Arizona Waiver History

■ July 13, 1982
  □ The Health Care Financing Administration (HCFA) granted Arizona an 1115 Research Waiver

■ October 1, 1982
  □ The Arizona Health Care Cost Containment System (AHCCCS) began serving people in its acute care program

■ Arizona was the first state to implement a statewide, Medicaid managed care system, based on prepaid, capitated arrangements with health plans
Arizona Waiver History

- **December 1988**
  - AHCCCS began phasing-in long term care services for individuals with developmental disabilities (DD)

- **January 1989**
  - AHCCCS began serving the elderly and individuals with physical disabilities (E/PD)
Arizona Long Term Care System (ALTCS) Guiding Principles

- Member-centered case management
- Consistency of services
- Accessibility of network
- Most integrated setting
- Collaboration with stakeholders
ALTCS Model

Potential ALTCS Member
2,750 Applications/Month

Financial/Medical Eligibility
1. Citizen/Qualified Alien
2. AZ Resident
3. $2,000/$3,000 Resources
4. $2,022 Income Maximum
5. Transfer of Resources
6. SSN
7. Medical Eligibility/PAS

ALTCS Program Contractors

DES-DDD

EPD Contractors
Bridgeway Health Solutions
Evercare Select
Mercy Care
SCAN LTC
ALTCS FFS – Tribal CM

Covered Services

Acute Care Services
Nursing Facility
ICF/MR
Hospice
Behavioral Health
HCBS
- Homemaker
- Personal Care
- Respite Care
- Attendant Care
- Home Health Nurse
- Home Health Aide
- Community Transition Services
- Transportation
- Adult Day Health
- Home Delivered Meals
- DD Day Care
- Habilitation
- Assisted Living Facilities

PCP/ CASE MANAGER

KEY
EPD - Elderly & Physically Disabled (Age 65+, Blind or Disabled)
ICF/MR - Intermediate Care Facility for Mental Retarded
NF - Nursing Facility
PAS - Pre Admission Screening
ALTCS Population – September 1, 2011

EPD
25,281
52%

DD
23,800
48%

NF:  27.6%
Own Home:  51.2%
Alt. Res.:  21.2%
99% + HCBS
Key Components of Serving Individuals with Disabilities Through a Managed Care Model

- Integrated continuum of care (long term care, acute care, behavioral health care)
- Commitment to serving members in the most integrated, appropriate and cost effective setting
- Development of and ongoing commitment to self-directed models of care
- Coordinated and informed case management
- Broad array of community settings, which facilitates member choice
- Availability of resources to facilitate transition into the community
Key Components of Serving Individuals with Disabilities Through a Managed Care Model

- State Oversight
  - Detailed contractual agreement and policies
  - Annual operational and financial review
  - Established network standards
  - Robust quality management standards, including monitoring of clinical performance measures and initiation of quality improvement projects
  - Regular case management monitoring and training
  - Regular monitoring of claims payment for timeliness and accuracy
  - Monthly review of grievances (member grievances and appeals, claims disputes)
  - Monitoring of medical management/utilization management
  - Regular review of financial viability
  - Consistent monitoring of HCBS placement against established targets
Questions