ANNUAL HCBS REPORT
CY 2016
(10/1/15– 09/30/16)

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(10/01/2015 – 09/30/2016)

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 disabilties (EPD) and individuals who have intellectual and developmental disabilities (IDD) through the Managed Care Organizations (Contractors) including the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) that strongly supports 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) the past four years after a marked decline over the course of Contract Years Ending (CYE) 09-12.

The AHCCCS Administration has accomplished these milestones by its Arizona Long Term Care System (ALTCS), a long term care program that promotes and adheres to the values of:

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

Guiding principles have also been 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 and other applicable settings are available to an individual as long as the cost of HCBS services 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 16 was the development of the Request for Proposal (RFP) for Contractors that serve the ALTCS membership who are elderly and/or who have physical disabilities (E/PD) beginning 10/01/17 (CYE 18). The submissions of response to the RFP will be evaluated and awarded in CYE 17. Highlights of the system changes incorporated into the RFP are noted in applicable sections throughout the report. General system design changes outlined in the RFP include, but are not limited to:

- Redistribution of the membership via new Geographic Service Areas
- Allowance of the enrollment of a new ATLCS member during a hospital stay
- Responsibilities for Contractors to refer ALTCS members for eligibility determinations for Serious Mental Illness including the provision of both Title XIX and non-Title XIX services.
- 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

The information that follows details efforts and initiatives aimed at improving the 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].

Ruben was enrolled with the ALTCS program as a result of his injuries from an auto accident. Prior to his accident, Ruben was employed as a Chef. He has been exploring potential **me*** (Member Empowerment) goals with his Case Manager. During that process, he expressed his desire to return to working as a Chef was not realistic because he uses a wheelchair for mobility and now the grease would splash in his face as he cooked. Ruben's Case Manager educated him about his opportunity to work and maintain his ALTCS benefits; she provided support and resources to help him achieve his personal goal including going to the Arizona@Work (One Stop) Career Center in Nogales, Arizona and obtaining information about the program for Ruben. Ruben received support from the Career Center in the form of vocational training to become a phlebotomist. He is currently awaiting his internship at the local hospital in Nogales. Once he completes this internship, his plans are to return to the workforce part-time as a phlebotomist.

Allen is 53 years old and was residing in an Assisted Living Center in rural Arizona. Due to Allen's medical conditions many of the individuals involved with his care didn't feel that Allen would be successful living on his own. Allen's Case Manager worked with him to identify Member Empowerment (**me***) goals to live in the community and be as independent as possible. His Case Manager scheduled appointments with is Primary Care Physician (PCP) to obtain consultation on Allen's goals and to make sure all his medical needs were stable. She also coordinated a Psychiatric Evaluation for Allen to ensure his capacity to make decisions. Once Allen and his Case Manager were able to determine that his physical and behavioral health needs were stable, his Case Manger presented him with a list and arranged for tours of low income housing in the area for him to consider. Allen selected an apartment and his Case Manager and a friend were able to assist him in filling out the application. Allen was approved for the apartment. The Case Manager was able to help him locate his belongings in storage and individuals who would be willing to help him move the furniture into his new home. The Case Manager was also able to assist in obtaining additional household items for Allen through donations including kitchen supplies, bathroom supplies and bedding. Attendant Care services were put in place to help Allen with his day-to-day needs. He also started life coaching with his behavioral health provider who was also able to facilitate enrollment into habilitation classes to help him learn to do laundry, cook and pay his bills. Allen continues to thrive in his new home and enjoys the socialization with the other residents at his complex.

Jeremy lived in several different skilled nursing and assisted living facilities before moving into a specialized behavioral health residential facility that provided integrated care to meet his physical and behavioral needs where he lived for 6 years. After a recent hospitalization, Jeremy decided he'd like to move to his parents' home. Jeremy and his parents worked with the Case Manager to

[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.

develop an action plan to ensure Jeremy's success at his parent's home. Jeremy's parents visited him at the facility and he, in turn, visited his parents at their home, extending their visits until such time they were all ready for the move. Jeremy moved home with his father who became his paid caregiver. Jeremy's transition was able to help him successfully reintegrate into the community. He now attends an Adult Day Program, goes to the gym and goes on walks with his father. He also has gone on family vacations and numerous family outings. Jeremy's new goal is to live in his own place.

Julissa has been an ALTCS member since she was a child, and is now an advocate for youth with disabilities. At the age of 9, Julissa had a stroke that left her partially paralyzed, unable to communicate and subject to seizures. Through the support of the ALTCS Contractor, Julissa started therapy, received a communication device and received assistance with activities of daily living. Over the past 10 years, Julissa has continued to make steady progress including graduating from high school. After graduating from high school, Julissa enrolled in a program that helped her manage her life with a head injury so she could prepare for employment. She made great strides in her physical abilities, cognitive function and overall life skills. She is now in the volunteer employment phase of the program. Julissa also participated in the Arizona Youth Leadership Forum for young adults with disabilities who are transitioning to the workforce and developing self-advocacy skills. She will return next year to offer her services as a mentor.

Leonard was living an isolated lifestyle with a non- supportive roommate when the Case Manager assisted Leonard and his family in finding placement in an Assisted Living Center (ALC). Following the move, Leonard continued to be isolated and did not socialize with other residents or participate in activities. His Case Manager recognized Leonard's challenges with socialization and referred him to a peer support group and for counseling. At first, Leonard would cancel his transportation and refuse to go. His Counselor reached out to him by making visits to the ALC and encouraged his participation in peer support. Leonard now participates in activities at the ALC and attends the peer support group on a regular basis including speaking publically at an event about the peer support group.

Lawrence became an ALTCS member following a Cardio Vascular Accident. He lives alone and has no family or informal support and was experiencing further decline in his health and independence. After a fall and resulting hospitalization, Lawrence was very hesitant to accept any help fearing this would take away his independence. The Case Manager was able to develop a rapport with Lawrence and he agreed to accept a few hours of attendant care. He gradually realized he would need more help – allowing for an increase in care. He is now very confident in the ALTCS Contractor's ability to assist him. He further accepted an emergency alert system referral and an in-home Primary Care Physician. Lawrence reports improved health as evidenced by losing unwanted weight, drinking more water, increased strength and ambulation, control of his diabetes and improved vision as the result of cataract surgery. Lawrence has become socially active within his neighborhood and his community church is providing Eucharistic Ministry weekly at his home.

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's 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 2016, 1,388 members received paid services from their spouse. The utilization of this service model option remains consistent with the 1,391 reported in 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 2016, 360 members utilized this member-directed option, a 13 percent decrease 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 new 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 to align with the execution of the new ALTCS EPD contract beginning 10/01/17. The Agency with Choice policy can be found on the AHCCCS website.

In CYE 2016, 3,395 members utilized this member-directed option, a 5 percent decrease from the previous year. It is important to note, a total of 268 (8%) members 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 and the Self-Directed Attendant Care and Agency with Choice member-directed options.

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

- ***Community Transition Service***

The implementation of the Community Transition Services option was approved by the Centers for Medicare and Medicaid Services 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.

The ALTCS EPD Contract beginning CYE 2018, incorporates enhanced affordable housing assistance requirements for Contractors to identify, refer and track progress of the membership's utilization of affordable housing. The Contractors are also required to build relationships with housing providers and public housing authorities for the purposes of developing innovative practices to expand housing options for ALTCS

- ***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.

- ***Prior Quarter Coverage for HCBS***

Beginning January 2014, AHCCCS members can be determined to have "Prior Quarter Coverage" eligibility and have health care coverage as early as three months prior to the month the prospective member applied for services. In order to be eligible for "Prior Quarter Coverage," the prospective member must have received one or more AHCCCS covered

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

services and would have met AHCCCS qualifications for eligibility at the time services were received.

- **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 E/PD 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 .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 .05-.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 had been presented, and unless a judicial enforcement action had been filed by Plaintiffs in December 2014, the Court would no longer retain jurisdiction of this matter after December 2014 and the case would be 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 10/01/15-09/30/16 was .04% which is lower than the historical low range (.05-.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 drive network development and to work with providers to ensure that members receive services appropriately.

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 has created the Community and Peer Empowerment (CAPE) program which aims to encourage and support the development of a naturally occurring community of peer support. Members offer help and services based upon their abilities. For example, one member may need assistance with lawn care, but is able to provide rides to the grocery store. By mutually supporting each other, members are able to work together to meet many of their needs as individuals and as a community. Members have also volunteered to act as community organizers for the program. They answer questions from community members about the program, organize community events, and organize transportation as needed.

- One Contractor has employed the Health Sense Program, a personal health support tool in the form of a remote monitoring system that is designed to help members stay healthy and independent at home. The system is made up of a few small devices that are strategically placed in the member's home. There are no cameras, microphones, beeps or buzzers. The system "learns" daily patterns of activity of the member within the home and notifies their Case Manager when patterns significantly change resulting in the Case Manager contacting the member to inquire and assess for potential interventions. Changes in activity patterns can sometimes signal an oncoming illness or condition change. The Health Sense Program allows for early intervention of health concerns and results in a member having improved quality of life by:
  - Timely visits with their Primary Care Physician
  - Fewer trips to the Emergency Room
  - Fewer inpatient stays in the hospital
  - Increased ability to remain independent in their own home

- One Contractor supported the development of two peer-led support groups and one Alzheimer's support group. One peer support group is comprised of young men that have

experienced a spinal cord injury. Topics discussed include education, housing, employment, relationships, community resources and personal stories. The second peer support group is for persons with Aphasia. Members meeting with peers with the same disabilities and challenges has been very positive. Members report they are far more comfortable communicating about their successes and challenges with someone that has the same lived experience. Initially supported and led by a Case Manager, the peer support groups are now starting to meet on their own. The third support group implemented this past year was also initiated and is currently facilitated by a Case Manager. Identified as a need in the region, the Case Manager collaborated with the Alzheimer's Association and started the first Spanish speaking Alzheimer's Support Group in Yuma.

- One Contractor utilizes *Healthify***,** a phone and online web tool to help Case Mangers quickly find critical social services such as food, housing and other local supports. All of the Case Managers have access and can simply enter a city, county or zip code and the type of resource they are searching and the application brings up the various resources that meet the request. The information is vetted annually for accuracy and Case Managers can submit new resources identified to expand the Healthify library. Having this resource on their phones allows Case Managers to provide Members with resources in their local community that can assist them with their independence and/or personal goals.

- One Contractor developed the Medication Management Program (PMMP) to assist members with poly-pharmacy issues, medication non-adherence and complex and potentially confusing medication issues. Post-doctoral pharmacy residents make home/telephonic visits with the member and the Case Manager in order to identify medication-related issues and educate the member/family on his/her medications. Each visit is tailored to meet the member's needs. The pharmacist reviews all prescriptions and over the counter medications and then, depending on the member's need, may also focus on a specific drug or therapeutic area, reconcile medications with current orders and/or review vitamins and herbal supplements. The goals of the program are to achieve better clinical outcomes and improve the member's quality of life.

- One Contractor's Behavioral Health Administration is charged with implementing opportunities for members, caregivers, Contractor and provider staff to learn how to support members with challenging behaviors using Positive Behavior Intervention and Support (PBIS) practices. Using the expertise of the Contractor's Behavior Analyst the following initiatives were undertaken:
    - Orientation materials were developed that provide a general overview describing PBIS practices, environmental strategies, and access to additional information. The intent is to make this information available on the Contractor's website for members, families, caregivers, and contracted provider agencies.
    - An initial resource list of PBIS trainings was compiled and will be disseminated through the Contractor's newsletters and posted on the Contractor's website, as well as other communication venues such as Facebook Live web chats.
    - A progress reporting template for the Contractor's funded specialized habilitation services was developed for statewide use to streamline reporting practices and standardize reviews and decision making related to service delivery.
    - Development of a tool to measure member satisfaction is underway related to services that utilize applied behavior analysis and positive behavior support interventions and strategies to monitor quality of service provision.

- A draft Procedural Guideline is being developed for Contractor personnel on how to access technical assistance from the agency's Behavior Analyst when experiencing challenges with the behavior planning process.

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.

- ***State Agency Merger***
  On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (DBHS) merged with AHCCCS in an effort to streamline monitoring and oversight of the Regional Behavioral Health Authorities throughout Arizona. DBHS and AHCCCS have historically been partners working to improve care for Arizonans receiving behavioral health services. Governor Ducey recommended formalizing the partnership by bringing DBHS and AHCCCS together. The administrative simplification did not change services members can receive, nor did it change how members receive services. The targeted focus on the provision of behavioral health services and the acquisition of personnel with the subject matter expertise brought forth by the merger, directly impacted the adoption of enhanced requirements for the ALTCS Contractors to refer for and serve members who have been determined to have a Serious Mental Ilness in the ALTCS EPD Contract beginning CYE 2018. More information about the merger and be found on the AHCCCS website.

- ***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 ALTCS EPD Contract beginning CYE 2018, incorporates additional case management qualifications and caseload requirements, for Case Managers serving members determined to have an Serious Mental Illness.

  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.

  - **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. Case Managers are also responsible for assisting members in identifying independent living/personal goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education, employment, recreation and socialization.

The ALTCS EPD Contract beginning CYE 2018, incorporates a requirement for Case Managers to educate members/family on End of Life Care, which encompasses all health care and support services provided at any age or stage of an illness. The goals of End of Life Care focus on comfort and quality of life. Services include Advance Care Planning, palliative care, supportive care and hospice.

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. 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 2016 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. The implementation phases and associated tasks are outlined below through March 2019.

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 y 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

- ***Network Development Plans***

  Each year, AHCCCS requires that ALTCS Contractors develop an adequate network and submit Network Development and Management Plans (Plans) 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.

  The Plan requires the Contractor to develop information on the following:
  - Evaluation of the previous year's Plan
  - Current status of network
    - How members access the system
    - Relationship between the various levels of the networks
  - Current network gaps
  - Immediate short term interventions when a gap occurs
  - Interventions to fill network gaps, and barriers to those interventions
  - Outcome measures/evaluation of interventions
  - Ongoing activities for network development
  - Coordination between Contractor departments and outside organizations, including member/provider councils
  - Specialty populations
  - Membership growth and utilization of services given the characteristics of the population

  AHCCCS requires its Contractors to develop and demonstrate the implementation of pro-active 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 2016 and have approved each Contractor's Plan and the methods for analyzing the network and identifying and addressing network gaps.

The ALTCS EPD Contract beginning CYE 2018, incorporates new requirements pertaining to network access and adequacy for members including developing and tracking timeliness goals for certain types of Durable Medical Equipment and strategies to ensure the sufficiency of the long term care paraprofessional workforce.

- ***Operational Reviews***
  AHCCCS regularly reviews its Contractors to ensure that their operations and performance is in compliance with Federal and State law; rules and regulations; and the AHCCCS Contract. 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
  - Increase AHCCCS knowledge of the Contractor's operational encounter processing procedures
  - 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 review which includes member's placement, HCBS living arrangement, HCBS service authorizations, needs assessment, timeliness of service visits and cost effectiveness study.

  The current Operation Review cycle began on February 2016 and will be completed by Fall 2017. The cycle consists of an Operational Review of each AHCCCS Contractor including the three E/PD and one DDD ALTCS Contractor for compliance with these requirements. When a Contractor is found to be out of compliance with AHCCCS standards, the Contractor must submit 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 was accepted.

- ***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 Direct Care Workers (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 CY 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 MCOs 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 2017:

- 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 an auditor role within the database to streamline tracking and documentation of training program audits by the MCOs and AHCCCS
- Development of new tracking practices and attestations to ensure the information is up-to-date and accurate

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 will conclude on March 31, 2018. Year One was designated to develop work plans outlining all grant components, which mapped implementation Years Two through Four.

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 regards to the FASI, the assessment received approval from the Office of Management and Budget OMB allowing all states within the TEFT demonstration to move forward with Round 1. Training and assessments for Round One of the FASI are in process and are looking forward to analyzing the results in 2017.

Arizona had a 19.3 percent response rate to the Round One Experience of Care survey. Both E/PD and DES/DDD members participated in the survey process, which included face-to-face and phone interviews by an independent third party. Results from the survey are below:

Arizona Mean Scores for Composite Measures, by Program and All Programs Combined

Composite Measure	DD		EPD		Programs Combined	
	Score	*n*	Score	*n*	Score	*n*
Getting Needed Services From Staff	92.4	46	95.5	117	93.9	163
How Well Staff Communicate and Treat You	90.1	43	92.9	120	91.5	163
Case Management	▼85.0	44	▲98.2	111	91.6	155
Choosing Your Services	85.2	47	90.3	117	87.7	164
Transportation	91.1	47	85.7	120	88.4	167
Personal Safety	98.2	49	99.2	122	98.7	171
Community Inclusion and Empowerment	80.1	49	80.8	122	80.5	171

▲ This program's score is **above** the average score for all HCBS programs (statistically significant at the p≤0.05 level).

▼ This program's score is **below** the average score for all HCBS programs (statistically significant at the p≤0.05 level).

Year Three has been a year of planning for Arizona. A vendor has been selected and will move forward with our Round Two Experience of Care Survey and assist with implementation of the survey in future years outside of the TEFT Grant.

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

- ***Home and Community Based Settings Rules***

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final Rules regarding requirements for home and community based services (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 Arizona Long Term Care Services (ALTCS) program members receiving services in the following residential and non-residential settings:

<u>Residential</u>

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

<u>Non-Residential</u>

- 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 Managed Care Organization (MCO) 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 comment, AHCCCS finalized the assessment and transition plan and submitted to CMS for approval in October 2015. In August 2016, AHCCCS received a letter from CMS on its Systemic Assessment and Transition Plan and is awaiting a meeting with CMS to discuss the substantive feedback.

In CY 2016, AHCCCS prioritized 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. 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 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 1000 members. A statistically significant number of settings statewide were randomly selected to participate in the assessment process.

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 are available on the AHCCCS website and 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. Both webinars are available on the AHCCCS website.

The assessments are scheduled for October – December 2016. Followed by a period to draft a report to CMS, a period to solicit public comment and final report submission to CMS tentatively planned for June 2017.

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 also 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.

In CY 2015, the ALTCS Advisory Council was instrumental in advising AHCCCS on the following initiatives:

  - Home and Community Based Setting Rules (HCBS Rules)– provided input on the residential and non-residential setting member and provider surveys for the purposes of assessing baseline data on Arizona's compliance with the HCBS Rules.
  - U.S. Department of Labor, Companionship Exemption – provided input on strategies to use when educating members about the requirements and potential impacts and resulting decisions they may have to make regarding the Direct Care Workers providing their care.

Additionally in CY 2015, an ALTCS Advisory Council member was appointed to the State Medicaid Advisory Committee.

In CY 2016, the meeting agenda evolved to include reports from the Contractors' Member/Provider Councils in an effort to share information/concerns from a broader audience of ALTCS members to be considered for discussion. As a result, the two main topics for discussion by the ALTCS Advisory Council include the impact of limited access to transportation on a member's personal goal achievement and the role peer supports can play in the ALTCS program. These issues are currently internal review items for AHCCCS and will continue to be agenda items for further discussion with the ALTCS Advisory Council.

- ***Olmstead Plan***
  Arizona's initial Olmstead Plan was developed in 2001. In CY 2014, the Olmstead Plan was reviewed and updated by the Olmstead Policy Academy facilitated by the Arizona Department of Health Services, Division of Behavioral Health Services (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 continued to undergo a 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.

  Once a final draft is completed, each state agency will initiate their respective public input processes to garner input from the public and 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. It is projected that in CY 2017, the final draft will be completed.

- ***Department of Labor, Companionship Exemption***
  Beginning January 1, 2015, a new federal rule was enacted by the United States Department of Labor (DOL) that impacts agencies employing Direct Care Workers (DCWs) to provide in-home services like attendant care, personal care, homemaker, habilitation and respite services.

  - The new rule requires agencies to pay DCWs overtime (a rate not less than time and one-half their regular rates of pay) for any hours worked over 40 hours per week. *For*

example, if a DCW makes $9.00 per hour, they must get paid $13.50 for each hour worked over 40 hours per week.

- The new rule also requires the agencies to pay the DCWs for the time they spend traveling from work with one member to work with another member. The travel time is considered hours worked and, therefore, included in a 40 hour work week.

It is important to note the new rule does not change the number of medically necessary services and service hours authorized by the Case Manager.

Over CYE 2015, AHCCCS participated in numerous technical assistance webinars provided by DOL, Centers for Medicare and Medicaid Services (CMS) and the National Resource Center for Participant Directed Services. Additionally, AHCCCS routinely engaged with Contractors, providers and the ALTCS Advisory Council to discuss the potential unintended consequences of the ruling on member choice and Direct Care Service Agency viability.

In CYE 2016, the following activities were conducted to educate members and mitigate disruptions to service delivery as a result of how a Direct Care Service Agencies' complies with the Companionship Exemption:

- Issued an educational letter to members regarding the ruling and, in order to preserve member choice, the potential to make new decisions about the DCWs providing their care.
- Reviewed and monitored data solicitied and provided by the Contractors regarding the impact, to members and DCWs, of Direct Care Service Agencies and Fiscal Intermediaries compliance with the ruling (i.e. disallowance of DCWs to work for more than 40 hours per week).
- Monitored Contractor reports that outline providers who have either eliminated a service or reduced a scope of work as a result of the impacts of these requirements to ensure any network gaps were appropriately and timely addressed.
- Incorporated language in policy stipulating a service provider's compliance with the rule shall have no bearing on a member's assessed needs and corresponding authorized services and service hours.
- Required Contractors to institute additional measures for Case Managers to monitor the health and safety of members who had to make new decisions about the DCWs providing their care to mitigate any unintended consequences.

- ***Autism Spectrum Disorder Advisory Committee***

On April 14, 2015, the Governor's Office established a statewide Autism Spectrun 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 Autism Spectrum Disorder (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 their 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 diagnosis and critical early intervention services, independently registering Board Certified Behavioral Analyst. For system level changes, the Committee recommended integrating physical and behavioral health care for individuals with ASD. AHCCCS, with assistance from DES/DDD, has convened an operational team with a variety of subject matter experts to assist in the development of the project plan for targeted implementation in concert with the next physical health acute care contracts beginning 10/01/18. The ASD Advisory Committee continues to meet quarterly and advise on the implementation of the recommendations.

- ***Performance Measures***
  AHCCCS has developed performance measure sets for all lines of business, including Long Term Care, to further align with the Centers for Medicare and Medicaid Services(CMS)' Core Set of Adult Health Care Quality Measures for Medicaid. The measures and related Minimum Performance Standards/Goals (MPS) became effective on October 1, 2015 for the contract year ending September 30, 2016. It is AHCCCS' goal to continue to develop and implement additional Core 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 reserved status) are shown below; the first for the E/PD membership, the second for the DES/DDD membership. AHCCCS uses the designation of "reserved status" to refer to performance measures that AHCCCS is interested in receiving the data for the purposes of tracking and trending, but has decided to withhold any regulatory action at this time. It is important to note for the measures whereby it is indicated a "baseline measurement year," AHCCCS will develop MPS and Goals once baseline data has been analyzed for these measures.

Elderly/Physically Disabled Measures	
Measure	**MPS**
Inpatient Utilization	95 Per 1000 Member Months
ED Utilization	80 Per 1000 Member Months
Hospital Readmission	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 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 Shots for Adults, aged 18 and Older (FVA)	75%
Advance Directives	55%
Percentage of Eligibles Who Received Preventive Dental Services	46%
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year[3]
Weight Assessment and Counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	50%

[3] CMS will be establishing the Minimum Performance Standards.

Elderly/Physically Disabled Measures in *Reserved* Status	
Measure	**MPS**
Screening for Clinical Depression and Follow-Up Plan	Baseline Measurement Year
Adults' Access to Preventive/ Ambulatory Health Services	75%
Diabetes Admissions, Short-Term Complications (PQI-01)	300 Per 100,000 Member Months
Annual Monitoring for Patients on Persistent Medications: Combo Rate	75%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	950 Per 100,000 Member Months
66 ALTCS/EPD Contract Revised 8/2016--10/01/2016 Heart Failure Admission Rate (PQI-08)	350 Per 100,000 Member Months
EPSDT Participation	68%
Developmental Screening in the First Three Years of Life	55%

DDD Performance Measures	
Measure	**MPS**
Inpatient Utilization	51 Per 1000 Member Months
ED Utilization	43 Per 1000 Member Months
Hospital Readmissions	11%
Adults' Access to Preventive/Ambulatory Health Services	75%
Breast Cancer Screening (BCS)	50%
Cervical Cancer Screening (CCS)	64%
Chlamydia Screening in Women (CHL)	63%
Comprehensive Diabetes Management	
CDC - HbA1c Testing	77%
CDC - HbA1c Poor Control (>9.0%)	41%
CDC - Eye Exam	49%
Flu Shots for Adults, Ages 18 and Older (FVA)	*75%*
Use of Opioids From Multiple Providers at High Dosage in Persons Without Cancer	Baseline Measurement Year
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%
Children's Dental Visits: (ages 2-21)	60%
Percentage of Eligibles Who Received Preventive Dental Services (1)	46%
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year; CMS will be establishing MPS

Childhood Immunization Status	
DTaP	85%
IPV(2)	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%
Adolescent Immunizations	
Meningococcal	75%
Tdap/Td	75%
Adolescent Combo 1	75%
HPV	50%

DDD Measures in *Reserved* Status	
Measure	**MPS**
Diabestes Admissions, Short-Term Complications (PQI-01)	67 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	282 Per 100,000 Member Months
Heart Failure Admission Rate (PQI-08)	75 Per 100,000 Member Months
Asthma in Younger Adults Admission Rate (PQI-15)	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:**
  AHCCCS utilized the methodology developed by the Centers for Medicare and Medicaid Services (CMS) for the Form 416 Report on participation in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services among members younger than 21 years of age during the contract year. This measurement includes ALTCS members. For the measurement period of CYE 2015, the overall rate of EPSDT visits among members enrolled with ALTCS Contractors was 39.3 percent, a statistically significant increase when compared with 36.7 percent in the previous year. It is important to note that due to the nature of the populations served, the EPD Contractors (serving individuals with physical disabilities and individuals who are aging) serve smaller numbers of children and adolescents compared to DES/DDD.

ALTCS PLANS - EPSDT Participation, CYE 2015

Minimum Performance Standard = 68%

Contractor	Total who Should Receive at least 1 Screening	Number with at least 1 Screening	Percent with at least 1 Screening	Relative Percent Change	Statistical Significance
Bridgeway LTC	78	27	34.6%	-20.3%	P=.255
	83	36	43.4%	n/a	
DES/DDD	15428	6063	39.3%	7.4%	**P<.001**
	14767	5407	36.6%	n/a	
United Healthcare	98	34	34.7%	34.5%	P=.175
	97	25	25.8%	n/a	
Mercy Care Plan LTC	225	91	40.4%	-2.7%	P=.814
	253	105	41.5%	n/a	
TOTAL	15829	6215	39.3%	7.1%	**P<.001**
	15200	5573	36.7%	n/a	

Shaded rows represent data from the previous measurement period

- **EPSDT Dental Participation:**
  In addition to EPSDT Participation, AHCCCS also utilizes the Form 416 report to generate EPSDT Dental Participation rates, based on members' receipt of preventive dental care. CYE 12 was the first year that this measure was formally calculated.

  For the measurement period of CYE 2015, the overall rate of EPSDT dental participation among members enrolled with ALTCS Contractors was 45.0 percent, a statistically significant increase when compared with 40.4 percent in the previous year.

EPSDT Dental Participation

Contractor	Total Eligible	Total who rec'd at least One Service	Percent with at least One Dental Service	Relative Percent Change*	Statistical Significance*
Bridgeway LTC	80	32	40%	17.3%	**P=.434**
	85	29	34.1%	n/a	n/a
DES/DDD	15784	7125	45.1%	3.7%	**P<.001**
	15139	6587	43.5%	n/a	n/a
United Healthcare	106	23	21.7%	86.2%	**P<.001**
	99	3	3%	n/a	n/a
Mercy Care Plan LTC	230	107	46.5%	3.8%	P=.701
	259	116	44.8%	n/a	n/a
TOTAL	16200	7287	45.0%	4.2%	**P<.001**
	15582	6735	43.2%	n/a	n/a

Shaded rows represent data from the previous measurement period

AHCCCS has established contractual Minimum Performance Standards(MPS) for these measures. For any of the measures for which ALTCS Contractors did not meet the MPS, AHCCCS requires Corrective Action Plans (CAPs). AHCCCS approves and monitors implementation of the CAPs. In CYE 2016, there were no CAPs issued by AHCCCS. AHCCCS also continues to monitor Contractor quality-improvement activities related to these measures through submission of annual Quality Assessment/Performance Improvement Plans and Evaluation reports. AHCCCS provides ongoing technical assistance to assist Contractors to achieve improved 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 Performance Improvement Project (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 this PIP was CYE 2014. AHCCCS has provided baseline rates to Contractors (shown below). The first remeasurement, which considers CYE 2016 data, will be conducted in mid-2017.

E-Prescribing Improvement Project

Number of Providers Prescribing at least one prescription by ALTCS E/PD Plans

(Age 0-64 years)

October 1, 2013 through September 30, 2014

ALTCS E/PD HEALTH PLANS Age 0-64 years			
Health Plan	**Number of providers prescribing at least one prescription**	**Number of providers prescribing at least one prescription electronically**	**Percent of Providers who prescribed at least one prescription electronically**
Bridgeway	1,767	662	37.46%
Mercy Care	4,102	1,883	45.90%
United Health Care	3,025	1,435	47.44%
Total	**5,869**	**2,545**	**43.36%**

E-Prescribing Improvement Project

Number of Providers Prescribing at least one prescription by ALTCS E/PD Plans

(Age 65+ years)

October 1, 2013 through September 30, 2014

ALTCS EP/D HEALTH PLANS Age 65+ years			
Health Plan	**Number of providers prescribing at least one prescription**	**Number of providers prescribing at least one prescription electronically**	**Percent of Providers who prescribed at least one prescription electronically**
Bridgeway	887	306	34.50%
Mercy Care	2,306	1,118	48.48%
United Health Care	1,561	715	45.80%
Total	**3,193**	**1,424**	**44.60%**

E-Prescribing Improvement Project

Number of Prescriptions Prescribed by ALTCS-EPD *(Age 0-64 years)*
October 1, 2013 through September 30, 2014

ALTCS HEALTH PLANS Age 0-64 years			
Health Plan	**Total Number of prescriptions prescribed**	**Total Number of prescriptions prescribed electronically**	**Percent of prescriptions prescribed electronically**
Bridgeway	21,308	4,937	23.17%
Mercy Care	64,868	14,926	23.01%
United Health Care	38,873	10,549	27.14%
Total	**21,308**	**4,937**	**23.17%**

E-Prescribing Improvement Project

Number of Prescriptions Prescribed by ALTCS-EPD *(Age 65+ years)*
October 1, 2013 through September 30, 2014

ALTCS HEATLH PLANS Age 65+ years			
Health Plan	**Total Number of prescriptions prescribed**	**Total Number of prescriptions prescribed electronically**	**Percent of prescriptions prescribed electronically**
Bridgeway	9,521	1,632	17.14%
Mercy Care	24,633	6,573	26.68%
United Health Care	14,870	4,175	28.08%
Total	**34,154**	**8,205**	**24.02%**

HCBS GROWTH AND PLACEMENT

The ALTCS program experienced a 2.0% in population growth from CYE 15. The largest percentage of growth (4%) in membership was experienced by DES/DDD compared to 0% growth in the EPD membership. The following table highlights the membership breakdown by placement setting types.[4]

In CYE 2016 despite the small population growth experienced in the ALTCS program the percentage of members residing outside of a nursing facility remained consistent with the trend in the past few years of 86 percent, marking the seventh year in a row that the percentage has exceeded 70 percent. This growth is largely attributable to the service options and HCBS activities addressed in this report.

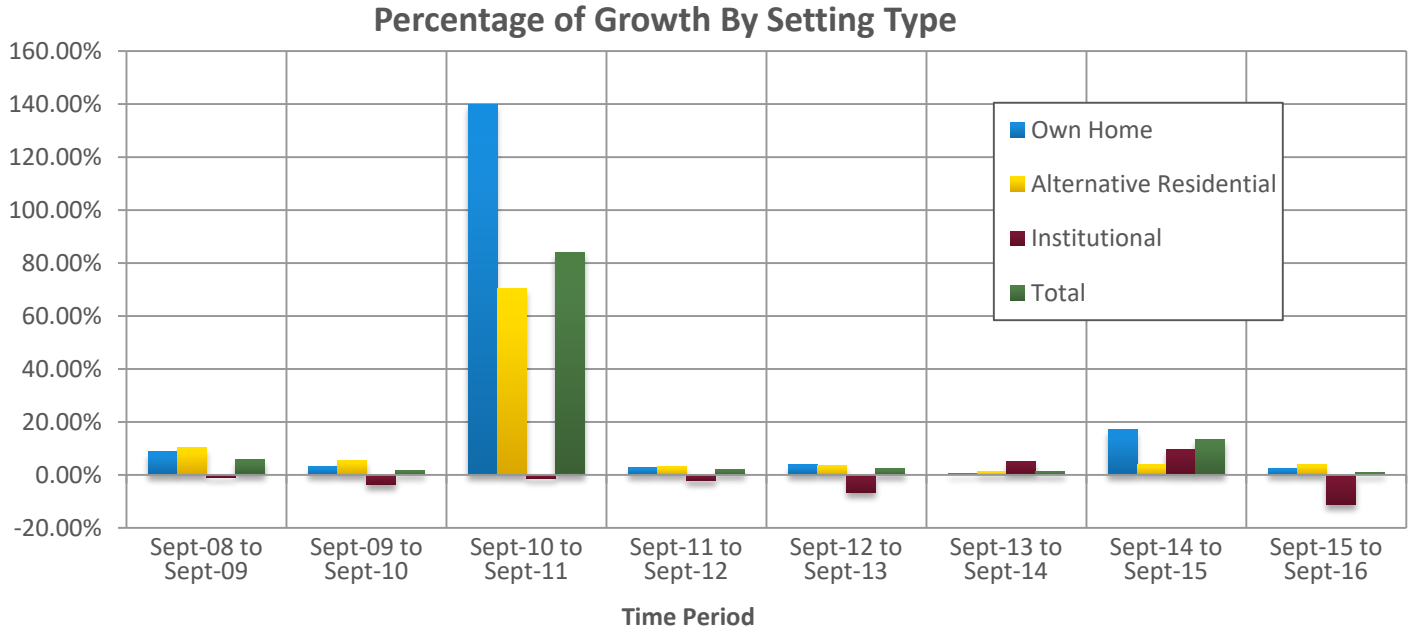
Membership Breakdown by Placement Setting Types – September 30, 2016						
Setting	**Bridgeway Health Solutions**	**Mercy Care Plan**	**United HealthCare**	**DES/DDD**	**Total**	**% of Total**
Own Home	2,353	5,537	5,025	22,279	35,194	62.28%
Assisted Living	1,544	2,101	2,471	8	6,124	10.84%
Group Home	0	75	19	2,808	2,902	5.14%
Developmental Home	0	5	0	1,433	1,438	2.54%
Behavioral Health Residential Facility	32	69	45	5	151	0.27%
Acute Services Only	66	170	117	2,991	3,344	5.92%
Total in HCBS Placements	**3,995**	**7,957**	**7,677**	**29,524**	**49,153**	**86.99%**
Skilled Nursing Facility	1,307	2,807	2,438	49	6,601	11.68%
ICF-ID	0	0	0	131	131	0.23%
Behavioral Health Inpatient Facility	0	4	11	0	15	0.03%
Total in Institutional Settings	**1,307**	**2,811**	**2,449**	**180**	**6,747**	**11.94%**
Placement Data Not Available	20	409	161	17	607	1.07%
Total Membership	**5,322**	**11,177**	**10,287**	**29,721**	**56,507**	**100.00%**

[4]The table outlines a new structure for capturing and reporting membership and placement data in an effort to ensure consistency across all tables and graphs in this reports. For example, the total of members receiving acute care only services are captured in the HCBS Placement data. A correction was made to remove the "Behavioral Health Residential Facility" data in the Institutional Settings category and incorporate it into the HCBS Placements category. Similarly a correction was made to highlight separately (neither in HBCS nor in the Institutional Placement categories) the number of individuals for which data was not available. The latter data was previously reported in an "other" catchall category in the Institutional Settings category.

The following chart outlines the distribution of placement setting type[5] for the period of September 2009 through September 2016. Since 2009 the proportion of members residing in their own homes increased from 49% to 69%, while the proportion of the members residing in institutions declined from 31% to 12%. At the same time, the proportion of members residing in alternative residential settings remains level with a range of 18-20%. This continues to demonstrate the maintenance of the shift in placement for E/PD and DES/DDD members towards more community-based placements.

Statewide Placement Percentage by Setting								
	Sep-09	Sep-10	Sep-11	Sep-12	Sep-13	Sep-14	Sep-15	Sep-16
Own Home	49%	50%	65%	65%	66%	66%	68%	69%
Alternative[6] Residential	20%	21%	20%	20%	20%	20%	18%	19%
Institutional	31%	29%	16%	15%	14%	14%	14%	12%
Total	100%	100%	100%	100%	100%	100%	100%	100%

The following graph shows the percentage of growth for each placement setting type[7] experienced since September 2009. The represented growth of members living in their own home is indicative of the growth that was seen in the overall population for DES/DDD in CFY 2016, the majority of whom are living in their own homes.



[5] For the purposes of this chart, the number of individuals receiving acute services only is captured in the "own home" category. Furthermore, the number of individuals for which placement data is not available is not reflected in the data below. The annual percentage change increases are the direct result of the data categorization changes noted in the introduction to this section (reference footnote #4).

[6] Includes Assisted Living, Group Homes, Developmental Homes and Behavioral Health Residential Facilities

[7] For the purposes of this graph the number of members receiving acute services only are reflected in the "own home" category. Furthermore, the number of individuals for which placement data is not available is not reflected in the data below. Outside of the population increase for DES/DDD, the annual percentage change of grow for the placement settings is a direct result of the data categorization changes noted in the introduction to this section HCBS Growth and Placement introductory section (reference footnote #4). Beginning 2011, DES/DDD placement information was incorporated.

The following table presents information detailing member placements based upon three age groupings[8] (0-21, 22-64 and 65 plus) as of the conclusion of CYE 16, September 30, 2016. Consistent with the historical trend of similar data for CYE 15, the number of members in the 65 year and older age group compose the highest proportion residing in institutional settings (26%). 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	18,258	12,151	8,162	38,571
Alternative Residential	594	4,621	5,401	10,616
Institutional	22	1,861	4,864	6,747
TOTAL	18,874	18,633	18,427	55,934
	0-21	22-64	65+	TOTAL
Own Home	97%	65%	44%	69%
Alternative Residential	3%	25%	29%	19%
Institutional	0%	10%	26%	12%
TOTAL	100%	100%	100%	100%

End of the Report

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

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