Arizona Health Care Cost Containment System
Arizona Long Term Care System

ANNUAL HCBS REPORT
CY 2009
(10/1/08 – 09/30/09)

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INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) Administration has implemented a long-term care program through the Arizona Long Term Care System (ALTCS) that strongly supports the opportunity for individuals enrolled in the ALTCS program to live in home and community based service (HCBS) settings.

The AHCCCS Administration has done this through a program that promotes the values of:

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

Guiding principles have also been established with 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 (see Attachment A):

- Member-Centered Case Management
- Accessibility of Network
- Collaboration with Stakeholders
- Consistency of Services
- Most Integrated Setting

Members and families are afforded the opportunity to actively participate in the process to select the services that will best meet their needs. HCBS and the applicable settings are available to an individual as long as these services cost no more than what nursing facility services would cost.

The AHCCCS Administration and its Program Contractors have operationalized these principles by emphasizing the development and maintenance of services and settings that provide for consistent growth of the percentage of consumers who are able to live in the community.

Arizona's Olmstead Plan that was 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 at http://azahcccs.gov/reporting/Downloads/OlmsteadPlan.pdf

Contract Year Ending 2009 (CY 2009) saw another year of slow but continued growth of the percentage of members living in HCBS settings. This slower growth rate continues to be expected, given that those remaining in nursing facility placements will require even greater creativity and network development efforts to successfully transfer their care to HCBS settings. AHCCCS does expect that in CY 2010 for the first time ever over 70% of members will be living outside of a nursing facility. The Spouse as Paid Attendant Caregiver and Self Directed Attendant Care service options that were added in CY 2008 to provide members more HCBS choices have continued to have a positive impact in the continued growth of the HCBS membership.

The information that follows details the experiences for CY 2009 and future initiatives to improve upon the quality and expansion of HCBS.

SPECIFIC HCBS ACTIVITIES

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

- ***Spouse as Paid Caregiver***

  Allowing a spouse to be paid caregiver was implemented 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 CMS waiver ALTCS members selecting this option will be 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 so that other ALTCS members can choose to live at home. 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 CY 2009 there were 625 members who received paid services from their spouse.

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

  SDAC is Arizona's initiative of implementing a Consumer Directed Care option for ALTCS HCBS members. SDAC offers ALTCS members the choice of directly hiring and supervising their own attendants, personal care providers or homemakers without going through an agency. It empowers members to have much more control over their lives, leading to increased satisfaction and improved quality of life. Individuals have the right and the ability to make decisions about how to best get their needs met, including determining, who will provide the services they need and when the services will be provided. The service option became available September 1, 2008. This service option is part of Arizona's Olmstead Plan. The SDAC policy can be found on the AHCCCS website at http://www.azahcccs.gov/Regulations/OSPpolicy/chap1300/Chap1300.pdf .

  The use of SDAC has been limited during CY 2009 with only about 60 members electing this service. Use of SDAC is expected to increase significantly once Arizona Administrative Code (rule) is approved. In CY 2008, Statute was passed to allow SDAC participating members to direct certain skilled nursing services to their SDAC caregiver. No action on these rules have been able to taken because there is a statewide moratorium on rules implementation. Once rules are approved, skilled services that a competent member can direct to their SDAC caregiver is expected to be:

  - 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. Sliding scale dosing for insulin;
- Permanent gastrostomy tube feeding; and
- Additional services with the approval of the Director and the Arizona State Board of Nursing.

- ***Community Transition Services***

The implementation of the Community Transition Services option is pending CMS approval and will be implemented soon after approval is received. This service will be utilized to assist the transfer of institutional members to their own home settings. Community Transition Services are generally intended to provide for basic household necessities (cookware, furniture, security deposits, utility setups, etc.). The Administration established a workgroup with representation from Program Contractors, consumers and advocates to develop policy recommendations related to scope of coverage, expenditure and frequency limitations and provider standards.

- ***Prior Period Coverage For HCBS***

Beginning October 1, 2006 Program Contractors have been allowed to cover HCBS services for Prior Period Coverage enrollment. This allows applicants to have HCBS services covered by the Program Contractor during the period between application and determination of eligibility. Such coverage allows greater flexibility in choice of service site. Previously such coverage was limited to acute care services and nursing facility services. Persons awaiting discharge from hospitals now can go directly back to their own home, with coverage of those services paid for once eligibility is determined and enrollment is complete.

- **Home and Community Based Services Litigation *Ball v. Rodgers (Betlach)***

AHCCCS has been involved with a class action lawsuit for several years concerning the availability of in-home services to ALTCS members. It was alleged that ALTCS members were not being provided HCBS in the amount necessary to allow members to live in their own home. The U.S. District Court for the District of Arizona decided in the plaintiff’s favor and issued final orders June 2005. In July 2007, the Ninth Circuit Court of Appeals reversed in part and affirmed in part the rulings of the federal District Court decision and remanded the case to the District Court for additional findings consistent with the Court of Appeals decision. In 2009 the District Court issued an Order, without hearing oral argument, that AHCCCS, prior to 2004, had violated the federal freedom of choice provision, the ADA, and the federal Rehabilitation Act. However, the April 2009 District Court Order found that AHCCCS "can no longer be held liable under the Medicaid Act's equal access provision based upon the Ninth Circuit's decision."

The AHCCCS Administration filed an appeal to the Ninth Circuit Court of Appeals in May 2009. Briefing has been completed. Plaintiffs have also filed Motions with the District Court requesting the appointment of a Special Master to investigate the Agency's compliance with the injunction and to require AHCCCS to implement a hotline and eliminate member preference profiles for back up services. No ruling has been issued on these matters. Although the District Court Judge has previously denied Plaintiffs' requests, Plaintiffs have renewed these Motions. Meanwhile, AHCCCS continues to file its monthly Gap in Critical Services Report.

History
Ball v. Biedess (Rodgers) as the case is known requires the AHCCCSA to eliminate all gaps in critical in-home services within two hours of the gap being reported. Critical services include Attendant Care, Personal Care, Homemaker and Respite services.

Implementation of the order began August 2005. All ALTCS members receiving in-home services were notified in writing of their rights under this order. Case Managers met with members and/or representatives to develop written contingency plans so that they would understand what steps to take in case of gaps in critical services. AHCCCS is now collecting monthly service gap information from the Program Contractors. Gaps in critical services are currently averaging approximately Five (5) hours for every 10,000 hours of authorized services.

Semi-Annual Gap In Service Reports
Contractors are required to report to AHCCCS an analysis of the previous six months Gaps In Services. The Semi-Annual Report outlines trends and corrective actions regarding gaps in services, grievances related to service gaps and other reports as deemed necessary to fulfill the settlement agreement in the Ball v. Biedess (Rodgers) case. Contractors use the analysis to drive network development and to work with providers to ensure members receive services appropriately and timely.

- ***Arizona State Hospital Transition Workgroup***

The ALTCS Program Contractors meet with staff from AHCCCS and Arizona State Hospital on a quarterly basis. These meetings are held to discuss discharge plans for the most difficult clients currently residing as inpatients at the facility. These clients typically not only have severe behavioral problems, which necessitate specialized community placements, but also serious and chronic medical conditions. Virtually all have been admitted to the hospital on court orders. Among the HCBS settings these members eventually reside in are small group homes dedicated to members with like behaviors, such as excessive fluid consumption. Because of the effective collaboration between all parties, the list of members requiring transition from the Arizona State Hospital continues to be very small. Network enhancements and active coordination of care practices have resulted in timely discharges to appropriate settings and a low recidivism rate.

- ***Other***

ALTCS Program Contractors have developed numerous initiatives over the years to enhance the quality of life of HCBS members.

  - In-home physician and nurse practitioner visits continue to be a key in assisting members to remain at home.
  - One Contractor has staff nurses who are certified to teach fall prevention classes. These classes, provided to members and family caregivers, help members remain safely at home.
  - One Contractor has applied for a grant to replicate a Stanford University program designed to advance the availability and capacity for community based prevention services targeting older adults to enable them to live independently for as long as possible. This is a peer driven model in which teachers are community members who have the same diagnoses as the members.
  - One Contractor has developed a home sharing/roommates program to match seniors and their housing needs, with the goal of providing companionship and shared expenses.
  - One Contractor transports members to wound care and infusion therapy, avoiding the need for temporary nursing facility placement.
  - One Contractor is redesigning their Welcome Home program. This program, currently telephonic, is designed to communicate with members recently discharged from the hospital. It includes reminders to follow up with doctor visits and medication reminders. This year the Contractor's nurses will be visiting members in the hospital prior to discharge, and at home after discharge.
  - One Contractor has case management staffs who participate in regional HUD housing authorities. The goal of this participation is to increase the number of housing vouchers for elderly and physically disabled persons.
  - Two Contractors cooperated in the development of a group home for two females with high risk behavioral health issues. These two members would have been institutionalized if the group home had not been developed.
  - The Contractor for developmentally disabled members has developed a senior retirement program for its members who are over 50 years of age. This is a daily congregate activities program for these members with developmental disabilities. These members typically live with aging parents or siblings, and this program enables them to continue to live independently.

- ***Consumer Success Stories***

  - One Contractor was faced with a challenging situation and developed a unique care plan for a 42 year old member with Multiple Sclerosis whose utmost desire was to remain at home. This member, who has two minor children, had to be temporarily placed in a nursing home after an exacerbation of her illness. The Contractor worked closely with the member's HCBS providers to meet the member's complex needs and schedule three separate daily shifts. The daily shifts, including early morning and late evening shifts, assisted the member

with toileting and hygiene needs, allowing her to remain in her own home versus placing her permanently in an assisted living or skilled nursing facility.

- One Contractor worked with a member who has advanced dementia. This member was unable to stay at her assisted living home due to wandering. Instead of placing her in a nursing facility, the Contractor located a family friend to become her attendant. The familiarity with the friend has calmed the member and allowed her to live at home with relatives.

- A Case Manager for a young stroke victim recognized that the member was bored at home, but had limited educational background to be able to find employment. The Case Manager assisted the member to access the resources to obtain a high school diploma, and even attended his graduation. The member is now enrolled in a community college, and plans to pursue a bachelor's degree.

OTHER HCBS ACTIVITIES

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

- ***Network Development Plans***

  AHCCCS requires that Program Contractors develop Network Development and Management Plans (Plans). The purpose of these Plans is to identify the current status of the network at all levels (institutional, HCBS, acute, alternative residential, etc.) and to project future needs based upon membership growth and changes in member profiles/service needs.

  The contract contains language that strongly directs the development of a Plan to support HCBS options. This includes:

  - Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings
  - Placing a priority on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting
  - Development of HCBS options that include provisions for the availability of services on a 7-day-a-week basis and for extended hours, as dictated by member needs
  - Support of the member's informal support system (e.g., family caregivers) through respite services, adult day health programs, etc.
  - Development of HCB services and settings to meet the needs of members who have cognitive impairments, behavioral health needs, and other special medical needs

The Plan requires the Program 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/changes

The Plan also calls for Contractors to promote Work Force Development as Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Efforts Contractors have made in CYE 2009 include:

- Membership on the Direct Care Workforce Committee
- Partnering with Community Colleges to develop caregiver courses and program credits to enable a career ladder into nursing training programs.
- Funding caregiver education and support program and community agencies to provide caregiver education to informal (unpaid) caregivers of elderly and disabled individuals.

AHCCCS evaluated the Plans that were submitted for CY 2009. Overall, the Plans presented proper analysis of the network and network gaps.

A key addition to the CY 2010 contract is a requirement that the Plan include specific pro-active strategies/actions the Contractor will take to reduce the percentage of HCBS members in Alternative Residential Settings once 25% or more of its HCBS membership resides in these settings. An example of one such strategy is that a Contractor has partnered with a community organization who has obtained housing for seniors through grant applications. The Contractor will work with the organization to help members find home sharing/roommate arrangements at no more than $300 a month. Often seniors can benefit from the companionship and bill sharing that comes from having a roommate. In home services can then be provided to support their desire for independent living.

- ***Interagency Council on Long-Term Care***

In 2001, legislation was passed to create the Interagency Council on Long-Term Care. The purpose of the council is "to help the state achieve a coordinated long-term care services delivery system." Additionally, the council is required to "define this state's long-term care obligations by coordinating applicable state and federal mandates that relate to long-term care services." Representation on the council includes legislators, several state agencies and several advocacy agencies.

The Council has been involved with two primary projects over the past couple of years. One has been the Direct Care Workforce Committee. See the Direct Care Workforce Development section that follows.

AZLinks: The other workgroup that has been established is a steering committee for AZLinks, Arizona's Aging and Disability Resource Center. The DES/Division of Aging and Adult Services (DAAS) was awarded the Aging and Disability Resource Center (ADRC) Grant in 2005 by the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS). The grant was for $750,000 over three years. DES/DAAS is partnering with AHCCCS, the Governor's Office on Aging, the Governor's Council on Developmental Disabilities, DES/Division of Developmental Disabilities, Area Agencies on Aging, Centers for Independent Living, community aging and disability groups, and the University of Arizona to create a coordinated system of information, assistance, and access for all persons seeking long-term care (LTC) services.

AzLinks builds on the strengths of different partner organizations to operate as a coordinated network of information, referrals, and services. Information about and access to LTC services must be available to all of Arizona's citizens to plan for and make informed decisions about their future needs in the most cost effective manner while choosing from a panoply of options that promote choice, independence, and dignity. Persons seeking services from the state and its contractors need to have a system that allows them to proceed from information and referral to eligibility application and determination to service acquisition, and, finally, to service coordination.

Partnerships: The AzLinks Partnership is a network of agencies providing ADRC services, by phone or in-person, and an enhanced interactive website, whose mission is to improve access to information and linkages to supports and services for aging consumers and for consumers with disabilities. As collaborative partners, the AzLinks Partnership will work together to help empower consumers to make informed choices and to streamline access to long-term care services by building an information and access infrastructure Between November 2008 and October 2009, the Maricopa County Partnership and the Mohave County Partnership continued their development, improving cross training, referral processes, and coordination of assistance to people with disabilities and older adults. In 2009, additional formal ADRC Partnerships were established in Pima, Pinal, and Gila counties.

AZ Links Reference Manual: The manual was developed by the partnering agencies covering the following topics: Aging; Physical Disabilities; Developmental Disabilities; Special Issues, including Mental and Behavioral Health; Alzheimer's disease; Depression; Dementia; Caregiver Support programs; Domestic Violence; Refugee Resettlement program; HIV services; Medicare, AHCCCS, and ALTCS; Legal; and Cultural Competence. Separate Regional Supplements have been compiled to include local agency-specific information, programs, and services plus local contact information. The manual and supplement were created to familiarize Information Specialists and Case Managers with populations that they do not typically serve as well as each partnering agency's procedures in handling referrals, intake,

and assessment. Additional regional supplements have been developed in those counties with ADRC partnerships.

AZ Links Website: The static website that went live on August 1, 2007 with the URL of www.azlinks.gov continues its ongoing refinements to improve "customer friendliness". The website provides links to many federal, state, and various other agencies integrating resources on aging; caregivers; disabilities; employment; financial help; fraud, scams, and legal matters; health, fitness, and nutrition; housing; independent living; insurance, Medicare/Medicaid, and other benefits; long term care choices; personal safety; socialization/recreation; transportation; tribal resources; and volunteering. The website routinely has nearly 16,000 unduplicated visitors each year, where information about resources to help support independent living and caregiver resources are nearly always the most sought after items. Other popular resources on the AZ Links site include information about employment, financial help, housing, long term care options, Benefits CheckUp, and important phone numbers (to other health and human service resources).

AzLinks Screening Tool and Common Intake Form: The partnering agencies developed a self-help Screening Tool, designed to provide information and options to consumers seeking information on services in their specific communities. It is currently functioning as a manual tool that is responded to by intake specialists within participating Area Agencies on Aging. The screening tool was automated and is available to individual users, as well as partner agencies. As noted in the last report, a common intake form has been developed to help streamline access to services. Currently the team is determining how best to implement the common intake process so as to minimize duplication. Instruction manuals for both the screening tools have also been developed.

- ***Direct Care Workforce Development***

Significant activities continue regarding the growing challenges of an adequate direct care (caregiver) workforce. The foundation for current activities began in March of 2004 when the former Governor Napolitano formed a 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. The Workgroup issued a report April 2005. A copy of the report can be found at
http://www.azahcccs.gov/Contracting/BiddersLibrary/ALTCS/Reference/CWGReport_Final_June2005.pdf .

AHCCCS' initial response to this report was to include paraprofessional workforce issues in the ALTCS RFP that was released February 2006. Since ALTCS makes up the largest payer group for paraprofessionals in the long-term care market, the Contractors are required to have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home services (attendant care, personal care and homemaker). Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership.

AHCCCS defines Work Force Development as all activities that increase the number of paraprofessionals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

A collaborative effort between AHCCCS, Department of Economic Security and Department of Health Services funded and created a Direct Care Workforce Specialist position in 2007 to provide coordination for direct care workforce initiatives, including recruitment and retention, training, and raising the qualifications of direct care professionals in Arizona.

The coordination of these activities by the Workforce Specialist occurs through the Direct Care Workforce Committee (DCWC). The Committee's primary focus over the past few years has been to establish training and competency standards for all in-home caregivers (housekeeping, personal care and attendant). Subcommittees of the DCWC are addressing curriculum, policy issues and public education. Recommendations from the DCWC are submitted to the Interagency Council on Long-Term Care for further direction. Members represent state agencies, for-profit and non-profit providers, program contractors, Area Agencies on Aging, caregivers, consumer advocacy organizations and community colleges.

AHCCCS expects to incorporate these training and competencies standards into its service specifications for attendant care, personal care and housekeeping during Contract Year 2010 and 2011.

For detailed information on the direct care workforce initiatives go to the following link: https://www.azdes.gov/intranet.aspx?menu=28&id=2434

- ***Medicaid Infrastructure Grant (MIG)***

In 2007, AHCCCS was awarded a four-year Medicaid Infrastructure Grant by the Centers for Medicare and Medicaid Services. The Arizona's Medicaid Infrastructure Grant (MIG) entitled the Arizona Employment and Disability Partnership (AEDP) is positioned within the ALTCS Unit of AHCCCS' Division of Healthcare Management.

The MIGs are authorized under the Ticket to Work and Work Incentive Improvement Act of 1999 and charged to remove systemic barriers and develop or enhance existing infrastructure (e.g. capacity building) that supports competitive employment and self-sufficiency of individuals with disabilities. Simply stated the goal is to ensure that individuals with disabilities have the opportunity to participate in the workforce and lessen their dependence on public benefits.

There are many stakeholders instrumental in the transition to work process and involved in supporting individuals with disabilities to have the support they need to transition to employment and self-sufficiency. Case managers and physicians are among two of the stakeholder groups who play an integral role in supporting

individuals with disabilities to make informed decisions about work, greater independence and self-sufficiency. Two of the current MIG initiatives are targeted for the case manager and physician stakeholder groups.

Case Managers: AHCCCS is working in partnership with the ALTCS Contractors to ensure their case managers have the information, tools and resources to aid them in supporting members to transition into greater self-sufficiency through available employment, housing and educational resources and supports. AHCCCS has identified the need for long term care case managers to be informed of resources and supports in the areas of education, housing and employment. Furthermore AHCCCS has noted the need for case managers to have access to tools that will support them in facilitating discussions with members, supporting them to identify their independent living goals and decisions about what resources or supports would be most appropriate to aid them in achieving those goals.

AHCCCS is utilizing MIG funding to develop the training curriculum modules, deploy a set of pilot training sessions to test the training curriculum, train the trainers within each plan to conduct the training and provide ongoing technical assistance throughout the first year of full scale training implementation by the long term care health plans. The pilot training was conducted in 2009 and the remaining activities will be implemented in 2010. The outcome of the training development initiative will include training curriculum modules for which all Contractors will be required to deliver to their respective case managers.

As a result of the implementation of the training initiative, case managers will have an understanding of the available education, housing and employment resources and supports available to members. The case managers will have access to practical tools including tools to assist them in engaging members in conversations about independent living and self-sufficiency goals. Lastly, tools will be provided to aid them in identifying and building relationships with locally specific resources.

Physicians: Frequently patients are inquiring of their physicians about what they should or shouldn't do at work because of limitations they experience as the result of a disability, injury or chronic illness. The training entitled, "Practical Stuff They Didn't Teach You in Medical School: Evidence-based Clinical Decision-Making About Patients and Work," is being employed by the Webility Corporation. The training is accredited for continuing medical education and provided at no charge for a total of 50 sessions to medical practices, hospitals and other healthcare organizations.

A multi-specialty team comprised of an occupational medicine physician, a physical therapist and a disability benefits program specialist conduct each training session. In each training session the attendees are provided a conceptual framework and taught a logical process to use in making clinical opinions in the stay-at-work and return-to-work process. Additionally the attendees learn how to obtain needed information and data upon which to base their employability opinions. Finally, attendees learn how to identify which patients (among those who have been "on disability" for a long time) might benefits from being told by a doctor that it is safe for them to work from a medical perspective and they may be eligible for programs that could help them successfully go back to work.

The intended outcome of the training is to have physicians informed about how to make good employability decisions and institute preventative measures and, thereby, lessen the opportunity for individuals who have become recently ill or injured while working never returning to work and transitioning to public benefits dependence. Conversely, the training is intended to support physicians to encourage those patients to work (who otherwise don't have a medical reason not to work) who are currently not working because of a disabling condition and currently dependent on public benefits.

- ***Performance Measures***

AHCCCS reports Performance Measures specific to the ALTCS elderly and/or physically disabled (E/PD) population. These measures include members in home and community-based settings.

Diabetes Care: The potential impact of diabetes on the Arizona Long Term Care System (ALTCS) is of significant concern to AHCCCS. Complications of diabetes can affect the ability of many E/PD members to remain in their homes or a less intensive community-based setting.

AHCCCS completed its report of the Diabetes Performance Measures in November 2009. These measures include ALTCS members in HCBS settings, as well as those in Nursing Facilities. Data are derived from AHCCCS encounters and from medical records.

AHCCCS used Healthcare Effectiveness Data and Information Set (HEDIS) 2009 specifications from the National Committee for Quality Assurance (NCQA) to measure three indicators of diabetes care. For the measurement period of CYE 2008, AHCCCS overall rates remained stable for all three measures. The overall rate of Hb A1c testing during the measurement year was 78.9 percent, compared with the previous rate of 80.1 percent (p=.439). The rate of members who had an LDL-C test or fasting lipid profile during the measurement year was 70.9 percent, compared with 72.0 percent in the previous measurement (p=.532). The rate of members who had a dilated eye (retinal) examination in the measurement year or a negative exam in the previous year was 59.8 percent, compared with 57.1 percent in the previous measurement (p=.157).

AHCCCS overall rates for two measures — Hb A1c testing and eye exams — exceeded the most recent HEDIS national means for Medicaid managed care plans, and the rate for lipid screening equaled the national average. The AHCCCS overall rate for eye exams also exceeded the most recent HEDIS commercial mean.

Initiation of Home and Community Based Services: The report of this Performance Measure was completed in August 2009. The intent of this study is to measure the health care services that primarily allow members at risk of institutionalization to remain in their homes or the community.

Among those included in the final sample, 94.4 percent received services within 30 days of enrollment, which was a statistically significant increase over the previous rate of 91.4 percent (p= .030).

EPSDT Participation: Using methodology developed by 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, AHCCCS measured this rate for ALTCS Contractors during the year. This measurement includes HCBS members.

For the measurement period of CY 2008, the overall rate of EPSDT visits among members enrolled with E/PD Contractors was 59.4 percent, compared with 62.7 percent in the previous year. Among members enrolled with DES/DDD, the rate was 56.0 percent, an increase from the previous rate of 46.4 percent.

AHCCCS has established contractual Minimum Performance Standards for these measures. For any of the measures for which ALTCS Contractors did not meet the MPS, AHCCCS required them to submit Corrective Action Plans (CAPs), which it approved, and is monitoring 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 has implemented a quarterly Adult and EPSDT Monitoring Report that all Contractors submit, which allows for better monitoring of rates of key indicators of quality. AHCCCS provides ongoing educational support and technical assistance to ALTCS Contractors to help them improve rates.

- ***Performance Improvement Projects***

In CYE 2008, AHCCCS had the following Performance Improvement Projects (PIPs) under way, which include HCBS members.

Advance Directives: This PIP includes HCBS members as well as those in nursing facilities, and is designed to increase the use of advance directives and ensure medical record documentation of these directives. During CYE 2009, Contractors continued interventions to educate members about advance directives and improve documentation of members' preferences for end-of-life care in their medical records. These interventions were implemented after Contractors were provided with baseline rates, based on the measurement period of CYE 2007. The AHCCCS overall baseline rate of advance directives documented in medical records was 36.8 percent.

The first remeasurement of performance will be conducted in mid-2010 for the measurement period of CYE 2009. Results for this measurement will be analyzed by placement (HCBS compared with nursing facility).

Influenza Vaccination: This PIP is intended to reduce inappropriate refusals of influenza vaccine by elderly and physically disabled members in both HCBS and nursing facility settings. A baseline measurement conducted for the measurement period of Sept. 1, 2007, through March 31, 2008, showed an AHCCCS overall rate of 54.0 percent (this includes members who specifically refused influenza vaccination, as well as those for whom documentation of a vaccination during the period was not found). Contractors have developed interventions to improve rates of vaccination among members, and a remeasurement of performance will be conducted in 2010 for the period of Sept. 1, 2009, through March 31, 2010. Results for this measurement will be analyzed by placement (HCBS compared with nursing facility).

HCBS GROWTH AND PLACEMENT TABLES AND GRAPHS

The following six pages contain tables and graphs that show the growth of the ALTCS elderly and physically disabled population over several time periods. These tables and graphs are accompanied by a description.

- Table 1 and Graph 1 — Statewide Placement and Percentage by Setting (January 2002-September 2009)
- Graph 2 — Percentage of Growth by Setting (January 2002-September 2009)
- Graph 3 — HCBS Placement Percentages by Program Contractor (2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009)
- Table 2 and Graph 4 — Alternative Residential Setting Placement Status (2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009)
- Table 3 and Graph 5 — Placement By Age Group By HCBS, ALF and Institutional (2009)
- Table 4 — Elderly and Physically Disabled Placement by Program Contractor (2009)

Table 1 and Graph 1
Statewide Placement and Percentage by Setting

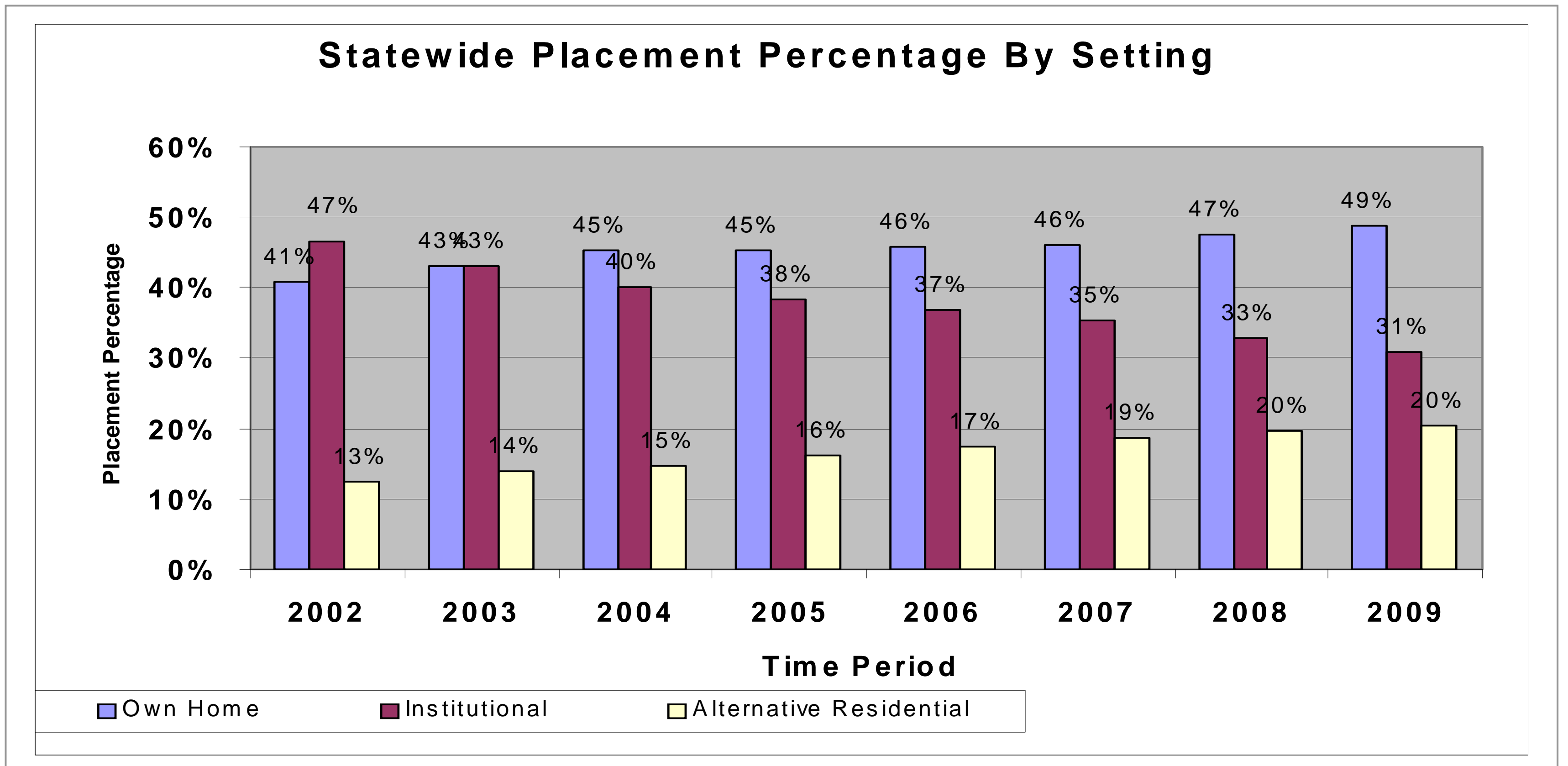
Table 1 and Graph 1 show the growth of the ALTCS elderly and physically disabled (EPD) population from January 2002 through September 2009. Of particular interest is that the number of Institutional members in September 2009 is less than that for September 2008 and the lowest it has ever been since January 2002. Graph 1 shows the distribution of members between Own Home, Alternative Residential and Institutions. The proportion of members residing in Alternative Residential settings remained at 20%. The proportion of members residing in their own homes increased from 47% in 2008 to 49% in 2009. The proportion of the members residing in Institutions declined from 33% in 2008 to 31% in 2009.

Table I

Statewide Placement Percentage By Setting

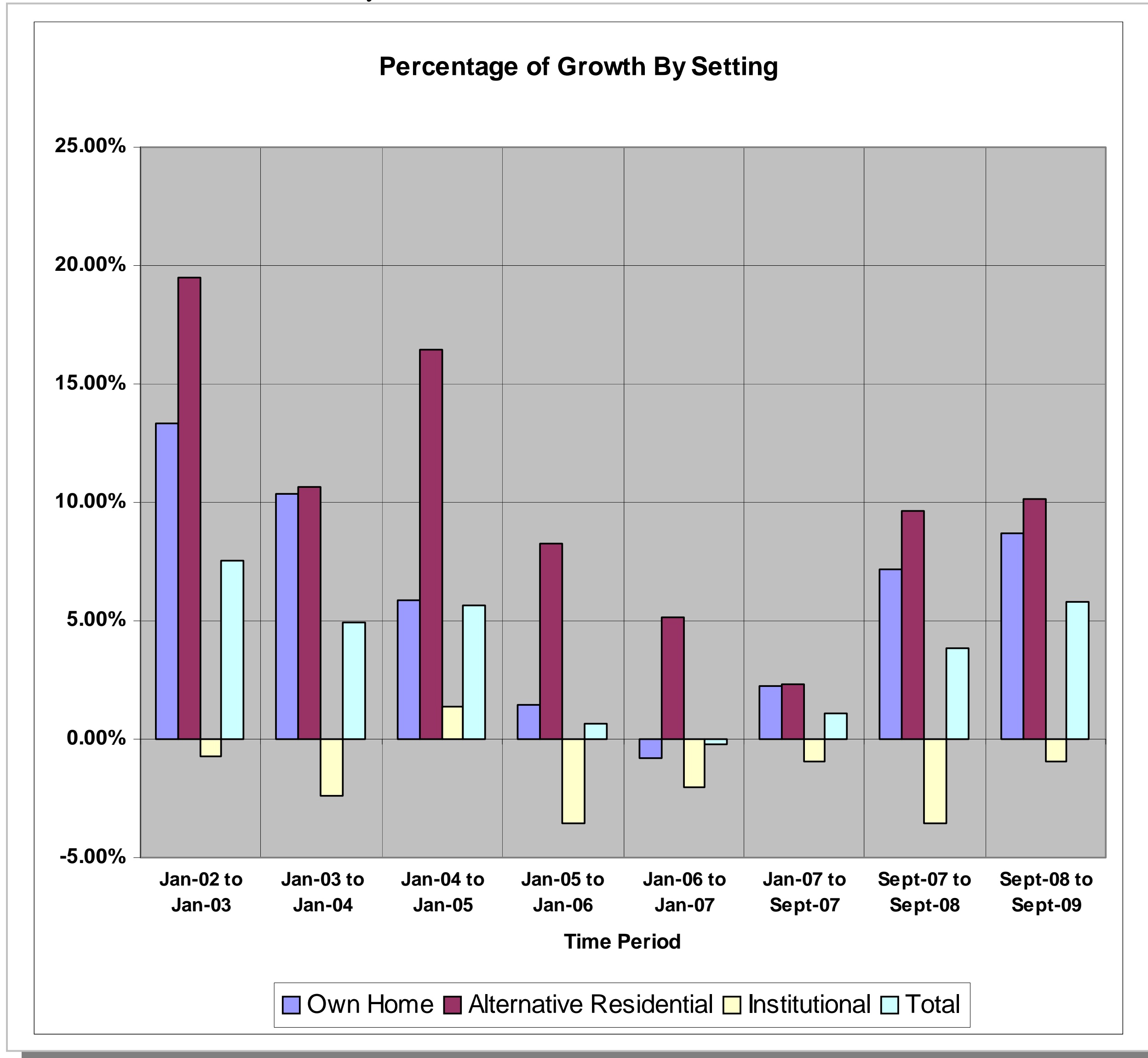
	Jan-02	Jan-03	Jan-04	Jan-05	Jan-06	Sep-07	Sep-08	Sep-09
Own Home	41%	43%	45%	45%	46%	46%	47%	49%
Alternative Residential	13%	14%	15%	16%	17%	19%	20%	20%
Institutional	47%	43%	40%	38%	37%	35%	33%	31%
Total	100%	100%	100%	100%	100%	100%	100%	100%

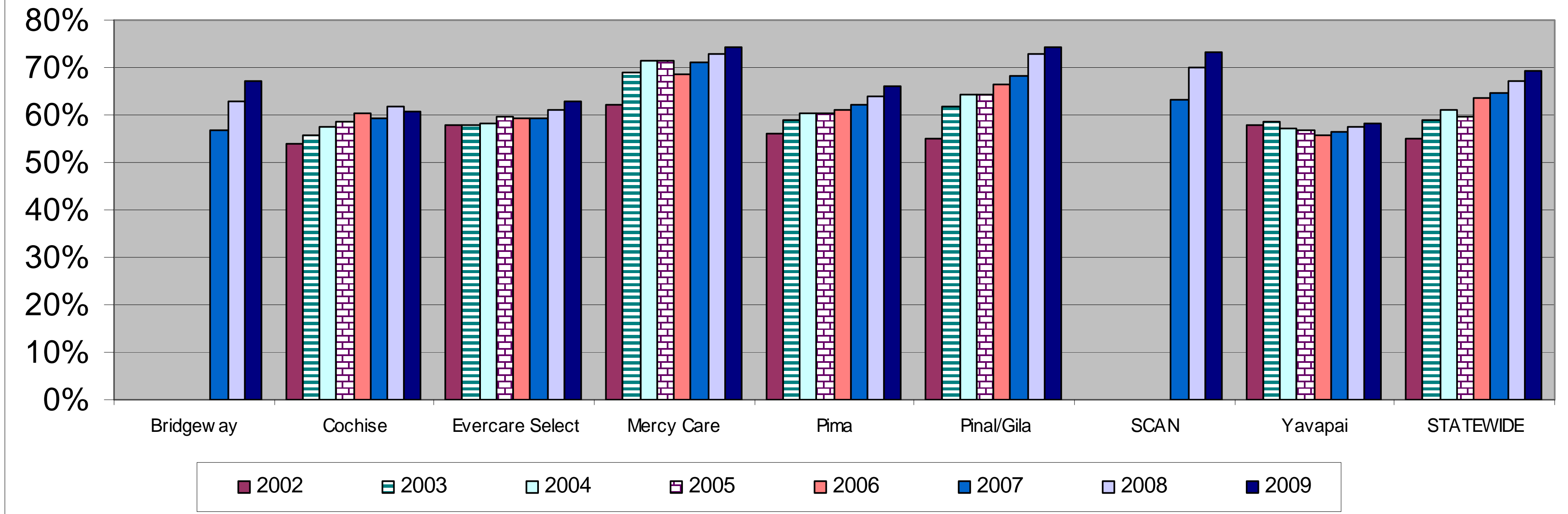
Graph I



Graph 2
Percentage of Growth by Setting

Graph 2 takes the information from Table 1 and shows the percentage of growth that each type of setting has experienced since January 2002. Own Home and Alternative Residential settings experienced growth compared to the previous reporting period. The Institutional (Nursing Facility) setting experienced a decline for the fifth consecutive year.





Graph 3
HCBS Placement Percentage by Program Contractor

This graph shows the HCBS placement growth by Program Contractors for the last eight contract years. All Program Contractors except one experienced growth in their HCBS membership in CY 2009. It is expected that the overall HCBS growth will continue.

Table 2 and Graph 4
Alternative Residential Setting Placement Status

Table 2 and Graph 4 show the growth and distribution of the members who reside in the different alternative residential placements, including those with a behavioral health license. Adult Foster Care (4 or less beds) has shown a continued decline both in number and the proportion of people residing in this setting. Assisted Living Centers were the only alternative residential setting to experience a growth in the proportion of residents residing in these settings.

Table 2

Alternative Residential

	CYE 02		CYE 03		CYE 04		CYE 05		CYE 06		CYE 07		CYE 08		CYE 09	
PLACEMENT	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Adult Foster Care	482	17.64%	447	14.75%	440	12.62%	400	10.51%	345	8.55%	297	7.11%	282	6.16%	249	4.94%
Assisted Living Center	1,096	40.12%	1,274	42.05%	1,540	44.18%	1,788	46.98%	2,069	51.29%	2,132	51.07%	2,276	49.72%	2,598	51.51%
Assisted Living Home	1,044	38.21%	1,211	39.97%	1,407	40.36%	1,520	39.94%	1,508	37.38%	1,640	39.28%	1,879	41.04%	2,055	40.74%
Behavioral Health	110	4.03%	98	3.23%	99	2.84%	98	2.57%	112	2.78%	106	2.54%	141	3.08%	142	2.82%
TOTAL	2,732	100.00%	3,030	100.00%	3,486	100.00%	3,806	100.00%	4,034	100.00%	4,175	100.00%	4,578	100.00%	5,044	100.00%

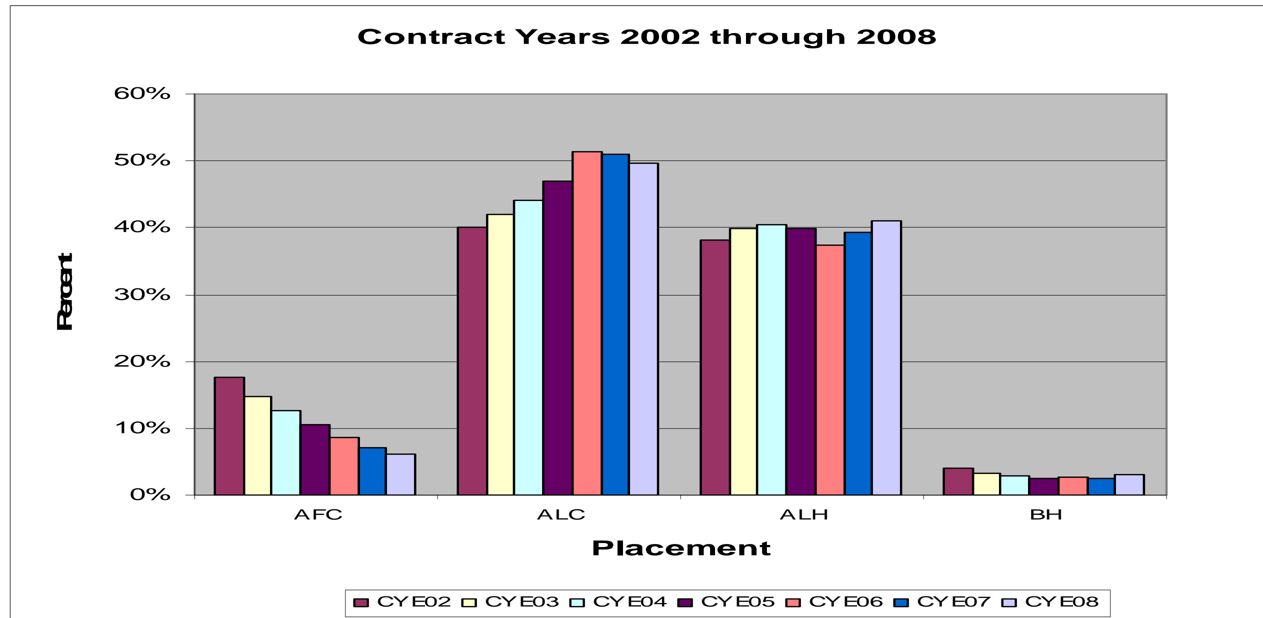


Table 3 and Graph 5
ALTCS EPD Placement by Age Group

This table and graph present information on the difference in member placement based on three age groupings (0 - 20, 21 - 64 and 65 plus). As expected, members in the 65 years and older age group have the highest proportion residing in institutional settings (36%). The 0 – 20 year age group has the lowest proportion of members residing in institutional settings (3%). Only 21% of members 21 – 64 years of age reside in institutional settings.

Table 3

ALTCS EPD Placement by Age Group – September 30, 2009

Does not include Not Placed and Acute Members

	0-20	21-64	65+	TOTAL
HOME	506	4,561	6,952	12,019
ALF	21	1,116	3,907	5,044
INST	15	1,549	6,044	7,608
TOTAL	542	7,226	16,903	24,671

	0-20	21-64	65+	TOTAL
HOME	93%	63%	41%	49%
ALF	4%	15%	23%	20%
INST	3%	21%	36%	31%
TOTAL	100%	100%	100%	100%

Graph 5

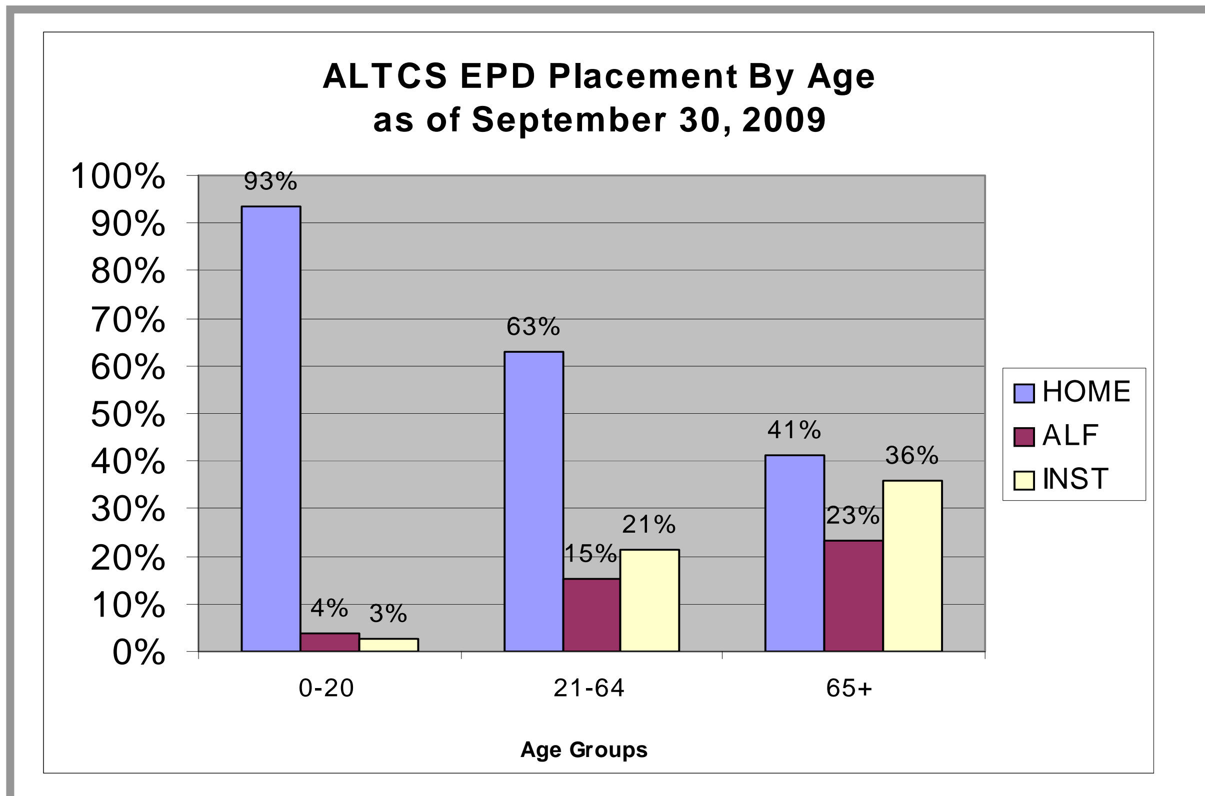


Table 4

ELDERLY AND PHYSICALLY DISABLED PLACEMENT BY PROGRAM CONTRACTOR REPORT AS OF 9/30/2009

Table 4

The table below shows the number of members placed in the various settings at the end of the Contract Year 2009
The Numbers represent placement by Program Contractor.

	HCBS									
Program Contractor	**Own Home**	**AFC**	**ALC**	**Behavioral Health**	**ALH**	**Total HCBS**	**Nursing Facility**	**Acute**	**Not Placed**	**COMBINED TOTAL**
Bridgeway Health Solutions	900	5	256	8	497	1,666	813	23	52	2,554
Cochise Health Systems	471	3	41	2	54	571	367	6	3	947
Evercare Select	1,495	7	427	25	273	2,227	1,318	36	11	3,592
Mercy Care Plan	4,721	147	949	79	220	6,116	2,126	156	86	8,484
Pima Long Term Care	2,142	62	213	7	399	2,823	1,454	32	30	4,339
Pinal/Gila Long Term Care	933	0	45	11	74	1,063	366	20	10	1,459
SCAN Long Term Care	880	22	596	9	494	2,001	736	38	38	2,813
Yavapai Long Term Care	476	3	71	1	44	595	428	12	14	1,049
Total EPD Population	12,018	249	2,598	142	2,055	17,062	7,608	323	244	25,237

Attachment A: ALTCS Guiding Principles

- *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.

- *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 Program 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 Program Contractors to meet members' needs which are not limited to normal business hours.

- *Most Integrated Setting*

Members are to be maintained in the least restrictive 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.