a timely manner. As a result of this coordination, the transportation vendor reported a performance improvement in August 2010 that showed 97% of P/GLTC members who utilized service arrived at their destination on time.

Another example of the effective use of JOC is the Attendant Care JOC meeting where providers were recently trained on accurate and timely reporting of non-provision of service (NPS) and the importance of responding to after-hours member calls within 15 minutes.

The *fourth level of communication* occurs rarely in large organizations but is commonplace within P/GLTC. As a result of the relatively flat structure of our organization, coordination, troubleshooting, and problem-solving occur among sections on a daily basis. CMs,

Network representatives, information systems, claims, prior authorization, QM or MM communicate regularly on member issues and operational concerns on a drop-in basis or in small informal, unscheduled meetings and emails. Such informal communications occur across all sections and position levels. There is a philosophy within P/GLTC that encourages and welcomes natural communication and immediate resolution without the need for a formal meeting whenever possible. More complex issues that cannot be easily resolved are elevated to the highest level using mechanisms established for formal resolution.

Pyramid diagram (top to bottom): Member Provider; Executive Management Communication; Formal Committee & Task Force Communication; Joint Operation Committee Communication; Direct Staff-To-Staff Communication

Requirement 40: Describe the process for accepting and managing provider inquiries, complaints and requests for information that are received outside the claims dispute process.

Current Providers: Personalized Response
Pinal/Gila Long Term Care (P/GLTC) is committed to preserving its provider network and maintaining ongoing open communications with its providers. The overall goal is a satisfied network of providers built around member specific needs. When warranted, our provider relations staff drives out to personally meet face-to-face to resolve provider and member issues. As the ALTCS program contractor for Pinal County for 20 years, and Gila County for 10 years, we have successfully forged strong professional relationships with our providers. P/GLTC is also a county-operated entity that has become very well integrated into the communities we serve.

Process for Inquiries, Complaints, and Requests
We are committed to handling all provider inquiries, complaints, and requests for information received through phone calls, personal contact, via email, in writing, or the electronic web system in a timely manner. If the complaint is received verbally the acknowledgement is implied, if the complain is received in writing the response is written within fived days. When issues are complex, requiring coordination with other departments for a resolution, they are responded to within 30 days, which exceeds the 90 day standard. Providers are free to contact any P/GLTC department, but are encouraged to contact Network Development and Management (NDM) in an effort to streamline provider communications. In terms of assessing the provider network, P/GLTC assigns a provider relations representative to each provider based on their service locations within the county to ensure immediate assistance to the provider. The determination of staffing levels for provider relations representatives is continually evaluated in order to provide an adequate ratio of contracted providers for each representative. The main role of the provider relations representative is to function as the official liaison between the provider and P/GLTC.

Provider relations representatives have been successful in establishing an open relationship with providers, accepting feedback, and offering assistance 24-hours a day, 7-days a week. For the small percentage of instances in which immediate contact is not made, the provider has the opportunity to leave a message and the provider relations representative guarantees contact within three business days. Providers are instructed to call for assistance with any issue, including but not limited to the use of P/GLTC website functionalities such as provider look up. We also provide information on links to additional important web sites such as; AHCCCS, ADHS, CMA, and P/GLTC's contract application process, Review of Qualifications (ROQ), and credentialing questions.

Prospective Providers
Provider relations representatives (PRR) are knowledgeable of the department's network needs and network growth goals. Armed with this knowledge, provider relations representatives take every opportunity to assist in filling these requirements in the conduct of their duties. For example, as they interact with providers in their assigned territories, provider relations representatives often assist in identifying additional potential providers that would enhance the network. The provider relations representative recruits prospective providers and provides hands-on technical assistance and consultation with the P/GLTC Review of Qualifications (ROQ) contract application process. Most recently, provider relations representatives were instrumental in recruiting potential applicants to become adult foster care home providers in rural areas of Pinal and Gila Counties by conducting public forums in Casa Grande, Maricopa, Globe, Payson, and Apache Junction.

Tracking and Follow Up
When P/GLTC receives a complaint from a provider, we view this as an opportunity for positive change and also as a means for

strengthening working relationships with contracted providers. Providers are encouraged to contact P/GLTC for assistance and resolution with their complaints. Provider relations representatives determine the validity and type of complaints, and discuss ways of addressing the issues before the complaint becomes a concern, which may result in a negative outcome for members or in contract termination. The process of validating complaints allows both P/GLTC and the provider an opportunity to manage performance effectively and proactively. Close monitoring of providers, practice patterns, complaints, and concerns may result in an increase of provider over-sight, educational in-services, joint operation meetings, and revisions to P/GLTC's provider training and education materials, such as provider manuals, notices, or newsletters.

PRRs monitor the type of complaint, resolution activities, and appropriate timelines. All complaints are thoroughly investigated by interviewing every participant involved. The intent of this process is to ensure that a fair and complete investigation is conducted. If an investigation finds a provider to be at fault, P/GLTC has a process for addressing complaints that assists the provider in working towards a resolution that is satisfactory and guarantees that a member is not compromised in any way. If satisfactory resolution cannot be obtained, then the possibility of contract termination exists. The provider relations supervisor manages and monitors the communication and resolution for timeliness and progress regarding provider inquiries, complaints, and requests for information. This process is monitored on a monthly basis in order to ensure compliance. We track, trend, and analyze provider complaints to allow us to increase provider satisfaction levels.

Network Development and Management uses a proprietary database called the Provider Information Management Systems (PIMS) that enables P/GLTC representatives to track, trend, and analyze both incoming and outgoing provider communications. This system stores

data that is utilized for multiple purposes including provider education documentation, provider demographic updates, provider inquiry trend analysis, and troubleshooting of concerns and complaints. Additionally, PIMS is used for storing contract monitoring and site visit documentation on physicians, attendant care, skilled nursing facilities, as well as assisted living homes and centers. NDM is implementing an enhancement to PIMS to capture provider contract information, education and training activities in real time via provider representatives' laptops. This expansion of technology to PIMS is the foundation for all NDM functions that includes credentialing, grievance and appeals, community relations and outreach, provider surveys, reports, staff assignments, newsletter topics, and letter templates. PIMS' enhancements streamline the process of compiling data and reporting requirements as well as assist provider relations representatives with timely identification of issues for discussion with providers.

Effective December 10, 2010, NDM redesigned the composition of the department to best service the needs of our providers. Two of the three provider relations representatives' primary focus is face-to-face interactions with their assigned providers and provider groups. Based on the square miles of Pinal and Gila Counties, this requires them to be out of the office for large amounts of time. PRRs have been issued Blackberries and laptops. This investment by P/GLTC allows the representatives to be fully functional and accessible to their assigned providers and P/GLTC staff while out of the office. The third provider relations representative's primary focus is audits of assisted living facilities, attendant care, skilled nursing facilities, and home care agencies. This position is designed to be more office-based, but is provided the same tools as the other representatives to remain fully functional and accessible whether in the office or out. The provider relations supervisor performs periodic monitoring by contacting providers to ensure quality customer service of the provider relations representatives.

P/GLTC utilizes the managed care industry's "best practice" of providing highly-personalized, face-to-face interaction with key providers while equipping them with updated information through website applications. In addition, Joint Operations Committee (JOC) meetings and training sessions are issue-focused, problem-solving meetings that are held with a selected provider with participation by representatives of many departments. An example of this is the Transportation Joint Operations Committee meeting where the transportation provider, NDM, Case Management, and Quality Management come together to discuss, analyze, and resolve individual and system barriers that keep members from arriving at their scheduled medical appointments in a timely manner. As a result of this coordination, MTBA, the transportation vendor, reported a performance improvement in an August 2010 report, which shows 97% of P/GLTC members who used their service arrived at their destination on time. These meetings have greatly enhanced service value by building trust and respect with our providers. The NDM section of P/GLTC believes in a strong, practical focus on interpersonal communication that builds collaborative relationships, minimizes provider concerns, and creates an atmosphere of cooperation towards member and provider issue resolution.

As part of a continuous effort to enhance relations with providers, satisfaction surveys are used to obtain feedback from contracted providers. The provider satisfaction survey is sent to a random sample of HCBS and medical providers. Responses are reviewed, summarized, and addressed as needed. As a result of findings from last year's cultural competency survey, a multi-disciplinary approach was used involving the Diversity Committee to implement a solution to address provider weaknesses that involved educational interventions by provider relations representatives.

Requirement 41: Describe the process for ensuring that provider services staff receive adequate training.

Philosophy
Pinal/Gila Long Term Care (P/GLTC) places a high priority on training provider services staff. Multiple educational methods are used. Training begins with Pinal County New Employee Orientation including instruction on Pinal County policies and procedures. P/GLTC specific training provides the basic tools needed to interact with others, build close professional relationships, give superior customer service, and educate network providers. We consider these tools essential in promoting effective operations and providing quality services.

Initial Hire
After the required Pinal County Orientation, network staff attends an in-house P/GLTC orientation and comprehensive training program. Employees are required to become familiar with the current AHCCCS/ALTCS contract. They review and understand:
- Title 42 of the Code of Federal Regulations,
- Arizona Administrative Code,
- AHCCCS Contractor Operations Manual (ACOM),
- AHCCCS Medical Policy Manual (AMPM),
- Arizona Revised Statues,
- P/GLTC Network Development and Management Plan,
- Cultural Competency Plan, and
- Business Continuity Plan.

Staff members are required to have a checklist validated and counter-signed by management to ensure completion of all training elements.

In addition, team members are provided training within the Network Management & Development (NM&D) department. Topics have included, but are not limited to: Provider Relations Customer Service, Sharpening Listening Skills, Provider Responsibilities, Provider Relationship Building, Provider Relationships that are Collaborative, Non-

Provision of Service, Effective Meetings, Grievance Systems, Business Continuity, Quality of Care Referrals, Appointment Availability, How to Conduct Surveys, Performance Indicators, Cultural Competency, and EPSDT requirements.

Annual Training
Staff receives training annually on the procurement process that addresses the Pinal County Procurement Code and is specific to the P/GLTC (NM&D) department. Annual training topics include refresher courses on quality of care referrals, the grievance system, and the Business Continuity Plan.

Each staff member receives annual and semi-annual performance evaluations that promote open dialogue and incorporate discussion of training needs.

Team members attend quarterly all-staff meetings that incorporate topics such as Cultural Competency and Diversity, Customer Service, and Managing for Results (MFR). Staff is also provided training on a number of subjects at semi-monthly NDM staff meetings. Subject topics at these meetings include credentialing processes, contract process, and performance training. One-on-one meetings are also held.

Other P/GLTC departments also provide educational in-services. The collaborative format assists in integrating the various departmental functions and help staff better understand the responsibilities of the other departments, furthering our collaborative approach. For example, claims department training communicated the process to set up and file electronic claims and how electronic funds transfers and electronic remits are submitted. This type of training expands the knowledge of employees by equipping them with information to provide quality provider communication. Provider relations staff members also receive annual training

regarding Fraud and Abuse and Corporate Compliance.

Non-P/GLTC Training:
P/GLTC Provider Relations staff members often take advantage of outside training opportunities. Examples include the annual Central Arizona Elder Abuse Conference, State of Arizona Procurement, and Emergency Response Training.

Focused Training
Provider relations staff members receive first-hand training on P/GLTC network initiatives. Innovative training topics include our AFC/ALF Expansion Plan, HCBS Development Plan, Workforce Development Plan, and the Medicare Advantage Special Needs Plan. The Adult Foster Care and Assisted Living Facility Expansion Plan Training involves the provider relations representatives attend one of six community forums within Pinal and Gila Counties. At these forums they observe the presentation and participate by explaining the eligibility, licensure and contracting process with attendees. For the Special Needs Plan Training, representatives are provided information about Centers for Medicare & Medicaid Service (CMS) which includes HSD tables, network requirements and deficiencies, the application process, and timelines.

Continued Training
P/GLTC conducts quarterly "Ideas Together" training events that are mandatory for all staff. At these meetings, a variety of subjects are covered that impact our members and our providers. Topics covered include hospice care, cultural competency, auditing, emergency management, aging simulation exercises, specialized provider speakers, grievance and disputes process, and advance directives. For example, a community radiation oncologist spoke about new advances in cancer treatment.

We empower team members to proactively identify training needs.

Informal participation in cross-functional meetings and/or other section staff meetings require approval from management. Participation in cross-functional meetings optimizes staff's opportunity to learn and participate in the resolution of operational matters.

A repository of information such as quick reference guides, specific educational materials, and provider newsletters are available as training tools to educate our network provider community.

We value the mentoring model we have developed that encourages and promotes employees to "walk in each other's shoes." For example, provider relations representatives accompany the credentialing coordinator to audit visits with delegated entities to understand the process and required standards.

County Sponsored Training
As employees of Pinal County, we have the opportunity for numerous county sponsored training events. For example, the training topics for the next three months are as follows with training time typically running one-half day to a full day. These training sessions are local. Classes are: Change Management, Effective Professional Writing, Working Across Generations, Creating a Team Environment, Excellence in Customer Service, Writing Advantage, Working at the Speed of Trust, Unleashing Talent, Performance Coaching, 4 Discipline of Executing, 7 Habits Maximizer, The 7 Habits of Highly Effective People Signature Program, Discrimination, Harassment, and the Hostile Work Environment.

Pinal County provides assistance to Pinal County employees in obtaining job related education. Pinal County provides limited financial aid in the form of tuition reimbursement for employees to enhance their education and training. P/GLTC managers actively mentor employees in their educational pursuits by providing guidance and tutoring. In addition, other opportunities include Dale Carnegie Learning Center, National Seminars

Training, the FEMA Emergency Management Series, and Southwest Leadership Program. Each month P/GLTC employees are provided a training newsletter with information about upcoming training opportunities.

Requirement 42: Describe the process for evaluating provider services staffing levels based on the needs of the provider community.

Pinal County is a major growth area in Arizona as well as the nation. Among Arizona's 15 counties, Pinal County had the fastest rate of population growth between 2000 and 2010, rising by 109.1 percent, new census figures show. Recognizing the large numbers of retirement-age persons Arizona attracts each year, the recent economic crisis, and the housing collapse, Pinal County anticipates an increasing need for services within the county. P/GLTC has developed an aggressive network development plan.

The role of Provider Services is to develop and support this growing network. Provider Relations must support the network with efficiency, effectiveness and quality in mind. The determination for staffing levels for Provider Relations Representatives is continually evaluated. Staffing levels are based on quality of service, required monitoring, number of providers and quarterly/annual visit timelines of P/GLTC contracted providers in the geographic areas of Pinal and Gila Counties. Provider communication is tracked in our Provider Information Management System (PIMS). Analysis and monitoring of provider inquiry volume and resolution is a primary determination for Provider Relations Representatives staffing. On an ongoing basis, provider relations representatives respond to provider inquiries within three days and resolution occurs within 30 days. The ability to meet these timelines without exception is an indication that staffing levels are appropriate.

Historically, three provider relations representatives monitor 260 contracts; representative of a much larger pool of providers. This ratio between contracted providers and Provider Relations staff results in solid working relationships and ultimately improves member service. As the number of providers is expected to increase

exponentially, the staffing level will be assessed and adjusted accordingly.

Evaluation Step 1: Relationship with Providers
The provider communities within both Pinal and Gila Counties have an established ongoing relationship with the staff at P/GLTC. The elderly and physically disabled population is expected to increase significantly in the coming years. P/GLTC is committed to continue building and maintaining excellent provider relations with contracted and non-contracted providers in order to meet an increasing demand for services. In a monthly review of inquires from providers, data indicate that issues are minimal when a close relationship is cultivated, combined with trust and professionalism. Provider Relations Representatives are available 7 days a week, 24 hours a day by laptop, e-mail, and Blackberry, and often field calls from providers after hours and on weekends. This is one example of P/GLTC's commitment to do what is necessary when it comes to provider satisfaction by offering availability to our providers around the clock. The dedication to providers has been successful in creating long lasting relationships and is the keystone to future endeavors.

Our integrated approach, with involvement from other departments such as Case Management, Medical Management and Quality Management, positively reflects quality service.

Evaluation Process Step 2: Review of Data
NDM reviews various data sets related to provider ratios. Utilization data by contracted and non-contracted providers is reviewed by the NDM Director to determine of strategies. For example, in reviewing utilization data we identified the providers with higher volumes of claims. We felt that this group would benefit from additional training on electronic claims capabilities, so we dispatched a

provider relations representative to meet with them one-on-one to provide additional training on billing and the EFT process for those who were not filing electronically.

The evaluation process also includes provider communication comments, special notes, and GEO mapping of member/provider geographic locations. Assessed is the number of providers, types of providers and their needs, the type of site visits needed quarterly, Joint Operations Committee meetings (JOC), special focus training, and audit periods to conduct these visits. The Non-Provision of Services process is reviewed daily to monitor gaps and monthly to determine education and training needs. Also considered is coaching/mentoring of attendant care agencies so they meet critical service needs, identify gaps and fulfill reporting requirements. Review of delineation of duties and time studies is completed. Adequacy is evaluated based on outcomes. Staff ratios are reviewed in order to meet AHCCCS availability on urgent issue resolutions, as in the case of an Immediate Jeopardy (IJ) as it pertains to provider services. We ensure that staff levels are adequate for providers to receive prompt response and assistance.

Ratios are important in the successful efforts to recruit, retain, and maintain a long-term care workforce necessary to meet the needs of the anticipated growth in the ALTCS membership and their access to care.

Evaluation Step 3: Provider Surveys
Of 300 providers randomly chosen to participate in the annual provider satisfaction survey, 25% responded. Results indicate that 73.3% of respondents are extremely satisfied and/or satisfied with their experiences with P/GLTC as compared to other similar health plans. A sample of the survey is included at the end of this section.

P/GLTC team members receive verbal and written comments. Feedback indicates that providers appreciate the relationships developed through our professional service. The scheduled provider service site visits prove that the needs of the provider community are being met.

The low number of P/GLTC provider claims disputes and appeals indicates that the level of provider satisfaction is high. Annual Provider Fairs have proven to be successful and are an opportunity for the provider community to interact with P/GLTC departments at all levels.

The commitment to the relationship between P/GLTC and providers was recently tested through redesign of the Member Councils. Participants were asked to sign a letter of commitment and fully participate in a more interactive manner. We were overwhelmed with the number of providers willing to volunteer their time to the Council. The result has been a highly interactive group of staff, providers, members, and member caregivers who work together to resolve issues and bring about effective change for everyone in the program.

Pinal/Gila Long Term Care
Annual Provider Satisfaction Survey

It is very important that Pinal County Department of Health and Human Services know your views about your interactions with Pinal/Gila Long Term Care. The information you give us will help us to know how well we are meeting your needs, and to find out where improvements can be made. We assure you that all responses are kept confidential. This survey is also available online at:
www.pinalcountyaz.gov/Departments/LongTermCare/NetworkDevelopment/Pages/Home.aspx#

The survey will only take a couple of minutes to complete.
We request that you complete it within 48 hours of receipt.

1. How satisfied are you with the 18-day claims processing turn around time?
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

2. How satisfied are you with the responsiveness of our staff on inquiries and concerns?
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

3. Overall how would you rate your experience with P/GLTC as compared to other ALTCS plans?
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

4. How satisfied are you with communications from P/GLTC in these areas?

a) web site
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

b) newsletters
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

c) blast fax
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

d) other electronic means
O Very Dissatisfied   O Dissatisfied   O Neutral   O Satisfied   O Extremely Satisfied

Other comments or concerns?

_____

_____

Please return your completed survey via one of the following choices: U.S. mail or confidential fax.
P.O. Box 2140, Florence, Arizona 85132
Fax: (520) 866-2906

If you wish to be contacted to discuss this further, please provide us with your contact information within the comments and concerns area of the survey. **Thank you for your participation and your time in completing this survey.**

Requirement 43: The Offeror must describe how their organization will handle the potential loss (i.e. contract termination, closure) in a GSA of a) a nursing facility and b) an assisted living facility.

The mission of Pinal/Gila Long Term Care (P/GLTC) is to provide comprehensive and coordinated healthcare services to elderly and/or physically disabled individuals who have difficulty taking care of themselves, both financially and physically so they can live independently as long as possible while maintaining an optimal level of health. In order to achieve our mission, we must ensure members receive high quality care and services from our contracted providers. We view this responsibility as a collaborative effort among P/GLTC, our providers, regulatory agencies, and other ALTCS and AHCCCS plans.

Prevention of Facility Closure
We take an integrated approach to the identification and prevention of any potential loss of a nursing home or assisted living facility. We require all facilities that face the possibility of closure or termination to provide us with a 60-day advance notice. This is in the contract and reviewed with the signing authority for all newly-initiated contracts and reinforced during annual compliance audits conducted for all Skilled Nursing facilities (SNFs) and Assisted Living facilities (ALFs). Prior to the onsite initial and annual compliance audit, our Provider Relations Representative reviews the Arizona Department of Health Services (ADHS) website facility site-visit reports in order to note deficiency citations, sanctions, and corrective action plan(s), when applicable for the most recent ADHS site visit date. This review is supplemented by our internal Compliance Audit tool which is focused on compliance with key contractual requirements. Based on the outcome of P/GLTC's audit, we may request the facility to submit additional corrective action plan(s) in coordination with the Organizational Credentialing Committee for facilities undergoing recredentialing. This request is made in coordination with the Chief Medical Officer (CMO), Dr. Bluestein and Director of Quality and Medical Management (DQMM), Kelly Morgan. All information

gathered during this process is tracked and trended to determine if the facility is either at risk of potential closure in the future or in immediate jeopardy of closure or termination by ADHS. P/GLTC may conduct focused investigations when data collected formally an informally from members and staff to substantiate a new or worsening issue within a SNF.

Critical Role of Provider Watch Committee
Any contracted organization or Long Term Care residences such as ALFs or Skilled Nursing Facilities where members' safety and health are potentially at risk may be placed on "Provider Watch" for closer monitoring. Provider Watch Committee (PWC) members include the senior Executive Management team representing the CMO, DQMM, CEO, Director of Case Management, the Chief Financial Officer, and the Contract Compliance Officer. The PWC meets monthly to regularly monitor those on Provider Watch. The DQMM convenes additional meetings to address urgent issues. The Committee's purpose is to determine the continued suitability of the facility as a residence for our members through the review and evaluation of all available data from Quality of Care concerns, ADHS' historical licensure site visits, grievances, appeals, focused site audits conducted at facility, and information regarding potential financial instability. The review determines whether members can continue to remain in the facility or be transitioned to another facility, whether a facility should be placed on an administrative hold to prevent additional members from placement, whether to withhold recredentialing or contract renewal, or whether to immediately terminate a contract. Provider Watch Committee actions are tracked and trended by the DQMM, with results included in the organizations' credentialing files.

Loss of Facility

Periodically, contracted residential facilities close their doors or are unable to meet the quality of care standards required by P/GLTC and ADHS. When our resources and efforts cannot prevent the closure of a facility, P/GLTC implements its Member Transition Policy and Procedure 04.21. This policy has been successfully implemented in the past with the closure of Desert Pavilion Skilled Nursing Facility and Lost Dutchman Adult Care Home when members were expeditiously and orderly transitioned in a systematic manner to alternate safe institutions or community-based settings, with minimal disruption to care.

Notification of Immediate Jeopardy Status

The Director of Quality and Medical Management (DQMM), the Chief Medical Officer (CMO) and Chief Executive Officer (CEO) are identified as recipients of information from AHCCCS. As such, they receive the email from AHCCCS of the notification of Immediate Jeopardy (IJ). Immediately, the DQMM informs the Director of Case Management (DCM) and the Director of Network Management and Development (DNMD) of the notification and status of the facility. An urgent Provider Watch Committee is convened to discuss the issue and develop a plan of action. The PWC consists of the Directors, the Quality Management (QM) Nurse, and the Supervisor of Provider Services. A Case Management Supervisor is included in the meeting to facilitate implementation of the interventions.

Because it is possible that there are other residents in the facility who are members of other AHCCCS/ALTCS plans, the P/GLTC Leadership team initiates a teleconference or face-to-face meeting with the leadership from other involved plans and the facility administrator to determine the lead program contractor, discuss the situation, options and potential interventions, and confirm the response plan which includes a staged response. The CMO assumes responsibility for clinical support and advised level of care placement. The ADHS licensing staff, city staff, and ombudsmen are included in the meeting to

provide input to the plan. The plan is submitted to ADHS for approval of our organization response and member transition plans. The Chief Executive Officer (CEO) contacts the Pinal County Assistant County Manager for Health and Human Services to inform and provide a short report on the activities. The CEO then notifies the Pinal County Public Relation Spokesperson to advise them of the situation.

Planning and Urgent Interventions

Execution and Collaboration

Network Management & Development Unit's Provider Relations staffs are deployed to perform the following preparatory and logistical support tasks:

- Identify providers with available services willing to accept members;
- Identify and contacts alternative providers;
- Mobilize all available emergency and routine transport based on member's need;
- Initiate contracting process, if applicable, for non-contracted facility;
- Initiate a county-approved procurement method, single case agreement, if applicable for a non-contracted facility;
- Coordinate with claims to ensure that facility payments reflect the last date of service; and
- Conduct an exit monitoring with the contracted provider and provide report to the appropriate committees.

Site Based Facility Support - Recognizing the need for staff on site, Medical Management Nurses, Case Managers, Behavioral Health Coordinators, and Network Development staff are dispatched to the facility, as needed. The nurses collaborate with the facility staff to provide triage assessments identifying the level of care required by each member. Case Managers conduct face-to-face contact with all members and collaborate with the facility staff to implement safety measures, and coordinate members' relocation.

A CM Supervisor is assigned as the liaison with the families and representative of the members residing in the facility. (S)he contacts each

authorized representative to notify him/her of the facility closure status and of actions being taken to ensure that the members continue to receive quality care and services, before, during and after member transition. The CM Supervisor offers the residents and representatives alternative placement and the CM Supervisor or designee arranges the transfer to another available, contracted or non-contracted facility that can manage the member's care requirements. Member and family choice and preferences are considered during this facility selection process. Behavioral Health staff assists members, facility staff, and others with coping services to optimize their effectiveness.

P/GLTC Office Based Operations - The PWC members and core staff remain in the P/GLTC office to facilitate processes from there. A Case Management Supervisor is assigned to remain at P/GLTC to act as a liaison with the members' families and representatives. The CM contacts each authorized representative to notify him/her of the facility status and of actions being taken to ensure that the members continue to receive quality care and services while transitioned to safe, alternative settings close to member's families when feasible. The CM offers residents and representatives alternative placement such as a community-based facility if members are determined to be suitable candidates for less restrictive settings. If alternative placement in requested, the CM arranges the member's safe transfer.

Facility Closure Trending
P/GLTC surveys the facility to determine the reason for closure so that facility turnover can be tracked in order to identify trends that may affect the effective functioning of our comprehensive network. This trending is a critical piece in the early identification of warning signs which serve as indicators of a possible or impending closure or termination. Once a trend is identified, interventions are put in place to prevent similar occurrences in the future. For example, as a result of the closure of Lost Dutchman ALF and Desert Pavilion SNF, we tightened contract requirements, increased

scrutiny through contract compliance, added additional elements to our Credentialing and recredentialing process, and actively monitor the informal communications from line staff such as Case Managers, QM and Provider Relations Representatives who visit contracted facilities on a routine basis. The goal is to become aware of potential closures long before an official notification from the facility or ADHS. Results of interventions are communicated back to the appropriate committees within the organization to evaluate effectiveness of interventions implemented.

Requirement 44: Describe the process for addressing provider performance issues, up to and including contract termination

Approach

We ensure that our members receive high quality care and services from our contracted providers whom we view and treat as partners in care provision. P/GLTC consistently addresses provider performance by using a variety of methods to monitor and ensure that our network standards are not compromised. Our integrated approach to provider performance management is grounded in our plan philosophy to build and maintain effective provider relationships while helping them meet performance standards that ensure the safety and optimal health of our members.

Prevention and Monitoring of Performance Problems

Provider Services Representatives conduct scheduled face-to-face site visits with providers on a quarterly basis and are available to providers and staff 24-hours a day, 7 days a week. This provides ongoing informal monitoring of performance as they help providers succeed by educating and reinforcing desired outcomes and behaviors prior to the development of problems.

In addition to this informal, consultative method, P/GLTC is continuously made aware of provider performance issues when they surface through various formal methods. These include formal annual contract compliance audits conducted by Network Management and Development, focused audits conducted by either Provider Services or Quality Management (QM) depending on the nature of the performance area, and formal committees, meetings, and task force reviews. The latter include the Credentialing and Peer Review Committee, Organizational Credentialing Committee, Cross Functional Task Force, Case Management Meetings, Grievance and Appeals investigations, the QM/Performance Improvement (QM/PI) Committee, Medical/Utilization Management (M/UM) Committee, and Provider Watch Committee.

Systems that support the analysis and trending of performance include PCM, the claims processing system, the Grievance and Appeals System, the Case Management System (Q Continuum), the Peer-protected quality of care concerns system, and the Provider Information and Management System (PIMS). During these meetings with information from available systems data, Provider Services may be directed to further investigate, research, or resolve provider performance concerns. In some cases, such as quality of care concerns, either our QM Director or our Chief Medical Officer investigates and communicates with providers directly to jointly discuss and resolve performance concerns.

Critical Role of Provider Services Representatives

Relying on information sources provided by our interdisciplinary teams, we monitor the performance of our network providers using our Provider Relations Representatives (PRR) as the focal point. PRRs perform more than 100 contract audits per year. When providers do not readily respond to our face-to-face site visit assistance efforts, a focused audit may be conducted and results immediately shared with providers with the goal being a desired change. Focused audits are conducted by a Quality Management team, Provider Relations Representative, or an inter-disciplinary audit team consisting of selected members from Quality Management and Provider Services. If serious deficiencies are uncovered, a formal request is made for a corrective action plan to be implemented within a requested time period.

For example, one of our CMs was notified by a member, that a staff employee at the ALF in which the member resided, was drinking alcohol while on duty. The CM immediately notified her Director who submitted a Quality of Care Concern. DQMM notified the DNDM who in turn, dispatched the Provider Relations Representative to drive the 30 miles to the facility after 6 pm to immediately investigate the concern. The concern was resolved within

30 minutes of notification when the owner acted cooperatively by immediately removing the caregiver from the premises while an internal investigation of the member allegations was conducted. This scenario illustrates our quick response to avert what could have been an undesirable situation with potential grave consequences.

Critical Role of Provider Watch Committee

Any contracted organization or Long Term Care residences such as ALFs, HHAs, Attendant Care Organizations, Adult Day Health, and Skilled Nursing Facilities where members' safety and health are potentially at risk may be placed on "Provider Watch" for closer monitoring. Provider Watch Committees consist of the senior Executive Management team consisting of the Plan Director, Chief Medical Officer, Case Management, QM, and Compliance Officer and can be convened at anytime based on need. The Committee's purpose is to determine the continued suitability of the facility as a residence for our members through the review and evaluation of all available data from ADHS' historical licensure site visits, grievance and appeals, and focused site audits conducted at facility. Questions about whether members can continue to remain in the facility or be transitioned to another facility, whether a facility should be placed on an administrative hold to prevent additional members from placement, whether to withhold recredentialing or contract renewal, or whether to immediately terminate a contract are addressed by the Provider Watch Committee.

Provider Performance Correction and Improvement

When performance problems do not lend themselves easily to direct, face-to-face assistance or when corrective action plans do not yield desired results, P/GLTC effectively utilizes another formal process called Joint Operations Committee (JOC). Here we bring the full expertise of various departments including QM, Case Management, Claims, and Network Management and Development to fully address recalcitrant provider performance problems. At these JOC meetings, focus is never punitive

but rather performance improvement-oriented. We specifically disclose our desired outcomes to ensure provider success by sharing our data and perceptions of their performance with a goal to have the providers formulate their own corrective action responses.

Once performance problems are acknowledged and intervention strategies agreed upon, the Joint Operations Committee Meetings are used to monitor and evaluate the effectiveness of interventions implemented. JOCs eventually end once performance results are achieved and maintained over time. The Joint Operations Committee typically lasts between two and six months depending on the complexity of problems and planned interventions. An example of this is the JOC on Transportation. P/G LTC and MTBA, the transportation vendor, collaborated on problem and barrier analysis and developed process improvements in communicating and coordinating rides among member, member's caregiver or facility and the MTBA's dispatchers, customer services and transportation operators. This collaboration resulted in a significant decrease in member complaints about waiting time and associated dissatisfaction.

Performance Rewards

P/G LTC also uses another effective method to prevent provider performance problems or quickly resolve them early. This method is performance-based compensation which has been effectively used to date with Assisted Living facilities. This innovative approach involves the use of aggregate provider concerns and ADHS licensure site visit data which includes scores on safety, medication, and other measures, to arrive at a composite score that allows P/G LTC to rank ALFs according to their overall performance. As a result, the Network Management and Development Unit created an ALF compensation system that rewards high performers. Similarly, in the area of clinical indicators we have a performance bonus system for PCPs and ALFs that is associated with the desired outcomes of members' in their care receiving annual flu shots.

Performance Monitoring Results

P/GLTC's program experience in the past 20 years shows that a collaborative approach often results in providers' responding to face-to-face guidance, education, consultation and technical assistance. Many contracted providers immediately correct performance issues to members' satisfaction when they are brought to their attention. Due to our unique track record and our ability to address and resolve member and provider issues in a rapid and effective manner, we have not had to terminate any physician providers in the past five years. Two SNFs were terminated in the past five years when quality of care concerns could not be corrected despite multiple efforts. The ultimate decision was finally reached judiciously and deliberately by the Provider Watch Committee.

Contract Termination and Provider Terminations Trending

P/GLTC is committed to our member-centered philosophy. By adhering to this philosophy, we do not compromise the standards established for contracted providers. When provider monitoring continues to identify uncorrected performance problems or the risks posed to members are immediate and life-threatening, decisions are quickly reached through emergency Provider Watch Committee meetings. At a final stage of the performance improvement process, and only after all possible resolutions have been exhausted, contract terminations may be exercised. The Network Director reports the planned actions to AHCCCS including the rapid execution of member transition plans which adhere to internal policies and procedures.

Furthermore, P/GLTC monitors all provider terminations in order to identify trends that may affect the effective functioning of our network. If a trend is identified, interventions are put in place to prevent similar occurrences in the future. Results of interventions are communicated back to the appropriate committees within the organization to evaluate effectiveness of interventions implemented.

Requirement 45: Offerors shall develop and maintain a provider network, supported by written agreements, which is sufficient to provide all covered services to ALTCS members.

P/GLTC shall submit the template(s) and the Network Attestation Statement to AHCCCS via the EFT/SFTP server by 3:00 p.m. on April 1, 2011. There will be no hard copy of this submission.

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

☐ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

☒ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶28 and ¶29; ALTCS Contract Section D, ¶28 and ¶29; ACOM Policy 415 Provider Network Development and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

Christine J. Liberto   3-28-2011

_____

(Network Administrator Signature)   Date