EXPERT REPORT OF DORIE SEAVEY, PH.D.
in
Ball v. Rodgers

INTRODUCTION

Statement of Qualifications. I serve as Director of Policy Research at PHI (formerly known as the Paraprofessional Healthcare Institute). PHI is a national non-profit based in the Bronx, New York that works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. With a staff of nearly 50 persons including national and state experts, we develop recruitment, training, supervision, and person-centered caregiving practices—and the public policies necessary to support them. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

As Director of Policy Research at PHI, I lead our policy research and analysis on Medicaid long-term care programs, and economic, financial, and policy issues affecting the direct-care workforce and the eldercare/disability services industry. Specifically related to the topic of this expert report, in 2006, I co-authored a major national report on state and local strategies for ensuring back-up personal care services under Medicaid HCBS. The report was written for the Public Policy Institute at AARP and is available at: http://assets.aarp.org/rgcenter/il/2006_19_pcs.pdf. In addition to reviewing relevant secondary sources, the information presented in the report relied on: (i) a 50-state survey sent to state officials with responsibility for Medicaid long-term care and aging programs that was designed to identify state practices in tracking the provision of authorized services and providing back-up or emergency personal care services; and (ii) follow-up telephone interviews with state and local officials in twelve states to investigate emerging state practices. This report remains the only comprehensive national analysis of what states are doing to support the development of effective back-up management systems.

My recent work has also addressed topics such as: state and local strategies to improve wages and benefits for direct-care workers, the cost of frontline turnover, Medicaid payment and procurement policies for home and community-based services, the development of systematic state-level management information systems for tracking and monitoring workforce-related data, and the development of labor market intermediaries such as registries to support consumers and workers under consumer-directed Medicaid HCBS programs.

I serve as one of PHI's lead technical assistance experts to a national team of long-term care workforce development experts at the National Direct Service Workforce Resource Center, a center funded by

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the Centers for Medicare and Medicaid Services (CMS). In May 2008, I delivered the opening plenary at the National Symposium on Strengthening the Home and Community-Based Direct Service Workforce, a symposium sponsored by CMS, the U.S. Department of Labor, and the U.S. Department of Health and Human Services. In March 2009, I addressed a Symposium at the Institute on Medicine on Health Reform for an Aging America.

I am formally trained as a labor economist and received my Doctorate in Economics from Yale University in 1987. Prior to my employment at PHI, I served as a senior member of several national evaluation and research teams investigating sectoral employment initiatives and employment brokering programs for low-income and disadvantaged job seekers, and also as a Senior Research Scientist at the Heller School at Brandeis University. Also prior to my employment at PHI, I served in as an expert witness in Ball v. Biedess, preparing a report in 2001 on the adequacy of reimbursement rates and paraprofessional wages in Arizona's home and community-based ALTCS programs. In 2003, I testified at the bench trial of the same case in U.S. District Court in Tucson.

A copy of my CV is provided in Appendix A. For my work in this case, my employer—PHI—is being compensated on a fee-for-service basis at the rate of $250 per hour.

Basis for Opinion. In preparing this report, I have relied upon the knowledge and experience I have gained over the last decade in the area of Medicaid long-term care systems and related workforce development issues. In addition to my work as an earlier expert in Ball v. Biedess, I also rely upon the specific knowledge I have of Arizona's HCBS programs, programs I have written about in two major national policy reports. My analysis also relies upon the research I conducted for a major national study of state and local strategies for ensuring back-up personal care services. Finally, I also rely upon my review of the documents listed in Appendix B of this report.

Purpose and Organization of Report. I was requested by Plaintiffs' counsel in Ball v. Rodgers to analyze the adequacy of the steps that AHCCCS has taken to address the problem of gaps in critical services for ALTCS members living in home-based settings. Specifically, I was asked to assess: 1) the extent to which the Defendants have created a system that provides services without gaps, provides replacement services within two hours, has back-up workers available, has an expedited grievance system, and has a hotline where members can report gaps in services; and 2) the extent to which the gap reports are reliable reports of the extent of any gaps in the system.

My report is organized into the following sections:

I. Brief Description of ALTCS Service Delivery System
II. Summary of Court's Orders Relating to Service Gap Standards, Programmatic Requirements, and Tracking and Reporting
III. Assessment of AHCCCS' Adoption of Service Gap Standards
IV. Assessment of AHCCCS' Implementation of Service Gap Programmatic Requirements
V. Assessment of AHCCCS' Service Gap Retrospective Tracking and Reporting
VI. Summary and Conclusions
VII. Appendices (CV and List of Documents reviewed)

I. BRIEF DESCRIPTION OF ALTCS SERVICE DELIVERY SYSTEM

AHCCCS is Arizona's state agency designated by the federal government to receive Medicaid monies and to ensure provision of services to individuals in Arizona eligible for Medicaid services. AHCCCS administers a statewide managed care system. This system consists of two programs: the Acute Care Program and the Arizona Long-Term Care System (ALTCS). ALTCS is the program responsible for providing long-term care services to persons who are either elderly, physically or developmentally disabled[1] if the individual passes both a financial and medical screen for the program. ALTCS is responsible for providing eligible persons (members) an array of health care services, including institutional services, and home and community-based services (HCBS), acute care, and behavioral health services.

ALTCS services are provided in Arizona's fifteen counties primarily through a network of nine managed care organizations called Program Contractors who are under contract with AHCCCS. Program Contractors coordinate, manage, and provide acute care, institutional care, HCBS, behavioral health services, and case management services to ALTCS members. Program Contractors agree to deliver a specific package of health care to beneficiaries in return for a monthly per member capitation payment from AHCCCS that blends the costs of nursing facility care, HCBS, acute medical care services, behavioral health services and case management services.

To provide HCBS to ALTCS members, Program Contractors subcontract with service providers such as home health agencies and agencies that provide personal care services. The service providers – currently numbering over 300 – in turn hire home care workers to provide actual services in member's homes and in alternative residential settings. A small number of ALTCS members direct their own care, hiring and supervising their own workers or hiring their spouses to perform the care. Program Contractors assign a case manager to each ALTCS member. The case manager coordinates care with the primary care provider and is responsible for identifying, planning, obtaining, and monitoring appropriate services that meet the member's needs.

As of August 2009, the ALTCS program served 48,830 members: 26,984 were persons who are elderly or physically disabled (EPD), and 21,846 were persons with a developmental disability (DD). The caseload has increased by nearly three-quarters since February 2000. As of September 2008, a third of the EPD population resided in nursing facilities, 47 percent resided in their own home, and the remaining 20 percent resided in alternative residential settings such as assisted living centers.

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[1] By statute, ALTCS services for individuals who are developmentally disabled are delivered by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) under a capitation agreement with AHCCCS. DES/DDD operates in the same manner as other Program Contractors and additionally administers a 100% state-funded program for persons who are developmentally disabled but who are not eligible for ALTCS.

II. SUMMARY OF COURT'S ORDERS RELATING TO SERVICE GAP STANDARDS, PROGRAMMATIC REQUIREMENTS, AND TRACKING AND REPORTING

The Court's June 28, 2005 Order (Docket 248) laid out a fairly comprehensive approach to addressing the problem of service gaps in the ALTCS system. This approach is all the more notable because, in general, the problem of gaps in Medicaid HCBS service delivery in this country is not well documented, federal statutory and regulatory requirements for ensuring back-up services are not highly developed, and state approaches to ensuring back-up service for personal assistance services are generally at an early stage of development.

The Court's approach can be viewed as comprehensive because it not only established basic *standards* for identifying and remediating service gaps, but it also required a set of *programmatic requirements related to providing back-up or emergency services* along with *system-wide tracking and monitoring*.

With respect to <u>service gap standards</u>, the Court ordered that:

1. AHCCCS' contracts with its Program Contractors should require that Program Contractors provide each qualified individual with critical services without gaps in those services. ¶1(D)
2. Unforeseeable gaps are to be corrected as quickly as possible, at least within two hours. ¶1(D)
3. Qualified individuals' other scheduled HCBS services may not be reduced because the cost of correcting a gap in critical services exceeds the cost of the service in which the gap occurred. ¶1(D)
4. All qualified individuals should be informed of their rights pursuant to the Court's orders. ¶7

The Court also required that Program Contractors institute some <u>specific programmatic components</u> to address the problem of service gaps. In particular, the Court ordered that:

1. AHCCCS monitor its entire program so that any critical services that are not being provided can be detected in enough time to implement back-up services and eliminate the gap in less than two hours ¶5. For the purposes of this report, I will refer to this requirement as the "**real-time verification requirement**."
2. Program Contractors should be required to have **back-up staffing available on-call** to substitute for those times when an unforeseeable gap occurs. ¶1(D)
3. AHCCCS develop adequate **alternative or contingency plans** for instances when a critical service is unable to be provided ¶2.
4. AHCCCS implement an **expedited grievance process** whereby each qualified individual may (¶6):
    a. Call a **hotline** and speak with a live operator to report any gap in critical services.
    b. Complete a standardized **form** reporting the gap and provide instructions for it to be mailed.
    c. Receive a **response**, via telephone or the mail, acknowledging the gap and providing a detailed explanation as to the reason for the gap and the alternative plan created to rectify that gap and any possible future gaps.

Finally, the Court set out some <u>system-wide retrospective tracking and monitoring requirements</u>. In particular, the Court ordered AHCCCS to conduct two types of reporting:

1. **Monthly reports of gaps in critical services** that provide Service Logs which have been redacted to protect beneficiaries' privacy. ¶5(B)

2. **Annual reports** concerning AHCCCS' methods for monitoring gaps in critical services throughout the state. ¶5(A)

The Court also provided two important definitions in its Order:

1. "*Critical services*" are defined as: "personal care services such as bathing, toileting, dressing, feeding, transferring to or from beds or wheelchairs, and assistance with other similar daily activities." June 28, 2005 Order, p. 2, ¶1(A). Note that this definition suggests that not all HCBS services are subject to the standards, program requirements and monitoring, but only that subset of HCBS that are vital to the daily health and basic functioning of ALTCS HCBS members.
2. A "*gap in critical services*" is defined as: "the difference between the number of hours of home care worker critical services scheduled in each qualified individual's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the qualified individual." June 28, 2005 Order, p. 2, ¶1(B).

III. ASSESSMENT OF AHCCCS' ADOPTION OF SERVICE GAP STANDARDS

There are three distinct levels to the AHCCCS service delivery system for ALTCS HCBS. The first level consists of the interface between AHCCCS and the nine Program Contractors health plans that serve as managed care organizations. The second level consists of interface between Program Contractors and their Case Managers. The third level concerns the interface between Program Contractors and the 300 Service Providers that they subcontract with to provide services in tens of thousands of member homes every day.

AHCCCS and Program Contractors. The evidence I reviewed suggests that AHCCCS has adopted explicit regulatory, administrative, and/or contracting language in its contracts with its nine Program Contractors and in the AHCCCS Contractor Operations Manual specifying the standards set by the Court. These standards relate to: delivering critical services without gaps, correcting unforeseeable gaps within two hours, not reducing other scheduled HCBS services to manage costs, and informing members of their rights pursuant to the Court's orders.

Program Contractors and Case Managers. The materials I reviewed show that Program Contractors have instructed their Case Managers to provide members with the AHCCCS letter stating member rights pursuant to the Court's Order. While that letter is a stand-alone document, members' understanding of their rights could be reinforced by making sure that these same rights are clearly stated in two other key forms that AHCCCS requires that members fill out and sign with their Case Managers, namely, the Critical Service Gap Report Form and Critical Service Contingency (Back Up) Plan. The Contingency Plan forms that I reviewed do not state that the member has the right to receive "critical services" without delay, and within two hours of the time that the Program Contractor is notified of a gap. Nor do they state that other services may not be reduced to make up for the critical services that the member did not receive on time.

Program Contractors and Service Providers. I did not have the full documentation necessary to comprehensively assess the extent to which Program Contractors have incorporated these same standards in their subcontracts with service providers. The needed documents would include: statements of service requirements and scope of work in service provider/vendor application forms, and Program Contractor's compete statements of policies and procedures.

IV. ASSESSMENT OF AHCCCS' IMPLEMENTATION OF SERVICE GAP PROGRAMMATIC REQUIREMENTS

The Court required that four programmatic components be put in place to improve the responsiveness of the ALTCS HCBS system to gaps in service. My assessment of AHCCCS' implementation of each of these components is as follows:

1. **Expedited grievance process**
   a. **Hotline**: The establishment of a "hotline" is the central feature of the expedited grievance process specified by the Court's orders. The hotline is to be staffed by a "live operator" whom members can call to report a gap in services. ***In the materials that I reviewed for this report, there is no evidence that such a live-operator hotline has been established either at the state level or in a uniform manner by Program Contractors.*** Instead, on different forms (Important Member Rights Notice, Critical Service Gap Report Form, and the Contingency Plan), members are instructed to call a variety of different telephone numbers, including those of the service provider, the Program Contractor, and case manager.[2] It is difficult to imagine that a single 911-type telephone number that members could call would not be preferable, and that a simple sticker or magnet could be distributed to members that could be affixed to a telephone or refrigerator.
   b. **Standardized grievance form to be mailed**: All Program Contractors appear to have such a form in place and case managers are instructed to distribute it to their clients. Program Contractors also appear to have in place policies and procedures that require them to provide a response via telephone or the mail acknowledging receipt of the form and notice of the gap.

2. **Real-time verification of service delivery**

The Court ordered that AHCCCS implement a monitoring system that would detect the non-provision of critical services in enough time to implement back-up services and eliminate the gap in less than two hours. In the field of home care and human services, a monitoring system with these characteristics is sometimes called a "field management system." The goal of such a system is to verify in "real time" whether the service provider's employee is present at the location where the services are to be provided and at the time that the services are to be provided. This kind of monitoring is distinct from retrospective tracking and monitoring.

My assessment is that AHCCCS has not implemented a monitoring system that meets the Court's requirement that service delivery be verified in a time frame that permits back-up response. The AHCCCS system relies exclusively on members calling in to their service provider, program contractor or case manager to report a gap, or alternatively mailing in a written report. As discussed above, the array

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[2] For example, on the "Important Member Rights Notice," members are instructed to "call your provider to report the issue. In addition, you may also call your program contractor or tribal contractor at the telephone numbers listed below…Your case manager will also provide you with phone numbers to call…" Some forms list both day telephone numbers and then after-hours numbers, and advise members to leave messages with an answering service. Yavapai County Long Term Care comes closer to implementing a "hotline" concept: According to the YCLTC Network Development and Management Plan, "YCLTC staff is available 24 hours a day, 7 days a week. Members and providers can contact a "live" person after hours by calling the local or toll-free phone numbers for YCLTC. The on-call person returns the call within 20 minutes of notification of the call. The on-call person contacts other contracted agencies to provide the scheduled services."

of phone numbers listed on the various forms given to members by their case managers may be confusing to members and there is no evidence that a live-operator hotline has been established.

I would also bring to the Court's attention the fact that the June 2009 Gap in Service Report indicates that *37 percent of the care gap incidents reported therein were not detected until a day or more after the scheduled care visit*. This suggests that placing 100 percent of the burden for service delivery verification on ALTCS members is not advisable.

Various information technologies have been developed, both telephone and web-based, to provide real-time verification of time and attendance in home-care settings and they are becoming more widespread in the field of home care and human services generally.[3] One form this technology can take is a telephone monitoring system that requires workers to call into their agency when they arrive and leave, allowing the agency to track the times of visits and hours provided. More complex monitoring systems add a "no-show" alert or notification feature, whereby if a call-in from a worker is not received by a scheduled time, the monitoring system notifies the provider agency via e-mail of the worker's absence.[4] South Carolina is an example of a state that has implemented a statewide automated system for monitoring the delivery of home care services across all its Medicaid waiver programs. The system is called Care Call and involves a toll-free telephone check-in and check-out system for in-home workers.[5]

3. **Back-up staffing on call**

The Court required that Program Contractors should be required by AHCCCS to have back-up staffing available on-call to substitute for those times when an unforeseeable gap occurs. ***In my review of AHCCCS contracts and Contractor Operations Manual, I found no mention of a requirement that Program Contractors have back-up staffing on call.***

Instead, AHCCCS relies on the more general requirement that Program Contractors shall ensure that "[t]here shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis. The development of home and community based services shall include provisions for the availability of services on a 7-day-a-week basis and for extended hours, as dictated by member needs."[6]

AHCCCS also relies on the concept of adequate "network development" for its Program Contractors. In sections on Ball v. Biedess (Rodgers) in its E/PD and DDD Contracts, AHCCCS states that "[i]n order to fulfill the settlement in the Ball v. Biedess (Rodgers) case the Program Contractor is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. The Program Contractor shall resolve gaps in critical services within two hours."[7] Provider Contractors must submit Network Development and Management Reports to AHCCCS on an annual

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[3] See D. Seavey & V. Salter (October 2006) *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*, Research Report #2006-19, Washington, DC: AARP Public Policy Institute, pp. 14-16.

[4] Telephony systems also can: recognize the location of origination of each call to verify that the home care worker is, indeed, in the client's home; collect information on the tasks that were performed for the client; and connect seamlessly to payroll and billing systems. An example of one of the country's largest contractors providing telephone and web-based field management is Sandata Technologies, Inc. (http://www.sandata.com).

[5] See D. Seavey & V. Salter (October 2006) *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*, Research Report #2006-19, Washington, DC: AARP Public Policy Institute, p. 12.

[6] AHCCCS Contract Amendment dated Oct. 1, 2008, Section D, Network Development, p. 52.

[7] AHCCCS Contract Amendments with E/PD and DDD, p. 54 and 50, respectively.

basis. These reports were not part of the material that I reviewed; it is possible that they may contain information on whether or not Program Contractors have put in place protocols to develop back-up staffing capacity.

I also reviewed the responses of all nine Program Contractors to a request by the ALTCS Administrator for information detailing each "Program Contractor's process for providing services in the event of a gap in service." The notion that Program Contractors will necessarily interpret AHCCCS' network development policy to mean that they should require that their service providers develop back-up staffing capacity is belied by the fact that only three of the nine Program Contractors—Pima Health Systems, DES/DDD and Mercy Care Plan—do appear to require their service providers or vendors to have back-up staffing on call:

- **DES/DDD** has instituted a requirement that its vendors have back-up staffing available.[8]
- **Mercy Care Plan**, in its Desktop Procedure for Non-Provision of Service Coordination (p. 1), states that "Providers are to ensure they have adequate back-up coverage at their agency."
- **Pima Health Systems** (PHS)—which has been dismantling its direct service provision and transferring its members and workers to community agencies—also requires that its providers have back-up caregivers on call.

A notable development within the ALTCS HCBS back-up system is that, in 2008, **PHS developed and negotiated a contract amendment for short notice/back-up caregiver services**.[9] The services are provided by one agency—Accent Care—to PHS providers that have exhausted their own staffing resources and are unable to find a caregiver. The back-up services are accessed through Case Managers or After Hours Staff who are notified when a replacement caregiver is needed but unavailable through the primary agency. Based on an analysis of six months of utilization data (from April – September 2008), *PHS reports that the increased availability of back-up staffing has had a noticeable impact on the use of unpaid caregivers*: "Overall, the percentage of hours provided by unpaid caregivers decreased from 92.19% to 70.34%, a 22% change. The use of unpaid caregivers when agency staff was not available decreased from 77.3% to 48.4%, a 29% change."[10]

This arrangement represents an important experiment within the ALTCS system regarding developing *network* back-up capacity. It may have replicability potential for other Program Contractors, and it is likely to shed light on the grey issue of whether the apparently high level of dependence of the ALTCS system on unpaid back-up services is a function of member choice or inadequate paid back-up staffing capacity.

Enlisting unpaid caregivers to serve as the first-line of back-up defense presumably is cost free whereas providing for back-up staff on call constitutes an additional expense for service providers. In theory, service providers can share the costs of maintaining a pool of back-up providers, and it may be that ALTCS Program Contractor networks lend themselves to such a pooled or shared arrangement. In my

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[8] DDD reports that, its Qualified Vendor Application (Section 5 Service Requirements/Scope of Work 5-2.6) states that: "The Qualified Vendor shall have a staff back-up plan at all times in order to ensure that appropriately trained back-up staff are available when the primary staff person is not available and the service is critical to assure the maintenance of health and safety of the consumers receiving the service."

[9] See: Memo March 4, 2009 from Patricia Alvarez Hurley, Director, Pima Health System to C.H. Huckleberry and Dennis Douglas, Pima County – Pima Health System Attendant Care Worker Program (with attachments)

[10] *Ibid*., p. 4.

2006 report on state and local strategies to ensure back-up, several examples of specialized pooled back-up agencies and pools were provided: two in California, one in Pennsylvania, and also the older Pima Health System back-up system which relied on a cadre of back-up caregivers who were payrolled by PHS.[11]

Short of a pooled back-up mechanism serving multiple providers, there are fairly standard procedures and preventive measures that individual providers can take to provide for back-up staffing. These measures are more likely to be feasible for larger employers, and include: recruiting workers who are available for "on-call" assignments and paying them for some proportion of the time that they are on call, employing floating staff whose full-time work assignment is filling in for absent workers, and assigning two workers to each client so that there is always someone who knows the client and can be reassigned if the other worker is absent or leaves the agency.

From a system-wide financial perspective, it should be noted that, while the ALTCS HCBS system places responsibility for providing back-up services on Program Contractors, Program Contractors undeniably have a financial incentive to allow or encourage back-up systems that rely on family caregiving and other informal supports. This is because Program Contractors are reimbursed according to a capitated (per member per month) payment *regardless of whether there is a high incidence of service gaps in their region or whether a significant proportion of back-up services are provided by informal (unpaid) supports or perhaps not provided at all*.

AHCCCS might consider introducing price signals that help guide the system toward stronger service delivery assurance. For example, adjustments could be made to AHCCCS' capitated rate structure based on the incidence of care gaps within each Program Contractor network. Alternatively, AHCCCS could require that Program Contractors delegate the accountability for providing back-up services to their service providers, building into service providers' negotiated rates the cost of creating and maintaining provider-specific back-up staffing and/or a network pool of paid back-up caregivers. In any case, it is clear that, to the extent that the ALTCS HCBS system experiences a non-negligible volume of service gaps that are resolved *not* with paid back-up staffing but rather with unpaid informal supports (or possibly not resolved at all), then Program Contractors are realizing additional gains or profits.

4. **Alternative or contingency plans**

It is fairly standard practice in the field of home care for agencies and their case managers to assign priority codes to their clients based on the acuity of client needs. It is also common for agencies and case managers to work with their clients to develop plans for emergency situations where a paid caregiver might not be available.

All Program Contractors do have in place a protocol that Case Managers use to develop contingency plans with their members. While the forms that the members and Case Managers complete are not

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[11] See D. Seavey & V. Salter (October 2006) *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*, Research Report #2006-19, Washington, DC: AARP Public Policy Institute, pp. 16-20. Prior to the privatization of its attendant care services, PHS's back-up staffing arrangements were described in PHS, Standards and Procedure, HCSS HC-II-0003, Subject: Temporary Scheduling of Home Care Support Services, 4/2008. PHS employed a cadre of "Attendant Care Worker (ACW) Spotters" and "Back-Up ACWs." A Spotter was an Attendant Care Worker (ACW) who temporarily provided services, but was not assigned or placed with a client. A Back-Up ACW was an ACW who had been assigned and placed with a specific client, had no routinely scheduled work hours, but provided services for the assigned client when the primary ACW is ill or otherwise unavailable.

identical across the nine Program Contractors, they generally: (i) indicate the member's service preference level,[12] (ii) instruct the member to call their caregiving agency/Case Manager/ Program Contractor, and then (iii) *either* advise the member to call family or friends who have agreed to be the member's back-up, *or* lay out a plan that specifies options such as the following: I need my services within 2 hours; I need service the same day; I need care within 48 hours; I can wait until the next scheduled service date; or I want my family member/informal caregiver to provide my care if my scheduled caregiver cannot be there.

Some Program Contractors give their members the choice to call their informal supports and not to call in to the agency (Bridgeway, SCAN). Most but not all Program Contractors use the form to also remind members of the limitations of replacement services (*e.g.,* that such services may not be provided if the member refuses services or is not available to receive the services when the caregiver arrives). Two Program Contractors (DDD and Yavapai) simply give the member a space on the form to write an answer to the question "If my provider does not show up for the scheduled shift, what is the back up plan?"; no designated space is used to identify family members or friends. Some but not all the forms remind the member that their preference for a replacement caregiver can be changed at any time.

My assessment of AHCCCS's protocol for contingency plans is as follows:

- Consistent with the Court's order, AHCCCS has created a protocol for Case Managers to develop "alternative or contingency plans" with members.
- Forms that Case Managers use for this purpose were in place for all nine Program Contractors. However, **there is no uniform Contingency Plan form**, and it is possible that some of the formulations pull for greater reliance on using informal support systems as the primary source of back-up coverage, particularly those that do not ask the member to call their agency to report service non-provision but rather permit the member to bypass calling in the service gap (which is important for the agency to know about even if the member wants to rely on unpaid caregivers).
- **The Contingency Plan forms that members sign do not clearly state the rights of members to services and to the provision of back-up critical services within two hours.**
- **Furthermore, the key protocol upon which the formulation of the Contingency Plan relies—the specification of Member Service Preference Level—is a protocol that, at least for those members with critical service needs, is inconsistent with and undermines AHCCCS' directive (consistent with the Court's Orders) that critical service gaps should be filled within two hours.**
- If agencies have back-up staff on call or can access a shared pool of back-up workers, then the alternative or contingency plans become a **complement** to back-up staffing provisions. But if agencies do not have back-up staff on call or have not access to a shared pool of back-up workers, then contingency planning—which tends to rely heavily on unpaid family caregivers and informal support systems—will **substitute** for back-up paid staffing. While some members may indeed prefer to receive their back-up services from their designated informal supports, it would not be in the self-interest of ALTCS members *as a group* to rely for their care on provider

[12] AHCCCS has instructed Program Contractors and their Case Managers to implement a protocol that assigns each member a rank-ordered service preference level (Member Service Preference Level). Case Managers assist the member or member representative in identifying their service preference level as one of the following four categories: 1) Needs service within two hours; 2) Needs service today; 3) Needs service within 48 hours; or 4) Can wait until next scheduled service date.

networks that essentially outsource their back-up function to members' informal support systems.

- Without detailed information on the extent to which Program Contractors have developed and utilize back-up staffing capacity, it is not possible to assess the extent to which alternative or contingency plans function as a **complement** to back-up staffing provisions in the ALTCS system or serve as a **substitute** for them. This is a key issue for AHCCCS and merits concerted attention and study.

V. ASSESSMENT OF AHCCCS' SERVICE GAP RETROSPECTIVE TRACKING & REPORTING

Retrospective tracking and monitoring is clearly an essential part of AHCCCS' quality assurance system for assuring timely service provision that is consistent with the care plans of ALTCS HCBS members. The tracking and monitoring system that AHCCCS has put in place has the potential to yield rich data—both cross-sectional and longitudinal—that can be used to monitor whether service providers and Program Contractors are meeting the goal of timely, stable service provision. Such data can provide important information that allows administrators to identify weak spots at both the service provider and Program Contractor levels that require corrective action as well as policies and protocols that support stable and timely service delivery.

My review was largely confined only to the top level of monitoring—that is, to the monthly Service Gap Reports submitted to the Court by Defendants—and not to material pertaining to how individual Program Contractors report and analyze their own non-provision of service incidents.[13] It is my opinion that at least this top level of monitoring is weak and rudimentary, and does not yet constitute a reliable indicator of the extent of any gaps in the system.

1. Monthly Gap in Service Reports

It is my assessment that the Gap in Service Reports (Gap Reports) that are submitted to the Court on a monthly basis are not reliable indicators of the extent of any gaps in the system. Furthermore, as presently constructed and reported, these reports are not a reliable indicator of whether the ALTCS system has a meaningful back-up system, nor do they shed light on whether Program Contractors and their service providers have created adequate back-up staffing capacity.

In particular, I find three types of problems with the monthly Gap Reports:

a. Their derivation from the Non-Provision of Service (NPS) Logs is extremely unclear.
b. The reporting form is poorly constructed and does not meet basic standards of statistical presentation and rigor.
c. The completed forms contain numerous nonsensical and/or incomplete entries.

With respect to the first problem—the derivation of the Gap Reports—I would note the following:

a. Contrary to the Court's Order, **the Gap Report is not a service log but rather a culled log that excludes non-provision of care incidents that Program Contractors determine do not represent "true" gaps in service.** In the materials I reviewed, there was no clear description of the criteria by which Program Contractors determine whether an NPS constitutes a critical service gap, nor is any information available on the number of NPS entries that were determined not to meet the criteria of a gap.[14] There are some indications in the materials that,

[13] I did review the following memorandum concerning information on how Pima Health Systems uses its NPS reporting: Memo March 4, 2009 from Patricia Alvarez Hurley, Director, Pima Health System to C.H. Huckleberry and Dennis Douglas, Pima County – Pima Health System Attendant Care Worker Program (with attachments).

[14] According to AHCCCS Medical Policy Manual, Chapter 1600 Case Management, Policy 1620 Case Manager Standards, p. 1620-15, there are six situations that are not to be considered gaps: a) non-availability of member to receive services; b) member refusal of caregiver because caregiver impaired by, say, drug or alcohol use (N.B. It is not clear to me why this situation does not constitute a legitimate care gap incident for which service providers and Program Contractors should be held accountable); c) member refusal of services; d) caregiver refusal to enter

if an NPS is reported, and the provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes unavailable, then this incident is *not* considered a gap.[15] If this is the case, then the Gap Reports are unable to shed light on the very phenomenon we wish to know about—namely, the ability of the system to deliver reliable, timely back-up services.

b. It is completely unclear whether or how the Member Service Preference Level (MSPL) information is used to determine when an NPS constitutes a gap. If an NPS is "resolved," is it only counted as a gap if the MSPL was not met?

c. On both the NPS and Gap Report forms, the *Reason for the NPS and the Gap* must be specified. On the NPS form, there are 11 "reasons" to choose from but on the Gap Report form there are only 6. Presumably, some of the "reasons" on the NPS form are not considered true gaps situations and/or categories have been aggregated, but in any case the logic behind the contraction of categories is not transparent.

With respect to the construction of the Gap Report form, I would note the following:

a. No totals of any kind are provided in the report. The Defendants and Plaintiffs are left to calculate their own subtotals and totals and these cannot be verified short of dusting off an adding machine or entering the entire form by hand into a searchable database such as Excel or Access.

b. The Defendants key metric for analyzing the adequacy of ALTCS back-up services is a ratio calculation of the total hours of gaps divided by the total number of hours of Attendant Care, Homemaker, Respite, and Personal Care. Leaving aside the questionable notion that one ratio could possibly constitute a sufficient metric for assessing the adequacy of the system, it would seem that the relevant denominator should be <u>not</u> the *total number of hours* across these four services but rather the *number of hours of critical services* that were delivered. In either case, neither of these hour counts is reported on the Gap Report form.

c. The report also does not specify the number of ALTCS members who were provided with critical services (it would be useful to know this by Program Contractor so that calculations could be made on a per member basis).

With respect to the third problem—nonsensical and/or incomplete entries—my review of the June 2009 report revealed the following problems:

a. Many incomplete entries (note that the blanks in the column titled "Explain How Gap Was Resolved" I think are to be interpreted as indicating that the gap was not resolved).

b. Numerous nonsensical entries, meaning that the information contained in the row does not make sense. For example, the last entry on p. 1 of the June Report indicates that 3 hours of attendant care were scheduled to be provided on 5/30/09 beginning at 10 AM. The member/ member's representative called in the following day at 2 pm to report that caregiver did not show. This gap was not resolved (column 10) and no hours were provided to resolve the gap (column 12) because the agency/Program Contractor/case manager was not alerted of the

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an unsafe environment; e) member and regular caregiver agree in advance to reschedule all or part of a scheduled service; and f) the provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes available.

[15] At the same time, I find entries in the Gap Reports that seem to reflect the very scenario that is defined as an NPS but not a gap—namely, a no-show of a caregiver, followed by the gap being filled in less than two hours by a replacement caregiver.

service gap (column 14). However, the entry for this care gap incident also indicates that the length of time before services were provided was 4 hours (column 13), but this is inconsistent with the fact that the gap was not even reported until more than 24 hours after the time services were scheduled to begin and the fact that no hours were provided to resolve the gap.

In sum, the incomplete formulation of the Gap Report, a high level of entry errors, and the lack of clarity about what NPS incidents have been excluded and included together significantly undermine the credibility of the report and limit its usefulness in understanding both the extent and causes of gaps, and whether and how the gaps are resolved.

Leaving aside the issue of the *volume* of actual service gaps in the system and the considerable problems with the Gap Reports that I have noted, the June 2009 report may be indicative of certain *patterns*. The following types of observations are possible using the information in the report:

- Of the non-provision of service gaps that agencies reported to Program Contractors, Program Contractors determined that 192 NPS incidents met the criteria of a gap in critical services (count of first column labeled "Program Contractor ID #")
- Nearly 4 in 10 incidents (37 percent) were reported not on but AFTER the day of scheduled service provision (count of dates in column 3 that were subsequent to corresponding date in column 5 as a percent of total number of service gap incidents).
- 11 percent of the incidents (22) were called in BEFORE the scheduled day of service, sometimes as many as 6 to 13 days prior to the scheduled day of service. In 91 percent of these incidents, however, an unpaid caregiver filled the gap because no agency staff was available (count of dates in column 3 that were prior to corresponding date in column 5 as a percent of total number of service gap incidents).
- **In a third of the service gap incidents reported on the June 2009 form, no back-up services at all (either paid or unpaid) were provided** (count of 64 blanks in 10th column labeled "Explain How Gap was Resolved").[16] **Only 9 percent of cases (17) were resolved with back-up staffing** (Attendant Care, Homemaker, Personal Care, or Respite). **The remaining cases (57 percent) were resolved with unpaid care. In other words, the June 2009 Gap in Service Report suggests that, of the service gap incidents reported that month, 90 percent were resolved either with unpaid care or were not resolved at all (*i.e.,* no hours were provided to resolve the gap).**
- Of the service gap incidents reported on the June 2009 form where *at least some* hours were provided to resolve the gap, 84 percent were met by relying on unpaid caregivers (count of "E" in 10th column as a percent of non-zero entries in 13th column).
- Of those incidents that relied for their resolution (partial or complete) on unpaid caregiving, 53 percent were attributable to "Consumer Choice," 35 percent to "No Agency staff available, " and 10 percent to "Other" (count of "1," "2," and "3" in the 15th column as a percent of count of "E" in 10th column).
- Given a set of hourly fee-for-service rates for each of the four HCBS services, it would be possible to use this form to calculate the implicit value of unpaid caregiving that was provided during the month of June to fill service gaps. This value, plus any difference between paid caregiver hours that were authorized and then actually provided to resolve the gap, is equal to

[16] See instructions to service providers for completing the 10th column in AHCCCS Contractor Operations Manual, Chapter 4 – Operations, Attachment A – Non-Provision of Services Log Instructions, p. 3 of 5, dated 4/2/07.

the gains or profits that Program Contractors realized from the operation of the ALTCS HCBS back-up system. Note that this calculation could be performed for each Program Contractor.

While it is unclear what kinds of service gaps are and are not recorded on the Gap in Service Reports, those screened into the June 2009 report suggest:

- A relatively high proportion of incidents that were **delayed in their reporting**, some by several days.
- A relatively high proportion of incidents that involved **no provision of back-up** services.
- A relatively high **dependence on unpaid caregivers** to resolve the gaps, with a third of these incidents attributable to non-availability of back-up staffing.
- A relatively **low incidence of the use or availability of paid back-up staffing**, even when service gaps were anticipated several days in advance of the scheduled service.

2. Annual Reports

The Court ordered that AHCCCS submit annual reports concerning its methods for monitoring gaps in critical services throughout the state. ***My opinion is that the reports that have been submitted are cursory and could be strengthened by reporting on how each Program Contractor is attempting to strengthen their provision of on-call back-up services.*** These reports could be structured to contain an analysis of the semi-annual trend reports that are submitted by each Program Contractor to AHCCCS. These reports also could report the results of: the gap-related sections of the Case Management Service Review (an annual review of Program Contractor case management records), AHCCCS' telephone survey of members and/or their representatives regarding their experiences with gaps in critical services; and a review of the Critical Service Gap Report Forms that were required by the Court as part of its requirement that AHCCCS develop an expedited grievance process.

VI. SUMMARY & CONCLUSIONS

The Court's June 28, 2005 Order (Docket 248) laid out a comprehensive approach to addressing the problem of service gaps in the ALTCS system. The Court's approach can be viewed as comprehensive because it not only established basic *standards* for identifying and remediating service gaps, but it also required a set of *programmatic requirements related to providing back-up or emergency services* along with *system-wide tracking and monitoring*.

My summary assessment of AHCCCS's initiatives along these three key dimensions is as follows:

A. Service Gap Standards

1. Standards set by AHCCCS for Program Contractors and their Case Managers

a. AHCCCS has adopted explicit regulatory, administrative, and/or contracting language in its contracts with its nine Program Contractors and in the AHCCCS Contractor Operations Manual specifying the standards set by the Court to: deliver critical services without gaps, correct unforeseeable gaps within two hours, not reduce other scheduled HCBS services to manage costs, and inform members of their rights pursuant to the Court's orders.

b. However, AHCCCS also has instructed Program Contractors and their Case Managers to implement a contingency planning protocol whereby a rank-ordered service preference level (Member Service Preference Level) is determined for each member. For at least those members with critical service needs, the Member Service Preference Level protocol is hardly consistent with and in fact undermines the intent of AHCCCS' directive (consistent with the Court's Orders) that critical service gaps should be filled within two hours.

c. Program Contractors have instructed their Case Managers to provide members with the AHCCCS letter stating their rights pursuant to the Court's Order. However, those rights are not clearly stated or reinforced in the Critical Service Gap Report Form and Critical Service Contingency (Back Up) Plan, two other documents which Case Managers must fill out with members.

2. Standards set by Program Contractors and Service Providers

I did not have the full documentation necessary to assess the extent to which Program Contractors have incorporated these same standards in their subcontracts with service providers. The needed documents would include: statements of service requirements/scope of work in service provider/vendor application forms, and Program Contractor's complete statements of policies and procedures.

B. Implementation of Programmatic Requirements Related to Service Gaps

1. Expedited grievance process

a. In the materials that I reviewed for this report, there is no evidence that a live-operator hotline has been established either at the state level or uniformly across Program Contractors.

2. Real-time monitoring

a. Whether or not the home care worker is at work clearly is the basic building block of service delivery assurance. This means that reliably verifying that scheduled hours are being filled in the present moment is absolutely essential.

b. The service delivery verification system currently operative within the ALTCS HCBS system is rudimentary and does not appear to meet the intent of the Court's Orders. Of the service gap incidents included in the June 2009 Gap in Service Report, 37 percent were not detected until a day after the scheduled care visit or longer.

c. Within the arena of home care and human services, field management information technologies are available that allow for real-time verification of time and attendance (*e.g.,* telephony). Such telephone and web-based verification technologies would represent a significant improvement on the current ALTCS system.

3. Back-up staffing on call

a. In my review of AHCCCS contracts and operation manuals, I found no mention of a requirement to service providers that Program Contractors have back-up staffing on call.

b. Instead, AHCCCS instructs Program Contractors to maintain sufficient staff to provide the authorized services and requires that they develop a Provider Network Development and Management Plan that ensures services will be provided. In addition, Program Contractors are instructed to implement *policies and procedures* "for providing services in the event of a gap in a member's services."[17]

c. The notion that Program Contractors will necessarily interpret AHCCCS' network development policy to mean that they should require that their service providers develop back-up staffing capacity is belied by the fact that only three of the nine Program Contractors—Pima Health Systems, DES/DDD and Mercy Care Plan—do appear to require their service providers or vendors to have back-up staffing on call.

d. Pima Health Systems has negotiated a contract amendment for short notice/back-up caregiver services with one of its service providers. The purpose of this contract is to make back-up staff available to other Pima providers. A recent 6-month utilization analysis by PHS concludes that the increased availability of back-up staffing resulting from this arrangement has reduced the use of unpaid caregivers. This arrangement represents an important experiment within the ALTCS system regarding developing network back-up capacity that may have replicability potential for other Program Contractors. It also sheds light on the grey issue of whether the apparently high level of dependence of the ALTCS system on unpaid back-up services is a function of member choice or inadequate paid back-up staffing capacity.

4. Alternative or contingency plans

a. AHCCCS has created a protocol for Case Managers to develop "alternative or contingency plans" with ALTCS members.

b. Forms that Case Managers use for this purpose were in place for all nine Program Contractors. However, there is no uniform form, and it is possible that some of the formulations pull for greater reliance on using informal support systems as the primary source of back-up coverage, particularly those that permit the member to bypass calling in the service gap to the agency and instead contact the family and friends whom they have designated as their back-up support.

c. The Contingency Plan forms that members must sign do not clearly state the rights of members to services and to the provision of back-up critical services within two hours.

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[17] AHCCCS EP/D Contract and DDD Contract, p. 54 and p. 51, respectively.

d. As noted in section on Service Gap Standards above (Section A (1)), as part of the development of each member's Contingency Plan, AHCCCS has instructed Program Contractors and their Case Managers to determine a rank-ordered service preference level (Member Service Preference Level) for each member. For at least those members with critical service needs, the Member Service Preference Level protocol is hardly consistent with and in fact undermines the intent of AHCCCS' directive (consistent with the Court's Orders) that critical service gaps should be filled within two hours.

e. Without detailed information on the extent to which Program Contractors have developed and utilize back-up staffing capacity, it is not possible to assess the extent to which alternative or contingency plans function as a **complement** to back-up staffing provisions in the ALTCS system or serve as a **substitute** for them. This is a key issue for AHCCCS and merits concerted attention and study.

C. Retrospective tracking and monitoring

1. The Gap in Service Report currently submitted to the Court on a monthly basis is not a reliable indicator of the extent of any service gaps in the system. Furthermore, as presently constructed and reported, this report is not a reliable indicator of whether the ALTCS system has a meaningful back-up system, nor specifically of whether Program Contractors and their service providers have created adequate back-up staffing capacity.
2. The Gap in Service Reports are flawed and unreliable for three main reasons: (i) their derivation from the Non-Provision of Service (NPS) Logs is extremely unclear; (ii) the reporting form is poorly constructed and does not meet basic standards of statistical presentation and rigor; and (iii) the completed forms contain numerous nonsensical and/or incomplete entries.
3. While I have made clear my concern that the retrospective tracking and monitoring system currently in place is not able to generate a clear picture of extent of gaps in the system, leaving aside the issue of the <u>*volume*</u> of actual service gaps in the system, the <u>*pattern*</u> of response suggested by the June 2009 Gap in Service report is disturbing: ***90 percent of the service gap incidents included in the June report were either resolved with unpaid care or were not resolved at all, meaning that no hours were provided to resolve the gap.***
4. The Annual Reports submitted to the Court have been cursory and could be considerably strengthened by reporting on how each Program Contractor is attempting to improve their provision of on-call back-up services as well as providing analyses of other AHCCCS reports, surveys, and forms that relate directly to the issue of service gaps.

In conclusion, while important system-wide changes have been made over the past few years by AHCCCS and its Program Contractors to address the service gap and back-up problems of ALTCS HCBS programs, three fundamental weak areas remain. The key problem areas are:

- **Limited capacity to verify real-time service delivery including lack of a uniform live-operator hotline for members to call at either the state level or for each Program Contractor;**
- **A lack of emphasis on developing adequate (paid) back-up staffing capacity relative to the system's reliance on member's alternative or contingency plans, which in turn appear to rely heavily on informal supports; and**
- **Inadequate retrospective reporting of service gaps combined with poor quality assurance metrics applied to the area of back-up service provision.**

Each of these weaknesses is highly amenable to improvement, and detailed suggestions have been made in the body of this report. It should be emphasized that the "ideal" home care system should seek to achieve a delicate balance between policies and procedures that create adequate back-up staffing capacity on the part of services providers, on the one hand, and client-specific advance-planning protocols and contingency plans on the other. The former ensures access to an adequate and identifiable supply of back-up or emergency workers while the latter ensures that clients have last-resort emergency coverage and that service providers have the basic information they need to manage the acuity needs of their client populations in short-notice or emergency situations.

Submitted September 14, 2009

Dorie Seavey, Ph.D.

APPENDIX: Documents Reviewed in Preparing of this Report

Court Orders

1. Order #1 (8/13/04) (Dkt. 212) – relief after trial
2. Order #2 (6/28/05) (Dkt. 248) – modifications to Injunction
3. Order Denying Motion to Enforce Court Orders (9/29/06) (Dkt 301)
4. Order #3 (4/24/09) (Dkt. 394) – relief after remand
5. Order #4 (8/14/09) (Dkt. 434) – supplemental evidence

Pleadings Regarding Compliance from November 2008 - Present

1. Defendant's Response to Objections to June Gap Report (8/20/09) (Dkt. 436)
2. Plaintiffs' Objections to June Gap Report (8/14/09) (Dkt. 435)
3. Plaintiffs' Objections to Motion Modify & Vacate Injunction (7/21/09) (Dkt. 425)
4. Def. Response to Objections to Gap Reports (7/11/09) (Dkt. 423)
5. Def. Cross-Motion to Modify & Vacate Injunction (7/10/09) (Dkt. 422)
6. Plaintiffs' Objections to Def. Gap Reports from Mar.-May 2009 (7/8/09) (Dkt. 421)
7. Plaintiffs' Response re: Compliance & Appoint Master (6/22/09) (Dkt. 416)
8. Defs Supplement re: Compliance with Injunction (5/31/09) (Dkt. 412)
   - Exhibit A Declaration of Susan Hawley, DDD
   - Exhibit B Declaration of Pam Hindriksen, Evercare
   - Exhibit C Declaration of Linda Collins, Pima Health System
   - Exhibit D Declaration of Rae Vermeal, Pima Health System
   - Exhibit E Declaration of Karen Bargerhuff, Mercy Care Plan
   - Exhibit F Declaration of kelley Guerriero, Evercare
9. Defs Response to Notice of Errata (5/29/09) (Dkt 410)
10. Notice Errata (5/28/09) (Dkt 409)
11. Defs Memorandum re: Compliance & Response re: Dkt. 404 (5/22/09) (Dkt 407)
    - Exhibit A Gap Report–March 2009
    - Exhibit B Declaration of PJ Schoenstene, ALTCS
    - Exhibit C§D Case Management (AHCCCS contract with health plans)
    - Exhibit D Charts from report on DDD services

    1. 18. Plaintiffs' Memo June 1, 2009 Status Conference (5/19/09) (Dkt 404)
       - Exhibit. 1 Summary of Gap Reports (within document)
       - Exhibit 2 Letters re: DDD Rate Reduction
12. Pls Motion to Extend & Modify Injunction & Appoint Master (5/19/09) (Dkt 403)
13. Defs 2d Supplement to Memo re Compliance with Injunction (12/16/08) (Dkt. 388)
14. Pls Memo re Issues Raised at Dec. 3, 2008 Status Conference (12/15/08) (Dkt. 387)
15. Defs Supplement to Memo re Compliance with Injunction (12/1/08) (Dkt. 383)
16. Defs Memo Re Compliance with Injunction (11/18/08) (Dkt 377)
    - Exhibit. A Section D - Case Management, AHCCCS Policy 1600
17. Pls Memo Regarding Def Compliance with the Court's Orders (11/14/08) (Dkt. 374)
    - Exhibit 1 Declaration of Catherine James
    - Exhibit 2 Declaration of Teresa Buhr
    - Exhibit 3 Declaration of Barbara Lillo

Exhibit 4 Declaration of Ellen DeForrest
Exhibit 5 Declaration of Nora Manka
Exhibit 6 Declaration of Michael Rembis
Exhibit 7 Section D Program Requirements
Exhibit 8 AMPM Chap. 4 Gap in Services Policy
Exhibit 9 Mercy Care Plan Back-up/Contingency Plan form

ALTCS Program Enrollment Data

a. ALTCS Enrollment Historical Summary
b. ALTCS Enrollment as of August 2009
    i. Pgs. 3-5, ALTCS enrollment by country and contractor (health plan)
c. ALTCS Enrollment as of June 2005
d. ALTCS Enrollment as of August 2004
e. ALTCS Enrollment as of February 2000
f. ALTCS Service Providers by Program Contractor

AHCCCS Contract Provisions (selected pages)

1. Elderly & Physically Disabled Contract (effective 10/1/08 to 9/30/09)
    ‣ pgs. 15-16, overview of ALTCS system
    ‣pgs. 36-39, case management
    ‣ pg. 51-54, network development, *Ball v. Biedess (Rodgers)*

2. Division of Developmental Disabilities Contract (effective 7/1/09 to 6/30/10)
    ‣pgs. 15-16, overview of ALTCS system
    ‣pgs. 33-36, case management
    ‣ pg. 48-51, network development, *Ball v. Biedess (Rodgers)*

AHCCCS Policies

1. Policy 413: Gap-In-Service Policy
    AHCCCS Contractor Operations Manual (ACOM)
2. Policy 420: ALTCS Network Summary
    ‣ see pg. 3 for Program Contractor (ALTCS health plan) Identification Numbers used in gap reports
3. Chapter 1600: ALTCS Case Management
    AHCCCS Medical Policy Manual (AMPM)
        ‣1610-1 to 28
        ‣Exhibit 1620-10: Sample Important Member Rights Notice Form
        ‣Exhibit 1620-11: Sample Critical Service Gap Report Form

AHCCCS Annual Compliance Reports (pursuant to ¶5(A) of Court's June 28, 2005 Order)

1. 2008 Annual Report (filed 8/24/08) (Dkt. 356)
2. 2007 Annual Report (filed 9/1/07) (Dkt. 321)
3. 2006 Annual Report (filed 8/31/06) (Dkt. 300)

AHCCCS Gap Reports

1. June 2009 Gap Report
2. May 2009 Gap Report
3. April 2009 Gap Report
4. March 2009 Gap Report
5. February 2009 Gap Report

6. January 2009 Gap Report
7. December 2008 Gap Report
8. November 2008 Gap Report
9. October 2008 Gap Report
10. September 2008 Gap Report
11. August 2008 Gap Report
12. July 2008 Gap Report
13. June 2008 Gap Report
14. May 2008 Gap Report

ALTCS Health Plan Policies Regarding Gaps in Services

A. BRIDGEWAY HEALTH SOLUTIONS

1. Bridgeway Cover Letter
2. Important Member Rights Notice
3. Critical Service Gap Report
4. Policy : Member Contingency Plan
5. Member Contingency Plan Form Instructions
6. Member Contingency Plan Form

B. COCHISE HEALTH SYSTEMS

1. Cochise Health Systems Cover Letter
2. Important Member Rights Notice
3. Critical Service Gap Report Form
4. Contingency Plan (Back-Up Plan) for Gaps in Service
5. Back-Up Plan (Contingency Plan) For In-Home Services Form

C. DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

1. DDD Cover Letter
2. Attachment A: Statewide Vendor Letter
3. Attachment B: Non-Provision of Services Log Instructions
4. Attachment C: Letter to Consumer and Family Member
5. Attachment D: Support Coordinator Responsibilities (email)
6. Attachment E: Critical Service Gap Report Form
7. Attachment F: Back-Up Plan/Contact Sheet
8. Attachment G: Policy 803.3: Back-Up Plans

D. EVERCARE SELECT

1. Evercare Cover Letter
2. Policy – Case Manager File Review
3. Policy – Initiation of Services
4. Policy – Reassessment and Ongoing Case Management
5. Policy – Processing Member Grievances and Quality of Care Concerns (QOC)/Quality of Service (QOS)
6. Policy – Member Case File Documentation Standards
7. Policy – Member Preference Level and Contingency Plans
8. Policy – Provider Gap Contingency
9. Policy – Self-Directed Attendant Care

E. MERCY CARE PLAN

1. Mercy Care Plan Cover Letter
2. Procedure for Member Service Preference Level-Contingency Plan Development
3. Procedure for Non-Provision of Service Coordination
4. Contingency Plan

5. Service Gap Report Form

F. PIMA HEALTH SYSTEM

1. Pima Health System Cover Letter
2. Standard I: Initial Contact/Visit
3. Standard III: Training
4. Memo – Care Plans for ALTCS Members
5. Memo – Monitoring, Reviews and Reassessments
6. On Call Procedure
7. Standards & Procedures - Monitoring of Non Provision of Service
8. Standards & Procedures - Personal Care and Homemaker Services
9. Standards & Procedures - Authorization of Attendant Care Services
10. Standards & Procedures - Temporary Scheduling of Home Care Support Services
11. Standards & Procedures - Referral for and Scheduling of Personal Care Aides
13. Memo March 4, 2009 from Patricia Alvarez Hurley, Director, Pima Health System to C.H. Huckleberry and Dennis Douglas, Pima County – Pima Health System Attendant Care Worker Program (with attachments)

G. PINAL-GILA LONG TERM CARE

1. Pinal/Gila Long Term Care Cover Letter
2. ALTCS Member Service Plan
3. Back-Up Plan form
4. Standard I: Initial Contact/Visit
5. Standard II: Needs Assessment/Care Planning
6. Administrative Standard III: Training
7. Standard IV: Placement/Service Planning
8. Standard V: Service Planning, Monitoring, and Reassessment
9. Memo: Care Plans for ALTCS Members
10. Memo: Monitoring, Reviews and Reassessments
11. Critical Service Gap Report Form
12. Initial Program Orientation (Member Handbook)
13. Provider Non Provision of Service Report form