



ANNUAL HCBS REPORT
Contract Year Ending 2020
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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). AHCCCS and the Contractors strongly support opportunities for individuals enrolled in the Arizona Long Term Care System (ALTC) program to live in home and community based service (HCBS) settings. To that end, AHCCCS has maintained a consistent trend of HCBS member placements (considering increases in population) either plateauing or increasing as evidenced by a 2 percent decrease in institutional placements during the reporting period.

AHCCCS has accomplished these milestones through its ALTC 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 ALTC 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 their goals(s) for achieving or maintaining his/her highest level of self-sufficiency. Education and up-to-date information about the ALTC 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 ensure delivery, quality, and continuity of services in accordance with the person-centered plans 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, 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.

The report details efforts and initiatives aimed at improving quality and promoting the expansion of HCBS. All of the efforts outlined in the report were implemented during the reporting period; notable priorities include activities specific to COVID-19 Public Health Emergency response, abuse and neglect prevention, Electronic Visit Verification, and the Home and Community Based Settings’ regulation training plan implementation.

THE MEMBER EXPERIENCE

A main 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 and accomplishments of members¹.

Ryan - is 38- years-old and living with Muscular Dystrophy; he is experiencing the inability to ambulate or use his extremities. Ryan has always spoken about getting his doctorate and writing a book as part of his care planning goal setting. Through the advancement of assistive technology, he can use a computer to further his education. In June 2020, Ryan received his doctorate in psychology and has completed the

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.

first book in a series of fiction novels and started the second book in the series. Adding to his list of accomplishments, Ryan also has started his own life coaching business and is a public speaker.

Stephen - is 57-years-old and has been residing in a nursing home since July 2020. He has become a leader, advocate, and innovator for change within the nursing home. He partnered with the director of the nursing home to create a “Big Hearted Blossoms” board where all members of the nursing home can leave positive accolades and “Thank You” notes for the staff. Stephen’s hope is that this board will build morale amongst the staff, helping them realize how valued and needed they are. Additionally, Stephen created training material for staff that depicts care concerns and needs from a patient’s perspective. During the holiday season, Stephen partnered with his case manager in distributing items from a “goodie” basket. This contained Christmas hats, glasses, toys, candy, etc. that staff and members alike could win by answering trivia questions correctly. During these especially difficult times with COVID-19 and facility lock down, Stephen chose to approach the pandemic with positivity, creativity and resiliency.

Amy - is a 21-year-old member living with Down Syndrome. She is a golfer that started playing the sport with the Special Olympics. After advancing to a varsity team for three years in high school, she made it to the state team in 2017, an accomplishment deemed the “Best Moment of the Year for Arizona High School Sports” at the “azcentral.com Sports Awards.” Amy was the first golfer with Down Syndrome to have played in the state tournament. Last year she became the first person with Down Syndrome to obtain an athletic scholarship at Paradise Valley Community College (PVCC). After completing her studies at PVCC, Amy will become an ambassador for the I’ve Got This Foundation, an organization her parents founded to promote opportunities for individuals with disabilities to learn and play golf.

Vicktor - At age 18, Vicktor aged out of the foster care system. “I got lucky,” said Vicktor. “The [Contractor] was able to help me find [an apartment].” With the support he received to learn independent living skills, Vicktor has learned the bus system, met his neighbors, joined his neighborhood Block Watch program, and made new friends. “I do stuff for people,” said Vicktor. “I help out the neighborhood.” Vicktor has even ventured into a bike messenger business with a company called Postmates. He explained, “It’s actually a very good app that people use for take-out [meals]. I choose my own hours. I actually have customers who prefer me over others. I’m fast, quick, simple, and they prefer it [that way].”

Ny’Kol - is 30-years-old and has been living with paraplegia since 2012. Her circumstances have not stopped her from pursuing a degree from the University of Arizona. In May 2021, she will graduate with her undergraduate degree in Pharmacology Science. Following graduation, in August 2021, she will start the four-year Pharmacology School program also at the University of Arizona. In addition to her studies, Ny’Kol has been working at a CVS Pharmacy in Phoenix. She desires one day to be a Pharmacist.

Denise – is 68-years-old and resided in a skilled nursing facility while setting and accomplishing some personal goals to volunteer by helping to recognize fellow resident birthdays and plan birthday and other holiday parties. With the support of her case manager, she was able to form a relationship with a greeting card manufacturer who sends her cards at no cost. As Denise and her case manager continued to discuss personal goals, it was clear this experience had improved Denise’s self-confidence. She was ready to work towards a new goal of moving to a less restrictive setting in the community. After many years living in a skilled nursing facility, Denise moved to an assisted living facility where she feels more independent. As no surprise, Denise has become active on the resident council. She has taken her spirit of giving back a step further by engaging the resident council members to help with writing and sharing greeting cards with other residents. Denise helps plan and celebrate monthly birthdays and continues to

write cards for all occasions for those that reside in the assisted living facility, their families, and staff. Denise has improved the quality of her life and the lives of those in her community.

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 Contract Year Ending (CYE) 2020, 1,717 members received paid services from their spouse, a 9 percent 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 do 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 AHCCCS Director and the Arizona State Board of Nursing.

The SDAC policy can be found on the [AHCCCS website](#).

In CYE 2020, 449 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 his/her 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, and
- 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 was postponed to CYE's 2018, 2019, and 2020 to align with the person-centered planning outlined in a forthcoming section. The aforementioned Case Manager training and tools have been incorporated into the person-centered planning initiative. In CYE 2019, the new standardized person-centered planning document and case manager training addressed 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. In CYE 2020, the AHCCCS policy was revised to include standard policy and procedure requirements for provider agencies utilizing this member-directed option specific to their roles and responsibilities pertaining to the monitoring of the Partnership Agreement between the agency and member and communication protocols aimed at ensuring the members have the supports they need to be successfully employing the model. The Contractors will monitor these standards during the annual quality monitoring visit.

The Agency with Choice policy can be found on the [AHCCCS website](#).

In CYE 2020, 2,081 members utilized this member-directed option, a 16 percent decrease from the previous year. It is important to note, a total of 178 members (8 percent) utilize the combination of the Agency with Choice and Spouse as Paid Caregiver service model options.

The chart below is a five-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. Historical reductions in utilization of the Agency with Choice member-directed option have resulted in the strategies noted above with respect to case manager training and the revised person-centered planning document.

Service Model Options – Annual Percent Change					
Annual Percentage Change in Utilization	CYE 2016	CYE 2017	CYE 2018	CYE 2019	CYE 2020
Spouse as Paid Caregiver	0%	10%	5%	-2%	9%
Self-Directed Attendant Care	-13%	12%	9%	-6%	9%
Agency with Choice	-5%	-5%	-10%	-14%	-16%

- **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 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 required 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

assist 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 a new ALTCS service for members with a dual sensory loss (both vision and hearing); it is planned to be effective October 1, 2021. 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 the visual, auditory, and environmental information to members that 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

In CYE 2018, 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. In CYE 2019 -2020, AHCCCS utilized the input from the stakeholder forums as well as additional meetings with dual sensory loss subject matter experts to inform the development of the draft policy parameters, including the development of an assessment tool to determine medical necessity. In CYE 2022, AHCCCS plans to make the service available to ALTCS members with a dual sensory loss that meet the medical necessity criteria.

- ***Addressing Social Isolation***

The AHCCCS Whole Personal Care Initiative (WPCI) was launched in 2019 to address the social risk factors that can have an impact on a person’s health and well-being. It is believed that these factors (i.e., socio-economic status, behaviors and physical environment) contribute more to health outcomes than access to health care. One social risk factor that AHCCCS wants to specifically address for the ALTCS population is social isolation. There is strong evidence that social isolation is associated with poor health outcomes and higher rates of mortality. For example, according to the Journal of Aging Life Care, social isolation has been identified as having the same magnitude of impact on a person’s health as high blood pressure, smoking, and obesity. Additionally, as the American Psychological Association reported on their website, it has been noted to increase a person’s risk of dementia by 40 percent.

In CYE 2019 and CYE 2020, AHCCCS explored the creation of a new habilitation service model that would support members to develop skills to build relationships and community connections in their community of choice and further their personal goal development. Members would have the options for this service to be provided by peers who experiencing aging or living with a disability.

- **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 are 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, the 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 two 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 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 five 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 two annual reports. If the aggregate rate of gaps for authorized services is 0.1 percent or more for two consecutive months, the plaintiffs can request a meeting with AHCCCS to address the concerns, and, if not satisfied with AHCCCS’ efforts, the plaintiffs may seek judicial intervention. If no judicial enforcement action was pending at the end of the 25th month following approval of the Settlement Agreement, 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 percent 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 the 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 the plaintiffs' counsel were no longer required after November 2014.

The average monthly occurrence of a gap in critical service, for the reporting period, was 0.04 percent 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. These requirements will be sunsetted to coincide with the introduction and implementation of Electronic Visit Verification (EVV) beginning January 1, 2021.

AHCCCS is leveraging the EVV mandate to develop a more streamlined reporting approach to ensure, track, and monitor timely service delivery and access to care for members. AHCCCS is currently working with the State's EVV vendor to make system customizations and standard reports to assist providers, Contractors, and AHCCCS in using EVV to mitigate access to care challenges. This includes mechanisms to track and monitor the time it takes for members to receive a service once it has been determined to be medically necessary. Additionally, the reporting will support monitoring scheduled service visits versus occurrences of late or missed visits and the actions the providers took in response to a late or missed visit.

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.

One Contractor is elevating the awareness of elder abuse by developing and implementing an awareness campaign that outlines the importance of an appropriate process and response to identifying and reporting elder abuse. The Contractor has formed an Elder Abuse Coalition that meets on a monthly basis. Upon request by the Coalition members, materials found on the National Center on Elder Abuse website is shared monthly with the coalition members including educational videos on the different types of abuse, how to report abuse, and how to offer support to those who have been a victim of abuse. The monthly meetings also serve as an opportunity for coalition members to network and share resources and services provided by their organizations to the senior community. For World Elder Abuse Awareness Day, the coalition sponsored the disbursement of informational flyers on the different types of elder abuse to those receiving meals from the senior nutrition center.

One Contractor transitioned their Member Advisory Councils to a virtual platform as a result of the COVID-19 Public Health Emergency because members wanted to stay connected. During one of the meetings, a member presented his personal experiences living independently in the community. He shared that he owns and operates an organization that assists people with disabilities to remain socially active and to be able to participate in community life. This presentation initiated conversation and raised other questions around ways to combat the feelings of isolation and how to participate in other social activities when people are staying in their homes to protect themselves during the pandemic. Council members suggested helping to bring resources to the members to keep them active in their homes since community engagement might put them at risk. This got the attention of the Contractor’s Member Empowerment Resource Team. They sought out and provided low-cost ideas about activities members could do at home, ranging from puzzles, color pages and books, exercise and meditation activities, yarn and crocheting patterns, art supplies, and starting to, or revisiting, playing a musical instrument. The team created activity boxes: “50 things to do for free at home.” Case managers could request an activity box filled with activities based upon an individual member’s interest and it was mailed to their home. Additional, input from the Member Advisory Council resulted in enhancements to the activity boxes that may support improve mood, cognition, stress reduction, and depression for the members experiencing limited social outlets due to the pandemic.

One Contractor created a provider referral portal to streamline the referral process for establishing in-home services in the most time efficient way. Previously, a case manager would make individual phone calls to agencies relaying the same member need information over and over. After waiting a day for responses, another round of calls would be made repeating this process until an agency and direct care worker was identified. At times this posed a challenge to meeting timeline requirements for timely delivery of service. With the introduction of the portal, initiation of the referral process begins when the case manager gathers pertinent data related to the referral from the member or their health care decision maker and enters it into the portal. Once submitted, the referral is available for the entire network of provider agencies to view and consider. The agency that accepts the referral first will be contacted by the case manager following an exchange of introductory emails. Thereafter, the agency staff facilitates an initial meeting with the member and once approved by the member, an authorization for service is completed and start date of service provision is verified.

One Contractor is a recipient of a Section 811 Project Rental Assistance program grant from Housing and Urban Development (HUD), which enables individuals with disabilities who are income and ALTCS-eligible to live in integrated, affordable housing. As part of the Contractor’s broader efforts around affordable housing, a total of 14 members, during this reporting period, moved into affordable housing with 10 members receiving rental subsidies through the voucher program. Of the 24 members housed, three members made progressive housing moves from Adult Developmental Homes and two from group homes to reside in their own homes. From the conception of the Contractor’s Affordable Housing program (from October 1, 2017 to September 30, 2020) a cumulative cost savings of over \$898,000 has resulted.

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.

- **COVID-19 Response**

AHCCCS implemented a number of actions to combat and support risk mitigation of COVID-19 in CYE 2020. These efforts include requesting and receiving approval on new 1115 Waiver authorities, expanding the provision of telehealth services, and coordinating the COVID-19 response with the Arizona Department of Health Services and Contractors. AHCCCS held weekly meetings with the Contractors at the beginning of the Public Health Emergency (PHE) and has since been able to transition to less frequent meetings. AHCCCS also maintains an extensive list of FAQs on the AHCCCS website to help address questions and concerns from Contractors and stakeholders.

In March 2020, AHCCCS submitted requests to CMS to waive certain Medicaid requirements to enable AHCCCS to combat the continued spread of COVID-19. One such request under the 1115 Appendix K authorities is to specifically address the unique needs of maintaining access to care for ALTCS members during the Public Health Emergency. The approved authorities, in part, permit flexibility to expand efforts to mitigating workforce shortages, maintaining network adequacy of HCBS providers, expanding the eligible population for home delivered meals, and permitting remote assessment planning and approvals. Additionally, AHCCCS was granted flexibility to allow HCBS providers to accompany members to the hospital and provide care simultaneously in order to alleviate some of the burden on a very taxed hospital system as well as support members who may be scared or concerned when families were not allowed in due to COVID-19.

More information on the Agency’s COVID-19 response can be found on the [AHCCCS website](#).

- **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 to streamline monitoring and oversight of the behavioral health delivery system via 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 their 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 participates in a phone discussion with Contractors regarding each member, following receipt of the monthly report to ensure any potential compliance issues are thoroughly investigated. Issues of noncompliance are reported immediately by the Contractor to the PSRB, the member’s attorney, and AHCCCS 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 his/her 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 percent of the net cost of institutional care for that member.
- **Non-Medicaid Service Coordination:** Case Managers identify and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs, 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 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.

AHCCCS evaluated the plans that were submitted for CYE 2020 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 2021. The final Person Centered Service Planning (PCSP) workgroup meeting was held on May 27, 2020. Subsequently, the PCSP initiative has moved from the planning phase to the implementation phase. Due to COVID-19, implementation of the new PCSP and related policies were postponed in CYE 2020. AHCCCS is planning to hold the PCSP Train-the-Trainer event during the next reporting period in March 2021, with implementation of the new PCSP tool/process to follow in June 2021.

Person Centered Service Planning Project	
Phase	Tasks
1	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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 ALTCS/Tribal Contractors in implementing PCP requirements
3	<ul style="list-style-type: none"> ▪ Develop competency-based training for case managers/support coordinators and others on person-centered thinking, philosophy and practice
4	<ul style="list-style-type: none"> ▪ Pilot testing for PCP forms, policies, and procedures and training for ALTCS/Tribal Contractor staff
5	<ul style="list-style-type: none"> ▪ Finalize all policies and procedures ▪ Create educational materials and/or educational sessions for members on person-centered service planning.

- **Electronic Visit Verification (EVV)**
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, 2021² and for in-home skilled nursing services (home health) by January 1, 2023.

The goals of instituting EVV in the AHCCCS program include:

- Ensuring, tracking, and monitoring timely service delivery and access to care for members,
- 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
- Prevention, detection, recovery of improper payments due to fraud, waste, and abuse.

During the reporting period, AHCCCS engaged in the following major milestones to prepare for implementation of EVV:

- Received approval from CMS on the good faith effort exemption permitting AHCCCS to extend the timeline for compliance to January 1, 2021,
- Collaborated with the state-sponsored vendor to perform required system testing for AHCCCS and Contractors,
- Engaged in User Acceptance Testing with the state-sponsored vendor,
- Drafted the AHCCCS EVV policy in preparation of a public comment period,
- Released and monitored the Alternate EVV Vendor's compliance with technical and business requirements,
- Developed and prepared for the release of the training for providers using the state-sponsored EVV vendor including a combination of live-interactive training and Learning Management System accessible training,
- Added member and provider resources to the AHCCCS EVV Website, including regularly updated FAQs, and
- Facilitated regularly scheduled meetings with provider groups representing industries subject to EVV.

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 their networks meet the needs of ALTCS members they serve. In the Plan, the Contractors 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 Contractors to incorporate a Workforce Development Plan. Additional information on Workforce Development can be found in the subsequent Workforce Development section.

² On December 5, 2019, AHCCCS received approval from CMS to extend the timeline for compliance through 01/01/21.

Specifically, AHCCCS requires the Contractor to provide information on many issues relating to network sufficiency in the Plan, 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 percent or more of a Contractor’s HCBS membership resides in such settings.

AHCCCS evaluated the Plans that were submitted for CYE 2020 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 2021.

● ***Abuse & Neglect Prevention Task Force***

The Abuse & Neglect Prevention Task Force convened in response to an Executive Order to ensure the health and safety of Arizona’s most vulnerable citizens. The Task Force examined a broad range of concerns and opportunities aimed at enhancing the prevention of abuse and neglect. The Task Force developed 30 recommendations that fall under the following themes:

- Statewide public awareness campaign to encourage a statewide culture of abuse, neglect, and exploitation prevention educating the broader public of that commitment.
- Prevention and accountability of all state agencies, in collaboration with private vendors and stakeholders, to develop, disclose, implement, and monitor policies and practices aimed at preventing abuse, neglect, and exploitation, reporting incidents, conducting investigations, and ensuring incident stabilization and recovery.
- Multi-agency coordination where AHCCCS, DES, ADHS, and other critical system partners work to employ a coordinated, multidisciplinary team approach in preventing and addressing incidents of abuse and neglect.
- Signage implementation on how to report abuse, neglect, and exploitation to be prominently posted in all settings in which vulnerable individuals reside and/or receive services.
- State agencies, in partnership with community-based organizations, to offer evidence based training on abuse, neglect, and exploitation prevention, reporting, and recovery to vulnerable individuals and their families.
- Improvements in identification, tracking, and analysis of incidents of alleged abuse and neglect, including mechanisms for making data readily available to the public.
- Workforce development strategies which fosters workplaces that uphold the ideals of respect, attentiveness, and active support for all individuals receiving services and providing services within the State Medicaid program.
- Adult Protective Services registry checks and training to investigators.

- Supportive resources to help manage caregiver stress.
- Public access to Setting Monitoring Reports that include monitoring reports for group homes and adult developmental homes to the extent allowed by statute and privacy restrictions.
- Review of confidentiality requirements to identify potential revisions to statute and agency policies to allow information sharing between parties while maintaining required privacy and confidentiality protections.

More information on the Abuse and Neglect Prevention Task Force can be found on the [AHCCCS website](#).

- ***Monitoring and Oversight***

AHCCCS regularly reviews Contractor operations to ensure compliance with federal and state law, rules and regulations, the AHCCCS contract, and AHCCCS policies. 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 the 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 ALTCS E/PD Contractors 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. AHCCCS' review of the ALTCS E/PD Contractors occurred from February to April 2019. Corrective Action Plans will be monitored until actions are sufficiently completed and the CAPs are closed.

The results of previous Operational Reviews are published on the [AHCCCS website](#).

- ***Contractor Administrative Actions***

AHCCCS utilizes a variety of Administrative Actions to address ongoing or serious Contractor noncompliance, including mandatory Corrective Action Plans, Notices 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 imposed Administrative Actions on the DES/DDD Contractor related to concerns with the Contractor’s Quality Management functions and significant noncompliance with contract requirements, as a result of a Focused Audit completed in 2018. Additionally, an Administrative Action in 2018 was imposed on the DES/DDD Contractor regarding concerns around claims payment issues related to the delivery of Habilitation Consultation (Hab-C) services. In 2019, AHCCCS imposed an Administrative Action on the DES/DDD Contractor related to a claims processing system that is not in line with HIPAA Compliant transactions. In 2020, AHCCCS imposed an Administrative Action on the DES/DDD Contractor related to concerns around coverage and authorization requirements specific to Augmentative and Alternative Communication (AAC) devices. These Administrative Actions remain open throughout 2020 and AHCCCS continues to provide enhanced monitoring and technical assistance through weekly leadership meetings and monthly meetings with DES/DDD Contractor subject matter experts (SMEs) to review strategies and progress of actions, barriers, and outcome measures as well as an onsite presence to provide direct oversight and guidance. It is anticipated that the DES/DDD Contractor will be able to close out some of the Administrative Actions during the next measurement period as significant progress was made during CYE 2020.

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 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 support the Direct Care Workforce Committee in developing competency standards and training for direct care workers (DCWs) in Arizona.

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. AHCCCS also manages 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.

AHCCCS initiated a pending cross-divisional project with the Division of Health Care Management and Provider Registration to identify and develop the following enhancements to the online database:

- 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,
- Incorporate an audit role within the database to streamline tracking and documentation of training program audits by the Contractors and AHCCCS, and
- Develop 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 issue a survey of DCWs in partnership with the provider industry to gain insight into strategies that may support recruitment and retention efforts.

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](#).

In an effort to support long-term care workforce capacity challenges, the Arizona Legislature passed and the Governor signed Senate Bill 1244 into law in 2019 to streamline the transition of in-home DCWs to work as a caregivers in assisted living facilities. Specifically, the statute (A.R.S. 36-446.15) requires the State Board that oversees caregiver training requirements for assisted living facilities to align the training, competency, and testing methodology with the AHCCCS DCW standards. Additionally, the statute permits DCWs to transition to working in assisted living facilities by only having to pass the medication administration training, which is allowable within the scope of practice for an assisted living caregiver and not a DCW.

Detailed information on the direct care workforce initiatives can be found on the [AHCCCS website](#).

- ***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 developmental 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 establish a 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 Home and Community Based Rules Arizona’s Systemic Assessment and 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 2017, 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 to ensure AHCCCS’ compliance with the HCBS Rules by March 2022. For the period of September 2017 – February 2019, AHCCCS engaged in multiple meetings and/or correspondence with CMS, pertaining to the outstanding requirements for AHCCCS to meet in order to obtain “final” approval of the Transition Plan.

In February 2019, CMS confirmed the current revisions to the Transition Plan to-date are satisfactory. However, CMS will not officially approve Arizona’s Systemic Assessment and Transition Plan until after the first round of site specific assessments have been completed, a public comment period is held, and the State’s reports to CMS are satisfactory.

In March – May 2019, AHCCCS held a public comment period including statewide stakeholder forums to provide information on updates made to the Transition Plan and solicit comments that will be used to help inform the implementation of the Transition Plan. During the public comment period, AHCCCS recruited stakeholders to participate in setting-specific workgroups to advise on the compliance assessment tools and tool kits for both members and providers. Workgroups were formed to represent each unique setting type and initial meetings started in August 2019.

Through March 2020, AHCCCS continued work with the HCBS Workgroups to create the assessment tool suite to be used to assess a setting’s HCBS compliance. The final versions of the tools included a provider self-assessment, member survey, and observation tool used to validate the provider’s self-assessment. In January-February 2020, AHCCCS held two provider training sessions to orient providers to the HCBS Rules the assessment tools and the quality monitoring process. The quality monitoring process was put on hold due to the COVID-19 PHE. In lieu of starting the compliance assessments, AHCCCS regrouped with the workgroups and Contractors to determine how to move forward with assessments amid a pandemic. It was decided to prioritize those settings that may have institutional characteristics and, therefore, potential candidates for “heightened scrutiny” based upon self-reported survey results and MCO quality monitoring history. Beginning October 2020, the Contractors planned to perform desk audits, for the targeted provide audience, using the provider self-assessment tool. The findings will be used to determine the prioritization of providers when the quality monitoring visits can safely resume during or after the PHE. Work continues on the reimagining and retooling of the assessments tools to accommodate COVID-19 response by providers.

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, state agencies, 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.

The ALTCS Advisory Council has advised on the State’s compliance with federal initiatives and service delivery system innovations as well as received information on notable topics of interest including, but not limited to:

Federal Initiatives:

- Home and Community Based Setting Rules
- U.S. Department of Labor, Companionship Exemption
- Electronic Visit Verification

Service Delivery System Design:

- The role peer supports can play in the ALTCS program
- 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
- New Community Intervener Service
- Integrated health care
- Revisions to the Agency with Choice member-directed option policy
- Person Centered Service Planning

Other Notable Topics of Interest

- Reporting quality of care concerns
- Supported decision making
- COVID-19 response

● *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. The respective state agencies 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 people experiencing homelessness 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 CYE 2015 – CYE 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 state agency merger between the Arizona Department of Health Services, Division of Behavioral Health Services, and AHCCCS in July 2016. It is important to note, that although the Olmstead Plan was not finalized, the respective agencies have been employing the program, policy, and practices outlined in the current draft version. AHCCCS has developed a strategy to resume the Olmstead Planning and finalize a new Plan in CYE 2021 that is reflective of both the aforementioned state agency merger and AHCCCS' integrated care delivery model that was implemented in October 2018.

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, Contractors, 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. Completed short term activities include, but are not limited to:

- Creating system maps and using consistent terminology across the system,
- Improving access to diagnosis and critical early intervention services,
- Independently registering Board Certified Behavioral Analysts and linking appropriate code set services,
- Creating a behavioral intervention policy,
- Creating specialized diagnosing provider list by Contractor,
- Leveraging Targeted Investments funding for integration,
- Implementation of Habilitation Consultation (Hab-C) by DES/DDD, and
- Development of Centers of Excellence.

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 have integrated physical and behavioral care under the AHCCCS Complete Care plans. ALTCS members with intellectual and developmental disabilities have integrated physical and behavioral health care provided by DDD's newly awarded sub-contractors beginning October 1, 2019. The ALTCS E/PD 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. Ongoing conversations continue to explore additional Centers of Excellence for members with ASD, coordination of benefits with third party liability, and aging members with ASD. Additional sub-groups are scheduled as needed to address specific topics or concerns proposed by committee members.

- ***Performance Measures***

AHCCCS worked to strategically align its statewide performance measures with the CMS Child and Adult Core Sets prior to implementation of mandatory child and behavioral health measure reporting. As a result, substantial updates were made to the Performance Measure sets found within the MCO contracts starting with CYE 2020. AHCCCS intends to prioritize its focus on meaningful measures specific to the population(s) served and high priority agency initiatives. It is AHCCCS' goal to incorporate Managed Long Term Services and Supports (MLTSS) focused performance measures as the data sources become valid and reliable.

In addition, AHCCCS transitioned from utilizing External Quality Review Organization (EQRO) calculated rates to measure and report MCO level data to utilizing MCO-calculated performance measure rates that have undergone EQRO validation starting with its 2020 performance measures. Beginning with its CYE 2021 contract amendments, AHCCCS transitioned from its use of internally established Minimum Performance Standards (MPS) to the use of national benchmark data (i.e., CMS Medicaid Median and NCQA HEDIS® Medicaid Mean) to evaluate MCO performance. AHCCCS also intends to utilize historical performance data to evaluate MCO, Line of Business, and Agency performance.

- ***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. AHCCCS considers a PIP as a planned process of data gathering, evaluation, and analysis to determine interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and usually last at least four years. While Contractors are required to select and implement their own PIPs to address self-identified opportunities specific to their plans, AHCCCS mandates other program-wide PIPs in which Contractors must participate, and monitors performance until each Contractor meets requirements for demonstrable and sustained improvement. ALTCS members were included as target member audiences for the PIPs noted below.

- **Back to Basics:** The Back to Basics PIP has been selected for the DES/DDD Contractor with a baseline measurement year of CYE 2019. The purpose of this PIP is to increase the number of children and adolescent well-child/well-care visits, and to increase the number of children and adolescents receiving annual dental visits.
- **Breast Cancer Screening:** The Breast Cancer PIP has been selected for ALTCS E/PD Contractors with a baseline measurement year of CYE 2019. The purpose of this PIP is to increase the number and percent of breast cancer screenings.

Baseline rates and additional details for both PIPs are anticipated to be included within CYE 2021 reporting.

HCBS GROWTH AND PLACEMENT

ALTCS program enrollment was negligible overall from CYE 2018. The most significant growth (4.4 percent) in membership occurred within the DES/DDD program, compared to a 6 percent decline in the EPD membership. The following table highlights the membership breakdown by placement setting type.

In CYE 2019, the percentage of members residing outside of a nursing facility remained consistent with the trend in recent years at 89 percent. This successfully sustained rate is largely attributable to the service options and HCBS activities available to members, which are addressed in this report.

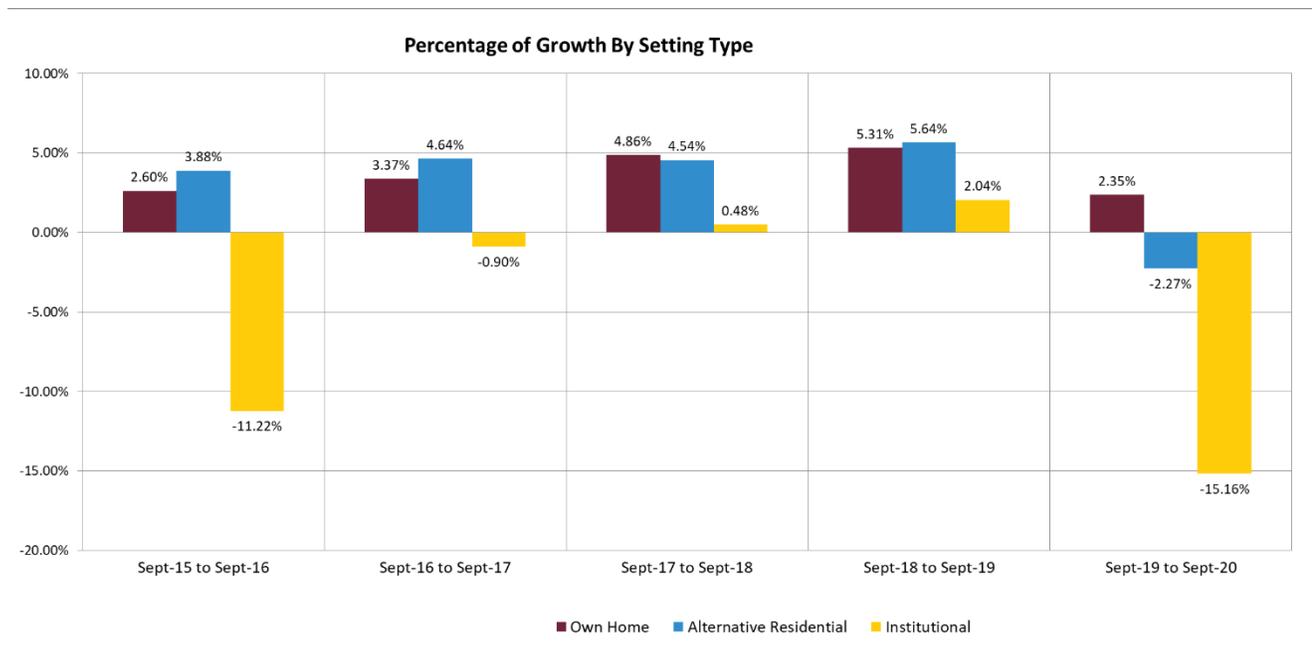
Membership Breakdown by Placement Setting Types - September 30, 2019						
Setting	Banner University Family Care	Mercy Care Plan	United Healthcare	DES/DDD	Total Membership	%of Total Membership
Own Home	3,300	5,920	4,460	27,387	41,067	64.31%
Assisted Living	1,447	2,557	2,810	23	6,837	10.71%
Group Home	0	4	1	3,282	3,287	5.15%
Developmental Home	0	1	1	1,570	1,572	2.46%
Behavioral Health Residential Facility	77	150	58	6	291	0.46%
Acute Services Only	91	193	177	3,513	3,974	6.22%
Total Membership in HCBS Placements	4,915	8,825	7,507	35,781	57,028	89.30%
Skilled Nursing Facility	1,506	2,448	1,703	14	5,671	8.88%
Institution for Mental Disease	0	0	1	0	1	0.00%
Residential Treatment Center	0	1	0	0	1	0.00%
ICF-ID	0	0	0	105	105	0.16%
Behavioral Health Inpatient Facility	0	5	17	0	22	0.03%
Total Membership in Institutional Settings	1,506	2,454	1,721	119	5,800	9.08%
Placement Data Not Available	43	712	74	201	1,030	1.61%
Total Membership	6,464	11,991	9,302	36,101	63,858	100.00%

The following chart outlines the distribution of placement setting type³ for the period of September 2016 through September 2020. Over a decade ago (2009) the proportion of members residing in their own homes was as low as 49 percent and has currently grown to 72 percent, while the proportion of the members residing in institutions declined from 31 percent (2009) to the current 9 percent. The proportion of members residing in alternative residential settings remains stable at 19 percent. This continues to demonstrate the program’s commitment to advancing initiatives which result in the shift of placement for EPD and DES/DDD members to community-based placements.

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.

Statewide Placement Percentage by Setting					
	Sep-16	Sep-17	Sep-18	Sep-19	Sep-20
Own Home	69%	69%	70%	70%	72%
Alternative Residential	19%	19%	19%	19%	19%
Institutional	12%	12%	11%	11%	9%
Total Membership	100%	100%	100%	100%	100%

The following graph shows the percentage of growth for each placement setting type experienced since September 2015. CYE 2020 shows an almost equal growth of members living in their own home to the reduction in those living in an alternative residential setting.



The following table presents information detailing member placements broken down by three age⁴ groupings (0-21, 22-64, and 65 plus) as of the conclusion of CYE 2020 (September 30, 2020). Consistent with the historical trend, the number of members in the 65 years and older age group compose the highest proportion of members residing in institutional settings (21 percent). Conversely, the 0-21 years of age group has the lowest proportion of members residing in institutional settings (0 percent). Only 9 percent of members 22-64 years of age reside in institutional settings.

⁴ The number of individuals for which placement data is not available is not reflected in the data.

ALTCS Placement by Age Group				
	0-21	22-64	65+	TOTAL
Own Home	21,934	14,132	8,958	45,024
Alternative Residential	739	5,127	6,122	11,988
Institutional	17	1,901	3,898	5,816
TOTAL	22,690	21,160	18,978	62,828
	0-21	22-64	65+	TOTAL
Own Home	97%	67%	47%	72%
Alternative Residential	3%	24%	32%	19%
Institutional	0%	9%	21%	9%
TOTAL	100%	100%	100%	100%

-- End of the Report --

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