ANNUAL HCBS REPORT CYE 2018

(October 1, 2017 – September 30, 2018)

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TABLE OF CONTENTS

INTRODUCTION 3

THE MEMBER EXPERIENCE 5

MEMBER INITIATIVES 8
- Spouse as Paid Attendant Caregiver 8
- Self-Directed Attendant Care 8
- Agency with Choice 9
- Community Transition Service 11
- Community Intervener Service 11
- Prior Period Coverage for HCBS 12
- HCBS Litigation: *Ball v. Biedess (Betlach)* 12

CONTRACTOR INITIATIVES 14

AHCCCS ADMINISTRATION AND OVERSIGHT 16
- Arizona State Hospital (AzSH) Collaboration 16
- Long Term Care Case Management 16
- Electronic Visit Verification 19
- Network Development Plans 20
- Monitoring & Oversight 21
- Contractor Administrative Actions 22
- Direct Care Workforce Development 22
- TEFT Grant 24
- Home and Community Based Settings Rules 26
- ALTCS Advisory Council 28
- Olmstead Plan 29
- Autism Spectrum Disorder Advisory Committee 30
- Performance Measures 31
- Performance Improvement Projects 35

HCBS GROWTH AND PLACEMENT 37
- Membership by Contractor and Setting Type 38
- Statewide Placement Percentage by Setting Type 38
- Percentage of Growth by Setting Type 39
- HCBS Placement by Age Group 40

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INTRODUCTION

The Arizona Health Care Cost Containment System (AHCCCS) has implemented a long-term care program that serves both individuals who are elderly and/or have physical disabilities (EPD) and individuals who have intellectual and developmental disabilities (IDD) through Managed Care Organizations (Contractors) including the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) that strongly support opportunities for individuals enrolled in the Arizona Long Term Care System (ALTCS) program to live in home and community based service (HCBS) settings. To that end, in recent years AHCCCS continues to see an increase of members residing in their own homes and institutional placements continue to remain consistent (considering increases in population) for the past six years after a marked decline over the course of Contract Years Ending (CYE) 09-12.

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

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

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

- *Member-Centered Case Management*
  The member is the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of long term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goals(s) for achieving or maintaining his/her highest level of self-sufficiency. Education and up-to-date information about the ALTCS Program, choices of options and mix of services must be readily available to members.

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

- *Person-Centered Planning*
  The Person-Centered Planning process maximizes member-direction and supports the member to make informed decisions, so that he/she can lead/participate in the Person-Centered Planning process to the fullest extent possible. The Person-

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

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

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

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

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

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

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

A major initiative for the ALTCS program in CYE 18, beginning 10/01/17, was the implementation of a new contract for Contractors that serve the ALTCS membership who are elderly and/or who have physical disabilities. In addition to retaining the incumbent United HealthCare Long Term Care and Mercy Care Plan Contractors, AHCCCS awarded a new contract to Banner - University Family Care. All three awarded Contractors also have acute care contracts with AHCCCS. As noted in the

CYE 2017 report the following system design features of the new contract include, but are not limited to:

- Redistribution of the membership via new Geographic Service Areas
- Allowance of eligibility determination and enrollment into the ALTCS Program of an individual during a hospital stay
- Responsibilities for Contractors to refer ALTCS members for eligibility determinations for Serious Mental Illness (SMI)
- Provision of non-Title XIX services for those members determined to have an SMI
- Addition of Advanced Care Planning services as part of a service array for End of Life care
- Standard background check requirements for Direct Care Workers

Major initiatives addressed in both CYE 17 and CYE 18 include two federal program requirements, Home and Community Based Settings (HCBS) Rules and Electronic Visit Verification (EVV). Additionally, the ALTCS Program instituted innovation into the program by incorporating Workforce Development requirements for Contractors and developing a new service for individuals with a combined vision and hearing loss. All of these initiatives are addressed in subsequent sections in this report.

The information that follows details efforts and initiatives aimed at improving quality and promoting the expansion of HCBS.

THE MEMBER EXPERIENCE

The priority of the ALTCS Program is to ensure that members are living in the most integrated setting and actively engaged and participating in community life (i.e. employment, education, volunteer, social and recreational activities). The following member stories exemplify how these priorities present themselves on a day-to-day basis in the lives of members[1].

James – Abandoned as a child, one man with a developmental disability found a family in midlife, thanks to a caring Colorado couple who opened their residence as an adult developmental home. A developmental home is a family home that provides a private bedroom and supports for up to three individuals with developmental or intellectual disabilities. In Arizona, the ALTCS plan contracts with residential agencies that represent over 1,200 developmental homes to provide services to eligible members. James arrived at Bob and Betty's home on a Friday as a three-day temporary guest. That was 10 years ago. Five years later, the couple retired to Arizona and brought James with them.

Jeffrey - is a 63 year old gentleman who chooses to live at home with his sister. Jeffrey's sister provides his care (both paid and unpaid) allowing him to successfully remain at home because he has frequent seizures, is unable to speak, unable to move

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

independently, and aspirates easily. He leads a life that includes his favorite televisions shows and Christmas movies, as well as visits from his church deacon. When his sister experienced an unexpected medical condition and was hospitalized, Jeffrey was transitioned to a Skilled Nursing Facility for a respite stay to ensure his needs were able to be met without interruption. After a brief respite stay in the Skilled Nursing Facility, Jeffery was transitioned back home when HCBS services could be resumed. The case manager's continued commitment to supporting Jeffrey in his home coupled with the provision of respite services supported his seamless transition back home from a Skilled Nursing Facility.

Mary – is a 100 year old woman whose goal was to remain in her home with her family as she wanted to be a part of her daughters' lives and to receive care from them. Mary was able to meet her goal. She lives with her two daughters who share caregiver responsibilities. Mary says it gives her peace of mind to always have a daughter with her in the home. This year, for the first time, her daughters took a break and utilized Mary's respite benefit to support their continued ongoing caregiver responsibilities. In addition to the HCBS services, the Case Manager was able to support Mary's goal by arranging in-home primary care physician services. Mary has had only 1 hospital admission in over 10 years. She attributes her longevity and good health to being able to remain in her home where she is comfortable and well cared for. Mary loves to have visitors and share stories of her life on her family farm in Ohio and keeping up with the news. Mary and her daughters have indicated they are grateful for the services that ALTCS provides and looking forward to celebrating Mary's 101st birthday in April.

Victoria –Prior to becoming ill, Victoria and her husband lived in another state where she opened her home to multiple foster children, adopting 5 of them. Victoria has a diagnosis of ALS and was able to receive care from one of her favorite people in the world, her husband, through the Spouse as Paid Attendant Caregiver program. Over the years, her husband cared for her, meeting every need while showing grace, integrity and love. Her family also did whatever they could to make her comfortable. Eventually, Victoria and her husband were able to move from their apartment and purchase a home. They were excited, but it needed some work, including a bathroom modification, to accommodate Victoria. Besides providing the home modification, the Contractor was able to furnish an electric wheelchair for Victoria. These services allowed Victoria to live at home and remain involved in her community. Through the years, she has done amazing things, despite her medical condition. Victoria is a large part of the ALS community and each year her family raises money to support the ALS Organization ($50,000 in 10 years). Victoria has shown others with the diagnosis that they can accomplish more than one would expect. She has been on skydiving excursions and ridden on the back of a Harley. She recently started visiting others with ALS who are not able to attend support groups. Her lifestyle changed as a result of her illness but her willingness to give back continues, with the supports and services provided by the ALTCS Program.

Marcel - is a 45 year old gentleman who has been diagnosed with Multiple Sclerosis. Prior to Marcel's disability he held a full time job and was very active in his community. Marcel was getting discouraged about not being able to give back to his community and

he expressed this to his Case Manager. They discussed ways he could volunteer, but Marcel couldn't think of anything that wouldn't require extensive physical activity. Marcel asked his Case Manager about possibly volunteering at the Kingman Area Food Bank. The Case Manager contacted the Kingman Area Food Bank to coordinate an interview with Marcel. Although many of the opportunities at the food bank require strenuous physical activity, Marcel would help to fulfill a need as equally important, data entry. The Kingman Area Food Bank receives applications daily for services and Marcel's job is to review each application in the computer, determine if individuals have used the service within the last 30 days, and make relevant notes on the application(s). Marcel feels encouraged and excited about what the future holds.

Angie – is a 64 year old woman who was born with Cerebral Palsy. She has used a wheelchair for mobility assistance since childhood. Additionally, her daily routine requires assistance from staff to support activities of daily living. Angie has been attending Arizona Western College for the past two years and has been accepted to Northern Arizona University to pursue her Bachelor's degree. Angie comments about her accomplishment stating, "I want to honor my mom's memory who has always wanted me to go to college." She adds, "I want to be an inspiration to others whether they have a disability, are older, or anybody. If I can do it, anybody can."

Jake – is a 23 year old gentleman who was involved with a motor vehicle accident. As a result, he was diagnosed with a head injury, traumatic brain injury and right side hemiplegia. When he met his Case Manager, he was unable to communicate, feed himself, or complete the activities of daily living without significant assistance. After his enrollment in ALTCS, he received counseling services to help him work on self-esteem related to his injuries; wound care following his brain surgeries to ensure healthy healing; and a caregiver that works with him to provide assistance allowing him to complete tasks as independently as possible including supervision support so his parents can continue to work. Additionally, Jake participates in physical therapy, speech therapy and is re-learning how to read. Recently, Jake is starting to walk and transfer and shower himself. He has started socializing with friends and extended family and taking trips to Pinetop and San Diego. Jake has also been able to engage in a conversation with his Case Manager about his goals to move to San Diego due to his love of the beach and return to college to finish his Bachelor's degree in Public Health.

Robert - It was Robert's first time attending *Day at the Lake* and he had one goal in mind: to go fishing. Robert stated that he grew up fishing and he has not been fishing in years. Robert generally is a man of few words and expressions and a simple fishing expedition helped him to experience an outward expression of joy. Robert, his Case Manager and another member went for a fishing ride. The driver of the boat stated that he knew a place on the lake that was a good spot and after about 20 minutes of having no luck, Robert got a tug on his pole. The pole was bending and the fish was fighting, but Robert was able to reel in the fish all on his own. Robert's smile grew as he was able to see how big the fish was and even hold the fish. This was a wonderful moment that captured the joy experienced by catching his first fish in many, many years.

Douglas - During a reassessment visit, the Case Manager was exploring member empowerment goals with Douglas and he expressed that he wanted to volunteer more in the community. Douglas told her about previously owning a restaurant and that it gave him a sense of purpose. In the group home where he resides, he helps in the kitchen but he wanted to do more. The Case Manager and group home Manager collaborated to identify some volunteer opportunities that might be a good fit for Douglas. Soon Douglas was volunteering at Feed My Starving Children and taking it upon himself to hand out packed lunches directly to homeless people, twice weekly at a couple of local parks. Douglas commented that it made him "feel good to put smiles on those faces by providing them with some sustenance." Douglas' drive to volunteer helped spark a bigger idea with the group home Manager and he found a store front in Mesa that was willing to let the members in the group home set up a tent in front and hand out meals to homeless individuals. Douglas' desire to volunteer was contagious! Before long, Douglas and his roommates went to help serve 75 meals to homeless people in the community on one day. Everyone helped out to make it an impactful day, the group home staff helped prepare and pack meals and the Case Manager arranged for donations to fill lunch bags, which included water, snacks and hygiene supplies. Douglas told his Case Manager that seeing how one idea can inspire others to volunteer and the enthusiasm of his peers was great to see.

MEMBER INITIATIVES

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

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

  In CYE 2018, 1,605 members received paid services from their spouse, a 5% increase from the previous year.

- ***Self-Directed Attendant Care (SDAC)***
  AHCCCS implemented Self-Directed Attendant Care (SDAC) on September 1, 2008. SDAC offers ALTCS members or their legal guardians the choice of directly hiring and supervising their own Direct Care Workers (DCWs) without the use of an agency. It empowers members to have more control over their lives, leading to increased satisfaction and improved quality of life. Under SDAC, individuals have

the right and the ability to make decisions about how best to have their needs met, including determining who will provide the services they need and when the services will be provided. Participating members are supported by the services of a qualified fiscal agent who performs all employer payroll functions and Case Managers who provide general assistance. Case Managers may utilize the SDAC member manual to support members serving in the capacity of the employer of their DCW. Additionally, Case Managers may authorize the member training service to have an AHCCCS registered provider provide training to the member on how to exercise their employer authority.

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

- Bowel care, including suppositories, enemas, manual evacuation and digital stimulation;
- Bladder catheterizations (non-indwelling) that does not require a sterile procedure;
- Wound care (non-sterile);
- Glucose monitoring;
- Glucagon as directed by the health care provider;
- Insulin, subcutaneous injection only if the member is not able to self-inject;
- Permanent gastrostomy tube feeding; and
- Additional services with the approval of the Director and the Arizona State Board of Nursing.

The SDAC policy can be found on the AHCCCS website.

In CYE 2018, 439 members utilized this member-directed option, a 9% percent increase from the previous year.

- ***Agency with Choice***

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

  During CYE 2012, AHCCCS worked in collaboration with a Development and Implementation Council comprised of ALTCS members, providers, community stakeholders and Contractors. The Council's primary function was to provide input

on programmatic changes AHCCCS needed to make in order to implement the new Agency with Choice member-directed option, including policy and form changes.

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

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

In CYE 2015 and CYE 2016, AHCCCS planned to work in collaboration with Contractors to implement the use of these specific tools, but implementation has been postponed to CYE 18, 19 and 20 to align with the person-centered planning outlined in a forthcoming section. The aforementioned Case Manager training and tools will be incorporated into the person-centered planning initiative. In CYE 19 – 20, the new standardized person-centered planning document and case manager training will incorporate documentation standards and strategies to support members in making an informed choice about any of the member-directed options (including Agency with Choice). Additionally, the document and training will support Case Managers on how to assess whether or not a member/IR is fulfilling their respective roles and responsibilities and how to determine the need for additional support. Furthermore, AHCCCS is in the process of working on policy revisions that will incorporate standard policy and procedure requirements for provider agencies utilizing this member-directed option. The Contractors will monitor these standards during the annual monitoring visit.

The Agency with Choice policy can be found on the AHCCCS website.

In CYE 2018, 2,877 members utilized this member-directed option, a 10% decrease from the previous year. It is important to note, a total of 249 (9%) members utilize the combination of the Agency with Choice and Spouse as Paid Caregiver service model options.

The chart below is a seven-year summary of the annual percentage change of the membership's utilization of the Spouse as Paid Caregiver service model option, the

Self-Directed Attendant Care and Agency with Choice member-directed options. Reduction in utilization of the Agency with Choice, member-directed option, has resulted in the strategies noted above to with respect to case manager training and the revised person-centered planning document.

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

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

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

- ***Community Intervener Service***
  AHCCCS is developing this new ALTCS service for members with a dual sensory loss (both vision and hearing) planned to be effective October 1, 2019, the next

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

reporting period. Individuals with a combined vision and hearing loss may have their physical health, mental health, safety and welfare impacted by their impairments. The Community Intervener service will provide visual, auditory and environmental information to members which they are unable to gather on their own and that supports them to lead self-directed lives. Community Interveners are paraprofessionals with specialized training that will support members to access and receive intervention and skill building support related to:

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

During the course of the reporting period, AHCCCS held two stakeholder forums with members, families and other stakeholders with expertise in serving individuals with a dual sensory loss. The purpose of the forums was to share information about similar services adopted by other State Medicaid Programs and to solicit information that could assist policy development including setting parameters for the scope of the service, medical necessity requirements and workforce development standards.

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

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

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

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

  In 2004 the Federal District Court concluded that AHCCCS failed to provide members with equal access and ordered that AHCCCS provide each individual who qualifies for critical services with those services without gaps in service. The

following year the Federal District Court issued an Order which required AHCCCS to eliminate gaps in critical in-home services within 2 hours and mandated that ALTCS Contractors have back-up staff available. AHCCCS was also required to file monthly reports of gaps in critical services with the Court and to implement an expedited grievance process where members could contact a hotline.

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

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

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

The average monthly occurrence of a gap in critical service, for the period of October 1, 2017-September 30, 2018, was 0.04% which is within the historical low range (0.01 - 0.08 range).

To perform ongoing review of the delivery of critical care services, AHCCCS continues to require Contractors to monitor monthly instances of gaps in services

and submit a Quarterly Gap in Critical Services Log. In addition a Semi-Annual Report must be submitted which outlines trends in service delivery and any corrective actions implemented regarding gaps in services and grievances related to service gaps. Contractors use the analysis to work with providers to ensure that members receive services appropriately and to inform network development.

CONTRACTOR INITIATIVES

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

Arizona Department of Economic Security (DES), Division of Developmental Disabilities (DDD)

- The Contractor's Employment Services Specialists worked with Arizona Department of Education (ADOE) and DES/Division of Employment and Rehabilitation Services/Vocational Rehabilitation to negotiate an Intergovernmental Service Agreement (ISA) on Transition Services. The ISA establishes a statewide, interagency collaboration to bring together the resources of the three parties to facilitate a seamless transition of high school students with disabilities from secondary school to the world of work with the intent of maximizing their employability and integration into the workforce and the community.

- The Contractor, in partnership with the DES/Office of Community Engagement, continues to conduct presentations to the First Responder community. Presentations are intended to help First Responders obtain a better understanding of approaches to working with individuals with developmental disabilities. The audience of First Responders includes law enforcement, firefighters, 911 dispatchers, hospital personnel, etc. A series of ten (10) videos was also added to the presentation materials to accommodate First Responders in remote areas to have access to these important tools to support engagement with individuals with developmental disabilities.

Mercy Care Plan

- The Contractor established a project called the Hospital Readmission Reduction Project to mitigate risk for members with comorbidities post an inpatient hospitalization stay. Approximately 80% of Mercy Care Plan's community-based members receive attendant care services. Recognizing a DCW is often the most reliable outside source of contact that members receive on a regular basis, a successful program was developed with six attendant care agencies to address the needs of members post-hospitalization.

  The Project was designed to develop and support innovative and creative approaches in communities through a grassroots effort to utilize DCWs in an

expanded role. Initially best practices and barriers were identified by the attendant care agencies. Each agency then designed a program that focused on assisting members who experienced weakness or disorientation post-hospitalization with tasks such as picking up medications and attending primary care provider visits within seven days of discharge from the hospital. The DCWs were trained to assist members in reintegration from the acute setting to the community, coordinating home health nursing visits and scheduling durable medical equipment and delivery. The program has been instrumental in providing education to front-line caregivers who are more likely to recognize and take the necessary steps to provide the member the supports necessary to avoid a hospital readmission and remain stable in the community.

- The Contractor has developed a program called Mercy Paws understanding that pets are so important to members and sometimes members put pet care before their own care. With no other informal support or care options for their pets, members may delay or defer hospitalization or needed medical care out of fear for the welfare of their animals. The program cares for pets while members are hospitalized. Members complete advanced directives for their pets which outline important facts about the pets and grants permission for Mercy Paws to provide boarding and basic medical treatment to the pet if the member is hospitalized. The Case Manager activates the program when a member is hospitalized including going to the member's home to coordinate the rescue of the animal. Pets are taken to a rescue or foster home until the member returns from the hospital. The program allows for members to be secure in the knowledge that their beloved pet is being well cared for; thus allowing members to focus on their own hospitalization and convalescence.

UnitedHealthcare Community Plan

- The Contractor's case management's culture of **Member Empowerment (me*)** expects and requires its staff to really listen to verbal and non-verbal cues from members that may point to a personal goal or quality of living style to explore further. The Contractor believes that regardless of abilities, all people have personal goals they want to achieve, but support may be required for the member to accomplish the goal. Volunteerism and community service are important and visible elements of one's commitment to demonstrate social responsibility to our communities. Case Managers are helping members connect-the-dots to worthy organizations in their communities and supporting a more integrative lifestyle. There are work groups in both urban and rural areas to help explore ideas further, address barriers to volunteerism (personal as well as systemic) and engage in creative planning efforts to further integrate and connect members to their communities by contributing in the lives of others (both human and non-human) and, in-turn, positively impacting their own quality of life.

Banner University Family Care

- The Contractor has recognized that due to the prevalence of dementia, it is important that Case Managers can detect signs of dementia sooner and connect members, their family, and caregivers with proactive care. The Contractor has leveraged the Banner Alzheimer's Institute and the University of Arizona Center on Aging to provide dementia capable trainings for all Case Managers in order to initiate more timely referrals to optimize short and long-term outcomes. The training leads to early detection, understanding of behavioral and psychiatric symptoms, communication tips, the use of non-pharmacologic interventions, adaption of the physical environment and end of life planning. The Case Managers were provided an opportunity to apply what they learned throughout the training utilizing various case studies.

AHCCCS ADMINISTRATION AND OVERSIGHT

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

- ***Arizona State Hospital (AzSH) Coordination***
  On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) merged with AHCCCS in an effort of administrative simplification and to streamline monitoring and oversight of the Regional Behavioral Health Authorities throughout Arizona. Prior to the transition, ADHS/DBHS was responsible for oversight and monitoring of members who were conditionally released from the AzSH. AHCCCS is now responsible for this function and requires Contractors to develop and implement policies and procedures to provide high touch Contractor care management and other behavioral health and related services to each member on conditional release from AzSH consistent with the member's Court Ordered Conditional Release Plan. As stated in Contract, Contractors actively participate in the member's discharge plan prior to release. Contractors are not permitted to delegate the care management functions to a subcontracted provider and must submit a monthly comprehensive status report for each member on Conditional Release to the Psychiatric Security Review Board (PSRB), the member's attorney and to the designated AHCCCS Medical Management (MM) staff. AHCCCS staff participate in a phone discussion with Contractors regarding each member following receipt of the monthly report to ensure any potential compliance issue is thoroughly investigated. Issues of noncompliance are reported immediately by the Contractor to the PSRB, the member's attorney and AHCCCS MM designated staff.

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

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

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

- **Member-Directed Options Information**: Case Managers regularly inform members about member-directed options and assist members and their families to make informed decisions about the service delivery model of care.

- **End of Life Care:** Case Managers educate members/families on End of Life Care, which encompasses all health care and support services provided at any age or stage of an illness.

- **Serious Mental Illness Determinations:** Case Managers assess for the appropriateness of and submit referrals for members to receive a Serious Mental Illness Determination and, once affirmed, ensure members receive entitled services including grievance and appeals processes.

- **Cost Effectiveness Analysis:** Case Managers assess the continued suitability, appropriateness, and cost effectiveness of the member's in-home services. HCBS placement is the goal for ALTCS members as long as cost effectiveness standards and the member's medical, functional, social and behavioral health needs can be met in that setting. The Case Manager regularly assesses the cost of the HCBS services and compares them to the estimated cost of institutionalized care. Placement in an HCBS setting is considered cost effective if the cost of HCBS services for a specific member does not exceed 100% of the net cost of institutional care for that member.

- **Non-Medicaid Service Coordination:** Case Managers identify and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs, including community resources/services that support members in achievement of personal or independent living goals.

- **Goal Development:** Case Managers assist members to develop meaningful and measureable goals, including personal goals and independent living goals. Case managers also provide members with information about local resources to help them transition to greater self-sufficiency in the areas of housing, education and employment, as well as identify goals and preferences around the areas of recreation, friendships, and family relationships.

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

AHCCCS evaluated the Plans that were submitted for CYE 2018 and approved each Contractor's Plan for the delivery of case management and the evaluation of the previous year's activities and outcomes.

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

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

In August 2016, AHCCCS entered into an Interagency Service Agreement with the Sonoran University Center of Excellence in Developmental Disabilities (UCEDD) at the University of Arizona, a recognized organization with subject matter expertise in the arena of person-centered service planning. A multi-stakeholder advisory workgroup has been established to solicit input from members, families, service providers and Contractors. The implementation phases and associated tasks are outlined below through CYE 2020. Phase 2 was completed during the reporting period and Phase 3 is in process and expected to be completed in the next reporting period. The workgroup continues to meet on a regular basis and will continue to do so throughout the duration of the initiative.

Person Centered Planning Project	
Phase	**Tasks**
1	▪ Research of best practices for compliance and implementation of the HCBS Rules ▪ Analysis of current practices in planning and functional assessment of DDD and Tribal Contractors
2	▪ Analysis of current practices in planning and functional assessment ▪ Determination of steps necessary to comply with PCP requirements ▪ Provide technical assistance and recommendations for uniform PCP policies, procedures and forms to guide MCO/Tribal Contractors in implementing PCP requirements
3	▪ Develop competency-based training for case managers/support coordinators and others on Person-Centered thinking, philosophy and practice
4	▪ Pilot testing for PCP forms, policies, and procedures and training for MCO/Tribal Contractor Staff
5	▪ Finalize all policies and procedures ▪ Develop a cadre of trained PCP facilitators in the community to assist members needing enhanced PCP as well as training members in helping to lead their own plans

- ***Electronic Visit Verification***

  Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement EVV for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) by January 1, 2020 and for in-home skilled nursing services (home health) by January 1, 2023.

  The goals of instituting EVV in the AHCCCS program include:

  - Ensuring timely service delivery for members including real time service gap reporting and monitoring;
  - Reducing provider administrative burden associated with scheduling and hard copy timesheet processing;
  - Accommodating the lifestyles of members and their families and the way in which they manage care
  - Accommodating service provider business decisions and preserving existing investment in systems; and,
  - Generating cost savings from the prevention of fraud, waste and abuse.

  During the reporting period, AHCCCS engaged in the following activities to help inform decision making on the system design:

  - Conducted stakeholder forums and facilitated a public comment period to solicit feedback on the system model design.

- Disseminated a service provider Request for Information (RFI) survey to obtain specific information and data from providers to support informed decision making on the allowable use of existing EVV systems.
- Gathered and analyzed public comments and RFI survey responses to help inform decisions for the EVV solution to be outlined in the Request for Proposal (RFP).
- Submitted to and received approval from CMS on an updated Advance Planning Document.

- Drafted and released the EVV RFP.
- Drafted and released the Independent Verification and Validation (IV&V) RFP.

More information on EVV can be found on the AHCCCS website.

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

The Plan requires the Contractor to develop information on many issues relating to network sufficiency, including but not limited to the following:
  - Evaluation of the prior year's Plan
  - Current status of network by service type
  - How members access the system
  - Relationship between the various levels of the networks
  - Current network gaps
  - Immediate short term interventions when a gap occurs
  - Interventions to fill network gaps, and barriers to those interventions
  - Evaluation of the interventions
  - Strategies utilized to increase the percentage of members living in their own home
  - Any network issues identified during member and provider council meetings
  - How the network is designed for populations with special health care needs

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

AHCCCS evaluated the Plans that were submitted for CYE 2018 and approved each Contractor's Plan, including the methods for analyzing the network and identifying

and addressing network gaps. AHCCCS is in the process of reviewing the plans for CYE 2019.

- ***Monitoring and Oversight***

  AHCCCS regularly reviews Contractor operations to ensure compliance with Federal and State law, rules and regulations, and the AHCCCS Contract. Monitoring activities include review and approval of contract deliverables, regular coordination meetings with Contractors, provision of technical assistance, and both Focused and Operational Reviews. Focused Reviews are conducted based on trending information specific to one Contractor or across Contractors to assess compliance in a specific area of focus and provide targeted technical assistance. Operational Reviews are conducted in order to:
  - Determine if the Contractor satisfactorily meets AHCCCS' requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, Arizona Administrative Code and 42 CFR Part 438, Managed Care.
  - Provide technical assistance and identify areas where improvements can be made as well as identifying areas of noteworthy performance and accomplishments.
  - Review progress in implementing recommendations made during prior reviews.
  - Determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures.
  - Perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 waiver.
  - Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364.

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

  The Operational Reviews are conducted in a three year cycle evaluating each AHCCCS Contractor, including the three EPD and one DDD ALTCS Contractor, once during the cycle. When a Contractor is found to be out of compliance with AHCCCS standards, the Contractor must submit and obtain approval of a Corrective Action Plan (CAP) to address the deficiencies. The process includes a follow-up on the status of each CAP six months after the CAP is accepted. The results of the Operational Reviews are published on the AHCCCS website. AHCCCS' review of the ALTCS Contractors occurred from February to July 2016, with corrective action plans monitored until actions were completed and CAPs closed within the six month time frame. AHCCCS is currently preparing for a new cycle of Operational Review, which will include onsite reviews of the ALTCS Contractors from February to June, 2019.

- ***Contractor Administrative Actions***
  AHCCCS utilizes a variety of Administrative Actions to address ongoing or serious Contractor noncompliance including mandatory CAP, Notice to Cure, and sanctions. AHCCCS posts any Administrative Actions imposed on a Contractor on the AHCCCS Website.

  In 2017, AHCCCS imposed administrative actions on the DES/DDD Contractor related to quality of care requirements and access to timely services through DES/DDD's process for identification and assignment of providers to meet authorized service needs for members. In 2018 AHCCCS conducted a Focused Audit of the Contractor's Quality Management functions identifying significant results in noncompliance with contract requirements. These Administrative Actions remained open during 2018 and AHCCCS continues to provide enhanced monitoring and technical assistance through monthly meetings with the Contractor to review strategies and progress of actions, barriers and outcome measures as well as an onsite presence to provide direct oversight and guidance.

  In 2018, AHCCCS issued a monetary sanction to Bridgeway Health Solutions for its failure to comply with contract requirements for conducting timely member visits and assessments as a relinquishing Contractor during the transition/readiness period of the newly awarded EPD contracts effective October 1, 2017. Bridgeway's failure to conduct member assessments during this time period as required delayed timely assessment of member needs as well as negatively impacted transition activities for implementation of the newly awarded contracts.

  These Administrative actions can be found on the AHCCCS website.

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

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

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

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

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

In CYE 2016, AHCCCS initiated a cross-divisional project with the Division of Health Care Management and Provider Registration to identify and develop the following enhancements to the online database scheduled for release in CYE 2019 to coincide with the new Provider Management System:

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

Beginning in CYE 2018 in response to ensuring the sufficiency of the long term care workforce, Contractors are required to designate a Workforce Development Administrator. Further, Contractors are required to submit and monitor a Workforce

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

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

Detailed information on the direct care workforce initiatives can be found on the AHCCCS website.

- ***TEFT Grant***
  The demonstration grant for Testing Experience and Functional Assessment Tools in Community-Based Long-Term Services and Supports, known as TEFT, is designed to test quality measurement tools and demonstrate e-health in Medicaid long term care services and supports. The TEFT grant funding was awarded on April 1, 2014 and was originally scheduled to conclude on March 31, 2018. Year One was designated to develop work plans outlining all grant components, which mapped implementation in years two through four. Due to approval delays from CMS to utilize the tools for Round 2, AHCCCS requested and was approved for a no cost extension through March 31, 2019.

  The purpose of the TEFT grant is to support States in furthering adult quality measurement activities under section 2701 of the Patient Protection and Affordable Care Act. The TEFT grant advances the development of two national, rigorously tested tools that can be used across all beneficiaries using Community-Based Long Term Services and Supports (CB-LTSS), an area in need of national measures. Additionally, the grant offers funding and technical support to demonstrate the use of a Personal Health Record (PHR) and test new electronic standards for interoperability among long term services and supports data.

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

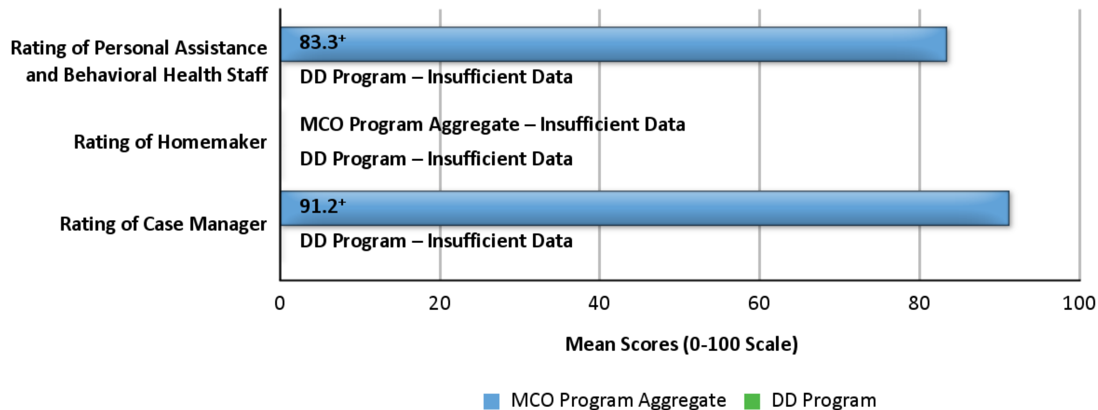
allowing all states within the TEFT demonstration to move forward with Round One. Round One training and assessments took place from March 2017 to July 2017. Truven and CMS analyzed the results to determine changes for the FASI tool for Round Two assessments. Round Two assessments were completed by all three ALTCS EPD Contractors in October 2017 and the final report will be completed in the next reporting period.

In 2016, due to the successful Round One testing, the Center for Medicare and Medicaid Services (CMS) was able to achieve a Consumer Assessment of Healthcare Providers and Systems (CAHPS) trademark for the Experience of Care survey. Under the new trademark, the survey was renamed as the CAHPS Home and Community Based Services Survey. In order to better utilize the CAHPS survey for Arizona, a workgroup was established to evaluate all questions and add any that may help Arizona better utilize the survey results. Below are topics of the additional questions created and approved by CMS for Arizona's version of the CAHPS Home and Community Based Services survey:

- Relationship of individuals that live with the member
- Identification as to whether or not family members are serving as paid caregivers
- Execution of the contingency plan to prevent gaps in care
- Quality of DCW training
- Timely follow up by Case Managers
- Personal goal development

Round Two of the Experience of Care survey was completed in June of 2018 with the final report available in August 2018. Arizona had a 7.04 percent response rate in Round Two of the survey. This was a 12.26% drop in response from Round One. Both EPD and DES/DDD members participated in the Round Two survey process, which included phone interviews by an independent third party. Due to timing and funding, the interviews were unable to be face to face interviews, which resulted in the lower response rate. Results from the Round Two survey are found on the next page.

Round Two Survey Results
Arizona Mean Scores for Composite Measures, by Program and All Programs Combined



+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Results based on fewer than 11 respondents were suppressed and are noted as "Insufficient Data."

- ***Home and Community Based Settings Rules***
  On January 16, 2014, CMS released final Rules regarding requirements for HCBS operated under section 1915 of the Social Security Act. The Rules mandate certain requirements for residential and non-residential settings where Medicaid members receive long term care services and supports. Specifically, the Rules establish requirements for settings to ensure that individuals receiving services are integrated into their communities and have full access to the benefits of community living.

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

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

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

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

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

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

In CYE 2016, AHCCCS prioritized the following site specific assessments in order to determine whether or not it is necessary and prudent to pursue the "heightened scrutiny" process CMS has instituted to allow states to preserve settings that are presumed to have institutional qualities and presumed not to be compliant with the HCBS Rules. Under the heightened scrutiny process, AHCCCS is responsible for identifying such settings and gathering and submitting evidence for CMS to make a determination as to whether or not the setting is or can become compliant by the end of the transition period. AHCCCS identified the following settings as potential candidates for the heightened scrutiny process:

- **Farmstead Community** – Defined as working ranches in rural areas on large parcels of land. There is one licensed farmstead community in Arizona serving eight members.

- **Memory/Dementia Care Units/Communities** – Defined as settings that provide supervisory and personal care services to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions. There are 79 memory/dementia care units/communities in Arizona serving approximately 1,000 members. A statistically significant number of settings statewide were randomly selected to participate in the assessment process.

The assessments were conducted in October – December 2016.

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

The assessment tools include the following:

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

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

In CYE 17, AHCCCS focused on preparing a revised Statewide Systemic Assessment and Transition Plan in response to CMS feedback and recommendations. AHCCCS received "initial approval" for the Plan in September 2017. In CYE 18, AHCCCS continued to collaborate with CMS to finalize the Transition Plan and prepare to implement remediation strategies outlined in the Plan to ensure the State's compliance with the HCBS Rules by March 2022. It is anticipated that AHCCCS will receive preliminary approval on the Transition Plan during the next reporting period and be in a position to begin implementation of the Transition Plan followed by a public comment period.

Detailed information on AHCCCS' activities to comply with the HCBS Rules can be found on the AHCCCS website.

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

In previous years, the ALTCS Advisory Council has advised on the State's compliance with Federal initiatives and identified opportunities for new service innovations including:

- Home and Community Based Setting Rules
- U.S. Department of Labor, Companionship Exemption
- Impact of limited access to transportation on a member's personal goal achievement
- Role peer supports can play in the ALTCS program
- Electronic Visit Verification
- Integration of aging individuals or individuals with a disability into the long term care workforce
- Contractor standards for identification of provider office accessibility in the Contractor's provider directories
- AHCCCS Quality Strategy

In CY 2018, the ALTCS Advisory Council provided input on, learned about and discussed the new Community Intervener service, supporting members to choose Contractors and providers, reporting quality of care concerns, and integrated health care.

- ***Olmstead Plan***

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

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

  There are still homeless people in Arizona who need a safe place to live. The 2014 Arizona Olmstead plan describes in detail how our community, including government and private funding, will come together to address housing needs. While an over-majority of individuals who are aging and individuals with intellectual and/or physical disabilities are living in integrated settings in their communities, they may not be actively engaged and participating in their communities. The working draft of the

Arizona Olmstead Plan outlines how the State can support these individuals to find resources, supports (i.e. assistive technology, employment, etc.) and individuals/agencies to provide the services.

In CY 2015 – CY 2016, the final draft remained under review by each of the state agency partners. Prior to finalizing the current draft of the Olmstead Plan, the Plan must reflect changes as a result of the aforementioned state agency merger. It is projected that the final draft will be completed in CY 2019.

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

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

  AHCCCS prioritized these recommendations and is currently in the process of operationalizing the recommendations into short term activities and system level changes. Short term activities include, but are not limited to, creating system maps, using consistent terminology across the system and in policy, and improving access to diagnosis and critical early intervention services, independently registering Board Certified Behavioral Analysts, creating a behavioral intervention policy, creating coordination of benefit/third party liability frequently asked questions document. For system level changes, the Committee recommended integrating physical and behavioral health care for individuals with ASD. Beginning on October 1, 2018, non-ALTCS members will have integrated physical and behavioral care under the AHCCCS Complete Care plans. ALTCS members with Intellectual and developmental disabilities will have integrated physical and behavioral health care provided by DDD's newly awarded sub-contractors beginning October 1, 2019. The ALTCS EPD Contractors have provided a fully-integrated product (long term services and supports, physical and behavioral health care) since the inception of

the program. Individuals with ASD may be eligible for any one of these Medicaid programs.

The ASD Advisory Committee continues to meet quarterly and advise on the implementation of the recommendations. Additional sub-groups are scheduled as needed to address specific topics or concerns proposed by committee members.

- ***Performance Measures***
  AHCCCS has developed performance measure sets for all lines of business, including Long Term Care, to further align with the CMS' Core Sets of Health Care Quality Measures for Medicaid. The measures and related Minimum Performance Standards (MPS) became effective on October 1, 2017 for the contract year ending September 30, 2018. It is AHCCCS' goal to continue to develop and implement additional Core Measures, including Managed Long Term Services and Supports (MLTSS) focused performance measures, as the data sources become valid and reliable. Current measures were chosen based on a number of criteria, which include greatest need for members, system ability to impact/improve results, alignment with national measure sets, and comparability across lines of business. Two sets of measures (including those in reserve status) are shown below - the first for the EPD membership, the second for the DES/DDD membership. AHCCCS uses the designation of "reserve status" to refer to performance measures for which AHCCCS is interested in receiving data for the purposes of tracking and trending, but has decided to withhold any regulatory action on at this time. It is important to note for the measures where a "baseline measurement year" is indicated, AHCCCS will develop a MPS once baseline data has been analyzed for each measure.

Elderly/Physically Disabled Measures	
Measure	**MPS**
Inpatient Utilization	95 Per 1,000 Member Months
Ambulatory Care - ED Utilization	80 Per 1,000 Member Months
Plan All-Cause Readmissions	17%
Follow-up After Hospitalization for Mental Health, 7 Days	85%
Follow-up After Hospitalization for Mental Health, 30 Days	95%
Mental Health Utilization	Baseline Measurement Year
Use of Opioids from Multiple Providers	Baseline Measurement Year

Use of Opioids at High Dosage in Persons Without Cancer	Baseline Measurement Year
CDC – HbA1c Testing	77%
CDC – HbA1c Poor Control (>9.0%)	43%
CDC – Eye Exam	49%
Flu Vaccine for Adults - Ages 18 – 64 yrs, 65 yrs and Older	75%
Advance Directives	65%
Percentage of Eligibles Who Received Preventive Dental Services	46%
Diabetes Admissions, Short-Term Complications	15 Per 100,000 Member Months

Elderly/Physically Disabled Measures in *Reserve* Status	
Measure	**MPS**
Screening for Clinical Depression and Follow-Up Plan	Baseline Measurement Year
Adults' Access to Preventive/ Ambulatory Health Services	75%
Annual Monitoring for Patients on Persistent Medications: Combo Rate	75%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	950 Per 100,000 Member Months
Heart Failure Admission Rate	350 Per 100,000 Member Months
EPSDT Participation – Ages 18 – 21 yrs.	68%
Developmental Screening in the First Three Years of Life	55%
Weight Assessment and Counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	50%
Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year

DES/DDD Performance Measures	
Measure	**MPS**
Inpatient Utilization	51 Per 1,000 Member Months
Ambulatory Care - ED Utilization	43 Per 1,000 Member Months
Plan All-Cause Readmissions	11%
Adults' Access to Preventive/Ambulatory Health Services	75%
Breast Cancer Screening	50%
Cervical Cancer Screening	64%
Chlamydia Screening in Women	63%
Advance Directives	65%
Use of Opioids From Multiple Providers	Baseline Measurement Year
Use of Opioids at High Dosage in Persons Without Cancer	Baseline Measurement Year
CDC - HbA1c Testing	77%
CDC - HbA1c Poor Control (>9.0%)	41%
CDC - Eye Exam	49%
Flu Vaccine for Adults - Ages 18 – 64 yrs, and Older	75%
Children's Access to PCPs, by age: 12-24 mo.	93%
Children's Access to PCPs, by age: 25 mo.-6 yrs.	84%
Children's Access to PCPs, by age: 7-11 yrs.	83%
Children's Access to PCPs, by age: 12-19 yrs.	82%
Well-Child Visits: 3-6 yrs.	66%
Adolescent Well-Care Visit: 12-21 yrs.	41%
Annual Dental Visits: 2-20 yrs.	60%

Percentage of Eligibles Who Received Preventive Dental Services	46%
Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year
Childhood Immunization Status	
DTaP	85%
IPV	91%
MMR	91%
Hib	90%
HBV	90%
VZV	88%
PCV	82%
Hepatitis A	85%
Rotavirus	60%
Influenza	45%
Combination 3 (4:3:1:3:3:1:4)	68%
Adolescents Immunizations	
Adolescent Meningococcal	75%
Adolescent Tdap/Td	75%
Human Papillomavirus Vaccine (HPV)	50%
Combination 1	75%
Combination 2	Baseline Measurement Year

DES/DDD Measures in *Reserve* Status	
Measure	**MPS**
Diabetes Admissions, Short-Term Complications	67 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	282 Per 100,000 Member Months
Heart Failure Admission Rate	75 Per 100,000 Member Months
Asthma in Younger Adults Admission Rate	75 Per 100,000 Member Months
Annual Monitoring for Patients on Persistent Medications: Combo Rate	75%
Weight Assessment and Counseling – Body Mass Index (BMI) Assessment for Children/Adolescents	50%
EPSDT Participation	68%
Developmental Screening in the First Three Years of Life	55%

- **EPSDT Participation:**
  Individual EPSDT Participation rates are not available for the reporting period. AHCCCS is currently redesigning measurement tools related to EPSDT Participation rates.

- **EPSDT Preventative Dental Services:**
  Individual EPSDT Preventative Dental Services rates are not available for the reporting period. AHCCCS is currently redesigning measurement tools related to EPSDT Preventative Dental Services rates.

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

  - *E-Prescribing:* The purpose of this PIP is to increase the number of prescribers electronically prescribing at least one prescription and increase the percentage of prescriptions which are submitted electronically, in order to improve patient safety. The baseline measurement period for the PIP was CYE 2014 (October 1, 2013 – September 30, 2014). AHCCCS has provided baseline rates to Contractors (shown below). The second remeasurement is inclusive of CYE 2017 (October 1, 2016 – September 30, 2017) data.

Percentages for the baseline measure period compared to the second remeaurement period for both indicators are included below.

E-Prescribing Improvement Project

Number of Providers Prescribing at least one prescription by ALTCS EPD Plans

ALTCS EPD HEALTH PLANS			
Health Plan	Percent of Providers who Prescribed at Least one Prescription Electronically CYE 2014	Percent of Providers who Prescribed at Least one Prescription Electronically CYE 2017	Overall Relative Percent Change
Bridgeway	37.70%	49.96%	32.52%
Mercy Care	47.62%	60.54%	27.13%
United Health Care	48.19%	61.07%	26.74%
Total	**49.74%**	**63.11%**	**26.89%**

E-Prescribing Improvement Project

Percent of Prescriptions Prescribed Electronically by ALTCS EPD Plans

ALTCS EPD HEALTH PLANS			
Health Plan	Percent of Prescriptions Prescribed Electronically CYE 2014	Percent of Prescriptions Prescribed Electronically CYE 2017	Overall Relative Percent Change
Bridgeway	21.29%	27.17%	27.61%
Mercy Care	23.99%	33.49%	39.58%
United Health Care	27.42%	36.39%	32.71%
Total	**24.57%**	**33.47%**	**36.21%**

E-Prescribing Improvement Project
Number of Providers Prescribing at least one prescription by DES/DDD Plan

DES/DDD PLAN			
Health Plan	Percent of Providers who Prescribed at Least one Prescription Electronically CYE 2014	Percent of Providers who Prescribed at Least one Prescription Electronically CYE 2017	Overall Relative Percent Change
DES/DDD	56.97%	67.40%	18.30%

E-Prescribing Improvement Project
Percent of Prescriptions Prescribed Electronically by DES/DDD Plan

DES/DDD PLAN			
Health Plan	Percent of Prescriptions Prescribed Electronically CYE 2014	Percent of Prescriptions Prescribed Electronically CYE 2017	Overall Relative Percent Change
DES/DDD	44.51%	62.00%	39.30%

- *Long Term Services and Supports (LTSS) - Assessment and Care Planning:* The purpose of this PIP is to establish a foundation that provides insight into the Contractors' current levels of performance (including the identification of notable areas needing improvement) and promote the evaluation/engagement of interventions aimed towards enhancing the Contractors' performance related to LTSS/MLTSS assessment and care planning through newly developed Center for Medicaid and CHIP Services and CMS measures. The baseline measurement period for the PIP is CYE 2018; baseline rates anticipated to be included within 2019 reporting.

HCBS GROWTH AND PLACEMENT

ALTCS program enrollment increased by 4.40% from CYE 16. The most significant growth (5.4%) in membership occurred within the DES/DDD program, compared to 3.3% growth in the EPD membership. The following table highlights the membership breakdown by placement setting type.

In CYE 2018 despite the population growth experienced in the ALTCS program overall, the percentage of members residing outside of a nursing facility remained consistent

with the trend in recent years at 87%, marking this the ninth consecutive year that the percentage has exceeded 70%. This growth is largely attributable to the service options and HCBS activities available to members, which are addressed in this report.

Membership Breakdown by Placement Setting Types - September 30, 2018						
Setting	Banner University Family Care	Mercy Care Plan	United HealthCare	DES/DDD	Total Membership	% of Total Membership
Own Home	3,081	6,046	4,165	24,995	38,287	62.79%
Assisted Living	1,401	2,670	2,706	7	6,784	11.13%
Group Home	0	5	7	3,071	3,083	5.06%
Developmental Home	0	3	0	1,478	1,481	2.43%
Behavioral Health Residential Facility	53	144	63	4	264	0.43%
Acute Services Only	86	217	127	3,058	3,488	5.72%
Total Membership in HCBS Placements	**4,621**	**9,085**	**7,068**	**32,613**	**53,387**	**87.56%**
Skilled Nursing Facility	1,763	2,952	1,821	43	6,579	10.79%
Institution for Mental Disease	0	1	0	0	1	0.00%
Residential Treatment Center	0	2	0	0	2	0.00%
ICF-ID	0	0	0	115	115	0.19%
Behavioral Health Inpatient Facility	0	4	17	0	21	0.03%
Total Membership in Institutional Settings	**1,763**	**2,959**	**1,838**	**158**	**6,718**	**11.02%**
Placement Data Not Available	38	664	142	24	868	1.42%
Total Membership	**6,422**	**12,708**	**9,048**	**32,795**	**60,973**	**100.00%**

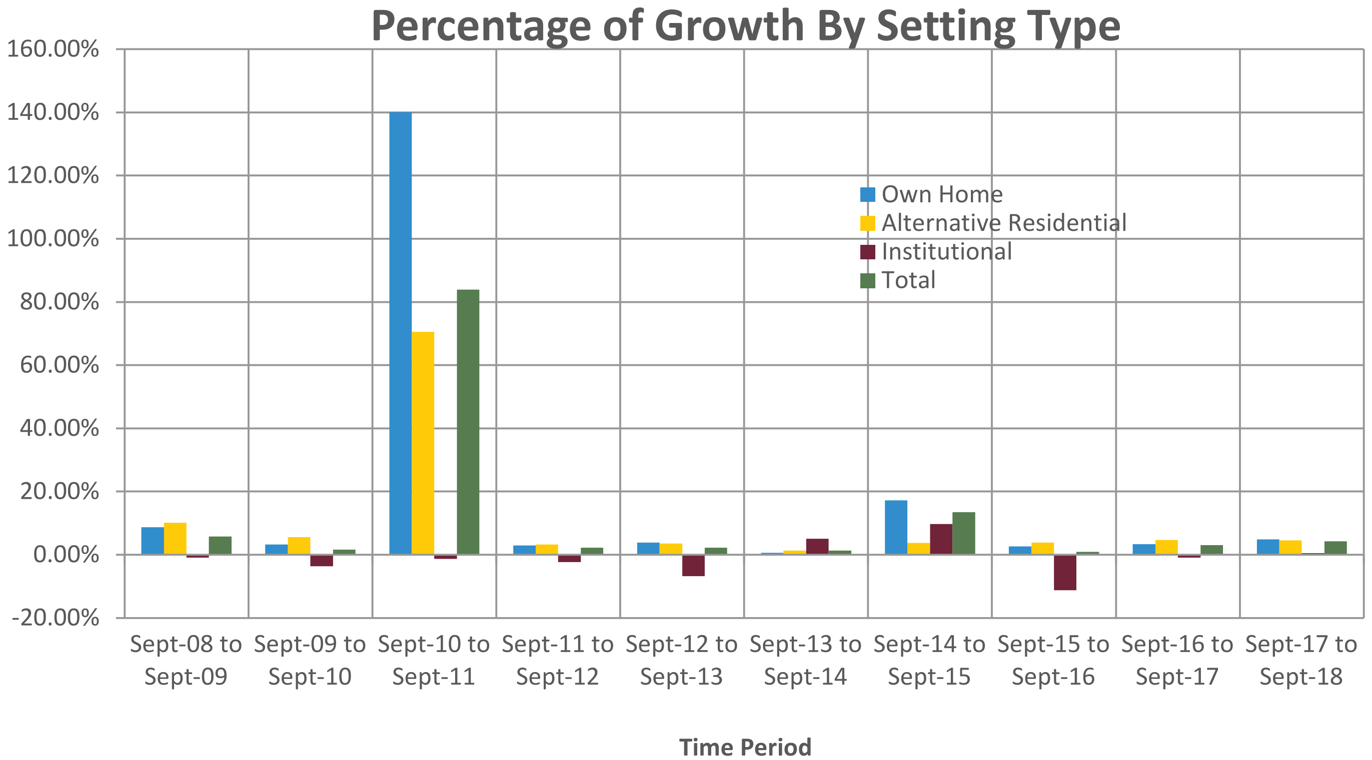
The following chart outlines the distribution of placement setting type[3] for the period of September 2009 through September 2018. Since 2009 the proportion of members residing in their own homes increased from 49% to 70%, while the proportion of the members residing in institutions declined from 31% to 11%. At the same time, the proportion of members residing in alternative residential settings remained stable in the range of 18-20%. This continues to demonstrate the program's commitment to advancing initiatives which result in the shift in placement for EPD and DES/DDD members to community-based placements.

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

The following graph shows the percentage of growth for each placement setting type[4] experienced since September 2009. The represented growth of members living in their

[3] The number of individuals receiving acute services only is captured in the "own home" category. Further, the number of individuals for which placement data is not available is not reflected in the data.
[4] Beginning 2011, DES/DDD placement information was incorporated.

own home is indicative of the growth in the overall population for DES/DDD in CYE 2018, the majority of who are living in their own homes.



The following table presents information detailing member placements broken down by three age[5] groupings (0-21, 22-64 and 65 plus) as of the conclusion of CYE 18 (September 30, 2018). Consistent with the historical trend, the number of members in the 65 year and older age group compose the highest proportion of members residing in institutional settings (24%). Conversely, the 0-21 year age group has the lowest proportion of members residing in institutional settings (0%). Only 10% of members 22-64 years of age reside in institutional settings.

ALTCS Placement by Age Group				
	0-21	22-64	65+	TOTAL
Own Home	20,083	13,028	8,655	41,766
Alternative Residential	629	4,967	6,016	11,612
Institutional	24	1,965	4,737	6,726
TOTAL	20,736	19,960	19,408	60,104
	0-21	22-64	65+	TOTAL
Own Home	97%	65%	45%	69%
Alternative Residential	3%	25%	31%	19%
Institutional	0%	10%	24%	11%
TOTAL	100%	100%	100%	100%

End of the Report

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