

Arizona Health Care Cost Containment System

Arizona Long Term Care System (ALTCS) Performance Measure

Initiation of Home and Community Based Services For Elderly and Physically Disabled Members



Measurement Period: October 1, 2009, through September 30, 2010

**Prepared by the Division of Health Care Management
August 2011**



*Thomas J. Betlach
Director, AHCCCS*

“Our first care is your health care”

Performance Measure Project Summary

Background: More than 10 million Americans require long-term care services, ranging from skilled nursing care to support services, such as help with activities of daily living (dressing and bathing, for example). Estimates of total U.S. spending on long-term care services range from \$194 billion to \$280 billion. Medicaid is the largest financier of long-term care services, with studies estimating the proportion at 40 percent or more of all long-term care spending.^{1,4}

Home and community-based services (HCBS) have become a growing part of states' Medicaid programs, providing a cost-effective alternative to institutional care for the elderly and physically disabled.⁵ Almost half (45 percent) of the long-term services and supports financed by Medicaid in 2009 were community based.⁶ With the appropriate services, many people who would otherwise live in nursing facilities are able to live in private homes or in community residential settings.

More than 67 percent of elderly and physically disabled people enrolled in the Arizona Long Term Care System (ALTCS) reside in home and community-based settings.

Purpose: AHCCCS medical policy requires that services for HCBS members are initiated within 30 days of enrollment, based on a personal visit and thorough assessment of service needs by a case manager. This measurement assesses the percentage of newly placed HCBS ALTCS members who received specific services within 30 days of enrollment, overall and by Contractor.

Goals: AHCCCS has established a Minimum Performance Standard (MPS) for ALTCS-contracted health plans (Contractors) that 92 percent of their members included in this measurement will have a service within 30 days of enrollment. The AHCCCS goal for this measure is 98 percent.

Methodology: The measurement period for the current study is October 1, 2009, through September 30, 2010. A representative random sample was selected for each Contractor. The sample frame consists of elderly and physically disabled (E/PD) members who:

- were enrolled for 30 days or more with an ALTCS Contractor during the measurement period,
- were newly placed in an HCBS setting, other than an assisted living facility, and
- were not ventilator-dependent, as Contractors are required to initiate services for those members within 14 days of enrollment.

Also excluded were members who died, were hospitalized, receiving hospice services, or refused services when these situations were documented as occurring within 30 days of enrollment.

Data were first collected from AHCCCS encounter data (records of claims paid by Contractors). If services within 30 days of enrollment were not found in AHCCCS encounter data, Contractors were asked to provide information from medical or case management records or their claims data. Data collected by Contractors were validated against documentation, such as copies of the pertinent sections of case management records, medical/service records from providers, or verification of claims paid by Contractors for qualifying services.

Results: In the current measurement, 97.1 percent of members received services within 30 days of enrollment, which did not represent a statistically significant difference from the previous rate of 96.0 percent. There was no significant difference in rates of initiation of services between rural and urban counties, or by members' race or ethnicity.

Rates by Contractor ranged from 88.2 percent to 100 percent. Six of eight Contractors exceeded the minimum standard and three achieved the AHCCCS goal.

**Arizona Health Care Cost Containment System (AHCCCS)
Arizona Long Term Care System (ALTCS)**

**PERFORMANCE MEASURE for INITIATION OF HOME AND
COMMUNITY BASED SERVICES**

For the Measurement Period October 1, 2009, through September 30, 2010

Introduction

It is estimated that roughly two-thirds of Americans age 65 and older today will eventually need some type of long-term care — ranging from personal care assistance for managing daily activities at home to nursing home care — for an average of three years.¹

At the same time, significant increases in the elderly population are occurring.² In less than 20 years, the number of Arizonans age 65 and older is expected to be over 2 million, or about 22.1 percent of the state's population.³

While the health of older Americans is improving overall, many are disabled and suffer from chronic conditions. About 80 percent of seniors have at least one chronic health condition, and 50 percent have two or more chronic health conditions, such as arthritis, hypertension, heart disease, diabetes and respiratory disorders.²

More than 10 million Americans, including about 6 million elderly and 4 million children and working-age adults, need long-term services and supports. Long-term care

consists of a variety of medical and social services to help meet the health and personal needs of people with chronic illness or disability. These services range from skilled nursing care to support services, such as help with activities of daily living (dressing and bathing, for example).

Medicaid is the main source of long-term care coverage and financing in the U.S., accounting for at least \$112 billion in expenditures.^{1,4} More than half of all Medicaid long-term care spending is for institutional care, but a growing share — 43 percent in 2007, up from 30 percent in 2000 — went to home and community-based services (HCBS).¹ More than \$45 billion in Medicaid dollars went to home health, personal care and other home and community-based services in federal fiscal year 2008.¹

Home and community-based services provide a cost-effective alternative to institutional care for the elderly and physically disabled.

— *The Kaiser Commission on Medicaid and the Uninsured*

These services provide a cost-effective alternative to institutional care for the elderly and physically disabled (E/PD). In addition, research has shown a strong connection between receiving services in the home and improved consumer satisfaction and overall quality of life.⁴

Arizona has developed an HCBS program that allows long-term care members to choose this option when appropriate. People receiving HCBS generally are more likely to have family caregiver involvement and assistance and have fewer needs resulting from cognitive impairments.

The AHCCCS HCBS Program

The Arizona Health Care Cost Containment System (AHCCCS) has provided home and community-based services to long-term care beneficiaries through a waiver from the Centers for Medicare and Medicaid Services (CMS) since 1989. Through its Arizona Long Term Care System (ALTCS), AHCCCS provides comprehensive coverage for HCBS members residing in their own homes or approved alternative residential settings, such as assisted living facilities or group homes. Covered services include care such as home health nursing, attendant or personal care, and home-delivered meals. Members may designate a family member or friend to provide attendant care; after completion of training, these caregivers can be paid by AHCCCS.

At the end September 2010, 64.3 percent of the 27,547 elderly and physically disabled Arizonans enrolled in ALTCS resided in home and community-based settings.

By providing a variety of alternative settings with differing levels of care, ALTCS members may be able to transfer from nursing homes to home or other community-based settings or delay institutionalization for a longer period of time.

Once eligibility for ALTCS is determined based on financial and medical criteria, E/PD members enroll with a contracted health plan (Contractor). Each member is assigned a case manager, who coordinates care with the member's primary care

provider (PCP) and other providers, addresses any problems with service delivery, and modifies the member's care plan based on changes in health status. Case managers visit new members and, in conjunction with those members or their representatives, assess needs to determine the most appropriate services and placement. AHCCCS requires that contracted health plans initiate home and community-based services within timelines to meet members' medical needs, but no later than 30 calendar days from their date of enrollment.

To ensure that member needs continue to be met in the most appropriate setting, case managers reassess members' physical and functional status at regular intervals and monitor the ongoing provision of services. AHCCCS also monitors service provision through regular reviews of Contractor operations.

AHCCCS annually measures the percentage of newly placed HCBS members who receive specific services within 30 days of enrollment. This measurement is conducted to determine individual Contractor compliance with performance standards in contract, as well as to analyze overall rates of initiation of services for HCBS members.

It should be noted that this measurement does not include all covered home and community-based services. For example, emergency-alert and home-modification services are not included because they are typically provided in conjunction with nursing, personal care or other supportive services. This measurement focuses on the health-related services that primarily allow ALTCS members to remain in their homes as long as possible (see Appendix A, Methodology, for a complete list of services and service codes included in this measurement).

Methodology

The measurement period for the current study is October 1, 2009, through September 30, 2010. A representative random sample was selected for each Contractor. The sample frame consists of E/PD members who:

- were enrolled for 30 days or more with an ALTCS Contractor during the measurement period, and
- were newly placed in an HCBS setting, other than an assisted living facility.

This study does not include ventilator-dependent members, as Contractors are required to initiate services for those members within 14 days of enrollment.

Data were first collected from AHCCCS encounter data (records of claims paid by Contractors). If services within 30 days of enrollment were not found in AHCCCS encounter data, Contractors were asked to provide information from medical or case management records or their claims data.

In analyzing initiation of services, AHCCCS did not include members who: died, were residing in and receiving services from an assisted living facility or nursing home, were admitted to a hospital, were receiving hospice services, or refused services when these situations were documented as occurring within 30 days of enrollment. Percentages of members who fell into one of the above categories are reported in Table 1.

Data Quality and Reliability

AHCCCS conducts validation studies to evaluate the completeness of encounter data. The two most recent annual studies of encounters submitted by ALTCS E/PD Contractors show encounter-omission rates of less than 5 percent for each year.

To validate additional information collected by Contractors, AHCCCS required documentation of services provided or reasons why a member did not receive services (for example, the member refused services while waiting for a family member to become trained to provide attendant care). Documentation provided by Contractors included copies of the pertinent sections of case management records, medical/service records from providers, or verification of claims paid by Contractors for qualifying services. This documentation was reviewed by AHCCCS staff with expertise in ALTCS case management.

Performance Standards

For this reporting period, AHCCCS set the Minimum Performance Standard (MPS) that Contractors must achieve for this measure at 92 percent. Contractors who do not meet the MPS must develop and implement corrective action plans, as approved by AHCCCS. If Contractors are already achieving the minimum standard, they should strive for the AHCCCS goal of at least 98 percent.

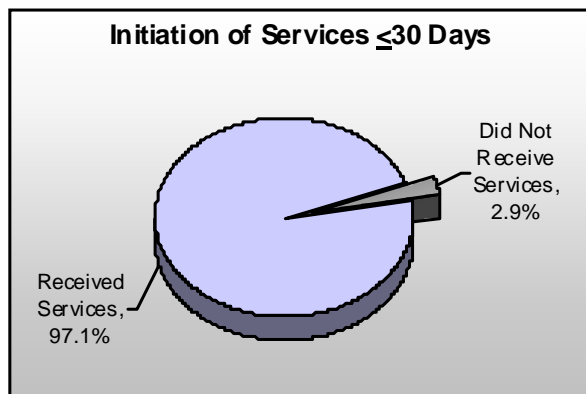
Results and Analysis

The original study sample included 766 HCBS members enrolled with eight Contractors serving ALTCS E/PD members. Of those, 108 people were excluded; (20) because they were residing in assisted living facilities or transferred to nursing homes, (8) were admitted to hospitals, (8) were receiving hospice services, (22) refused services (50) were waiting for a family member or friend to complete training as their paid caregiver and did not want someone else to provide services in the first 30 days of enrollment (Table 1).

Member exclusions by Contractor were:

Exclusions by Contractor	
Bridgeway Health Solutions	17
Cochise Health Systems	12
Evercare Select	9
Mercy Care LTC	17
Pima Health System LTC	39
Pinal/Gila LTC	6
SCAN LTC	1
Yavapai County LTC	7
TOTAL	108

Among the remaining 658 people, 639 or 97.1 percent received services within 30 days of enrollment (Table 2), not statistically significant over the previous rate of 96.0 percent ($p = .304$).



There was no significant difference in rates of initiation of services between rural and urban counties. There also were no significant differences in rates for members who identified themselves as Hispanic, Native American, Black or "other", compared with non-Hispanic White members.

Rates by Contractor ranged from 88.2 percent to 100 percent. Six of the eight Contractors exceeded the Minimum Performance Standard and three achieved the AHCCCS goal.

Discussion

Given the variety and complexity of members' needs and personal situations when they enroll in the ALTCS program, Contractors' case managers face distinct challenges in ensuring that enrollees have prompt access to home and community based services that fit with their individual choices and needs. Despite these challenges, the overwhelming majority of new ALTCS members placed in HCBS settings receive services within 30 days of enrollment.

Since much of the data for this measure is collected from case management records when claims or encounters for services are not available, Contractors must ensure that case managers thoroughly and consistently document when home and community-based services are initiated for new members or when members or authorized representatives refuse services. Over the past few years, AHCCCS has worked with Contractors to improve documentation.

Quality Improvement Initiatives

ALTCS Program Contractors have developed numerous initiatives over the years to enhance the quality of life of HCBS members, several of which facilitate timely access to care. These include:

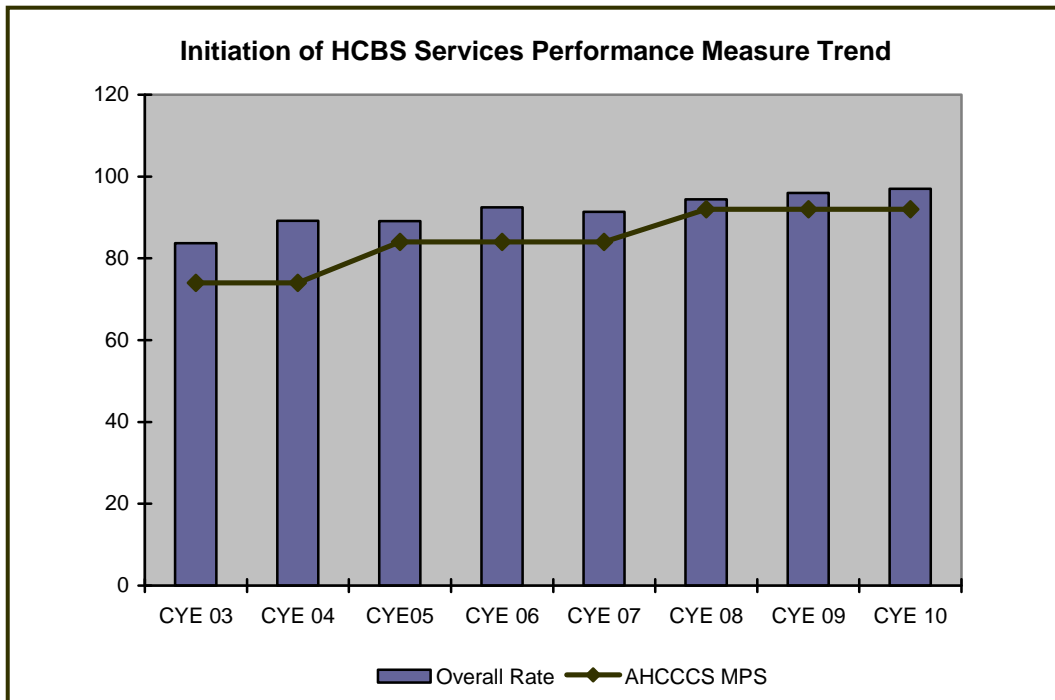
- Monitoring service provision to HCBS members within one to two weeks of enrollment. Reports are run at regular intervals and provided to case managers.
- The use of automated case management systems, which can be used to track timeliness of service initiation and generate reminders for case managers to follow up.
- The development of multi-disciplinary teams that combine case management, medical management and quality management staff to more closely monitor needs of members in the HCBS program and develop new ways to facilitate timely access to care.

Conclusions

AHCCCS raised the minimum performance level two years ago in order to encourage continued improvement. As a result, Contractors have implemented interventions that have continued to lead to overall improvement and continued progress toward the long-range goal for ensuring timely initiation of services for members in home and community based settings. Of the four Contractors who will provide services to Arizonans enrolled in the ALTCS program with a start date of October 1, 2011, one exceeded the Minimum Performance

Standard and three exceeded the AHCCCS Goal.

Contractors that did not meet the MPS will be required to implement corrective action plans to bring their rates up to the standard. In May of 2011, AHCCCS awarded contracts to four Contractors to provide services to Arizonans enrolled in the Arizona Long Term Care System (ALTCS) program with a start date of October 1, 2011. Previous Contractors not awarded and not meeting the MPS are not required to implement corrective action plans.



References

¹ Engquist G, Johnson C, Lind A, Barnette LP. Policy Brief: Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options. Center for Health Care Strategies. Hamilton, NJ. May 2010. Available at:

http://www.chcs.org/publications3960/publications_show.htm?doc_id=1253871. Accessed July 6, 2010.

² Wan H, Sengupta M, Velkoff VA, DeBarros KA. *65+ in the United States: 2005*. U.S. Census Bureau, Current Population Reports, P23-209, U.S. Government Printing Office, Washington, DC, December 2005. Available at: <http://www.census.gov/population/www/socdemo/age.html#elderly>. Accessed June 12, 2006.

³ The state long-term care health sector Characteristics, utilization and government funding: 2010. American Health Care Association. Washington, DC, November 2010. Available at:

http://www.ahcancal.org/research_data/trends_statistics/Pages/default.aspx

Accessed June 27, 2010.

⁴ Medicaid: A primer. Kaiser Commission on Medicaid and the Uninsured. Washington DC. June 2010. Available at:

<http://www.kff.org/medicaid/upload/7334-04.pdf>. Accessed July 6, 2010.

⁵ Appelbaum R, Schneider B, Kunkel S, Davis S. A guide to quality in consumer directed services. Scripps Gerontology Center. Miami University. May 2004. Available at:

<http://www.hcbs.org/files/42/2099/Guidefront.pdf>. Accessed June 21, 2005.

⁶ Eiken, S., K. Sredl, B. Burwell, L. Gold, Medicaid Long-Term Care Expenditures in FY2009, Thomson Reuters, August 2010.

Accessed June 27, 2011.

For questions or comments about this report, please contact:

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Table 1
AHCCCS ALTCS PERFORMANCE MEASURE
INITIATION OF HOME AND COMMUNITY BASED SERVICES
Exclusions from Analysis of Initiation of Services, All Contractors
Measurement Period: October 1, 2009, through September 30, 2010

Reason	n	Percent
Member in Assisted Living Facility/Nursing Facility	20	18.5%
Member Admitted to Hospital	8	7.4%
Member Receiving Hospice Services	8	7.4%
Member Refused Services	22	20.4%
Member Awaiting Designated Caregiver to be Trained	50	46.3%
Died	0	0.0%
Total	108	100.0%

Table 2
AHCCCS ALTCS PERFORMANCE MEASURE
INITIATION OF HOME AND COMMUNITY BASED SERVICES
WITHIN 30 DAYS OF ENROLLMENT, BY CONTRACTOR
Measurement Period: October 1, 2009, through September 30, 2010

Minimum Performance Standard: 92%

Contractor	n	Number who Received Service Within 30 Days	Percent who Received Service Within 30 Days	Relative Percent Change	Statistical Significance
Evercare Select	56	55	98.2%	-0.2%	p=1.00
	62	61	98.4%		
Pima Long Term Care	148	142	95.9%	-1.3%	p=.750
	144	140	97.2%		
Cochise Health Systems	17	15	88.2%	-11.8%	p=.111
	33	33	100.0%		
Yavapai County LTC	32	29	90.6%	-5.0%	p=.645
	43	41	95.3%		
Mercy Care Plan	194	192	99.0%	-0.5%	p=1.00
	174	173	99.4%		
Pinal /Gila Long Term Care	60	60	100.0%	11.1%	p=.015
	70	63	90.0%		
SCAN Long Term Care	55	55	100.0%	6.2%	p=.093
	103	97	94.2%		
Bridgeway Health Solutions	96	91	94.8%	3.1%	p=.568
	99	91	91.9%		
TOTAL	658	639	97.1%	1.1%	p=.304
	728	699	96.0%		

Notes:

Statistically significant values are shown in bold ($p \leq .05$)

Shaded rows show results of previous measurement, Oct. 1, 2008 through Sept. 30, 2009

**Arizona Health Care Cost Containment System (AHCCCS)
Arizona Long Term Care System (ALTCS)
Performance Measure Methodology
2011**

Project Title: **Initiation of Home and Community Based Services (HCBS)**

Background: Health care services and supports should be provided to members in the Arizona Long Term Care System (ALTCS) who are residing in home and community-based settings as quickly as possible after enrollment. These services and supports include, but are not limited to: adult day health care, attendant care, behavioral health services, habilitation services, home-delivered meals, home health aide services, home health nursing, homemaker assistance, home infusion therapy and respiratory therapy.

Arizona Health Care Cost Containment System (AHCCCS) medical policy requires that service be provided within the first 30 days after enrollment to new ALTCS members who are placed in the Home and Community Based Services (HCBS) program.

Purpose: The purpose of this study is to evaluate ALTCS Contractor compliance with AHCCCS medical policy in initiating services to newly enrolled elderly and physically disabled (E/PD) members in the HCBS program.

Measurement Period: October 1, 2009, through September 30, 2010

Study Questions: 1. What is the number and percentage (overall, by urban and rural counties, and by individual Contractor) of sample members to whom a service was provided within 30 calendar days of enrollment?
2. For those members who did not receive services within 30 calendar days of enrollment, what were the reasons?

Population: E/PD members in home and community based settings

Sample Frame: *The sample frame consists of E/PD members who met the following criteria:*

- Enrolled in ALTCS with the same Contractor for 30 or more days during the measurement period.
- Enrolled on the last day of the measurement period.
- Placed in an HCBS setting (H placement code) or temporary setting (Z placement code) during the measurement period.

Sample Frame Exclusions:

- Members with Prior Period Coverage (PPC). PPC is a retroactive coverage period for which Contractors are financially responsible for paying for covered services.
- Members placed in settings other than H or Z any time during the first 30 days of enrollment.
- Members placed in Assisted Living Facilities (ALFs) any time during the first 30 days of enrollment, as they are receiving services on the first day of placement in such facilities. Members residing in ALFs will be identified by the following Residence Codes contained in the AHCCCS Prepaid Medical Management Information System (PMMIS) Recipient Subsystem (CA 161): 5, 6, 8, 9, B, E, F, G, K, L, P and R.
- Members with encounters for hospital, nursing facility or hospice services, as identified by bill types 11X, 21X, 81X or 82X.
- Members who died within 30 days of enrollment.
 - Members who are not in hospice and die in the first 30 days are in the death category
 - Members who are in hospice in the first 30 days of enrollment (all or part of that time) and who also die during that time (or any time after) are included in the hospice category of exclusions in the table.

Sample Selection:

A statistical software package will be used to select a random representative sample by Contractor from the sample frame. The sample size will be determined using a confidence level of 95 percent and a 5-percent confidence interval, plus oversampling to account for exclusions and missing records.

Data Sources:

AHCCCS recipient enrollment data will be used to identify members who meet the sample frame criteria. AHCCCS encounter data, and member medical records and/or case management files, and Contractor claims data will be used to identify services received by members in the sample frame.

Data Collection:

Data will be first collected from AHCCCS administrative (encounter) data. If acceptable services are not identified as being provided within 30 days of enrollment, AHCCCS will request that Contractors use medical records, case management files or their own claims data to verify whether any of the services measured in this study were provided to those members within the first 30 days of enrollment. If services were not provided within 30 days, Contractors will be instructed to provide the reason and any supporting documentation for each case.

Contractors will be required to collect data using the AHCCCS standardized methodology in an electronic format provided by AHCCCS. Each Contractor will be provided an electronic file of its sample members for whom encounters for services within 30 days of enrollment were not found in the AHCCCS encounter system. After collection of data, Contractors will return the data to AHCCCS in the predetermined electronic format.

Confidentiality Plan:

AHCCCS continues to work in collaboration with Contractors to develop, implement and maintain compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements.

The Data Analysis & Research (DAR) Unit maintains the following security and confidentiality protocols:

- To prevent unauthorized access, the sample member file is maintained on a secure, password-protected computer, by the DAR project lead,
- Only select Division of Health Care Management (DHCM) employees, who enter or analyze data, have access to study data.
- Sample files given to Contractors are tracked to ensure that all records are returned.
- All employees and Contractors are required to sign a confidentiality agreement.

- Member names are never identified or used in reporting.
- Upon completion, all study information is removed from the computer and placed on a compact disk, and stored in a secure location.

Data Validation: The sample frame will be validated to ensure that members meet criteria for inclusion in the study.

Data files received back from Contractors will be reviewed to ensure that:

- all members included in the sample are listed in the returned data file,
- services meet numerator criteria for this performance measure,
- all requested information is provided.

Service data provided by Contractors must be accompanied with documentation of the source data (i.e., copy of the pertinent section of the medical record or case management file and/or a copy of a paid claim), including the date(s) of service. Contractor-supplied data will be validated by staff of the AHCCCS ALTCS unit

Indicators:

1. The number and percentage (overall, by urban and rural counties, and by individual Contractor) of sample members who received at least one acceptable home and community-based service within 30 days of enrollment during the measurement periods.
2. The number and percentage of members who did not receive an acceptable home and community-based service within 30 days of enrollment, by reason category.

Denominator: 1. The number of members who meet the sample frame criteria

Numerators: 1. The number of sample members who receive an acceptable service within 30 days of enrollment in ALTCS

Analysis Plan:

- The numerator will be divided by the denominator to determine the indicator rate.
- Data for services received within 30 days will be analyzed by Contractor, as a statewide aggregate, and by urban and rural counties.
- When calculating rates for initiation of services within 30 days of enrollment (study question #1), members will be excluded from the denominator for the following reasons if supported by appropriate Contractor documentation.

- AHCCCS will report the number of sample members excluded from the denominator, by Contractor, in the following categories:

- Refused all applicable services, including those who refused services while waiting for a designated caregiver to be trained
- Members who were not in hospice and died within 30 days of enrollment comprise the death category.
- Were admitted to a hospital or nursing facility within 30 days of enrollment.
- Received hospice services within the first 30 days of enrollment (all or part of that time) and who also die during that time (or any time after) are included in the hospice category.
- Were placed in an assisted living facility within 30 days of enrollment.

- Outliers will be identified using standard deviations and patterns of abnormal distribution of data.

- Differences between prior study results will be analyzed for statistical significance and relative change.

- The following assumptions will be used to determine whether the indicator criteria was met:

- Members included in the sample sent to Contractors for whom data was not received back from the Contractor or for whom service data was not supported by appropriate documentation will be counted as having no service within 30 days.
- Any service documented by the Contractor that did not include the date it was first delivered will be counted as being provided outside the 30-day

requirement.

- Comparative Analysis:**
- Overall rates for urban and rural counties will be compared.
 - Individual Contractor rates will be compared to the Contractor's rate for the previous measurement and to the AHCCCS Minimum Performance Standard and Goal.

Deviations from HEDIS: This indicator is based on an AHCCCS contractual requirement and is not based on any nationally recognized methodology, such as the Healthcare Effectiveness Data and Information Set (HEDIS).

Deviations from Previous Methodology: AHCCCS excluded from the sample frame sent to Contractors members who were hospitalized, or received nursing facility or hospice services during the first 30 days of enrollment using Uniform Billing (UB) bill type codes associated with encounters:

- 11X – Hospital (inpatient)
- 21X – Nursing facility
- 81X – Hospice (nonhospital based)
- 82X – Hospice (hospital based)

In the current measurement, these members were excluded from Contractor samples prior to sending samples for data collection to each Contractor. In previous measurements, bill types were not used to exclude members from the sample frame prior to Contractor data collection. Contractors provided documentation of these services within 30 days of enrollment when appropriate, and such members were excluded from each Contractor's final sample prior to analysis.

Quality Control: To ensure consistency and reliability in data abstraction, AHCCCS:

- provides each Contractor with the methodology for this measure,
- provides each Contractor with a data specification sheet, file layout, and data dictionary for this measure,
- provides each Contractor with detailed written instructions for data collection,
- provides updates and ongoing technical assistance to Contractors regarding data collection for this measure.

Arizona Health Care Cost Containment System (AHCCCS)

Arizona Long-Term Care System (ALTCS) Performance Indicator

Instructions for submission of data

The data layout and instructions described must be followed for submission to ensure accuracy of data translation and acceptance of data elements by AHCCCS.

- All variable fields must be left justified.
- All variable fields are to be used exactly as indicated in the proceeding tables.
- If information does NOT exist for any variable field, leave blank spaces in the columns.
- Do not add any “new” variables that are not listed in the proceeding table.
- Do not change variable names.
- Do not change the order of the variable fields.
- All dates should be formatted as mm/dd/yyyy. Thus, January 2, 2010, would be reported as 01/02/2010.
- The format has been designed for accurate importing of the data into AHCCCS software. Any changes to the format could result in lost information and a request for the Contractor to resubmit the data.
- Do not change information provided by AHCCCS. Any discrepancy in provided information, please provide AHCCCS with separate notation of difference and reason for change.
- Submit the data files using the SFTP server. Contact Lucy Valenzuela (e-mail: lucy.valenzuela@azahcccs.gov).
- **Data must be submitted to AHCCCS by close of business May 2, 2011.**

ANY DEVIATIONS FROM THE INSTRUCTIONS FOR SUBMISSION OF DATA WILL NOT BE ACCEPTED AND RETURNED TO THE CONTRACTOR.

Contact information:

Technical questions related to the data request: should be directed to Lucy Valenzuela at: lucy.valenzuela@azahcccs.gov (preferred) or call (602) 417-4753.

All other questions related to the project should be directed to Rochelle Tigner at rochelle.tigner@azahcccs.gov (preferred) or call (602) 417-4683.

LAYOUT OF MEMBER IDENTIFIED FILE

Variable	Variable Name	Format	Length	Start Column	End Column
1	AHCCCS ID	Text	9	1	9
2	Contractor	Text	6	10	15
3	Last Name	Text	30	16	45
4	First Name	Text	20	46	65
5	Placement Code	Text	2	66	67
6	Placement Begin Date	Date	10	68	77
7	Placement End Date	Date	10	78	87
8	ALTCS Enrollment Begin Date	Date	10	88	97
9	ALTCS Enrollment End Date	Date	10	98	107
10	Date Of Birth	Date	10	108	117
11	Date Of Death	Date	10	118	127
12	Gender	Text	1	128	128
13	Race	Text	2	129	130
14	Fiscal County	Text	2	131	132
15	Residential County	Text	2	133	134
16	Service Code	Text	5	135	139
17	Service Date	Date	10	140	149
18	Exclusion Begin Date	Date	10	150	159
19	Exclusion End Date	Date	10	160	169
20	Reason For Exclusion	Text	10	170	179
21	Other	Text	50	180	229

Description of Included Elements

1	AHCCCS ID	9-digit alpha number assigned to a member upon enrollment into AHCCCS
2	Contractor	6-digit number that tells what Contractor the member was enrolled with
3	Last Name	Last name of member as listed in AHCCCS system
4	First Name	First name of member as listed in AHCCCS system
5	Placement Code	ALTCS placement code
6	Placement Begin Date	Date that member became eligible for Home Community Based Services.
7	Placement End Date	Date that member's Home Community Based Services ended.
8	<i>ALTCS Enrollment Begin Date</i>	Date (not including prior period coverage) member was enrolled with the Contractor
9	ALTCS Enrollment End Date	Date that member's ALTCS enrollment ended
10	Date of Birth	Date that member was born as listed in AHCCCS system
11	Date of Death	Date that member expired as listed in AHCCCS system
12	Gender	Male or Female
13	Race	Race of member as listed in AHCCCS system
14	Fiscal County	County of financial responsibility
15	Residential County	County in which the member resides
16	Service Code	Five digit code that identifies specific service provided
17	Service Date	Date that service was first provided to member (this is not the date that the case manager authorized the service)
18	Exclusion Begin Date	Date that a service began making a member eligible for exclusion
19	Exclusion End Date	Date that a service ended making a member eligible for exclusion
20	Reason For Exclusion	Reason why service was not provided within 30 days of enrollment. (Drop-Down box is provided that includes the acceptable exclusions.)
21	Other	Other reason why service was not provided within 30 days of enrollment

Appendix A: Acceptable Home and Community Based Services

Adult Day Health		Other	
	S5100 Day Care service; per 15 minutes. S5101 Day Care service; per ½ day. S5102 Day Care service; per diem.	S5180 and S5181– applies to following:	
		S5180 Home health respiratory therapy, initial evaluation.	
Attendant Care		S5181 Home health respiratory therapy, NOS; per diem.	
	S5125 Attendant care service; per 15 minutes.	Habilitation Services	
Home-Delivered Meals		T2021 Day habilitation waiver; per 15 minutes	
	S5170 Home-delivered meals; per meal including preparation.	T2020 Day Habilitation, waiver; per diem.	
Home Health Aide		T2017 Habilitation residential, waiver; per 15 minutes.	
	T1021 Home health aide or Certified Nurse Assistant (CNA); per visit.	Behavioral Health	
Home Health Nursing		T1019 Personal care services; per 15 minutes.	
	G0154 Nursing Care, in the home; per hour (w or w/o *Modifier TG)	T1020 Personal care services, not for IP or residential care facilities; per diem.	
Home Infusion		H2014 Skills training and development; per 15 minutes. (w or w/o *Modifier HQ)	
	S9379 Home Infusion Therapy; per diem. Not otherwise classified.	H2025 Ongoing support to maintain employment; per 15 minutes.	
Personal Care		T2018 Habilitation, supported employment, waiver; per diem.	
	T1019 Personal care services; per 15 minutes.	T2019 Habilitation, supported employment, waiver; per 15 minutes.	
Respite		H2019 Therapeutic behavioral services (<i>Behavioral Health Therapeutic Day Program</i>); per 15 minutes. (w or w/o *Modifier TF)	
	S5150 Unskilled, not hospice; per 15 min in home respite care.	H2020 Therapeutic behavioral services (<i>Behavioral Health Therapeutic Day Program</i>); per diem.	

S5150 Group, not hospice; per 15 min respite care. (*Modifier HQ)	H0036 Community psychiatric supportive treatment, Face to Face (<i>Behavioral Health Medical Day Program</i>); per 15 minutes.
S5151 Unskilled, not hospice; per diem in home respite care.	Behavioral Health, cont.
Homemaker	H0036 Community psychiatric supportive treatment, Face to Face (<i>Behavioral Health Medical Day Program</i>); per 15 minutes. (*Modifier TF)
S5130 Homemaker services, NOS; per 15 min.	
	H0037 Community psychiatric supportive treatment program (<i>Behavioral Health Medical Day Program</i>); per diem.

*Modifier HQ – Modifier for group setting

*Modifier TF - Modifier for intermediate level of care

*Modifier TG - Modifier for complex/high level of care.