Chart 17. Grievance Data

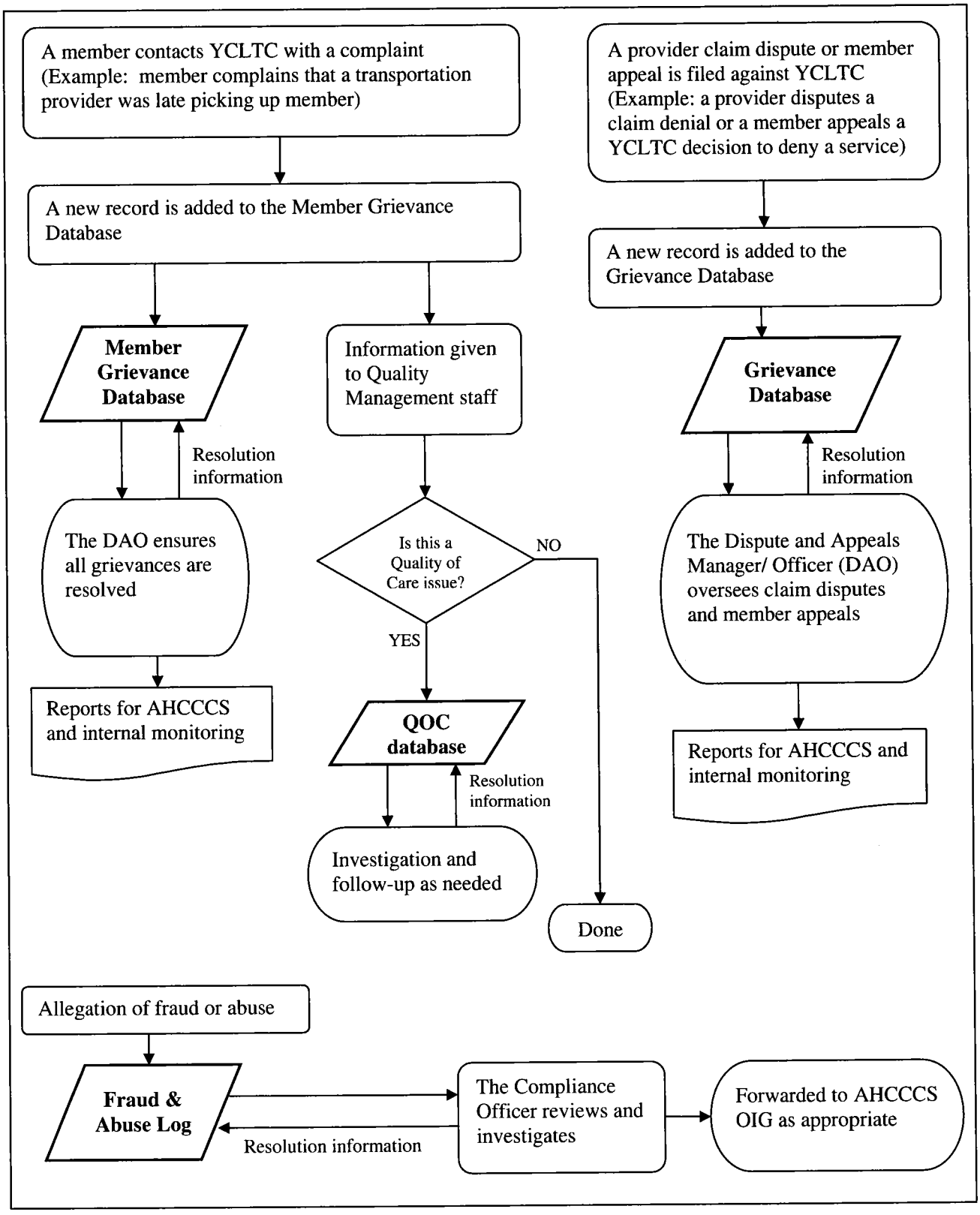


Chart 18. Provider Network

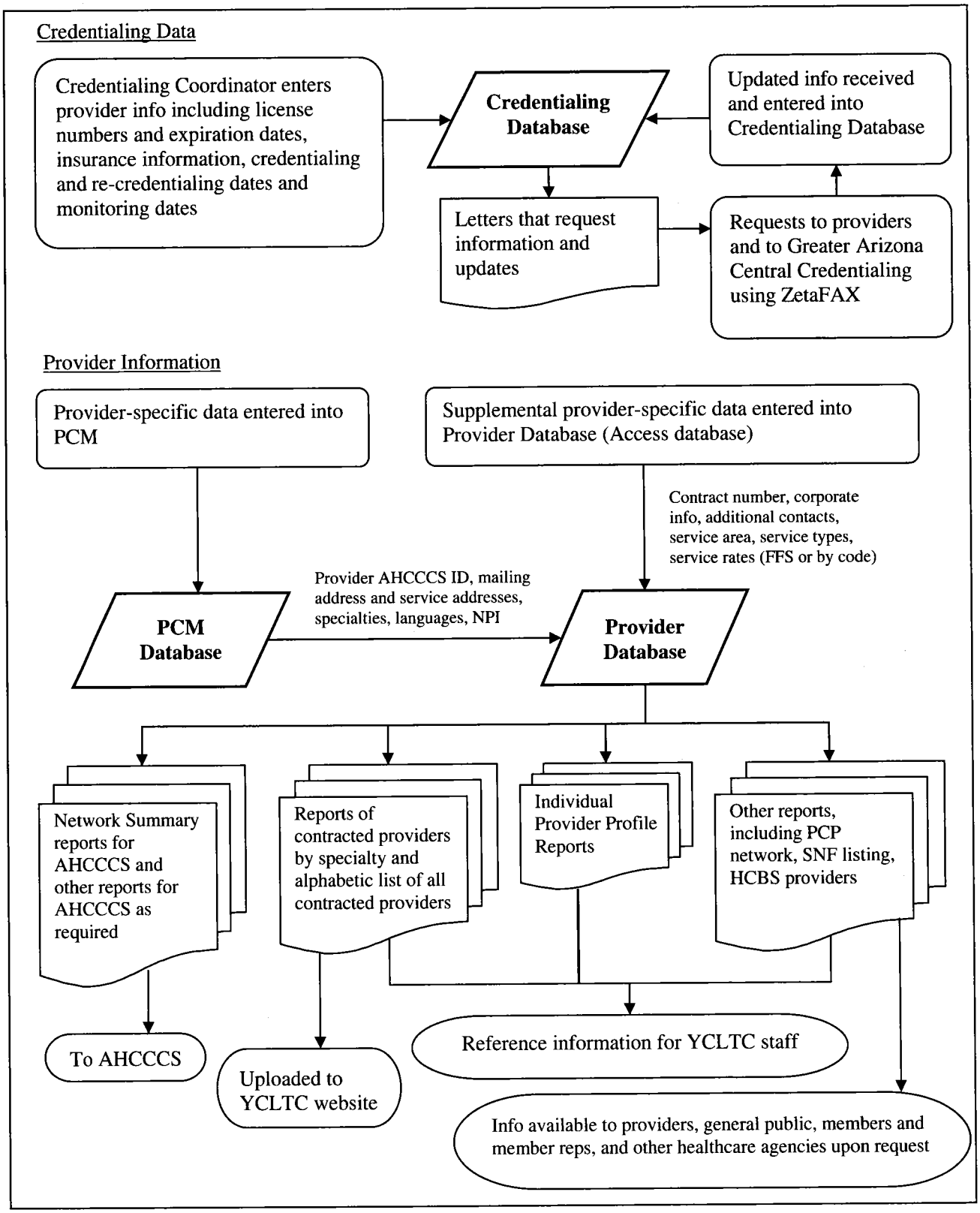
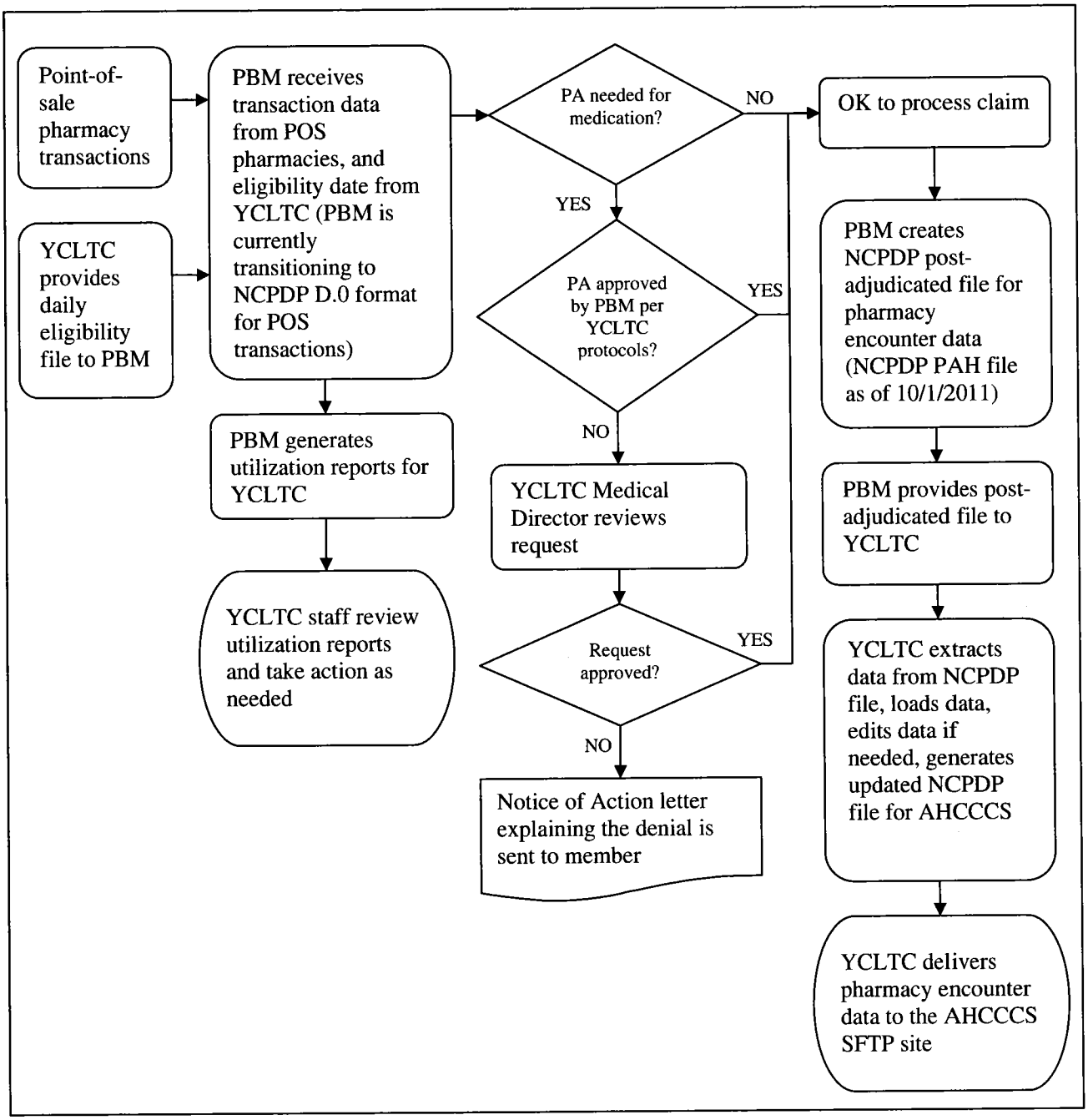


Chart 19. Pharmacy data



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

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

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

Basic Productivity Software

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

Plexis Claims Manager (PCM)

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

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

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

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

Q-Continuum System

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

EDI

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

Plexis Alerts

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

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

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

Benefits/Claims Management Software

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

Current version is Plexis Claims Manager 9.2.0

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Case Management Software

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

Current version is Q-Continuum System 1.0.4

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Cell (513) 252-6105
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Microsoft Office Software

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

Current version is Microsoft Office 2003

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

Electronic Data Interchange (EDI)

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

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

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

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

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

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

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

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

HIPAA and Protected Health Information

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

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

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

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

Electronic claims and Medicare crossover

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

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

Electronic Funds Transfer

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

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

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

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

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

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

EHRs (electronic health records)

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

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

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

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

Paper reduction technology

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

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

C. ORGANIZATION – GRIEVANCE SYSTEM Q.15

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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