



Arizona Health Care Cost Containment System (AHCCCS)
Arizona Long Term Care System (ALTCS)
Elderly/Physically Disabled (E/PD)/ Developmentally Disabled (DD)
Performance Improvement Project:
Long Term Services and Supports - Assessment and Care Planning

Creation Date: October 2018

Implementation Date: October 1, 2018

Revision Date: February, 2019

Background: Long Term Services and Supports - Assessment and Care Planning

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). AHCCCS and its 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) settings¹ and promotes independence and choice as fundamental concepts for all members.

Case management is the process that involves reviewing the ALTCS member's strengths and service needs with the member/guardian/designated representative and the case manager. The process includes²:

- Service Planning and Coordination
- Brokering of Services
- Facilitation and Advocacy
- Monitoring and Assessing
- Review and Reassessment

In serving ALTCS members, the case manager shall promote the values of dignity, independence, individuality, privacy, choice and self-determination, and adhere to the ALTCS guiding principles of²:

- Member-Centered Case Manager
- Member-Directed Options
- Person-Centered Planning
- Consistency of Services
- Accessibility of Network
- Most-Integrated Setting
- Collaboration with Stakeholders



The case management review should result in a mutually agreed upon, appropriate, and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting². The service plan shall include identified services and supports, also known as Long-Term Services and Supports (LTSS), which are intended to support the ability of the member to live or work in the setting of their choice, which may include the individual’s home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.³ LTSS may be provided in a variety of settings, including nursing or intermediate care facilities, in the home, or in community-based settings⁴.

Contractors are required to assess that LTSS services a member receives align with those that were documented in the member’s LTSS treatment plan as stipulated within the Managed Care Regulations, Agency Policy, and ALTCS E/PD and DD Contracts^{5/6}. To assist with this monitoring, the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services (CMS) have recently developed measures that provide information about assessment and care planning processes for people receiving LTSS through Contractors, otherwise known as Medicaid Managed Long-Term Services and Supports (MLTSS)⁴.

Purpose:

The purpose of this Performance Improvement Project 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 measures through these newly developed Center for Medicaid and CHIP Services and CMS measures.

AHCCCS Goal:

The goal is to demonstrate a statistically significant increase for each of the included indicators, followed by sustained improvement for one consecutive year.

Measurement Period:

Baseline Measurement	October 1, 2017 through September 30, 2018
Intervention Year	October 1, 2018 through September 30, 2019
First Re-measurement	October 1, 2019 through September 30, 2020
Second Re-measurement	October 1, 2020 through September 30, 2021

Study Question:

What is the percent, overall and by Contractor, of:

- MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements,
- MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements, and



- MLTSS plan members 18 years of age and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days its development.

Eligible Population:

Per the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*; the eligible population varies per indicator.

Population Exclusions:

Per the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*; the population exclusions vary per indicator.

Population Stratification:

The population will be stratified by Contractor.

Sample Frame:

A sample will be selected from all members that meet the eligibility criteria for each indicator per the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*. Noted variations include:

- Measures collected on a Contract Year Ending (CYE) basis (i.e. October 1 through September 30) with an anchor date of September 30 of the measurement year.

Sample Selection:Year 1

A combined randomized sample of 411 members will be selected per Contractor and evaluated to determine the measure rates. The total sample selected will be 453 members which is inclusive of a 10% oversample. The same systematic sample will be used to calculate all included indicators.

Subsequent Years

A combined randomized base sample of 411 members will be selected per Contractor and evaluated to determine the measure rates; however, the total sample population selected will be 453 members which is inclusive of a 10% oversample. If the total population for a specific Contractor is less than 411 members, the entire population will be included, with no oversample selected. The same systematic sample will be used to calculate all included indicators.

Study Definitions



LTSS Assessment - A face-to-face discussion with the member in the home using a structured or semi-structured tool that addresses the member's health status and needs and includes a minimum of nine core elements and may include supplemental elements. There must be documentation that an assessment was conducted face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in another location that is not the member's home, is not permitted except in the following circumstances:

- The member was offered an in-home assessment and refused the in-home assessment (either refused to allow the care manager into the home or requested a telephone assessment instead of an in-home assessment),
- The member is residing in an acute facility (hospital, skilled nursing facility, other post-acute care facility) during the assessment time period, or
- The state regulations exclude the member from a requirement for in-home assessment.

For more detailed information related to the core and supplemental elements referenced above, see Attachment A - LTSS Assessment Core and Supplemental Elements.

LTSS Care Plan - A document or electronic tool which identifies member needs, preferences and risks, and contains a list of the services and supports planned to meet those needs while reducing risks. The document must include evidence that a member agreed to the care plan. A care plan may be called a "service plan" in certain MLTSS plans.

There must be documentation that the care plan was discussed during a face-to-face encounter between the care manager and the member. The care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may not be done by phone except in the following circumstances:

- The member was offered a face-to-face discussion and refused (either refused face-to-face encounter or requested a telephone discussion instead of a face-to-face discussion), or
- The state regulations exclude the member from a requirement for face-to-face discussion of a care plan.

Note: If multiple care plans are documented in the measurement year, use the most recently updated plan.

For more detailed information related to the core and supplemental elements referenced above, see Attachment B - LTSS Care Plan and Care Plan Update Core and Supplemental Elements.

Care Manager - The person responsible for conducting an assessment and care plan with a member. The LTSS organization may designate an organization employee or a contracted employee; the care manager is not required to have a specific type of professional license. Note:



For the purposes of this study, and to reflect the Arizona Medicaid system structure, this includes Case Managers for the ALTCS E/PD populations and Support Coordinators for the ALTCS DD population.

New Members - Members who were newly enrolled in the health plan after May 1 of the year prior to the measurement year (i.e. members enrolled after May 1, 2017 for the CYE 2018 measurement year).

Established Members - Members who were enrolled in the health plan prior to May 1 of the year prior to the measurement year (i.e. members enrolled prior to May 1, 2017 for the CYE 2018 measurement year).

Home - The location where the member lives; may be the member’s residence, a caregiver’s residence, an assisted living facility, an adult-foster care, a temporary residence or a long-term care institutional facility.

Standardized tool - A set of structured questions that elicit member information; may include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the LTSS organization or state to assess risks and needs.

Indicator Criteria:

**Indicator 1: Long-Term Services and Supports (LTSS)
Comprehensive Assessment and Update**

<p>Indicator 1: Percentage of MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements</p>	<p>Numerator:</p> <p><u>Rate 1: Assessment of Core Elements</u> The number of MLTSS plan members who had either of the following:</p> <ul style="list-style-type: none"> • For new members: A comprehensive LTSS assessment completed within 12 business days*, with all nine (9) core elements documented, or • For established members: A comprehensive LTSS assessment completed at least once during the measurement year, with all nine (9) core elements documented. <p><u>Rate 2: Assessment of Supplemental Elements</u> The number of MLTSS plan members who had either of the following:</p>
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	<ul style="list-style-type: none"> • For new members: A comprehensive LTSS assessment completed within 12 business days of enrollment with nine (9) core and at least twelve (12) supplemental elements documented, or • For established members: A comprehensive LTSS assessment completed during the measurement year with nine (9) core and at least twelve (12) supplemental elements documented. <p>Denominator: Systematic sample drawn from eligible population.</p>
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*For the purposes of the *Long Term Services and Supports - Assessment and Care Planning PIP*, Contractors will be measured based on requirements set forth within the document; however, rates will also be generated for applicable Contractor's in alignment with the timeframes included as part of the Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual for reporting purposes.

**Indicator 2: Long-Term Services and Supports (LTSS)
Comprehensive Care Plan and Update**

<p>Indicator 2: Percentage of MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements.</p>	<p>Numerator:</p> <p><u>Rate 1: Care Plan with Core Elements</u> The number of MLTSS plan members who had either of the following:</p> <ul style="list-style-type: none"> • For new members: A comprehensive LTSS care plan completed within 30 days of enrollment, with all nine (9) core elements documented, or • For established members: A comprehensive LTSS care plan completed at least once during the measurement year with all nine (9) elements documented. <p><u>Rate 2: Care Plan with Supplemental Elements Documented</u> The number of MLTSS plan members who had either of the following:</p> <ul style="list-style-type: none"> • For new members: A comprehensive LTSS care plan completed within 30 days of enrollment with nine (9) core elements and at least four (4)
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	supplemental elements documented, or <ul style="list-style-type: none"> For established members: A comprehensive LTSS care plan created during the measurement year with nine (9) core elements and at least four (4) supplemental elements documented.
	Denominator: A systematic sample drawn from the eligible population.

*For the purposes of the *Long Term Services and Supports - Assessment and Care Planning PIP*, Contractors will be measured based on requirements set forth within the document; however, rates will also be generated for applicable Contractor’s in alignment with the timeframes included as part of the Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual for reporting purposes.

Indicator 3: Long-Term Services and Supports (LTSS) Shared Care Plan with Primary Care Practitioner

Indicator 3: Percentage of MLTSS plan members 18 years of age and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days its development	Numerator: The number of members whose care plan was transmitted to their PCP or other documented medical care practitioner identified by the plan member within 30 days of the date when the member agreed to the care plan.
	Denominator: A systematic sample drawn from the eligible population.

Data Sources:

AHCCCS administrative data will be used to identify the eligible population. A systematic sample will be drawn from the identified eligible population, with numerator compliance determined through case management record review.

Data Collection:

This study will be conducted via hybrid methodology in alignment with the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*.

Confidentiality Plan:

AHCCCS and its Contractors maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. Only AHCCCS employees who analyze data for this project will have access to study data. Requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research. Member names are never identified or used in reporting.

Quality Assurance Measures:



Case management records will be thoroughly reviewed prior to detailed validation to ensure that all study perimeters are accurate and complete. Once rates have been established, AHCCCS will track and trend the data to ensure consistency with other available internal data and/or similarly aligned initiatives. Additionally, external reports may be evaluated to determine rate alignment for comparative purposes.

Data Validation:

The Data Validation Studies examine case management record review documentation provided by the Contractors, via thorough review and comparison with each indicator's technical specifications to ensure alignment with the associated technical specifications.

Analysis Plan:

The data will be analyzed in the following ways:

- The numerator(s) will be divided by the denominator(s) to determine the indicator rate(s).
- Results will be analyzed as a statewide aggregate and by individual Contractor.
- Results will be analyzed by urban and rural county groups.

Comparative Analysis:

For the purpose of comparative analyses, the following will be considered when applicable and meaningful to future improvement:

- Results will be compared with prior years to identify changes and trends.
- Rural and urban area results will be compared to identify any significant disparities in geographic area types.
- Individual Contractor results will be compared with each other, the statewide aggregate (weighted/non-weighted), and the AHCCCS goal.
- Results may be compared by other stratifications as deemed appropriate [i.e. age, race/ethnicity, gender, enrollment (new versus established)].
- Results will be compared to the results of any other comparable studies, if available.
- In the future, differences between overall baseline study results and overall re-measurement results will be analyzed for statistical significance and relative change.

Limitations:

None noted at this time.

Works Cited

¹Annual HCBS Report CY 2017. Arizona Health Care Cost Containment System. (2018). Retrieved from https://www.azahcccs.gov/Shared/Downloads/HCBS/AnnualHCBS_Report_CYE2017.pdf

² AHCCCS Medical Policy Manual, Section 1610 – Guiding Principles and Components of ALTCS Case Management. Arizona Health Care Cost Containment System (AHCCCS). (2018). Retrieved from <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1610.pdf>

³ Federal Register 42 CFR 438.2 – Definitions. Centers for Medicare & Medicaid Services (CMS). (2016). Retrieved from <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>



⁴ Federal Register 42 CFR 438.330 – Quality assessment and performance improvement. Centers for Medicare & Medicaid Services (CMS). (2016). Retrieved from <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>

⁵Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual. Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services. (2018). Retrieved from https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

⁶AHCCCS Medical Policy Manual, Section 900 – Quality Management and Performance Improvement Program. Arizona Health Care Cost Containment System (AHCCCS). (2018). Retrieved from <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/910.pdf>

For general or technical questions regarding this methodology, please contact Jamie Robin, AHCCCS Quality Improvement Manager at Jamie.Robin@azahcccs.gov.



ATTACHMENT A
LTSS Assessment Core and Supplemental Elements

The member's assessment must include documentation of the following nine (9) core elements and the date of the assessment:

1. Documentation that Activities of Daily Living (ADL) were assessed, or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
2. Documentation of acute and chronic health conditions (may document condition names only).
3. Documentation of current medications (may document medication names only).
4. Assessment of cognitive function using a standardized tool. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
5. Assessment of mental health status using a standardized tool. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
6. Assessment of home safety risks (e.g., home fall risks, bathroom safety, chemical hazards, food preparation safety, crime). A standardized tool is not required. Documentation that there are no home safety risks meets this element.
7. Confirm living arrangements (e.g., nursing facility, institution, assisted living, adult foster care, general community, other setting).
8. Confirm current and future family/friend caregiver availability. Documentation of family/friend caregivers (paid or unpaid) who assist the member (with ADL, instrumental activities of daily living, health care tasks, emotional support), their availability and contact information. Documentation that no family/friend caregiver is available meets this element.
9. Documentation of current providers (e.g., primary care practitioner; individual or company providing home health, personal aide assistance, physical therapy, occupational therapy, adult day care, respite care, meal delivery, transportation services, primary care, specialty care).



The member's assessment must document evidence of nine (9) core elements defined above and evidence of at least twelve (12) supplemental elements, and the date of the assessment.

Supplemental elements include the following:

1. Documentation that Instrumental ADL were assessed, or that at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
2. Documentation of the current use of assistive device or technology to maintain or improve mobility; for example, wheelchair, walker, scooter, cane, crutches, prostheses. Documentation that the member does not use an assistive device or technology meets the element.
3. Assessment of the member's self-reported health status using a standardized tool or question. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
4. Assessment of behavior abnormalities that can result from a cognitive or psychological condition; for example, sleep disturbances, wandering, aggression, urinary incontinence, disinhibition, binge eating, hyperorality, agitation (physical or verbal outbursts, general emotional distress, restlessness, pacing, shredding paper or tissues, yelling), delusions (firmly held belief in things that are not real) or hallucinations (seeing, hearing or feeling things that are not there). Documentation that the member has no behavior difficulties meets the element.
5. Assessment of the member's self-reported activation or self-efficacy using standardized tool. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
6. Documentation of vision needs, including whether the member has impaired vision and uses a device (corrective lenses, visual aids, specialized computer software and hardware) to address that need. Documenting that the member does not have impaired vision meets this element.
7. Documentation of hearing needs, including whether the member has impaired hearing and uses a device (e.g., hearing aid, specialized computer software and hardware that increase hearing or communication capacities) to address that need. Documenting that the member does not have impaired hearing meets the element.
8. Documentation of speech needs, including whether the member has a speech impairment and uses a device (e.g., specialized computer software or hardware that increase



communication capacities) to address that need. Documenting that the member does not have impaired hearing meets the element.

9. Documentation of physical/occupational therapy needs, including whether the member needs physical or occupational therapy. Documenting that the member does not have physical/occupational therapy needs meets the element.
10. Screening for history of falls and/or problems with balance or gait. Documenting that the member has no history of falls, no fall risk or no problem with gait or balance meets the element.
11. Assessment of the member's alcohol or other drug use using a standardized tool (either current alcohol use or current illicit drug use. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
12. Documentation of smoking status, including whether the member is a current smoker.
13. Documentation of the current or planned use of community, public or plan resources to address social risk factors; for example, eligibility for Medicare, Medicaid, Supplemental Security Income, transportation services, food subsidies, electric/gas subsidies, housing subsidies.
14. Assessment of the member's social support in community; for example, from friends and family, faith-based community, senior center or other nonmedical facility for group activity, or other community-based groups (arts, volunteer, theater, education, support group).
15. Assessment of member's self-reported social isolation or loneliness using a standardized tool. Documentation that the member is too cognitively impaired to provide self-report on a standardized tool meets the element.
16. Documentation of cultural and linguistic preferences; for example, preferred language, need for interpreter services.
17. Documentation of the existence of an advance care plan.
18. Documentation of current participation or preference for participating in work or volunteer activities. Documenting the member's current work or volunteer status meets the element.



19. Documentation of recent use of medical services, which can include the ED, hospitalization, home health, skilled nursing facility, paid home health care.

For more detailed information refer to the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services (CMS) *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*.



ATTACHMENT B

LTSS Care Plan and Care Plan Update Core and Supplemental Elements

The initial care plan or care plan update must include documentation of the following nine (9) core elements and the date of the care plan: *(Note: Assessment of the member and development of the care plan may be done during the same encounter or during different encounters.)*

1. At least one individualized member goal (medical or non-medical outcome important to the member, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking out social contact, taking a special trip, living to see a relative's life milestone). Documentation that member is too cognitively impaired to provide a goal and has no family members is sufficient to meet this element.

Note: Goals that are determined solely by the provider without member input, or automatically generated based on patient conditions or risk factors, do not count as a member goal.

2. A plan of care to meet the member's medical needs. Documentation that the plan addresses the member's needs or that the member does not have medical needs.
3. A plan of care to meet the member's functional needs. Documentation that the plan addresses the member's needs or that the member does not have functional needs.
4. A plan of care to meet the member's needs due to cognitive impairment; for example, support for behavioral difficulties, caregiver support or education to address cognitive impairment, support for engaging the member in activities. Document that the plan addresses the member's needs or that the member does not have needs resulting from cognitive impairment.
5. A list of all LTSS services and supports the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including the amount (e.g., hours, days) and frequency (e.g., every day, once a week). Documentation that the member does not receive LTSS meets the numerator criteria.
6. A plan for the care manager to follow up and communicate with the member (e.g., a follow-up and communication schedule).
7. A plan to ensure that the member's needs are met in an emergency (e.g., the care assistant or home health aide cannot get to the member's home, natural disaster). At a minimum, the plan must include the name of LTSS organization staff or a contracted provider to contact in an emergency.



8. Documentation of the family/friend caregivers who were involved in development of the care plan, and their contact information. Documentation of no family/friend caregiver involvement meets the element. Documentation that family/friend caregivers were invited but declined to participate in care planning meets the element.
9. Documentation that the member or the member's representative (i.e., power of attorney) agrees to the completed care plan, or appeals the care plan. Documentation includes the member/ representative's verbal agreement received by the case manager by telephone or in person, or a written agreement by the member/representative mailed to the case manager mail (e.g., a signature). Documentation that a care plan was discussed or reviewed does not meet the measure. Agreement or appeal by the member/representative must be documented.

The initial care plan or care plan update must include documentation of nine (9) core elements defined above and evidence of at least four (4) supplemental elements, and the date of the care plan: *(Note: Assessment of the member and development of the care plan may be done during the same encounter or during different encounters.)*

Supplemental elements include the following:

1. A plan of care to meet the member's mental health needs (e.g., depression, anxiety). Documentation that either the plan addresses the member's needs or that the member does not have mental health needs.
2. A plan of care to meet the member's social or community integration needs; for example, through planned social activities with friends and family, participation in community based activities, participation in work or volunteer activities. Documentation that the member does not have social or community integration needs meets the numerator criteria.
3. The duration (how long services will be provided or when need for services will be assessed) of all LTSS the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), or the time (date) when services will be reassessed. Documentation that the member does not receive LTSS meets the numerator criteria.
4. Contact information for the member's LTSS providers. Documentation that the member does not receive LTSS meets the numerator criteria.
5. A plan to assess the member's progress toward meeting established goals, including a time frame for reassessment and follow-up.
6. Documentation of barriers to the member meeting defined goals; for example, life, community or health factors that may make it difficult for the member to meet goals.



7. The member's first point of contact. The care manager's contact information meets this element if it is provided to the member.

8. Contact information for member's primary care practitioner (PCP), or a plan for connecting the member to a PCP if the member does not currently have one

For more detailed information refer to the Center for Medicaid and CHIP Services and Centers for Medicare & Medicaid Services (CMS) *Measures for Medicaid Managed Long Term Services and Supports Plans Technical Specifications and Resource Manual*.