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March 16, 2007

Jenny Foshee
Office of State Procurement
1509 West Seventh Street, Room 300
Little Rock, AR 72201-4222

Dear Ms. Foshee:

Innovative Resource Group, LLC d/b/a APS Healthcare Midwest (APS) is excited to respond to the **State of Arkansas for Medical Utilization Management Services, administered by the Department of Finance and Administration-Employee Benefits Division (EBD)**. As an organization dedicated to delivering high quality, custom designed specialty programs, particularly for State government and employers, we are eager to share our unique capabilities and experience with EBD described below.

APS' Overall Specialty Healthcare Experience

APS is a national, Specialty Healthcare Company that serves more than **20 million lives** through our array of healthcare products. We have over **1,200 employees** and more than **20 office locations** throughout the United States, including locations in **Arkansas, Arizona, California, Florida, Georgia, Hawaii, Louisiana, Maryland, Massachusetts, Missouri, Montana, North Dakota, Oklahoma, Puerto Rico, Texas, Washington, West Virginia, Wisconsin and Wyoming.**

In addition to the medical management services proposed in our proposal to EBD, APS also offers other specialty healthcare services that include:

- Health Management (including wellness and disease management services)
- Medical Case Management;
- Behavioral Health Care;
- Employee Assistance Programs and Work Life Services;
- Absence Management, including Short-term Disability and Family Medical Leave Management;
- 24/7 Nurse Help Line; and
- Informatics Consultation.

One of APS' key differentiating features is that we have the broadest experience of any specialty healthcare company in the industry with **15 years of Medical Management experience, more than 10 years of Disease Management experience, and more than 20 years of Behavior Modification experience, through our Behavioral Health and**

Employee Assistance Programs. In addition, APS is a two time EAPA Quality Award recipient and the 2005 Disease Management Association of America (DMAA) Best Government Disease Management Program Award recipient.

APS was founded on the belief that specialized healthcare management can yield a different kind of managed care company – A full service specialty healthcare organization, offering a comprehensive portfolio of healthcare products and services to manage the *whole person* at any given point along the healthcare continuum. Whether the person is suffering simultaneously from both diabetes and depression or has acute leukemia, APS' knowledgeable and experienced clinicians are able to deliver quality services resulting in optimal health and demonstrable outcomes.

The State's Account/Operational Team

To ensure we deliver our commitments and meet EBD's program performance expectations, APS will establish a team to directly serve the State. These individuals include:

- **One (1) Account Executive - Scott Strang, PhD, MBA**
- **Four (4) Utilization Review/Utilization Management Nurses - TBD**

As EBD's Account Executive, Dr. Strang will have ultimate responsibility for ensuring the success of your program, and will work with all other operations staff to accomplish this end. He will be responsible for meeting with EBD (in person and via teleconference as necessary), offering strategic program analysis and planning, and that all elements are coordinated and functioning properly before and beyond contract start up. Dr. Strang will also be responsible for meeting with EBD's key representatives to review utilization reports for trends, issue resolution, client satisfaction, monitor performance guarantees, and identify any opportunities for program improvement. In addition, Dr. Strang will be charged with establishing a partnership with EBD other external vendors to ensure a seamless process for participants. It is his overall responsibility to ensure all program components are fully understood and integrated into the delivery of services and that issues or concerns are quickly identified, addressed, and resolved through implementation and the life of the contract. Given that Dr. Strang will be based locally in Little Rock, Arkansas, he will be extremely accessible to the State when needed.

Upon contract award, APS will immediately begin to recruit for **Utilization Review (UR) Nurses** who will be based out of our existing Montana Service Center. These individuals will be fully trained on EBD's benefits to ensure superior service to your members and the providers that care for them. Dr. Strang will communicate regularly with our Montana UM team to discuss the program's performance, resolve issues quickly, etc., to ensure we meet the State's expectations and performance standards.

Utilization Management Experience – APS' Montana Service Center

Our Montana Service Center, where the State's team will be housed, has been operational since the mid 1980's through our predecessor companies. Our Montana Service Center is a full-service operation as a myriad of specialty services including medical and behavioral utilization management and case management, maternity services, and Employee Assistance Programs.

Specifically, APS provides medical utilization and case management services to a number of diverse customers from large employers to health plans out of our Montana Service Center. Examples include the State of Montana, the Federal Employees Plan, Blue CHIP Program, the Montana University System, the Montana Association of Counties, Montana Comprehensive Health Association, and the Montana Unified School Trust. We have also had a long standing relationship with Blue Cross Blue Shield of Montana since 1986. As part of their medical utilization and case management program, APS has developed seamless interfaces with the Plan and local facilities, efficient workflows, and positive working relationships with their staff over the years to ensure their program's continued success.

In addition, APS provides a range of services including disease management and behavioral healthcare services to other customers out of our Montana Service Center such as the Indiana Comprehensive Health Insurance Association, Micron Technology, Cerner Corporation, and the United Food and Commercial Workers of Arizona. Furthermore, APS provides behavioral utilization management services to customers including the State of South Carolina, the State of Maryland, the State of Georgia (Medicaid), and the State of Arkansas (Medicaid) from our other service centers scattered across the United States.

APS will use our experience serving other utilization management customers to ensure your program is a success.

APS' Arkansas Presence & State Government Experience

APS already possesses experience building a successful program for the State of Arkansas. Currently, we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for 400,000 Medicaid recipients (lives) under the age 21. APS was selected to administer the State's program in July 2003, and established an office in Little Rock, Arkansas with approximately 30 staff to serve the State's eligible recipients. **Scott Strang, PhD, MBA**, our proposed Account Executive for EBD's program, is based in Little Rock and oversees the State's existing Medicaid Program. As a result, we believe Dr. Strang will be a good fit as the Account Executive for EBD's program. He is already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State. This included establishing two separate Provider Advisory Groups for inpatient and outpatient provider groups with memberships that

range from community mental health centers to for-profit provider groups to hospital systems. In addition, when we first won the contract, we aggressively reached out to local providers to train them on our innovative web-based preauthorization system, which was completely customized to meet the State's specifications. Trainings occurred through a variety of means such as road shows, teleconferences, etc. As a result, APS achieved incredible buy-in from the provider community. In fact, **within the first week of the program's launch date, we had a 90% provider participation rate for our web-based system, and now tout a 99% usage rate for active providers to date.**

Furthermore, APS has achieved high satisfaction rates amongst the local provider community as indicated by our latest satisfaction survey below:

- 91% of respondents were overall satisfied the service they received from APS
- 94% of respondents either agree or strongly agree that APS' Staff have been accessible and willing to assist in resolving any problems with the authorization process.
- 91% of respondents either agree or strongly agree that APS Care Coordination consultations have been accessible to their agency upon request.
- 94% of respondents either agree or strongly agree that when they need help, APS staff members are accessible and responsive.

Comments have also included:

The APS reviewers are very collegial and provide good questions and assistance. Thank you all so much. Your system is user-friendly and captures the essence of inpatient continued stay reviews.

APS has been very accessible/supportive of our agency in assisting in improving quality of care. I have felt the relationship to be collaborative, focusing on quality care for children of Arkansas.

In addition to Arkansas, APS has a long and successful background assisting State governments in their efforts to manage services and health care delivery for their employees and family members. Currently, we administer 42 programs through contracts in 23 states, including Arkansas, California, Georgia, Florida, Indiana, Hawaii, Louisiana, Maryland, Mississippi, Missouri, Montana, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Texas, Washington, West Virginia, Wisconsin, Wyoming and Puerto Rico.

APS will use the same level of commitment and enthusiasm for EBD's program as we have and continue to do for our existing Medicaid contract with Arkansas as well as our other State contracts.

Extensive Interface Experience

APS has a long history of establishing successful data exchanges with numerous trading partners, vendors, and providers for our customers – we will do the same for EBD as well as your Third Party Administrators and benefit partners. Our extensive experience includes over 100 active interfaces that are currently transmitting and receiving eligibility, claims, authorizations, and assorted assessments and case history data. Below are just a few examples of our data transfer capabilities with our customer's third party vendors:

Customer	TPA	Interface Type	Frequency	Lives
Motorola	Medstat	Authorization and Claims	Weekly	62,000
State of Wyoming	ACS	Medical Authorizations	Daily	55,000
The Dow Chemical Company	Medstat	Claims	Monthly	52,000
State of Georgia	Artemtrix	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	48,000
	Morehouse	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	
Campbell Soup Company	Ingenix	Authorizations and Claims	Monthly	24,000
Indiana Comprehensive Health Insurance Association	ACS	Medical Authorizations	Weekly	7,550

APS is fully capable of handling any data exchange needs a customer may require in terms of volume, frequency, type and size. The technical capabilities and configuration of the sending entity will determine the best method of data transmission. This may include secure file transfer protocol (FTP) methodologies (data is usually exchanged by posting on a secure FTP site that allows APS to both send and receive data), CD-Rom, zip files, electronic mail, and tapes to support batch file transfers. When data needs to be shared or consolidated (e.g., visits, treatments, authorized services, etc.), wherever possible APS also uses industry standard interfaces such as ANSI X12 / HIPAA compliant interfaces. We will work with the State and your information partners to ensure data exchanges between APS, EBD and your selected vendors all meet current HIPAA regulations for encryption and security.



A Proposal to the State of Arkansas
Medical Utilization Management Services
1.24 Contract Information



Vendors should note the following regarding the State's contracting authority, and amend any documents accordingly. Failure to conform to these standards may result in rejection of proposal.

- 1) The State of Arkansas may not contract with another party:**
 - a. To indemnify and defend that party for any liability and damages. However, the State Procurement Official may agree to hold the other party harmless from any loss or claim resulting directly from and attributable to the State's use or possession of equipment, software or services and reimburse that party for the loss caused solely by the State's use or possession (this is the only form of indemnification to which the State Procurement Official can agree).**
 - b. Upon default, to pay all sums to become due under a contract.**
 - c. To pay damages, legal expenses or other costs and expenses of any party.**
 - d. To continue a contract once the service has been terminated.**
 - e. To conduct litigation in a place other than Pulaski County, Arkansas.**
 - f. To agree to any provision of a contract which violates the laws or Constitution of the State of Arkansas**

APS complies.

- 2) A party wishing to contract with the State of Arkansas should:**
 - a. Include in its proposal that the laws of the State of Arkansas govern the contract.**
 - b. Acknowledge in its' proposal that contracts become effective when awarded by the State Procurement Official.**

APS agrees that the laws of the State of Arkansas govern the contract. In addition, we acknowledge that contracts become effective when awarded by the State Procurement Official.



A Proposal to the State of Arkansas
Medical Utilization Management Services
1.25 Vendor References



ACTIVE REFERENCES

Company Name	Montana University System
Contact Name	Paul Bogumill
Contact's Title	Director of Benefits for the State of Montana
City	Helena
State	Montana
E-Mail Address	pbogumill@oche.montana.edu
Telephone Number	(406) 444-0329
Description of Services Furnished	Utilization Management, Disease Management and Employee Assistance Program Services

Company Name	Blue Cross/Blue Shield Montana
Contact Name	Sharon Robinson
Contact's Title	Director Medical Management
City	Helena
State	Montana
E-Mail Address	Sharon.Robinson@bcbsmt.com
Telephone Number	(406) 444-8430
Description of Services Furnished	Utilization & Case Management, Disease Management, Behavioral Healthcare, and Employee Assistance Program Services

Company Name	The State of Arkansas
Contact Name	Roy Jeffus
Contact's Title	Medicaid Director
City	Little Rock
State	AK
E-Mail Address	roy.jeffus@medicaid.state.ar.us
Telephone Number	(501) 682-1671
Description of Services Furnished	Utilization Management, retrospective audits, continuing education, inspections of care and Care Coordination for Inpatient and Outpatient mental health services for Medicaid Recipients under age 21.

A Proposal to the State of Arkansas
Medical Utilization Management Services
1.25 Vendor References



TERMINATED REFERENCES

Company Name	P5 eHealth Services, Inc.
Contact Name	Camile Drew
Contact's Title	Vice President Sales & Marketing
City	Salt Lake City
State	Utah
E-Mail Address	cdrew@p5Health.com
Telephone Number	801-412-7913
Description of Services Furnished	Medical & Behavioral UM/CM Services and Maternity Services

Company Name	The State of Ohio
Contact Name	Mitali Ghatak
Contact's Title	Enhanced Care Management Program Director
City	Columbus
State	Ohio
E-Mail Address	ghatam@odjfs.state.oh.us
Telephone Number	(614) 466-4693
Description of Services Furnished	<p>Disease Management Services (Medicaid)</p> <p>In August 2004, APS was selected by the Ohio Department of Job and Family Services (ODJFS) to administer multiple regions of the State of Ohio's Enhanced Care Management (ECM) Program, and by April 1, 2005, APS had satisfactorily met the State's extensive readiness requirements for Cuyahoga County, the largest county in Ohio. The ECM was a new statewide program available to Ohio Medicaid consumers receiving services through the Aged, Blind, or Disabled Fee-For-Service program who suffered from the following chronic illnesses: adults with asthma, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, non-mild hypertension, or diabetes, and asthma for children under the age of 21. While our services were well received by the State as well as its members and provider community, the ECM program was rescinded on September 30, 2005 due to legislative changes in Medicaid and lack of funding from the legislature.</p>

A Proposal to the State of Arkansas
Medical Utilization Management Services
1.25 Vendor References



Company Name	Briggs and Stratton Corporation
Contact Name	Barbara Ehlers
Contact's Title	Manager, Group Insurance Plan Administration
City	Milwaukee
State	Wisconsin
E-Mail Address	ehlers.barbara@basco.com
Telephone Number	(414) 259-5887
Description of Services Furnished	Medical Utilization Management and Behavioral Utilization & Case Management (APS still provides EAP services).





Medical Utilization Management Services

2.0 Scope of Work

Details of Scope:

A. Utilization Management/Review

- 1) The Vendor shall perform, in a timely and prompt manner, pre-certification review, continued stay review, and retrospective review based on medical necessity, appropriateness of care, and appropriate level of care for:
 - a) Inpatient hospital admissions;
 - b) Sub-acute admissions;
 - c) Inpatient rehabilitation
 - d) Skilled nurse facility;
 - e) Residential treatment;
 - f) Transplants
 - g) Cognitive rehabilitation
 - h) Limited out-patient hospital surgical procedures
 - i) Physical therapy, occupational therapy, speech therapy
 - j) Chiropractic services
 - k) Radiology
 - l) Prior approval for home infusion therapy, organ/tissue transplants, nursing service
 - m) Certain outpatient surgical procedures
 - n) And other services

Innovative Resource Group d/b/a APS Healthcare Midwest (APS) is pleased to present our proposal to provide a comprehensive Utilization Management (UM) Program on behalf of the Department of Finance and Administration – Employee Benefits Division (EBD) for the Arkansas State Employees and Public School Employees, retirees and dependents.

APS acknowledges that the pre-certification reviews, continued stay reviews, and retrospective reviews based on medical necessity, appropriateness of care, and appropriate level of care for the services listed above are included in our proposed program for EBD and will be performed in a timely and prompt manner.

APS is a national, leading Specialty Healthcare Company with expertise in providing all facets of healthcare services. We seek to personalize and enhance the care provided to EBD's members by addressing their needs holistically, and by seeking input from medical providers, behavioral health experts, family members and other care givers. As we demonstrate throughout our proposed UM approach for EBD, APS has a long and successful background assisting states in their efforts to manage services and health care delivery in a cost-effective manner.

We currently administer 42 Programs in 23 States across the United States, including Arkansas, California, Florida, Georgia, Hawaii, Indiana, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Montana, New York, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Texas, Washington, West Virginia, Wisconsin and Wyoming.



Medical Utilization Management Services

2.0 Scope of Work

APS' Arkansas Experience

APS already possesses experience building a successful program for the State of Arkansas. Currently, we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for 400,000 Medicaid recipients (lives) under the age 21, 55,000 of whom we authorized for mental health services. APS was selected to administer the State's program in **July of 2003**, and established an office in Little Rock, Arkansas with approximately 30 FTEs to serve the State's eligible recipients. **Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock and oversees the State's existing Medicaid Program.**

Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State. When APS first won the contract, we aggressively reached out to the provider community through a series of regional presentations introducing APS' philosophy, business model, technology and key staff members. This was followed by an extensive series of teleconference training sessions on the use of an innovative web-based preauthorization system, which was completely customized to meet the State's specifications. As a result, APS achieved incredible buy-in from the provider community. In fact, within the first week of the program's launch date, we had a 90% provider participation rate for our web-based system, and now tout a 99% usage rate for active providers. APS' outreach to the provider community has also included the establishment of two (2) Provider Advisory Groups.

The Inpatient Advisory Group is composed of representatives (mostly CEOs) of five acute psychiatric hospitals and five free standing psychiatric residential treatment facilities. The outpatient advisory group is composed of representatives of five (of 15) community mental health centers and five for profit outpatient service providers. Each group meets on a quarterly basis and serves as a forum for providers to give APS feedback about its services and for APS to engage the provider community in dialogue regarding quality improvement issues.

Furthermore, APS has achieved high satisfaction rates amongst the local provider community as indicated by our latest satisfaction survey below:

- 91% of respondents were overall satisfied the service they received from APS
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- 91% of respondents either agree or strongly agree that APS Care Coordination consultations have been accessible to their agency upon request.
- 94% of respondents either agree or strongly agree that when they need help, APS staff members are accessible and responsive.

Comments have also included:

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.0 Scope of Work

The APS reviewers are very collegial and provide good questions and assistance. Thank you all so much. Your system is user-friendly and captures the essence of inpatient continued stay reviews.

APS has been very accessible/supportive of our agency in assisting in improving quality of care. I have felt the relationship to be collaborative, focusing on quality care for children of Arkansas.

APS will use the same level of commitment and enthusiasm as we did for our existing Medicaid contract with the State for EBD's program.

APS' Utilization Management Experience

APS has been providing **Medical Utilization and Case Management services for 16 years; and Behavioral Health Utilization and Case Management for 15 years.** As an added value to EBD, APS has provided **Disease Management services for 12 years and Employee Assistance Programs for over 20 years.**

Some of our UM clients include the **State of South Carolina, State of Maryland, State of Wyoming, Indiana Comprehensive Health Insurance Association, Hawaii Medical Service Association (Blue Cross Blue Shield of Hawaii), Blue Cross Blue Shield of Montana, and the State of Nevada effective July 1 of 2007,** to name a few.

APS' mission is to provide quality, holistic care management services to participants; to monitor and evaluate the quality and appropriateness of services provided; and to collaborate with participants and providers to facilitate provision of the most cost-efficient utilization of health care resources necessary to achieve improved health outcomes across the continuum of care. We are dedicated to working with our customers to tailor our programs specific to your unique needs, philosophy, and benefit structure.

We fully understand and appreciate that a *one size fits all approach* is ineffective in meeting our customers' needs. As such, our UM Program addresses the full spectrum of inpatient and outpatient health care therapies and settings. From straightforward inpatient review to identification of potentially complex cases for management, we offer a comprehensive selection of services to promote efficient use of health care resources and optimal outcomes.

The overall goal of APS' utilization review program is to assure the *right* care is delivered at the *right* time in the *right* setting.

Through a multidisciplinary team of highly-qualified clinicians, APS focuses on safe, efficacious and optimal utilization (level of care/length of stay) by concentrating **on the whole member** as opposed to just the episodic issue at hand, promoting an active treatment plan focused on recovery, and an individual's collaboration with that plan.

Our UM Program is designed to:

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.0 Scope of Work

- Eliminate inappropriate inpatient admissions or reliance on institutional settings whenever possible;
- Promote the use of alternative levels of care;
- Reduce length of stay and improve overall health outcomes;
- Target interventions and supports that are cost effective without sacrificing quality;
- Reinforce a collaborative approach between members, families, providers and other community-based supports;
- Emphasize employment, social and other natural supports and methods of self-determination as appropriate; and
- Emphasize recovery and resilience.

Local & Customized Service Delivery

APS will build upon our established relationships with community and provider organizations to form a partnership to advance the best possible health care outcomes in Arkansas. As such, APS will provide EBD with locally-based staff to best serve your membership from our established office in Little Rock.

As discussed above, Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock. Dr. Strang is an excellent fit as the Account Executive for EBD's program. He is already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

In addition, APS is pleased to establish an experienced, focused clinical team in our Montana Service Center to serve EBD's members. This team will include four (4) Nurse Reviewers and two (2) Health Coaches (if awarded the Disease Management services contract) to serve EBD's members.

APS is entirely experienced in developing experienced, focused teams to best serve our customers. For example, in Montana, APS has been serving Blue Cross Blue Shield of Montana since 1986. APS has spent the past 18 years building an infrastructure that specifically addresses the needs of BCBSMT. We maintain offices with more than 79 employees throughout Montana in Butte, Billings, Helena and Missoula. From our mutual hard work and cooperation over the years, we have created innovative programs and synergies between our medical and behavioral health services that have resulted in a truly holistic approach to personal well-being and have repeatedly demonstrated savings. Currently, we provide medical/surgical Utilization Management, Case Management, and Population Management services for the plan. In addition, as a part of the Population Management program, APS manages chronic illness for diabetes, congestive heart failure, coronary artery disease, depression, low back pain and maternity for the plan's approximately 141,000 commercial and Medicare members.

In another example, in 2004 APS was selected by the State of Wyoming Office to provide services. The program is responsible for utilization management, peer review, case

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.0 Scope of Work

management and quality assurance services for medical and behavioral health, including substance abuse. APS also provides wellness and prevention programs and education, working in partnership with a full spectrum of Wyoming Public Health and Human Services officials and programs.

APS provides comprehensive disease management to address, at a minimum, the following chronic illness/disease states: **asthma, diabetes, coronary artery disease, congestive heart failure, high-risk maternity, chronic obstructive pulmonary disease, and depression**. We also provide complex case management services for those identified with trauma, congenital disease, hemophilia, cancer, and other identified high-cost, high-risk conditions. Furthermore, we provide wellness (prevention and education) services to the entire population, including 24-hour access to nurse consultation via a dedicated toll-free number.

Using state-of-the-art technology, including a suite of proprietary APS risk management and predictive modeling tools, the program identifies individuals through claims data, outreach and other health risk appraisal activities to determine appropriate level of care.

Care managers/Health Coaches work with the patients and support the physicians' treatment plan as well as find resources for the Medicaid client as needed (transportation to office visits, food, clothing, etc.) The APS program is designed to support physicians and other healthcare providers and assist in supporting the treatment plan and encouraging patient compliance.

Another example of our success building customized programs is in the State of Louisiana. Since April of 2004, APS has provided Disease Management and Health and Wellness services to the State of Louisiana Office of Group Benefits (OGB) targeting **diabetes, coronary artery disease, congestive heart failure, hypertension, hyperlipidemia, asthma, and COPD**. Our current offering for OGB includes **telephonic health coaching; face-to-face health coaching utilizing locally-based Regional Health Coaches; health and preventative self-management; complex case management; worksite health promotion and biometric screenings; educational materials; web-based tools; and physician engagement and outreach**. In 2006, we conducted more than **63** health fairs/lunch and learns; **43** provider site visits; and **48** home visits.

Furthermore, APS contracted with the Georgia Department of Community Health in October of 2005 to provide population and disease management services. The program provides **health coaching, care coordination, education, provider assistance, a 24-hour nurse call center, and pharmacy consultation**. The overall objectives of the program are designed to help those with chronic illnesses (**asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, hemophilia, psychiatric disorders, substance abuse**) to better understand and manage their health care needs, to drive evidence-based best practices, to achieve superior clinical and financial outcomes, and to lessen the cost burden of health-related expenses for the state.

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.0 Scope of Work

Our strategy places Health Coaches in health care locations – hospitals, physician practices, community clinics – where our Health Coaches can develop effective disease management relationships with members and providers to shift services to primary care settings.

In the State of Georgia we have received seven contract awards since our original relationship in 1999. In addition, APS received the national disease management leadership award from the Disease Management Association of America for Outstanding Provider Engagement Initiative for our Georgia Enhanced Care Program.

Lastly, combined with the breadth and depth of our experience, an additional advantage for EBD is APS' **Clinical Resource Network** which includes **20 in-house (APS employee) Medical Directors** and an additional **77 consulting physicians** who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development.

APS offers EBD measurable member and provider outcomes that will result in a significant increase in health status, while introducing new methods of quality improvement and technology. Our experience is a great asset to the success of EBD. Because of the tremendous vision expressed in your RFP, the importance of choosing a company with a track record of successful, scaleable and replicable outcomes is paramount. It is important that EBD have a vendor practiced in the art of solving problems and introducing change in the most obvious, straightforward and prioritized manner. This only comes with experience.



Medical Utilization Management Services

2.1 General Requirements

Wyoming. This involved establishing effective program policies, procedures, and internal workflows as well as successful interfaces with our subcontractor partners. These individuals will use their experience, insight and enthusiasm to ensure each and every component of EBD's UM program is a success. APS will identify other key implementation resources, consisting of multi-disciplinary subject matter experts, at the time of EBD's initial implementation kick-off meeting. In short, we have a record of satisfied customers due to our experienced personnel and infrastructure. In choosing APS, EBD will benefit from a partner with seasoned staff who have with a broad healthcare knowledge base, including the intricacies and challenges of large State government operations, and have delivered well-received, customized program solutions.

Company Background

APS is a National Specialty Healthcare Company founded in 1992 by Dr. Kenneth A. Kessler, a physician and healthcare executive with more than 30 years of experience. Since APS' inception, Dr. Kessler's vision has been to build a different kind of healthcare company – one that offers a unique suite of integrated specialty healthcare products and services that manage the healthcare needs of individuals through the entire continuum of care. To bring this vision to life, APS initially established a reputation of success in the healthcare market by focusing on behavioral healthcare and Employee Assistance Programs (EAP) services. By 1999, APS had been successful in building a recognizable customer base in these market areas consisting of health plans, commercial employers, and public sector employers, as well as several large state-wide Medicaid contracts.

With a strong foothold in two key healthcare markets, APS began to mobilize a strategic plan of targeted acquisitions designed to increase the depth and breadth of our product offerings. In 1999, APS acquired Vydas Resource Inc. (VRI), a healthcare company offering medical management services, as well as a unique line of proprietary Informatics-based tools. Through the acquisition of VRI, APS moved its business into the medical management arena and expanded its capabilities across all products through the addition of Informatics tools.

In 2001, APS continued to strengthen its medical management line of business, as well as add products geared to support the changing needs of the employer market through the acquisition of Innovative Resource Group (IRG). With this acquisition, APS diversified into the disease management and physical medicine markets and also added a portfolio of absence management products and wellness services. In addition, with this acquisition APS also expanded its analytical capabilities with the addition of a complete Informatics Consulting Division. This Division brought additional data analysis tools and staff expertise to APS' Informatics capabilities that are used to support each of our products.

Company History

1992 APS founded by Ken Kessler, M.D., a pioneer in behavioral healthcare.



Medical Utilization Management Services

2.1 General Requirements

- 1995** APS acquires CH/ECP, Inc., a behavioral healthcare and employee assistance program (EAP) company.
- 1998** APS establishes a Public Programs division, focused on providing services to government agencies.
- 1999** APS enters care management business through the acquisition of VRI. APS establishes operations in Puerto Rico.
- 2001** The company officially changes its name to APS Healthcare, Inc., to reflect its focus on holistic health management. APS acquires EAP and behavioral healthcare business of Sheppard Pratt Health System.
- 2002** APS acquires Innovative Resources Group (IRG) and increases its depth of informatics and health management capabilities. APS receives its first Employee Assistance Professional Association Quality Award for EAP Excellence.
- 2003** Leading private equity firm, **H.I.G. Capital**, invests in APS.
- 2005** Eileen Auen, a senior-level healthcare industry executive, is appointed CEO. APS receives the Disease Management Association of America's Recognizing Excellence Award for best government disease management program.
- 2006** APS approaches **\$200** million in revenue. APS adopts the tagline "Healthy Together" to reflect its focus on physical and mental healthcare management. APS receives the Disease Management Association of America's Outstanding Provider Engagement Initiative award.

APS is an Award Winner

Today, APS is one of the leading providers of *Integrated Health Management Solutions* with more than **16** years of experience providing quality-driven medical programming; **20** years of experience providing EAP and Work/Life services; and **15** years of experience providing behavioral healthcare services. We currently serve over **1,000** customers, representing approximately **20** million lives across the United States, including Hawaii and Puerto Rico.

APS Healthcare's Achievements

Two-Time EAP Digest/Employee Assistance Professionals Association Quality Award recipient for employee assistance program excellence

Disease Management Association of America's Recognizing Excellence Award for Best Government Disease Management Program

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.1 General Requirements

Disease Management Association of America's Recognizing Excellence Award for Outstanding Provider Engagement Initiative

Fellowship Award from Community Behavioral Health Association for Outstanding Service to Provider

Named one of the top 10 disease management companies in 2005 and 2006 by Health Industries Research Companies

Programs for disabled populations have earned "Promising Practices" recognition by the Centers for Medicare & Medicaid Services (CMS)

International Cardiff Award for Software Systems Design

APS has over **1,200** employees and more than **20** office locations throughout the United States. For example, APS has Operations Centers and Staff Model/Account Management offices in **Arizona, Arkansas, California, Florida, Georgia, Hawaii, Louisiana, Maryland, Michigan, Montana, North Dakota, Puerto Rico, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming.**

These facilities are all connected via a centrally managed Wide Area Network. Our facilities range in size from five person offices to 400 person regional service centers. This variety gives us experience setting up and supporting virtually any size office in any geographic location. Our current operations use more than 208 servers providing support for myriad activities including hosting health information and wellness website products, claims payment systems, email, advanced statistical predictive modeling, statistical and qualitative reporting, and collaborative team tools.

Our product portfolio includes:

- Health Management including Wellness and Chronic illness management services
- Medical Utilization Review and Case Management;
- Behavioral Healthcare Management;
- Absence Management, including Short-term Disability and Family Medical Leave Management; and
- Informatics Consultation.

APS also partners with leading specialty companies to further complement our product offerings upon customer request. These have included:

- Biometric health screenings
- Disease Management services beyond our core conditions (e.g., renal and end-stage renal disease)
- Web-based Health Risk Assessment and Lifestyle Management Programs



Medical Utilization Management Services

2.1 General Requirements

- 24/7 Nurse Line and Health Decision Support

We are the **ONLY** specialty healthcare company with extensive experience delivering Medical Management, Disease Management, Behavioral Health and Employee Assistance Programs. In addition, we are the **ONLY** Medical Management vendor in the industry that also has more than **20 years of behavioral change experience.**

Our continuum of Health Management Solutions are supported by a **Behavioral Change Paradigm**, which makes our programs more effective in changing negative health behaviors and achieving positive clinical, and thus financial outcomes. We understand the impact of motivators, environment, culture, literacy and demographics and know how to link physical and behavioral health for each participant to achieve sustained outcomes.

Public Sector Experience

APS has a long and successful background assisting State governments, like Arkansas, in their efforts to manage services and health care delivery for their employees and family members. Currently, we administer **42** programs through contracts in **23** states, including **Arkansas, California, Georgia, Florida, Indiana, Hawaii, Louisiana, Maryland, Mississippi, Missouri, Montana, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Texas, Washington, West Virginia, Wisconsin, Wyoming and Puerto Rico.**

APS has a proven history of business integrity and adherence to contractual obligations, and has never lost a customer due to a performance issue.

Arkansas Experience

It's important to note that APS already possesses experience in the State of Arkansas. Currently, we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for **400,000** Medicaid recipients (lives) under the age 21, **55,000** of whom we authorized for mental health services. APS was selected to administer the State's program in July 2003, and established an office in Little Rock, Arkansas with approximately **30** FTEs to serve the State's eligible recipients. Scott Strang, PhD, MBA, our proposed Executive Director for EBD's program, oversees the State's existing Medicaid Program.

Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State. When APS first won the contract, we aggressively reached out to the provider community through a series of regional presentations introducing APS philosophy, business model, technology and key staff members. This was followed by an extensive series of teleconference training sessions on the use of an innovative web-based preauthorization system, which was completely customized to meet the State's specifications. As a result, APS achieved incredible buy-in from the provider community. In fact, within the first week of the program's launch date, we had a **90%** provider participation rate for our web-based system, and now tout a **99%** usage rate for active providers. APS' outreach to the provider community has also included the establishment of **two** Provider Advisory Groups. The Inpatient Advisory Group is

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.1 General Requirements

composed of representatives (mostly CEOs) of five acute psychiatric hospitals and five free standing psychiatric residential treatment facilities. The outpatient advisory group is composed of representatives of five (of 15) community mental health centers and five for profit outpatient service providers. Each group meets on a quarterly basis and serves as a forum for providers to give APS feedback about its services and for APS to engage the provider community in dialogue regarding quality improvement issues.

Furthermore, APS has achieved high satisfaction rates amongst the local provider community as indicated by our latest satisfaction survey below:

- 91% of respondents were overall satisfied the service they received from APS
- 94% of respondents either agree or strongly agree that APS' Staff have been accessible and willing to assist in resolving any problems with the authorization process.
- 91% of respondents either agree or strongly agree that APS Care Coordination consultations have been accessible to their agency upon request.
- 94% of respondents either agree or strongly agree that when they need help, APS staff members are accessible and responsive.

Comments have also included:

The APS reviewers are very collegial and provide good questions and assistance. Thank you all so much. Your system is user-friendly and captures the essence of inpatient continued stay reviews.

APS has been very accessible/supportive of our agency in assisting in improving quality of care. I have felt the relationship to be collaborative, focusing on quality care for children of Arkansas.

APS will use the same level of commitment and enthusiasm as we did for our existing Medicaid contract with the State for EBD's program.

Additional Experience: State of Wyoming

In 2004, APS was selected by the **Wyoming Office of Medicaid** to provide services for the state of **Wyoming** Medicaid population in a national model for integrated wellness, health management and chronic care improvement for public sector beneficiaries. The program is responsible for utilization management, peer review, case management and quality assurance services for medical and behavioral health, including substance abuse. APS also provides wellness and prevention programs and education for all **Wyoming** Medicaid recipients, working in partnership with a full spectrum of **Wyoming Public Health and Human Services** officials and programs.

APS provides comprehensive disease management to address, at a minimum, the following chronic illness/disease states: **asthma, diabetes, coronary artery disease, congestive heart failure, high-risk maternity, chronic obstructive pulmonary disease, and depression.** We



Medical Utilization Management Services

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also provide complex case management services to Medicaid clients identified with: trauma, congenital disease, hemophilia, cancer, and other identified high-cost, high-risk conditions. Furthermore, we provide wellness (prevention and education) services to the entire population, including 24-hour access to nurse consultation via a dedicated toll-free number.

Using state-of-the-art technology, including a suite of proprietary APS risk management and predictive modeling tools, the program identifies Medicaid patients through claims data, outreach and other health risk appraisal activities to determine appropriate level of care, which will be provided by case managers and disease managers.

Care managers/Health Coaches work with the patients and support the physicians' treatment plan as well as find resources for the Medicaid client as needed (transportation to office visits, food, clothing, etc.) The APS program is designed to support physicians and other healthcare providers and assist in supporting the treatment plan and encouraging patient compliance.

APS' Healthy Together total population health management program helped the State avoid more than **\$127** million in unnecessary healthcare costs in its first reconciliation year, which ended on December 31, 2005. APS managed an average of more than **7,800** clients per month. The average cost avoidance for clients, while still maintaining quality care, was **\$135** each month, which was **\$36** above the target savings per member per month.

In addition to the financial benefits, APS Health Coaches also helped clients achieve significant improvements in prevention measures such as diabetes testing, eye exams, glucose monitoring, statin usage, cholesterol monitoring, bronchodilator usage and other preventative treatments and testing to improve their overall health and well-being.

APS Program Success in Wyoming

APS' Disease Management programs have been especially designed to target unnecessary ER visits by fostering greater knowledge of how best to use the health care system and increasing the member's ability to recognize the signs and symptoms that can lead to an ER visit in sufficient time to address the issue in an outpatient setting. **Health coaches that identify a member who has had one or more unnecessary ER visit(s) attempt to:**

- 1. Determine if the member has a medical home and, if not, help him/her establish one;**
- 2. Assess the level of social support available to the member;**
- 3. Provide disease specific educational services; and**
- 4. Refer the member to a behavioral health specialist if necessary.**

Immediately upon initiating its Disease Management program in **Wyoming**, APS began to monitor Medicaid members who had seven visits or more to the ER. This group of frequent ER utilizers was cross-matched with all Medicaid members in our Clinical Care Management System to determine if they were either currently being case managed or enrolled in the Disease

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Medical Utilization Management Services

2.1 General Requirements

Management program. Members who were not case managed or enrolled in one of our programs but met the clinical criteria were assigned to either a case manager or a disease manager depending on the diagnosis of the emergency visit. Those members who did not meet one of the clinical criteria for our Disease Management programs but had high ER utilization were referred on to a case manager.

As a result of APS' efforts with Medicaid members with chronic conditions, even as the number of people covered by Wyoming Medicaid increased by three percent from January 2004 to June 2005, expenditures for Medicaid decreased by nearly 9%.

Brent Sherard, MD, MPH, director of the Wyoming Department of Health, credits the decrease, in part, to the drop in the use of expensive emergency department services by clients, as well as support and education provided to clients through APS' Disease Management program, which empowers clients to take more responsibility for their own care and reinforces when to appropriately seek medical care. Our program drove a drop in non-emergent ER claims from \$1.2 million in 2004 before the Wyoming Disease Management program began, to just over \$870,000 in 2005. As illustrated by these savings, we have a proven ability to coordinate frequent ER management with our Disease Management activities. We were able to achieve these savings because of our knowledge and experience working with the Medicaid program and Medicaid members.

Terri Green, medical policy manager for the Wyoming Department of Health stated, *"The project has positively impacted the member population by promoting lifestyle modifications and treatment plan compliance, providing education and support, and helping those living with chronic disease feel their best and improve their overall quality of life."*

Our work has consistently received awards, high praise, and recognition from government agencies, industry trade groups, and individual recipients. For example, APS was recognized in October 2005 by the Disease Management Association of America as having the **"Best Government Disease Management Program in the United States"** for our landmark partnership with the State of Wyoming, where we have exceeded all financial and clinical performance measures.

Al Lewis, President of the Disease Management Purchasing Consortium International, Inc. called Wyoming's disease management program, *"The most innovative and comprehensive disease management program in the country with more savings per capita than any other State Medicaid disease management program."*

C. provide your definition of utilization management services;

APS defines UM services as the process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.



Medical Utilization Management Services

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To help ensure members receive the appropriate level of care, APS performs reviews of medical and behavioral healthcare services to monitor and evaluate treatment requests. Utilizing a mind and body approach, APS' URAC-accredited UM combines the use of informatics-based tools and nationally recognized clinical practice guidelines into a holistic method for effectively managing healthcare costs while achieving optimal outcomes for members.

APS' multi-disciplinary team of clinicians, including registered nurses, registered psychiatric nurses, licensed social workers and licensed professional counselors, evaluates treatment requests using a collaborative approach to managing the comprehensive needs of each member.

Our utilization review process is also used as a vehicle for identifying members who could benefit from case management. As APS reviewers gather clinical data associated with the review process, sophisticated algorithms are then used to identify cases that are appropriate for case management.

APS is capable of reviewing any type of healthcare service and can customize its UM program to meet EBD's specific needs.

D. specify the delivery of services including a description of the delivery model for utilization management services;

APS will provide services telephonically and on-site in Arkansas. As discussed above, we will provide EBD with locally-based staff to best serve your membership from our established office in Little Rock.

Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock. Dr. Strang is an excellent fit as the Account Executive for EBD's program. He is already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

In addition, APS is pleased to establish an experienced, focused clinical team in our Montana Service Center to serve EBD's members. This team will include ~~four (4)~~ Nurse Reviewers and ~~two (2)~~ Health Coaches, if EBD purchases the Disease Management Program, to serve EBD's members.

An additional advantage to be utilized for EBD is APS' Clinical Resource Network which includes ~~20~~ in-house (APS employee) Medical Directors and an additional ~~17~~ consulting physicians who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development.

APS' Montana Service Center is full-service with ~~79~~ FTEs who provide the complete continuum of behavioral and care management services including UM, Case Management, Disease



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Management, Behavioral Healthcare, Employee Assistance Programs and Informatics Analyses (Predictive Modeling). From this service center we provide care management for a wide variety of clients including the State of Montana, Montana University System (MUS), Montana Unified School Trust (MUST), Blue Cross Blue Shield of Montana, Indiana Comprehensive Health Insurance Association (ICHIA), Montana Comprehensive Health Association, Federal Employee Program, UFCW Local 99 (Arizona), Micron Technology, and Cerner Corporation, to name a few of our customers.

APS is pleased to propose a team of highly qualified and respected health care professionals to provide UM services. This team is available for both the implementation and operations phases of this contract and devoid of any potential conflicts. APS is ready to serve and advocate for the best outcomes for EBD and your members.

APS' operations have an outstanding reputation in delivering quality review services. Key values inherent in our programs are a dedication to local operation and personnel that are focused, knowledgeable and respected by clients. In the body of this proposal, we describe APS' UM programs in a number of states. We include detail about their populations, issues, activities and results. We also describe assessment tools, procedures and technology we have already developed. Our in-depth knowledge and experience in all aspects of the health care delivery system provide us with a strong base from which to develop an efficient and effective program for EBD that assesses and reviews cases properly, and provides effective decision support tools that enhance planning.

We are able to assist EBD in ways that will dramatically mitigate "*learning curve*" issues, establish trust, and exceed expectations. We invite a close inspection of our references and the quality of our work. Additionally, we look forward to helping EBD continue to move the system forward and to increase the quality and effectiveness of your UM Services. We believe that our partnership with you will enhance the services and improve the health of the State of Arkansas' employees and their families.

E. provide information on the individuals providing utilization services;

Two key members of EBD's Program include **Scott Strang, EBD's Locally-Based Account Executive and Cheryl Harkin, RN, MBA, Executive Director, Montana Service Center.**

Local Account Executive

APS' proposed Account Executive for EBD's program is Dr. Strang as described above. He is based in Little Rock and oversees the State's existing Medicaid Program. We provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for 400,000 Medicaid recipients (lives) under the age 21, 55,000 of whom we authorized for mental health services. APS was selected to administer the State's program in July 2003, and established an office in Little Rock, Arkansas with approximately 30 FTEs to serve the State's eligible recipients. Dr. Strang will have authority to act on behalf of APS for all daily activities related to the performance of the contract.



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Dr. Strang will be available to EBD to assist with facilitation of communication and reporting. Additional duties will include:

- Ensuring all services necessary to provide continuous and full compliance with the review requirements of the UM contract;
- Determining and recommending staffing needs, interviewing and selecting staff, directing and motivating staff, conducting regular staff meetings and reviewing staff performance;
- Distributing and prioritizing work flows among staff;
- Working with the Medical Director to develop and update review criteria;
- Leading and coordinating provider relations communication and education efforts;
- Coordinating all reporting activities associated with the contract; and
- Troubleshooting any seen and unforeseen problems or delays.

Experienced Medical Leadership

Cheryl Harkin, Executive Director, Montana Service Center, has 27 years of clinical experience. She received her B.S. in Nursing from Loretta Heights College, and her M.B.A., from the University of Phoenix. She is a current member of the Colorado Rehab Insurance Nurses Group, and has held previous memberships in the Colorado Health & Life Claims Association (president), the Wyoming Homecare Alliance (board member), the National Association of Homecare, and the National Hospice & Palliative Care Organization.

In addition to her current position as Executive Director, Ms. Harkin also acted as the Clinical Director of APS' Montana Service Center in the past. In this position, she was responsible for directing division medical services and operations; reorganizing the medical services division to promote cross-functional team concepts and operational performance improvement; and developing strategic initiatives for client satisfaction and retention.

Over her career, Ms. Harkin has held numerous clinical and management positions. This includes Manager of the Medical Surgical and Orthopedic Units for the Community Medical Center in Missoula where she was responsible for the daily operations of a 41-bed medical surgical unit; daily operations of a 10-bed orthopedic unit; and chaired the Nursing Education Committee. She also acted as the Director for Home Health and Hospice in Wyoming where she managed daily operations of two cost centers, implemented a performance improvement program, as well as authored and implemented a homecare compliance plan. She was the Operations Manager for the Adult Care Clinic at Denver Health Medical Center, where she managed the daily operations of three large ambulatory clinics; chaired the Community Health Services Triage Committee; and was a member of numerous hospital and community health committees. She was the Branch Manager and Regional Outcomes Expert for Coram Healthcare where she had operational and financial responsibility for the Colorado regional branch of a national home infusion company including P&L, pharmacy operations, inventory & warehouse, nursing services, sales, nutritional support. She also had regional responsibility for their proprietary outcomes-program-including presentations and sales support. Furthermore, she spent seven years in Group Health for a major indemnity carrier and in an HMO program.



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In the event that it becomes necessary for the APS team to replace any key personnel including nurse reviewers, physician reviewers, information system personnel, and other available review personnel. APS will utilize the resources within our corporation to find the most qualified individual. If that is not possible, APS is expert at health care specialty search, using recruitment firms when necessary. APS recruitment successes are evident in the quality personnel employed in our utilization and medical review operations throughout the United States. APS also provides cross training of staff. This requires our personnel to understand the job requirements of their respective counterparts, as well as have an understanding of associated functional areas. APS strives to replace all key personnel and management staff within 30 days or less. If a shorter period is necessary we will work with the client to establish an acceptable timetable.

APS has the capability and willingness to perform all the tasks associated with the smooth implementation and operation of the UM program. Our proposed staff plan will ensure that all commitments are met and that sufficient personnel are available to cover all contingencies. As part of our overall strategy, we believe it is in our best interest to continually train and provide educational opportunities to our staff. We believe these opportunities will keep them abreast of new procedures and technologies, which will benefit you, the client. When replacement personnel arrive on-site, we will conduct thorough training programs designed specifically for their job position, EBD's contract and other APS requirements.

F. Vendor must notify EBD if any changes in vendor's representative

APS confirms our understanding that we must notify EBD of any changes in the Account Executive position.

Replacement Personnel Plan

APS understands the importance of having back-up personnel plans in the event that problems arise in the availability of key personnel. We also understand that the quality and professional credentials of those identified to work on EBD's program are material factors in EBD's selection of a UM vendor. In this light, we will comply with all of EBD's specifications related to personnel replacement:

- APS will use all commercially reasonable efforts to ensure the continued availability of those individuals mentioned throughout our proposal.
- We will not remove these identified staff from the project without prior, written consent from EBD, except for legal or disciplinary issues. In these situations, we will still make a reasonable effort to give EBD 30 calendar days of prior written notice of the removal.
- If the removal of a listed individual is permitted or if an individual becomes unavailable, we will submit the resumes for two (2) replacement people for each person removed or who otherwise becomes available. APS will submit the two (2) resumes, along with such other information as EBD may reasonably request, within five (5) business days after the



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decision to remove a person is made or the unavailability of a listed person becomes known to EBD.

- APS understands that if EBD rejects both replacement candidates due to their failure to meet the minimum qualifications identified in the RFP, or if we fail to provide the notice required under this Section or fail to provide two qualified replacement candidates for each removed or unavailable person, that we will be in default and the cure period for default specified elsewhere in EBD's contract will not apply. We understand that EBD will have the right to terminate the contract and to have the specified damages for termination due to default.
- APS understands that if the proposed replacement candidates meet the minimum qualifications of the contract but still substantially reduce the value EBD perceived it would receive through the work of the original individual(s), EBD has the right to reject any candidate that it determines will provide it with diminished value.
- APS understands that if EBD rejects both proposed candidates for any legal reason other than their failure to meet the minimum qualifications identified in the RFP, then such rejection may be determined a termination for convenience.
- APS understands and agrees to remove any individual working on the project if EBD determines that any such individual has or may interfere with EBD's interests (i.e., providing a healthy and safe environment for its employees and guests at its facilities; ensuring its operations are carried out in an efficient, professional, legal and secure manner). In these cases, APS will follow the procedures mentioned above for replacing unavailable people.

In those instances where personnel replacement is necessary, APS will use both internal resources and external recruiting agencies to expeditiously identify potential replacements who meet EBD's requirements as well as possess equivalent credentials and experience as the original staff member. Our first line of support will be to utilize the resources within our corporation to find the most qualified individual. This may include developing a **personnel replacement plan**, which will identify potential staff within our organization who are available to replace any staff listed by name in our proposal. In addition, whenever possible, APS will provide cross-training to staff serving EBD. This requires each of our personnel to understand the job requirements of their respective counterparts, as well as have an understanding of associated functional areas.

If we are unable to locate a qualified individual internally, APS utilizes health care specialty search and recruitment firms who specialize in identifying executive level and operational staff within the healthcare industry. These recruitment agencies are already familiar with APS' high expectations, and understand the caliber of individuals required to work effectively within our infrastructure as well as serve our customers.

G. Vendor must agree to change the assigned vendor's representative at EBD's request

As stated above, APS agrees change the Account Executive at EBD's request. APS expects to work collaboratively with EBD to locate and hire staff and to assure that each staff member will



Medical Utilization Management Services

2.1 General Requirements

meet your needs. **We will recruit with your involvement; and we welcome any recommendations and/or referrals you may have.**

We understand this process to be collaborative and recognize that the staff members assigned to work with EBD will work one-on-one with your key representatives and your members, therefore staffing should be conducted in accordance with your preferences and mindful of your specific needs.



A Proposal to the State of Arkansas



Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

Acknowledge each item/submit documentation as required with proposal:

A. The Utilization Management (UM) company must have at least (5) five years experience in the business of utilization review/precertification, preferably with experience in working with state or federal government clients.

APS successfully meets the minimum years of experience requirement for Utilization Management (UM). APS has provided **Medical Utilization and Case Management services for 16 years; and Behavioral Health Utilization and Case Management for 15 years.**

As an added value to EBD, We have been providing **Disease Management services for 12 years and Employee Assistance Programs for over 20 years.**

Our UM clients include the State of Maryland, State of South Carolina, State of Montana and State of Wyoming; as examples.

B. The company must use recognized UM software criteria.

We use the following criteria:

- Milliman USA Guidelines (10th Edition revised 2006) for medical/surgical inpatient review and ambulatory services;
- HCIA-Sachs;
- American Society of Addiction Medicine (ASAM 2nd Edition revised 2001) for chemical dependency reviews; and
- Health Management Strategies (HMS) for Psych reviews.

These guidelines are integrated into our clinical documentation system. This allows for immediate online access for Nurse Reviewers. Nurse Reviewers not only review member status against guidelines, they document status at each review in APS' integrated MIS used for managing UM, Case Management and Disease Management cases.

C. The company will have some UR certified nurses performing UR for the EBD members.

APS plans to augment its existing staff and recruitment is underway to hire **four (4) Nurse Reviewers** who will be specifically focused on EBD's program. **A minimum qualification for our Nurse Reviewers is that they be licensed Registered Nurses.** Our clinical staff must meet the following stringent qualifications to join the APS team of professionals:

- Must be a currently licensed Registered Nurse with a working knowledge of medical procedures and practices for medical reviews.
- Must be a Registered Nurse with at least 3 years of psychiatric experience, Licensed Social Worker, or Licensed Professional Counselor for behavioral health reviews.

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Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

- Must have 3 years experience in acute inpatient care.
- Must have working knowledge of CPT-4 and ICD-9 codes.
- Must have computer skills.
- Must have excellent customer service, written and oral communication skills.

APS' approach in hiring RNs who will focused on EBD's program provides the kind of concentrated attention and resources that are needed in order to facilitate continuous quality improvement and cost savings. This approach is successful because it is devoted to focused program initiatives and a single customer, EBD. This approach promotes excellent staff morale, a shared mission of positive outcomes, and quality care for EBD and its members. The end result is a program that is highly engineered to demonstrate clinical excellence and sound fiscal results.

D. The company will require continuing UR education for their nursing staff.

Yes, APS confirms that we require continuing UR education for our nursing staff.

It is our policy to provide our clinicians with the opportunity to enhance their professional knowledge by encouraging attendance at in-service programs and participation in external continuing education programs. APS' training program is designed to provide opportunities for CEU credits and ensure our staff are kept apprised of the latest developments in disease management. We provide a minimum of **15** training programs a year, a majority of which allow for the opportunity to earn CEU credits. Our on-site training facility is equipped with all of the latest technological advancements to ensure an optimal learning environment.

In addition, for clinicians who choose to participate in outside training opportunities, APS is flexible in allowing time off to attend courses. Our policy is to reimburse all costs associated with completion of professional development requirements.

Clinical Staff Training Process

We continually monitor nursing and other staffing to ensure adequate resources are available to meet our obligations. To ensure clinical staff have the appropriate training to perform their job responsibilities consistent with APS' quality standards, all clinical staff must complete a formal training program. We maintain a state of the art training facility on-site at our National Medical Management Center and our training programs are led by APS' National Training Manager. The National Training Manager's responsibilities include administering, organizing and conducting company-training programs for clinical and non-clinical staff. Additionally, the National Training Manager implements new training programs, assists with system development and facilitates systems initiatives between IT and APS' Medical Management Division.

The APS training model establishes early mentor relationships between new and seasoned APS staff. Highly experienced personnel work hand in hand with newly hired staff throughout training and on an ongoing basis. This assures that program participants benefit from the



Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

knowledge of some of the most experienced and successful health care professionals in the industry. We have outlined our training program for clinical staff below.

We have included a sample orientation schedule for a new utilization management reviewer below.

Orientation Schedule For New UM Reviewer

- Training Curriculum
- APS portfolio
- Utilization Management Overview
 - Structure
 - Nursing staff
 - Medical Directors
 - Support staff
 - Case Management
 - Disease Management
 - Relationship to clients
- Introduction to computers
 - APS Care Connection®
 - Eligibility screens for various clients
- APS Care Connection® Training
 - APS Care Connection® Overview
 - Member Search, Coverage & Creating Temporary Members
 - Starting an Admission & Leakage Reason
 - Diagnosis and Procedures
 - Clinical Information
 - Notes
 - Reminders & Letters
 - Concurrent Review & Discharge
- Utilization Management Review Process
 - Preadmission
 - Admission
 - Concurrent
 - Case Management Referral
 - Medical Director Referral
 - Levels of care reviewed
 - Inpatient
 - Ambulatory
 - Inpatient Rehabilitation
 - Skilled Nursing
- Criteria
 - Milliman Care Guidelines



Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors

- Inpatient and Surgical Care
- General Recovery Guidelines
- Recovery Facility Care
- Ambulatory Care
- APS OB assessment
- APS Newborn assessment
- Client Overview
- Contracts
- URAC self study
- Policies and Procedures
- Department of Labor (DOL) regulations
- HIPAA
- Language line
- Phone etiquette
- Human Resources Orientation
- Sales to Service
- Reporting
- Healthwise
- Websites
- Quality Improvement

Additionally, recognizing the importance of behavioral change in UM and the impact behavioral health conditions have on a person's overall health, all clinicians are trained to assess every program participant for behavioral and social risk factors that may be negatively impacting their health status. This component of our training is unique among UM vendors. Our training reflects this and incorporates strategies to support effective behavior change. It includes detailed behavior training to assist our clinicians in getting individuals fully-engaged in the disease management and/or case management process, and motivating behavioral changes which enable participants to successfully achieve their self-management goals and sustain an optimal level of health.

Our behavioral health leaders have spent significant time developing comprehensive behavioral training modules to provide education and instruction to our clinicians on skills related to behavior modification and have created a comprehensive behavioral modification training program. Sample discussion areas include:

Vocabulary – The ABC's of Behavior

- Response cost
- Primary reinforcement
- Secondary reinforcement
- Positive reinforcement
- Negative reinforcement



**Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors**

- Punishment (negative and positive)
- Extinction
- Discriminative stimuli
- Association bonds (habit)

Increasing the Frequency of a Desirable Behavior (Building Bonds)

- Shaping/successive approximation
- Stimulus and response generalization
- Reducing response cost
- Modeling and behavioral rehearsal
- Adding cues – Behavioral guidance prompting/fading
- Adding consequences
- Premack Principle
- Schedule of reinforcement

The Importance of Cognitions

- Span the delay of reinforcement
- Reframe/reinterpret/cognitive restructuring
- Abstinence Violation Effect (AVE)
- Cognitive Dissonance

The Key Ingredients of Change

- Skill acquisition
- Expectancy for positive consequences
- Self efficacy
- Supportive environment
- Supportive coach/trainer
- Meta-change - Supportive coach/trainer environment

Why People Don't Change?

- Conflict and ambivalence
- Delay of reinforcement
- Motivation

When to Use Active/Reflective Listening

- Early during a case-in order to build rapport after greeting and brief discussion (confirmation) of mission and before you go into the disease specific assessment.
- When you don't understand what the participant is trying to say - his/her message.
- When the participant says something that strikes you as unusual, peculiar or out of character; something doesn't make sense.
- When you want to affirm something the participant is saying.

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Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

- When you want the participant to know that you are listening.
- When you want to lead the participant toward a goal, such as a helpful reframe or a particular problem solving strategy.
- As part of motivational interviewing in order to resolve ambivalence about change.

E. Currently service at least with at least 25,000 employees (employees include actives, COBRA, and non-Medicare primary eligible retirees); describe the population you serve.

APS services many clients with at 25,000 employees. We have provided information below on two – the **State of South Carolina and the State of Maryland**.

State of South Carolina

For the **State of South Carolina**, which has **194,704** employees, we provide **Behavioral Health Utilization and Case Management** services. Features of the program that have worked smoothly and contributed to the overall success and satisfaction include:

- Hiring locally-based, dedicated **State of South Carolina** staff;
- Loading of daily eligibility file updates from the State;
- Coordination with the medical administrator, **Blue Cross Blue Shield of South Carolina**, for common deductible and out-of-pocket accumulations and \$1,000,000 lifetime maximum;
- Coordination of benefits for Medicare beneficiaries and the pre-existing condition exclusion; and
- Compliance with the customer requirement to display APS claims payment information so that State representative, acting on behalf of a subscriber, can monitor the actions taken by APS on specific cases.

Specifically, APS has provided behavioral health services to the **State of South Carolina's State Group Health Plan** since January of 2002. Over our history with the State, we have partnered with **Blue Cross Blue Shield of South Carolina (BCBSSC)** to deliver the highest quality Behavioral Health Management Program. Some of the accomplishments we achieved for the State over the course of our relationship have included but are not limited to:

- Building a **comprehensive mental health/substance abuse provider network in a rapid timeframe**. For example, when APS first began providing managed behavioral health services to the **State of South Carolina** in January of 2002, our network consisted of **259** credentialed individual providers. **By the end of the second quarter, we had credentialed 766 individual practitioners, 24 hospitals, 18 programs and 41 agencies.**
- Establishing **dedicated account management and operational teams** to serve the Plan's program. This includes an exclusively dedicated Account Executive, **Linda Smith**,



Medical Utilization Management Services

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Network Coordinator, Nancy Heathcott, MA, EIP Specialist, Neena Dhanashan, as well as a team of Care Managers, Member Referral Coordinators, and Claims Processors.

- Effectively containing costs for the Plan under Parity legislation.
- Establishing positive provider partnerships through dedicated staff, varied provider educational activities, and cooperative utilization management practices. In fact, according to the South Carolina Facility Satisfaction Survey, 100% of facilities were satisfied with the overall manner in which APS handles the managed mental health care of its members.
- Developing customized protocols to improve coordination of care. For example, for the State of South Carolina, APS has developed customized interface protocols with the State's medical vendor, BCBSSC, with regard to co-occurring clinical cases and claim payment.
- Developed effective data exchanges with EIP and BCBSSC for eligibility, shared deductibles, and out-of-pocket accumulator data.
- Developed a customized EIP website, <https://sosceip.apshealthcare.com>, which contains both Plan member claims and eligibility data. This website, which is updated on a daily basis enables EIP staff to answer member questions regarding claims and eligibility issues.
- Achieving significant savings for the Plan that include:
 - Negotiation of Low Provider Rates – APS saved the Plan 43% on inpatient services, 38% on partial hospitalization services, 36% on intensive outpatient services, and 13% on outpatient services.
 - COB Procedures – APS has saved the Plan nearly \$5 million in coordination with carriers for the State.

State of Maryland

APS has served as the State of Maryland's Behavioral Healthcare and Employee Assistance Program vendor since 2001. The State of Maryland has 88,000 employees.

To serve the State, we have assembled a highly qualified team of Account Management, Clinical, Customer Service, Claims, Network, Quality and Reporting professionals who are dedicated to their account. APS' State of Maryland team has worked to provide the highest caliber of service to employees and their dependents and retirees. Since the very successful implementation in 2001, APS' dedicated State of Maryland team works on a daily basis to meet or exceed every performance guarantee mandated by the State. The team is not only well versed in the State of Maryland culture and benefits structure, but has forged indispensable

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Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

relationships with key **Department of Budget and Management** staff and the local provider community enabling us to be more than just a vendor, but rather their partner.

APS helped design, develop and implement the State's unique EAP counseling model that provides up to three supervisory-mandated sessions as well as Critical Incident Stress Debriefings for agencies experiencing traumatic work situations.

The dedicated APS Account Service Manager for the State has participated in all of the State's Open Enrollment Committee meetings since APS began managing employees' mental health and substance abuse benefits. Not only does APS attend every agency's scheduled Open Enrollment Meeting and Agency Benefit Coordinator Training Session, but APS has presented on topics related to mental health and substance abuse at hundreds of Health Fairs and Conferences around the State.

Additional highlights of our program for the State and historical success in providing quality behavioral healthcare and EAP services to their members includes, but is not limited to:

- APS has built a comprehensive mental health/substance abuse provider network in **Maryland** to specifically meet the clinical and geographic needs of the State's members. This network now includes **3,244 practitioners** and **54 facilities**.
- APS has developed a sub network of EAP Affiliates specifically for the State who are designated to their contract to provide face-to-face counseling services for employees referred to the EAP.
- The dedicated **State of Maryland** clinical team has received **positive reviews from the State's external auditors**. Some of the auditors' comments included positive remarks on the clinical team's overall motivation and dedication to providing service to the State, staff concerns with patient confidentiality, timeliness of utilization review decisions, and level of clinical supervision.
- APS has maintained exceptionally high levels of telephone service performance since the life of our contract with the State. Since 2001, we have achieved an average speed of answer of **21 seconds or less** and will continue to exceed the State's standards in this area.

In addition to achieving high levels of service and clinical satisfaction, as well as providing a fully customized program, APS has consistently demonstrated our effectiveness to the State in terms of cost savings. APS has achieved outstanding savings for the State due to the integrity of our clinical services and competitive provider discounts.

F. The company shall not administer any part of this contract by an off shore service center.

APS does not administer any part of its programs utilizing an off shore service center. **Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock.** Dr. Strang is an excellent fit as the Account Executive for EBD's program. He is

A Proposal to the State of Arkansas



Medical Utilization Management Services 2.2 Minimum Qualifications of Vendors

already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

In addition, APS is pleased to establish an experienced, focused clinical team in our Montana Service Center to serve EBD's members. This team will include four (4) Nurse Reviewers and two (2) Health Coaches, if EBD chooses to purchase the Disease Management Program, to serve EBD's members.

G. Have a certificate to perform utilization management services for the state of Arkansas Department of Health and provide a copy in this RFP.

Yes, APS is authorized to conduct business in the State of Arkansas. APS has provided our certificate to perform UM services for the State of Arkansas as **Attachment II**.

H. The company must demonstrate a track-record of on-going coordination of services with major health plans, preferably ones located in the State of Arkansas.

APS already possesses experience building a successful program for the State of Arkansas. We were selected to administer the State's **U21 Medicaid Mental Health Utilization Management and Quality Improvement Program** in July 2003, and established an office in Little Rock, Arkansas with approximately **30** FTEs to serve the State's eligible recipients. Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State including with the State's individual health plans.

Upon award of EBD's UM contract, APS will immediately begin by working with EBD to develop a specific plan for on-gong coordination of services and data sharing.

We have established administrative and clinical interfaces that allow for "*just in time*" communication about events in an individual's life that lead us to intervene and make cross-referrals to our clients' benefit partners.

For example, we provide worksite wellness and disease management services for the **State of Louisiana Office of Group Benefits (OGB)**, APS has developed interface protocols, procedures and workflows with their benefit partners, including **United Behavioral Health (UBH), Catalyst Rx, FARA Benefit Services and Patient InfoSystems**. There has been a high level of cooperation between the vendor companies in an effort to provide exceptional service to the **OGB** membership and collaboratively reduce overall costs to **OGB**, including increasing referrals and collaboration between the programs and establishing an on-going rapport.

APS has worked with **Catalyst Rx, OGB's** pharmacy vendor, on a project that resulted in identification of **3,912 OGB** members who were not participating in **Catalyst's Diabetic Sense Program** nor were they engaged with the APS Healthy Together Program. APS is now in the process of targeting this population to engage in both programs.



Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors

In addition, APS has worked collaboratively with **Patient InfoSystems, UBH and FARA** to develop a process for obtaining information real time when a patient is admitted to the hospital enabling us to contact the individual and enroll them in the program prior to their discharge from the hospital.

Another great example of our ability to establish successful partnerships with our clients' benefit partners includes our program for **Mellon Financial Corporation** for which we provide a range of interventions for individuals affected by high-risk pregnancy, asthma, diabetes, cardiac issues, low back pain and depression. Based upon our expertise, we have been able to effectively establish one of our most cooperative partnerships to date with **Highmark** and in doing so; **Mellon's** program is one of the most successful in the United States.

Highmark and APS have collaboratively developed criteria that would prompt a Health Coach to refer a participant to case management services. For example, these triggers include:

- AIDS related illness
- Coma
- Complex newborns
- Systemic Lupus Erythematosus
- Head Injury
- Neuromuscular Disease
- Osteogenesis Imperfecta
- Cystic Fibrosis
- Burns
- Transplants
- Parkinson's Disease
- Spinal Cord Injury
- Neoplasm
- Alzheimer's
- Cerebral Palsy
- Huntington's Chorea

Other supportive criteria includes:

- Complex benefit coordination
- Frequent re-admission
- Lack of support system
- Palliative care
- Complicated situation with advanced directives/POA/guardianship
- Non-compliance
- Coordination of hospice
- Vacillating between acute, home health, SNF
- Polypharmacy
- Experimental treatments
- Multi-system failure
- High Risk maternity cases
- Overwhelmed caregiver
- Functional problems
- Coordination of care across multiple providers and/or care sites
- Pain management
- Need for community resources
- Monitoring and arranging advanced technological equipment
- Multiple home health services

Our experienced and focused Health Coaches are trained on these interface protocols and also have on-line access to this information via the APS Intranet. When it is determined that a



Medical Utilization Management Services

2.2 Minimum Qualifications of Vendors

participant requires services through **Highmark**, an APS Health Coach will “warm transfer” the participant to a representative at **Highmark** so appropriate services can be arranged.

By including **Highmark** in the implementation process and establishing clear lines of communication early in the process, we were able to effectively create a sound, collaborative foundation to provide quality care. Not only have we been able to proactively identify patients for care; but we have also been able to use our resources to assist **Highmark** in establishing contact and engaging patients.

In another example, we collaborate with **Blue Cross of Idaho** for **Micron Technology**. As soon as the contract award was announced, APS reached out to **Blue Cross of Idaho** to establish interface protocols and include them in the implementation process. We established monthly care coordination meetings and collaboratively developed workflows and processes for referring participants to the health plan and other available benefits when appropriate.

We have their current case management trigger list to identify and refer cases for case management. We have also developed a customized process for how they should be notified of such cases. **Currently, our process involves both telephonic and fax notification.**

In addition, as a part of our program for **Micron**, we routinely review claims data using our informatics tools to identify patients who frequently utilize emergency room services. We identify those patients who have not designated a PCP. These patients are flagged and appropriate referrals are made. Additionally, for those patients who use the ER for non-urgent medical care, we assist **Blue Cross of Idaho** in providing the necessary clinical support, education, and guidance as to the most appropriate means to utilize the healthcare system.

In addition to our success coordinating care with health plans, we understand that establishing open lines of communication and coordinated testing plans between APS, and the health plans from the very beginning is critical to the important function of data transfer and data management, and we have experience doing it.

Seamless Data Exchange

APS has the ability to accept client and provider information in a variety electronic formats. Data exchange protocols acceptable to EBD and its health plan partners will be identified and implemented during the implementation period and may include Internet, SFTP, BBS, diskette, tape, Iomega Zip, Castlewood Orb, CD-ROM, and most other current technologies.

APS will accept a flat file of mutually accepted format, when provided with a current data dictionary. We will create the interfaces needed to import this data into our application for our Coaches’ use in the care management process. We will also convert the data into EBD’s preferred format needed for the APS Informatics team to analyze and report to EBD. Because of the complexity of the data, APS will work with EBD to define and import various interfaces including claims, provider, lab and other types of data exchange.



**Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors**

For exports, APS recommends the use of SFTP for most data transfers. If EBD wishes, APS will also provide this data encrypted with PGP on CD, with separate, out-of-bandwidth communication of strong passwords. APS also recommends daily updates of add/change/delete records using SFTP for file transfers. (We can also accept tapes, CD's or other mutually acceptable media, providing appropriate precautions are taken to encrypt and track the data in transit). APS will work with EBD to clearly define the nature of Add/Change/Delete transactions, and test to be sure they are correct. An annual reconciliation file, or "trac-up" file, of all eligible individuals and their eligibility history is recommended for cross-checking the systems. APS recommends that large updates occur during evenings or weekends. This allows the fastest loading with no degradation or conflicts with provider online activities. APS proposes that the other data exchanges be sent monthly via SFTP (secure FTP) either via our SFTP site, or an SFTP site provided by one of the trading partners involved in the transaction. APS will work with the host to assure file naming conventions, encryption and schedules are all mutually acceptable and to the best advantage of the program.

Below are additional examples of the organizations with whom we interface on behalf of our customers:

Payor	Interface Type
ACS	Medical/pharmacy/eligibility/provider file
Aetna	Medical claims/eligibility
Anthem	Medical/eligibility/provider file
BCBS Alabama	Medical/eligibility/provider file
BCBS Georgia	Medical/eligibility/provider file
BCBS Hawaii	Medical/pharmacy/eligibility/provider file
BCBS Missouri	Medical claims
BCBS Montana	Medical/pharmacy/eligibility/provider file
Blue Cross Idaho	Medical claims/eligibility
Caremark	Pharmacy claims
CIGNA	Medical claims
Eckerd Health Services	Pharmacy claims
Great-West	Medical claims/eligibility
Hewitt	Eligibility
HIGHMARK-BCBS	Medical/eligibility/provider
The Principal	Medical/eligibility/provider file
United Healthcare	Medical claims/eligibility
Walgreens	Pharmacy claims



Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors

APS has a team of IT professionals on staff, including experienced programmers who work exclusively with our customer's partners to develop customized data interface protocols. We are fully capable of handling any data exchange needs a customer may require in terms of volume, frequency, type and size. The technical capabilities and configuration of the sending entity will determine the best method of data transmission. This may include file transfer protocol (FTP) methodologies (data is usually exchanged by posting on a secure FTP site that allows APS to both send and receive data), CD-Rom, zip files, electronic mail, and tapes to support batch file transfers; and use VPNs, remote access connectivity using Citrix Metaframe for live interfaces or any other secure transmission or appropriate media.

Our experience and ability to be flexible to our clients' unique demands or specifications around system linkages will ensure we can meet EBD's specific needs in this area.

I. The company must agree, that during implementation and for the first year after implementation, to meet with EBD on a weekly basis or as requested by EBD either in person or telephonically; after the first year meet with EBD and/or the Arkansas State and Public School Life and Health Insurance Board on a monthly basis or as requested by EBD either on-site at EBD or telephonically to report on the general progress of the Vendor in this endeavor and the interaction with our members.

Yes, APS agrees that during implementation and for the first year after implementation, to meet with EBD on a weekly basis or as requested by EBD either in person or telephonically; after the first year to meet with EBD and/or the Arkansas State and Public School Life and Health Insurance Board on a monthly basis or as requested by EBD either on-site at EBD or telephonically to report on the general progress of this endeavor and the interaction with EBD's members.

APS' Account Management Philosophy

APS' philosophy and approach to account service is *proactive* and *collaborative* in nature with a clear focus on superior customer and clinical service. Since each client is different and has unique needs, our role is to fully understand the challenges faced by members as well as the organization and create innovative and effective solutions that are both cost effective and do not sacrifice quality care. **APS views account management as the vehicle that drives the success of our clients' programs through personalized, hands-on attention and collaborative client partnerships.**

This is accomplished by establishing an open and responsive environment for our clients that is built upon trust so we can understand their unique issues as they occur and address them in a timely manner. By developing a strong working relationship with

Your Account Executive is responsible for ensuring all facets of your UM, Program are functioning to your satisfaction from implementation and throughout the contract term.



**Medical Utilization Management Services
2.2 Minimum Qualifications of Vendors**

our clients, we can identify and even anticipate industry and client-specific trends that negatively impact their programs. As a result, we can create innovative programs or delivery systems for EBD as partners to counter each challenge faced by our clients and their participants.

Our approach to account servicing involves identifying an Account Executive as the client's key liaison who is accountable and will have ultimate responsibility for a successful implementation and ongoing account management.

We have identified Scott Strang, PhD, MBA, who is already established in the State of Arkansas and oversees the State's existing Medicaid Program in which we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for 400,000 Medicaid recipients (lives) under the age 21.

J. The company must agree to allow EBD and/or its designated representatives and Legislative Audit the right to audit all records maintained by the UM Vendor and/or its affiliates relative to the UM Vendor's performance under the contract. The UM Vendor agrees that upon forty eight (48) hours notice by the EBD or Legislative Audit to the UM Vendor, the EBD, Legislative Audit or EBD's chosen auditor shall have the right to perform financial, performance, and other special audits on such records maintained by the UM Vendor during regular business hours throughout the contract period. The UM Vendor agrees that confidential information including, but not limited to, medical and other pertinent information relative to Plan Participants in the Plan, shall not be disclosed to any person or organization for any purpose without the expressed, written authority from EBD; selected company will make available all records, as defined by the selected auditor, for review at no cost to the EBD. Any ancillary fees, which may be incurred by the EBD for the on-site audits, should be included in your proposed rate for UM services.

APS confirms its agreement to allow EBD and/or its designated representatives and Legislative Audit the right to audit all records maintained by APS relative to our performance under the contract.



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

1) State the full name of your organization and describe its structure, including your main and branch offices. Indicate whether it operates as a corporation, partnership, or individual. If it is incorporated, include the state in which it is incorporated. Indicate the month and year your organization was established. List the names and occupation of those individuals serving on your organization's Board of Directors.

Full Name & Structure

Our legal name is Innovative Resource Group LLC d/b/a APS Healthcare Midwest (APS). Innovative Resource Group, LLC d/b/a APS Healthcare Midwest is a wholly-owned subsidiary of APS Healthcare Bethesda, Inc. APS Healthcare Bethesda is a for-profit, privately-owned corporation, which was incorporated in Iowa in September of 1991 and began operations in 1992.

APS is a financially sound company with more than 12 years of experience in Disease Management/Wellness, 16 years of experience in the Medical Management arena combined with over 15 years of Behavioral Health experience, as well as over 20 years of experience providing Employee Assistance Program services. Since our inception, we have grown our business steadily, creating an attractive client list.

We currently serve over 1,000 customers, representing approximately 20 million lives across the United States, including Hawaii and Puerto Rico. In addition, APS is the 2006 Disease Management Association of America's Leadership Award Recipient for Outstanding Provider Engagement Initiative, the 2005 Disease Management Association of America's Recognizing Excellence Award Recipient for Best Government Disease Management Program, and two-time EAP Digest/Employee Assistance Professionals Association Quality Award Recipient for EAP Excellence.

APS was also named one of the top 10 Disease Management Companies in both 2005 and 2006 by Health Industries Research Companies.

APS has more than 20 office locations throughout the United States. For example, APS has Operations Centers and Staff Model/Account Management offices in Arizona, Arkansas, California, Florida, Georgia, Hawaii, Louisiana, Maryland, Michigan, Montana, North Dakota, Pennsylvania, Puerto Rico, Texas, Utah, Washington, West Virginia, Wisconsin and Wyoming.

Our product portfolio includes

- Health Management (including Wellness, Lifestyle and Disease Management services)
- Medical Utilization Review and Case Management;
- Behavioral Health Utilization Review and Case Management;
- Employee Assistance Program and WorkLife Services;

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

- Absence Management, including Short-term Disability and Family Medical Leave Management; and
- Informatics consultation, predictive modeling and decision support services.

We are distinct among vendors due to the depth and breadth of our state, county and local government contracts. APS is particularly well known for innovative program operations and seamless transitions, and has received high praise from many government agencies regarding its abilities. We administer 42 Programs in 23 States across the United States, including Arkansas, California, Florida, Georgia, Louisiana, Maryland, Massachusetts, Mississippi, Missouri, Montana, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Washington, West Virginia, Wisconsin and Wyoming.

For our state clients, APS has developed innovative, collaborative models of utilization management, case management, disease management, provider relations, and quality improvement processes that emphasize community partnership, training, technical assistance, and compassionate clinical care. We have been highly successful in providing care coordination, data analyses, and technical assistance, resulting in increased access and improved clinical outcomes, while controlling costs associated with acute care. The APS model views the member and their family in the context of their community, their treatment needs, and their ability to access and utilize services.

Main & Branch Offices

APS has more than 20 office locations throughout the county. This includes our Corporate Headquarters in Silver Spring, Maryland and our established office in Little Rock, Arkansas. In addition, we have offices in the following States:

- | | |
|--------------|-----------------|
| • Arizona | • Pennsylvania |
| • California | • Puerto Rico |
| • Georgia | • Texas |
| • Hawaii | • Washington |
| • Louisiana | • West Virginia |
| • Maryland | • Wisconsin |
| • Montana | • Wyoming |
| • Ohio | |

State Incorporated

APS Healthcare Bethesda is a **for-profit, privately-owned corporation**, which was incorporated in Iowa in September of 1991 and began operations in 1992.

Board of Directors

APS Healthcare Bethesda, Inc.'s Board of Directors includes:



**Medical Utilization Management Services
2.6 Questionnaire – A. Organization Structure**

Name	Title/Occupation	Organization
Eileen Auen	CEO	APS Healthcare, Inc.
Dr. Kenneth A. Kessler	Chairman of the Board	APS Healthcare, Inc.
Brett McIntyre	Chief Financial Officer	APS Healthcare, Inc.
Tony Tamer	Co-founder & Managing Partner	H.I.G. Capital
Sami Mnaymneh	Co-founding partner	H.I.G. Capital
Chris Weidenhammer	Managing Director	H.I.G. Capital
Rick Rosen	Managing Director	H.I.G. Capital
Jeffrey Krauss	General Partner	PSILOS Group Management
Steve Epstein, Esquire	Founding Member & Senior Health Partner	Epstein, Becker & Green, P.C.
Joe Kenary	Managing Director & Executive Management Committee Member	CapitalSource Finance, LLC

2) Provide the name, title, address, phone number, and fax number of the contact person for this RFP.

Contact Person	Alex Kozersky Vice President, National Sales
Address	8403 Colesville Rd., Suite 1600 Silver Spring, Maryland 20910
Phone Number	(914) 666-3323 Office (914) 479-2510 Cell
Email Address	akozersky@apshealthcare.com
Fax Number	(301) 563-7338

3) Provide a copy of the most recent annual report for your organization and parent organization (if applicable).

APS Healthcare Midwest (APS) is a wholly owned subsidiary of APS Healthcare Bethesda, Inc., a private, for-profit specialty healthcare organization.

4) Provide your company's (and your parent firm's, if applicable) most recent audited financial statements including any auditor's recommendations or opinions.

APS has provided audited financial statements for 2005 as Attachment JJ. APS' Chief Executive Officer, Eileen Auen; Chief Financial Officer, Brett McIntyre; and Christopher Gorton, MD, MHSA, Chief Medical Officer and President, APS Commercial Programs would be

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Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

happy to further discuss the company's financial results and prospects. Additionally, a discussion with representatives from our largest investor, **H.I.G. Capital**, can be arranged upon request.

5) Do you have a SAS 70? If so provide a copy in this response.

APS is not required to have a SAS 70 report. Our internal claims processing operations are evaluated by an external auditing organization, and any identified deficiencies are reported to management for resolution.

6) List the name and principal occupation/business of any entity or person owning 10% or more of your organization.

The following table details persons/entities with ownership interest in APS. Please note that the table contains substantial investors – any entity or person owning 10% or more of APS. Management and individuals that own nominal amounts of APS comprise the remaining investors:

Names	Ownership	Nature of Entity
H.I.G. Capital, LLC	44%	Investment Fund
Ken Kessler, MD	16%	President

7) State if the proposed account manager, any officers or principals and/or their immediate families are, or have been within the preceding 12 months, employees of the State of Arkansas.

Neither the proposed account manager, officers, principals; nor their immediate families are or have been employees of the State of Arkansas within the preceding 12 months.

8) Complete the table below for your entire book of business as of 12/31/2006. Include covered members (total number of employees and dependents managed by your utilization management services.

APS has provided statistics for our **Commercial Book of Business for Utilization Management** services below, which excludes our public sector programs for Medicaid populations.

Utilization Management - Covered Members		
	Public Sector	Private Sector
Precertification	575,500	2,924,494
Continued Stay Review	575,500	2,924,494



Medical Utilization Management Services
2.6 Questionnaire – A. Organization Structure

Utilization Management - Covered Members		
	Public Sector	Private Sector
Retrospective Review	575,500	2,924,494
Medical Case Management	50,500	2,924,494
Disease Management	167,000	864,600
Demand Management (*These numbers reflect the customer base of our demand management partner, CareNet.)	305,000	1,000,500

9) For the office in which you propose to place this business, complete the following:

APS' capacity is expansive. We are a national, Specialty Healthcare Company that serves more than **20 million** lives through our array of healthcare products. We have over **1,200 employees**, including more than **350 clinicians** throughout the nation who use their expertise and collaborative care management strategies to deliver holistic UM, Case Management, Wellness/Health Promotion, Disease Management, Behavioral Healthcare and Employee Assistance Program services for our clients' employees/members, such as EBD. In addition, because of our size, APS offers EBD the customization and flexibility that allows true integration and partnership – **Arkansas-based office, Arkansas-based experience, seasoned operational staff, and successful partnerships with Arkansas' provider community.**

We are large enough to have substantial resources and capabilities, yet small enough to have a deep understanding of the State of Arkansas, EBD, and its members. The staffing structure below attempts to identify those staff that are in Missoula, Montana, which will serve EBD's members.

For example, APS has not included staff who are located in our customer-focused units throughout the country, such as staff in **Atlanta** who serve the **State of Georgia**, in **Cheyenne** who serve the **State of Wyoming**, **Charleston** who serve the **State of West Virginia**, in **Jefferson City** who serve the **State of Missouri**, in **Tallahassee** who serve the **State of Florida** and of course in **Little Rock** who serve the **State of Arkansas** to name a few. If we were to include those staff, the numbers below would grow exponentially.

Local Model & Partnership Approach

EBD's program will be delivered from our established local service center in Little Rock, Arkansas and our service center in Missoula, Montana. We have strategically designed staffing to maximize the attention given to care coordination and utilization management/review, quality assurance initiatives, local collaboration and overall effective management of resources. We



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

have also dedicated sufficient resources to assure that all IT and reporting requirements are met in a timely and accurate manner.

Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock. Dr. Strang is an excellent fit as the Account Executive for EBD's program. He is already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

In addition, APS is pleased to establish an experienced, focused clinical team in our Montana Service Center to serve EBD's members. This team will include ~~four~~ (4) Nurse Reviewers and ~~two~~ (2) Health Coaches to serve EBD's members if you choose to purchase the Disease Management program.

APS has already began assembling a team of the best and brightest to assist with the UM Program. We will recruit your team with your involvement. We understand this process to be collaborative and recognize that these staff members will work one-on-one with EBD's key representatives and your members, therefore staffing should be conducted in accordance with your preferences and mindful of your specific needs.

EBD's Proposed Account Executive will provide your organization with a single point of contact for account questions and issues. The Account Executive will monitor the UM Program's success and work with your key contacts to analyze reports and determine program strategy. In addition, the Account Executive will ensure that all program components are fully understood and integrated into the delivery of services and that any issues or concerns identified are quickly addressed and resolved. In addition, the Account Executive will serve as a liaison to the local physician and provider community.

EBD's Nurse Reviewers will identify and manage cases through the continuum of care including inpatient and outpatient services provided to the patient in all settings. The Nurse Reviewers will interact with all disciplines to assist the patient in understanding and implementing the best possible care within available benefits. Their responsibilities include:

- Receiving notification of services and pursuing the information required to review the medical necessity of services and the appropriateness of the treatment setting;
- Verifying the patient's eligibility and benefit coverage;
- Assessing the extent of illness, injury, or disability and the patient's current and future treatment requirements;
- Reviewing medical necessity of each case, applying established medical criteria;
- Conducting ongoing review of active cases regarding the medical necessity for continued services or treatment;
- Conducting telephonic medical record review at select high-volume inpatient facilities and other facilities to obtain current and timely medical information;
- Coordinating and negotiating alternative treatment plans and discounted services;



Medical Utilization Management Services
2.6 Questionnaire – A. Organization Structure

- Facilitating timely discharge and/or transition to appropriate levels of care;
- Working with local physicians and providers to educate them on the program;
- Providing guidance and support on the use of evidence-based treatment guidelines medicine in their practices;
- Responding to physician/provider inquiries related to the program; and
- Ensuring physicians are integral members of each patient’s care management plan.

Lastly, combined with the breadth and depth of our experience, an additional advantage for EBD is APS’ **Clinical Resource Network** which includes **20** in-house (APS employee) **Medical Directors** and an additional **77** consulting physicians who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development. They span clinical specialties in **Psychiatry, Pediatrics, Cardiology, OB-GYN, Endocrinology, Paleontology, ENT, Nephrology, Oncology, Pulmonary Disease, Physical Medicine and Rehabilitation, Dentistry, Allergy/Immunology and Orthopedic Surgery** to name a few of the specialties represented.

Staffing -Full time equivalent employees			
	Utilization Management Services	Disease management	Certification
Intake Personnel	10	10	
Clinical Staff	9	7	

Staffing			
	Utilization Management Services	Disease Management	Certification
Full time equivalent RNs	8	6	
Full time equivalent MDs	0	0	
Part time MDs	1	1	

APS wants to be EBD’s partner. If selected to provide services, APS will use its extensive experience and all the resources at its disposal to: (1) Ensure that the Program is primarily focused on healthcare outcomes, both clinical and fiscal; (2) Ensure that providers are increasingly involved in clinical program development, are effectively educated and supportive of nationally-recognized standards of care and Best Practices; (3) Provide input to strengthen, support and coordinate services with those provided by other existing programs; (4) Set an agenda for the inclusion of member, family and provider voices in the formation of processes and procedures for the program; and (5) Assure ongoing review and refinement of APS policies and communications.

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Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

APS can deliver a high-quality product that meets or exceeds EBD's specifications. We understand that EBD is seeking to purchase expertise and experience, capability and capacity. A highly qualified vendor with substantial experience, such as APS, can deliver all components in a highly-successful UM Program.

10) Provide the total number of MDs employed by your organization to provide utilization management services. Break out the number by physician's specialty.

As discussed above, APS has developed our **Clinical Resource Network, which is led by our Chief Medical Officer and President of Commercial Programs, Kit Gorton, MD** and includes **20** in-house (APS employee) **Medical Directors** and an additional **77** consulting **physicians** who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development.

They span clinical specialties in **Psychiatry, Pediatrics, Cardiology, OB-GYN, Endocrinology, Paleontology, ENT, Nephrology, Oncology, Pulmonary Disease, Physical Medicine and Rehabilitation, Dentistry, Allergy/Immunology and Orthopedic Surgery** to name a few of the specialties represented.

For the **20** who are direct employees of APS – our onsite Medical Directors – their numbers by physician specialty are below:

Family Medicine	Five (5)
Psychiatry	Eight (8)
Internal Medicine	Six (6)
Pediatrics	One (1)

11) If your organization were awarded the contract, provided the number and types of new staff you would need to hire to implement and administer the contract.

To augment our existing Arkansas and Montana staffing and to successfully serve EBD, APS would hire **four (4) Nurse Reviewers** and **two (2) Health Coaches**, if EBD chose to purchase the **Disease Management Program**.



Medical Utilization Management Services
2.6 Questionnaire – A. Organization Structure

- 12) Identify the individual in the following positions within your organization and supply a resume for each position listed:
- a. Service Center Medical Director
 - b. Operations Director
 - c. Case Management Director
 - d. Account Executive

Descriptions of the qualifications and experience of the proposed personnel for EBD's Program is provided below, with more extensive experience for each provided in Attachment KK.

Kathleen Evans, MD, Service Center Medical Director

Kathleen Evans, MD, serves as our Medical Director and provides clinical leadership and oversight. Dr. Evans received her medical degree from the University of Arizona in 1991. Her clinical experience includes public health, full spectrum family medicine with both clinic and hospital members, and urgent care. She is also currently working on an interdisciplinary PhD in medical ethics and policy.

She provides consultation to the nursing staff of Utilization Management and Case Management, and oversees the denial/appeal process. She is instrumental in the development of clinical tools and workflows for nurse reviewers and Case Managers.

Cheryl Harkin, Executive Director, Montana Service Center (Operations Director – Case Management Director)

Ms. Harkin has 27 years of clinical experience. She received her B.S. in Nursing from Loretta Heights College, and her M.B.A., from the University of Phoenix. She is a current member of the Colorado Rehab Insurance Nurses Group, and has held previous memberships in the Colorado Health & Life Claims Association (president), the Wyoming Homecare Alliance (board member), the National Association of Homecare, and the National Hospice & Palliative Care Organization.

In addition to her current position as Executive Director, Ms. Harkin also acted as the Clinical Director of APS' Montana Service Center in the past. In this position, she was responsible for directing division medical services and operations; reorganizing the medical services division to promote cross-functional team concepts and operational performance improvement; and developing strategic initiatives for client satisfaction and retention.

Over her career, Ms. Harkin has held numerous clinical and management positions. This includes Manager of the Medical Surgical and Orthopedic Units for the Community Medical Center in Missoula where she was responsible for the daily operations of a 41-bed medical surgical unit; daily operations of a 10-bed orthopedic unit; and chaired the Nursing Education Committee. She also acted as the Director for Home Health and Hospice in Wyoming where she managed daily operations of two cost centers, implemented a performance improvement program, as well as authored and implemented a homecare compliance plan. She was the



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

Operations Manager for the Adult Care Clinic at Denver Health Medical Center, where she managed the daily operations of three large ambulatory clinics; chaired the Community Health Services Triage Committee; and was a member of numerous hospital and community health committees. She was the Branch Manager and Regional Outcomes Expert for Coram Healthcare where she had operational and financial responsibility for the Colorado regional branch of a national home infusion company including P&L, pharmacy operations, inventory & warehouse, nursing services, sales, nutritional support. She also had regional responsibility for their proprietary outcomes-program-including presentations and sales support. Furthermore, she spent seven years in Group Health for a major indemnity carrier and in an HMO program

Scott Strang, PhD, MBA, Proposed EBD Account Executive

Dr. Strang earned a doctorate in Clinical Psychology from the University of Missouri, St. Louis in 1986 and a Master of Business Administration from Owen Graduate School of Management at Vanderbilt University in 2001. Following completion of his M.B.A, Dr. Strang served as Chief Operating Officer for a comprehensive community mental health center in Oak Ridge, Tennessee.

Dr. Strang has provided clinical services in both inpatient and outpatient settings. He began his career as a staff psychologist and then treatment program director at St. Louis State Hospital. He shifted his practice to an outpatient basis in 1993, when he joined Greenleaf Services outpatient facility in Dalton, Georgia.

In addition to traditional outpatient clinical services (e.g., assessments and psychotherapy with adolescents, adults and families), Dr. Strang also supervised and co-led Chemical Dependency and Substance Abuse Intensive Outpatient Programs for adolescents and adults through Greenleaf. In 1999, Dr. Strang joined a private practice group in Nashville, splitting his practice between adolescent and adult clients.

- 13) Describe the staff of the utilization management team, including qualifications and experience for:**
- a. Physician/Medical Director**
 - b. Registered Nurses**
 - c. Licensed Practical Nurses/Licensed Vocational Nurses**
 - d. Non-Clinical Phone Personnel**
 - e. Managers**
 - f. Other**

Hiring Qualified Staff

APS designs its programs with staffing requirements foremost in mind. We understand the importance of having sufficient highly qualified staff to assure effective operations. As APS grows, we allocate focused staffing teams to each of our programs to assure their undivided attention to providing the highest level of responsiveness possible.



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

In developing our staffing model for this program, the following overriding values and practices were kept in mind:

- The success of the UM process is predicated upon a staffing plan that provides sufficient personnel with superior credentials and experience so that individual needs and cost plans are accurately and sensitively reviewed; and
- The success of the UM process relies upon the organizational skill of APS, as attention to detail and the timely flow of documentation are critical to success.

Toward this end, APS has prepared a detailed assessment of tasks and deliverables, in order to accurately assess the type and number of staff needed to deliver high quality Utilization Review that is person-centered, consistent with individual needs and is cost effective. This analysis led to the development of a staffing model that includes:

- *Clinical staff* who review authorization requests, communicate with providers and provide training and technical assistance;
- *Reviewers* who will complete retrospective and post-payment reviews and provide training and technical assistance;
- *Quality Improvement staff* who design QI studies, aggregate data and analyze data related to authorizations;
- *Administrative Support staff* who manage scheduling, track and file medical records, assemble written materials and assure the timely flow of information across the authorization process; and
- *Medical Directors and consultants* who provide expert technical assistance to clinical staff and second level review of files when needed.

Specific information about qualifications of these positions is addressed in **Attachment KK**.

Focused Clinicians Implementing National Best Practices

APS will implement a Utilization Review program in Arkansas that seeks to refine the existing system under the leadership of EBD staff members. Our processes make recovery, resiliency and self-determination paramount. Our vision remains focused on ensuring the quality and appropriateness of all State-funded services. This vision will be realized by:

- Improving provider clinical and administrative practices in both documentation and appropriateness of service provision, including coordination across providers;
- Ensuring a high quality bio-psychosocial assessment and case formulation;
- Promoting best practices through the utilization management program, provider training, and all aspects of the work performed; and
- Enhancing the use of assessment results in service selection (e.g. outpatient therapy, psychosocial rehabilitation) and recovery/service plan development.

A Proposal to the State of Arkansas



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

APS has designed our service approach for the State of Arkansas to maximize program efficiency. We will provide contract-specific training to each person involved in clinical decision-making to ensure a complete understanding of the covered benefits, population served, and clinical criteria that guides “hands on” reviews of authorization requests, provider supports, peer-to-peer consultations, and special team reviews.

Staff directly involved will have the qualifications detailed below.

Minimum Staff Qualifications

At a minimum, our staff must meet the following qualifications:

Utilization Management

Our UM/CM nurses have worked at APS for an average of **5** years and have a combined **43** years of healthcare industry experience. We staff clinical expertise in rehabilitation, maternity, oncology, diabetes, cardiac, pulmonary, psychiatric, and chemical dependency. Our UM nurses work in coordination with our **on-site Medical Directors** to affect appropriate, coordinated care for your members presenting with an acute or chronic condition. Our clinical staff must meet the following stringent qualifications to join the APS team of professionals:

- Must be a currently licensed Registered Nurse with a working knowledge of medical procedures and practices for medical reviews.
- Must be a Registered Nurse with at least 3 years of psychiatric experience, Licensed Social Worker, or Licensed Professional Counselor for behavioral health reviews.
- Must have 3 years experience in acute inpatient care.
- Must have working knowledge of CPT-4 and ICD-9 codes.
- Must have computer skills.
- Must have excellent customer service, written and oral communication skills.

Minimum Supervisor Qualifications

UM and CM supervisors must meet the same educational and training qualifications as all UM and CM nurses with additional criteria as noted below.

Utilization Management Supervisor

Our supervisory qualifications are similar to those of our UM nurses; however, they must have at least five, as opposed to three, years of experience and present the leadership skills necessary to accomplish their demanding roles.

- Must be a currently licensed Registered Nurse with a working knowledge of medical procedures and practices for medical reviews.
- Must be a Registered Nurse with at least 3 years of psychiatric experience, Licensed Social Worker, or Licensed Professional Counselor for behavioral health reviews.
- Must have 5 years experience in acute inpatient care.
- Must have working knowledge of CPT-4 and ICD-9 codes.



Medical Utilization Management Services
2.6 Questionnaire – A. Organization Structure

- Must have computer skills.
- Must have excellent leadership, customer service, written and oral communication skills.

14) Would you be willing to hold regional meetings with, and send education material to, the provider community, as the EBD deems appropriate, to educate them regarding the utilization management program? Describe any other methods you would use to communicate the implementation of utilization management to selected hospitals and physicians. Describe any examples, including promotional materials, in which you have previously done this for your clients.

Yes, APS would certainly be willing to hold regional meetings with and send educational materials to the provider community according to EBD's specifications.

APS has a proven record of accomplishment with implementing and expanding services nationally. This record demonstrates our strong commitment to engaging providers and stakeholders in the utilization review process. We have saved hundreds of millions of dollars and brought associated technology improvements in delivery systems across the United States. We have increased service penetration and created new avenues to access. APS will collaborate with EBD to help Arkansas providers to enhance service delivery by furnishing regular feedback regarding performance, reinforcing best practices, and promoting recovery, resiliency, and self-determination.

Immediately after contract award, APS will design Provider Orientation and Community Orientation programs in collaboration with EBD. This includes development of an Orientation Agenda as well as an initial Provider Manual. APS already possesses experience building a successful program for the State of Arkansas. Currently, we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for **400,000** Medicaid recipients (lives) under the age 21. APS was selected to administer the State's program in July of 2003, and established an office in Little Rock, Arkansas with approximately **30** FTEs to serve the State's eligible recipients.

Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State. When APS first won the contract, we aggressively reached out to the provider community through a series of regional presentations introducing APS philosophy, business model, technology and key staff members. This was followed by an extensive series of teleconference training sessions on the use of an innovative web-based preauthorization system, which was completely customized to meet the State's specifications. As a result, APS achieved incredible buy-in from the provider community. In fact, within the first week of the program's launch date, we had a 90% provider participation rate for our web-based system, and now tout a 99% usage rate for active providers. APS' outreach to the provider community has also included the establishment of two Provider Advisory Groups. The Inpatient Advisory Group is composed of representatives (mostly CEOs) of five acute psychiatric hospitals and five free standing



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

psychiatric residential treatment facilities. The outpatient advisory group is composed of representatives of five (of 15) community mental health centers and five for profit outpatient service providers. Each group meets on a quarterly basis and serves as a forum for providers to give APS feedback about its services and for APS to engage the provider community in dialogue regarding quality improvement issues.

Furthermore, APS has achieved high satisfaction rates amongst the local provider community as indicated by our latest satisfaction survey below:

- 91% of respondents were overall satisfied the service they received from APS
- 94% of respondents either agree or strongly agree that APS' Staff have been accessible and willing to assist in resolving any problems with the authorization process.
- 91% of respondents either agree or strongly agree that APS Care Coordination consultations have been accessible to their agency upon request.
- 94% of respondents either agree or strongly agree that when they need help, APS staff members are accessible and responsive.

Comments have also included:

The APS reviewers are very collegial and provide good questions and assistance. Thank you all so much. Your system is user-friendly and captures the essence of inpatient continued stay reviews.

APS has been very accessible/supportive of our agency in assisting in improving quality of care. I have felt the relationship to be collaborative, focusing on quality care for children of Arkansas.

APS will use the same level of commitment and enthusiasm as we did for our existing Medicaid contract with the State for EBD's program.

Furthermore, our program for the **State of Georgia** was awarded the 2006 Disease Management Association of America's (DMAA) Leadership Award for **Outstanding Provider Engagement Initiative**.

"APS' partnerships with the Morehouse School of Medicine's National Center for Primary Care, as well as other providers in Georgia, underscores the benefits of working with physicians in a team environment to achieve better outcomes for people with chronic disease," DMAA Executive Director Tracey Moorhead said. "Provider engagement is critical to realizing disease management's full potential, and we applaud APS for its initiative in this area."

"Georgia's Department of Community Health Disease Management Program, 'Georgia Enhanced Care,' will make a difference in the lives of the populations served," said Dr. Rhonda Medows, commissioner of the Georgia Department of Community Health. "APS



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2.6 Questionnaire – A. Organization Structure

has been a key contributor to this success through its application of innovative strategies targeted at Georgia's most vulnerable Medicaid members."

"We are delighted to partner with APS in its grassroots engagement approach, bringing Georgia's most vulnerable Medicaid members together with providers and community supports to achieve better health practices and improved outcomes in quality and costs," said George Rust M.D., director of the National Center for Primary Care at Morehouse School of Medicine.

Empowering Providers to Succeed

The APS Utilization Review System emphasizes community partnership, training, technical assistance, and compassionate clinical care. We will work closely with your contracted providers to empower them to successfully deliver clinically appropriate services. One of the first steps in this process will be Orientation Sessions for all participating providers during the transition period. These Orientation Sessions will allow APS to acquaint providers with the administrative processes and clinical philosophies of the newly instituted utilization review program. They also will provide an opportunity for early input from providers on program operations and trainings that would best support success. We are committed to conducting a Training Needs Assessment that will help us evaluate the capabilities of the provider network and offer specialized trainings that will promote the use of evidence-based and promising practices. In determining the focus of our training programs, we will collaborate with EBD to ensure that our approach to improving care is in accordance with EBD's objectives.

APS interprets our role in Arkansas as more than a utilization review organization. We view ourselves as a care management agent and will work closely with providers to develop the most appropriate treatment plan. Our interactions will be a form of technical provider assistance to review the entire treatment and discharge plan in light of the patient's history, current needs and expressed concerns. We will collaborate with providers in the development and monitoring of appropriate treatment plans, suggesting medically necessary services that meet patients' needs by supporting the goals of stability, rehabilitation and recovery, as well as addressing immediate, acute needs.

Our approach to UM is based on a person-centered approach. As part of our utilization review process, we will work with each provider to identify the patient's individual motivations and goals for treatment and incorporate these into the person centered plan and state guidelines for service delivery when gaps are evident. We will focus on the whole person, evaluating all components that impact an individual's ability to function optimally, including issues such as social supports, transportation, financial/legal issues, psychosocial functioning and obstacles to treatment compliance.

APS will offer peer-to-peer consultations in all cases where the reviewer is not in complete concurrence with the requested approach to care. Our proposed approach ensures physician involvement early in the review process, well before any adverse determination is rendered. In



Medical Utilization Management Services

2.6 Questionnaire – A. Organization Structure

the event that, following consultation with one of our Medical Directors, the most appropriate course of treatment is not agreed upon, we will offer an internal two-level appeal process that supports discussion and consultation with a board-certified psychiatrist who was not previously involved with the determination.

APS views part of our role within the service delivery system as a facilitator to assist in identifying gaps in performance and provide training and technical assistance that will help providers to self-correct. Our program features a continuous quality improvement program that supports substantial training and technical assistance based on medical record review findings.

Formation of Quality Improvement Committees

APS deeply values community partnerships, stakeholder involvement and accountability. One of the first activities of APS in Arkansas will be to establish a stakeholder advisory process. We believe that this strategy is entirely consistent with the goals of Arkansas' vision for UM.

APS believes that stakeholder collaboration is essential to developing community-wide understanding and ownership of desired system outcomes and the means to achieve them. APS staff will work with EBD staff and any stakeholder groups you recommend, to ensure that the UM process is accurate, sensitive and cost effective. This *"team at the table"* approach assures that implementation and operational problems are addressed with the ultimate focus on those we serve.

This process will help us successfully transition and implement the UM program. The stakeholder process includes the following:

- Collaborating with EBD regarding identification of key system stakeholders to be included in the transition planning process; and
- Implementing a series of meetings with these key stakeholders to collaboratively develop new UM processes that empower patients, serve providers and meet system needs.

"APS Healthcare has been very effective in establishing rapport with the provider community and with consumers of service. They have instituted quality improvement councils for each group. Those councils have been helpful in shaping the new system and in minimizing resistance, misinformation and anxiety about this major change."

Stephen Mullins, Director, Office of Behavioral Health and Alternative Health Care of DHHR in West Virginia in a letter of recommendation

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Medical Utilization Management Services 2.6 Questionnaire – B. Medical Management

1) Are any portions of the review processes subcontracted to other organizations? If so, describe the sub-contracted arrangement.

No, APS provides all portions of the review processes. No portions are subcontracted.

2) What are your days and hours of operation for utilization management services? Use central time zone.

APS will establish a dedicated toll free number for EBD members and providers to access our services, without incurring long distance charges. Our business hours are 8:00 a.m. to 5:00 p.m. CST, Monday through Friday, except for recognized holidays. However, APS provides Plan Participants and providers with 24/7 access to clinicians.

3) What is your process for accepting after hours telephone calls from Plan Participants and providers?

APS provides Plan Participants and providers with 24/7 access to clinicians. After hours calls are answered live by an after hours clinician who gathers pertinent information on the case. The caller will then receive a call back the next business morning so that a more complete clinical review and subsequent authorization determination can be performed.

4) As Attachment A provide a flow diagram of your certification process from receipt of the initial telephone call, proceeding through all the possible services you provide and ending with the final decision, including appeals. Indicate within the flow diagram the level of staff responsible for each step of the process and the timeframes required between each step of the process.

As requested, APS has provided our UM Flow Diagram as Attachment AA.

Utilizing a multi-disciplinary team of highly-qualified clinicians, APS focuses on safe, efficacious and optimal utilization (level of care/length of stay) by concentrating on the whole patient as opposed to just the episodic issue at hand, promoting an active treatment plan focused on recovery and resilience, and an individual's collaboration and continued compliance with that plan.

Our URAC-accredited UM Program is designed to:

- Eliminate inappropriate inpatient admissions or reliance on institutional settings whenever possible;
- Promote the use of alternative levels of care;
- Reduce length of stay and improve overall health outcomes;
- Target interventions and supports that are cost effective without sacrificing quality;
- Reinforce a collaborative approach between members, families, providers and other



Medical Utilization Management Services

2.6 Questionnaire – B. Medical Management

- community-based supports;
- Emphasize employment, social and other natural supports and methods of self-determination as appropriate; and
- Emphasize recovery and resilience.

We fully understand and appreciate that a *one size fits all approach* is ineffective in meeting our customers' needs. As such, our UM Program addresses the full spectrum of inpatient and outpatient health care therapies and settings. From straightforward inpatient review to identification of potentially complex cases for management, we offer a comprehensive selection of services to promote efficient use of health care resources and optimal outcomes. Services include:

- Eligibility determination
- Pre-admission and admission reviews
- Medical necessity reviews
- Concurrent reviews
- Retrospective reviews
- Discharge planning and follow-up
- Complaints and appeals
- Reporting
- Ongoing support

More detailed information describing our standard UM process is below.

- 5) Describe the process of pre-admission and admission certification, including how the reviewer:
- a. Categorizes the type of service when a call is received, e.g., outpatient vs. inpatient.
 - b. Verifies eligibility and level of benefits.
 - c. Obtains clinical information, e.g., fax, phone, mail, etc.
 - d. Determines the appropriate level of care.
 - e. Determines an initial appropriate length of stay and triggers for continued stay review based upon the assigned diagnosis.
 - f. Refers cases to physician reviewers.
 - g. Identifies cases for case management or disease management as well as how a reviewer determines if a patient is already being managed by one of these programs.

Step One: Clinical Assessment

The first step in the review process involves the completion of a comprehensive telephonic assessment by an APS clinical reviewer. Medical reviews are performed by Registered Nurses with specialized knowledge of utilization review. Behavioral reviews are performed by either a licensed clinical social worker or a nurse with mental health and/or substance abuse expertise.



**Medical Utilization Management Services
2.6 Questionnaire – B. Medical Management**

As a part of the initial assessment our reviewers gather relevant clinical information to determine if the surgery, admission or procedure is medically necessary. This includes the review of the practitioner's assessment of the patient's condition and severity of illness; patient treatment history and outcomes; other diseases, illnesses or health conditions; as well as the patient's psychosocial, support and treatment needs. Specifically, the following information is requested during the initial review:

- Demographic information;
- Name, address, and phone number of admitting/attending physician or provider, and name, address, and phone number of facility;
- Diagnosis;
- Procedure (when applicable);
- Clinical information substantiating necessity of acute inpatient treatment and/or necessity of services provided or proposed to be provided;
- Criteria/guideline used to determine medical necessity;
- Discharge plan; and
- Psychosocial factors to identify/assist continuum of care needs.

Step Two: Medical Necessity Determination

Once all critical clinical information necessary to make the utilization review decision is obtained, the APS Reviewer evaluates and compares the data to nationally recognized clinical criteria/guidelines to identify the proper setting for delivery of effective health care for the patient. We use the following criteria sets:

- Milliman USA Guidelines (10th Edition revised 2006) for medical/surgical inpatient review and ambulatory services;
- HCIA-Sachs;
- American Society of Addiction Medicine (ASAM 2nd Edition revised 2001) for chemical dependency reviews; and
- Health Management Strategies (HMS) for Psych reviews.

Reviewers use these automated criteria/guidelines, maintained in electronic format, to evaluate the medical necessity of care and/or setting for the requested medical/behavioral service. If the criteria are met, the reviewer may certify the admission or service and will notify the requestor verbally at the time of the review. In addition, letters are issued to the patient, attending physician and facility confirming the authorization of services.

If the criteria are not met, the reviewer will refer the case to an APS Medical Director for review. APS Medical Directors are licensed, registered, or certified MDs with expertise in determining issues relating to medical necessity of medical, surgical, obstetric, rehabilitation and behavioral health services. The APS Medical Director may approve or deny admission or days. When making a determination, the APS Medical Director considers community standards of care and



Medical Utilization Management Services

2.6 Questionnaire – B. Medical Management

reviews all available clinical information and requests additional information if necessary. All cases referred to an APS Medical Director are reviewed within 24 hours.

The APS Medical Director may make a determination or recommendation based on the information present or may contact the member and/or authorized representative and attending physician to discuss the request and to gather additional information. If the determination or recommendation is that medical necessity is present, a certification is issued and authorization letters are sent accordingly. If the determination or recommendation is that there is not medical necessity, a non-certification determination is issued. The requester is informed verbally at the time of the call and a letter is also sent, which cites the specific clinical reason why a denial was given by the physician performing the review, information on the appeals process, as well as information on the APS Medical Director who performed the review, including name and credentials.

Step Three: Concurrent Review

APS' Clinical Care Management System produces daily reports that indicate whether a concurrent review should be initiated with each active patient. After the initial pre-certification, concurrent reviews are scheduled to occur on the last covered day. Subsequent reviews are scheduled in intervals in accordance with the APS' adopted criteria.

The purpose of the concurrent review is to evaluate the patient's functioning and determine the next course of action, whether it is to step down to another level of care or discharge. During the concurrent review process APS Reviewers collect and re-evaluate the clinical data that was obtained during the initial review to determine whether the patient continues to meet criteria for the procedure/admission. This includes review of the following:

- Requested length of stay/frequency/duration of services;
- Practitioner assessment of member condition and severity of illness;
- Axis I-V of the DSM diagnosis, if behavioral health;
- Other diseases, illness, or health conditions;
- Support network;
- Treatment history, outcomes, and plan; treatment records, if appropriate;
- Discharge plan and/or transitional care plan (Assess for need for other care management services, e.g., disease management);
- Evaluation and assessment of the individual member's psychosocial, support, and treatment needs; and
- Evaluation and assessment of the local area delivery system's ability to meet those needs.

In addition, the reviewer will confirm member demographics, eligibility and benefits with each review to ensure the patient's case file is up to date. APS Clinicians are also available to provide consultation to the requestor in terms of answering any questions they may have around the review process.



Medical Utilization Management Services
2.6 Questionnaire – B. Medical Management

Step Four: Discharge Planning

APS provides discharge planning on all admissions. Discharge planning is an important and proactive feature of our UM services. APS Reviewers assist in developing a discharge plan during the initial request for services and continue to hone the discharge plan with each subsequent review. APS' discharge planning process requires the coordination and involvement of key APS clinical staff, providers, family member and other informal and community support systems of care. APS carefully manages the case throughout the continuum of care, coordinating closely with providers to ensure the effective management of each patient's treatment.

Discharge planning begins at the time of pre-certification and the authorization of the initial length of stay. Goals for discharge and follow-up care are documented in the initial treatment plan. Resolution of symptoms is key to achieving discharge. Progress toward symptom reduction and stabilization are monitored by APS Reviewers and recorded in the member's clinical record. Progress toward symptom reduction and stabilization also forms the basis for concurrent review decisions.

As a part of the discharge plan, the APS Reviewer identifies any anticipated needs based upon the clinical characteristics of the case, as well case management triggers that are based upon both diagnostic categories and situational needs. The APS Reviewer acts collaboratively and in a highly interactive role with the facility's discharge planner to ensure the member is prepared for smooth discharge and post-hospitalization medical care. As an example, the reviewer will be checking for home safety and the overall ability of the primary caregiver's capacity to provide adequate support and care on behalf of the member.

Cases are closed according to the following criteria:

- The member no longer has any medical or behavioral health needs require utilization case, or disease management.
- The client instructs the reviewer to close the case.
- The member becomes ineligible.

All information gathered and actions taken during the review process are documented in APS' Clinical Care Management System, called the Clinical Care Management System. Clinical Care Management System provides APS with an on-line care management infrastructure and enables our clinical staff to track member progress through the care continuum, identify members who could benefit from Case Management, automates the assessment process for stratification and generate reports on savings.

6) Describe the qualifications of staff responsible for documenting patient demographics for requests received telephonically.

Non-licensed administrative staff or a nurse reviewer may perform this process. APS' intake staff are routinely the first point of contact for all new incoming UM cases. When a call is



Medical Utilization Management Services

2.6 Questionnaire – B. Medical Management

received for UM services, our customer service staff gathers demographic information from the caller for the member requiring services, as well as basic information on the type of services being requested.

Licensed health professional staff monitor non-licensed administrative staff who utilize approved scripts. Non-licensed administrative staff consult with licensed health professionals for direction and consultation as needed.

APS requires evidence of excellent communication and problem-solving skills, a professional attitude, and supportive personality traits, including empathy and listening skills.

7) Describe the qualifications of staff responsible for accepting clinical information for requests received telephonically.

Only licensed health professionals may perform clinical reviews. **A minimum qualification for our Nurse Reviewers is that they be licensed Registered Nurses.** Our clinical staff must meet the following stringent qualifications to join the APS team of professionals:

- Must be a currently licensed Registered Nurse with a working knowledge of medical procedures and practices for medical reviews.
- Must be a Registered Nurse with at least 3 years of psychiatric experience, Licensed Social Worker, or Licensed Professional Counselor for behavioral health reviews.
- Must have 3 years experience in acute inpatient care.
- Must have working knowledge of CPT-4 and ICD-9 codes.
- Must have computer skills.
- Must have excellent customer service, written and oral communication skills.

8) Indicate the specific medical/surgical criteria and/or guidelines used to conduct utilization review in both the inpatient and outpatient areas utilizing the format below. Check all appropriate areas:

Criteria	Inpatient	Outpatient
Milliman	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
InterQual	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Internally developed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Other: (indicate specific criteria)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No



Medical Utilization Management Services
2.6 Questionnaire – B. Medical Management

We use the following criteria:

- Milliman USA Guidelines (10th Edition revised 2006) for medical/surgical inpatient review and ambulatory services;
- HCIA-Sachs;
- American Society of Addiction Medicine (ASAM 2nd Edition revised 2001) for chemical dependency reviews; and
- Health Management Strategies (HMS) for Psych reviews.

9) Describe the capabilities and processes of customizing criteria to local norms.

APS is flexible in its programs and processes and is willing to utilize criteria designated by EBD. While the use of the nationally recognized criteria ensures consistent review practices, we also recognize that they were not developed to accommodate for geographic nuances. APS already possesses experience building a successful program for the State of Arkansas. Currently, we provide utilization management, continuing education, inspections of care and care coordination for inpatient and outpatient mental health services for 400,000 Medicaid recipients (lives) under the age 21, 55,000 of whom we authorized for mental health services. APS was selected to administer the State's program in **July of 2003**, and established an office in Little Rock, Arkansas with approximately 30 FTEs to serve the State's eligible recipients. **Scott Strang, PhD, MBA, our proposed Account Executive for EBD's program, is based in Little Rock and oversees the State's existing Medicaid Program.**

Since contract award, APS has worked tirelessly to develop positive provider partnerships throughout the State. When APS first won the contract, we aggressively reached out to the provider community through a series of regional presentations introducing APS' philosophy, business model, technology and key staff members. This was followed by an extensive series of teleconference training sessions on the use of an innovative web-based preauthorization system, which was completely customized to meet the State's specifications. As a result, APS achieved incredible buy-in from the provider community. In fact, within the first week of the program's launch date, we had a 90% provider participation rate for our web-based system, and now tout a 99% usage rate for active providers. APS' outreach to the provider community has also included the establishment of two (2) **Provider Advisory Groups.**

The Inpatient Advisory Group is composed of representatives (mostly CEOs) of five acute psychiatric hospitals and five free standing psychiatric residential treatment facilities. The outpatient advisory group is composed of representatives of five (of 15) community mental health centers and five for profit outpatient service providers. Each group meets on a quarterly basis and serves as a forum for providers to give APS feedback about its services and for APS to engage the provider community in dialogue regarding quality improvement issues.

As a result, the criteria will be reviewed annually by our on-site Medical Directors to ensure they are appropriate for the healthcare delivery system in Arkansas. As a part of this review, our



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Medical Directors will identify areas that may require modification in order to address the variances that exist in healthcare in Arkansas.

- 10) For the office you propose to service this account, provide the following telephone information for calendar year 2006. If your organization has separate phone lines for intake staff and RN staff, provide information for both units. Provide reports documenting your responses for items listed below. Include these reports as Attachment BB.
- a. Total number of telephone calls received in the utilization management unit.
 - b. Total abandonment rate for the utilization management unit.
 - c. Average hold time for the utilization management unit.

Total number of telephone calls received in the utilization management unit: **29,832**
Total abandonment rate for the utilization management unit: **1.3%**
Average hold time for the utilization management unit: **Not Applicable; however 92% of calls answered within 30 seconds.**

Please see Attachment BB to review documentation substantiating our responses to questions a through e below.

- 11) For the office you propose to place this business, provide the total number of retrospective reviews performed and the total number of days associated with these cases. Include this information for cases with a discharge date during 2006.

2006 Results	
Total Number of Retrospective Reviews	47
Today Number of Days	141

The statistics above may appear to be low; however it should be noted that APS has established effective relationships with the facilities with whom we work collaboratively, facilitating ease of contact.

- 12) For the office you propose to place this business, what was the average time between receipt of complete clinical information to rendering review decisions to the attending physician for inpatient admissions and outpatient surgical requests for services?

We are in alignment with URAC and the DOL regulations and are 100% in compliance with their stringent timelines.

On average, APS' Nurse Reviewers are able to communicate their decisions to providers and members within 24 hours of the initial call regarding an admission.



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It is our policy to conduct utilization decisions, notifications, and confirmations in a timely manner to enhance coordination and continuity of care, and accommodate the clinical urgency of review situations. In addition, we align ourselves with NCQA and URAC and adhere to their stringent timeliness guidelines which provide for the following:

- 1) In urgent situations a determination or recommendation and notification of the Member or Authorized Representative, and treating practitioner(s) and facility representative(s), as applicable within *the earlier of (1) as soon as possible taking into account the medical exigencies of the review; or (2) seventy-two (72) hours* of initially receiving the request for the review; and
- 2) In other prospective situations the determination and notification is accomplished within *15 calendar days* of receiving the initial request.

APS has had **100%** compliance with these guidelines in 2006.

13) Describe in detail the procedures for handling review beyond the expertise of the medical decision tree software.

Our UM/CM nurses have worked at APS for an average of **5 years** and have a combined 43 years of healthcare industry experience. We staff clinical expertise in rehabilitation, maternity, oncology, diabetes, cardiac, pulmonary, psychiatric, and chemical dependency. Our UM nurses work in coordination with our **on-site Medical Directors** to affect appropriate, coordinated care for your members presenting with an acute or chronic condition.

An additional advantage to be utilized for EBD is APS' **Clinical Resource Network** which includes **20 in-house (APS employee) Medical Directors** and an additional **77 consulting physicians** who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development.

14) Complete the table below for the office that would provide service for this account.

APS has provided our medical utilization statistics below. Please note statistics for behavioral utilization management have not been provided as they don't relate to the RFP's scope of work.

	Number of Inpatient Cases Reviewed	Number of Continued Stay Reviews
Medical	4,639	3,376
Surgical	1,935	1,110
Maternity	1,082	269
Psychiatric and Substance Abuse	N/A	N/A



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	Number of Inpatient Cases Reviewed	Number of Continued Stay Reviews
Total	7,656	4,755

15) What are your criteria or protocols for when continued stay review should be initiated? Is continued stay review ever conducted on-site and if so in what situations?

Yes, for certain customers and dependent upon the availability of regionally based staff, APS does perform concurrent reviews on-site, based on the severity of the patient's condition, treatment, discharge/transitional care planning, and individual patient needs.

Reviews are typically performed telephonically. However, there are exceptions to this process. At the request of specific customers, APS will send qualified clinicians on-site to conduct medical necessity reviews and coordinate care management responsibilities. On-site reviews are most appropriate for complex cases that require heightened coordination and can benefit from in-person contact with an experienced APS clinical professional.

Concurrent Review

APS' Clinical Care Management System automatically generates daily reports that indicate whether a concurrent review should be initiated with each active participant. After the initial pre-certification, concurrent reviews are scheduled based on the severity of the participant's condition, treatment, discharge/transitional care planning, and individual participant needs; and:

- Ranges from daily to every three (3) days for acute inpatient hospital care; and
- Every 3-7 days for skilled nursing facilities and inpatient physical rehabilitation.

Subsequent reviews are scheduled in intervals in accordance with APS' adopted criteria.

The purpose of the concurrent review is to evaluate the participant's functioning and determine the next course of action, whether it is to step down to another level of care or discharge. Concurrent review helps to reduce and avoid unnecessary health claim costs while monitoring the quality of participant care. Special attention is paid to the participant's medical needs and to working with the physician to reach a consensus as to the most appropriate course of action. In addition, it reduces unnecessary hospital days by:

- Reviewing the certified hospital stay to ensure that the need for hospitalization continues; and
- Identifies potentially complex or catastrophic cases for possible referral to case management

During the concurrent review process, APS Care Managers collect and re-evaluate the clinical data that was obtained during the initial review to determine whether the participant continues to



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meet criteria for the procedure/admission. Progress toward symptom reduction and stabilization forms the basis for concurrent review decisions. This includes review of the following:

- Participant’s admitting diagnosis and treatment history
- Planned course of care
- Expected discharge date
- Expected discharge needs
- Axis I-V of the DSM diagnosis for behavioral health admissions;
- Case management / disease management referrals

If at any time during the review process the participant ceases to meet the level of care, the Care Manager will work collaboratively with the facility and/or provider to negotiate an appropriate lower level of care and/or transfer to an appropriate setting.

All information gathered and actions taken during the review process are documented in APS’ Clinical Care Management System. Our platform provides us with an on-line, integrated care management infrastructure and enables our clinical staff to track participant progress through the care continuum, to identify participants who could benefit from CM, automates the assessment process for stratification and generates reports on savings.

16) Complete the table below for the office that would provide service for this account.

APS has provided our medical utilization statistics below. Please note statistics for behavioral utilization management have not been provided as they don’t relate to the RFP’s scope of work.

	Admissions per 1,000 members	Inpatient Days per 1,000 members
Total (for all admissions)	29.9	77.2
Newborns born with complications	0.47	9.87
Cases retrospectively reviewed	0.16	0.49
Cases requiring acute care rehabilitation centers	0.16	2.49
Cases requiring mental health acute care centers	N/A	N/A

17) Complete the table below for your public sector clients.

APS has provided our medical utilization statistics below. Please note statistics for behavioral utilization management have not been provided as they don’t relate to the RFP’s scope of work.



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	Admissions per 1,000 members	Inpatient Days per 1,000 members
Total (for all admissions)	43.8	145.05
Newborns born with complications**	0.47	9.87
Cases retrospectively reviewed**	0.16	0.49
Cases requiring acute care rehabilitation centers**	0.16	2.49
Cases requiring mental health acute care centers	N/A	N/A

** Represents our book of business.

18) What is your average turn around time from receipt of complete clinical information to the rendering of a certification decision? Is your organization capable of providing monthly reports indicating the numbers of requests processed by number of days from receipt of clinical information to the rendering of a certification decision?

If the criteria are met for the requested procedure/admission, the clinical reviewer will certify the care. The determination is communicated upon receipt of all necessary information and communicated to the requestor at the time of the review. In addition, a notification letter is sent to the physician, facility and patient. **If the request does not appear to meet medical necessity the case is referred to an APS Medical Director for peer review. The APS Medical Director will review the case within 24 hours of receipt and communicate a determination within that timeframe.**

For our entire UR book of business, APS has consistently provided an immediate response to requests for services 100% of the time when all necessary information is provided. Furthermore, if a facility/provider does not provide the information necessary to determine medical necessity, the member is never penalized and their care is not delayed. In such cases APS will authorize the care based on information provided and perform a retrospective review once the facility/provider supplies the necessary clinical information. This process is transparent to the member and does not affect their care in any way.

Yes, APS is capable of providing monthly reports indicating the numbers of requests processed by number of days from receipt of clinical information to a rendering of a certification decision.



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19) For the office you propose to place this business, provide your non-certification rates for the top ten diagnoses for inpatient admissions reviewed through your review program. For calendar year 2006, include the number of requests received, number of requests initially non-certified, and the number of requests which were overturned on appeal.

APS' top ten diagnoses non-certification report is unavailable at this time. However, we have provided our 2006 statistics for number of requests received, number of requests initially non-certified, and number of requests overturned on appeal below for calendar year 2006 below:

Measure	2006
Number of requests received	12,411
Number of requests initially non-certified	763
Number of requests which were overturned on appeal	81

20) Describe your process for updating clinical protocols including the frequency of updates.

APS utilizes established Clinical Criteria, as defined below, for triage/referral, admission and continued stay for both mental health and substance abuse services for the following levels of care: inpatient, partial hospitalization, intensive outpatient, outpatient, rehabilitation, and 23-hour observation. The multidisciplinary Provider Advisory Group, under the leadership and direction of the APS QI Medical Director, develops these criteria. The appropriate APS QI Committee grants subsequent approval, with the final approval being granted by the Corporate Quality Improvement Committee. The APS clinical criteria are reviewed as necessary, but at least annually.

The APS Medical Necessity and Level of Care Determination Criteria (UM Criteria) are intended to be a starting point and common reference for clinical discussion. As such, they focus on the patient's clinical history, presenting symptoms, and available resources in recommending a level of care. However, in addition, the APS clinical staff reviewing the clinical information must consider the following issues when applying the criteria to a given individual: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment. APS also recognizes that resources for the full continuum of care do not exist in all parts of the local delivery systems. In those cases, APS may recommend a higher level of care than medically necessary in order to assure safe, effective treatment. "Medical Necessity" is used here to mean care, which is determined to be effective, appropriate, and necessary to treat a given patient's disorder.



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PROCEDURE

The PAG completes a review of the APS Clinical Criteria as necessary, but at least annually. The criteria review includes:

- Input from the network providers who are enrollees of PAG
- Input from APS utilization management staff
- New technologies or new uses of existing technologies, as appropriate
- New developments within the field of mental health and substance abuse
- Impact on consistency with APS Clinical Practice Guidelines
- Review of nationally accepted resources such as DSM-IV and Milliman & Robertson Optimal Recovery Guidelines

Following the PAG review, the recommended changes and updates are submitted to the appropriate Quality Improvement Committee for review and approval.

Approved suggestions for additions, deletions, or other changes are incorporated in the clinical criteria.

The final draft is submitted for *final* approval to the Corporate Quality Improvement Committee. All APS utilization management staff, including Physician Advisors, receive copies and training on the newly revised clinical criteria. The most current UM Criteria are also posted on the APS Website.

The APS UM Criteria is disseminated to the APS network providers in the following manner:

- a. Existing Providers are notified by postcard or letter that the UM Criteria have been revised and that the revised criteria are posted on the APS Website. For providers without access to the Internet, a paper copy is offered.
- b. New providers are notified in the “welcome to the network” letter of the location of the UM Criteria on the APS Website. For providers without access to the Internet, a paper copy is available upon request.

Proper understanding and application of APS clinical criteria is monitored on an ongoing basis through APS’ Inter-Rater Reliability Program

21) Explain your process and procedures for protocol development for new procedures or new technology.

APS utilizes a standardized process across the organization for the identification, evaluation, and approval of new technologies or new uses of existing technologies both at the Corporate and operating unit level. In some circumstances the final approval of new technologies is not completely under APS’ control, as in those circumstances when the health plan has the final



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approval of whether a procedure or medication will be covered by the enrollee's benefit package. In those instances, recommendations for approval of new technologies are communicated to client organizations for inclusion in the benefit packages/drug formulary. The Corporate Quality Improvement Committee (CQIC) is responsible for the Clinical Technology Program.

PROCEDURE

Section 1: Identifying New Technologies

A. The Corporate Quality Improvement Medical Director is responsible for maintaining currency with the new technologies available in the field of mental health and substance abuse. This includes, but is not limited to, identifying, researching, evaluating and seeking approval of new technologies that are appropriate use by APS enrollees. Recommendations for new technology assessments may also be made by operating unit staff, client organizations, network providers, or enrollees.

B. The Provider Advisory Group (PAG), and/or an ad hoc group of appropriate professionals with expertise in the technology, reviews and discusses new technologies on an annual basis

C. If a client organization, provider, enrollee or other APS staff * identifies a new technology, the Corporate Quality Improvement Medical Director verifies that the new technology meets the above definition of new technology and is not excluded by relevant contracts.

1. If the request meets the definition of a new technology, the initiator of the request will be notified, in writing, within 30 days of receipt of the request.

2. If the request does not meet the definition of a new technology, the initiator of the request will be notified, in writing, within 30 days of receipt of the request.

D. If the new technology meets the criteria stated in "C", the Quality Improvement Medical Director will then research, evaluate and seek approval of the new technology.

Section 2: Research and Evaluation of New Technology

A. The Corporate APS Quality Improvement Medical Director or designee, researches the new technology. This research may include, but is not limited to, a review of:

- Nationally accepted literature data bases, (e.g. Medline Data Base);
- Government publications;
- Published scientific evidence (Peer reviewed and double blind studies utilizing nationally accepted statistical techniques are given more weight);
- Published practice parameters or guidelines documenting accepted uses;
- FDA and/or other government regulatory body approvals, as required, and
- When appropriate the process for obtaining input from specialists with expertise in the technology under evaluation includes:



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- o The Medical Director will identify the specialist using his/her knowledge of current research through literature review or personal experience;
- o an evaluation /opinion of the technology's efficacy is solicited from the specialist; 3) documentation of the specialist's opinion is forwarded to the PAG.

B. Upon completion of the research, the Corporate Quality Improvement Medical Director submits the findings and recommendation to the PAG for their review and recommendation(s).

C. The PAG, and/or an ad hoc group of appropriate professionals, reviews all data submitted by the Corporate Quality Improvement Medical Director and makes a recommendation for the use/non-use of the new technology.

D. The PAG recommendation is based upon the following four decision-making criteria:

- Adequate peer reviewed literature supports net positive health outcome
- The positive outcome is attainable outside the investigational setting
- The technology is as beneficial as existing non-investigational alternatives
- FDA or other governmental regulatory approvals, as required

Section 3: Approval Process

A. The PAG makes a recommendation, and their recommendation for use/non-use of the new technology is documented in the PAG minutes and on the APS Technology Request Form.

B. The Corporate Quality Improvement Medical Director presents the PAG recommendation at the next scheduled CQIC for its approval.

C. The CQIC reviews the recommendation and ensures that the established criteria and procedures for new technology review have been followed. The CQIC then makes the final decision regarding the approval/denial. In some circumstances the final approval of new technologies is not completely under APS' control, as in those circumstances when the health plan has the final approval of whether a procedure or medication will be covered by the enrollee's benefit package. In those instances, recommendations for approval of new technologies are communicated to client organizations for inclusion in the benefit packages/drug formulary. When the CQIC has made the final decision, the decision becomes applicable to all divisions.

D. The Corporate Quality Improvement Medical Director notifies each of the Division Medical Directors of the final decision.

E. The Corporate Quality Improvement Medical Director or designee then presents the recommendations, to the client organizations.



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Section 4: Implementation of New Technologies

A. Once approved, by APS (and by client organizations, when necessary) APS divisions are responsible for the education of the provider network, enrollees, and APS staff of the approval of new technologies.

B. Approved new technologies are also integrated into relevant APS Clinical Criteria and Clinical Practice Guidelines, as indicated.

Section 5: Informing Enrollees of New Technology Review Processes

A. APS informs enrollees of its new technology review processes. It may use any of the following methods:

- Enrollee newsletter
- Enrollee brochures
- Targeted mailings
- APS website

22) Provide your definition of an experimental/investigational procedure or test and describe your review/authorization process.

APS defines experimental/investigational procedures or tests as treatment that has not been approved by the FDA (if the treatment is subject to FDA approval) and there is no medically and scientifically accepted evidence that clearly demonstrates that the treatment 1) is proven safe; 2) is expected to produce greater benefits than the standard treatment without posing a greater adverse risk to the enrollee; and meets the coverage terms of the health benefit plan and is not specifically excluded by the plan.

APS' review/authorization process would be the same as that described previously in our proposal.

23) Provide your definition of a cosmetic procedure and describe your review/authorization process.

APS utilizes the client's plan documentation as provided in their benefit summary as a guideline to determine eligibility of a proposed procedure for coverage. Broadly defined--a cosmetic procedure can be considered any surgical procedure or portion of a procedure which is performed primarily to improve physical appearance.

Upon receipt of a request for precertification, the Care Manager will first review the account-specific requirements regarding available benefits and limitations. If appropriate to initiate further review, the Care Manager will obtain applicable clinical information such as the practitioner assessment of the member's condition, treatment history with outcomes and planning, and additional treatment records as appropriate. This information will be compared to



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Milliman Care Guidelines. If any uncertainty exists as to whether the proposed procedure is medically necessary, the data will be referred to a Physician Clinical Reviewer for consideration.

APS' review/authorization process would be the same as that described previously in our proposal.

24) While performing concurrent review, if it is determined that continued stay is not medically necessary, what is your procedure for notifying the member and the provider(s)?

If at any time during the review process the participant ceases to meet the level of care, the Care Manager will work collaboratively with the facility and/or provider to negotiate an appropriate lower level of care and/or transfer to an appropriate setting.

All information gathered and actions taken during the review process are documented in APS' Clinical Care Management System. Our platform provides us with an on-line, integrated care management infrastructure and enables our clinical staff to track participant progress through the care continuum, to identify participants who could benefit from CM, automates the assessment process for stratification and generates reports on savings.

Review decisions are **communicated to the requestor verbally** at the time of the review and **in writing to the patient, provider and facility**. Decision letters are automatically generated from APS' Clinical Care Management System and sent out on the same day that the decision is made.

25) What sources of peer review literature does your company utilize?

APS utilizes a wide variety of peer review literature including all of the major medical journals, various online resources, Milliman guidelines, etc. However, only those hardcopy resources and websites that originate from official organizations or have been validated by our Corporate and Senior Medical Directors and approved by our Clinical Advisory Panel are designated and circulated as legitimate reference sources; such as government or government authorized agencies; professional organizations (e.g., AMA, CMSA); and accredited websites (e.g., URAC accredited websites).

Examples of the online resources utilized include:

Medicine/Drugs/Pharmaceutical	
http://www.fda.gov	FDA home page
http://www.fda.gov/orphan/designat/index.htm	FDA orphan drug
www.medlineplus.gov	National Library of Medicine (National Institute of Health)
www.ncbi.nlm.nih.gov	Pub Med site. National Library of Medicine (National



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http://www.ncbi.nlm.nih.gov/entrez/query.fcgi	Institute of Health)
http://www.ghp.georgia.gov/wps/output/es_ES/public/Provider/MedicaidManuals/Physicians_Injectable_Drug_List_01_2004.pdf	Medicaid Injectable Drug List, 2004
www.louisianaseniorx.org	This website contains information about senior citizens in regard to pharmaceutical aid
http://www.fda.gov/search/databases.html	Databases on the FDA website

Cancer-Related	
http://www.fda.gov/search/databases.html	Chemotherapy and drugs for cancer treatment
http://www.fda.gov/cder/cancer/	FDA approved chemotherapy drugs
http://www.cc.nih.gov/	National Institute of Health (NIH) Home chemotherapy information
http://www.nci.nih.gov	NCI cancer site
www.cancerlinks.com	Chemotherapy and drugs for cancer treatment

26) If you use internally developed clinical criteria, are they cross-matched to other published medical criteria such as Milliman or InterQual? If so, what is the frequency of this process?

Yes, our internally developed clinical criteria are cross-matched to other published medical criteria. Criteria and clinical screening scripts are reviewed at a minimum, annually, to incorporate developments in clinical practice, to demonstrate compliance with federal and/or state law, and to ensure they are appropriate for the enrollee population.

27) Are the criteria available to providers? If yes, describe how.

Criteria are available online for providers to access via APS' website. A webpage will be established for the UM Program, similar to what we already have established for our public sector program for the State of Arkansas.

28) Does your system prompt the reviewer to take certain out-of-system steps before proceeding, e.g., review of paper criteria, Plan Participant eligibility, in-network status of provider?

Yes, our Clinical Care Management System includes prompts.



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29) Is there a formal panel of physician specialists to review cases? If yes, how many physicians are on the panel? How many physician specialties are represented? Are the physicians board certified?

Yes, an additional advantage for EBD is APS' Clinical Resource Network which includes 20 in-house (APS employee) Medical Directors and an additional 77 consulting physicians who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development. The physicians are board certified. They span clinical specialties in Psychiatry, Pediatrics, Cardiology, OB-GYN, Endocrinology, Paleontology, ENT, Nephrology, Oncology, Pulmonary Disease, Physical Medicine and Rehabilitation, Dentistry, Allergy/Immunology and Orthopedic Surgery to name a few of the specialties represented.

30) Describe the processes followed when a planned medical or surgical admission fails to meet the medical necessity criteria used by your medical review staff. At what stage of the review does physician-to-physician communication initiate?

Non-certification Process

In UM processes, if the appropriate criteria are met, the Nurse Reviewer makes a decision to certify. If the Nurse Reviewer is unable to make a decision to certify, the case is referred to a Medical Director or other peer clinical reviewer. APS provides the opportunity for a peer-to-peer conversation if requested by the attending physician or other ordering provider. The Medical Director or other peer clinical reviewer may certify or not certify based on the information presented. Only Medical Directors and/or clinical peer reviewers have the authority to render a medical necessity non-certification decision.

Communication of the determination is made as appropriate, to the member, physician or other designated provider, and facility. The claims administrator is also notified.

For any non-certification determination, the written notification includes:

- The principal reason for the non-certification,
- Reference to the specific plan provision relied upon in making the non-certification,
- A description of appeal rights including applicable time limits for filing appeals,
- Instructions on appeal procedures,
- If applicable, the statement that, "A claimant has the right to bring civil action under 502(a) of ERISA following an adverse benefit determination" (non-certification or an administrative non-certification), and
- The availability of the clinical rationale and criteria used for the decision in writing upon request and free of charge,
- Written notification of certification contains a statement that approval does not constitute a guarantee of payment.



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APS performs its UM services in compliance with prudent layperson legislation. These functions are coordinated with the payer of services.

Procedure for Referring Denied Cases to Outpatient Facilities

Negotiations of this type are usually accomplished via contact with the facility's UR and discharge planners, through telephonic contact as we receive concurrent clinical updates. Of course, all involved parties (patient, provider and facility) are notified both telephonically and in writing following any denials.

Most frequent scenarios include:

- Request for transfer to inpatient rehab or LTAC – the patient meets criteria for SNF or home care (diagnosis might be CVA, post op total joint replacement, traumatic brain injury etc.)
- Request for inpatient length of stay when outpatient more appropriate – i.e. for "minor" surgeries which are classified as "ambulatory" per Milliman Care Guidelines

Medical Necessity Appeals Process

Upon a non-certification notification, the option(s) for appeal are offered to the member, facility, and provider, verbally and/or in writing. The appeal process may be initiated either by telephone or in writing by the member (or a personal representative on the member's behalf), the attending physician (or other ordering provider), or a representative from the facility rendering service.

The following levels of appeals are available although there are variations. The variations are dependent on the state specific regulations as well as the delegation arrangement with the health plan. The levels of appeals include:

- Standard Level I (Expedited Level I is available);
- Standard Level II Appeal (Expedited Level II is available);
- Level III Appeal; and
- External, Independent Appeal.

As part of our policy, the appeals peer reviewer must be someone other than the physician (or other peer) clinical reviewer who made the initial determination or recommendation not to certify. In addition, the appeals reviewer may not be a subordinate of the physician (or other peer clinical reviewer) who made the initial determination or recommendation.

31) What percentage of cases is referred to the physician review staff?

23% of cases are referred to the physician review staff.



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32) Are there situations when cases are referred to a physician review staff member for other than medical necessity of setting, admission, or length of stay? If so, describe when this would occur.

Yes, there are situations. For example, to discuss continuity and coordination of services, the exchange of information across all levels of care, and to discuss of emerging technologies, discuss medical trends.

33) What percentage of reviews do physicians who are at least half-time employees of your organization perform?

For APS' proposed program for the State of Arkansas, APS has included the coverage equivalent of a **1.5** FTE Medical Director who is a board certified physician with an active practice – **Dr. Katie Evans**. Dr. Evans will be focused on EBD's UM Program and will be supported by APS' Clinical Resource Network, which is an additional advantage to EBD.

Our **Clinical Resource Network** includes **20** in-house (APS employee) Medical Directors and an additional **77** consulting physicians who support our care management programs in various capacities including providing clinical leadership, facilitating quality oversight, reinforcing best practices and supporting new product development.

34) What percentage of cases referred to the physician review staff result in direct contact with the treating physician? What percentage of those treating physicians contacted by the physician review staff change their proposed treatment plan?

Our UM philosophy is to avoid adverse determinations by establishing a dialogue with treating physicians utilizing our Nurse Reviewers who are able to provide physicians with information that would not be readily available as a part of the medical record and which will often impact the treatment plan and facilitate appropriate, cost-effective care.

Additionally, we provide all treating physicians with the opportunity to consult with an APS Medical Director – peer to peer – to collaborate and develop a mutually agreed upon plan of care.

Based upon our experience, when an adverse determination is made, most physicians do not choose to engage in a peer-to-peer discussion. However, our Medical Directors are still available and willing to forward guidelines upon request.

35) What percentage of physician reviews are performed by physicians who are specialty matched and board certified?



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100% of physician reviews are performed by physicians who are specialty matched and board certified.

36) As Attachment CC, provide a description of the non-authorization process and include copies of sample non-authorization letters to Plan Participants and providers.

As requested, APS has attached its non-certification process and copies of sample non-authorization letters to Plan Participants and providers, as **Attachment CC**.

37) Can provider networks be loaded within your system? If a provider is not within a network what is your process for advising the Plan Participant and provider of the out of network status?

Yes, provider networks can be loaded within APS' Clinical Care Management System. When a facility/provider or member calls to obtain certification for services, APS' reviewers always verify if the provider/facility is a participating network provider. For example, for our client, the State of Montana, our clinical staff has access to the Blue Cross Blue Shield of Montana network, which is updated on a daily basis to ensure accurate information is available on the network status of providers at all times.

If a member is requesting services and the reviewer determines that the selected treatment provider is out of network, APS provides education to the member on how the use of a non-network provider will impact their out of pocket costs. In addition, we work with the member to locate a comparable in-network provider and assist them in connecting to this resource. In our experience, members are often agreeable to switching to an in-network provider to ensure they receive the most robust benefit.

If a provider's office calls to certify care for a member at a facility and the facility is not participating in the network, APS will educate the provider's office on how this will impact the member's benefit in terms of additional out of pocket expenses. Again, in our experience, we have found that in such cases the provider's office will go back to the member with this information and select an in-network facility to instead provide the necessary care. However, to ensure that members are always informed of the impact of using a non-network facility, APS will also send a letter to the member to communicate that they are using a non-network facility and provide education on how this will affect their out of pocket expenses.



Medical Utilization Management Services
2.6 Questionnaire – B. Medical Management

38) As a component of the review process, approval of the use of out-of-network services, facility as well as physician/ancillary services will be required of the utilization management Vendor. Describe your process of authorizing out of network benefits including how you determine a provider is not within the network, criteria for approving out of network benefits, and how you communicate the decision to the claims administrator and member. Provide an overview of report(s) that will be provided to the State on a regular basis that provide information related to services approved out of network.

APS understands that as the UR vendor, we will have responsibility to review and approve the use of out-of-network services, facility, as well as physician/ancillary services. As a part of APS' authorization process we will assist in steering members to in-network resources to obtain services. During the implementation process, APS will work with the State's network vendor, AHS, to develop a process for the loading of their network into our Clinical Care Management System, as well as processes for regular refreshes of the network. As a result, all staff serving the State will have on-line access to your network.

When authorizing services, APS staff will verify the network status of the treatment provider through the on-line directory in our Clinical Care Management System. All attempts will be made to direct members to in-network resources. However, we recognize that there are circumstances where the existing network may not have the appropriate resources to meet a patient's needs. As a result, out of network benefits will be approved when which there are no adequate network resources within reasonable distance to the patient or the patient requires specialty services not available through the network.

When out of network benefits are authorized, APS will communicate this to the participant and claims administrator telephonically at the time of the authorization and in writing within 24 hours. The notification will detail the rationale for authorizing out of network services and information the care being authorized. In addition, information related to out of network benefit authorization will be communicated to the State as a part of our quarterly reporting package, which will detail out of network utilization and rationale for authorizing out of network benefits.

39) Describe in detail how you measure cost savings.

Calculating Savings

APS' Clinical Care Management System assists us in calculating savings based on regional average cost per day and average length of stay per procedure and diagnosis guidelines. APS uses nationally recognized sources, which most frequently include Milliman USA care guidelines, Health Management Strategies (HMS) criteria and ASAM, to support our assumptions around the determination of cost savings. Once data is collected, reporting analysts work with the customer's account management staff to develop the final report on savings.



Medical Utilization Management Services
2.6 Questionnaire – B. Medical Management

APS' Clinical Care Management System collects both hard and soft savings as described below. APS' clinical personnel rely on Milliman USA care guidelines to assist in determining appropriate care for each member. The guidelines list benchmarks for costs associated with age, gender and region.

As part of the healthcare delivery process, our Utilization Management staff follows the Milliman USA guidelines to coordinate care with other disciplines, such as ambulatory case management, disease management, provider relations and quality improvement. This is important in making the patient's transition from a hospital setting to another level of care in a safe and effective manner. With the combination of our UM staff and the care guidelines, **Hard Savings can be shown when days are negotiated to outpatient services, skilled nursing, residential treatment, partial hospitalization, home health, etc.** This is a regular function of our UM staff and our reviewers look for opportunities in each case, if at all possible.

Our Utilization management staff use the Milliman USA guidelines in planning for inpatient care and projecting the length of stay a patient may require. If the patient has an optimal recovery, an extended stay is not required and adequate discharge planning has occurred, the patient can often go home within the certified length of stay. **An averted hospital stay may be interpreted as a Soft Savings, and this interpretation is also currently reflected in our Case Management Savings reports, (TSO).** Most importantly, the Milliman guidelines are observed by the reviewers as clinical indicators of when it is appropriate to transition a patient to the next level of care or to home. In addition to the guidelines, reviewers also use their clinical training and evaluations of the individual circumstances of each patient in determining treatment patterns and goal lengths of stay.





Medical Utilization Management Services

2.6 Questionnaire – C. Appeals Management

Standard Level II Appeal: Level II Appeals are offered when either a Level I Clinical or Administrative Appeal has been accessed and the appellant does not concur with the Level I Appeal decision. The Level II Appeal is submitted verbally or in writing to the Appeals Specialist, who triages the clinical from the administrative appeals and submits the request to the Level II Appeals Sub-committee for their determination. The Level II Appeals Sub-committee includes at least one actively practicing practitioner who is of the same or similar clinical specialty that typically treats the disorder, performs the procedure, or provides the treatment. This practitioner will not have participated in any of APS' prior decisions on the case. The appellant or their representative has the right to appear in person or via telephone conference call before the Level II Appeal Sub-committee. Standard Level II Appeals are resolved no later than 15 calendar days after APS' receipt of the Standard Level II Appeal request for Pre-Service Claims and 30 calendar days after APS' receipt of the Standard Level II Appeal request for Post-Service Claims, or sooner as required by state or federal law.

External, Independent Appeals

In accordance with NCQA guidelines, APS has also established an External, Independent Appeal process to accommodate those states that require independent review organizations (IROs) to handle appeals, particularly in those cases in which APS is delegated all levels of appeals. Under this scenario, APS provides the IRO with all relevant documentation to make a clinically sound determination. APS implements the decision of the IRO within the time frame specified by the IRO.





Medical Utilization Management Services
2.6 Questionnaire – D. Quality Management

2) Provide your staff turnover rate by all operations positions involved in the utilization management, case management and disease management programs for 2006 for your company as well as the office for which you propose to place this business.

APS has provided our staff 2006 turnover rates for UM, CM and DM programs company wide as well as from our Montana Service Center, which will serve the State.

Program Type	Company Wide	Office Serving the State
Utilization/Case Management – UM Nurses	6%	9%
Disease Management – Health Coaches (RNs)	5%	42% (Out of the 7 positions, 3 terminated with APS, 2 of which were due to a medical condition and retirement. However, over 70% of the current team has been with APS for the past 3 years).

3) Explain your internal audit process including, but not limited to, the number of cases reviewed in a given frequency, the frequency of the audit process, the types of cases chosen for audit, and the methodology for choosing cases for audit. Include in your description how you ensure consistent application of UM criteria.

UM AUDITING PROCESS

APS monitors the performance of our UM team and individuals to ensure compliance with program protocols and philosophy, as well as Utilization Review Accreditation Commission (URAC) Standards. Team performance also indicates the general level of understanding of program protocols and may reflect areas of need for training, orientation, and continuing reviewer education. Audits capture the following types of information:

- Was the preauthorization tab completed correctly?
- Was the demographics tab correctly completed?
- Was the appropriate guideline/criteria chosen?
- Was the guideline/assessment Updated?
- Was the decision adequately documented?
- Was the clinical information documented adequate to support the days approved?

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Medical Utilization Management Services

2.6 Questionnaire – D. Quality Management

16) Describe in detail the process for identifying and resolving provider quality issues; e.g., inappropriate care requested/rendered, non-licensed provider.

See our response to Question 7 above.

17) Provide a copy of the internal quality assurance criteria and guidelines.

See our response to Question 8 above.

18) Complete the following table for business handled during 2006 in the office which you propose to place this business.

The data below reflects our medical utilization experience of our Montana Service Center, which we propose to serve the State:

Program	Number of cases Authorized	Number of cases non-authorized	Number of cases appealed	Number of cases overturned on appeal
Inpatient Admissions	7,656	678	312	70
Outpatient Procedures	1,188	85	30	11
Outpatient tests	Outpatient test all under outpatient umbrella.			

19) Does your company provide physician profiling reporting? If yes, how often are they produced and are these reports shared with the provider?

No, APS does not provide physician profiling reporting under our Utilization Management Program. This function is typically handled by the Health Plan.



**Medical Utilization Management Services
2.6 Questionnaire – E. Case Management**

1) Utilizing the following format, indicate which elements are used to identify potential cases for case management:

Elements	Outpatient	Inpatient
Specific computerized trigger diagnoses	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Length of stay		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Emergency room utilization	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Claims screening/dollar thresholds	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Laboratory/diagnostic testing results	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
UM nurse reviewer identification/referral	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Physician referral	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Member referral	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Health risk appraisals/health status questionnaires	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Psycho-social indicators	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

2) Does your organization have on-line criteria for identifying potential Plan Participants for case management services?

Yes, APS' Clinical Care Management System houses built in prompts or triggers that alert our reviewers when a case may be appropriate for referral into EBD's case management (CM) program.

As clinical data is entered into the system during the utilization review process it is evaluated for specific triggers that would indicate a need for more intensive oversight. Triggers for CM can include, but are not limited to:

- Emergency re-admission within 15 days;
- Hospitalization of more than 9 days;
- High risk diagnosis;
- Multiple admissions (three in six months);
- Rehabilitation needs;
- Diabetic;
- Development of complications; and
- Risk for potential emergency room/hospital use.

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Medical Utilization Management Services 2.6 Questionnaire – E. Case Management

The system automation coupled with our reviewers' expertise enables APS to effectively refer members to CM via the utilization review process in a timely manner. As a part of our protocols, APS reviewers can contact EBD and EBD can contact your CM vendor as described in the Q&A; **or** we can establish direct referral processes with PDB, Inc. (PDB) and contact them directly.

APS staff will also make themselves readily available to PDB to share additional clinical history and other relevant information so that their case manager has a clear and accurate picture of the rationale for the referral to CM, as well as pertinent details that will assist PDB in effectively managing the member's care. Our staff is also available to provide consultation and guidance. For example, we offer expertise in behavioral health for psychiatric and substance abuse cases to ensure appropriate management of such cases.

Going forward, APS would like to suggest EBD take advantage of our Informatics tools as another mechanism for identification of patients for CM. Through the use of our tools, APS can provide EBD and PDB with the additional and pertinent information to target patients for your CM program early on, before high dollar claims are incurred. This more proactive approach to case identification could be coupled with our UR services, providing the ability to intervene in a timelier manner.

3) What percentage of cases identified/referred is accepted into the case management program?

88-90% of cases identified/referred are accepted into CM.

4) What are the qualifications of the staff responsible for managing individual Plan Participants?

APS provides services using a **Collaborative Care Model** in which we maintain a team of clinicians with diverse specializations spanning the medical, disease and behavioral healthcare arenas, including those with experience in pediatrics, rehabilitation, medical-surgical, oncology, diabetes, substance abuse, geriatrics and psychiatry. These clinicians work in tandem with the primary Care Manager within our **primary care model**, to manage the care of each member.

Minimum qualifications of our CM staff include:

- Certification as a Case Manager; or
- RN Licensure and three (3) years clinical practical experience.

Our CM staff includes **licensed registered nurses, registered psychiatric nurses, licensed professional counselors, licensed social workers and certified case managers** who are responsible for providing clinical management and coordination of high-risk medical and behavioral cases.



**Medical Utilization Management Services
2.6 Questionnaire – E. Case Management**

In addition, APS employs specialty clinicians to support the CM process; these include **registered dietitians, registered therapists, certified diabetes educators and pharmacists.**

All levels of staff involved in care management processes are screened for appropriate qualifications and receive extensive orientation with periodic, ongoing education and training and ongoing monitoring of quality.

We employ a very comprehensive training approach and maintain a **formal, internal training program**, led by our **National Training Manager**. Our National Training Manager's responsibilities include administering, organizing and conducting company-training programs for clinical and non-clinical staff.

The APS training model establishes early mentor relationships between new and seasoned APS staff. Highly experienced personnel work hand in hand with newly hired staff throughout training and on an ongoing basis. This assures that plan participants benefit from the knowledge of some of the most experienced and successful health care professionals in the industry.

Additionally, recognizing the importance of behavioral change in Utilization and CM and the impact behavioral health conditions have on a person's overall health, all clinicians are trained to assess every plan participant for behavioral and social risk factors that may be negatively impacting their health status. Our training reflects this and incorporates strategies to support effective behavior change. It includes detailed behavior training to assist our clinicians in motivating individuals to become fully-engaged in the CM and disease management processes, and in motivating behavioral changes which enable participants to successfully achieve their self-management goals and sustain an optimal level of health.

Our behavioral health leaders have spent significant time developing comprehensive behavioral training modules to provide education and instructions to our clinicians on skills related to behavior modification and have created a comprehensive behavioral modification training program. Sample discussion areas include:

- Vocabulary – The ABC's of Behavior
- Increasing the Frequency of a Desirable Behavior (Building Bonds)
- The Importance of Cognitions
- The Key Ingredients of Change
- Why People Don't Change?
- When to Use Active/Reflective Listening

Ongoing Training

It is our policy to provide our clinicians with the opportunity to enhance their professional knowledge by encouraging attendance at in-service programs and participation in external continuing education programs. APS' training program is designed to provide opportunities for CEU credits and ensure our staff are kept apprised of the latest industry developments. We

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Medical Utilization Management Services 2.6 Questionnaire – E. Case Management

provide a minimum of **15** training programs a year, a majority of which allow for the opportunity to earn CEU credits. For example, in 2006 we provided training programs covering the following topics **Breast Cancer Management; Obesity: Pharmacologic Approaches; Alcohol & Depression; Update on Asthma & Allergic Rhinitis; Virtual Dialogues in Dyslipidemia: Focus on Triglycerides; Rationale for Use of Insulin Early in the Course of Type 2 Diabetes; and Dyslipidemia & Women** to name a few of our programs. Our on-site training facility is equipped with all of the latest technological advancements to ensure an optimal learning environment.

In addition, for clinicians who choose to participate in outside training opportunities, APS is flexible in allowing time off to attend courses. **Our policy is to reimburse all costs associated with completion of professional development requirements.**

Lastly, our **on-site Medical Directors** are actively involved in the CM process; and our Care Managers participate in weekly rounds with our Medical Directors to discuss complex cases. APS maintains a **Clinical Resource Network** which includes **20 in-house (APS employee) Medical Directors** and an additional **77 consulting physicians** who support our care management programs.

As already stated throughout our proposal, APS has a wealth of experience creating focused service delivery systems for our clients. We are confident that we can establish the necessary resources that EBD deserves in a timely, expedient manner.

5) What percentage of admissions was referred to the case management program during 2006 for the office for which you propose to place this business?

56.65% of admissions were referred to the CM Program during 2006.

It should be noted that for EBD, APS is proposing a Little Rock, Arkansas-based Account Executive, Scott Strang, PhD, MBA. Dr. Strang is an excellent fit as the Account Executive for EBD's program. He is already familiar with many of the State's nuances such as the legislative climate, provider communities, etc., and will use his experience to ensure EBD's program is a success.

In addition, APS is pleased to establish an **experienced, focused clinical team** in our Montana Service Center to serve EBD's members. This team will include **four (4) Nurse Reviewers** and **two (2) Health Coaches**, if EBD chooses to purchase our Disease Management Program, to serve EBD's members.

APS plans to augment its existing staff and recruitment is underway to hire **four (4) Nurse Reviewers** who will be specifically focused on EBD's program. Our approach in hiring RNs who will be focused on EBD's program provides the kind of concentrated attention and resources that are needed in order to facilitate continuous quality improvement and cost savings. This



Medical Utilization Management Services

2.6 Questionnaire – E. Case Management

approach promotes excellent staff morale, a shared mission of positive outcomes, and quality care for EBD and its members. The end result is a program that is highly engineered to demonstrate clinical excellence and sound fiscal results.

6) What percentage of admissions was managed within your case management program during 2006 in the office for which you propose to place this business?

18% of admissions were managed within our CM Program during 2006.

7) What percentage of outpatient requests received was referred to the case management program during 2006 in the office for which you propose to place this business?

23% of outpatient requests received were referred to the CM Program during 2006.

8) How do you define your role in working with the patient, family, attending physician and hospital discharge staff?

APS' Care Managers work collaboratively with the participant, family, attending physician and health care team on the participant's individualized care plan to accomplish the goals and objectives, including:

- Consulting with medical and other health care professionals for further evaluation and input
- Presenting alternatives to care that obtain maximum quality of care and optimize the benefits available to the participant, as well as maximize cost savings
- Providing information regarding resources available for the participant
- Monitoring the participant's progress with periodic review of the participant's condition in coordination with the care plan
- Performing rate negotiations as appropriate
- Encouraging use of provider networks

We always attempt to involve participants' families or other supports in the CM process. **APS has learned, through experience, that inclusion of significant persons in the participant's life, in the treatment planning process, is essential to achieving positive outcomes.** We believe this is very valuable to the CM process, as families/caregivers can confirm how well the participant is coping and functioning, as well as serving as a resource for assisting the participant in their compliance with the recommended care plan.

As a standard feature of our CM process, **we always identify the participant's social supports and ask for permission to speak with and involve these individuals in CM.** Throughout the CM process, we will leverage the use of family and other significant others to help carry out the CM care plan, as appropriate.



Medical Utilization Management Services
2.6 Questionnaire – E. Case Management

Provider Collaboration

During the CM process, APS Care Managers routinely reach out to participants' providers. The Care Manager contacts the provider to establish a partnership, in which information is shared regarding their patient's clinical condition and the appropriateness and effectiveness of the treatment plan. APS provides a **framework for consistent communication** between the participant and their treating providers. We view our role as being the **central coordinator** for all medical care management initiatives for each participant in our CM program. Our program is structured so that we serve as the **single point of coordination** for the healthcare needs of participants enrolled in our program. Through our efforts, APS:

- Provides the physician with information regarding other medical and social services accessed by the plan participant
- Assures that the participant understands their plan of care
- Works with non-compliant participants, to develop more acceptable plans of care, in cooperation with their physician
- Reminds the participant of critical appointments, reducing the physician's no-show rate and improving health outcomes for participants

This provider-supportive approach is effective at improving health and corresponding financial outcomes as well as improving participant and provider satisfaction. Our approach enhances the participant's treatment experience, which assures compliance, and ensures that all appropriate resources and relevant information is coordinated in an integrated fashion.

Collaboration with Hospital Discharge Staff

As a standard component of our CM Program, APS will work with local hospitals and other facilities to facilitate timely discharge and/or transition to appropriate levels of care.

The APS clinician acts in an assertive and highly interactive role with the hospital and/or facility's discharge planner to ensure the participant is prepared for a smooth discharge and post-hospitalization medical care. Our discharge planning process requires the coordination and involvement of key APS clinical staff, providers, family members and other **community-based support systems** of care. We carefully manage the case throughout the care continuum, coordinating closely with providers to ensure the effective management of each participant's treatment to reduce the change of readmission.

As a part of the discharge plan, the clinician works collaboratively with the hospital and/or facility's discharge planner to ensure the participant is prepared for post-hospitalization medical care. As an example, the clinician checks for the overall ability of the primary caregiver's capacity to provide adequate support and care on behalf of the participant.



**Medical Utilization Management Services
2.6 Questionnaire – E. Case Management**

9) How is the availability of alternative services identified and assessed? Approved? Describe the role EBD will play in the approval process.

As a part of our approach, we closely-monitor high-risk/high-cost services and specifically promote interventions and supports that are cost effective without sacrificing quality and the use of alternative levels of care which emphasize recovery and resilience.

APS routinely reviews utilization and claims data on a **monthly basis** to evaluate utilization trends and changes in medical practices. We also routinely review medical literature to stay abreast of new procedures and emerging technologies, identifying, researching, and evaluating the applicable new procedure and/or technology for safety and efficacy. On a **quarterly basis**, or more frequently if desired by EBD, we will meet with you to discuss the trends we have identified, discuss opportunities for changes in utilization protocols based on the identified trends and discuss potential implementation of protocols specific to emerging technologies and practices.

In addition, APS staff can participate in interdisciplinary tele-conferences with EBD to review high-risk cases.

10) For the following statistics, provide information for calendar year 2006 for the office you propose to place this business:

- a) Total number of maternity admissions
- b) Total number of members who received high risk maternity screening
- c) Total number of members who either returned or completed the high risk maternity screening information
- d) Total number of members identified as high risk
- e) Total number of member managed through case management services
- f) For cases managed in "e" above, provide outcome information

a) Total number of maternity admissions?	1,000
b) Total number of members who received high risk maternity screening	<p>This question is applicable to APS' Healthy Additions Maternity Management Program, in which yes, we do conduct a comprehensive maternity screening of all identified and engaged members. Following assessment, identified members are stratified according to their risk level and appropriate interventions are employed.</p> <p>This is not applicable to our proposed UM Program.</p>



Medical Utilization Management Services
2.6 Questionnaire – E. Case Management

<p>c) Total number of members who either returned or completed the high risk maternity screening information.</p>	<p>This question is applicable to APS' Healthy Additions Maternity Management Program, in which yes, we do conduct a comprehensive maternity screening of all identified and engaged members. Following assessment, identified members are stratified according to their risk level and appropriate interventions are employed.</p> <p>This is not applicable to our proposed UM Program.</p>
<p>d) Total number of members identified as high risk.</p>	<p>This question is applicable to APS' Healthy Additions Maternity Management Program, in which yes, we do conduct a comprehensive maternity screening of all identified and engaged members. Following assessment, identified members are stratified according to their risk level and appropriate interventions are employed.</p> <p>This is not applicable to our proposed UM Program.</p>
<p>e) Total number of member managed through case management services</p>	<p>82 cases were managed in our CM Program in our Montana Service Center in 2006.</p>
<p>f) For cases managed in "e" above, provide outcome information</p>	<p>APS has provided outcomes specific to our Healthy Additions Maternity Management Program below:</p> <ul style="list-style-type: none"> ➤ The Maternity Program <ul style="list-style-type: none"> ○ 13% increase in members educated in 2005. ○ 54% increase in number of pregnant women screened for risk. ○ 94% full-term births compared to national average of 87.9% for those enrolled in the program ○ 10% increase in referrals to the health plan's other programs (e.g., smoking cessation, CM).



**Medical Utilization Management Services
2.6 Questionnaire – E. Case Management**

	<ul style="list-style-type: none">○ 148% increase in members mailed an Antepartum Depression Survey.➤ Postpartum Depression (PPD)<ul style="list-style-type: none">○ 95% of members screening positive for PPD had an improved Edinburgh Postnatal Depression Scale (EPDS) score at the 3-month follow up.○ 84% of members' EPDS score changed from positive to negative for depression at the 3-month follow up
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11) If your maternity program identifies members at risk through other than a screening tool, describe your processes.

Yes in our Healthy Additions Maternity Management Program, members at risk are identified via our automated screening tool.

APS' Maternity Health Coaches gather participant information using our advanced technology platform. The health risk assessment tool explores the expectant mother's demographic data, risk factors, behavioral and medical co-morbidities, lifestyle, psychosocial well-being, and willingness to learn self-management skills.

During the automated assessment, our Maternity Health Coaches capture the following risk factors within our system:

- Personal and family medical history (i.e., birth defects, blood disorders, hypertension, etc. as well as their relationship to the mother).
- Risk factors (i.e., drug abuse/current, < 18/>35 years old, cesarean section planned this pregnancy/history, diabetes, pre-term labor/birth history, hypertension, obesity, nutritional compromise, multiple gestation, smoker, thyroid dysfunction, recurrent miscarriages (>2), etc.).
- Environmental lifestyle:
 - Exposure to harmful agents (i.e., alcohol, cats, work hazards, etc.)
 - Occupation (i.e., homemaker, light/heavy assembly, stand >4 hours, number of hours, etc.)
 - Household (i.e., lives alone, with father, with siblings, etc.)
 - Initial Smoking Status (i.e., <10/day, 10-20/per day, 20-40/ day, >40/day etc.)

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2.6 Questionnaire – E. Case Management

- Present Smoking Status (i.e., quit 1st / 2nd / 3rd trimester, <10/day, 10-20/per day, 20-40/ day, >40/day)

In addition, APS can identify expectant mothers who would benefit from our Maternity Program through a variety of avenues including:

- Comprehensive claims analysis (i.e., medical, pharmacy, disability, etc.);
- Successfully partnering with physicians;
- Pre-notification referrals, whereby EBD requires all expectant mothers to contact APS for a maternity assessment; and
- Self-referrals.

This ensures that most participants during the early stages of their pregnancies are screened and that appropriate interventions can be immediately implemented if risks are identified.

Additionally, we have assisted with and devised a number of outreach efforts to increase enrollment for numerous clients. These efforts include:

- Conducting pharmacy claims analysis to identify individuals with prenatal vitamin prescriptions who are not already enrolled in APS' Healthy Additions Program. This will enable us to reach out to these individuals and encourage them to participate in the Healthy Additions program;
- Attending meetings with Key Representatives within EBD to brainstorm strategies about effective promotional activities;
- Distribution of materials including program brochures to potential participants;
- Developing content for inclusion in materials EBD is already distributing to members and providers (i.e. member and provider newsletters);
- Sending educational materials that are customized to the unique needs of each expectant mother via mail;
- Providing program text that can be posted on your internet, as well as creating a web site that educates your members on the program so that they can access information at their own convenience and within the privacy of their home or office;
- Conducting structured outreach and offering incentives to high volume obstetricians; and
- APS' Account Executive can participate in health fairs and other EBD-sponsored events to personally dialogue with members and communicate the services available to them and the benefits of participating in our program.

Once identified and engaged in our Healthy Additions Program, all mothers are provided with the following regardless of risk:

- Toll-free consultation, education, assessment, and referral services with qualified, experienced registered nurses and counselors;
- Personal telephone contact and follow-up;



Medical Utilization Management Services
2.6 Questionnaire – E. Case Management

- Educational materials and products (e.g., maternity books, prenatal vitamins, etc.) to increase enrollment;
- Access to a comprehensive resource library of books and videos;
- Coordination and collaboration with physicians or other health care providers;
- Ongoing psychosocial support;
- Treatment compliance monitoring;
- Postpartum follow-up; and
- Lactation education, support, and follow-up.

We have chosen to structure our Healthy Additions Program this way to ensure we identify all pregnancy-related risk factors early on, to enhance each mother's knowledge of healthy behaviors, and to provide meaningful interventions that help the mother achieve a healthy pregnancy and ultimately deliver a healthy baby. Our results speak directly to our Program's success. **The average return on investment (ROI) for this program ranges from 1.5:1 up to 3:1**

12) Does your program provide maternity education materials to Plan Participants? Provide samples of these materials in Attachment FF.

Yes, our Healthy Additions Maternity Management Program includes educational materials. Samples have been included in Attachment FF.

Once the assessment is completed, the Maternity Health Coach reviews the risk factors and sends appropriate educational material to the expectant mother. The expectant mother could receive any combination of the books detailed below, depending upon the risk factors identified:

- What to Expect When You're Expecting, Heidi Murkoff, Arlene Eisenberg & Sandee Hathaway, BSN, 3rd Edition;
- Your Pregnancy Week by Week, Glade Curtis, M.D., OB/GYN, 4th Edition, 2000;
- Your Pregnancy After 35, Revised Edition, 2001, Glade Curtis, M.D., OB/GYN;
- Mayo Clinic Guide to a Healthy Pregnancy, Roger W. Harms, MD; or
- When You're Expecting Twins, Triplets, or Quads Proven Guidelines for a Healthy Multiple Pregnancy, Barbara Luke, MD & Tamara Eberlein, Revised Edition.

Additional books on infant care to address the physical as well as the emotional needs of the entire family are also provided as appropriate include:

- What to Expect the First Year, Heidi Murkoff, Arlene Eisenberg & Sandee Hathaway, BSN, 2nd Edition;
- What to Expect the Toddler Years, Heidi Murkoff, Arlene Eisenberg & Sandee Hathaway, BSN; or
- The Complete Book of Breastfeeding, Marvin S. Eiger, MD and Sally Wendkos Olds, 3rd Edition.





Medical Utilization Management Services
2.6 Questionnaire – F. Disease Management

1) Does your organization currently have disease management programs in place?

Yes, APS has an established Disease Management Program in place, and is more than able to offer such services to the State at your request.

APS is a full-service National Specialty Healthcare organization. We offer a **comprehensive, integrated portfolio** of healthcare programs and services to optimize the health outcomes of each individual served. We provide a unique array of specialty healthcare services to **more than 1,000 customers**, providing **20 million** lives access to our comprehensive portfolio. We have been **providing Disease Management services since 1994, Medical Utilization and Case Management services since 1990, Behavioral Health Utilization and Case Management since 1990 and Employee Assistance Programs since 1985.**

Our DM clients represent a variety of customer types including State governments, employers and health plans. Some of our DM customers include:

Sample Health Management Clients	
State of Georgia	State of Louisiana
State of Wyoming	State of Missouri
Micron Technology	Laclede Gas Company
Southern Company	Jason Corporation
Blue Cross Blue Shield of Montana	Blue Cross Blue Shield of Hawaii
Cerner Corporation	Mellon Financial Corporation

APS is ideally suited to provide the best available disease management (DM) services based on our **10+ years of experience** providing not only disease management, but also medical, disability and physical medicine services enabling us to successfully intervene on all aspects of an individual's health, wellness and functioning. In addition, we are the **ONLY** DM vendor in the industry that also has more than **20 years of behavioral change experience**. Some of the key program features which distinguish us from the competition include:

- **Our Capabilities** - A full complement of DM services – from wellness to chronic illness management - that allows us to apply a Continuum of Interventions.
- **Our Experience** - Our DM Program is supported by a Behavioral Change Paradigm that is based on APS' more than **20 years** of behavioral healthcare and employee assistance program experience to assist people in modifying their health habits.
- **Our People** - We use a multi-disciplinary team to provide services that includes the use of registered nurses, behavioral clinicians, certified diabetic educators, respiratory therapists, occupational therapists, dieticians, pharmacists, and physicians.
- **Data Analysis** - We maintain a dedicated Informatics Consulting division to support our customers' programs by providing sophisticated analytical services using both proprietary and commercial tools.



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- **Integrated Service Delivery** - We deliver an integrated service that reduces costs, while improving overall quality of care.
- **Flexibility** – We can tailor program components and delivery methods to meet each customer’s unique needs and goals for the program.

As an integrated service delivery provider, APS is well-positioned, fully-capable, and experienced in the coordination of our programs and services with existing internal and externally delivered programs, as well as community-based resources. Through our efforts as a single point of contact, we warmly connect participants, and serve as their link to securing appropriate and necessary health services.

We effectively educate, inform and collaborate with them, their physicians and specialists, resulting in better coordination of overall care. In this role, APS ensures that resources available to participants are utilized in the most efficient and effective manner. As a result, APS always ensures that all interventions and recommendations provided represent the most clinically advantageous and cost-effective for both the participant and the client. This model has proven to sustain higher levels of participant satisfaction and ensures we address all issues that are impacting a participant proactively and aggressively.

2) Which diagnoses are managed within your disease management programs?

APS’ disease or condition-specific programs include:

Healthy Together...Breathe Easy!	<ul style="list-style-type: none"> • Asthma • Chronic Obstructive Pulmonary Disease (COPD)
Healthy Together...Take Heart!	<ul style="list-style-type: none"> • Heart Failure • Coronary Artery Disease • Hypertension • Hyperlipidemia
Healthy Together...Take Control!	<ul style="list-style-type: none"> • Diabetes
Healthy Together...A Healthy Perspective!	<ul style="list-style-type: none"> • Depression
Healthy Together...Back on Track!	<ul style="list-style-type: none"> • Low Back Pain
Healthy Together...New Horizons!	<ul style="list-style-type: none"> • Cancer
Healthy Together...Healthy Additions!	<ul style="list-style-type: none"> • Maternity / Prenatal • High-Risk Maternity



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3) How long have the diagnoses you are managing been operational?

APS has been providing DM services since 1994. We have outlined our specific experience by diagnoses below:

Disease	Start Date
Asthma	1996
Chronic Obstructive Pulmonary Disease (COPD)	2002
Diabetes	1999
Heart Failure	1998
Coronary Artery Disease	2002
Hypertension	2002
Hyperlipidemia	2002
Depression	2002
Low Back Pain	2002
Cancer	2005
Maternity	1994

4) Are these programs operational in the office you are proposing for this business?

Yes, disease management (DM) services are currently handled out of our Montana Service Center. APS is proposing to build a complete team to handle both UM and DM if the State chooses to offer DM services. Specifically, we have included two (2) Health Coaches to handle the State's DM program if APS is selected to administer DM services. As a result, all UM and DM operations will be handled in one central location, our Montana Service Center, from which we proposed to serve the State.

5) Identify the total number of members managed within the disease management programs by diagnosis for calendar year 2006.

In the following table, APS has provided the total number of commercial members actively managed within the disease management programs by diagnosis for calendar year 2006:

Disease	Active Membership
Asthma	16,293
At Risk Cardiac	43,777
Cancer	209
COPD	2,790
Depression	10,405



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Disease	Active Membership
Diabetes	36,428
Heart Failure	7,592
Hemophilia	95
Low Back Pain	4,029
Maternity (High Risk)	687
Obesity	412
Schizophrenia	3,372
Smoking	205
Stress	346

6) Provide a description of how you measure the results of the disease management program.

OUTCOMES & REPORTING

A disease management program must demonstrate through patient improvement and/or reduction in healthcare expenses that it has had a beneficial impact, or it cannot claim to be successful. Ideally, an effective disease management program should be able to demonstrate reduction in symptom presentation and illness severity scores on an individual basis and financial savings overall.

Within APS' Healthy Together Disease Management Programs, outcomes for each participant are continuously tracked and measured through our Clinical Care Management System. During each contact with a participant and/or their treatment provider(s), our Health Coaches gather relevant data and information and enter this data into the Clinical Care Management System. From a reporting standpoint, our primary goal is to gather accurate information in a timely manner, and to organize that information in a meaningful way while maintaining confidentiality. Our sophisticated reporting capabilities allow us to identify trends in a client's population and create solutions geared towards overall program improvement and superior participant care. We work collaboratively with each client to establish mutually agreed upon program measures, develop a system to monitor results, and capture cost savings.

APS' data warehouse affords our organization with superior reporting capabilities, as we are able to pull necessary data with ease and accuracy. We maintain a complete set of data within our working data set, and have successfully built an IT infrastructure that supports the ability for all data to be available in production without having to access archived files. As a result of our ability to support large volumes of data within our production systems, our working data set comprises approximately 15 years worth of detailed medical care management data.

Our data warehouse has the strength to capture an enormous wealth of data, the flexibility to pull all data elements into countless configurations to suit the needs of each client, and the ability to compare such information across APS' entire book of business. As a result, we are able to offer



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accurate, meaningful, and timely reports with a targeted analysis that focuses on creating the most successful programs for our customers.

APS typically provides quarterly and annual **Activity/Intervention Tracking Reports** to clients. However, we can provide these more often, for example, monthly, if requested by the client. The Activity/Intervention Tracking Reports include the following information by disease state:

- Number of program participants
- Number disenrolled
- Number of educational material mailings
- Number of program participants in active care management
- Number of care management contacts
- Number of Health Buddy units mailed
- Number of Health Buddy units in active use

APS also provides an annual **Outcomes and Return-on-Investment Report** which includes the following information:

- Disease-Specific Clinical Markers (Based on HEDIS measures)
- Utilization/Financial Measures
 - Number of emergency room visits
 - Number of inpatient admissions
 - Number of program participants readmitted to the hospital within 30 days of discharge
 - Total disease-specific healthcare costs
- Work productivity measures
 - Lost work days
 - Lost school days
- Satisfaction
 - Program participant
 - Client

Details on Clinical and Financial Outcomes Measures for each disease state are provided in Attachment NN.

Maximized Clinical Outcomes

APS has success in generating improved clinical outcomes, positive total healthcare cost reductions and high participant satisfaction rates. Below is a specific case example demonstrating how our disease management services improve the clinical outcomes of the participants we serve.



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Case Example: 66 Year Old Female with Coronary Artery Disease

A 66 year old female parish school board retiree was enrolled in the Healthy Together Take Heart program in May 2004. The member presented with a history of coronary artery disease that was treated with a single-vessel bypass graft four years ago. Primary risk factors included hypertension, dyslipidemia, mild obesity and recent physical inactivity. The member's blood pressure upon enrollment was 146/67 mm Hg (Stage One Hypertension). Her body weight was 168 pounds with a body mass index of 27.5 kg/m². The member's tolerance to regular exercise was affected by pain associated with osteoarthritis of the knees.

Based on the initial and ongoing assessments conducted during each contact with the member, the APS Health Coach spent considerable time discussing and reviewing dietary guidelines for fat, cholesterol and sodium intake with the member. Suggested daily caloric intake was discussed, and practical goals were established for slow, gradual weight loss.

The pursuit of an on-line weight reduction and support program was encouraged based on the member's busy life-style and the difficulty she had experienced scheduling and participating in several community-based programs. The APS Health Coach reviewed exercise precautions, including knee protection techniques, adequate foot wear and monitoring for perceived exertion, cardiac signs and symptoms with the member. The member re-engaged in a regular exercise program at a local fitness facility under the guidance and support of her cardiologist.

Following 5 months of participation in the Healthy Together Program, the member's blood pressure has decreased and remains in the pre-hypertensive category or below (i.e. 120/60-135/65 range).

The member has actively participated in a program of regular water aerobics, gentle strengthening and land exercises including walking and bicycle riding 3-5 times per week.

The member has lost 18 pounds placing her in the top part of the normal weight range for her height with a body mass index of just under 25 kg/m².

More importantly, the member reports *"feeling wonderful and is doing fabulously"* with her return to a healthy lifestyle



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Return on Investment

Each program is capable of achieving a different ROI. APS is willing to commit to a specific Return on Investment (ROI) for each program we manage for our clients. Our ROI methodology involves a six-step process that has been certified by the Disease Management Purchasing Consortium. Below you will find a brief description of how we calculate the ROI for our programs.

Step 1: Establish a defined base period for the client, to avoid measuring against a moving target. Our preference is to use the 12-month period preceding program implementation. In addition, APS will determine the base population for each disease state regardless of severity. It is important to address the acute and emerging needs of higher-risk individuals, as well as to provide preventive/wellness services to those who are at lesser risk, preventing them from becoming high-risk participants in future years.

Step 2: Calculate the total health care costs for the population within each disease state. APS will use total healthcare dollars in this calculation because studies have shown that individuals with chronic conditions use more system-wide health care resources than those without a chronic disease.

Step 3: Determine a mutually agreed upon population to be used as the “Control Group” in the calculation of ROI for the client. APS will divide the Control Group into subgroups based on the disease states covered under contract.

Step 4: Repeat steps 1-3 after the first full 12-month period following program implementation and allowing for a 3-month claim run out period.

For example, the following timeline illustrates the start and end dates of each savings period:

Year	Date	Activity
2004		Implementation
2005	January 1	Program Starts
2005	April 1	Start of Year 1 Savings Period
2006	March 31	End of Year 1 Savings Period
2006	April 1	Start of Year 2 Savings Period
2006	July 1	Calculate Year 1 ROI/Savings

Step 5: Adjust for economic events over the course of the year. For example, determine whether or not inflation, contracting strategies, changes in risk strategies or pharmacy costs impact overall health care costs from one period to the next.

Step 6: Calculate the ROI; some examples are below:



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Client Population Under APS Management			
	Participants	Total Charges	PMPY
Baseline	135,417	\$320,101,230	\$2,364
End of Year 1	136,000	\$337,579,200	\$2,482
Trend: 5.0%			
Control Group			
	Participants	Total Charges	PMPY
Baseline	42,600	\$210,000,000	\$4,930
End of Year 1	41,000	\$216,279,100	\$5,275
Trend: 7.0%			
Savings Calculation			
Total Charges End of Year 1 (No Interventions at 7% Trend)		\$344,009,280	
Total Charges End of Year 1 (With Interventions)		\$337,579,200	
Total Savings		\$6,430,080	
Total Fees for Year 1		\$1,778,880	
ROI: 3.6 to 1			

Results

APS has success in generating improved clinical outcomes, positive total healthcare cost reductions and high member satisfaction rates through our Healthy Together Program. Some of the clinical and financial results we have achieved include:

- ROIs ranging from 2:1 to 5:1
- 97% member satisfaction rate

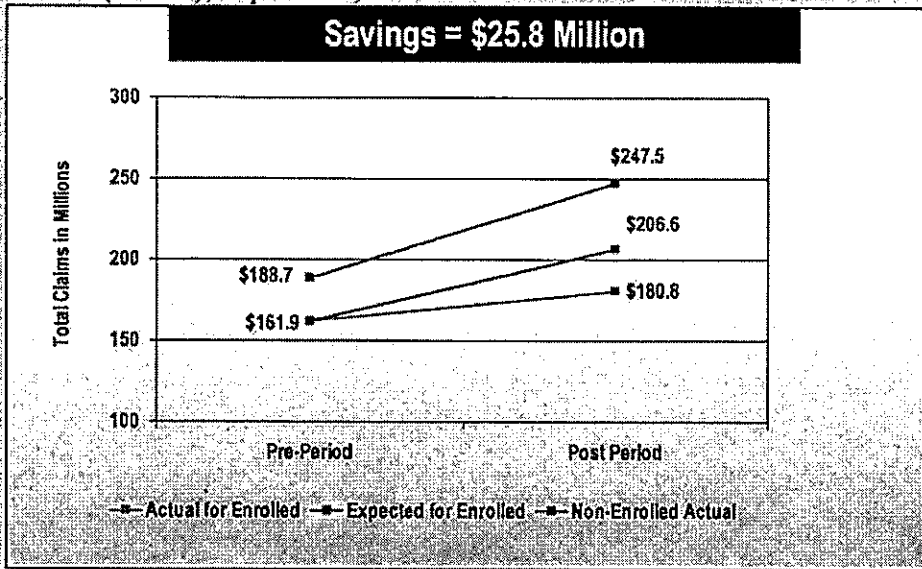
In addition, below we have provided examples of the impact that Healthy Together has had for some of our customers:



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Case Example of First Year Savings Achieved

- Large state employer with 212,500 eligible members
- Incidence of chronic illness of 18.62%
- 47.2% of total expenditures due to treatment of members with chronic illnesses
- DM programs implemented to address asthma, at risk cardiac, chronic obstructive pulmonary disease (COPD), depression, and diabetes



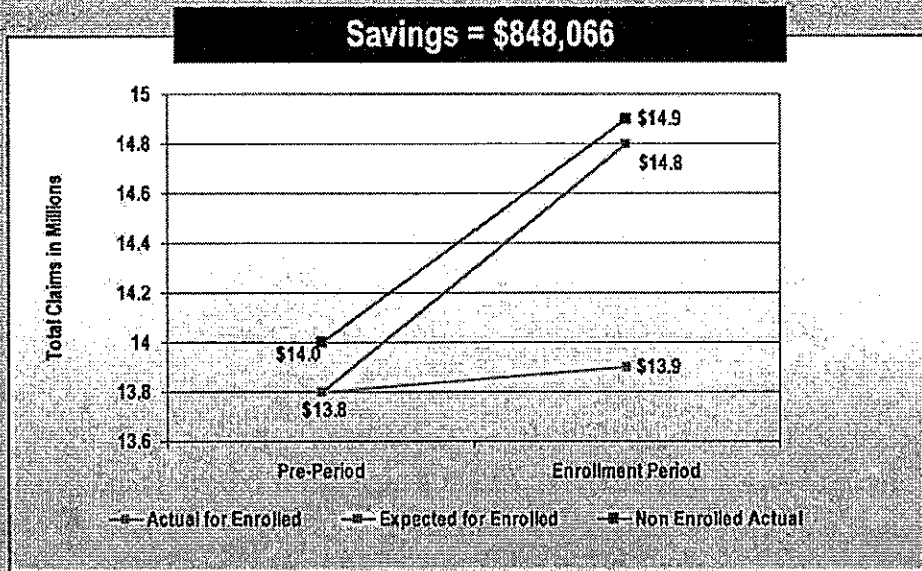
*Savings is calculated by difference between expected for enrolled vs. actual for enrolled

Case Example of First Year Savings Achieved

- Major financial services corporation with 22,200 eligible members
- Suspected chronic incidence rate of 20%
- DM programs implemented to address asthma, at risk cardiac, depression, diabetes, low back pain and maternity



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**Savings is calculated by difference between expected for enrolled vs. actual for enrolled*

Some of the condition-specific results APS has achieved under our Healthy Together Program include:

Percent Improvement by Condition		
Diabetes	4%	Improvement in HbA1C Screening Reaching HbA1C Goal
	75%	
	15.1%	Improvement in Microalbuminuria Screenings Improvement in participants obtaining lipid panels
	63%	
	25%	Increase in adequate blood pressure control (130/80)
	26.8%	Improvement in dilated retinal eye exams
	17%	Improvement in adequate cholesterol control (LDL-C < 100 mg/DL)
Depression	23.5%	Continuous Anti-Depressant Therapy
		<ul style="list-style-type: none"> ● 120-day acute phase ● 84-day acute phase
Asthma	64%	Appropriate Preventative Therapy
Back Pain	32.4%	Non-Steroidal Anti-Inflammatory Therapy
Decrease in Utilization by Condition		
Diabetes	30%	Decrease in Inpatient Admissions
Depression	37.5%	Decrease in Inpatient admissions
Heart Failure	40.5%	Decrease in Inpatient admissions



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Back Pain	45.5% Decrease in ER visits 31.8% Decrease in Office visits
Asthma	37% Decrease in Emergency room visits
COPD	34.4% Decrease in Emergency room visits 32.4% Decrease in Inpatient admissions

Further testaments to our program success are demonstrated through the direct quotes from program members, as detailed below:

“My coach feels like an old time friend that I can talk to about anything and everything. She is sincere, caring and very knowledgeable and professional. I love her! She is a credit to your organization.”

“My Health Coach could not be any more perfect for the job. She is caring and knowledgeable and really makes me feel as though she is more close to me personally than she really is. You couldn’t have picked anyone better.”

“Great program – very beneficial! My APS Health Coach is quite knowledgeable and motivating. Having a personal coach has helped me obtain information relative to my total health care!”

“Just want to say the Health Coach who has kept in contact with me has been kind and considerate every time I spoke with her. In addition to being pleasant, she has been helpful as well and asked if she had permission to call again.”

7) For the various diagnoses managed, provide a description of how you identify members potentially at risk.

IDENTIFICATION

APS utilizes multiple sources to identify individuals with a covered disease state, including

- Informatics Tools analyzing medical, pharmacy and behavioral claims data
- Health risk assessments; and
- Referrals from the participant, provider, the client and the client’s benefit partners.

We can accept **monthly medical, behavioral and pharmaceutical claims data, and corresponding participant eligibility data.** While we do not require receipt of all three data sets (medical, behavioral and pharmaceutical); to best support the Healthy Together DM Program, the more responsive our clients’ health plans can be in providing us with data, the more successfully we can provide services.



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We use a comprehensive suite of proprietary and licensed informatics tools, which includes John's Hopkins Adjusted Clinical Groups (ACGs) Case-Mix System, Predictive Modeling (*proprietary and Johns Hopkins*) and our proprietary Treatment Gap Analysis informatics tool to assess the health status of each customer's population, identify high risk members, and stratify the population by risk. Our Informatics Tools are described in more detail below:

- **Predictive Modeling** – Johns Hopkins' statistical data integration tool that can accurately predict next year's high-risk program participants by analyzing historical claims data to identify program participants who will benefit from our services.
- **Adjusted Clinical Groups (ACGs)** - Utilizing the Johns Hopkins ACG Case-Mix System, APS analyzes up to two years of claims data to sort a population into several health status categories and predict the population's need for health services, or their illness burden - a measure of a population's sickness level or medical complexity.
- **Treatment Gap Analysis** - A proprietary clinical data-mining tool used to analyze claims data to identify instances of sub-optimal clinical care.

APS' model offers DM purchasers a validated and more effective method to successfully identify individuals, who represent the most costly claimants. For example, our proprietary predictive modeling tool can identify more individuals with a co-morbid diagnosis of both diabetes and depression than other commonly used predictive modeling methods (5.43% more as validated in a recent study); and the ability to successfully target such individuals for intervention, combined with our expertise in behavioral change and DM, enables us to provide our customers with a powerful skill set that will dramatically improve outcomes and decrease healthcare costs.

Through using our powerful forecasting tools, we are **able to identify 96.6% of participants via claims data**. As a result, employing our comprehensive suite of proprietary and licensed informatics tools to assess the health status of each customer's employee population ensures that at least 96% of individuals appropriate for the program will be identified and outreached to, including:

- Individuals who have a history of treatment for a particular condition or have been recently diagnosed; and
- Individuals at risk, who may not be identifiable, based solely on clinical data, enabling us to provide *preventive, proactive* health management services.



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For example, APS recently analyzed claims data we received from a client for the periods of 9/1/2003 – 8/31/2004 and 9/1/2004 – 8/31/2005. From our analysis, we were able to identify that the most prominent diseases for both periods were coronary artery disease, followed by diabetes and depression. In addition, from a cost standpoint, lung cancer, prostate cancer and diabetes accounted for the greatest overall disease costs. Whereas, lung cancer, congestive heart failure and COPD accounted for the greatest per member cost.

Other important takeaways from our analysis were:

- Average medical cost per member increased by 6.1% from year 1 to year 2
- Relative cost is high. Relative cost is the cost for members with a disease condition as compared to the cost for members without a disease condition. The data indicates that the cost for those with a disease condition range from 3.99 to 42.87 higher than those without a disease condition. In addition the relative cost for those with a disease condition increased from period 1 to period 2 with a range of increase from 14.6% to 39.4%. This information is highlighted in yellow in the chart below

Relative Cost Trend All Costs				Percent of Membership Trend			
Condition	Period 1 Relative Cost	Period 2 Relative Cost	Percent Change	Condition	Period 1 Percent of Population	Period 2 Percent of Population	Percent Change
Asthma	6.91	5.61	-18.885%	Asthma	1.379%	1.432%	3.854%
Breast Cancer	14.94	12.06	-19.324%	Breast Cancer	0.183%	0.199%	8.377%
Colon Cancer	14.12	12.33	-12.674%	Colon Cancer	0.058%	0.095%	63.334%
Cardiac Disease	6.92	8.34	20.611%	Cardiac Disease	2.814%	2.730%	-2.974%
Lung Cancer	30.75	42.87	39.405%	Lung Cancer	0.061%	0.090%	47.787%
Prostate Cancer	11.47	10.19	-11.199%	Prostate Cancer	0.268%	0.284%	5.771%
CHF	35.33	22.81	-35.447%	CHF	0.239%	0.209%	-12.594%
COPD	16.41	18.97	15.570%	COPD	0.412%	0.392%	-4.762%
Depression	3.48	3.99	14.641%	Depression	1.725%	1.737%	0.709%
Diabetes	6.39	7.67	20.008%	Diabetes	1.911%	1.928%	0.899%
Low Back	7.41	6.16	-16.978%	Low Back	0.919%	0.834%	-9.339%
Period 1 average medical cost per member = \$1,651				Period 1 average medical cost per member = \$1,651			

The prevalence rates by disease condition are increasing for many of members. The rate of increase ranges from less than 1% to over 63%

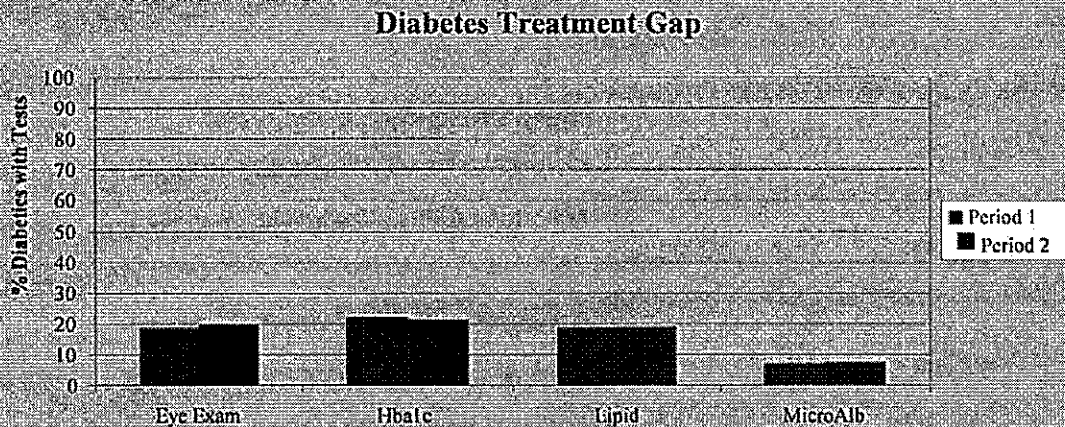
The connection between diabetes and cardiac disease is well known. If an individual has diabetes, he is twice as likely to have heart disease or a stroke as someone without diabetes. Persons with diabetes also tend to develop heart disease or have strokes at an earlier age than



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other people. Given the high prevalence of both diabetes and CAD, APS recommended that these conditions should be the primary focus of the client's program.

Additionally, we applied our standard **Treatment Gap Analysis** to the client's data. Treatment gap analyses measure whether or not members with particular conditions are receiving good care, or "best practice."



The chart above is an example of a common measure applied against diabetics. It illustrates the number of members who are receiving best practice care for diabetes. The number of members who are not receiving this care is then the treatment gap. As you can see, **less than 20% of their members were receiving best practice care. Our goal is to make sure 100% of those members are receiving best practice care.**

For each client, once the population assessment is completed, each individual is risk stratified and the appropriate DM initiatives are employed to meet their specific health needs.

8) What is your process for enrolling members in the disease management programs?

ENROLLMENT

APS telephonically outreaches to every identified participant, whether stratified as *low, moderate or high*.

If the State chooses to purchase DM services from APS, we will work with the State to design a customized engagement approach based on the characteristics of your population, culture and program goals. We will use multiple, layered tactics to inform individuals of the program and engage them that range from **online, mail, telephone and on-site activities**.



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Our strategies also involve designing multi-faceted promotional campaigns that include **posters, mail, participation at on-site events and email announcements** aimed at positively positioning the program and informing all members of the services available

Once program participants are identified, APS is aggressive in our efforts to outreach to all individuals within a client's population who have been identified with a covered condition. For example, **we contract with Telematch to obtain accurate data and increase our contact and response rates.** In addition to Telematch, we also work **collaboratively with our clients to locate program participants.**

Once identified, a **minimum of three attempts is made at different times of the day** (morning - 7am to 11am), (afternoon - 11am to 3pm), (evening - 3pm to 8:30pm) over a two (2) week period until we reach the individual or their caregiver or parent. If the APS outreach staff reaches an answering machine, a general message may be left requesting a call back. This message will include the name of the company and a telephone number for a return call and does not contain any Personal Health Information (PHI).

If the individual cannot be reached after three (3) telephone attempts, an "Unable to Reach You" letter will be sent. If after a minimum of three attempts by telephone and the mailed postcard, we are still unable to reach the individual, the information is communicated to the Account Executive who then works with the Health Plan to strategize and problem solve.

9) Is your disease management program an opt-in or an opt-out program?

APS can structure our Healthy Together Programs using either an Opt-Out or Opt-In enrollment strategy; however, we prefer to employ an "Opt Out" enrollment design whereby all identified individuals are automatically enrolled in the program unless they notify APS of their unwillingness to participate. We have chosen to structure our program this way to achieve the highest enrollment rates. For instance, under our Opt-Out programs, we have achieved a **90+% enrollment rate.**



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10) Describe your processes of managing members in the disease management programs.

HOLISTIC APPROACH

As recent studies have documented a definitive link between mental and physical health, APS brings a unique skill set to our DM programs, which enables us to achieve superior results. We operate under the belief that managing healthcare for the mind and body improves overall health and reduces total spending on healthcare. **As such, our philosophy and approach is to manage mental and physical health together, resulting in improved outcomes for program participants.** We understand and actively manage the interplay between the mind and body through our more than 20 years of behavioral change experience. We have embedded proven behavior change strategies in all of our programs including the **Transtheoretical Model, Social Cognitive Model, Motivational Interviewing and Cognitive Behavioral Theory** to better understand motivators and affect positive, sustained health decisions. Our programs are focused on holistic management of both the behavioral and medical facets, which contribute to how an individual will manage their health.

In addition, we utilize **multi-disciplinary teams** to provide services that include the use of **Registered Nurses, Licensed Practical Nurses, Registered Dietitians, Physical Therapists, Licensed Social Workers and Certified Diabetes Educators, Pharmacists, Psychologists and Physicians.** Through our approach, we are able to effectively address both medical and behavioral co-morbidities and generate the best possible outcomes for each participant in our care.

APS' DM Program employs an approach to patient care that **emphasizes behavioral change, education, evidence-based guidelines, compliance, self-management and physician support and involvement.** Our approach is holistic and focuses on providing individuals with assistance with all co-morbid conditions and issues that are impacting their overall health, including all obstacles/barriers to their compliance such as economic hurdles, healthcare access problems, housing issues, occupational problems, transportation issues, child care and legal/financial concerns, and communication and cognitive difficulties. This approach correctly takes into account the impact of co-morbid conditions and psychosocial and socioeconomic factors on an individual's ability to change their behavior and manage their condition.

We establish a **collaborative relationship with the participant, their provider and caregivers**, in which we work as a team. We are involved with a participant on a **proactive basis** to help avoid exacerbations and/or lessen their severity. And, by engaging the participant's physician in this process, participants receive more **appropriate care**, generally in a **lower cost setting.** The empowerment of both participants and providers results in reduced costs for the client and improved health outcomes and quality of life for the participant.



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Our goal is to help members make healthier, more educated lifestyle choices, to manage their illnesses better and become more knowledgeable about which healthcare services most cost-effectively serve their individual needs. Below, we have detailed how we specifically manage individuals enrolled in our DM programs.

Risk Assessment

APS telephonically and/or face-to-face outreaches to every identified member, whether stratified as low, moderate or high and each is assessed. A Health Coach will conduct a comprehensive baseline assessment to confirm the diagnosis and collect additional information regarding the individual's risk factors, co-morbidities, readiness to change, functional and psychosocial status, understanding of their disease/condition process, adherence to their treatment regimen, etc.

For each and every participant enrolled in our program, we identify and address **all of their health risks, including all co-morbid conditions and obstacles to their compliance** such as economic hurdles, healthcare access problems, housing issues, occupational problems, transportation issues, child care and legal/financial concerns, and communication and cognitive difficulties.

For example, in addition to obtaining information on the participant's health and severity of their condition, we also gather information on:

- Participant's perception of their health and an understanding of their specific motivators for maintaining a healthy lifestyle
- Readiness to change
- Participant's personal health goals
- Participant's relationship with their physician and identification of issues that may be disrupting a positive relationship
- Cultural and linguistic characteristics of each participant that impact how they understand and communicate information on their health
- Available transportation and challenges
- Support system
- Information on the participant's home environment (i.e., home, apartment, stairs, etc.)
- Information on the participant's medication regime and identification of specific reasons why participant is not complying
- Identification of psychosocial issues
- Assessment for mental health and substance abuse issues
- Assessment of economic status and barriers to obtaining required medical supplies and services
- Obtain information on the participant's job (if employed), including type of work, hours, and stressors
- Assessment of any legal stressors/issues



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- Assessment of child/eldercare responsibilities (if applicable) and stressors

All of our assessments also include screening for depression and substance abuse, as well as questions to assess for the presence of the most common co-morbid conditions. **For example within the diabetes assessment are questions to assess for depression and cardiovascular disease. When a co-morbid condition is identified, APS Health Coaches use our co-morbidity assessment tools to further evaluate the other medical conditions that are impacting the participant's health.**

APS' paradigm for DM is holistic and focuses on providing individuals with assistance with all co-morbid conditions and issues that are impacting their overall health. The primary disease is typically addressed first. However, our intervention methodologies are tailored according to the participant's motivation to address their risk factors and their confidence to make a change.

In each of our interactions with participants, our clinicians provide:

- Motivational counseling;
- Behavioral modification;
- Education and guidance on the participant's condition;
- Recommendations on changes the participant can make to improve their health;
- Medication compliance monitoring;
- Physician outreach and coordination; and
- Monitoring participant compliance with recommendations and intervening when non-compliance is identified.

APS Understands How to Change Member Health Behavior

APS leverages established behavioral health research and our expertise as a behavioral healthcare organization to assess every member for behavioral and social risk factors that may be negatively impacting their health status, as well as motivate them toward change. The goals of our behavior change strategies are 1) to improve members' capacity for self-management by getting them fully-engaged in the disease management process; and 2) to and to improve their relationships and communication with their providers.

We work with the member to customize the care management plan so that it appropriately addresses any physical and/or cognitive limitations and focuses on the participant's specific motivators for change. As a result, we **empower** enrollees through education and assure their full engagement in the treatment and management process.

The results of the assessment determine the type and frequency of interventions employed and allows for the maximum success of the treatment plan through its acceptance and understanding. Throughout the life of the program, Health Coaches will engage and work with participants. The frequency of contact will ultimately be dictated by the participant's needs and can



Medical Utilization Management Services
2.6 Questionnaire – F. Disease Management

increase/decrease based on a variety of factors, including clinical deterioration, a stressful event, improvement in self-management skills or other circumstances.

Interventions

APS employs a variety of member interventions, all of which are **specifically tailored to align with each participant’s specific motivators for change and address any obstacles to achieving their desired goals.**

APS employs a **Primary Health Coach Model**. As the participant’s personal health advocate, **the Health Coach works closely with the participant to facilitate appropriate care and to serve as an important link between the participant, their healthcare provider(s), and community services.** This provides continuity, familiarity and a sense of teamwork for all individuals coordinating the participant’s care.

In addition, we utilize multi-disciplinary teams to provide services, including registered nurses, licensed practical nurses, certified diabetic educators, respiratory therapists, occupational therapists, dieticians, social workers, pharmacists, psychologists and physicians who work in partnership to manage the entire healthcare needs of each participant enrolled in our Healthy Together Program. While each participant has a primary contact, the team-approach allows for services to be provided by staff with medical expertise that matches the primary diagnosis, and to also have access to behavioral clinicians to address other issues the participant may have that may be impacting their medical condition.

Detailed information specific to intervention components for those identified and stratified as ***Low, Moderate*** or ***High*** is provided below.

Low Risk Intervention Activities:

- Welcome Call
- **Follow-up Every Six (6) Months**
- Triage to a Health Coach per Identified Trigger(s) or Member Request
- On-line Supporting Tools & Resources

Moderate Risk Intervention Activities:

- Welcome Call
- **Follow-up at Ninety (90) Days and a Minimum of Every Six (6) Months or Per Required Need**
- Triage to a Health Coach per Identified Trigger(s) or Member Request
- Collaboration with Physicians/Practitioners
- Coordination with the customer’s other Benefit Vendors
- On-line Supporting Tools & Resources



**Medical Utilization Management Services
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High Risk Intervention Activities:

- Welcome Call and Assessment
- **Follow-up at Two (2) Weeks and a Minimum of Every Four (4) Months or Per Required Need**
- Collaboration with Physicians/Practitioners
- Coordination with the customer's other Benefit Vendors
- On-line Supporting Tools & Resources

Email Reminders

Email reminders provide education on a variety of important health care topics. This includes an outline of the recommended preventative health services that should be followed in accordance with the participant's age/gender and are consistent with national guidelines. Other reminders can include medication and dietary compliance and reinforcement; and instructions on behavior modification and lifestyle adjustments, including:

- Weight Management
- Tips for a Healthy Heart
- Good Nutrition/Healthy Eating
- Exercise/Fitness Training
- Safety
- Stress Management
- Cholesterol Management
- Tobacco/Smoking Cessation
- Skin Protection

Monitoring & Follow-Up

APS **maintains contact with every member** at intervals that are customized according to their disease state/condition, assessed risk severity and individual needs. The purpose of each contact is to provide a framework to assess and monitor each member's progress as well as identification of obstacles that are hindering progress.

At each interaction, the member is re-assessed, at which point, the plan of care, the interventions employed and their frequency are adjusted to address the member's current acuity level and to ensure the most optimal outcomes.



Medical Utilization Management Services

2.6 Questionnaire – F. Disease Management

Participant Case Study

- 42 Years Old
- Recently diagnosed with Diabetes and Depression
- Heavy Smoker
- Overweight with BMI>25

Assessment

- Health Coach assessment call with Member
- Member concerned about being newly diagnosed with diabetes
- Symptoms of depression present for 6-8 weeks
- Anxiety and stress over being “afraid to eat”
- Reported side effects from oral medication
- Elevated blood pressure
- Increase in appetite
- Difficulty functioning at work and getting there on time
- Isolating self

Interventions

- Due to work schedule Health Coach follow up calls occur after hours
- Focus on diet education – started on 1500 calorie diet
- Educated Member on Diabetes care and the importance of HbA1c testing
- Coaching on starting exercise program
- Mailed Diabetic Self-Care Handbook
- Referred to Diabetic Educator in community
- Discussed stress management strategies
- Discussed Depression with Member and connected him to a professional for medication consultation and psychotherapy
- Reconnected Member with his physician
- Helped Member identify social supports and increase his use of them

Results

- Member reports blood pressure is lower
- Member and spouse (who loves to cook) now collaborate and prepare foods together that are healthy
- Has now started taking walks with his kids, bike riding and going to the park. “The Health Coach helped me identify activities I could easily do with my kids. It’s so much easier to fit into my schedule than going to a gym.”
- Actively involved in psychotherapy and reports that his depression has improved. “I took my kids out to a theme park this weekend. We haven’t done anything fun like that for a long time.”
- Performance at work improved. “I feel better both mentally and physically, so it’s been easier to get to work and do what I’m supposed to do.”



Medical Utilization Management Services

2.6 Questionnaire – F. Disease Management

- Regularly monitors blood sugar and calls his doctor if his levels go up

APS is an expert in creating customized solutions in the area of wellness and disease management. In fact, our program for the State of Wyoming was awarded the Disease Management Association of America's award for Best Government Disease Management Program in 2005. An important part of the value that APS can offer the State is our experience implementing programs that have a significant focus on member engagement and the use of innovative technology solutions.

Our first year results for this program have just been announced:

APS Healthcare, one of the country's leading specialty healthcare companies, and the Wyoming Department of Health's EqualityCare program announced that APS' Healthy Together total population health management program helped the state avoid more than \$12.7 million in unnecessary healthcare costs. These results were for the first reconciliation year, which ended on Dec. 31, 2005.

Through the Wyoming EqualityCare program, APS managed an average of more than 7,800 clients per month through its Healthy Together health management programs, which includes programs for clients with asthma, coronary artery disease, chronic obstructive pulmonary disease, chronic heart failure, depression, diabetes and other disease states. The average cost avoidance for clients, while still maintaining quality care, was \$135 each month, which was \$36 above the target savings per member per month. APS health coaches focused on achieving significant improvements in prevention measures such as diabetes testing, eye exams, glucose monitoring, statin usage, cholesterol monitoring, bronchodilator usage and other preventative treatments and testing to improve their overall health and well-being.

Additional Services

In addition, if the State is interested, APS can offer a myriad of other online services. This includes access to our APS' on-line Lifestyle Management Programs. These programs and tools promote health awareness and include educational interventions to more effectively address the lifestyle behaviors and leading cost-drivers, such as stress, nutrition, obesity, and smoking that impact health and productivity in our customer populations. We have provided information on the programs, educational resources and intervention tools available to participants below.



Medical Utilization Management Services

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Commit to Quit! Tobacco/Smoking Cessation Program

The program interventions provide participants with a custom-tailored program to meet individual quitting needs. Commit to Quit! is unique in that it addresses the four main typologies of smokers—dependency (addiction), negative affect, habit based, and social celebrator. By providing individualized typology information and education about smoking-related behaviors, Commit to Quit! gives participants the tools for lasting behavior change.

- 43% quit smoking as a result of participating in the program.
- 70% of participants made a quit attempt.
- 97% of those who quit expressed confidence in their ability to stay quit.

The Healthy Weigh! Weight Management Program

The program addresses the three critical elements of successful weight loss and maintenance: nutritional habits (food); physical activity patterns (body); and the psychological, emotional, and behavioral patterns (mind) that influence them. The program incorporates awareness and self-monitoring activities with techniques for making healthier food choices, increasing physical activity, and breaking the negative patterns between emotions and eating.

- 69% lost weight as a result of participating in the program.
- 81% intend to better manage their weight as a result of participating in the program.
- Of those who lost weight, 50% lost between 1–8 lbs and 30% lost between 5–12 lbs.
- 61% improved their eating habits.
- 48% increased their physical activity level.
- 88% are confident in their abilities to manage their weight since participating in the program.

Eat Right! Nutrition Improvement Program

The program simplifies the complex task of making healthy eating decisions and helps modify unhealthy eating behaviors. Eat Right! provides participants with smart and creative strategies to improve eating habits over time, both in terms of food selection and methods for handling challenging situations.

- 95% made a positive change in their nutritional habits since participating in the program.
- 96% are confident they can eat a healthy diet since participating in the program.
- 92% rated the program as good to excellent.

Bounce Back! Stress Management Program

The program identifies the specific sources for stress and provides tailored tactics for better managing and coping with stress resulting from work, school, family, health, relationships, and



Medical Utilization Management Services

2.6 Questionnaire – F. Disease Management

finances. Bounce Back! assists participants in improving stress-coping skills, reducing stress levels, and managing the physical and psychological consequences of chronic stress.

- **54% reported a decrease in stress symptoms since participating in the program.**
- **86% have made positive changes in how they manage stress.**
- **95% are confident in their ability to manage stress since participating in the program.**

Care™ for your Health Program

APS' online Care™ for Your Health chronic condition self-management program helps members to manage chronic conditions and results in positive health behavior changes. The program provides the education and self-management skills needed to better manage chronic health condition(s). The program focuses on the following key areas:

- A member's understanding of their treatment plan;
- Motivation and self-confidence associated with managing their condition(s);
- Managing medical, emotional, and personal issues; that may be associated with their condition(s);
- Improved relationships and communications with their doctor and pharmacist;
- Staying on their medications;
- Managing issues such as sleep, pain, fatigue and depression, and stress;
- Assisting members in understanding how to get the social support that they may need;
- Goal setting and planning skills; and
- Helping members make better lifestyle choices concerning weight management, stress management, eating properly, and smoking cessation.

11) What is your policy for when a member is managed in disease management vs. case management?

APS understands that for our DM programs to be successful, outreach and coordination with our customer's benefit partners and local providers is critical. As part of our program, we work in close partnership with our customers and their benefit vendors, including the medical vendor for case management, if appropriate, to ensure that there is a common understanding of the goals for the program and the specific structural components necessary to meet those goals. We understand this to be our responsibility and we rise to the challenge of integrating all of the medical programs to optimize the health of the State's employees if chosen to administer DM services.

As part of our normal practice, APS refers patients from our DM program to our customers' case management vendor(s) as appropriate. As a provider of medical case management services, we know that many case management vendors have established criteria for case management referrals (e.g., diagnosis, number of admissions, etc.). During implementation, we obtain the



Medical Utilization Management Services
2.6 Questionnaire – F. Disease Management

case management vendor's trigger list to ensure our staff understands when to refer a DM patient to case management. We also load the trigger list into our clinical system so that our Health Coaches can easily view such information, and facilitate appropriate and streamlined referrals.

As an example, APS' case management trigger list under our medical utilization program includes the following:

Stand-alone triggers:

- AIDS related illness
- Burns
- Coma
- Transplants
- Complex newborns
- Parkinson's Disease
- Systemic Lupus Erythematosus
- Spinal Cord Injury
- Head Injury
- Neoplasm
- Neuromuscular Disease
- Alzheimer's
- Osteogenesis Imperfecta
- Cerebral Palsy
- Cystic Fibrosis
- Huntington's Chorea

Supportive criteria:

- Complex benefit coordination
- Assessing need for private duty nursing
- Advocating for members on issues requiring legal/ethical intervention
- Multi-system failure
- Frequent re-admission
- High Risk maternity cases
- Lack of support system
- Overwhelmed caregiver
- Palliative care
- Functional problems
- Complicated situation with advanced directives/POA/guardianship
- Coordination of care across multiple providers and/or care sites
- Monitoring and arranging advanced technological equipment
- Pain management
- Coordination of hospice



Medical Utilization Management Services

2.6 Questionnaire – F. Disease Management

- Need for community resources
- Vacillating between acute, home health, SNF
- Non-compliance
- Polypharmacy
- Multiple home health services
- Experimental treatments

APS will work with the State's case management vendor to ensure members are referred to case management services if appropriate.

Establishing Effective Interface During Implementation

During implementation, APS meets with our customers' key medical vendor representatives so that we may develop the appropriate interface protocols to ensure clear lines of communication are adopted for continuity and to optimize outcomes for all of members and their families. The purpose of such meeting is to:

- Orient them to APS as a company (e.g., history, mission, philosophy, etc.);
- Educate them about the DM programs the customer selects us to administer;
- Define clear roles and responsibilities;
- Establish seamless interface protocols regarding:
 - Cross-referrals to and from Medical Case Management and our DM Program
 - "Warm transfer" procedures to ensure participants do not have to repeat clinical information more than once and ensure they are satisfied with the care they receive; and
 - Follow-up procedures.
- Identify potential joint opportunities to enhance coordination of care; and
- Designate vendor liaisons to ensure each party has accountable and knowledgeable resource(s) to call, who can clarify questions, resolve issues quickly and provide consultation for complex or special cases.

APS would also provide the medical vendor(s) and other benefit vendors with materials on our programs and referral information to encourage both electronic and telephonic referral to our programs, and vice versa. This type of collaborative and proactive approach from the program's onset results in identifying and enrolling more participants into our programs, and ultimately improving participant outcomes. Our goal is to ensure our customers' vendors are aware of the programs available to their members, how to identify a need for additional services, and how to refer them to APS as quickly as possible. As a result, they will have a general understanding of what types of programs address what types of issues, and can then facilitate an immediate referral to one of our programs as necessary.

Furthermore, to ensure our DM services and the services provided by our customers' medical partners represent a cohesive care delivery system, APS typically recommends that we implement the following as a part of our program:



Medical Utilization Management Services

2.6 Questionnaire – F. Disease Management

- Develop cross-referral criteria between benefits to ensure participants are transitioned to appropriate programs;
- Educating staff on cross-referral criteria so that all parties are clear on the process;
- Designate a clinical professional at APS to serve as the liaison to the customer's external partner's health staff. This individual will be readily accessible to their staff for consultation.
- Schedule monthly teleconference calls between key case management and disease management staff to discuss complex cases that may need to be transitioned from one benefit to the other, real-time referrals, etc.
- Provide cross-training to external health staff on DM and likewise have our staff participate in training on their services;
- Provide external health staff with access to our Medical Director for consultation as needed;
- Inviting other vendors to participate in our Provider Advisory Groups; and
- Having the Account Executive meet with key representatives from the other health vendors on at least a quarterly basis.

For example, APS has established a unique interface with one of our customer's case management vendors to facilitate streamlined referrals. Under this arrangement, Medical Case Managers fax over referral requests to APS' Health Coaches for patients who are either unexpectedly admitted into an inpatient setting or being discharged from an inpatient setting for an APS covered disease state. Our Health Coaches also notify their Medical Case Managers if a DM patient requires case management (e.g., patient enrolled in an APS DM program seeks an elective procedure at a hospital, has a stroke, etc.). APS looks forward to developing a customized interface with the State's medical vendors as well as your other healthcare partners if chosen to administer your DM programs.

12) How do you communicate with the members?

Our Healthy Together program model was built to be flexible because we understand the uniqueness of our participants and their motivators for change. As such, **our Disease Management program engagement and intervention strategies are delivered telephonically, via the internet and in print (e.g., communication materials, self-care books, etc.) to maximize reach and participation.** For example, for those participants who require high-touch to succeed, their relationship with their Health Coach will be their focal point for the program and we will ensure their continued engagement through our primary Health Coach model. For others who are less high-touch and more technology driven, their continued active engagement will be ensured through our online programming.





Medical Utilization Management Services
2.6 Questionnaire – H. Transplant Network

1) Do you have a transplant network? If so please describe and include a price sheet in the cost section of this RFP.

No, APS does not have a transplant network.

2) Describe your review program that handles transplant request.

APS has provided an excerpt from our transplant P&P for a specific customer below to demonstrate our experience in this area:

CM will notify Medical Review contact when:

1. CM is advised of potential transplant.
2. The patient begins the transplant.
3. Stem cell transplant, when the high dose therapy given prior to stem cell re-infusion is started.
4. The patient is discharged from the hospital.
5. Note if still within the time frame of the global fee or not.

Medical Review will determine member's eligibility for the transplant.

1. Confirm with Medical Review contact if the transplant will be performed at a **Blue Quality Centers for Transplant**. This network includes medical institutions that are leaders in:

- Bone Marrow/Stem Cell
- Heart
- Lung
- Heart/Lung
- Liver
- Simultaneous Pancreas/Kidney

If so, then the global fee will be in effect and no negotiations are allowed.

2. If not performed at a Blue Quality Center, determine if the facility is a Blue Card Participant. If it is a Blue Card Participant, **then no negotiations are to be done** and all charges will run through that state's Blue Card Program.
3. CM contacts the transplant coordinator at facility to determine if member within global fee and assist with discharge needs. See attached list of transplant centers and names of coordinators.



Medical Utilization Management Services
2.6 Questionnaire – H. Transplant Network

4. Transportation should be discussed and arranged when the member is listed on the hospital's transplant list. Lodging should also be discussed.

THE GLOBAL FEE

1. The global fee includes or is the usual length of stay for a specific transplant.
2. The global fee usually begins the day **before** the transplant and includes **all charges** both inpatient and outpatient within the 39-50 days post-transplant.

EXCEPTION:

Bone Marrow includes all services rendered **30 days prior** to transplant and are applied to the transplant benefit, but not the global fee. This exception is to capture the billing for the high dose chemotherapy and harvesting.

Some Transplant Centers & Coordinators

Mayo Clinic/Rochester, MN
Univ. Wash/Seattle Hospital
Univ. Utah/Salt Lake City Hospital
Univ. Colorado/Denver Hospital
Stanford Univ. Med Center/California
Univ. Wisconsin Hospital/Madison, WI

National Marrow Donor Program

Vanderbilt University Medical Center
Stem Cell Transplant Program
1301 22nd Ave. South
2665 TVC
Nashville, TN 37232-5505

Nashville VA Medical Center
1310 24th Avenue South
Nashville, TN 37212-2637



Medical Utilization Management Services
2.6 Questionnaire – H. Transplant Network

3) Do you currently have an operational process in place to provide specialty matched peer review of transplant cases? If so, describe the process and provide a list of each specialty on your transplant review panel.

Yes, APS currently refers to AMR, an external URAC-accredited organization, to provide specialty matched peer review of transplant cases. As requested, we have provided a sampling of the specialties on our transplant review panel below:

<p>LIVER: Gastroenterologist General Surgeons General Surgeons with subspecialty of transplants</p>	<p>KIDNEY: Urologist Nephrologist</p>
<p>HEART: Cardiologist Cardiovascular Surgeon</p>	<p>LUNG: Thoracic Surgeon Pulmonologist</p>
<p>BONE MARROW: Hematologist/Oncologist</p>	<p>CORNEAL: Ophthalmologist</p>

In addition, APS has access to internal transplant physician reviewers to assist in this area. These individuals include:

<p>LIVER General Surgeons: • D. Garrett, MD • C. Siverhus, MD</p>	<p>KIDNEY Urologist: • M. Horowitz, MD • P. Slocum, MD • Nephrologist: M. Hanna, MD</p>
<p>HEART Cardiologist: • L. Kumar, MD • D. Zwicke, MD</p>	<p>LUNG Thoracic Surgeon: D. Garrett, MD Pulmonologist: • S. Brown, MD • M. Rasansky, MD</p>
<p>BONE MARROW Hematologist/Oncologist: N. Geimer, MD</p>	<p>CORNEAL Ophthalmologist: R. Davenport, MD</p>





Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

1) Complete the list below indicating automated system capabilities. Indicate if capabilities are available for utilization management, inpatient and outpatient, case management, and/or disease management programs and file layout or copies of these reports. Vendor will provide a detailed description of the process to request ad hoc and customized recurring reports to include any charges to be incurred by EBD for these requests. Vendor will include an estimated average turn around time for these types of reports.

APS has filled out the following table for our integrated system, CareEnhanced Clinical Management Software (CCMS), which handles not only medical utilization management, but also case management and disease management services.

Question:	Response
Does the system have the following automated capability?	
Display hospital activity for the last six months?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Document relevant patient history?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Generate lists for callbacks, follow-up calls, incomplete cases, etc?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Track and flag physicians with aberrant practice patterns?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Feature a diagnosis code using ICD-9 and CPT-4 coding conventions?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Feature a DRG coding methodology?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Provide system linkage between UM and claims administrator?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Flag procedures that are not covered due to potential cosmetic, experimental/investigational/research or other?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Capture date of initial authorization request?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Capture date of predetermination decision?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Capture date(s) of continued stay review?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Capture date(s) of continued stay review decisions?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Capture services (including ICD-9 diagnosis and CPT-4 procedure codes) Approved and denied?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Capture days/services initially/subsequently requested?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Capture days/services initially/subsequently approved/non-authorized?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Service classification (elective/emergency)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Have free form message capability?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Other/Describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

SOFTWARE SYSTEM

APS' CCMS, which will be used for the EBD account, is our integrated IT platform for managing UM, CM and DM cases. In 1998 a thorough product analysis was performed where multiple systems were reviewed by experienced clinical professionals in our organization to determine which software system would best meet the needs and requirements of our organization when performing our care management services. CCMS was chosen due to its ability to support integrated UM/CM/DM programs, member-centric focus and ability to ensure the clinical integrity and consistency of APS' programs. The system was built by a medical team of physicians and Case Managers with the assistance of a panel of specialists. Some of the key features of this system include, but are not limited to:

- All program participant and clinical data is centralized in an organized, automated system to support our existing care management infrastructure, while allowing flexibility for future enhancements and expansion;
- Automatic alerts to improve the quality of care management by notifying clinical staff when program participant intervention is needed;
- Detailed tracking of program participants across the care continuum and effective management of caseloads;
- Connectivity and interaction, cases can be forwarded to another clinician or department; and
- Extensive, detailed reporting capabilities.

We have invested significant time in the customization of our system, including developing a **Clinical System Advisory Panel**, comprised of clinicians, outcomes analysis, reporting and IT staff. The Clinical Advisory Panel built custom assessments, care strategies, and reports that have enabled us to streamline processes and report outcomes to our customers. The panel currently meets on a quarterly basis to discuss and implement system enhancements. During the development and implementation of the system, they met on a weekly basis to assure that the system would comprehensively meet the needs of both our operational staff and our client partners.

CCMS consists of main modules, tables, and screens, which are integrated into a single system for data collection, analysis, and reporting. CCMS integrates intake, assessment, clinical activity, interventions, referrals, and case management into one database. Specifically, APS' clinical staff utilizes CCMS to manage members through:

- Collection and analysis of member data;
- Documentation of all clinical activity and educational interventions;
- Capturing and reporting on savings and outcomes information; and
- Creation of billing statements.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

This system houses all clinical data gathered from participants and their physicians for our UM/CM/DM programs and provides automated decision-support system logic. In tandem with the expertise of our clinical staff, our system ensures that all services provided under our programs are based on nationally recognized guidelines and evidence-based medicine.

The clinical treatment pathways included with CCMS complement the expertise of our clinical staff and help our staff coordinate the best treatment and care possible for the program participant. It allows us to plan for the program participant's long-term and short-term care needs, while help us take a more holistic approach to the program participant's treatment.

Utilizing the pertinent, individualized information gathered from patients and/or providers, as well as family members, including compelling risk factors, such as medical history and co-morbid conditions, care plans are automatically generated by the system. The care plans and alerts use clinical rules from evidence-based medicine, which are founded upon national standards and practice guidelines, improving continuity of care and reducing program participant biases among our clinical staff.

As clinical data is entered into the system, automated prompts are sent to APS' clinical staff that:

- Trigger program participant monitoring;
- Assess new or worsening symptoms;
- Monitor lifestyle behavior changes (e.g. medication compliance, smoking cessation, weight reduction, and exercise);
- Assess compliance with the treatment regimen;
- Assess treatment failures;
- Assess educational needs;
- Provide education regarding potentially avoidable risk factors; and
- Assess the adequacy of support services for the program participant.

Requesting Ad Hoc Reports

APS has extensive capabilities to execute and deliver customized or ad hoc reports as requested by EBD. Our reporting capabilities are extremely flexible and reports can be. APS can draw upon all data elements captured in our data warehouse to create customized reports based upon your needs.

Creating a custom report begins with understanding EBD's reporting needs and developing programming that meets those needs. We have a dedicated Reporting Department with seasoned staff who are experienced in responding to ad hoc reporting requests. While APS' standard reports meet the majority of our customers' requests, there are always special needs that arise that require additional data extracts or reports. During implementation, we would like the opportunity to fully understand the scope and complexity of EBD's ad hoc reporting needs.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

APS employs a Report Request tracking system to document special reporting requests, and reviews these on a daily basis. Your Executive Director will coordinate with our reporting team to deliver EBD ad hoc requests as necessary. This includes clarifying any questions, documenting report requirements, and scheduling the report for development. Many reports can be produced very quickly but some require research and more intensive development. The reporting staff works with the customer to ensure the data is accurate and timely.

Fees for ad hoc reports are typically determined by the amount of programming necessary and the overall complexity of the request. However, due to the comprehensiveness of our standard reporting package, significant modifications are rarely requested; therefore most modifications are completed without extending an additional fee to the client. APS also works with the client to prioritize requests and negotiate timeframes for customized ad-hoc reports. Turnaround time is dependent upon the complexity of the request and the priority of the request, and can range from a day to several weeks.

APS has provided a sampling of reports in **Attachment GG**.

2) Describe the system of identification (i.e., computer-driven by diagnosis, International Classification of Diseases-9 (ICD-9), etc.).

In terms of identification, APS groups by types of care:

- Medical
- Surgical
- OB
- Mental Health
- Chemical Dependency

- Lower levels of care:
 - Skilled Nursing
 - Residential
 - Partial Hospital
 - Intensive Outpatient.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

- 3) For reporting to clients, provide samples of the following reports in Attachment GG. If samples are not available, indicate if sample reports can be created prior to implementation of this contract.
- a) Quarterly admit and bed days reports by medical, surgical, obstetrics, psychiatric, and substance abuse treatment.
 - b) Quarterly admit and bed day reports by MDC.
 - c) Quarterly admit and bed day reports by employee, dependent, gender, and age categories.
 - d) Quarterly diagnostic testing requests processed by procedure and test.
 - e) Quarterly reports of total cases and days non-authorized, total appeals, and total cases overturned on appeal.
 - f) Quarterly case management reports indicating total cases screened, total cases referred to case management.
 - g) Monthly telephone statistics including total calls received, total calls abandoned, and average hold-time. Reports will be required by telephone line for intake staff and RN staff for utilization management if separate telephone lines are maintained.
 - h) Total cases processed by number of days from receipt of complete clinical information for utilization management services.
 - i) Data transmission error reports for transmissions sent to claims administration.

a. Quarterly admit and bed days reports by medical, surgical, obstetrics, psychiatric, and substance abuse treatment.	Included in standard reports submitted as Attachment GG.
b. Quarterly admit and bed day reports by MDC.	Included in standard reports submitted as Attachment GG.
c. Quarterly admit and bed day reports by employee, dependent, gender, and age categories.	Not a standard report. However, APS can provide an as ad hoc report before implementation if awarded the contract.
d. Quarterly diagnostic testing requests processed by procedure and test.	Not a standard report. However, APS can provide an ad hoc report before implementation if awarded the contract.
e. Quarterly reports of total cases and days non-authorized, total appeals, and total cases overturned on appeal.	Included in standard reports submitted as Attachment GG.
f. Quarterly case management reports indicating total cases screened, total cases referred to case management.	Included in standard reports submitted as Attachment GG.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

<p>g. Monthly telephone statistics including total calls received, total calls abandoned, and average hold time. Reports will be required by telephone line for intake staff and RN staff for utilization management if separate telephone lines are maintained.</p>	<p>Included in standard reports submitted as Attachment BB.</p>
<p>h. Total cases processed by number of days from receipt of complete clinical information for utilization management services.</p>	<p>This is an internal quality assurance report and not typically part of our standard customer reports. However, APS can provide an ad hoc report before implementation if awarded the contract.</p>
<p>i. Data transmission error reports for transmissions sent to claims administrator.</p>	<p>The transfer process has changed over time so that. As most of our data exchange processes are electronic, incomplete transmissions no longer occur. Data transmission via FTP or SFTP is our preferred method used to send a complete authorization files to our customers' claims vendors. While we do not currently create transmission error reports, if requested, we can create an ancillary report with a row count as verification for the file the claims administrator received. APS can provide an ad hoc report before implementation if awarded the contract at the State's request.</p>

4) For reporting to clients, which of the following data elements are included in reports?

	Yes	No
	Standard	Special Request
Age/sex breakdown	X	
Employee, spouse, dependent breakdown	X	
Referral source		X
Plan or subgroup	X	
Benefit option	X	
Admitting diagnosis	X	
Discharge diagnosis		X
Type of service breakdown	X	



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

	Yes	No
	Standard	Special Request
Requested inpatient days	X	
Certified inpatient days	X	
Total actual inpatient days	X	
Non-certified days	X	
Days saved	X	
Admissions per 1,000 employees		X
Admissions per 1,000 members	X	
Days per 1,000 employees		X
Days per 1,000 members	X	
Average length of stay	X	
Number of days saved	X	
Total outpatient requests	X	
Estimated savings for utilization management services	X	
Estimated savings for case management	X	
Estimated savings for disease management	X	
Total cases handled through maternity program	X	
Total number of high risk maternity cases managed	X	
Admissions and bed days by MDC	X	

5) What is the time frame for your regular reports to your clients? Attach samples of your regular and optional reports, including an explanation of each report. Address in detail how these reports reconcile to each other.

Typically, our reporting turnaround timeframes are within 45 days of quarter end in order to prepare and analyze the reports. This process ensures reports are presented in a clear manner with an analytic eye so that they are meaningful to our customers. However, we can provide reports within 15 calendar days as required by the State's specifications.

Copies of our standard reports are presented in Attachment GG and optional reports as Attachment OO. Our report includes a glossary of terms that explains and reconciles each other.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

6) What comparative benchmarks do you provide to evaluate cost and utilization patterns and trends?

To evaluate cost and utilization patterns and trends, APS uses Milliman criteria, which benchmarks average length of stay (ALOS), Admits per 1,000, and Bed days per 1,000, and compares these statistics to loose, moderate and well managed statistics from Milliman’s data bank of national benchmarks.

7) Confirm you are capable of receiving eligibility information in the file layout described in Appendix B.

As stated in the “UM Vendor Questions” document dated March 6, 2007, the State uses UM Standard HIPAA Enrollment or Eligibility transactions as defined by the published HIPAA Implementation guides. APS confirms we are capable of receiving eligibility information in this file layout.

8) How do you propose to communicate the number of visits, treatments or authorized services to the EBD’s TPA(s)? Describe in detail including file layouts if applicable.

APS’ ELECTRONIC TRANSMISSION EXPERIENCE

APS has a long history of successful data exchanges with numerous trading partners, vendors, and providers. Our extensive experience includes over 100 active interfaces that are currently transmitting and receiving eligibility, claims, authorizations, and assorted assessments and case history data. Below are just a few examples of our data transfer capabilities with our customer’s third party vendors:

Customer	TPA	Interface Type	Frequency	Lives
Motorola	Medstat	Authorization and Claims	Weekly	62,000
State of Wyoming	ACS	Medical Authorizations	Daily	55,000
The Dow Chemical Company	Medstat	Claims	Monthly	52,000
State of Georgia	Artemtrix	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	48,000
	Morehouse	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

Customer	TPA	Interface Type	Frequency	Lives
Campbell Soup Company	Ingenix	Authorizations and Claims	Monthly	24,000
Indiana Comprehensive Health Insurance Association	ACS	Medical Authorizations	Weekly	7,550

Below are additional examples of the organizations with whom we interface on behalf of our customers:

Payor	Interface Type
ACS	Medical/pharmacy/eligibility/provider file
Aetna	Medical claims/eligibility
Anthem	Medical/eligibility/provider file
BCBS Alabama	Medical/eligibility/provider file
BCBS Georgia	Medical/eligibility/provider file
BCBS Hawaii	Medical/pharmacy/eligibility/provider file
BCBS Missouri	Medical claims
BCBS Montana	Medical/pharmacy/eligibility/provider file
Blue Cross Idaho	Medical claims/eligibility
Caremark	Pharmacy claims
CIGNA	Medical claims
Eckerd Health Services	Pharmacy claims
Great West	Medical claims/eligibility
Hewitt	Eligibility
HIGHMARK BCBS	Medical/eligibility/provider
The Principal	Medical/eligibility/provider file
United Healthcare	Medical claims/eligibility
Walgreens	Pharmacy claims

As a result, APS is more than capable of seamlessly exchanging data with the State's TPA(s). APS recognizes that the State's file transmissions are done via secure WebDAV. We will work with the State and information providers to ensure that the file transfers between APS, EBD and your selected vendors all meet current HIPAA regulations for encryption and security. Our experience and ability to be flexible to our clients' unique demands or specifications around system linkages will ensure we can meet the State's specific needs in this area.



Medical Utilization Management Services

2.6 Questionnaire – I. Systems, Data Transfer and Reporting Capabilities

The method and frequency of claims payor notification is dependent upon the client's needs and the data exchange capabilities of the claims payor. APS' core systems are typically complete enough to encompass the vast majority of data elements needed for most activities. When data needs to be shared or consolidated (e.g., visits, treatments, authorized services, etc.), wherever possible APS uses industry standard interfaces such as ANSI X12 / HIPAA compliant interfaces.

When no standard is possible, or system age or other interface limitation makes the standard impractical, APS develops custom interfaces to move data between systems. APS has extensive experience linking to other computer systems or sub-systems to perform data exchange; and designing and maintaining critical data interfaces for some of the largest employers in the United States and their vendor partners. We are able to extract and export data on a daily, weekly or monthly basis. With each customer we assess their data exchange needs and then build customized interfaces.

APS has a team of IT professionals on staff, including experienced programmers who work exclusively with our customer's partners to develop customized data interface protocols. We are fully capable of handling any data exchange needs a customer may require in terms of volume, frequency, type and size. The technical capabilities and configuration of the sending entity will determine the best method of data transmission. This may include secure file transfer protocol (FTP) methodologies (data is usually exchanged by posting on a secure FTP site that allows APS to both send and receive data), CD-Rom, zip files, electronic mail, and tapes to support batch file transfers. When a web application is not available, APS uses VPNs, and remote access connectivity using Citrix Metaframe for live interfaces.



Medical Utilization Management Services

2.6 Questionnaire – J. Client Service

APS also trains staff on how to utilize **TDD (Telecommunications Device for the Deaf) machines and local “Relay” services** to communicate with persons who are hearing impaired. As a result, we are more than capable of serving the State’s members who are fluent in languages other than English as well as those with hearing impairments.

3) Does your organization provide communication and patient education materials to participants? How often? Would you be willing to customize these materials for the EBD? Provide a sample of the most recent communications release. Confirm that your proposal provides a fee quotation for supplying this service, including the cost of mailing any communication materials to participant home locations. All member communication material must be approved by EBD prior to publication.

PROMOTION

Yes, APS has the capability to produce a broad array of member communication and educational materials. Under our UM program, member communication materials typically include materials such as authorization and non-authorization letters that help explain their program benefits. These standard materials, which will be sent to homes of EBD’s members upon service access, are included in APS’ quoted rates for your UM program. Sample member letters are included in **Attachment BB**.

To promote EBD’s program, APS will provide customized program language to include in your Member Summary Plan Descriptions so members are well informed of the benefits and how to access services. Program language can also be posted on the State’s employee Intranet for easy access. Your **Executive Director, Dr. Strang**, along with your Implementation Manager will work with you during implementation to ensure your promotional needs are met. In addition, we will open EBD’s toll-free line at least 30 days in advance of the actual program live date so that members and their providers can call and get personal assistance with any questions or concerns they may have regarding benefits. It’s important to note that APS will obtain approval from EBD on all member communication materials prior to publication.

If EBD decides to purchase disease management and nurse line services, APS can offer a broader spectrum of communication materials. For example, in **Attachment PP**, we have included sample disease management brochures used for our current contract with **Blue Cross Blue Shield of Montana** as an example of what we can offer. During the finalist presentation, we would like the opportunity to discuss EBD’s expectations around communication and educational materials to ensure we meet your needs.





Medical Utilization Management Services

2.6 Questionnaire – O. Administration Information

sooner as required by state or federal law. Please see our appeals process for more details in **Section C. Appeals Management**. APS will ensure our appeals process complies with all State of Arkansas regulations.

In addition, requests from our legal department for medical records require a turnaround time of 20 days.

3) In connection with the furnishing of supplies or performance of work under the contract, comply with the Fair Labor Standards Act, Fair Employment Practices Act, Equal Opportunity Employment Act and all other applicable federal and state laws, regulations and executive orders and further agrees to insert the foregoing provision in all subcontracts awarded hereunder?

In connection with the furnishing of supplies or performance of work under the contract, APS complies with the Fair Labor Standards Act, Fair Employment Practices Act, Equal Opportunity Employment Act and all other applicable federal and state laws, regulations and executive orders. APS further agrees to insert the foregoing provision in all subcontracts awarded hereunder.

4) Do you agree to the requirements as outlined above? If "no," list any variations and the reasons for them. Describe your policy for records and information management addressing storage, transfer, destruction, accuracy and confidentiality.

Yes, APS agrees to the requirements as outlined above. Please note again that we also understand that EBD requires written consent from EBD prior to releasing such information to any individuals or organizations other than EBD. However, obtaining prior written consent every time we share information with other individuals or organizations may hinder APS' ability to conduct timely utilization review (UR) activities (e.g., we may need to share information with an outside physician for expert consultation on a UR issue, etc.). As a result, as part of our standard operations, we establish Business Associate Agreements with any outside organizations to ensure we can share this type of information (related to direct patient care or UR decisions) with appropriate organizations as needed in a timely manner without having to obtain prior written consent each time. APS agrees to obtain prior written consent from for other types of information (e.g., sending data to a third party administrator for an outcomes study, etc.) that would not hinder the UR process.



Medical Utilization Management Services

2.6 Questionnaire – O. Administration Information

RECORDS MANAGEMENT

Data Storage & Backup

APS maintains data on all active cases. Cases are maintained within the system for two (2) years and then are archived and stored offsite in a secured data vault. APS is required to maintain clinical records for six to ten (6-10) years following the most recent case activity or longer as required by applicable laws. At any point time, all data is available to appropriate staff for analytical purposes.

APS maintains database backups with redundancy to eliminate potential disruption of service or loss of data due to system or program failures. We support established protocols that ensure the reliability of all information systems components. For example, our servers are backed up to tape every night. The saved data is managed in weekly cycles, including archiving the last full backup from the end of each month. APS maintains both on-site and off-site facilities for retention and storage of backup files and software. Tapes are stored offsite with a bonded, licensed national company with secure storage. APS inspects the site annually.

Key servers are built with redundant hardware components to provide maximum availability. RAID-5 disk storage is used for production servers. This allows for "hot swapping" of failed hard disks and spares on the shelf. As a result, APS is able to continue operating in the event of a disk failure without service interruption.

The APS SQL server based system includes the appropriate checkpoint and restart capabilities necessary to ensure reliability and recovery, including disaster recovery. Transactions can be stored automatically to tape and restored to the identical server for disaster recovery purposes. The SQL server has the built-in capability to restart the server where it was interrupted according to committed and/or uncommitted transactions. This process is known as "roll-back" or "roll-forward."

Full system backup is copied and/or archived and are stored in the same geographic location as the source systems on a monthly basis. A sample of archived backups must be tested quarterly to ensure that they are recoverable. After a two year time period, archived data is copied to another tape to avoid possibilities of data destruction and media deterioration. Data archived to the CD is copied within a five (5) year period. Any media utilized for archiving purposes should be evaluated for its archival lifespan.

Data Transfer

APS has a long history of successful data exchanges with numerous trading partners, vendors, and providers. Our extensive experience includes over 100 active interfaces that are currently transmitting and receiving eligibility, claims, authorizations, and assorted assessments and case history data. Below are just a few examples of our data transfer capabilities with our customer's third party vendors:



Medical Utilization Management Services

2.6 Questionnaire – O. Administration Information

Customer	TPA	Interface Type	Frequency	Lives
Motorola	Medstat	Authorization and Claims	Weekly	62,000
State of Wyoming	ACS	Medical Authorizations	Daily	55,000
The Dow Chemical Company	Medstat	Claims	Monthly	52,000
State of Georgia	Artemtrix	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	48,000
	Morehouse	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	
Campbell Soup Company	Ingenix	Authorizations and Claims	Monthly	24,000
Indiana Comprehensive Health Insurance Association	ACS	Medical Authorizations	Weekly	7,550

As a result, APS is more than capable of seamlessly exchanging data with the State's TPA(s). APS recognizes that the State's file transmissions are done via secure WebDAV. We will work with the State and information providers to ensure that the file transfers between APS, EBD and your selected vendors all meet current HIPAA regulations for encryption and security. Our experience and ability to be flexible to our clients' unique demands or specifications around system linkages will ensure we can meet the State's specific needs in this area.

The method and frequency of claims payor notification is dependent upon the client's needs and the data exchange capabilities of the claims payor. APS' core systems are typically complete enough to encompass the vast majority of data elements needed for most activities. When data needs to be shared or consolidated (e.g., visits, treatments, authorized services, etc.), wherever possible APS uses industry standard interfaces such as ANSI X12 / HIPAA compliant interfaces. When no standard is possible, or system age or other interface limitation makes the standard impractical, APS develops custom interfaces to move data between systems.

We are fully capable of handling any data exchange needs a customer may require in terms of volume, frequency, type and size. The technical capabilities and configuration of the sending entity will determine the best method of data transmission. This may include secure file transfer protocol (FTP) methodologies (data is usually exchanged by posting on a secure FTP site that allows APS to both send and receive data), CD-Rom, zip files, electronic mail, and tapes to support batch file transfers. When a web application is not available, APS uses VPNs, and remote access connectivity using Citrix Metaframe for live interfaces.





Medical Utilization Management Services

2.6 Questionnaire – Q. Electronic Transactions

1) The Bidder shall perform claims processing and other electronic transactions on behalf of EBD according to the Standards for Electronic Transactions as defined by HIPAA statutes and regulations. EBD considers the Bidder a 'Business Associate' as defined by HIPAA. EBD performs the functions of both a 'Plan Sponsor' and 'Covered Entity' under HIPAA. When acting as a 'Plan Sponsor, EBD may conduct non-standard transactions with the Bidder. When acting as a health plan/covered entity, EBD is required to conduct the required electronic transactions with other covered entities in the standard X12 format. 45 CFR § 162.923 and specifically § 162.025(a). Pursuant to 45 CFR § 162.923(c) EBD may utilize a Bidder to conduct HIPAA standard transactions. The Bidder, or any subcontractor performing a HIPAA standard transaction, shall comply with applicable HIPAA regulations including, but not limited to, the privacy and transaction and code set regulations. EBD, when acting as a health plan, must specifically comply with 45 CFR § 162.925. The Bidder shall comply with 45 CFR § 162.925 and agrees to the prohibitions listed in 45 CFR §162.915.

APS is more than capable of performing electronic transactions of behalf of EBD according to the Standards for Electronic Transactions as defined by HIPAA statutes and regulations. We confirm that we comply with applicable HIPAA regulations for HIPAA standard transactions, including but not limited to the privacy and transaction and code set regulations. Furthermore, APS complies with 45 CFR § 162.925 and agrees to the prohibitions listed in 45 CFR §162.915.

The hallmark of all of APS' programs is our comprehensive data collection process. We capture and analyze substantial information about individual members to facilitate their care for numerous clients, including the States of Georgia, Louisiana, Maryland, Mississippi, Missouri, South Carolina, West Virginia, Wisconsin and Wyoming to name a few. In addition we have achieved great success exchanging data with our health plan clients, including Blue Cross Blue Shield of Montana, Hawaii Medical Service Association (Blue Cross Blue Shield of Hawaii), Blue Cross Blue Shield of Utah, Coventry of Louisiana, Coventry of Georgia, Coventry of Iowa, Coventry of Delaware, Advocate Health Partners, Destiny Health Plan, Community Health Choice, and Unicare Health Plans.

APS has over two decades of experience linking to other computer systems or sub-systems to perform data exchange; and designing and maintaining critical data interfaces for some of the largest employers in the United States and their vendor partners. Therefore, APS knows what it takes to establish interfaces which conform to the specific requirements of each. We are able to extract and export data on a daily, weekly or monthly basis to facilitate all critical mission functions. With each customer we assess their data exchange needs and then build customized interfaces. APS is also experienced in establishing interfaces between our Clinical Care Management System and all types of external systems, including authorizations, eligibility systems, provider network lists, and clinical records.



Medical Utilization Management Services
2.6 Questionnaire – Q. Electronic Transactions

Below are just a few examples of our data transfer capabilities with our customer's third party vendors:

Customer	TPA	Interface Type	Frequency	Lives
Motorola	Medstat	Authorization and Claims	Weekly	62,000
State of Wyoming	ACS	Medical Authorizations	Daily	55,000
Dow Chemical	Medstat	Claims	Monthly	52,000
State of Georgia	Artemtrx	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	48,000
	Morehouse	Pharmacy, Claims, Eligibility, & Provider Data	Monthly	
Campbell Soup Company	Ingenix	Authorizations and Claims	Monthly	24,000
Indiana Comprehensive Health Insurance Association	ACS	Medical Authorizations	Weekly	7,550

Below are additional examples of the organizations with whom we interface on behalf of our customers:

Payor	Interface Type
ACS	Medical/pharmacy/eligibility/provider file
Aetna	Medical claims/eligibility
Anthem	Medical/eligibility/provider file
BCBS Alabama	Medical/eligibility/provider file
BCBS Georgia	Medical/eligibility/provider file
BCBS Hawaii	Medical/pharmacy/eligibility/provider file
BCBS Missouri	Medical claims
BCBS Montana	Medical/pharmacy/eligibility/provider file
Blue Cross Idaho	Medical claims/eligibility
Caremark	Pharmacy claims
CIGNA	Medical claims
Eckerd Health Services	Pharmacy claims
Great-West	Medical claims/eligibility
Hewitt	Eligibility



Medical Utilization Management Services

2.6 Questionnaire – Q. Electronic Transactions

Payor	Interface Type
HIGHMARK BCBS	Medical/eligibility/provider
The Principal	Medical/eligibility/provider file
United Healthcare	Medical claims/eligibility
Walgreens	Pharmacy claims

An example of our data exchange process involves our customer, Micron Technology and their Health Plan, Blue Cross of Idaho. As soon as the contract award was announced, APS reached out to Blue Cross of Idaho to establish interface protocols and include them in the implementation process. We established monthly care coordination meetings and collaboratively developed workflows and processes for referring participants to the health plan and other available benefits when appropriate. We also have their current case management trigger list to identify and refer cases for case management. Furthermore, we have developed a customized process for how they should be notified of such cases. Currently, our process involves both telephonic and fax notification.

In addition, as a part of our program for Micron Technology, we routinely review claims data using our informatics tools to identify patients who frequently utilize emergency room services. We identify those patients who have not designated a PCP. These patients are flagged and appropriate referrals are made. Additionally, for those patients who use the ER for non-urgent medical care, we assist Blue Cross of Idaho in providing the necessary clinical support, education, and guidance as to the most appropriate means to utilize the healthcare system.

For EBD, APS' IT staff will work with EBD and your benefit partners' information technology leaders to integrate our health information technology structures. Upon award, APS will immediately begin by working with EBD and your health plans to develop a specific plan for integrating data. We understand that establishing open lines of communication and coordinated testing plans between APS, and the health plans from the very beginning is critical to the important function of data transfer and data management, and we have experience doing it. APS has the ability to accept client and provider information in a variety of electronic formats. Data exchange protocols acceptable to EBD and your health plan partners will be employed during the implementation period and may include Internet, SFTP, BBS, diskette, tape, Iomega Zip, Castlewood Orb, CD-ROM, and most other current technologies.

As clarified in Addendum 1, claims processing is not requested in this RFP.



A Proposal to the State of Arkansas



Medical Utilization Management Services Subcontractor Information

- e. To conduct litigation in a place other than Pulaski County, Arkansas.
- f. To agree to any provision of a contract which violates the laws or Constitution of the State of Arkansas

CareNet complies.

- 2) A party wishing to contract with the State of Arkansas should:
 - a. Include in its proposal that the laws of the State of Arkansas govern the contract.
 - b. Acknowledge in its' proposal that contracts become effective when awarded by the State Procurement Official.

CareNet agrees that the laws of the State of Arkansas govern the contract. In addition, CareNet acknowledges that contracts become effective when awarded by the State Procurement Official.

1.25 VENDOR REFERENCES

Vendors must submit, with the proposal, at least six (6) references, of which three (3) must be active and three (3) must be terminated, reference accounts located in the United States who have been provided client services of a same or similar nature in the last five (5) years. Reference must include, contact person, telephone number and email address.

ACTIVE REFERENCES

Company Name	San Antonio Military Multi-Market
Contact Name	Trancetta Brown
Contact's Title	Contracting Officer
City	Lackland
State	Texas
E-Mail Address	trancetta.brown@lackland.af.mil
Telephone Number	(210) 292-5233
Description of Services Furnished	Nurse Line Services
Company Name	Community Health Choice
Contact Name	Jane Scott
Contact's Title	Manager, Operations
City	Houston
State	Texas
E-Mail Address	jane.scott@communityhealthchoice.org
Telephone Number	(713) 295-2279
Description of Services Furnished	Nurse Line Services

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Medical Utilization Management Services Subcontractor Information

Company Name	US Family Health Plan (Formerly CHAMPUS)
Contact Name	Sharon Vollers
Contact's Title	Director of Quality Management
City	Houston
State	Texas
E-Mail Address	sharon.voller@christushealth.org
Telephone Number	(713) 812-6838
Description of Services Furnished	Nurse Line Services

TERMINATED REFERENCES

CareNet has only had one terminated customer:

Company Name	WellCare (Harmony Health Plan)
Contact Name	Esther Morales
Contact's Title	Senior Director of Health Services
City	Chicago
State	Illinois
E-Mail Address	Esther.Morales@wellcare.com
Telephone Number	(800) 608-8158
Description of Services Furnished	Nurse Line Services

2.1 GENERAL REQUIREMENTS

The selected bidder must:

- A. Provide a mission statement and an organizational chart**

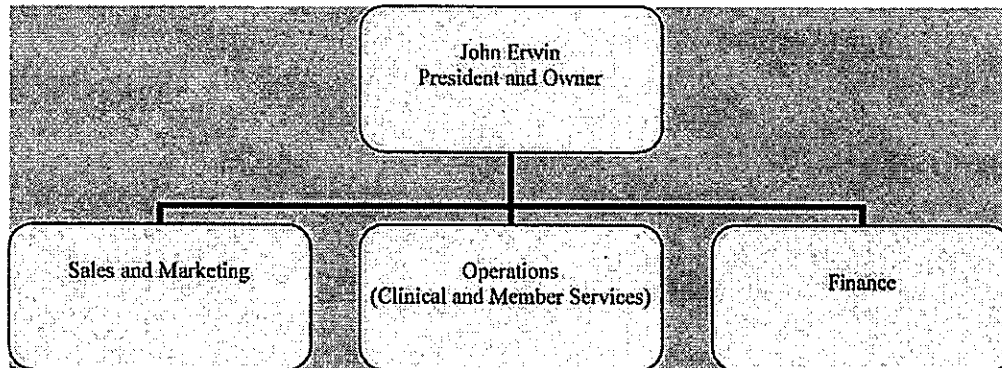
CareNet's sole mission is to create a healthier and happier population.

Company Organizational Structure

John Erwin, President and Owner of CareNet, oversees all administrative functions, including Sales and Marketing, Operations and Finance.

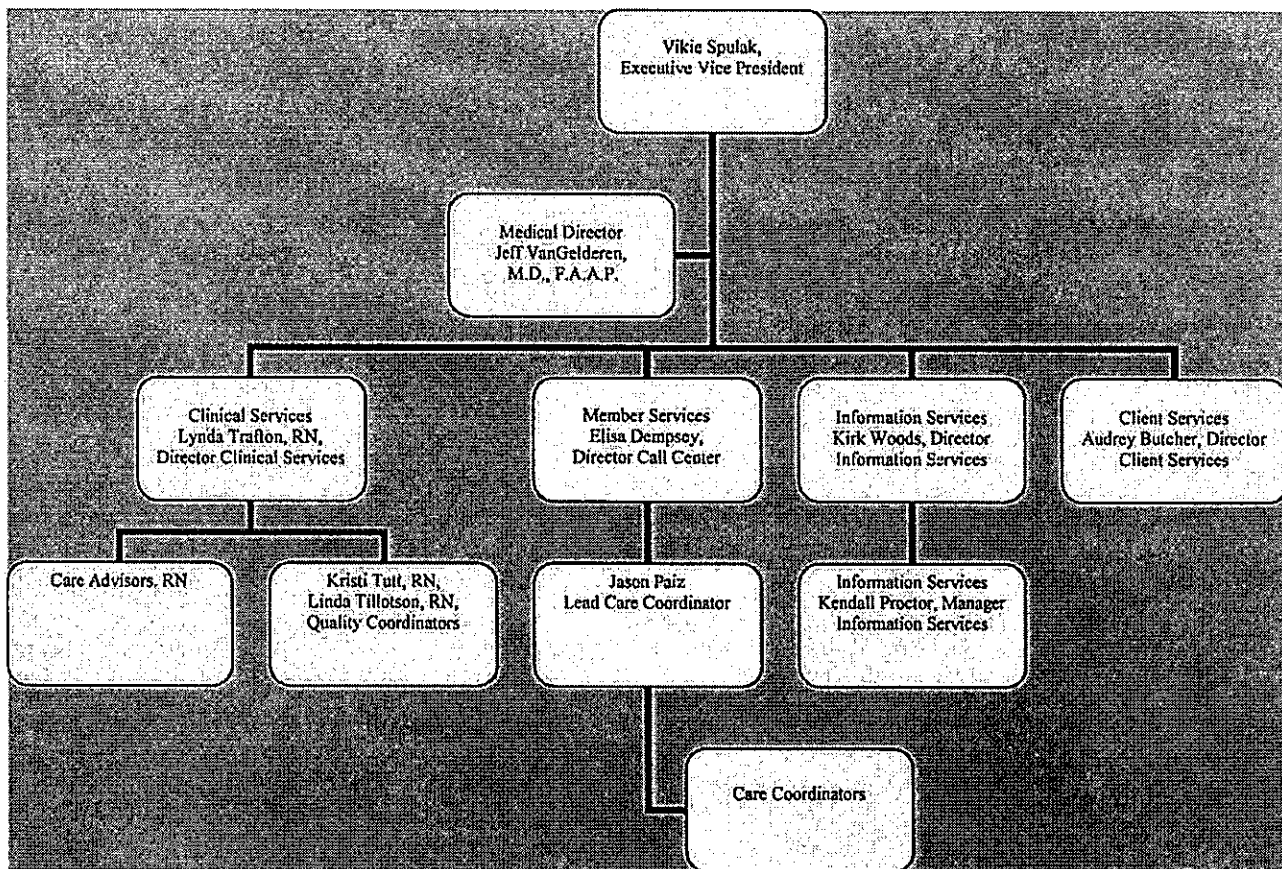


**Medical Utilization Management Services
Subcontractor Information**



Operations Organizational Structure – Clinical and Member Services

Vikie Spulak, Executive Vice President, oversees the Clinical and Member Services Operations. CareNet’s Medical Director, Dr. Jeff Van Gelderen provides senior clinical leadership and oversight over its Clinical Services.







**Medical Utilization Management Services
Subcontractor Information**

D. The company will require continuing UR education for their nursing staff.

Not applicable as CareNet is not the prime contractor for utilization management services. However, CareNet Care Advisors complete continuing educational credits.

E. Currently service at least with at least 25,000 employees (employees include actives, COBRA, and non-Medicare primary eligible retirees); describe the population you serve.

Yes, CareNet meets this requirement. CareNet has a number of customers with over 25,000 employees. For example, we have provided a brief table of some of CareNet's large customers below:

Customer	Program Summary
Benefit Planners/FiServ	Benefit Planners is a third party administrator serving more than 250 employers with over 600,000 plan participants worldwide. Benefit planners provides a range of benefit administration and HR outsourcing services to include: medical, dental, prescription drug programs, utilization review, enrollment automation and customized PPO networks.
Community Health Choice (CHC)	CHC is a Medicaid HMO licensed in the state of Texas. CHC is owned and operated by the Harris County Hospital District. CHC provides care to approximately 50,000 Medicaid Star members.
San Antonio Military Multi-Market (SAMMM)	The SAMMM (Lackland Air Force Base, Wilford Hall, Fort Sam Houston, Brooks Army Medical Center, & Randolph Air Force Base) provides quality comprehensive medical care and customer service to over 204,000 Department of Defense beneficiaries in the San Antonio healthcare region. The Advice Line acts as a key entry point into the Military Health System and is a vital component of the total customer satisfaction objective.
US Family Health Plan – (Formerly CHAMPUS)	US Family Health Plan (USFHP) is a government sponsored managed care plan providing health benefits for eligible family members and retirees of all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health and NOAA. USFHP serves the healthcare needs of almost 20,000 military beneficiaries in Southeast Texas and

A Proposal to the State of Arkansas



Medical Utilization Management Services Subcontractor Information

Customer	Program Summary
	Louisiana and over 100,000 nationwide.

F. The company shall not administer any part of this contract by an off shore service center.

CareNet will not administer any part of this contract by an off shore service center.

G. Have a certificate to perform utilization management services for the state of Arkansas Department of Health and provide a copy in this RFP.

Not applicable as CareNet is not the prime contractor for utilization management services. However, all CareNet Care Advisors participate in the Nurse Licensure Compact (NLC) of which the State of Arkansas is a member.

H. The company must demonstrate a track-record of on-going coordination of services with major health plans, preferably ones located in the State of Arkansas.

CareNet has a long track-record of serving and coordinating nurse line services with health plan customers as well as hospital systems. For example, CareNet provides real time data via electronic feeds or HIPAA compliant faxes to its health plan clients immediately following each clinical encounter. Through secure web portals and FTP sites, CareNet also provides information that can be coordinated with a Health Plan's other health management programs (e.g., disease management, wellness, utilization/case management, etc.). These exchanges can be daily weekly or monthly. For example, CareNet serves approximately 50,000 Medicaid Star members through their relationship with Community Health Choice. CHC is a Medicaid HMO licensed in the state of Texas, and is owned and operated by the Harris County Hospital District.

CareNet also provides nurse line services to other hospital systems and related healthcare customers such as Scripps Medical Foundation and CHRISTUS St. Elizabeth Hospital.

- Scripps Medical Foundation specializes in internal medicine, family practice and pediatrics. All physicians are on the medical staff of Children's Hospital and Health Center, Scripps Mercy Hospital and Scripps Memorial Hospital Chula Vista.
- CHRISTUS Hospital-St. Elizabeth is a 461-bed health care facility in Beaumont, Texas, and is the largest hospital between Houston and Baton Rouge, Louisiana. St. Elizabeth is a regional leader in outpatient services, cardiology, oncology, neurology, pediatrics, general surgery, birthing, neonatal care, cardiac rehabilitation, and

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diagnostic imaging.

I. The company must agree, that during implementation and for the first year after implementation, to meet with EBD on a weekly basis or as requested by EBD either in person or telephonically; after the first year meet with EBD and/or the Arkansas State and Public School Life and Health Insurance Board on a monthly basis or as requested by EBD either on-site at EBD or telephonically to report on the general progress of the Vendor in this endeavor and the interaction with our members.

Not applicable as CareNet is not the prime contractor for utilization management services. However, CareNet will attend and assist APS during onsite meetings as needed.

J. The company must agree to allow EBD and/or its designated representatives and Legislative Audit the right to audit all records maintained by the UM Vendor and/or its affiliates relative to the UM Vendor's performance under the contract. The UM Vendor agrees that upon forty eight (48) hours notice by the EBD or Legislative Audit to the UM Vendor, the EBD, Legislative Audit or EBD's chosen auditor shall have the right to perform financial, performance, and other special audits on such records maintained by the UM Vendor during regular business hours throughout the contract period. The UM Vendor agrees that confidential information including, but not limited to, medical and other pertinent information relative to Plan Participants in the Plan, shall not be disclosed to any person or organization for any purpose without the expressed, written authority from EBD; selected company will make available all records, as defined by the selected auditor, for review at no cost to the EBD. Any ancillary fees, which may be incurred by the EBD for the on-site audits, should be included in your proposed rate for UM services.

CareNet will comply with the above statement.

2.3. CONTRACTOR'S RESPONSIBILITIES

Contractor to provide all labor, equipment, facilities, supplies, and other services to include consulting services as needed/ specified. Do you agree? If not explain.

CareNet agrees with the statement above.



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Medical Utilization Management Services Subcontractor Information

5) Do you have a SAS 70? If so provide a copy in this response.

Not applicable.

6) List the name and principal occupation/business of any entity or person owning 10% or more of your organization.

The President of CareNet, John Erwin, owns 100% of CareNet.

7) State if the proposed account manager, any officers or principals and/or their immediate families are, or have been within the preceding 12 months, employees of the State of Arkansas.

For the EBD account, APS proposes Scott Strang, PhD, MBA as your Account Executive or Executive Director. In addition, neither Dr. Strang nor any officers or principals of APS or CareNet have been employees of the State of Arkansas within the preceding 12 months.

8) Complete the table below for your entire book of business as of 12/31/2006. Include covered members (total number of employees and dependents managed by your utilization management services.

CareNet's book of business for demand management services as of 12/31/2006 is provided below. The remaining statistics reflect APS' book of business for utilization management services as of 12/31/2006.

Utilization Management - Covered Members		
	Public Sector	Private Sector
Precertification	575,500	2,924,494
Continued Stay Review	575,500	2,924,494
Retrospective Review	575,500	2,924,494
Medical Case Management	50,500	2,924,494
Disease Management	167,000	864,600
Demand Management	305,000	1,000,500

9) For the office in which you propose to place this business, complete the following:

APS has provided staffing information for CareNet's call center below:



**Medical Utilization Management Services
Subcontractor Information**

Staffing -Full time equivalent employees			
	Utilization Management Services	Disease management	Certification
Intake Personnel	15	N/A	High School Diploma Required.
Clinical Staff	18	N/A	RN or above

Staffing			
	Utilization Management Services	Disease Management	Certification
Full time equivalent RNs	18	N/A	RN or above
Full time equivalent MDs	None	N/A	N/A
Part time MDs	1	N/A	Medical Degree, Board certified

10) Provide the total number of MDs employed by your organization to provide utilization management services. Break out the number by physician's specialty.

CareNet has one Medical Director, **Dr. Jeffrey T. Van Gelderen**. Dr. Van Gelderen is board certified in Pediatrics, and is a Fellow of the American Academy of Pediatrics. CareNet choose Dr. Van Gelderen due to his experience in Pediatrics as more than 65% of nurse line services related to pediatric care. We have provided a brief biography of his experience in **Question 12** below. In addition, his resume is provided in **Attachment VV**.

11) If your organization were awarded the contract, provided the number and types of new staff you would need to hire to implement and administer the contract.

CareNet does not anticipate the need for hiring additional staff to serve the EBD account.

12) Identify the individual in the following positions within your organization and supply a resume for each position listed:

- a. **Service Center Medical Director**
- b. **Operations Director**
- c. **Case Management Director**
- d. **Account Executive**

State of Arkansas
OFFICE OF STATE PROCUREMENT
1509 West Seventh Street, Room 300
Little Rock, Arkansas 72201-3966
501-324-9321

ADDENDUM I

TO: All Vendors

FROM: Jenny Foshee

DATE: March 5, 2007

SUBJECT: SP-07-0326 Medical Utilization Management Services

The following change(s) to the above-referenced Request for Quotation. The change has been made as designated below:

- Change of specification(s)
- Additional specification(s)
- Change of bid opening time and date
- Cancellation of bid
- Other

Appendix B – Business Agreement (listed in RFP as Appendix D)

Appendix D – File Layout (listed in RFP as Appendix B)

All other language and terms and conditions shall remain the same.

The specifications by virtue of this addendum become a permanent addition to the above-referenced Request for Quotation. **FAILURE TO RETURN THIS SIGNED ADDENDUM MAY RESULT IN REJECTION OF YOUR BID.**

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE OFFICE OF STATE PROCUREMENT.

If you have questions, please contact me at 501-324-9314.



VENDOR SIGNATURE

3/16/07
DATE

COMPANY Innovative Resource Group, LLC d/b/a APS Healthcare Midwest (APS)



ATTACHMENTS TABLE OF CONTENTS

- AA. UM Flow Diagram
- BB. UM Telephone Reports
- CC. Non-Authorization Process / Copies of Sample Participant & Provider Non-Authorization Letters
- DD. QM Program Documents & Department Organization Chart
- EE. HEDIS Data
- FF. Sample Maternity Education Materials
- GG. Sample Reports
- HH. Organizational Chart
- II. Arkansas UM Certificate/Letter
- JJ. Audited Financial Statements
- KK. Resumes & Job Descriptions:
- LL. Sample Provider Education Materials
- MM. URAC certificate
- NN. Clinical and Financial Outcomes Measures
- OO. Optional Reports
- PP. Communication and Educational Materials
- QQ. Insurance Certificate
- RR. W-9 form
- SS. Disaster Recovery Plan
- TT. HIPAA Policies & Procedures
- UU. Signed Business Associate Agreement
- VV. Subcontractor Resumes

