



## **ARIZONA LONG TERM CARE SYSTEM**

# **ANNUAL HCBS REPORT CY 2015**

**(10/1/14 – 09/30/15)**

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Division of Health Care Management**



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# **ANNUAL HCBS REPORT – CYE 2015**

(10/01/2014 – 09/30/2015)

## **INTRODUCTION**

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a long-term care program through the Managed Care Organizations (Contractors) including the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) that strongly supports 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, in recent years AHCCCS continues to see an increase of members residing in their own homes and institutional placements continue to remain constant (even with increases in population) the past three years after a marked decline over the course of Contract Years Ending (CYE) 09-CYE12.

The AHCCCS Administration has accomplished these milestones by its Arizona Long Term Care System (ALTCS), a long term care program that promotes and adheres to the values of:

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

Guiding principles have also been 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/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining his/her goal(s) for achieving or maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

- *Member-Directed Options*

To the maximum extent possible, members should be afforded the opportunity to exercise responsibilities in managing their personal health and development by making decisions about how best to have their needs met including who will provide the service and when and how the services will be provided.

- *Consistency of Services*

Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and the Contractor.

- *Accessibility of Network*

Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed by the Contractors to meet members' needs which are not limited to normal business hours.

- *Most Integrated Setting*  
Members are to live in the most integrated setting. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- *Collaboration With Stakeholders*  
The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

Members and families are afforded the opportunity to actively participate in the selection of services that will best meet their needs. HCBS and other applicable settings are available to an individual as long as the cost of HCBS services 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. The Olmstead Plan is available on the AHCCCS web page located at <http://azahcccs.gov/reporting/Downloads/OlmsteadPlan.pdf>. Current efforts to update and regularly monitor the progress of the Olmstead Plan are outlined in subsequent sections of this report.

In Contract Year Ending 2015 (CYE 2015) the ALTCS program experienced a small population growth for individuals served by DES/DDD which resulted in an increase to the number of members residing in their own homes. The percentage of members residing outside of a nursing facility remained 86 percent, marking the sixth year in a row that the percentage has exceeded 70 percent. This growth is largely attributable to the service options and HCBS activities addressed in this report.

The information that follows details efforts and initiatives aimed at improving the 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 members<sup>1</sup>.

**Daniel** has overcome many obstacles in the past six years including nearly losing his life due to valley fever in 2011. Daniel moved into an Assisted Living Center in August 2011 after rehabilitation in a Skilled Nursing Facility. He has taken great strides to improving his health and quality of life. With the assistance of nutritional counseling, gastric by-pass surgery and regular exercise Daniel has lost 250 pounds. During the same time period, Daniel changed from a very shy person with no desire to interact with others outside of his family to joining the garden club, making friends and enjoying community outings. Today, Daniel enjoys visits home with his family while adhering to and maintaining his healthy eating habits. A few weeks ago after a ten year lapse in employment, Daniel

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<sup>1</sup> 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.

become employed as a dishwasher after receiving vocational rehabilitation services and supports to develop skills and prepare for employment. He independently rides the bus to work. Daniel continues to enhance his social life through activities facilitated by the Assisted Living Center and is interested in dating.

**Steve**, after experiencing a debilitating stroke just before turning 50 years of age, has put maximum effort into his rehabilitation. In addition to physical therapy he regularly exercises in an athletic facility to gain strength and lose weight. He has progressed from residing in a Skilled Nursing Facility an Assisted Living Center to now living in an apartment with a roommate. Steve is supported to living independently with attendant care services and vehicle modifications which enable him to drive. Steve has an active social life and is also involved with the local Independent Living Center. He volunteers and serves other individuals with disabilities through teaching classes on independent living. Steve's future goal is to expand on his culinary skills, that he developed prior to the stroke, to open a café at the Independent Living Center.

**Antonio** is 21 years old and has been an ALTCS member since the age 9. He has muscular dystrophy, chronic obstructive pulmonary disease and utilizes an electric wheelchair for mobility. Antonio lives with his parents and receives attendant care services. He graduated from high school with honors and will soon be graduating from Arizona State University with a major in Astrophysics. He looks forward to pursuing further interests in space and science. In order for Antonio to get to school independently, he had a goal to obtain a van with a wheelchair lift. The Case Manager connected him with the local Independent Living Center and, through that resource; he was able to find an accessible van. As a result, Antonio was able to use transportation independently. His family drives him to the local Metro Station so he can independently commute to school.

**Robby** is a graduate of Prescott High School. As part of his school transition program, Robby was exposed to several different employment opportunities. His final stop was at New Frontiers, a natural foods grocery store. It turned out it was a great fit for him and the store offered him a job when he graduated in 2010. In 2014, New Frontiers became Whole Foods. Robby transitioned seamlessly to the new logo and the new management. Recently, the new General Manager at Whole Foods talked to Robby and told him that she thought he could do more than bagging and janitorial tasks. She gave Robby the option of choosing to work in the meat, deli or produce departments. Robby choose the produce department accepting both the promotion and raise. Visit the following website to find out more about Robby: <http://www.youtube.com/watch?v=LzGO0jWaqeM>

**Robert** is now a full time Yavapai County employee after starting his employment journey in a day treatment and training program. As a result of his full time employment, he purchased a home and is excited about the plans for his future. Visit the following website to find out more about Robert: <https://vimeo.com/133190355>

**Daniel** is 59 years old and, as a result of an injury while a teenager, he is paralyzed from the neck down. Daniel had the support of family, friends and others who encouraged him to go back to school. Daniel graduated and obtained his Master's Degree in Public Administration. His Case Manager shared with him the Arizona Disability Benefits 101 website ([www.az.db101.org](http://www.az.db101.org)) to learn about how individuals with disabilities can work, earn income and maintain important benefits such as long term care services. He is now employed part time. Daniel utilizes his achievements to encourage other ALTCS members to go to work. Recently, Daniel shared his story at the Pima Advisory Council meeting. He is an example of how individuals can enhance their quality of life by working and earning income.

**Serina** suffers from lupus, chronic kidney disease, depression and occasional episodes of pancreatitis. Serina attended the Contractor's Abilities Workshop and learned about the Arizona Disability Benefits 101 website ([www.az.db101.org](http://www.az.db101.org)) and how individuals with disabilities can continue to receive Medicaid benefits while working. As a result, she told her Case Manager that she was very impressed by the Workshop and wanted to set a personal goal to learn how to use a computer. Serina worked with her Case Manager to develop a detailed me\* (Member Empowerment) goal. The Case Manager assisted Serina to meet her two goals for completing a Dial-a-ride application and enrolling in a computer class with the City of Mesa. Serina finished the 3 week course in record time and received a Certificate of Completion. Serina has now set a new me\* goal of finding a job.

## **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 an Attendant Care service option which allows a spouse, who is qualified to provide basic health care services to their husband or wife, to be compensated for providing Attendant Care services. Per the Arizona's 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. This service is part of Arizona's Olmstead Plan. The Spouse as Paid Caregiver waiver information can be found on the AHCCCS website at <http://azahcccs.gov/reporting/federal/waiver.aspx>.

In CYE 2015, 1,391 members received paid services from their spouse, a 6.5 percent increase from the previous year.

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

SDAC is Arizona's initiative designed to provide a Member-Directed Care option for ALTCS HCBS members. The service option became available on September 1, 2008.

SDAC offers ALTCS members or their representatives the choice of directly hiring and supervising their own attendant care workers, 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 qualified fiscal agents who perform 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 Direct Care Worker. 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 attendant care worker. A member can now direct their attendant care worker 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 at: <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1300.pdf>.

In CYE 2015, 416 members elected this service, a 9 percent increase from the previous year.

- **Agency with Choice**

On January 1, 2013, AHCCCS implemented and instituted a new member-direct option, the Agency with Choice member-directed option. 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 participate in the Agency with Choice option. 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 who would also like the support offered by a provider agency. For provider agencies, the new 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, AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools, but implementation was postponed to CYE 2016 to align with other program development activities.

The Agency with Choice policy can be found on the AHCCCS website at: <http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1300.pdf>.

In CYE 2015, 3,584 members elected this service option, a 10.5 percent increase from the previous year. It is important to note, a total of 257 (7%) members utilize the combination of the Agency with Choice and Spouse as Paid Caregiver options.

- ***Community Transition Service***

The implementation of the Community Transition Services option was approved by the CMS in 2010. This service provides financial assistance to members to move them 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.

- ***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.

- ***Prior Quarter Coverage for HCBS***

Beginning January 2014, AHCCCS members can be determined to have "Prior Quarter Coverage" eligibility and have health care coverage as early as three months prior to the month the prospective member applied for services. In order to be eligible for "Prior Quarter Coverage," the prospective member must have received one or more AHCCCS covered services and would have met AHCCCS qualifications for eligibility at the time services were received.

- ***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 E/PD members enrolled in the ALTCS Program concerning the availability of critical in-home services. Critical services include 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 .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 25<sup>th</sup> 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 .05-.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 25<sup>th</sup> month following approval of the Settlement. No allegations of violations had been presented, and unless a judicial enforcement action had been filed by Plaintiffs in December 2014, the Court would no longer retain jurisdiction of this matter after December 2014 and the case would be dismissed in its entirety. Gap Reports to Plaintiffs' counsel were no longer required after November 2014.

To perform ongoing review of the delivery of critical care services, AHCCCS continues to require Contractors to submit a monthly report outlining instances of gaps in services. The Semi-Annual Report outlines trends and corrective actions regarding gaps in services and grievances related to service gaps. Contractors use the analysis to drive network development and to work with providers to ensure that members receive services appropriately.

The average monthly occurrence of a gap in service, for the period of 10/01/14-09/30/15 was .07% which is very low and consistent with the historical low range (.05-.08 range).

- **Arizona State Hospital Transition Workgroup**

The ALTCS Contractors meet with staff from AHCCCS and the Arizona State Hospital on a quarterly basis. The purpose of these meetings is to discuss discharge plans for the most difficult to place clients currently residing as inpatients at the facility. The clients typically not only have severe behavioral problems, which necessitate specialized community placements, but also have serious and chronic medical conditions. Virtually all have been admitted to the hospital on court orders. These members eventually reside in HCBS settings such as small group homes dedicated to members with similar behavioral challenges. Network enhancements and active coordination of care practices by the Contractors have resulted in timely discharges to appropriate settings and a low recidivism rate.

In CYE 2014, a new form was created and initiated to streamline the client staffing process. This transition form has allowed for an increase in targeted discussion for individualized planning, while utilizing an effective use of time to more readily discuss core clinical criteria for each patient.

## **CONTRACTOR INITIATIVES**

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

- One Contractor implemented the use of the Healthify software and phone application for Case Managers to have resource information accessible while in the field. All Case Managers have the application loaded on their cell phone. The Case Manager simply enters a city, county or zip code and the type of resource they are searching and the application brings up the various resources that meet the request. In addition to searching for community resources on the phone application, the Case Managers are required to enter new resources into Healthify to further expand the Healthify library. The locally sourced information supports Case Managers to provide members with resources in their local community that can assist them with furthering independence and personal goals.
- One Contractor hosted their 3rd Annual Health Fair for members. The purpose of the Health Fair was to encourage their members to participate in and take ownership of their health care. The health fair served as a “One Stop Shop” for medical tests, screenings, and health education. A total of 166 members attended the health fair and, as a result, a total of 618 current care gaps were addressed for those members including tests (i.e. Diabetic Eye Exams), vaccines (i.e. Flu Vaccines) and screenings (i.e. Body Mass Index). Member participation increased by 38% over the previous year’s event. In addition to the health services and information members received, members commented that the Health Fair was an opportunity for them to get dressed up, get out and meet new people.
- One Contractor has directly engaged Case Management staff in the direct monitoring of reportable health measures for members on their caseload. This allows the Case Managers to provide support to members to set up appointments with their Primary Care Physician. Specifically, a performance measurement tool was created to identify all of the labs, exams, and screening a member needs to monitor and improve his/her health condition. At each visit with the member, the Case Manager discusses the tool and leaves a copy for them to give to their Primary Care Physician at the next appointment.

- One Contractor has created a Palliative Care for Dementia Program (Dementia Program). It is a joint venture between the Contractor and a Hospice provider. The goal of the Dementia Program is to decrease the overall costs for maintaining members in the community by focusing on decreasing hospitalizations and nursing home placement, minimizing medications, maximizing member comfort in the home and to provide support to the member and family. The Dementia Program educator works in collaboration with the Case Manager to help maintain the member in their own home for as long as possible. The program is not hospice service and does not replace the services provided by the primary care provider (PCP). To that end, the Dementia Program includes home visits from a dementia educator, phone support from a physician (Geriatrician), psychiatric nurse practitioner, and a clinical pharmacologist. The palliative care staff assesses and documents a member's cognitive and functional levels. Further, they discuss the goals of care and assist with completion of Advance Directives. Lastly, they provide a 24/7 phone support line for caregivers that is operated by either a nurse or social worker. Additionally, caregivers receive education on:
  - Disease progression & common complications
  - Behaviors & sleep issues
  - Recognizing delirium, dysphagia & pain
  - Methods to connect beyond words (sensory)
  - Preparing for further decline

## AHCCCS ADMINISTRATION AND OVERSIGHT

The following is a summary of other activities that touch on broader long-term care issues, but do 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.

- ***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 their 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.
- **Cost Effectiveness Analysis:** Case Managers assess the continued suitability 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 services and compares them to the estimated cost of institutionalized care. Placement in the setting is considered cost effective if the cost of

HCBS services for a specific member does not exceed 100 percent 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. Case Managers are also responsible for assisting members in identifying independent living/personal goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education, employment, recreation and socialization.

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. 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 2015 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 support Case Managers to fulfill their roles and responsibilities AHCCCS worked in tandem with the ALTCS Contractors to adjust case management case load formulas. The previous formulas did not account for significant workload requirements that have increased over the years for ALTCS Case Managers. New standards were implemented for Institutional, HCBS, and Assisted Living case loads that reduced the maximum allowable members per case load allowing for increased case management staffing. The new standards were successfully adopted by all MCOs and incorporated in CYE 2014 contracts with an effective date of April 2015.

The following represents the **new** weighted caseload values, (the old weights have been inserted for comparison). It is important to note that a Case Manager's caseload (overall) cannot exceed a weighted value of 96. Additionally, there were no changes to the case load weights for members who only receive Acute Care services.

**For members residing in their own home (Own Home):**

A weighted value of (*previous* - 2.0) **2.2** is assigned. Case managers may have up to (*previous* - 48) **43** HCBS members ( $43 \times 2.2 = 96$ )

**For members residing in an Assisted Living Facility (ALF):**

A weighted value of (*previous* - 1.6) **1.8** is assigned. Case managers may have up to (*previous* - 60) **53** ALF members ( $53 \times 1.8 = 96$ )

**For members only receiving Acute Care services (ACO):**

A weighted value of **1.0** is assigned. Case manager may have up to **96** Acute Care Only members ( $96 \times 1.0 = 96$ )

**For members residing in an institutional setting (NF):**

A weighted value of (*previous* - 0.8) **1.0** is assigned. Case managers may have up to (*previous* - 120) **96** institutionalized members ( $96 \times 1.0 = 96$ )

If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

$$\begin{aligned} & \text{(# of Own Home members x 2.2)} \\ & \quad + \\ & \quad \text{(# of ALF members x 1.8)} \\ & \quad + \\ & \quad \text{(# of ACO members x 1.0)} \\ & \quad + \\ & \quad \text{+ (# of NF members x 1.0)} \\ \hline & = 96 \text{ or less} \end{aligned}$$

In CYE 2015, the AHCCCS Medical Management/Case Management Unit revised the Case Management Operational Review (OR) tool. The purpose was to consolidate the oversight of the Contractors and better evaluate compliance with all case management standards versus select standards during the OR process. The oversight of the Contractors for all standards occurs on an ongoing basis throughout the contact year. For example, AHCCCS monitors timeliness standards for visitations through a deliverable report outside of the OR process. The new enhanced OR process incorporates all standards including how the Contractor incorporates those standards into their respective policies and procedures. For example, AHCCCS incorporated into the OR process a review of the Contractors policies and procedures for timeliness standards related to initial contact, assessment, service initiation and ongoing reassessment visitations. Additionally, during the OR process, AHCCCS reviews compliance with timeliness standards through case file audits. The new tool will be implemented for the upcoming Operational Review cycle scheduled for CYE 2016.

- **Network Development Plans**

AHCCCS requires that ALTCS Contractors develop an adequate network and submit Network Development and Management Plans (Plans) to demonstrate that their networks meet the needs of ALTCS members. These Plans 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.

The Plan requires the Contractor to develop information on the following:

- Evaluation of the previous year's Plan
- Current status of network
  - 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
- Outcome measures/evaluation of interventions
- Ongoing activities for network development
- Coordination between Contractor departments and outside organizations, including member/provider councils
- Specialty populations
- Membership growth and utilization of services given the characteristics of the population

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

AHCCCS evaluated the Plans that were submitted for CYE 2015 and have approved each Contractor's Plan and the methods for analyzing the network and identifying and addressing network gaps.

- ***Operational Reviews***

AHCCCS regularly reviews its Contractors to ensure that their operations and performance is in compliance with Federal and State law; rules and regulations; and the AHCCCS Contract. 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.
- Increase AHCCCS knowledge of the Contractor's operational encounter processing procedures.
- 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 use a process approved by the Centers for Medicare and Medicaid Services (CMS) utilizing established standards based upon contract terms with AHCCCS Contractors. Review of case management standards evaluate compliance with case management staff orientation and training; service review which includes member's placement, HCBS living arrangement, HCBS service authorizations, needs assessment, timeliness of service visits and cost effectiveness study. This review also includes an interview of selected Case Managers to determine understanding of case management roles and responsibilities, member service options, coordination of services, how to access resources, member goal setting etc. and to evaluate the effectiveness of the Contractor's orientation and ongoing training.

From September 2013 to August 2014, AHCCCS conducted an Operational Review of each AHCCCS Contractor including the three E/PD and one DDD, ALTCS Contractors for compliance with these requirements. When the Contractor was found to be out of compliance with AHCCCS standards, the Contractor was required to submit a Corrective Action Plan (CAP) to address the deficiencies. Throughout CYE 2015 AHCCCS conducted follow up on these CAPs. Any open CAPs will remain in effect until the next Operational Review, scheduled for early 2016.

- ***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 care givers 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 Direct Care Workers. Additionally, in 2014, AHCCCS implemented and continually monitors an online database that serves as a tool to support the portability or transferability of Direct Care Worker testing records from one employer to another employer. The online database also serves a secondary purpose to assist in monitoring compliance with the AHCCCS Direct Care Worker training and testing initiative.

In CY 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 MCOs 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 Direct Care Workers providing respite services to pass the competency tests in order to provide care to ALTCS members continue to be identified for future implementation, as well as utilization of the online database to crosscheck Direct Care Workers with Medicare and Medicaid exclusions lists.

Detailed information on the direct care workforce initiatives can be found at the following link: [www.azahcccs.gov/dcw](http://www.azahcccs.gov/dcw).

- **TEFT Grant**

The demonstration grant for Testing Experience and Functional Assessment Tools in Community-Based Long-Term Services and Supports, known as TEFT, is designed to test quality measurement tools and demonstrate e-health in Medicaid long term care services and supports. The TEFT grant funding was awarded on April 1, 2014 and will conclude on March 31, 2018. Year One was designated to develop work plans outlining all grant components, which mapped implementation Years Two through Four.

The purpose of the TEFT grant is to support States in furthering adult quality measurement activities under section 2701 of the Patient Protection and Affordable Care Act. The TEFT grant

advances the development of two national, rigorously tested tools that can be used across all beneficiaries using Community-Based Long Term Services and Supports (CB-LTSS), an area in need of national measures. Additionally, the grant offers funding and technical support to demonstrate the use of a Personal Health Record (PHR) and test new electronic standards for interoperability among long term services and supports data.

Arizona has selected both ALTCS populations (individuals who are elderly, have physical and/or developmental disabilities) to participate in the Member Experience of Care Survey and the testing of the FASI (Functional Assessment Standardized Items) tool. Arizona was initially participating in the HITECH components also (Personal Health Record and Electronic Long Term Services and Supports Standards); however, a change in Agency direction resulted in the state discontinuing those two components as of December 2015. During Year Two, Arizona received results from the Round One Experience of Care Survey and worked to complete planning efforts related to FASI tool with Round One testing to be conducted in Summer 2016.

Arizona had a 19.3 percent response rate to the Round One Experience of Care survey. Both E/PD and DES/DDD members participated in the survey process, which included face-to-face and phone interviews by an independent third party. Results from the survey are below:

### Arizona Mean Scores for Composite Measures, by Program and All Programs Combined

Composite Measure	DD		EPD		Programs Combined	
	Score	n	Score	n	Score	n
Getting Needed Services From Staff	92.4	46	95.5	117	93.9	163
How Well Staff Communicate and Treat You	90.1	43	92.9	120	91.5	163
Case Management	▼85.0	44	▲98.2	111	91.6	155
Choosing Your Services	85.2	47	90.3	117	87.7	164
Transportation	91.1	47	85.7	120	88.4	167
Personal Safety	98.2	49	99.2	122	98.7	171
Community Inclusion and Empowerment	80.1	49	80.8	122	80.5	171

▲ This program's score is **above** the average score for all HCBS programs (statistically significant at the  $p \leq 0.05$  level).

▼ This program's score is **below** the average score for all HCBS programs (statistically significant at the  $p \leq 0.05$  level).

- **Home and Community Based Settings Rules**

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final Rules regarding requirements for home and community based services (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 Arizona Long Term Care Services (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 Managed Care Organization (MCO) 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 by the end of the projected five year transition period in October 2021.

After review and consideration of all public comment, AHCCCS finalized the assessment and transition plan and submitted to CMS for approval in October 2015. AHCCCS is currently awaiting feedback and approval from CMS on its Systemic Assessment and Transition Plan.

Detailed information on the Systemic Assessment and Transition Plan can be found at the following link: [www.azahcccs.gov/hcbs](http://www.azahcccs.gov/hcbs).

### • ***ALTCS Advisory Council***

The ALTCS Advisory Council is made up of ALTCS Members and their family members/representatives. Additionally, representatives from ALTCS Contractors, providers and state and advocacy agencies also 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. As the ALTCS program continues to develop new and innovative practices to serve 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 is AHCCCS' Olmstead Plan agency-specific action plan. Council Members advise AHCCCS on activities aimed at making the 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.

In CY 2015, the ALTCS Advisory Council was instrumental in advising AHCCCS on the following initiatives:

- Home and Community Based Setting Rules (HCBS Rules)– provided input on the residential and non-residential setting member and provider surveys for the purposes of assessing baseline data on Arizona’s compliance with the HCBS Rules.
- U.S. Department of Labor, Companionship Exemption – provided input on strategies to use when educating members about potential decisions they may have to make regarding the Direct Care Workers providing their care as a result of a Direct Care Service Agency’s decision to comply with the new Fair Labor Standards Act regulation.

Additionally in CY 2015, an ALTCS Advisory Council member was appointed to the State Medicaid Advisory Committee.

- ***Olmstead Plan***

Arizona’s initial Olmstead Plan was developed in 2001. In CY 2014, the Olmstead Plan was reviewed and updated by the Olmstead Policy Academy facilitated by the Arizona Department of Health Services, Division of Behavioral Health Services (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. Each state agency (ADHS/DHBS, AHCCCS and DES/DDD) 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 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 developmental and physical disabilities are living in integrated settings in their communities, they may not be actively engaged and participating in their communities. The 2014 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.

The final draft continues to undergo a review by each of the three state agency partners. It is projected that in CY 2016, the final draft will be completed. Once a final draft is completed, each state agency will initiate their respective public input processes to garner input from the public and 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 hosted and facilitated by ADHS/DBHS. 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.

- ***Department of Labor, Companionship Exemption***

Beginning January 1, 2015, a new federal rule was enacted by the United States Department of Labor (DOL) that impacts agencies employing Direct Care Workers (DCWs) to provide in-home services like attendant care, personal care, homemaker, habilitation and respite services.

- The new rule requires agencies to pay DCWs overtime (a rate not less than time and one-half their regular rates of pay) for any hours worked over 40 hours per week. *For example*, if a DCW makes \$9.00 per hour, they must get paid \$13.50 for each hour worked over 40 hours per week.
- The new rule also requires the agencies to pay the DCWs for the time they spend traveling from work with one member to work with another member. The travel time is considered hours worked and, therefore, included in a 40 hour work week.

It is important to note that the new rule does not change the number of medically necessary services and service hours authorized by the Case Manager.

Over CYE 2015, AHCCCS participated in numerous technical assistance webinars provided by DOL, Centers for Medicare and Medicaid Services and the National Resource Center for Participant Directed Services. Additionally, AHCCCS routinely engaged with Contractors, providers and the ALTCS Advisory Council to discuss the potential unintended consequences of the ruling on member choice and Direct Care Service Agency viability.

Priorities for CYE 2016 include:

- Issuing an educational letter to members regarding the ruling and, in order to preserve member choice, the potential to make new decisions about the DCWs providing their care.
- Reviewing and monitoring data provided by the Contractors regarding the impact, to members and DCWs, of Direct Care Service Agencies and Fiscal Intermediaries compliance with the ruling (i.e. disallowance of DCWs to work for more than 40 hours per week).
- Monitoring Contractor reports that outline providers who have either eliminated a service or reduced a scope of work as a result of the impacts of these services and inability to provide these services at the current rates.
- Incorporating language in policy stipulating a service provider's compliance with the rule has no bearing on a member's assessed needs and corresponding authorized services and service hours.
- Requiring Contractors to institute additional measures for Case Managers to monitor the health and safety of members who had to make new decisions about the DCWs providing their care to mitigate any unintended consequences.

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

On April 14, 2015, the Governor's Office established a statewide ASD Advisory Committee representing a broad range of stakeholders that included providers, health plans, advocacy groups, and families to address and provide recommendations to strengthen services for the treatment of Autism Spectrum Disorder (ASD). The Committee created recommendations out of 5

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 their recommendations which were published to the AHCCCS website: <https://www.azahcccs.gov/shared/ASD.html>

AHCCCS is now tasked with prioritizing and operationalizing these recommendations into short term activities and system level changes. Short term activities include, but not limited to, creating communication plans, using consistent terminology, and improving access diagnosis and critical early intervention services. For system level changes, the Committee recommended integrating physical and behavioral health care for individuals with ASD. AHCCCS, with assistance from DES/DDD, has convened an operational team with a variety of subject matter experts to assist in the development of the project plan.

The ASD Advisory Committee will continue to meet quarterly and advise on the implementation of recommendations.

- ***Performance Measures***

AHCCCS is currently modifying performance measure sets for all lines of business, including Long Term Care which includes HCBS members, to further align with the CMS' Core Set of Adult Health Care Quality Measures for Medicaid. The measures and related Minimum Performance Standards/Goals became effective on October 1, 2013 for the contract year ending September 1, 2014. The AHCCCS decision to transition to a new measure set was partially driven by a desire to align with measure sets such as the Adult Core Measure Set, Meaningful Use and other measure sets being implemented by CMS. It is AHCCCS' goal to continue to develop and implement additional Core Measures as the data sources become valid and reliable. Initial 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. The measures are shown below which are specific to Long Term Care and HCBS members.

Measure	MPS	Goal	Methodology
Inpatient Utilization	TBD	TBD	HEDIS - IPU
ED Utilization	TBD	TBD	HEDIS - AMB (Ambulatory Care)
Readmissions within 30 days of discharge	TBD	TBD	Adult Core
Follow-up After Hospitalization within 7 Days	50%	80%	Adult Core
Follow-up After Hospitalization within 30 Days	70%	90%	Adult Core
Adults' Access to Preventative/Ambulatory Health Services	75%	90%	HEDIS - AAP
<b>Comprehensive Diabetes Management</b>			
-- HbA1c Testing	83%	91%	Adult Core
-- LDL-C Screening	75%	91%	Adult Core
-- Eye Exam	60%	68%	HEDIS
Diabetes Admissions, short-term complications	TBD	TBD	Adult Core
<b>Flu Shots for Adults</b>			
Ages 18-64	55%	80%	AHCCCS
Ages 65+	60%	80%	AHCCCS
Chronic Obstructive Pulmonary Disease Admissions	TBD	TBD	Adult Core
Congestive Heart Failure Admissions	TBD	TBD	Adult Core
EPSDT Dental Participation	46%	56%	CMS 416 data will be used (Line 12.a./Line 1.b.)
EPSDT Participation	68%	80%	CMS 416 will be used (Line 10)
Advance Directives	55%	75%	AHCCCS
Screening for Clinical Depression and Follow-Up Plan	TBD	TBD	Adult Core

TBD – AHCCCS will develop MPS and Goals once baseline data has been analyzed for these measures

AHCCCS reports Performance Measures specific to the EPD (individuals with physical disabilities and individuals who are aging) population. These measures include members in home and community-based settings. The Performance Measures are as follows:

- **EPSDT Participation:**

AHCCCS utilized the methodology developed by the Centers for Medicare and Medicaid Services (CMS) for the Form 416 Report on participation in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services among members younger than 21 years of age during the contract year. This measurement includes HCBS members. For the measurement period of CYE 2014, the overall rate of EPSDT visits among members enrolled with ALTCS Contractors was 36.7 percent, a statistically significant decrease when compared with 42.4 percent in the previous year. It is important to note that due to the nature of the populations served, the EPD Contractors (serving individuals with physical disabilities and individuals who are aging) serve smaller numbers of children and adolescents compared to DDD.

### ALTCS PLANS - EPSDT Participation, CYE 2014

*Minimum Performance Standard = 68%*

Contractor	Total who Should Receive at least 1 Screening	Number with at least 1 Screening	Percent with at least 1 Screening	Relative Percent Change	Statistical Significance
Bridgeway LTC	83	36	43.4%	9.8%	P=.615
	81	32	39.5%	n/a	
DES/DDD	14767	5407	36.6%	-14.7%	<b>P&lt;.001</b>
	12893	5532	42.9%	n/a	
United Healthcare	97	25	25.8%	54.6%	P=.122
	96	16	16.7%	n/a	
Mercy Care Plan LTC	253	105	41.5%	33.3%	<b>P=.011</b>
	302	94	31.1%	n/a	
<b>TOTAL</b>	15200	5573	36.7%	-13.6%	<b>P&lt;.001</b>
	13372	5674	42.4%	n/a	

Shaded rows represent data from the previous measurement period

- **EPSDT Dental Participation:**

In addition to EPSDT Participation, AHCCCS also utilizes the Form 416 report to generate EPSDT Dental Participation rates, based on members' receipt of preventive dental care. CYE 12 was the first year that this measure was formally calculated.

For the measurement period of CYE 2013, the overall rate of EPSDT dental participation among members enrolled with ALTCS Contractors was 40.4 percent, a statistically significant increase when compared with 36.6 percent in the previous year.

## EPSDT Dental Participation

Contractor	Total Eligible	Total who rec'd at least One Service	Percent with at least One Dental Service	Relative Percent Change*	Statistical Significance*
Bridgeway LTC	85	29	34.1%	78.6	<b>P=.025</b>
	89	17	19.1%	n/a	n/a
DES/DDD	15139	6587	43.5%	6.6	<b>P&lt;.001</b>
	15256	6226	40.8%	n/a	n/a
United Healthcare	99	3	3%	-76.4%	<b>P=.011</b>
	109	14	12.8%	n/a	n/a
Mercy Care Plan LTC	259	116	44.8%	20.0%	P=.067
	328	122	37.2%	n/a	n/a
<b>TOTAL</b>	15582	6735	43.2%	6.9%	<b>P&lt;.001</b>
	15782	6379	40.4%	n/a	n/a

Shaded rows represent data from the previous measurement period

AHCCCS has established contractual Minimum Performance Standards (MPS) for these measures. For any of the measures for which ALTCS Contractors did not meet the MPS, AHCCCS requires Corrective Action Plans (CAPs). AHCCCS will approve and monitor implementation of the CAPs. AHCCCS also continues to monitor Contractor quality-improvement activities related to these measures through submission of annual Quality Assessment/Performance Improvement Plans and Evaluation reports. AHCCCS provides ongoing technical assistance to Contractors to help them improve rates.

- **Performance Improvement Projects**

In addition to performance measures, AHCCCS also implements performance improvement projects (PIPs) to drive member health outcomes and boost Contractor performance on selected state and national health care priorities. HCBS members were included in the PIP reported below.

- *E-Prescribing*: The purpose of this Performance Improvement Project (PIP) is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions which are submitted electronically, in order to improve patient safety. The baseline measurement period for this PIP was CYE 2014. AHCCCS has provided baseline rates to Contractors.

E-Prescribing Improvement Project  
 Number of Providers Prescribing at least one prescription by ALTCS  
 E/PD Plans  
 October 1, 2013 through September 30, 2014

ALTCS E/PD HEALTH PLANS Age 0-64 years			
Health Plan	Number of providers prescribing at least one prescription	Number of providers prescribing at least one prescription electronically	Percent of Providers who prescribed at least one prescription electronically
Bridgeway	1,767	662	37.46%
Mercy Care	4,102	1,883	45.90%
United Health Care	3,025	1,435	47.44%
<b>Total</b>	<b>5,869</b>	<b>2,545</b>	<b>43.36%</b>

E-Prescribing Improvement Project  
 Number of Providers Prescribing at least one prescription by ALTCS  
 E/PD Plans  
 October 1, 2013 through September 30, 2014

ALTCS EP/D HEALTH PLANS Age 65+ years			
Health Plan	Number of providers prescribing at least one prescription	Number of providers prescribing at least one prescription electronically	Percent of Providers who prescribed at least one prescription electronically
Bridgeway	887	306	34.50%
Mercy Care	2,306	1,118	48.48%
United Health Care	1,561	715	45.80%
<b>Total</b>	<b>3,193</b>	<b>1,424</b>	<b>44.60%</b>

E-Prescribing Improvement Project  
 Number of Prescriptions Prescribed by ALTCS-EPD  
 October 1, 2013 through September 30, 2014

ALTCS HEALTH PLANS Age 0-64 years			
Health Plan	Total Number of prescriptions prescribed	Total Number of prescriptions prescribed electronically	Percent of prescriptions prescribed electronically
Bridgeway	21,308	4,937	23.17%
Mercy Care	64,868	14,926	23.01%
United Health Care	38,873	10,549	27.14%
<b>Total</b>	<b>21,308</b>	<b>4,937</b>	<b>23.17%</b>

E-Prescribing Improvement Project  
 Number of Prescriptions Prescribed by ALTCS-EPD  
 October 1, 2013 through September 30, 2014

ALTCS HEALTH PLANS Age 65+ years			
Health Plan	Total Number of prescriptions prescribed	Total Number of prescriptions prescribed electronically	Percent of prescriptions prescribed electronically
Bridgeway	9,521	1,632	17.14%
Mercy Care	24,633	6,573	26.68%
United Health Care	14,870	4,175	28.08%
<b>Total</b>	<b>34,154</b>	<b>8,205</b>	<b>24.02%</b>

## HCBS GROWTH AND PLACEMENT

The ALTCS program experienced a 2.7% in population growth from CYE 14. The largest percentage of growth (4.8%) in membership was experienced by DES/DDD compared to a total .05% in growth for the Contractors serving individuals with physical disabilities and individuals who are aging (EPD). The following table highlights the membership breakdown by placement setting types. It is important to note, the following table also outlines a new structure for capturing and reporting membership and placement data in an effort to ensure consistency across all tables and graphs in this reports. For example, members receiving acute care only services are included in the “own home” data. Similarly in the institutional placement category, the “other” data is a catchall category for placement data including the number of individuals for which placement data is unavailable at the point in time and the number of members residing in Behavioral Health Inpatient Facilities and Institutions for Mental Disease. This formula is carried forward in all of the reports presented below. Therefore, changes in the year to year comparison data are impacted. The descriptions include notes to describe the impact of the new formula on the data presented. Year to year comparison data presented in subsequent reports will be consistent.

Setting	Bridgeway Health Solutions	Mercy Care Plan	United HealthCare	DES/DDD	Total Membership	% of Total Membership
Own Home <sup>2</sup>	2,462	6,016	4,973	24,112	37,563	67.83%
Assisted Living	1,652	2,114	2,232	15	6,013	10.86%
Group Home	0	103	30	2,720	2,853	5.15%
Developmental Home	0	5	0	1,348	1,353	2.44%
<b>Total Membership in HCBS Placements</b>	<b>4,114</b>	<b>8,238</b>	<b>7,235</b>	<b>28,195</b>	<b>47,782</b>	<b>86.28%</b>
Skilled Nursing Facility	1,294	2,909	2,397	48	6,648	12.00%
Other <sup>3</sup>	20	400	114	189	723	1.31%
ICF-ID	1	0	1	127	129	0.23%
Behavioral Health Residential Facility	27	51	22	0	100	0.18%
<b>Total Membership in Institutional Placements</b>	<b>1,342</b>	<b>3,360</b>	<b>2,534</b>	<b>364</b>	<b>7,600</b>	<b>13.72%</b>
<b>Total Membership</b>	<b>5,456</b>	<b>11,598</b>	<b>9,769</b>	<b>28,559</b>	<b>55,382</b>	<b>100.00%</b>

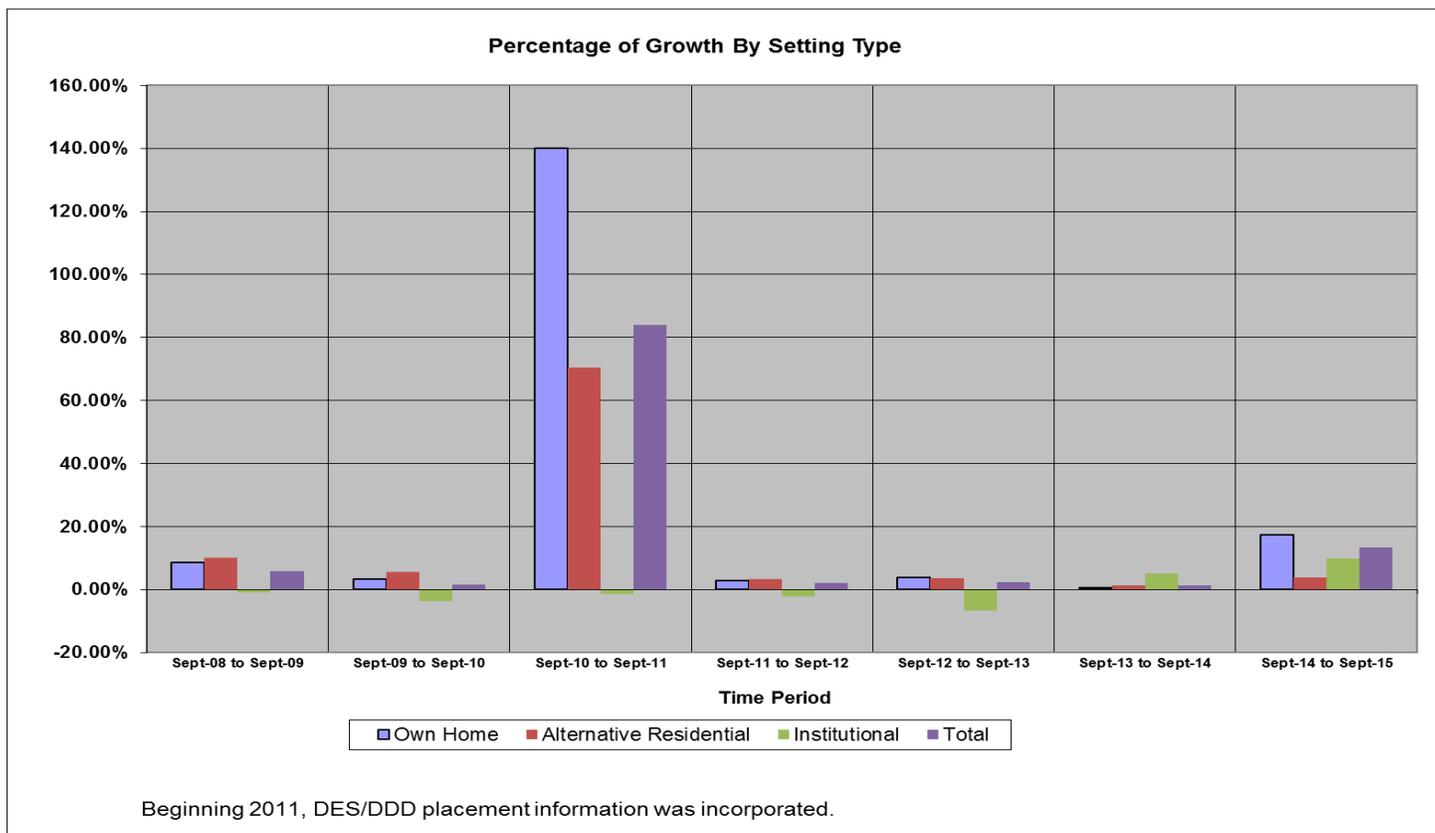
The following chart outlines the distribution of placement setting type for the period of September 2009 through September 2015. Since 2009 the proportion of members residing in their own homes increased from 49% to 68%, while the proportion of the members residing in institutions declined from 31% to 14%. At the same time, the proportion of members residing in alternative residential settings remains the same with the exception of a September 2015 decreased by 2%. This continues to demonstrate the shift in placement for E/PD and DES/DDD members towards more community-based placements while institutional placements continue to remain constant (even with increases in population) at 14% over the past three years.

<sup>2</sup> Incorporates the account of members receiving acute services only

<sup>3</sup> Incorporates the number of members for which placement data is not available at this point in time. Additionally, the category includes the number of members placed in Behavioral Health Inpatient Facilities and Institutions for Mental Disease. The number of individuals residing in the latter settings was too low to report data while ensuring health care information privacy protections.

Statewide Placement Percentage by Setting							
	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15
Own Home	49%	50%	65%	65%	66%	66%	68%
Alternative <sup>4</sup> Residential	20%	21%	20%	20%	20%	20%	18%
Institutional	31%	29%	16%	15%	14%	14%	14%
<b>Total</b>	<b>100%</b>						

The following graph shows the percentage of growth for each placement setting type experienced since September 2009. The represented growth of members living in their own home is indicative of the growth that was seen in the overall population for DES/DDD in CFY 2015, the majority of whom are living in their own homes. Additionally, the individuals who are receiving acute services only are now represented in this category. The sub-population was not previously captured in the “own home” placement category. Similarly, the represented growth in institutional placements is solely due to the incorporation of the “other” data (catchall) category, as noted in the introductory paragraph, for placement data including the number of individuals for which placement data is unavailable at the point in time and the number of members residing in Behavioral Health Inpatient Facilities and Institutions for Mental Disease. The number of individuals residing in Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities actually slightly decreased from last year, but not enough of a decrease to be reflected in the chart above noting the distributions of placement setting types.



<sup>4</sup> Includes Assisted Living, Group Homes and Developmental Homes

The following table presents informational detailing member placements based upon three age groupings (0-20, 21-64 and 65 plus) as of the conclusion of CYE 15, September 30, 2015. Consistent with placement data for CYE 14, the number of members in the 65 year and older age group compose the highest proportion residing institutional settings (29%) Conversely, the 0-20 year age group has the lowest proportion of members residing in institutional settings (1%). Only 11% of members 21-64 years of age reside in institutional settings.

<b>ALTCS Placement by Age Group</b>				
	<b>0-20</b>	<b>21-64</b>	<b>65+</b>	<b>TOTAL</b>
<b>Own Home</b>	17,471	11,938	8,153	37,562
<b>Alternative Residential</b>	582	4,467	5,170	10,219
<b>Institutional</b>	204	1,977	5,421	7,602
<b>TOTAL</b>	18,257	18,382	18,744	55,383
	<b>0-20</b>	<b>21-64</b>	<b>65+</b>	<b>TOTAL</b>
<b>Own Home</b>	96%	65%	43%	68%
<b>Alternative Residential</b>	3%	24%	28%	18%
<b>Institutional</b>	1%	11%	29%	14%
<b>TOTAL</b>	100%	100%	100%	100%

End of the Report



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