



ANNUAL HCBS REPORT CYE 2019

(October 1, 2018 – September 30, 2019)

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INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a long-term care program that serves both individuals who are elderly and/or have physical disabilities (EPD) and individuals who have intellectual and developmental disabilities (IDD) through Managed Care Organizations (Contractors) including the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). AHCCCS and the Contractors strongly support opportunities for individuals enrolled in the Arizona Long Term Care System (ALTCS) program to live in home and community based service (HCBS) settings. To that end, AHCCCS has maintained a consistent trend of HCBS member placements (considering increases in population) for the past eight years, after a marked decline in institutional placements as of CYE 2011.

The AHCCCS Administration has accomplished these milestones through its ALTCS Program that promotes and adheres to the values of:

- Choice
- Independence
- Self-determination
- Dignity
- Individuality

Guiding principles were established under the belief that every effort should be made to support the ability of individuals to reside in HCBS settings. These guiding principles are as follows:

- *Member-Centered Case Management*
The member is the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of long term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goals(s) for achieving or maintaining his/her highest level of self-sufficiency. Education and up-to-date information about the ALTCS Program, choices of options and mix of services must be readily available to members.
- *Member-Directed Options*
To the maximum extent possible, members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making decisions about how best to have needs met including who will provide the service and when and how the services will be provided.
- *Person-Centered Planning*
The Person-Centered Planning process maximizes member-direction and supports the member to make informed decisions, so that he/she can lead/participate in the Person-Centered Planning process to the fullest extent possible. The Person-Centered Plan safeguards against unjustified restrictions of member rights, and

ensures that members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible. The Plan ensures responsiveness to the member's needs and choices regarding service delivery and personal goals and preferences. The member and family/representative shall have immediate access to the member's Person-Centered Plan.

- *Consistency of Services*

Development of network accessibility and availability serve to ensure delivery, quality and continuity of services in accordance with the Person-Centered Plan as agreed to by the member and the Contractor.

- *Accessibility of Network*

Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for aging members and members with disabilities, cultural preferences, and individual health care needs. Services are available to the same degree as services for individuals not eligible for AHCCCS.

- *Most Integrated Setting*

Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

- *Collaboration With Stakeholders*

Ongoing collaboration with members/families, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

Members and families are afforded the opportunity to actively participate in the selection of services that will best meet their needs. HCBS applicable settings are available to an individual as long as the cost of HCBS does not exceed the net cost of institutionalization for that member.

Arizona's Olmstead Plan, developed in 2001, has influenced the changes made to the ALTCS Program over the years. Current efforts to update and regularly monitor the progress of the Olmstead Plan are outlined in a subsequent section of this report.

The report details efforts and initiatives aimed at improving quality and promoting the expansion of HCBS.

THE MEMBER EXPERIENCE

The priority of the ALTCS Program is to ensure that members are living in the most integrated setting and actively engaged and participating in community life (i.e. employment, education, volunteer, social and recreational activities). The following member stories exemplify how these priorities present themselves on a day-to-day basis in the lives of members¹.

Patricia - is a 79-year-old member who enjoys volunteering and serving as an advocate for her peers. With encouragement from the case manager, Patricia began attending the Contractor's member advisory council meetings (MAC). During a recent MAC meeting, a guest speaker presented on a new six-week, community-based program for individuals with disabilities to become community advocates. Patricia was interested in and successfully graduated from the six-week program. She continues to attend monthly MAC meetings, taking what she has learned and sharing this with other residents at the Senior Living Center she resides in. Patricia also volunteers with Lost Peepers, a peer support group for individuals who have low vision and/or blindness. She enjoys crocheting; she crochets various stuffed items such as sock monkeys, bears, turtles, dolls, cats, dogs and mice. She has donated handmade bookmarks to the local library and stuffed animals to the Church Bazaar. Patricia has spent more than 19,000 volunteer hours making and donating thousands of handmade crocheted items to the ER Pediatric Department at the local hospital. Patricia states crocheting is her special talent that helps her focus on "positive feelings" and helping others feel better.

Jacob - became quadriplegic from a motor vehicle accident 18 years ago, when he was 18 years old and thereafter became eligible for ALTCS. After living with his mother, two years ago he was placed in a nursing home for a period of eight months to recover from an infection. Once he recovered he was unable to return back home and he became concerned that he would have to live in a facility long-term. His Case Manager told him he had options and developed a plan to move him into an assisted living facility. Jacob has worked to gain more independence and desires to share what he has learned along his journey to help others recover and gain their independence. In the past year, Jacob reached out to several of his friends who are also paralyzed, and they formed The Quad Squad. The Quad Squad's mission is to reach out to newly paralyzed members and assist them early in their injury to adjust and recover as fully as possible. They provide support, education, hope, and companionship to these individuals. The Quad Squad is also looking to educate healthcare professionals as to what it's like to be paralyzed. The Quad Squad just completed their first website and brochure; they are looking to book their first speaking engagement soon. As Jacob says, "This is not what I planned for my life, but it is my responsibility to share what I have learned to make a difference.

Angelina - was born with cerebral palsy and has resided at a nursing home since 2005. She has been attending the local community college for the last two years and recently

¹ AHCCCS received authorization from each member to use or disclose personal or health information for the purposes of AHCCCS publications. The authorizations are on file.

enrolled with Northern Arizona University where she is actively working on obtaining her bachelor's degree. She was recently elected President of the Contractor's Member Advisory Council and attends both local and statewide meetings. Angelina's own words describe what drives her success. She says, "I want to honor my mom's memory who always wanted me to go to college. I want to be an inspiration to others whether they have a disability, are older, or anybody. If I can do it anybody can."

Allan - was living in the community with several roommates when he became acutely ill and was hospitalized and subsequently needed the care provided in a nursing facility. As he recovered, he wanted to return to the community. He was discouraged when he realized that he would be unable to return to his previous residence. To further complicate matters he didn't have enough income to pay for food and rent. Allan's Contractor introduced him to a community partner that helped him apply for Veteran Administration funds that were available to veterans of the Korean Conflict during Peacetime. Through this program, he was able to receive enough income to allow him to live independently in the community. Today he rents a nice little casita on the grounds of a large home.

Mona - was diagnosed with Multiple Sclerosis in 2011. While living in a rental home with her husband, a fall detected by an emergency alert system led to the discovery that Mona was in an abusive relationship. Mona told her Case Manager that she no longer wanted to live in her rental home. The case manager provided Mona with several available housing options and she applied, and was approved, for HUD housing. She states she is now able to focus on her treatment and is accepting her diagnosis. She has gotten her life back, both mentally and physically, and looks forward to working on her next goals of walking, eating healthy, and living a healthier life.

Steve – has always lived a fast-paced life as an event planner who traveled the world and a personal chef who helped manage the family's estate in Northern California. He said that he would cook healthy, fresh meals for the family, but would always choose unhealthy, fast food type meals for himself. He said that he took care of everyone else but himself, which eventually led to a stroke in 2012. Steve was in a skilled nursing facility when his doctor told him that his stroke was due to his unhealthy choices. He said it was that day when he changed his mindset and took his second chance at life. Steve began to receive long term care services in 2013 which allowed him to pursue his new purpose in life. He said having long term care assists him with getting out in the community, living a fulfilling life, and helping others to choose healthy lifestyles. The homemaker service allows him to have a clean home, have fresh and healthy groceries, and have fruits and vegetables prepped and ready for him. This allows him to stay on track with his goal of living a healthy lifestyle. Steve has since helped create the concept for Café Cultivate at his local Center for Independent Living, Ability360. He has authored a cooking section in the LivAbility magazine and a book; he teaches cooking and nutrition classes in the community and was selected by Ability360 to travel to Napa Valley for a conference on "healthy kitchen healthy lives" to help implement the program at Ability360.

Ada - wanted to be more active and gain physical strength because her usual activities consisted of watching television and spending time with her daughter at home. She stated that being bored has not helped with feelings of depression. Ada's Case Manager provided education about the adult day healthcare services, senior centers, and behavioral health services. This was a topic of discussion at every assessment visit for a period of a year before Ada started attending the senior center five days a week. She has shared that this has given her "purpose" and that she looks forward to attending daily. She stated that not only has she gained friendships, but she has also been able to lift light weights and exercise at least three times a week, resulting in a 5 lb weight loss. She has been attending meditation classes and started sewing, which helps her relax. She has been volunteering and helps to bring food to peers during meal times. Ada stated she is happy and proud of her continued progress and continues to encourage her friends and peers to exercise with her; she wishes more people would join the senior center.

Tammy - shared during a reassessment visit with her Case Manager that she is "tired of being seen as a woman in a wheelchair." She stated she would like to be a part of a community and be able to share with her peers ways to save money on groceries by using different mobile apps, coupons and to acquire free or reduced items. Tammy reported she saved over \$3000 since January 2018. The Case Manager worked to get her exposure at an Advisory Council meeting to present a topic, "Shopping on a Dime." A week before the presentation, the Case Manager met with her at home to practice for the Advisory Council Meeting. Subsequently, Tammy was asked to present at the annual Abilities Workshop in Maricopa County. After the presentation, Tammy shared with her Case Manager that "it was a blessing to be given an opportunity to present." She said that she felt "great and for 30 minutes I was able to feel normal again and my disability had disappeared." Tammy did such a wonderful job she was asked by an attendant care agency to present to their staff of caregivers and share her tips on shopping on budget for a household.

Sarah - had a desire to be more independent and to live on her own. Her Case Manager referred her to the Contractor's Housing, Engagement, Resources and Opportunity (HERO) program. It was determined that Sarah was a candidate for the federal Section 811 Project Rental Assistance Program. Sarah moved into her own apartment and receives habilitation services to help improve her cooking, money, and community safety skills. Her mother is excited and stated about her new home, "It's huge. It's really beautiful. It's bright. The neighborhood is nice and very well maintained." Her mother recalled, "Of course, I was nervous about her having an apartment. I really see Sarah has grown since she's been on her own, she's doing really well!"

MEMBER INITIATIVES

The following is a summary of specific HCBS related activities undertaken by the ALTCS Contractors and AHCCCS.

- ***Spouse as Paid Attendant Caregiver***

AHCCCS implemented the Spouse as Paid Caregiver service option on October 1, 2007, after receiving a waiver from the Centers for Medicare and Medicaid Services (CMS). Spouse as Paid Caregiver is a service model option which allows a spouse, who meets basic qualifications, to provide and be compensated for providing direct care services for their husband or wife. Per the Arizona 1115 Waiver, ALTCS members selecting this option are limited to 40 hours per week of Attendant Care or like services (homemaker and personal care). Allowing married members this service option has assisted in reducing the challenges of ensuring an adequate caregiver workforce. The Spouse as Paid Caregiver waiver information can be found on the [AHCCCS website](#).

In CYE 2019, 1,576 members received paid services from their spouse, a 2% decrease from the previous year.

- ***Self-Directed Attendant Care (SDAC)***

AHCCCS implemented Self-Directed Attendant Care (SDAC) on September 1, 2008. SDAC offers ALTCS members or their legal guardians the choice of directly hiring and supervising their own Direct Care Workers (DCWs) without the use of an agency. It empowers members to have more control over their lives, leading to increased satisfaction and improved quality of life. Under SDAC, individuals have the right and the ability to make decisions about how best to have their needs met, including determining who will provide the services they need and when the services will be provided. Participating members are supported by the services of a qualified fiscal agent who performs all employer payroll functions and Case Managers who provide general assistance. Case Managers may utilize the SDAC member manual to support members serving in the capacity of the employer of their DCW. Additionally, Case Managers may authorize the member training service to have an AHCCCS registered provider provide training to the member on how to exercise their employer authority.

During CYE 2010, Arizona Administrative Code (rule) was amended to allow SDAC participating members to direct certain skilled nursing services to their DCW. A member can now direct their DCW to perform the following skilled services:

- Bowel care, including suppositories, enemas, manual evacuation and digital stimulation;
- Bladder catheterizations (non-indwelling) that does not require a sterile procedure;
- Wound care (non-sterile);
- Glucose monitoring;
- Glucagon as directed by the health care provider;
- Insulin, subcutaneous injection only if the member is not able to self-inject;

- Permanent gastrostomy tube feeding; and
- Additional services with the approval of the Director and the Arizona State Board of Nursing.

The SDAC policy can be found on the [AHCCCS website](#).

In CYE 2019, 411 members utilized this member-directed option, a 6% percent decrease from the previous year.

- ***Agency with Choice***

On January 1, 2013, AHCCCS implemented and instituted a new member-directed option, Agency with Choice. The option is available to ALTCS members who reside in their own home. A member or the member's Individual Representative (IR) may choose to utilize Agency with Choice for the provision of his/her care. Under this option, the provider agency and the member/IR enter into a formal partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker and the member/IR serves as the day-to-day managing employer. Agency with Choice presents an opportunity for members interested in directing their own care, but would otherwise like the support offered by a provider agency. For provider agencies, the option affords them an opportunity to support members in directing their own care.

During CYE 2012, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders, and Contractors. The Council's primary function was to provide input on programmatic changes AHCCCS needed to make in order to implement the new Agency with Choice member-directed option, including policy and form changes.

In CYE 2013, the primary focus was on supporting Contractors to educate members/IRs about all the available service model options including member-directed options. While Contractors monitor the delivery and quality of services on a routine basis, in CYE 2014, AHCCCS prioritized the development of tools for the purpose of assessing members' support needs for directing their care under this option. The following are examples of those monitoring tools.

- Developed a Case Manager refresher training to ensure Case Managers are able to support members/IRs to make informed choices about electing member-directed options.
- Developed tools to educate Case Managers on how to assess whether or not a member/IR is fulfilling their respective roles and responsibilities and how to determine the need for additional support
- Developed a provider assessment tool that helps providers and Contractors assess whether or not a provider agency is fulfilling its respective roles and responsibilities and whether or not additional technical assistance is required.

In CYE 2015 and CYE 2016, AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools, but implementation was postponed to CYE’s 2018, 2019 and 2020 to align with the person-centered planning outlined in a forthcoming section. The aforementioned Case Manager training and tools have been incorporated into the person-centered planning initiative. In CYE 2019, the new standardized person-centered planning document and case manager training addressed documentation standards and strategies to support members in making an informed choice about any of the member-directed options (including Agency with Choice). Additionally, the document and training will support Case Managers on how to assess whether or not a member/IR is fulfilling their respective roles and responsibilities and how to determine the need for additional support. Furthermore, in CYE 2020, the AHCCCS policy will incorporate standard policy and procedure requirements for provider agencies utilizing this member-directed option specific to their roles and responsibilities pertaining to the monitoring of the Partnership Agreement between the agency and member and communication protocols aimed at ensuring the members have the supports they need to be successful employing the model. The Contractors will monitor these standards during the annual quality monitoring visit.

The Agency with Choice policy can be found on the [AHCCCS website](#).

In CYE 2019, 2,469 members utilized this member-directed option, a 14% decrease from the previous year. It is important to note, a total of 209 (8%) members utilize the combination of the Agency with Choice and Spouse as Paid Caregiver service model options.

The chart below is an eight-year summary of the annual percentage change of the membership’s utilization of the Spouse as Paid Caregiver service model option, the Self-Directed Attendant Care and Agency with Choice member-directed options. Reduction in utilization of the Agency with Choice member-directed option has resulted in the strategies noted above with respect to case manager training and the revised person-centered planning document.

Service Model Options – Annual Percent Change								
Annual % Change in Utilization	CYE 2012	CYE 2013	CYE 2014	CYE 2015	CYE 2016	CYE 2017	CYE 2018	CYE 2019
Spouse as Paid Caregiver	28%	0%	6%	6.5%	0%	10%	5%	-2%
Self-Directed Attendant Care	22%	9.5%	18%	9%	-13%	12%	9%	-6%
Agency with Choice ²			67%	10.5%	-5%	-5%	-10%	-14%

² Agency with Choice was implemented in CYE 2013 with a total of 1,945 members electing the service model option.

- ***Community Transition Service***

The implementation of the Community Transition Services option was approved by CMS in 2010. This service provides financial assistance to members to move from an ALTCS long term care institutional setting to their own home or apartment. The option offers up to \$2,000 to defray transition costs such as security and utility deposits for an apartment or home, essential furnishings, or other moving expenses. Contractors also provide assistance to members who may experience financial challenges that present barriers to making a transition into a home or apartment in the community. This is not an uncommon scenario because, during their tenure in the nursing facility, the discretionary income members receive is limited to the special needs allowance. It may take a few months for the share of cost to be reduced to zero after the member has transitioned out of the nursing facility. In these circumstances, Contractors may assist the member with obtaining Section 8 housing or moving into homes that have month-to-month leasing opportunities versus a requirement upfront for first and last month's rent. Members may also receive financial assistance from family members to make the transition.

In an effort to support a member's affordable housing needs, beginning October 1, 2017, AHCCCS required all Contractors to have a designated housing expert that is responsible for identifying housing resources and building relationships with contracted housing providers and public housing authorities for the purposes of developing innovative practices to expand housing options and, furthermore, assisting case managers in making appropriate referrals for members in need of housing. The housing expert is required to monitor and maintain a list of members with affordable housing needs to inform these efforts, including reporting outcomes of the housing referrals.

- ***Community Intervener Service***

AHCCCS is developing a new ALTCS service for members with a dual sensory loss (both vision and hearing); it is planned to be effective October 1, 2020. Individuals with a combined vision and hearing loss may have their physical health, mental health, safety, and welfare impacted by their impairments. The Community Intervener service will provide visual, auditory, and environmental information to members which they are unable to gather on their own and that supports them to lead self-directed lives. Community Interveners are paraprofessionals with specialized training that will support members to access and receive intervention and skill building support related to:

- Communication
- Information
- Environment
- Social/Emotional Support
- Activities

In CYE 2018, AHCCCS held two stakeholder forums with members, families, and other stakeholders with expertise in serving individuals with a dual sensory loss. The purpose of the forums was to share information about similar services adopted

by other State Medicaid Programs and to solicit information that could assist policy development including setting parameters for the scope of the service, medical necessity requirements, and workforce development standards. In CYE 2019, AHCCCS utilized the input from the stakeholder forums as well as additional meetings with dual sensory loss subject matter experts to inform the development of the draft policy parameters, including the development of an assessment tool to determine medical necessity.

- **Prior Period Coverage For HCBS**

Since 2006, Contractors have been allowed to cover HCBS services for “Prior Period Coverage” enrollment. This allows applicants to have HCBS services covered by the Contractor during the period between application and determination of eligibility. Such coverage allows greater flexibility in the choice of a service site. Persons awaiting discharge from hospitals can go directly back to their own home, with coverage of those services paid for once eligibility is determined and enrollment is complete.

- **Home and Community Based Services Litigation: *Ball v. Betlach***

In January 2000, a class action lawsuit *Ball v. Biedess* (later amended to *Ball v. Betlach*) was filed on behalf of EPD members enrolled in the ALTCS Program concerning the availability of critical in-home services. Critical services are Attendant Care, Personal Care, Homemaker and Respite services which provide bathing, toileting, dressing, feeding, and transferring to or from beds or wheelchairs, and assistance with other similar daily activities. In addition to other claims, Plaintiffs alleged a violation of 42 USC 1396a(a)(30)(A), the Medicaid Equal Access provision. A Settlement Order in this matter was approved by the Federal District Court in October 2012. Nevertheless, this case had been in litigation for more than a decade and had been appealed to the Ninth Circuit Court of Appeals on two separate occasions. Below is a brief summary of the major events.

In 2004 the Federal District Court concluded that AHCCCS failed to provide members with equal access and ordered that AHCCCS provide each individual who qualifies for critical services with those services without gaps in service. The following year the Federal District Court issued an Order which required AHCCCS to eliminate gaps in critical in-home services within 2 hours and mandated that ALTCS Contractors have back-up staff available. AHCCCS was also required to file monthly reports of gaps in critical services with the Court and to implement an expedited grievance process where members could contact a hotline.

Two years later, in 2007, the Ninth Circuit Court of Appeals concluded that Congress did not intend to create a private right of action under 42 USC 1396a(a)(30)(A), reversing the District Court. In 2010, the District Court ordered AHCCCS to establish a single toll free hotline for members to report gaps and to modify all relevant contracts, forms, and policies to explicitly require that ALTCS Contractors have back-up workers available. (From October 2010 to September 2013 the hotline received less than 5 calls each month concerning gaps in services).

Mediation was subsequently explored. After several assessment conferences were scheduled by the Court of Appeals, the parties agreed to settle the litigation in principle. A fairness hearing was scheduled in early October 2012, and on October 30, 2012, the Federal District Court approved the Proposed Settlement Agreement. As part of the Settlement, AHCCCS agreed to provide Plaintiffs an additional 24 months of gap reports and 2 annual reports. If the aggregate rate of gaps for authorized services is 0.1% or more for two consecutive months, Plaintiffs can request a meeting with AHCCCS to address the concerns, and, if not satisfied with AHCCCS' efforts, Plaintiffs may seek judicial intervention. If no judicial enforcement action was pending at the end of the 25th month following approval of the Settlement, the case would be dismissed.

As required by the Settlement Agreement, AHCCCS continued to file monthly gap reports which remained very low: The percentage of gap hours remained in the 0.05% - 0.08% range. Pursuant to the federal District Court Order dated October 26, 2012, the Court retained jurisdiction of this case through December 2014 for the purpose of hearing any issues regarding alleged violations of the terms of the Settlement Agreement. The Settlement Agreement provided for limited Court jurisdiction through the end of the 25th month following approval of the Settlement. No allegations of violations were presented, and because no judicial enforcement action was filed by Plaintiffs in December 2014, the Court no longer retained jurisdiction of the matter after December 2014 and the case was dismissed in its entirety. Gap Reports to Plaintiffs' counsel were no longer required after November 2014.

The average monthly occurrence of a gap in critical service, for the period of October 1, 2018-September 30, 2019, was 0.04% which is within the historical low range (0.01 - 0.08 range).

To perform ongoing review of the delivery of critical care services, AHCCCS continues to require Contractors to monitor monthly instances of gaps in services and submit a Quarterly Gap in Critical Services Log. In addition a Semi-Annual Report must be submitted which outlines trends in service delivery and any corrective actions implemented regarding gaps in services and grievances related to service gaps. Contractors use the analysis to work with providers to ensure that members receive services appropriately and to inform network development.

AHCCCS is leveraging the Electronic Visit Verification (EVV) mandate to develop a more streamlined reporting to ensure, track and monitor timely service delivery and access to care for members. AHCCCS is currently working with the State's EVV vendor to make system customizations and standard reports to assist providers, Contractors and AHCCCS in using EVV to mitigate access to care challenges. This include mechanisms to track and monitor the time it takes for members to receive a

service once it has been determined to be medically necessary as well as monitoring scheduled service visits versus occurrences of late or missed visits.

CONTRACTOR INITIATIVES

The Contractors engage in a number of initiatives aimed at ensuring members are living in the most integrated setting as well as participating in community life. The following are examples of those initiatives.

One Contractor contracts with a primary care provider (PCP) group that provides primary care to members in their own homes, in assisted living facilities, and in skilled nursing facilities. The group added a new type of worker in the community setting called a Community Health Worker (CHW). The CHW is a frontline public health worker who is recruited from the community and has a grassroots understanding of services available in the communities they serve. CHWs have a cultural awareness of the needs of the community and help to fill a potential void in communication between the PCP and the member. PCPs refer CHWs to members that require ongoing education about a disease process or assistance with following the provider’s treatment plan. The CHWs provide services that meet specific member needs. They can include: on-demand virtual visit with the PCP; assistance with non-medical community resources such as grocery delivery or utility assistance; coaching of healthy behaviors such as smoking cessation or a healthy diet; supporting the prevention and the control of chronic diseases such as review of blood sugar monitoring or sodium restrictions; providing social support; and monitoring blood pressure, pulse oximetry, temperature and weight. This additional support from the CHW engages members with the care they need, where they need it; it simplifies the delivery of their medical care and helps them achieve better health.

One Contractor has collaborated with a community partner to help members recover entitled income in an effort to help them transition from a nursing facility (SNF) to their own home or another community-based setting. Some members were identified as being eligible for unrecognized income through the Social Security Administration (SSA) or the Veteran’s Administration (VA). For example, Case Managers and the community partner met with unmarried members without income who lived in nursing facilities. This agency helped members identify potential income and assisted members in completing and submitting the paperwork. As a result of this partnership, members became eligible for and started to receive benefits from the SSA and VA. Members were able to have more choices, direct their own care, and meet their goals. As a result of these efforts, the Contractor has been able to discharge over ten members into the community from a SNF.

One Contractor continues to support members through the Member Advisory Councils to host annual “Abilities Workshops” events. The Abilities Workshops provide an opportunity to share information regarding housing resources, returning back to work or volunteerism, and educational opportunities as well as health and wellness topics with presentations given by representatives from community agencies or other professionals. This year, the workshops focused on providing an opportunity to promote, prepare, and support presentations delivered by our Members. Council Hosts and Case Managers

helped members prepare their topics, assisted with creating their material, and provided coaching tips. In Maricopa County, the theme was *me being me** and the Member Key Note Speaker was inspirational to everyone in the room, as supportive comments were readily shared by the audience: “*I will not give up because of Mark;*” “*His life story and how he talked about being me...he made a difference to me;*” “*Mark gave me a vision of life.*” The Key Note Speaker set the stage for the second presenter, another Member-led topic pertaining to shopping for the household economically, where information was provided about online applications and other resources that can help stretch dollars.

One Contractor promotes the contributions of members in the local arts community. The Contractor contracts with The Opportunity Tree, a business that employs 10 members to create art in the form of candle holders, called candle “blocks.” Weighing about three pounds each, these decorative objects made of masonry and stone are sold exclusively at Taliesin West in Scottsdale and are among the gift shop’s best-selling items. The Taliesin Project allows members to be gainfully employed as artists.

One Contractor is a recipient of a Section 811 Project Rental Assistance program grant from Housing and Urban Development (HUD) which enables individuals with disabilities who are income and ALTCS-eligible to live in integrated, affordable housing. As part of the Contractor’s broader efforts around affordable housing, during this reporting period a total of 36 members moved into affordable housing with three members receiving rental subsidies through the voucher program. Of the 36 members housed, two members made progressive housing moves from Adult Developmental Homes that resulted in a cost savings over \$32,000. From the conception of the Contractor’s Affordable Housing program (from October 1, 2017 to September 30, 2019) a cumulative cost savings of over \$570,000 has resulted. These affordable housing opportunities have made a huge impact in their lives, promoting choice and a sense of community, rescuing members from domestic violence, substandard living, financial crisis, homelessness, housing instability, and enabled members to make progressive moves into the community. Stable housing has improved self-reported health outcomes including uninterrupted sleep, reduced the stress from constantly moving, and a decrease in seizure activity.

AHCCCS ADMINISTRATION AND OVERSIGHT

The following is a summary of other activities that touch on broader long-term care issues, but also address HCBS as a component. Some of these activities involve collaborative efforts with other Arizona state agencies, while others are exclusive to AHCCCS and its Contractors.

- ***Arizona State Hospital (AzSH) Coordination***

On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) merged with AHCCCS in an effort to streamline monitoring and oversight of the Regional Behavioral Health Authorities throughout Arizona. Prior to the transition, ADHS/DBHS was responsible for oversight and monitoring of members who were conditionally released from the AzSH. AHCCCS is

now responsible for this function and requires Contractors to develop and implement policies and procedures to provide high touch Contractor care management and other behavioral health and related services to each member on conditional release from AzSH consistent with the member's Court Ordered Conditional Release Plan. As stated in Contract, Contractors actively participate in the member's discharge plan prior to release. Contractors are not permitted to delegate the care management functions to a subcontracted provider and must submit a monthly comprehensive status report for each member on Conditional Release to the Psychiatric Security Review Board (PSRB), the member's attorney and to the designated AHCCCS Medical Management (MM) staff. AHCCCS staff participate in a phone discussion with Contractors regarding each member following receipt of the monthly report to ensure any potential compliance issues are thoroughly investigated. Issues of noncompliance are reported immediately by the Contractor to the PSRB, the member's attorney and AHCCCS designated staff.

- ***Long Term Care Case Management***

Each ALTCS-enrolled member receives case management services provided by a qualified Case Manager. ALTCS Case Managers utilize a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice.

Case Managers conduct regular home visits with HCBS members to ensure quality services are being provided without gaps; to determine the services necessary to meet the member's needs, while in the most integrated setting; to provide member specific education to the member and his/her family; and to introduce alternative models of care delivery when appropriate.

The following are examples of how Case Managers execute their aforementioned roles and responsibilities.

- **Member-Directed Options Information:** Case Managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.
- **End of Life Care:** Case Managers educate members/families on End of Life Care, which encompasses all health care and support services provided at any age or stage of an illness.
- **Serious Mental Illness Determinations:** Case Managers assess for the appropriateness of and submit referrals for members to receive a Serious Mental Illness Determination and, once affirmed, ensure members receive entitled services including grievance and appeals processes.
- **Cost Effectiveness Analysis:** Case Managers assess the continued suitability, appropriateness, and cost effectiveness of the member's in-home services. HCBS placement is the goal for ALTCS members as long as cost effectiveness standards and the member's medical, functional, social and

behavioral health needs can be met in that setting. The Case Manager regularly assesses the cost of the HCBS services and compares them to the estimated cost of institutionalized care. Placement in an HCBS setting is considered cost effective if the cost of HCBS services for a specific member does not exceed 100% of the net cost of institutional care for that member.

- **Non-Medicaid Service Coordination:** Case Managers identify and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs, including community resources/services that support members in achievement of personal or independent living goals.
- **Goal Development:** Case Managers assist members to develop meaningful and measureable goals, including personal and independent living goals. Case managers also provide members with information about local resources to help them transition to greater self-sufficiency in the areas of housing, education and employment, as well as identify goals and preferences around the areas of recreation, friendships, and family relationships.

Contractors are required to submit a Case Management Plan and Evaluation on an annual basis which addresses how the Contractor will implement and monitor case management and administrative standards outlined in AHCCCS policy including specialized caseloads. Beginning October 1, 2017, new weighted caseload standards for EPD Case Managers serving members determined to have a Serious Mental Illness were established, with an effective date of October 1, 2019. The evaluation of the Contractor's Case Management Plan from the previous year must also be included in the Plan, highlighting best practices, lessons learned and strategies for continuous improvement.

AHCCCS evaluated the Plans that were submitted for CYE 2019 and approved each Contractor's Plan for the delivery of case management and the evaluation of the previous year's activities and outcomes.

In an effort to enhance the person-centered approach and further maximize member/family self-determination, AHCCCS initiated a process to:

- Create alignment of practices, forms and monitoring of person-centered service planning (PCP) approach and personal goal development;
- Support members to have the information and supports to maximize member-direction and determination; and
- Develop processes to document health and safety risks and safeguard against unjustified restrictions of member rights in accordance with the Home and Community Based Settings rules.

In August 2016, AHCCCS entered into an Interagency Service Agreement with the Sonoran University Center of Excellence in Developmental Disabilities (UCEDD) at the University of Arizona, a recognized organization with subject matter expertise in the arena of person-centered service planning. A multi-stakeholder advisory

workgroup has been established to solicit input from members, families, service providers and Contractors. The implementation phases and associated tasks are outlined below through CYE 2020. Phase Three is still in process, but expected to be completed during the next reporting period along with Phases Four and Five. The workgroup continues to meet on a regular basis and will continue to do so throughout the duration of the initiative.

Person Centered Planning Project	
Phase	Tasks
1	<ul style="list-style-type: none"> ▪ Research of best practices for compliance and implementation of the HCBS Rules ▪ Analysis of current practices in planning and functional assessment of DDD and Tribal Contractors
2	<ul style="list-style-type: none"> ▪ Analysis of current practices in planning and functional assessment ▪ Determination of steps necessary to comply with PCP requirements ▪ Provide technical assistance and recommendations for uniform PCP policies, procedures and forms to guide ALTCS/Tribal Contractors in implementing PCP requirements
3	<ul style="list-style-type: none"> ▪ Develop competency-based training for case managers/support coordinators and others on Person-Centered thinking, philosophy and practice
4	<ul style="list-style-type: none"> ▪ Pilot testing for PCP forms, policies, and procedures and training for ALTCS/Tribal Contractor Staff
5	<ul style="list-style-type: none"> ▪ Finalize all policies and procedures ▪ Create educational materials and/or educational sessions for members on Person-Centered Service Planning.

- **Electronic Visit Verification (EVV)**

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement EVV for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) by January 1, 2021³ and for in-home skilled nursing services (home health) by January 1, 2023.

The goals of instituting EVV in the AHCCCS program include:

- Ensuring, tracking and monitoring timely service delivery and access to care for members;
- Reducing provider administrative burden associated with scheduling and hard copy timesheet processing;
- Accommodating the lifestyles of members and their families and the way in which they manage care;
- Accommodating service provider business decisions and preserving existing investment in systems; and,
- Prevention of fraud, waste and abuse.

³ Subsequent to the current reporting period and on December 5, 2019, AHCCCS received approval from CMS to extend the timeline for compliance through 01/01/21.

During the reporting period, AHCCCS engaged in the following major milestones to prepare for implementation of EVV:

- Released, evaluated and awarded the EVV vendor and Independent Verification and Validation (IV&V) vendor contracts.
- Obtained approval from CMS and the Arizona Department of Administration (ADOA), Information Technology Authorization Committee on EVV contracts and budgets.
- Initiated the development of business rules sessions with the selected EVV vendor to meet general and state specific requirements.
- Released a provider survey to support and incentivize provider engagement as well as help solicit data to inform planning and business rule development.

More information on EVV can be found on the [AHCCCS website](#).

- ***Network Development Plans***

Each year, AHCCCS requires that ALTCS Contractors develop an adequate network and submit a Network Development and Management Plan (Plan) to demonstrate their networks meet the needs of ALTCS members they serve. In the Plan, the Contractors identify the current status of the network at all levels (institutional, HCBS, acute, alternative residential, etc.) and project future needs based upon membership growth and changes in member profiles/service needs. As a component of the Network Development Plans, AHCCCS requires Contractors to incorporate a Workforce Development Plan. Additional information on Workforce Development can be found in the subsequent Workforce Development section.

Specifically, AHCCCS requires the Contractor to provide information on many issues relating to network sufficiency in the Plan, including but not limited to the following:

- Evaluation of the prior year's Plan
- Current status of network by service type
- How members access the system
- Relationship between the various levels of the networks
- Current network gaps
- Immediate short term interventions when a gap occurs
- Interventions to fill network gaps, and barriers to those interventions
- Evaluation of the interventions
- Strategies utilized to increase the percentage of members living in their own home
- Any network issues identified during member and provider council meetings
- How the network is designed for populations with special health care needs

AHCCCS requires its ALTCS Contractors to develop and demonstrate the implementation of proactive strategies to reduce the percentage of members in Alternative Residential Settings once it is determined that 20% or more of a Contractor's HCBS membership resides in such settings.

AHCCCS evaluated the Plans that were submitted for CYE 2019 and approved each Contractor's Plan, including the methods for analyzing the network and identifying and addressing network gaps. AHCCCS is in the process of reviewing the plans for CYE 2020.

- ***Monitoring and Oversight***

AHCCCS regularly reviews Contractor operations to ensure compliance with Federal and State law, rules and regulations, the AHCCCS Contract, and AHCCCS Policies. Monitoring activities include review and approval of contract deliverables, regular coordination meetings with Contractors, provision of technical assistance, and both Focused and Operational Reviews. Focused Reviews are conducted based on trending information specific to one Contractor or across Contractors to assess compliance in a specific area of focus and provide targeted technical assistance. Operational Reviews are conducted in order to:

- Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in Contract, AHCCCS Policies, Arizona Revised Statute, Arizona Administrative Code and 42 CFR Part 438, Managed Care.
- Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
- Review progress in implementing recommendations made during prior reviews.
- Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
- Perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 waiver.
- Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

The reviewers utilize established standards based upon statutes, contract terms, and policy requirements. Review of case management standards evaluate compliance with case management staff orientation and training, service reviews which includes member placement, HCBS living arrangements, initial contact and HCBS service initiation, needs assessment and care planning, timeliness of service visits and completion of the cost effectiveness study.

The Operational Reviews are conducted in a three year cycle evaluating each AHCCCS Contractor, including the three EPD and one DDD ALTCS Contractor, once during the cycle. When a Contractor is found to be out of compliance with AHCCCS standards, the Contractor must submit and obtain approval of a Corrective Action Plan (CAP) to address the deficiencies. The process includes a follow-up on the status of each CAP six months after the CAP is accepted. AHCCCS' review of the ALTCS EPD Contractors occurred from February to April 2019. Corrective Action Plans will be monitored until actions are sufficiently completed and the CAPs

are closed. AHCCCS is currently preparing the Operational Review of the DDD ALTCS Contractor, which will include an onsite review in June 2020.

The results of the Operational Reviews are published on the [AHCCCS website](#).

- ***Contractor Administrative Actions***

AHCCCS utilizes a variety of Administrative Actions to address ongoing or serious Contractor noncompliance including mandatory Corrective Action Plans, Notices to Cure, and sanctions. AHCCCS posts any Administrative Actions imposed on a Contractor on the AHCCCS Website.

In 2017, AHCCCS imposed administrative actions on the DES/DDD Contractor related to quality of care requirements and access to timely services through DES/DDD's process for identification and assignment of providers to meet authorized service needs for members. In 2018, AHCCCS imposed administrative actions on the DES/DDD Contractor related to concerns with the Contractor's Quality Management functions and significant noncompliance with contract requirements, as a result of a Focused Audit completed in 2018. Additionally, an administrative action in 2018 was imposed on the DES/DDD Contractor regarding concerns around claims payment issues related to the delivery of Habilitation Consultation (Hab-C) services. In 2019, AHCCCS imposed administrative action on the DES/DDD Contractor related to a claims processing system that is not in line with HIPAA Compliant transactions. These Administrative Actions remain open throughout 2019 and AHCCCS continues to provide enhanced monitoring and technical assistance through monthly meetings with the Contractor to review strategies and progress of actions, barriers and outcome measures as well as an onsite presence to provide direct oversight and guidance.

These Administrative actions can be found on the [AHCCCS website](#).

- ***Direct Care Workforce Development***

Significant activities continue regarding the growing challenges related to ensuring the establishment of an adequate direct care (caregiver) workforce. The foundation for current activities began in March of 2004 when former Governor Napolitano formed the Citizens' Workgroup on the Long Term Care Workforce. The purpose of the Workgroup was to study the issue of the direct care workforce and provide recommendations regarding potential strategies to improve the workforce.

In an effort to address the recommendations outlined in a report issued by the Workgroup in April 2005, AHCCCS, the Department of Economic Security and the Department of Health Services funded and created a Direct Care Workforce Specialist position from 2007 - 2012 to provide coordination for direct care workforce initiatives, including recruitment and retention, training, and raising the qualifications of direct care professionals in Arizona. The Workforce Specialist coordinated the activity of the Direct Care Workforce Committee, which established training and competency standards for all in-home caregivers providing homemaker, personal care and/or attendant care services.

Beginning October 1, 2012, AHCCCS formally incorporated the competency standards, training curriculum and testing protocol into its service specifications for attendant care, personal care and housekeeping. All in-home caregivers are now required to pass standardized examinations based upon the competency standards established by the Committee in order to provide care to ALTCS members in their homes.

AHCCCS and the Contractors continue to conduct initial and annual audits of the Approved Direct Care Worker Training and Testing Programs to ensure the programs are in compliance with AHCCCS standards pertaining to the training and testing of DCWs. Additionally, in 2014, AHCCCS implemented and continually monitors an online database that serves as a tool to support the portability or transferability of DCW testing records from one employer to another employer. The online database also serves a secondary purpose to assist in monitoring compliance with the AHCCCS DCW training and testing initiative.

In CYE 2015, AHCCCS created online computer-based training (CBT) modules to support users to learn how to set up the accounts and enter and access data within the online database. The CBT modules have proven to be an effective technical assistance tool for users. Additionally, AHCCCS and the Contractors formally incorporated the utilization of the online database into monitoring and auditing tools for both Direct Care Service Agencies and Approved Direct Care Worker Training and Testing Programs. Priorities related to revisions to the standardized curriculum, development of alternate standardized competency tests and requirements for DCWs providing respite services to pass the competency tests in order to provide care to ALTCS members continue to be identified for future implementation.

In CYE 2016, AHCCCS initiated a cross-divisional project with the Division of Health Care Management and Provider Registration to identify and develop the following enhancements to the online database scheduled for release in CYE 2020 to follow the release of the new online Provider Management System:

- Institute a crosscheck of DCWs in the database with Provider Registration databases to conduct Medicare and Medicaid exclusion checks
- Distinguish DCWs in the database based upon employment or contracting status with the DCW Agency
- Create additional functionality in the online database to enhance user experience
- Incorporation of an auditor role within the database to streamline tracking and documentation of training program audits by the Contractors and AHCCCS
- Development of new tracking practices and attestations to ensure the information is up-to-date and accurate

Beginning in CYE 2018 in response to ensuring the sufficiency of the long term care workforce, Contractors are required to designate a Workforce Development

Administrator. Further, Contractors are required to submit and monitor a Workforce Development Plan as part of the Network Development and Management Plan to ensure the sub-contracted workforce of paraprofessionals is adequately resourced, stable and capable of providing quality care to members. The Workforce Development Plan must include measures to proactively identify potential challenges and threats to the viability of the workforce as well as develop and implement interventions to prevent or mitigate access to care concerns for members. In addition to developing and implementing specific workforce development interventions, the Contractors have chosen to collaboratively develop and utilize standardized retention metrics for utilization by all providers.

AHCCCS has developed a Workforce Development policy for all lines of business, including ALTCS, in the AHCCCS Contractors Operations Manual found on the [AHCCCS website](#).

In an effort to support long-term care workforce capacity challenges, the State’s Legislature passed and the Governor signed Senate Bill 1244 into law in 2019 to streamline the transition of in-home DCWs to work as a Caregivers in Assisted Living Facilities. Specifically, the statute (A.R.S. 36-446.15) requires the State Board that oversees Caregiver training requirements for Assisted Living Facilities to align the training, competency and testing methodology with the AHCCCS DCW standards. Additionally, the statute permits DCWs to transition to working in Assisted Living Facilities by only having to pass the medication administration training, which is allowable within the scope of practice for an Assisted Living Caregiver and not a DCW. Once the Administrative Rules are finalized, AHCCCS will modify its policy to allow Caregivers to satisfy all competency requirements for DCWs.

As a result of AHCCCS’ prioritization of long term care workforce development, the Agency has been requested to present at a number of national conferences and has been featured in news articles and publications.

As an example, an Arizona Daily Star article may be found [here](#).

The National Association of States United for Aging and Disabilities publication entitled “Collaboration to Address HCBS Workforce Challenges in MLTSS Programs” may be found [here](#).

Detailed information on the direct care workforce initiatives can be found on the [AHCCCS website](#).

- ***Home and Community Based Settings Rules***

On January 16, 2014, CMS released final Rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The Rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long term care services and supports. Specifically, the Rules establish

requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living.

In Arizona, these requirements impact the ALTCS Program members receiving services in the following residential and non-residential settings:

Residential

- Assisted Living Facilities
- Group Homes
- Adult and Child Development Homes
- Behavioral Health Residential Facilities

Non-Residential

- Adult Day Health Programs
- Day Treatment and Training Programs
- Center-Based Employment Programs
- Group-Supported Employment Program

Between November 2014 and May 2015, AHCCCS conducted a systemic assessment of Arizona’s HCBS settings to determine its current level of compliance, provide recommendations for identified variances, and outline a process for continuous monitoring. The systemic assessment process included a review of Arizona Revised Statutes, Arizona Administrative Code (licensing Rules), and AHCCCS and Contractor policies and contracts.

AHCCCS engaged various stakeholders in the assessment process and in the development of the transition plan. A total of 10 stakeholder meetings were held. The purpose of the meetings was to dialogue with and solicit input from stakeholders about the preliminary assessment findings and draft recommendations to ensure compliance with the HCBS Rules. AHCCCS made revisions to the Assessment and Transition Plan based upon the input received. The meetings also served as an orientation for stakeholders and a strategy to support stakeholders in providing informed public comment in August 2015. Following the stakeholder meetings, AHCCCS enacted an official public comment period from August 1 – 31, 2015 which included eight public forums hosted by AHCCCS throughout the state. AHCCCS published the draft Systemic Assessment of Arizona’s HCBS settings and the draft Transition Plan for coming into compliance.

After review and consideration of all public comments, AHCCCS finalized the Assessment and Transition Plan and submitted to CMS for approval in October 2015.

In CYE 2016, AHCCCS prioritized the following site specific assessments in order to determine whether or not it is necessary and prudent to pursue the “heightened scrutiny” process CMS has instituted to allow states to preserve settings that are presumed to have institutional qualities and presumed not to be compliant with the HCBS Rules. Under the heightened scrutiny process, AHCCCS is responsible for identifying such settings and gathering and submitting evidence for CMS to make a

determination as to whether or not the setting is or can become compliant by the end of the transition period. AHCCCS identified the following settings as potential candidates for the heightened scrutiny process:

- **Farmstead Community** – Defined as working ranches in rural areas on large parcels of land. There is one licensed farmstead community in Arizona serving eight members.
- **Memory/Dementia Care Units/Communities** – Defined as settings that provide supervisory and personal care services to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions. There are 79 memory/dementia care units/communities in Arizona serving approximately 1,000 members. A statistically significant number of settings statewide were randomly selected to participate in the assessment process.

The assessments were conducted in October – December 2016.

AHCCCS worked in collaboration with a multi-stakeholder/multi-disciplinary workgroup to create the assessment process and tools. Multi-disciplinary teams were created to conduct the assessments including representatives from case management, quality management and provider relations. In some instances, community members volunteered to participate in assessment activities in accordance with federal privacy guidelines.

The assessment tools include the following:

- Facility Self-Assessment Tool
- Member Interviews and File Review Tool
- Observation and Community Interviews Tool

AHCCCS hosted and conducted three webinars to train the assessment teams on their respective roles and responsibilities for the assessments. AHCCCS also hosted and conducted three webinars to orient the selected facilities on expectations and how to prepare for the assessments.

In CYE 2017, AHCCCS focused on preparing a revised Statewide Systemic Assessment and Transition Plan in response to CMS feedback and recommendations. AHCCCS received “initial approval” for the Plan in September 2017 to ensure the State’s compliance with the HCBS Rules by March 2022. For the period of September 2017 – February 2019, AHCCCS engaged in multiple meetings and/or correspondence with CMS, pertaining to the outstanding requirements for the State to meet order to obtain “final” approval of the Transition Plan.

In February 2019, CMS confirmed the current revisions to the Transition Plan to-date are satisfactory. However, CMS will not officially approve Arizona’s Systemic

Assessment and Transition Plan until after the first round of site specific assessments have been completed, a public comment period is held, and the State's reports to CMS are satisfactory.

In March – May 2019, AHCCCS held a public comment period including stakeholder forums, statewide, to provide information on updates made to the Transition Plan and solicit comments that will be used to help inform the implementation of the Transition Plan. During the public comment period, AHCCCS recruited stakeholders to participate in the setting-specific workgroups to advise on the compliance assessment tools and tool kits for both members and providers. Workgroups were formed to represent each unique setting type and initial meetings started in August 2019.

Detailed information on AHCCCS' activities to comply with the HCBS Rules can be found on the [AHCCCS website](#).

- ***ALTCS Advisory Council***

The ALTCS Advisory Council is comprised of ALTCS Members and their family members/representatives. Additionally, representatives from ALTCS Contractors, providers and state and advocacy agencies serve on the Council. AHCCCS used a Council to help create and implement Agency with Choice, a member-directed option, in 2011-2013. The contributions of the council members were invaluable to the program development and implementation process. With the continued development of new and innovative practices to serve ALTCS members, AHCCCS prioritized the maintenance of the advisory group to identify opportunities for system improvements, assist in the development of the initiatives and support program monitoring and oversight activities. The Council assisted the ALTCS Program in developing a work plan that addresses opportunities for new service innovations or systemic issues impacting ALTCS Members. The work plan for the Advisory Council is AHCCCS' ALTCS Olmstead Plan and, therefore the ALTCS Advisory Council assists in providing oversight on the State's compliance with the Olmstead Plan. Council Members advise AHCCCS on activities aimed at making system improvements. Individual Council members are asked to provide input and feedback on ALTCS program activities from their own personal or professional experience, expertise, or perspective. ALTCS Advisory Council members are encouraged to identify topics for discussion as well as provide input on topics that AHCCCS brings forward to solicit stakeholder input from members.

The ALTCS Advisory Council has advised on the State's compliance with Federal initiatives and service delivery system innovations as well as received information on notable topics of interest including, but not limited to:

Federal Initiatives

- Home and Community Based Setting Rules
- U.S. Department of Labor, Companionship Exemption
- Electronic Visit Verification

Service Delivery System Design

- Role peer supports can play in the ALTCS program
- Integration of aging individuals or individuals with a disability into the long term care workforce
- Contractor standards for identification of provider office accessibility in the Contractor's provider directories
- New Community Intervener Service
- Integrated health care
- Revisions to the Agency with Choice member-directed option policy

Other Notable Topics of Interest

- Reporting quality of care concerns
- Supported Decision Making

- ***Olmstead Plan***

Arizona's initial Olmstead Plan was developed in 2001. In CYE 2014, the Olmstead Plan was reviewed and updated by the Olmstead Policy Academy facilitated by ADHS/DBHS. The Olmstead Policy Academy brought together representatives from government entities, consumers, community members, service providers (health care, independent living and housing providers) and advocates interested in seeing those most in need paired with available housing and supports to integrate into the community.

The Olmstead Policy Academy provided a number of technical assistance and learning opportunities to help inform the planning process to update the Olmstead Plan. The respective state agencies underwent a Plan development and review process with both internal and external stakeholders. Each agency has a consumer advisory board that was engaged and provided input on the agency specific action plans. The ALTCS Advisory Council assisted AHCCCS in developing the AHCCCS/ALTCS specific action plan.

There are still homeless people in Arizona who need a safe place to live. The 2014 Arizona Olmstead plan describes in detail how our community, including government and private funding, will come together to address housing needs. While an over-majority of individuals who are aging and individuals with intellectual and/or physical disabilities are living in integrated settings in their communities, they may not be actively engaged and participating in their communities. The working draft of the Arizona Olmstead Plan outlines how the State can support these individuals to find resources, supports (i.e. assistive technology, employment, etc.) and individuals/agencies to provide the services.

In CYE 2015 – CYE 2016, the final draft remained under review by each of the state agency partners. Prior to finalizing the current draft of the Olmstead Plan, the Plan must reflect changes as a result of the state agency merger between the Arizona Department of Health Services, Division of Behavioral Health Services and AHCCCS in July 2016. It is important to note, that although the Olmstead Plan was

not finalized, the respective agencies have been employing the program, policy and practices outlined in the current draft version. AHCCCS is currently in the process of developing a strategy to resume the Olmstead Planning and finalize a new Plan in CY 2020 that is reflective of both the aforementioned state agency merger and the State's integrated care delivery model that was implemented in October 2018.

Once a final draft is completed, each state agency will initiate their respective public input processes to inform the final revisions to the Plan. Subsequent to the approval of the final and updated Plan, each state agency agreed to actively participate in quarterly Olmstead Policy Academy meetings. The primary purpose of the meetings will be to inform one another of progress made on the agency specific action plans, identify strategies to address any implementation barriers and discuss strategies for collaboration. In addition to the Olmstead Policy Academy meetings, each state agency has developed, at a minimum, annual review processes to monitor and receive input on the Plan implementation from both internal and external stakeholders.

- ***Autism Spectrum Disorder Advisory Committee***

On April 14, 2015, the Governor's Office established a statewide Autism Spectrum Disorder (ASD) Advisory Committee representing a broad range of stakeholders that included providers, Contractors, advocacy groups, and families to address and provide recommendations to strengthen services for the treatment of ASD. The Committee created recommendations from the five workgroups: Early Identification and Diagnosis, Evidence-Based Treatment, Reducing System Complexity, Increasing Network Capacity, and Adults with ASD. In February 2016, the ASD Advisory Committee finalized recommendations which were published to the [AHCCCS website](#).

AHCCCS prioritized these recommendations and is currently in the process of operationalizing the recommendations into short term activities and system level changes. Completed short term activities include, but are not limited to:

- Creating system maps and using consistent terminology across the system;
- Improving access to diagnosis and critical early intervention services;
- Independently registering Board Certified Behavioral Analysts and linking appropriate code set services;
- Creating a behavioral intervention policy;
- Creating specialized diagnosing provider list by Contractor;
- Leveraging Targeted Investments funding for integration;
- Implementation of Habilitation Consultation (Hab-C) by DES/DDD;
- Development of two Centers of Excellence.

For system level changes, the Committee recommended integrating physical and behavioral health care for individuals with ASD. Beginning on October 1, 2018, non-ALTCS members have integrated physical and behavioral care under the AHCCCS Complete Care plans. ALTCS members with Intellectual and developmental disabilities have integrated physical and behavioral health care provided by DDD's

newly awarded sub-contractors beginning October 1, 2019. The ALTCS EPD Contractors have provided a fully-integrated product (long term services and supports, physical and behavioral health care) since the inception of the program. Individuals with ASD may be eligible for any one of these Medicaid programs.

The ASD Advisory Committee continues to meet quarterly and advise on the implementation of the recommendations. Ongoing conversations continue to explore Centers of Excellence for members with ASD and coordination of benefits with third party liability. Additional sub-groups are scheduled as needed to address specific topics or concerns proposed by committee members.

- **Performance Measures**

AHCCCS has developed performance measure sets for all lines of business, including Long Term Care, to further align with the CMS’ Core Sets of Health Care Quality Measures for Medicaid. The measures and related Minimum Performance Standards (MPS) became effective on October 1, 2018 for the contract year ending September 30, 2019. It is AHCCCS’ goal to continue to develop and implement additional Core Measures, including Managed Long Term Services and Supports (MLTSS) focused performance measures, as the data sources become valid and reliable. Current measures were chosen based on a number of criteria, which include greatest need for members, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business. Two sets of measures (including those in reserve status) are shown below - the first for the EPD membership, the second for the DES/DDD membership. AHCCCS uses the designation of “reserve status” to refer to performance measures for which AHCCCS is interested in receiving data for the purposes of tracking and trending, but has decided to withhold any regulatory action on at this time. It is important to note for the measures where a “baseline measurement year” is indicated, AHCCCS will develop a MPS once baseline data has been analyzed for each measure.

Elderly/Physically Disabled Measures	
Measure	MPS
Inpatient Utilization – General Hospitalization/Acute Care	205 Per 1,000 Member Months
Ambulatory Care - ED Utilization	73 Per 1,000 Member Months
Plan All-Cause Readmissions	14%
Follow-up After Hospitalization for Mental Illness, 7 Days	60%

Elderly/Physically Disabled Measures	
Measure	MPS
Follow-up After Hospitalization for Mental Illness, 30 Days	85%
Mental Health Utilization	TBD
Use of Opioids at High Dosage in Persons Without Cancer	TBD
Comprehensive Diabetes Care – HbA1c Testing	86%
Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%)	43%
Comprehensive Diabetes Care – Eye Exam	55%
Flu Vaccinations for Adults - Ages 18 – 64 yrs, 65 yrs and Older	18-64 years - 75% 65 years and older – 75%
Advance Directives	65%
Diabetes Short-Term Complications Admission Rate	20 Per 100,000 Member Months
Adults' Access to Preventive/Ambulatory Health Services	85%
Annual Monitoring for Patients on Persistent Medications: Combo Rate	87%
Breast Cancer Screening	55%
Colorectal Cancer Screening	65%
Concurrent Use of Opioids and Benzodiazepines	Baseline Measurement Year
Developmental Screening in the First Three Years of Life	55%
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Baseline Measurement Year
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Baseline Measurement Year

Elderly/Physically Disabled Measures in Reserve Status	
Measure	MPS
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	90 Per 100,000 Member Months
Heart Failure Admission Rate	128 Per 100,000 Member Months
EPSDT Participation	68%
Percentage of Eligibles Who Received Preventive Dental Services	46%

DES/DDD Performance Measures	
Measure	MPS
Annual Monitoring for Patients on Persistent Medications: Combo Rate	87%
Asthma Medication Ratio	Baseline Measurement Year
Inpatient Utilization – General Hospitalization/Acute Care	48 Per 1,000 Member Months
Ambulatory Care - ED Utilization	43 Per 1,000 Member Months
Plan All-Cause Readmissions	10%
Adults' Access to Preventive/Ambulatory Health Services	85%
Breast Cancer Screening	55%
Cervical Cancer Screening	30%
Chlamydia Screening in Women	57%
Colorectal Cancer Screening	65%
Advance Directives	65%
Use of Opioids at High Dosage in Persons Without Cancer	TBD

DES/DDD Performance Measures	
Measure	MPS
Comprehensive Diabetes Care - HbA1c Testing	86%
Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)	43%
Comprehensive Diabetes Care - Eye Exam	55%
Concurrent Use of Opioids and Benzodiazepines	Baseline Measurement Year
Flu Vaccinations for Adults - Ages 18 – 64 yrs, and Older	18-64 years - 75% 65 years and older – 75%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Baseline Measurement Year
Children's Access to PCPs, by age: 12-24 mo.	95%
Children's Access to PCPs, by age: 25 mo.-6 yrs.	87%
Children's Access to PCPs, by age: 7-11 yrs.	90%
Children's Access to PCPs, by age: 12-19 yrs.	89%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life: 3-6 yrs.	66%
Adolescent Well-Care Visit: 12-21 yrs.	41%
Annual Dental Visits: 2-20 yrs.	60%
Percentage of Eligibles Who Received Preventive Dental Services	46%
Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	TBD
Developmental Screening in the First Three Years of Life	55%
Initial Visit Within 30 Days for Members Newly Identified with a CRS Condition	75%
<i>Childhood Immunization Status</i>	
DTaP	76%
IPV	88%
MMR	89%
Hib	88%

DES/DDD Performance Measures	
Measure	MPS
HBV	88%
VZV	88%
PCV	77%
Hepatitis A	85%
Rotavirus	65%
Influenza	45%
Combination 3 (4:3:1:3:3:1:4)	68%
Combination 7	50%
Combination 10	25%
<i>Immunizations for Adolescents</i>	
Adolescent Meningococcal	85%
Adolescent Tdap/Td	85%
Human Papillomavirus Vaccine (HPV)	25%
Combination 1	85%
Combination 2	21%

DES/DDD Measures in Reserve Status	
Measure	MPS
Diabetes Admissions, Short-Term Complications	5 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	10 Per 100,000 Member Months
Heart Failure Admission Rate	5 Per 100,000 Member Months
Asthma in Younger Adults Admission Rate	6 Per 100,000 Member Months
Weight Assessment and Counseling – Body Mass Index (BMI) Assessment for Children/Adolescents	50%
EPSDT Participation	68%

- **Performance Improvement Projects**

In addition to performance measures, AHCCCS also implements Performance Improvement Projects (PIPs) to drive member health outcomes and improve Contractor performance on selected state and national health care priorities. ALTCS members were included in the PIP reported below.

- *Long Term Services and Supports (LTSS) - Assessment and Care Planning:*
The purpose of this PIP is to establish a foundation that provides insight into the Contractors' current levels of performance (including the identification of notable areas needing improvement) and promote the evaluation/engagement of interventions aimed towards enhancing the Contractors' performance related to LTSS/MLTSS assessment and care planning through newly developed Center for Medicaid and CHIP Services and CMS measures. The baseline measurement period for the PIP is CYE 2018. AHCCCS is currently in the process of internal collaboration, data review, and validation of the CYE 2018 PIP data. As such, baseline rates and additional details are anticipated to be included within 2020 reporting.

HCBS GROWTH AND PLACEMENT

ALTCS program enrollment increased by 5% from CYE 2018. The most significant growth (5.4%) in membership occurred within the DES/DDD program, compared to 4.8% growth in the EPD membership. The following table highlights the membership breakdown by placement setting type.

In CYE 2019, despite the population growth experienced in the ALTCS program overall, the percentage of members residing outside of a nursing facility remained consistent with the trend in recent years at 88%. This successfully sustained rate is largely attributable to the service options and HCBS activities available to members, which are addressed in this report.

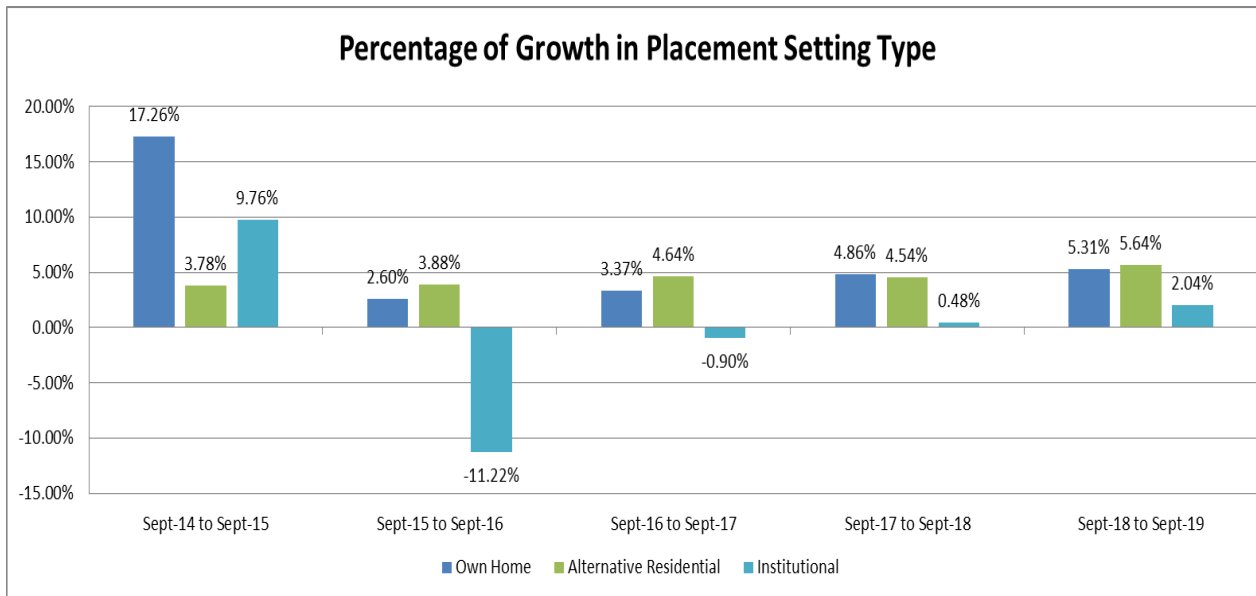
Membership Breakdown by Placement Setting Types - September 30, 2019						
Setting	Banner University Family Care	Mercy Care Plan	United HealthCare	DES/DDD	Total Membership	% of Total Membership
Own Home	3,255	6,077	4,541	26,205	40,078	62.52%
Assisted Living	1,498	2,786	2,959	16	7,259	11.32%
Group Home	0	4	4	3,151	3,159	4.93%
Developmental Home	0	1	0	1,539	1,540	2.40%
Behavioral Health Residential Facility	86	158	62	3	309	0.48%
Acute Services Only	95	189	169	3,450	3,903	6.09%
Total Membership in HCBS Placements	4,934	9,215	7,735	34,364	56,248	87.75%
Skilled Nursing Facility	1,807	2,897	1,990	39	6,733	10.50%
Institution for Mental Disease	0	1	1	0	2	0.00%
Residential Treatment Center	0	1	0	0	1	0.00%
ICF-ID	0	0	0	108	108	0.17%
Behavioral Health Inpatient Facility	0	7	15	0	22	0.03%
Total Membership in Institutional Settings	1,807	2,906	2,006	147	6,866	10.71%
Placement Data Not Available	63	749	118	56	986	1.54%
Total Membership	6,804	12,870	9,859	34,567	64,100	100.00%

The following chart outlines the distribution of placement setting type⁴ for the period of September 2009 through September 2019. Since 2009 the proportion of members residing in their own homes increased from 49% to 70%, while the proportion of the members residing in institutions declined from 31% to 11%. At the same time, the proportion of members residing in alternative residential settings remained stable in the range of 18-20%. This continues to demonstrate the program’s commitment to advancing initiatives which result in the shift of placement for EPD and DES/DDD members to community-based placements.

Statewide Placement Percentage by Setting											
	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15	Sep-16	Sep-17	Sep-18	Sep-19
Own Home	49%	50%	65%	65%	66%	66%	68%	69%	69%	70%	70%
Alternative Residential	20%	21%	20%	20%	20%	20%	18%	19%	19%	19%	19%
Institutional	31%	29%	16%	15%	14%	14%	14%	12%	12%	11%	11%
Total Membership	100%	100%	101%	100%	100%	100%	100%	100%	100%	100%	100%

The following graph shows the percentage of growth for each placement setting type experienced since September 2014. This represents an almost equal growth of members living in their own home and those living in an alternative residential setting and indicative of the growth in the overall membership growth in CYE 2019.

⁴ The number of individuals receiving acute services only is captured in the “own home” category. Further, the number of individuals for which placement data is not available is not reflected in the data.



The following table presents information detailing member placements broken down by three age⁵ groupings (0-21, 22-64 and 65 plus) as of the conclusion of CYE 2019 (September 30, 2019). Consistent with the historical trend, the number of members in the 65 year and older age group compose the highest proportion of members residing in institutional settings (24%). Conversely, the 0-21 year age group has the lowest proportion of members residing in institutional settings (0%). Only 10% of members 22-64 years of age reside in institutional settings.

ALTCs Placement by Age Group				
	0-21	22-64	65+	TOTAL
Own Home	21,151	13,726	9,104	43,981
Alternative Residential	688	5,080	6,499	12,267
Institutional	20	2,041	4,805	6,866
TOTAL	21,859	20,847	20,408	63,114
	0-21	22-64	65+	TOTAL
Own Home	97%	66%	45%	70%
Alternative Residential	3%	24%	32%	19%
Institutional	0%	10%	24%	11%
TOTAL	100%	100%	100%	100%

-- End of the Report --

⁵ The number of individuals for which placement data is not available is not reflected in the data.