

DDD Provider Forum Summary Report  
Institute for Human Development  
Northern Arizona University

Dr. Kelly D. Roberts, Executive Director  
Nicholas Blum, Project Coordination  
Corey Lee, Graduate Assistant

July 29, 2019

## Executive Summary

### ***Background***

Between April 3 and May 21, 2019, ten forums (with 252 total attendees) soliciting feedback from providers of Long Term Services and Supports (LTSS) for persons with disabilities in Arizona were jointly facilitated by Northern Arizona University, Institute for Human Development staff and Arizona's Department of Economic Security, Division of Developmental Disabilities staff. Feedback was sought on the following topics: (1) Thoughts on an alternate service delivery model? (2) Governor Ducey's Executive Order regarding Enhanced Protections for Individuals with Disabilities; (3) What is going well with LTSS? (4) What needs to be improved? and (5) What are solutions for improvement? Feedback from the forums was analyzed with qualitative research methods, identifying the most prevalent themes.

### ***Results – Themes of feedback in order of prevalence***

Responses on Alternate Service Delivery Model: *Billing Concerns; Elimination of Small Providers; Negative Precedent Set by Other States; Changes in Provider Reimbursement Rates; Concerns with a Strict Medical Model*

Responses on Governor Ducey's EO: *Sexual Violence Training; Funding/Rate Increases for New Requirements*

What is going well with LTSS: *Options/Choices Available to Members; Person-centered Planning System*

What needs to be improved with LTSS: *Communication between DDD and Providers; Issues with Monitoring Practices; Support Coordinator Training Concerns; Support Coordinator Turnover; Vendor Call Process; Authorizations; Financial Concerns.*

Solutions for Improvement of LTSS: *Family Education; Provider Involvement in Decision Making; Increased Funding.*

### ***Recommendations – Based on Analysis of Feedback***

Thoughts on Alternate Service Delivery Model: Review effect of alternate model precedent in other states; Review effect of alternate model on billing and payment practices; Consider feedback from persons/families with DD in the process; Review applicability of the medical model.

Thoughts on Governor Ducey's EO: Develop and implement increased training regarding the protection of persons with disabilities with all stakeholders; Ensure rates are considered if providers have any new requirements (e.g., training).

Current System of LTSS: Increase the provision of uniform training for support coordinators; Increase/improve communication with providers and family members; Review effectiveness of vendor call system; Review effectiveness of authorization system; Increase funding for DDD; Provide higher rates of payments for vendors.

# Table of Contents

<b>Introduction .....</b>	<b>4</b>
<b>Methodology.....</b>	<b>5</b>
<b>Data Analysis.....</b>	<b>6</b>
<b>Results .....</b>	<b>7</b>
<b>Alternate Service Delivery Model Summary .....</b>	<b>7</b>
<b>Governor Ducey’s Executive Order .....</b>	<b>13</b>
<b>LTSS Results .....</b>	<b>17</b>
LTSS—What is Going Well.....	17
LTSS—What Needs Improvement.....	19
LTSS—Solutions for Improvement.....	33
<b>Discussion .....</b>	<b>35</b>
<b>Alternate Service Delivery Model Discussion .....</b>	<b>35</b>
<b>Governor Ducey’s Executive Order Discussion .....</b>	<b>37</b>
<b>LTSS Discussion.....</b>	<b>37</b>
<b>Appendix—Transcripts from each Provider Forum.....</b>	<b>41</b>
<b>Tucson (South) .....</b>	<b>42</b>
<b>Yuma (South) .....</b>	<b>62</b>
<b>Sunnyslope (Central).....</b>	<b>83</b>
<b>Prescott (North).....</b>	<b>101</b>
<b>Mesa (East).....</b>	<b>117</b>
<b>Phoenix (West) .....</b>	<b>138</b>
<b>Flagstaff (North).....</b>	<b>156</b>
<b>Phoenix (Central).....</b>	<b>178</b>
<b>Chandler (East).....</b>	<b>191</b>
<b>Surprise (West).....</b>	<b>210</b>

## Introduction

In 2019, the Institute for Human Development (IHD) at Northern Arizona University (NAU) was contracted by Arizona’s Department of Economic Security (DES), Division of Developmental Disabilities (DDD) to partner on ten provider feedback forums across the state of Arizona to communicate with and solicit feedback from providers of long term services and support (LTSS) for persons with disabilities across the state. A scope of work was developed between IHD and DDD, which outlined the expectations and deliverables from both parties.

IHD’s responsibilities included: working with DDD staff to secure appropriate and accessible facilities for conducting the forums; providing water and cookies to forum attendees; training and assigning qualified personnel to serve as facilitators for all ten forums; maintaining and organizing contemporaneous notes of feedback generated from these sessions; facilitating the transcription of the recorded sessions; analyzing the resulting data; and reporting on the results.

DDD’s responsibilities included: determining the general geographic locations and overall schedule of the provider feedback forums (ensuring that locations encompassed all of DDD’s “districts”); communication and outreach to providers about these forums; assigning at least one DDD representative to each forum, to assist the IHD facilitator with answering questions and communicating DDD updates and developments to the forum providers; and working collaboratively with IHD to develop the PowerPoint presentation that was used to guide each forum.

All ten provider forums were held between April 3, 2019 and May 21, 2019 (See Table 1). Every session was led by a trained facilitator from IHD and a DDD staff member. Feedback was solicited and analyzed by IHD staff (See Methodology section for more information). This full report, in combination with the Executive Summary and a summary PowerPoint, constitute the full reporting.

Table 1 – Location, Schedule, and Attendance of Provider Feedback Forums

<b>DDD District</b>	<b>City</b>	<b>Date</b>	<b>Meeting Time</b>	<b>Number of Attendees Total: 252</b>	<b>Location</b>
East	Mesa	4/24/19	10:00am - noon	26	Mesa Public Schools Student Service Center 1025 N. Country Club Dr. Mesa, AZ 85201
East	Chandler	5/14/19	10:00am - noon	46	Chandler Downtown Public Library Copper Room South 22 S. Delaware St. Chandler, AZ 85225
Central	Sunnyslope	4/15/19	10:00am - noon	20	Sunnyslope Community Center 802 East Vogel Ave. Phoenix, AZ 85020

Central	Phoenix (2)	5/8/19	5:30pm - 7:00pm	12 in-person 37 by WebEx	Gompers 6601 N. 27th Ave. Phoenix, AZ 85017
West	Phoenix (1)	4/25/19	10:00am - noon	13	DES/RSA Training Room 1 & 2 2nd Floor 515 N. 51st Ave. Phoenix, AZ 85043
West	Surprise	5/21/19	10:00am - noon	21	Surprise City Hall Community Room 16000 N. Civic Plaza Surprise, AZ 85374
South	Tucson	4/3/19	10:00am - noon	35	Easterseals Blake Foundation 7750 E. Broadway Blvd. Ste. C150 Tucson, AZ 85710
South	Yuma	4/9/19	10:00am - noon	8	Easterseals Blake Foundation Yuma Mission Valley Plaza 3860 W. 24th St. 2nd Floor Yuma, AZ 85364
North	Prescott	4/23/19	10:00am - noon	15	Prescott Valley Civic Center 7501 E. Skoog Blvd. Room 331 Prescott, AZ 86314
North	Flagstaff	4/30/19	10:00am - noon	19	Little America "Flagstaff Room" 2515 E. Butler Ave. Flagstaff, AZ 86004

### **Methodology**

The IHD Executive Director assigned IHD staff to lead provider forums based upon each staff member's availability, interest, and qualifications. The intent was for the facilitator from IHD to be neutral in the solicitation of feedback.

IHD personnel, in collaboration with DDD personnel, developed a PowerPoint presentation and accompanying facilitator "script" to be used as guides for each forum and to provide consistency between forums.

The IHD Executive Director in conjunction with the IHD Project Coordinator developed and delivered a neutral facilitator training program, which combined general information regarding the role of a neutral feedback solicitor as well as project specific information. Seven facilitators (covering nine forums) attended the training on April 1, 2019 (either in person or by Zoom teleconferencing system). This session was recorded and later viewed by one facilitator, prior to their assigned facilitation date.

Feedback was solicited from the forum attendees using four processes designed to allow for the acceptance of multiple forms of feedback. These processes provided accessibility for persons with disabilities and allowed for flexibility and increased comfort with responding. The four processes for gathering feedback were:

1. Verbal/in-person feedback
2. Verbal feedback solicited and recorded contemporaneously by the facilitator during the meeting on large sheets of paper (which were made digital using data entry)
3. Note cards provided to meeting attendees at the beginning of every session to record any written feedback (cards were collected, converted to electronic text, and the feedback included in the data analysis)
4. E-mails, in that an IHD and a DDD email address were provided to all forum attendees for use in the provision of written feedback, which was welcomed after each session.

Feedback was solicited on three general topics, with two topics using three related questions and one topic using one question (see Table 2).

Table 2 – Topics and Questions used to Solicit Feedback

	TOPIC 1	TOPIC 2	TOPIC 3
<b>Topic Description</b>	Current state of LTSS in Arizona	Thoughts on Alternate Delivery Model	Governor Ducey’s Executive Order - Enhanced Protections for Individuals with Disabilities
<b>Feedback Question(s)</b>	<ul style="list-style-type: none"> <li>• What is going well with LTSS?</li> <li>• What needs to be improved?</li> <li>• What are the solutions for improvement?</li> </ul>	<ul style="list-style-type: none"> <li>• What benefits do you see in an integrated health care model?</li> <li>• What could be some of the challenges?</li> <li>• Do you have any other thoughts?</li> </ul>	<ul style="list-style-type: none"> <li>• What are your thoughts?</li> </ul>

**Data Collection.** Attendance at the provider forums varied by location. Attendance was determined based upon sign-in sheets and physically counting the number of people in the room. IHD and DDD personnel confirmed attendance with one another. Nine forums allowed for in-person attendance only. One forum allowed for in-person and remote attendance through WebEx teleconference software. The WebEx system was implemented by DDD staff, and all feedback from the WebEx chat was read aloud in the room to be captured by the IHD facilitator. The total attendance numbers, by location, are included above in Table 2.

### Data Analysis

Transcriptions of all recordings were provided by a professional transcription service. Data collected contemporaneously by the facilitator and through note cards and emails were added to the database of the transcriptions and thus included in the analysis. The data were scrubbed of

all personal identifying information and then analyzed by IHD staff, including a trained graduate assistant with experience with qualitative analysis. The data were categorized, coded and synthesized into themes. A combination of traditional qualitative content analysis (i.e., Constant Comparative Analysis) as well as industry-approved qualitative analysis software (NVivo) were used to analyze the data. The analysis was guided by the IHD Executive Director. The results are presented below.

## **Results**

Following is a summary of the results of ten provider forums that were held to solicit input on three topics. The results are presented in the order of: (1) DDD proposed alternate service delivery model, (2) Governor Ducey's executive order, and (3) LTSS. Results are presented as direct quotes taken from the transcribed forum sessions and from the note cards and emails. The results for each topic are provided by key theme and each quote, or series of quotes, are prefaced with the forum location from where the quote originated.

### **Alternate Service Delivery Model Summary**

The resulting data are presented below as direct quotes from the transcribed forum sessions and data from note cards and emails. Key themes derived from the data include: (1) Billing Concerns; (2) Eliminating Small Providers; (3) Precedents from Other States; (4) Rates/payments; and (5) Concerns with a "Medical Model".

#### **(1) Billing Concerns**

##### Sunnyslope

"Their [MCO's] billing is terrible and challenging, and payment is terrible and challenging. It concerns me greatly. And I don't think families understand how things could be under the MCO model. I also understand that while some of the integration has worked in other states, there's real mixed reviews about all long-term services and supports being handled by an MCO."

##### Prescott

"I mean, I just think it would be a nightmare to keep everybody authorized through the health plan. I mean, we already have a hard enough time staying on top of our authorizations with DDD, and we don't have to go through what you have to with a health plan."

"From an agency point of view it seems like, you know, right now we have one entity that we bill, which is DDD, so like you said, we could have...we could possibly be billing DDD, maybe three separate MCOs. From an admin point of view that is a nightmare to figure out, you know, oh, these members are United Health, these members are Mercy Care, these members are DDD. And just to keep track of that is horrible."

"But if it's going to be so difficult to just get payment... And like I said, already with the two AHCCCS plans we have in place right now, it's been incredibly difficult. So have them [DDD] look at that."

### Mesa

“And the other problem when the RFP came out is the billing side changed their Medicare waiver process at about the same time, where we now have to bill Medicare instead of getting a waiver. And contractually, our contracts say that whatever Medicare pays, that’s what we have to accept. And so all of us that were involved—and they rolled it out kind of agency by agency, and you didn’t know when all of a sudden they were going to stop denying your Medicare waivers. And so we saw firsthand pennies on the dollar of what we normally would have received from DDD and now were receiving from Medicare and we’re being told you’re stuck with that rate. And so that just sent shock waves for every vendor because if that same thing is going to happen with the MCOs, then yeah, then we’re all out of business. And the members suffer.”

“Somebody that has secondary insurance. We have to bill their insurance first and get an EOB, a denial, and so since DDD is the payer of last resort, it can take six months before I finally get paid for those therapy visits. And so as a therapist you’re probably more aware than me. And so the point I’m making is that why can’t DDD just pay us timely and let them go chase down the secondary insurance. It’s not my problem.”

### West Phoenix

“Well, do you remember that positive I told you about how quickly DDD pays? [Laughter.] It took my medical plan, dental plan 94 days to pay my dentist for a cleaning. And I’m waiting in the 11th month for wedges for a person’s wheelchair. And I don’t know of a provider that can go a year without getting paid.”

### Flagstaff

“And then how would the rate schedules look under – and I’m not saying you [the forum facilitators] should have the answer. Have they taken into account though, what are the rates going to look like? Because we’re already struggling up here, trying to find providers at the rates that we get reimbursed. So those are all my concerns when we look at that model.”

### West Phoenix

“I think my biggest concern with the new model is the authorization portion of it because I have worked on the other end where it’s just the Medicaid members versus the long-term care members, where we have to go every three months and get 12 sessions and then be denied by the medical directors at the AHCCCS plans because it’s not deemed medically necessary, or they’ve had too many visits that year. So is that going to jeopardize our members on getting services, and are we going to be cancelling services, putting them on hold because we’re waiting for the AHCCCS plans to respond to our auths, getting the additional information. Just the manpower alone managing those auths is a huge financial burden for any provider, because you have to up your admin, and you’re working ten times harder to get additional information. So that’s my concern.”

### Chandler

“From a billing perspective, for companies across the board, we would like to put this in bold, in big letters please. With changing over the long term services of the hab[ilitation] services, over into the insurance companies, that gives the insurance companies 90 days to process those claims. They do not have to pay you until the 90-day mark. Right now we are getting a five-day turnaround from DDD, which helps a lot of us smaller companies. Or just our companies that

just do DDD. If we go into that, and heaven forbid you get a denial back, the insurance company then gets 45 days from then. So if they answer you back on the 89th day, and say no, we're not paying this for whatever reason, they then get 45 days from that point of saying no. And then not only that, you get two times to get that denial answered, and then you have to write an appeal. And each step you take with that is 45 days. And heaven forbid they get a backlog; they will let you know. And then you get a year to argue that claim denial. That will not help DDD services across the board for us providers who have to consistently pay our staff to come in and deal with the more difficult members, you know. We all do it, because yes, we do like this line of work. We do like helping people. But at the end of the day, our people still need to go home with paychecks."

"So from a billing perspective, switching any of the hab[ilitation] services or the 24-hour care over to an insurance that can take 90 days, then 45 twice, then another 45 to answer an appeal. That is not going to help us unless they can guarantee a five-day turnaround, just like DDD does. Because I know some of us even bill twice a month compared to once a month, because our companies are smaller. So we don't bill them once a month, we bill them twice a month for DDD. So that will not be a positive thing."

"So as a biller, you guys are going to have to definitely step up your contracts if it goes into these situations."

"The billing multiple MCOs instead of just billing one system is a big concern for the time with that as well. The fact that they don't have to contract with all of us, so we're not guaranteed who we're contracting with, and we could [b]e losing a lot of the members that we currently have."

## **(2) Eliminating Small Providers**

### Tucson

"The only way they can save money is to eliminate providers, cut rates, and reduce services in order to improve their return. And I think as, you know, [redacted name]'s more the expert than I am, but I think that's the examples from other states. There are many fewer providers, much less choice in who's [out there], a longer waiting list."

"So what they're going to do is figure out almost an annual cost per person, and if that person's acuity changes, if they need more support or less, the provider—this is why the small providers will disappear, I believe—the larger providers will be able to accommodate folks because they have bigger margins to work on. The small ones will disappear."

### Surprise

"My concern is there's over 500 agencies in Arizona, and we all operate at different levels of, you know, size. So if we integrate, and now we have to become contracted with United and Mercy Care – and I've been in business now five years, and I'm up against [provider redacted] who's international and been around over 30 years, and we're all trying to get contracted. Yeah, maybe the first year they might just give everyone a contract because of utter chaos, right. But then after that, when it's time to renew, they may just decide to go with the larger agencies, and half of us are going to go out of business."

“And for a lot of us, this is what we do. This is our passion. I’ve worked over ten years just to get to where I am now, and this is all I know how to do. So I think my concern as a business owner and also someone who is very passionate about what I do every day is that there is an absolute possibility that I won’t be in business when this takes place, because of the simple fact that United probably already has people they’re contracted with that do the same thing that I do.”

#### Chandler

“The reality of this, just to kind of alert you guys, to advocate for your agencies, is the MCOs have their own business model. They are for profit. They have clearly said they don’t plan on contracting with all 400 agencies. So it’s a matter of you submitting your proposal, they’re going to look at who has the most services, so if you’re just a small HCBS service agency, the chance of you getting that contract are not going to happen. My concern with this after having attended that meeting was, our members have built relationships with the agencies they’re with. Whether you’re small, whether you’re large, there’s a relationship. And if that agency is not given that contract, that member now doesn’t have service, and they have to go somewhere else. And for some of us, we’ve served our members for 15 years and they don’t want to switch.”

“The one thing I’m really concerned about too is if the State is looking at this for their budget and everything overall, what’s going to end up happening if we do end up moving to that plan? You’re going to end up seeing a lot more unemployment, agencies like you said, I’ve heard that too, where they’re going to have their run of who their pick is. Agencies will lose their contracts, so we’re going to have unemployment going with DDD, because the jobs will be cut as well, because they’re not going to be able to sustain with this model moving to that model.”

### **(3) Precedents from Other States**

#### Tucson

“In other states it’s been woefully unsuccessful.”

#### Sunnyslope

“Their [MCO’s] billing is terrible and challenging, and payment is terrible and challenging. It concerns me greatly. And I don’t think families understand how things could be under the MCO model. I also understand that while some of the integration has worked in other states, there’s real mixed reviews about all long-term services and supports being handled by an MCO.”

#### Mesa

“But if we look at those other states—and I’ve only looked at Iowa as one—it went really, really bad for the members in Iowa when this transition took over for the LTSS services. Members did not get anything good out of that.”

“And I really worry about members and us as providers, where that goes if we’re going into the same sort of model that these other states have historically already gone into. We need to learn from those states what worked and what didn’t work so that we’re not there. We are doing something great in the state of Arizona. We are No. 1 in that area, and it’s like the only area that Arizona wins. [Laughter.] We’ve got to stay there. We can’t go backwards.”

#### Flagstaff

“I spent some time looking at what’s happened in other states, and I can’t find any successes. Every state that has tried this is just having all kinds of problems with it. I think that there’s an idea that there is, for the State, that there would be some kind of economies of scale. That in the long run, there would be money to be saved. Well not only do I not believe that, but I don’t believe that this is the place that you want to try to save money. These are people’s lives. This isn’t an acute illness; this isn’t even a long-term illness. This is a whole different service, and these MCOs just aren’t set up to handle that at this point.”

#### **(4) Rates/Payments**

##### Tucson

“Because of the rates and how low therapists get reimbursed through DDD, this is actually attractive to me, to be able to go directly to the insurance provider themselves and take kind of DDD out of the mix of it. So this is attractive to me.”

##### Prescott

“I have contracts with, EPD contracts with Banner and United Healthcare, and my experience is that the MCO keeps 10% or 5%, depending upon the MCO, of the rate. So the published rate, they just decide to keep it. So DDD doesn’t keep anything. The published rate is the rate the providers get paid. And it’s all dependent upon how well you negotiated with your MCO. But I’ve heard stories of 20% going back to the MCO. And I refuse to contract with those particular MCOs because I wasn’t going to provide the service 20% less than the AHCCCS fee for service schedule. So why would we want to go play in that sandbox?”

##### Mesa

“...the biggest concerns, unanswered questions at the time were continuity of care for the member, who would be able to provide the services, if we were going to need a contract with the MCOs, what the rates were going to look like, what the billing was going to look like—...”

“...so the concern was no one would be able to provide the services at the current rates, the market rates, outside of what DDD is currently doing.”

##### West Phoenix

“I think we have to look at the motive. I mean, insurance companies are in business to make a profit for their shareholders. I don’t expect that Mercy Care or United Healthcare or Banner or any of the traditional MCOs that we currently see here are going to function like DDD. They’re in business to make money. And DDD is in business to spend their fund balance each year. And so I contract with United Healthcare and Banner, and they don’t give me the published rate. They give me 90% of the published rate. Banner gives me 95% of the published rate.”

“So we also contract with United Healthcare and Mercy Care. Some of the rates are fine. But other rates are 10% of what the AHCCCS fee schedule is. Ten percent. And do the math on that. You pay your therapist \$40, which is the going rate, pretty much, for an assistant in the DDD world, and you’re getting reimbursed 20. Ten percent of the AHCCCS fee schedule. So there would need to be a... I mean, I just don’t see how it’s possible. It would wipe out services overnight if they kept the current rates that we get.”

### Flagstaff

“And then secondarily, I would say that – I contract with United Healthcare currently to serve the EPD population here in Flag and all over Arizona. Well, the Northern half. And they take 10% right off the top, right off the fee for service schedule. So what makes me think they’re not going to take 10% off my DDD rate schedule? It’s what they do. And it’s not right. And so I’m absolutely opposed to this. It’s a bad idea. If our current system that is flexible and meets the needs of our people in the most cost effective way possible is not broken, then why are we going to fix it? So that’s where I’m at with this.”

### Chandler

“A couple things. I’m concerned about the rates, when we go to contract with the health providers, with the insurance companies. We have an okay rate now. I know that insurance companies have low rates. And right now, we’re doing the best we can with what we have, and I couldn’t go any lower as a provider. And to pay our providers, our therapists, they can’t go any lower.”

“My concern is we are from an underserved area. We have a hard time getting therapists. It’s gotten better over the last few years, but there’s a lot of areas still in Arizona that aren’t. So if we go to this system, is it going to be one statewide rate? So that tier two, tier three, we don’t get those additional rates to entice therapists to come further out.”

## **(5) Concerns with Medical Model**

### Sunnyslope

“Speaking about the QA oversight, I think one of the issues is some of the folks that are coming back and looking at incidents are coming from the medical model and they do not understand that this is not a medical service, this is a...this is someone’s life. So they’re not very understanding of that.”

“Yeah, and it really scares me that we’re going to this medical model.”

“MCOs operate on a medical model. I don’t think they understand the services and supports that we offer for long-term services. They are not very responsive when you come to them and talk about a member needing more services and supports. And I feel that as provider organizations we’re going to be forced to kind of fill those gaps, and we’re not going to get paid for those gaps.”

### Mesa

“I think [redacted name] makes a really great point, that we have to figure out a way to make sure that what we’re doing inside of DDD fits into this medical model, and we can make it conform to what we have to do to draw down the federal money because there’s no way that Arizona wants to pay for these services out of their own pocket.”

### West Phoenix

“I’m going to be real quick because I would just echo what both of you have said. Those are major concerns for us as well. Yeah, medical model versus an independence model.”

## Flagstaff

“The medical model is very frightening to me. DDD, I was told in the spring forum a couple of weeks ago, that DDD is a managed care organization, which is frightening to me. The social model is really going away, and that doesn’t serve the human being. And I know this has been an issue since a long time, but people with intellectual disabilities on the mild to moderate level, if they’re not long term care, they get nothing. And so someone said in the meeting, oh they get case management. Well they get nothing. They get no support in the community. If they do not have a family member who is taking care of them, or getting them into the community, they are getting nothing. And I said, just send them straight to Corrections, because this is just the pipeline for that.”

“Well, you piecemeal a person, and you take them out of community. And we need our, every one of our persons with a developmental disability in our community. There is no way that a healthcare plan that only cares about the bottom line is going to look at that individual as a human being, in a multi-disciplinary way, with a team understanding of what needs to happen for that individual, and for that community.”

“I’m also very concerned that these MCOs, these potential MCOs for DD services, have no long term care services and supports experience. When the RFP came out last year, and it was being discussed, I kept saying, please quit calling our clients patients. And they kept doing it anyway. They don’t understand. They don’t get better. Our clients don’t get better. They may improve in some respects and stuff, but it’s different than what can be handled by a medical model. I spent some time looking at what’s happened in other states, and I can’t find any successes. Every state that has tried this is just having all kinds of problems with it. I think that there’s an idea that there is, for the State, that there would be some kind of economies of scale. That in the long run, there would be money to be saved. Well not only do I not believe that, but I don’t believe that this is the place that you want to try to save money. These are people’s lives. This isn’t an acute illness, this isn’t even a long term illness. This is a whole different service, and these MCOs just aren’t set up to handle that at this point.”

*Note -multiple terms were used to speak about the medical model and the non-medical model. Providers referred to the current model as the non-medical model, another used the terminology independence model, and a common term in the literature is social model. The terminology, medical model, was used to refer to the alternate model.*

## **Governor Ducey’s Executive Order**

The resulting data, presented below as direct quotes from the transcribed forum sessions, are inclusive of data from note cards and emails. Key themes derived from the data include: (1) sexual violence training and (2) Funding/Rate Increases to Compensate Providers for New Requirements.

### **(1) Sexual Violence Training**

#### Yuma

“Yeah, I think there should be some training associated with identifying behaviors that are associated to abuse. Not just physical abuse, but mental abuse, financial abuse.”

“I would want to have caregivers trained. All the way down to caregivers.”

#### Prescott

“I’m going to put on my government employee hat that I haven’t put on for a while and I am going to say that I feel like whatever is decided and whatever training is developed, I feel like that training should be required of all agencies.”

“Training and fact-based monitoring of that training, because I’ll get a monitor who literally I have to call and appeal because they’re saying in my opinion you should have. And this is not a world that opinions [matter]. It has to be fact-based, data driven, accurate information. And so I’m nervous about it.”

#### Mesa

“So it starts at a lower level where you have to teach them how to say no, you teach them about boundaries, relationship awareness, how to dress, how to talk, how to have relationships, and then you kind of raise the bar a little bit and go to other levels. That would be something that I would recommend that the work groups consider. I’m working with a couple other agencies to kind of spearhead this. And again, it’s something very near and dear to my heart, and I’m all in about this.”

“And so you’re teaching not just the individual themselves, but you’re also training staff, because some staff have really hard times with boundaries, because they want to be the friend, they want to be the whatever, and so you’ve got to teach staff also how to approach the individual with touch, and boundaries, and personal space and all that. Because we all work together, so it has to be not just the individual with IDD.”

#### West Phoenix

“I think I’ve heard from a number of providers and I agree that it would be nice with respect to training issues if we had a sanctioned curriculum, because it is such a loaded moral and political set of issues that it’s going to be very messy if we’re training different things at different agencies.”

#### Flagstaff

“We need to be working at educating the clients, individuals, as to their sexuality, good touch, bad touch, and we’re ignoring that. It’s the elephant in the room, and you really can’t do one without the other.”

#### Central Phoenix

“I think always we can improve upon our training to signs and symptoms of abuse and neglect. And then the frequency in which we train that. Because you can’t do it enough.”

“I think we also have to remember, we focus a lot on staff – rightly so – to focus on our members, and teaching our members skills. Self-advocacy skills, how to say no, conversations that as an industry, we’re not comfortable having directly with our members. We need to start having those conversations.”

#### Chandler

“Obviously it’s a great idea and things we need to do, but some concerns with the annual abuse/neglect monitoring, knowing how to find it, all that bit.”

## **(2) Funding/Rate Increases to Compensate Providers for New Requirements**

### Tucson

“It’s not that I’m known to beat a dead horse, but one of the things that I think is lacking in the order is the funding.”

### Yuma

“I hate to go back to funding, but funding is an issue.”

“And when you have a profession that goes from not being a minimum wage job to now a minimum wage job, not only the quality, but also the quantity of individuals. And when you don’t have the funding, as we’ve had these rate increases, that filters down to the providers, then they have to make changes. And sometimes that’s in staffing. And a decrease in staffing, you may have overworked individuals who may be less likely to recognize something that’s going on.”

### Sunnyslope

“I’m actually on one of the work groups, but I have some concerns about the annual training and will there be funding associated with the increased cost for annual training?”

“On a further note, does anybody realize that counts that makes these decisions realize that maybe if they funded the DDD system properly that things would run even better than the, quote, MCOs or insurance companies?”

“There is something we don’t hardly ever talk about, and that is the provider’s inability to provide one-to-one care whenever requested. The majority of it is driven by rate, because without rates you can’t hire the qualified person and give them the extra training they need to handle somebody who’s very behavior challenging, which puts them on a one-on-one status in the first place.”

“So that could be the solution, easy solution, is fully fund[ing DDD].”

### Prescott

“I have thoughts on the executive order and for the work groups that have been put together as a part of the governor’s order. So I’m worried about us making our response too big. And that sounds callous on its surface because what happened to this young lady was horrific and should have never been allowed to happen. However, we’ve had people in this situation in our system before, and we’ve had people killed in our system before. This one got national attention, and so now we have this big response. But the reality is that if these work groups come together and put together a huge protocol that needs to be followed, it’s going to have to be funded. That protocol is going to have to be funded. No protocol without corresponding dollars for its implementation.”

“I just want to talk about a potential response that could be costly to providers. And let’s say that never, ever, ever is a member to be alone with one staff, that there always has to be two staff.

Well, if they mandate that, they have to pay for it. Look at therapy. We're having a hard enough time getting therapists. So now a therapist has to have an observer in the room at all times? This could get ridiculous. If you think about the social workers that may or may not be involved in these groups, it could turn into something outrageous. And if it does, they need to recognize the dollars that are associated with it."

#### Mesa

"I know these work groups are going to come up with all kinds of suggestions, and some of them will be implemented. And my biggest concern as a provider is that there's going to be some suggestion or some change that's not going to be funded. So on this list, the governor and the legislature and all the powers that are considering these suggestions need to make sure that there's dollar signs tied to what we have to implement. Whether that's never having a client alone with somebody—imagine if a therapist always had to have an observer in the room, and they had to pay somebody to cart along with them. That would double your cost almost. And so they can come up with all kinds of suggestions, and who knows what's going to come up. I just want it funded."

#### West Phoenix

"It would be incredibly expensive. Every therapist having two people in the room every time. But anyway, it could explode into something that absurd. I doubt it will get that absurd. But that's just an example. And there are going to be many implementations that are going to cost lots of money."

#### Flagstaff

"I think the key here is on prevention. And it's great to talk about recognizing abuse, but we need to prevent it before it begins. So my feedback for Governor Ducey would be that he needs to direct our funding where our values are. And back to what [name redacted] was saying – he's not here any more – about workforce development. Our staff need to be paid what they're worth. We can't have minimum wage staff in a revolving door with the most access to our most vulnerable people, and think that that's safe."

"But my comments on this order are that, coupled with a cautionary note to the work groups to not overreact and create overly burdensome suggestions that could, in fact, pounce on the rights of the people we're trying to serve, it could take away independence, and it could be incredibly costly. Imagine if one of the work groups said that all therapists must have an aide watching them for every session, it would cost millions of dollars. And so, I would say any suggestions they come up with must be fully funded."

"Kind of going off of what someone was saying, the lack in funding. My sister-in-law works for a skilled nursing facility specifically in the Phoenix area, and I know that one of her biggest complaints is always short staffed. They always have a short staffing of nurses, people are calling off, things like that. And they do get paid enough, each individual who's working there at the time, but because they can't get paid more, it causes it to where they have not a lot of nurses available on staff to check up on the patients. Those are actual patients there. So I would say a lack of funding for more staffing, so we can pay what we have to who we have. For purposes of DDD, we have to have a specific ratio. But that's not required by a skilled nursing facility. You don't have to have 12 nurses per floor, things like that. They're on long shifts and everything. So

this specifically of what happened to the individual, I would assume part of it is that there's a lack of staffing and individuals there. Because otherwise he wouldn't have to that. That's my two cents."

#### Central Phoenix

"I'm all for raising the standards of training for our providers, but it's unfunded. And we need to do something that provides funding to agencies to ensure quality care is being delivered."

#### Chandler

"Annual training for all staff, is there going to be compensation for this? That costs a lot of money. With our day programs, our employees are already Monday through Friday, getting overtime. They have to do a Saturday overtime training, where's the funding going to come for this?"

### **LTSS Results**

The questions posed to the forum participants associated with LTSS were: What is going well with DDD LTSS? What needs to be improved? And what are solutions for improvement? The resulting data are presented by question. The results presented are direct quotes from the transcribed forum sessions, note cards, and emails.

Key themes derived from the data, presented by question posed, include:

What is working: (1) Options/Choices Available to Members and (2) Person-Centered Planning System.

What Needs Improvement: (1) Communication Between DDD and Providers, (2) Issues with Monitoring Practices, (3) Support Coordinator Training Concerns, (4) Support Coordinator Turnover, (5) Vendor Call Process, (6) Authorizations, and (7) Financial Concerns.

Solutions for Improvement: (1) Family Education, (2) Provider Involvement in Decision-Making, and (3) Increased Funding.

### **LTSS—What is Going Well**

#### **(1) Options/Choices Available to Members**

##### Tucson

"I think what is going well is having options to have places that they can try out, so our members can try out."

"And having an option as a parent to be able to decide on where she's going to live, where she's going to be happy..."

"...we have choices of day services and providers"

##### Prescott

“I believe that, in my opinion, what is going well, it gives person centered choices, family centered choices, and also gives the members choices whether they will get services in the home, or with DTA, or group home as they desire.”

“I feel that our providers at this time have lots of different choices from various different providers within the network system. I am concerned that the provider list will be limited going with a different system.”

### Mesa

“Just the variety of services available to our members. You go to conferences all over the country and when people find out what Arizona is providing it’s one of the best in the whole country as far as the needs of the members, and particularly with AAC, there’s nothing like it.”

“So positive, families have a lot of options in terms of which agency they select. There really are a lot of agencies available to families.”

### Flagstaff

“I think one thing powerful about the way the long term care system works, at least related services, is that the family has a lot of say in the IFSP and the direction they want to go. Services aren't always available, they can't always get what they want. But it is an important part of that process and I think that's important.”

## **(2) Person-Centered Planning System**

### Yuma

“And they’re trying to do a more person centered approach and the new tool is intended to [meet] in the meetings, and be a more person centered approach. So I think it’s a great intention for what we’re trying to accomplish, that being more person centered. Still don’t know that I like the tool.”

“So I think it’s important as you go down this road to think about the relationships, and who’s primary and secondary in it because when you start doing person centered planning there gets to be a lot of people in the sphere of that plan, and it’s not always—like there’s been a time that DDD believed that they were in control of something, you know, they were the ones that were having the primary relationship. And I think there are many times nowadays is their recognition that they have not got the primary relationship.”

### Prescott

“I believe that, in my opinion, what is going well, it gives person centered choices, family centered choices, and also gives the members choices whether they will get services in the home, or with DTA, or group home as they desire.”

“I do definitely feel that it is person centered.”

“The current system of service delivery is flexible, it’s person centered.”

## LTSS—What Needs Improvement

### (1) Communication Between DDD and Providers

#### Outlier Responses:

##### Surprise

“I have to say the relationship with some of the Support Coordinators, the communication. The concern for the members, the concern for the whole flow of everything through the services, their interest in the agencies, the qualified vendors, it’s appreciated.”

##### Central Phoenix

“I have to say, one of the things that I’ve been very appreciative of late is receiving information from the Division to prepare us for the addition of new services. Giving us guidance as to what is expected, and what is required. When I first started ten years ago, I wasn’t getting that information. And it was very frustrating. So to be given information in advance is very, very helpful, and I really appreciate that.”

#### Common Responses:

##### Tucson

“One of our concerns—and this does tie into communication somewhat—is that there are times that we need an elaboration or a clarification on something and we’ll send emails, we’ll call, and we get back nothing or we get back a couple of answers that don’t correspond well to each other, and it’s come from DDD.”

“And one of the things that I’ve always felt strongly about is the variance in the communication.”

##### Yuma

“I think communication can always get better. Sometimes we have meetings that are changed and we never get an email or a call, and then they asked us why we missed it.”

##### Sunnyslope

“The families get it, and so sometimes we just have support coordinators show up and be like, well, we scheduled a meeting with the family here at your center. So they don’t always include the agency in their information emails.”

“I think areas for improvement would be communication. I know the division just recently started a provider newsletter, which is good, but I think there needs to be more communication with the division with different things that are going on.”

##### Prescott

“The concern I have is that when you call or get online to get information that the information may not all be accurate or the individuals you’re calling bounce you around to other individuals that continue to bounce you around before you can get the information that is accurate or needed. Once you find the right person it is a waterfall of amazing, great information. But trying to find

the proper person is very difficult. I don't want to say poor access because the information is amazing once you eventually get to the place you're supposed to be."

### West Phoenix

"But the biggest negative I think for us is that the division has trouble communicating with providers. I think that the pilot, the therapy pilot is a pretty good example. I'm a member of AAPPD as well, and we had a couple folks from DDD come in and talk about the pilot that's going to happen to therapies, and it's not a bad idea. It's actually, I thought it was very...it definitely has positive benefits. But during the provider meeting that we had a couple weeks ago it was poorly explained, so a lot of providers left the meeting feeling what is this pilot, what is going...? They just didn't understand a lot of it."

"So that's concerning to me that families somehow aren't getting the understanding of what exactly these meetings are for. So maybe it's a communication thing, maybe they don't open up the DDD website, because the box that pops up works really well. It pops right up. You can't get rid of it on the screen without reading it, so that part I like."

"But I do think that that is an example of a communication issue that is frustrating for providers because you're making the argument at the field level repeatedly. And we get auditors, and it's like, well, what are the auditors trained, where's the audit handbook? So I would just say that generalizes to a much broader concern about transparency and communication, both internally for DDD and externally with providers and families."

"Continue with the provider [outreach] that DDD has started. So AAPPD very much appreciates that. We'd like to continue to see that become more robust. On the communication side, it's having that consistent communication from the division to all providers. We think that's really helpful so we'd love to continue to see that become more robust. And then on the communication, there was some conversation about this. I don't know how to describe it. But we have these district meetings that providers go to. The information that is shared in those district meetings is never consistent, consistently shared. So is there a way to have a website where all the information that is going to be shared for every district meeting is all in one place so that every provider can see all the information that's shared at all district meetings to help with that?"

"Last year what happened was very unfortunate. They basically had told all the therapy providers—and this is just something for improvement, I guess it's a communication thing—that you had to become Medicare certified. Yeah. And that was an AHCCCS statute, basically. Well, it wasn't in the DDD provider handbook. They put it into the DDD provider handbook without really saying anything and said it was retroactive. And then there was confusion on what exactly that meant. Did it mean our agency, which is a home and community based HCBS agency needs to become a home healthcare agency, a proper home healthcare agency that is federally certified by Medicare? And there was so much confusion, and there were no answers. And eventually we ended up certifying the providers through a very cumbersome process to get them as basically a non-Medicare provider so they could...so we could get a waiver, basically, for our services. So I just think that sometimes that stuff should be communicated. And it's probably coming from AHCCCS, obviously. AHCCCS says get your act together and then DDD kind of push out these things very quickly, and it catches us all like by surprise."

## Flagstaff

“I think there needs to be more collaboration, where network providers, institutional memory of the Arizona network, DDD staff and AHCCCS are in the same room collaborating on issues that can benefit the members.”

“And the third thing I had, which is fixable, is communication. So as an example, yesterday I asked a Support Coordinator to change the start date on an authorization, because it was eight days before we actually started. The Support Coordinators and the Supervisors didn’t know anything about the new value based purchasing initiative, that requires that providers strive to serve people within seven days. So they were refusing to change it. Why wouldn’t they know about that? That’s something that should have come down from the top. I just think that we need to improve a lot of the communication to Support Coordinators. Maybe it goes through too many channels, I don’t know. But it just isn’t getting to where it needs to be. And also then, communication from the Division to providers. You know, if it weren’t for [AAPPD], we wouldn’t know very much at all. So that’s important. But the Division has provider meetings up north. They seem to think that, like Havasu or wherever, Kingman, is next door to Flagstaff. So we only end up going to one. And I brought up the suggestion before, we have teleconferencing at DES. We use it for RSA all the time, why can’t we use it for the provider meetings?”

“But one of my recommendations for solving the communication and sort of the blocked pipes if you will, because we still come across so many time[s] where nobody can make a decision because the right people aren’t there. And so my suggestion would be to give Support Coordinators and Regional Supervisors more autonomy, and be able to make and approve decisions, as it relates regionally. That would hopefully involve some rate increases when a certain, specific region requires it. Or certain additional supports like extra staff, or compensation for transportation, when it requires it in their specific regions.”

“A suggestion for improvement would be to improve communication so that when there’s a concern or a complaint filed with DDD, with VR, with DES, that there’s not a way that it’s pushed back on the provider. Because I’ve seen that happen. Where then they’ll sort of put it back on the provider, and have the provider receive the complaint.”

“The other thing that I think would be important is that if there is a concern or a complaint, about a notice of action or a denial, or a delay in the approval of certain services, that DDD gets that, but also the health plan gets that, and also AHCCCS. So that there’s a level of accountability, and it’s not just one entity that’s receiving that communication, but a variety, so others can follow up on where things are in the process.”

“I’ve got to say, I’m totally on board with [name redacted], it doesn’t make sense. And if we think we have communication issues now, working with the DDD, what do you think it’s going to be like if we’re working directly with a United Healthcare entity? it to me doesn’t make sense. From a parent standpoint, and from a provider agency standpoint. I think – what’s it going to look like if you need to get ahold of the person in charge of your support coordination? Is that a local person I can call on the phone?”

“Along those lines is the openness of communication. The ability for us to speak directly to DDD, and have our voices heard.”

“But your guys’ internal communication sometimes is a barrier. We get different messages from executive leadership and provider meetings and actual support coordination, and it’s hard to communicate to 2,000 people.”

“We have a continuing issue with not being appropriately notified of scheduled meetings. The ISP meetings, from Support Coordination. We are proactive, reaching out to coordination to query them as to when the next meeting is. Invariably we’re getting notified after the fact. To make matters worse, when we then receive the document, there are goals that are being written that make no sense. With no input from us. And we need to do a better job. There needs to be more collaboration in terms of how one identifies what a goal should be. Is it achievable? Is it measurable? I thought that was the fundamental, core responsibility to have it measurable and achievable, and yet these goals that are coming out of coordination are so far from that.”

“[Name redacted] says communications can be improved. I’d like to see more provider meetings to keep us updated on the changes that are being made.”

“Okay, I have two comments right now. [name redacted] says, these provider meetings are often given with short notice, and offered during daytime hours, making it hard to have input and ask questions. PS, thanks for the evening on this one.”

“[Name redacted] says ability for providers to attend meetings to improve collaboration amongst all involved in the client’s care.”

### Chandler

“I would say maybe communication with some Support Coordinators. I have noticed even with families, there can be a lack of response and available resources. We do try to refer out if there’s a service we can’t help with, and guide families. Sometimes we’re hesitant to push it back on the Support Coordinator for those kind of things.”

“We kind of have the same issue of the Support Coordinators, they’re very hard to get a hold of, especially when we need to add modifiers to our members and stuff like that.”

“There is a lack of communication when you guys update your prices, so that when we put in our billing, there’s no – the rate books weren’t being updated for providers to implicate the payments. We were submitting it with old prices on it, and then the whole rejections and stuff going on about that. So there needs to be better communication.”

“Kind of along the same lines, the Support Coordinators, I understand DDD is understaffed, so I would love that to change, where you guys could have more Support Coordinators. Because right now, if you try to get the assigned Support Coordinator on the phone, it’s very difficult. Then you try to get the Supervisor on the phone, and try to escalate it, you can’t get the Supervisor on the phone. And now it’s gotten to where that customer service line is the best way to get a call back. And usually the reason to call is because we’re not getting those ISPs back in a timely manner. Which they’re not getting back, and then sometimes that delays goals, it delays documentation and so forth.”

“So rolling off of the communication with Support Coordinators, a really big issue we have is contact information. We know that Support Coordinators are changing all the time, but Focus is not updated with the correct Support Coordinators, the phone numbers we call are not correct, Supervisors are incorrect. So it takes us a while to get in touch with the right people.”

“And then also in regards, you guys had talked about Support Coordinators, it is very difficult to get ahold of them, and they are switching. So I just want to reiterate that that is an issue. And I know it’s budgets and whatnot, but I just wanted to touch base on that, that it’s difficult.”

“As far as Support Coordinators, the lack of communication and support from them is tremendous.”

## **(2) Issues with Monitoring Practices**

### Tucson

“Because now we have people going into situations—and we’re not accusing agencies of abuse or anything, but there’s no oversight. And right now day programs and residential programs kind of check in on each other and say hey, this person has bruises on him, or this person’s lunch is really something for the trash can. And that’s not going to happen if it’s the same pair of eyes making the lunch as it is working in the day program.”

“So when I’ve seen people go into these same programs 24/7, I have to question where is that oversight. Our program monitors do not have the time or availability to go into these programs on a regular basis. And I’m talking regular as in weekly, or even monthly. Some of us, we don’t see our monitor for months at a time. So we had a situation very similar to the situation that was at the [provider redacted]...”

### Surprise

“The monitors are a little bit heavy and hard, intimidating at times. We try to please DDD and do our best, but it causes some anxiety and some stress, and there’s not that unity of seeing our perspective and trying to resolve the issues. It’s just kind of, we have to put up and shut up. And we don’t get heard. So I do appreciate these opportunities, these forums.”

### Sunnyslope

“We have DTA monitoring now, HCBS monitoring, group home monitoring, we have OLCR, and then we have the quality assurance unit. There’s always somebody out monitoring us, always. And sometimes the requests for information and so forth, especially on the QA side, the turnaround is really quick and somewhat over burdensome, and sometimes very much like this was six months ago, but I need it this week kind of thing.”

“And just real quickly, to tag onto one earlier thought of [name redacted], was that consistency among monitors. We’ve had monitors come out and one cite us for a certain issue, and we had the same issue at another home, and it wasn’t cited, and then it ended up that it shouldn’t have been cited.”

“As far as the monitoring process, at least our agency, I understand that they would like to see you in action without it being planned, but they come and then they expect hours upon hours of

your administrative time on very, very short notice. So if there was a way they could do a drop-in visit with the expectation of it just being their insight for 15 minutes and then schedule a time for it to actually be there, because I don't know if everybody else does it, but when they come it's hours, and I might have a meeting."

#### Mesa

"And furthermore with that, no one is checking in on the agencies and making sure that everybody is doing what they're supposed to do. So I'll receive an evaluation that I'm supposed to create a care plan, and the goal is two words, literally two words. And when that went to a coordinator who's not necessarily qualified to do that, but no one is holding that agency accountable for this lack of documentation, and then I have to fight for a new auth for that evaluation. So again, no one's holding an agency accountable."

#### Central Phoenix

"Not just to build on what she said, but monitoring groups to consistency among monitors, we find inconsistent. And so if you could maybe look at that. Actually between all the services, yes."

"And I certainly understand the need for investigations, but it appears as though the pendulum may have swung a little bit too far. We're getting investigations on bruises that we write up, on people who are susceptible to bruises. And so if maybe just a little bit more thought goes into that, because we're spending a lot of time on investigations, which we understand. Investigations sometimes need to be made. But maybe be a little bit more thoughtful in – yeah, absolutely, thank you."

"[Name redacted] says training for providers on how to conduct investigations."

"I do agree with one of the comments that we could help in the monitoring area, where we could stay consistent and not deviate from those specifics."

"[Name redacted] says provide training for providers on how DDD monitors interpret standards so that there is more consistency."

#### Chandler

"Monitors, I've had a situation in the past where we are surrounded by a community garden, library park, community pool. And a monitor had said that that wasn't enough. So that took a toll on our business, because we had to provide a bus. We've tried doing the Sunbound thing, it didn't work. So with those extra expectations cost money. So when you expect, you also have to look at the compensation, if the money is providing for that service or that additional need. So monitor consistency would be very helpful."

"Well, even with DDD right now that we're all just going through, we still have program monitors coming in. We still have OLCR licensed safety inspections. A lot of different stuff going on. How many more inspections and monitorings are we going to have once we have multiple MCOs that we're contracted with? And even just having different requirements for what we have to do for each MCO is a big concern as well."

### **(3) Support Coordinator Training Concerns**

### Tucson

“So from what I’ve experienced a lot of it is that we have a lot of new support coordinators and most of, from a personal basis, most of our issues, we don’t have a lot of issues with the old support coordinators, but the newer support coordinators that haven’t received the training or the, you know, the experience, that’s when it becomes a really big deal, and that’s when the communication falls short.”

### Surprise

“I think a suggestion would be for, especially for support coordination training, I really think DDD needs to be doing the training, but I think providers and parents need to be involved in that. Because I think there’s a lot of input both ways that that support coordination could really benefit from.”

### Yuma

“Again, another thing that I see that I’m assuming that it has to do with the training is more invitations to ISP meetings coming from the newer support coordinators versus the older support coordinators. So those are coming through to me regularly, again, from the more...the less seasoned support coordinators. So I’m assuming that the new training is really putting an emphasis on that and as a provider I really appreciate that.”

“I just think that the needs to be improved would be the points where training for the newer support coordinators maybe re-train some of the old guard.”

### Mesa

“Well, I was just saying training for support coordinators.”

### Central Phoenix

“[Name redacted] says training and follow up for support coordination, and what is required to meet the needs of each individual.”

“In terms of training of support coordination, an area that again, becomes a repetitive challenge. And that is Support Coordinators who are coming to the ISP meeting without ever reading a progress report. Without ever reading the documentation that is being submitted. And my managers are coming back and saying, oh the Support Coordinator said they don’t have time to read it.”

## **(4) Support Coordinator Turnover**

### Tucson

“I would say while there are really good support coordinators, there’s high turnover in the support coordinator role, which leads to challenges on the provider side because there’s not continuity across time, and then when we do have needs, sometimes we don’t know the support coordinator’s not there anymore, and so we spend a lot of time trying to track down the right person to get the needs met and addressed.”

### Surprise

“We know there’s been a lot of turnover in Support Coordinators, obviously, and sometimes you’ll get a different one every single time.”

#### Yuma

“I’m sure it has to do with pay, I would assume, I don’t know. But the turnover seems to be—and I get this because of our district meetings that they bring staff down, and we don’t have someone in employment services, or one person is covering the entire state, which is impossible.”

#### Sunnyslope

“But we can’t blame the support coordinators because they come in with very little experience and the turnover is horrific. So I believe that the support coordinator position needs to be re-looked at, revamped, and truly supported, and recognition for the critical role that it plays in people’s lives.”

#### West Phoenix

“And then my second negative has to be just the, unfortunately, the turnover of support coordination. It’s not... You know, our software, for example, it links onto a support coordinator and it’ll auto email secure emails to them for quarterlies and stuff like that, and evaluations, and a lot of times we find that they’re not with the division anymore, or they’re in another department. So just the turnover of support coordination is difficult for providers to constantly juggle. Support coordinators are supposed to be this case manager, right, that knows the child and... But the turnover is just vast, so it’s hard to accomplish.”

#### Flagstaff

“And then the rotating door with the Support Coordinators. I run into parents all the time in the community, and they’re like yeah, we’ve had – we haven’t had the same Support Coordinator for a year, in over five years. There’s no way they can actually get to know a person with that much turnover.”

#### Central Phoenix

“One of the challenges that we have had is just the number of Support Coordinators we’ve had over the years. And it’s even worse with the Nursing Supervisors. The turnover of Support Coordinators and Nursing Supervisors. And our son as a very complex medical history, and having to go through that every single time with a brand new person, to get them to fully understand where he came from, what he’s doing, and what we’re trying to prevent, is a challenge. And my wife spends a lot of energy going through that every single time. Whereas the times that we’ve had the same Support Coordinator for three years, things go so smoothly. And she has everything prepared ahead of time, so the meetings are really quick.”

#### Chandler

“Kind of along the lines of support coordination is the onboarding process that they have. So there’s been a lot of turnover, and I feel like any time – I could call five different Support Coordinators and get five different answers. And that’s really challenging when we need a clear answer.”

### **(5) Vendor Call Process**

### Sunnyslope

“What I’d like to see improved with them is a lot of coordinators are not providing almost any information. You get date of birth, age, male or female, and what service they’re looking for. You may not get the cross roads, you may not get anything about them, and yet you’re being asked to make a determination. And then they tell you just email the support coordinator, which you do, and they’ll tell you here’s the ISP, but would you please accept, go back into the system and put a yes in there. You don’t want to put a yes in the system because then you’ll get auto assigned, potentially, and you haven’t even seen or met the person. So just some bugs need to be worked out of that still.”

### Mesa

“So we still really struggle with finding clients that need services but do not appear on the focus lists that are coming out, I guess, referral list. For speech, OT and PT we have a difficult time finding members that we know exist in the valley that need the services that we’re not getting the referrals.”

“So we talked about the vendor call process of getting new members. But sometimes it seems like there wasn’t a lot of discussion with providers on how that new system was designed, because in our world we have a therapist that has a time slot available, and if we request that member and it’s granted to us, then we have to provide services, but yet if they don’t match up to the time slot available, then we’re not able to. Because it’s not like we have an unlimited number of providers available for any number of members. And so it’s almost like they didn’t, when they constructed this new system they didn’t understand how it works in the real world. And so there needs to be an ability to find out more information about the member before we commit to be able to...before we know. And even to talk with them to see if it’s going to match up personality-wise and schedule-wise.”

### West Phoenix

“The service notifications that come out for referrals in the vendor call system works really well, but it’s really dependent on a support coordinator to put in enough information, so most of the time when you see the notification you do have to send an email to the support coordinator and ask for additional information, even the cross roads, because telling me Phoenix doesn’t help much. So there’s still some education that maybe needs to happen, but I like that at least it’s there and you can see it.”

### Flagstaff

“One of the problems we have is there’s tons of vendor calls in Flagstaff even, right now. But to pick up DDD clients, we know, we’re going to try and provide services for as long as the family wants, usually is what it comes down to. And the issue is we know we can provide services now, but we’re not sure what will happen down the road.”

### Chandler

“Because of where we’re located. Yesterday I went and looked, because we needed new speech clients. And I pulled up all of Maricopa, all of Casa Grand, and there was not one member from Maricopa and Casa Grand in need of speech. And I find that hard to believe, because we actually have a clinic in Casa Grand, and a lot of people don’t even know that we’re there yet. And we

have all the time, members saying, oh I wish I knew you were here, or how long have you guys been here? We have families that, why didn't my Support Coordinator tell me you guys were here."

"Going back to the vendor call, I've been dealing with [name redacted] and one of the things we've found is that it's timing out. And so it's not a matter – when the Support Coordinator puts it into the system, it times out after three days if nobody responds. And so the issue is they're looking at extending that. And what we would like to see – and this is what we've said – is let it extend out as long as it needs to, until the member is served. Once the member has the services assigned, so that way she could find all the people that aren't finding it. Because what's happening right now is it times out. Support Coordinator either one, has to follow up with the family, which they're not doing until the next 90 day, and then they're re-inputting it at the 90 day. So the member is going 90 days without a service."

## **(6) Authorizations**

### Surprise

"A provider that's been working for four years all of a sudden has to stop because we don't know if we're getting an authorization, and we're being told if there's no auth, do not provide the service. Which there's inconsistency there and things like that."

### Prescott

"I would add an on call person. They need to have a support coordinator on call. That can actually load an auth for any district, for any client, even if it's just a one or three day auth to get it bridged till the weekend's over. They need to have somebody that has the authority to do something until take an IR. Oh gosh we'll have somebody answer the toll-free number for an IR. But we won't have somebody to toll-free handle an auth that case management didn't load, support coordination didn't load."

"Okay, and I'm going to piggyback here a little bit on the after hours individual that can maybe put an emergency auth in even for a short period of time. That same person, to give them something else to do, could go in and be able to push the start date forward on an authorization."

### Mesa

"But the reason I wanted the mi[c] was to say we have a problem with backdating of auths, and that needs to not happen anymore."

"It should never happen. Because one of the metrics we're going to be measured on, that we're already being measured on, in case you don't know, is how fast you can get people into service. And so when they backdate an auth 14 days, you're already out of compliance. You have no way to fix that. And they're not using the little date you enter in Focus, and they're not using the date you click "I accept the authorization." They're using the date that the support coordinator put in as the start date of the auth, which I think is crazy. It should be the date I accepted the auth, because maybe I have decided not to accept the auth."

"So as far as authorizations are concerned is that we need to get... We're being evaluated as a...what's it called? We're being evaluated on getting people into service within the first seven

days, timeliness of service delivery. So we can't have backdating of auths. That has to stop. And if there is a reason to have an override it should be at the highest levels of DDD."

"And some suggestions for improvement on that are that they use the date that the provider accepted the auth because that's when we made the agreement to do the service instead of the start date of the auth. And if they don't want to use that date, then they need to use the estimated start date that we're required to enter when we accept the auth, because there's an estimated start date field you have to fill in when you accept an auth. And I think either one of those is better than the start date of the auth."

#### Flagstaff

"DDD needs to only allow very high level people – [name redacted], [name redacted] – only them to be allowed to backdate authorizations. Maybe. [Laughs.] To backdate authorizations. They should never be able to put an authorization in with a date prior to today's date. Because it's screwing up people's statistics."

#### Central Phoenix

"improvement in authorizations, both timeliness and accuracy"

#### Chandler

"And then the other thing I wanted to talk about was, as far as authorizations, I wish there was a way that SCs could get alerted when an authorization is about to expire, so that they could give us, the authorization, at least a bridge off to cover us while the meetings are taking place."

### **(7) Financial Concerns**

#### Tucson

"One of the primary issues that providers are dealing with now are the financial aspect of it. So educating people on the need for the increasing in rates, and the whole impact of Prop 206 is a problem."

"So as a therapy provider—and I'm not as familiar with everyone else's situation—but I know that our rates are very, very low. In fact we lose money for every child we see within our services."

"And I think that there's a perception that this is like each year going down to the legislature and requesting additional dollars for the, I don't know, some sort of wing at one of the higher education institutions, and it's not. It's health and safety. And yet for some reason we're going down there every year and we're asking. We're asking for our state to find the money, and we're asking them to increase rates. This should be an automatic. It should be this is health and safety of people, and it's not an automatic."

"And I think it's the state's responsibility to step up and make sure that the costs of care are being fully covered, and that hasn't happened forever."

"The majority, by far the majority of our minimum wage staff that are struggling to survive in this environment that the state has created for them, I mean, they have two or three jobs."

### Surprise

“My second biggest issue is it’s really hard to budget when we’re basically, on the rates we pay the providers, every nickel from the rate the agency gets, and then another nickel goes to that, and the overhead. So what we’re seeing is the Prop 206 money, and the nickels and dimes from this and that and the other thing. You can’t budget on that, because you don’t know how much it’s going to be, you don’t know when it’s coming in.”

### Yuma

“Rates. Rates could be improved.”

“But it also leaves the suffering party to be the member, because the quality of the caregiver is directly proportional to the rate availability. And I think that that’s a giant piece that we have seen that’s broken in the system. The quality of caregiver has diminished, to some degree.”

“I’m sure it has to do with pay, I would assume, I don’t know. But the turnover seems to be—and I get this because of our district meetings that they bring staff down, and we don’t have someone in employment services, or one person is covering the entire state, which is impossible.”

“They pay timely. I know when the payment’s going to be coming and it’s there. The others are a little more difficult to collect from. And they’ll withhold stuff. They’re a lot more on [approval] than dealing with the services that are [on that].”

“And when you have a profession that goes from not being a minimum wage job to now a minimum wage job, not only the quality, but also the quantity of individuals. And when you don’t have the funding, as we’ve had these rate increases, that filters down to the providers, then they have to make changes. And sometimes that’s in staffing. And a decrease in staffing, you may have overworked individuals who may be less likely to recognize something that’s going on.”

### Sunnyslope

“As an agency we bill a lot of different payers, and I must say that billing is actually pretty easy and payment is pretty quick, especially in comparison to some of the other payers.”

“I would ditto what [name redacted] said about the billing and payment system. Works really well in comparison to the MCOs. And I would say that a lot of the problems that have already been voiced in regard to ISPs, the vendor referral system have all stemmed out of DDD inadequately paying support coordinators.”

“And of course there needs to be a lot more funding in the system.”

“I just want to reiterate the funding issue. And I really am thankful that DDD is on top of getting us funded. And if there are issues through that with DDD they get right on top of it. In comparison, when I work with some of the MCOs in the past or insurance companies, they can take forever. And it could be just as simple a thing as they say they scan the CMS form in, and I

go there six months later after I've been battling trying to get paid for three or four members, and they say but, you know, it's scanned in here, look at this, look at this. This is an actual incident.”

“We're facing a crisis unless there is adequate funding provided for services recognizing how serious the problem is, particularly in the Phoenix area.”

#### Prescott

“The range ratio way of billing for group home services allows for the division to pay not more, but not less than what's necessary to staff the unique configuration of that group of people.”

“One thing that didn't end up on 'needs to be improved' is rates. Provider rates need to be improved. And then on solution for improvement—well, I already have I wanted to pay support coordination more. Didn't I put that somewhere? Yeah, I think that was a solution to not enough support coordinators. So I think the solution is to pay them more. So I think it actually belongs on the other one.”

“But one of the things it would be is that school districts and other people are paying more, and so a solution might be upgrade the reimbursement structure for therapists so it's worth their while, especially in a rural area where they have to drive three hours to do an hour therapy session.”

#### Mesa

“The rates to support staff at a livable wage.”

“That all of the systems don't match, and thus there's not a funding mechanism. There can be a continuity of services. There's just not a pay mechanism and otherwise by not having fully integrated all of the delivery systems and the payment mechanisms. I think we're too encapsulated still.”

“But anyway, back on the negative side for DDD, it all comes back down to rates. And I think unfortunately DDD can't... We used to have career ladders inside of provider agencies back when our pay was adequate. And we used to promote from within, and we used to have talent inside of agencies to write behavior plans and talent that used to could write amazing teaching strategies and make a difference for people. We haven't been funded to the degree necessary to have those expertise anymore. And if you do, please hold onto them, because they're rare.”

#### West Phoenix

“Yeah, so I think somebody wanted to hint about rates, and so we're all waiting for that to return back to earlier directions. And I know that's a complex political machine, so in one way the DDD is just the front person for legislative policy. So I would say yes, the rates continue to be an issue.”

“Overall the providers that we hear from in our agency, I think a negative is that the system is not properly funded, and that the 15% cuts that we received during the Great Recession, we didn't get that back. Inflation was cut out, never been provided. And then you had the minimum wage. And DDD put out that we've only covered half of the cost to the minimum wage, and I think AAPPD would estimate that that's even less than that. And I think that we need DDD to

help us with being properly funded. And I know that there's political issues with that. But helping and being able to talk about what's actually happening out there and what is happening in the community and with services would be helpful so that members' legislators know what's going on in the community."

### Flagstaff

"The second thing that I wanted to talk about was the funding and the costs in Flagstaff especially. Flagstaff is not considered a rural area, but it certainly is much different than Phoenix or Tucson. And that's not really taken into account in the rates. And the whole minimum wage issue. I understand it's a political issue. But our clients and their families don't get that. This isn't directed at you [forum facilitators]. And we're being – I hate to use the word punished – but we're just barely, we're not even barely eking by. We're failing. And it doesn't seem like anyone believes that. I've invited people to come look at the books at [name redacted], and see what it is we're facing, and nobody's taken me up on it. All we hear is, well we can't give Flagstaff too much money, because the people across the street – meaning the legislature – will be upset. And minimum wage isn't the only thing. When you increase the minimum wage, all the costs in Flagstaff went up, and they were high to begin with. So our housing costs are horrible now. I think it's 140%, I think, is what I've heard, of. Yeah. Of the average. I'm not sure if that's national. Anyway, certainly want to stress that. And I would hope that the Division would be more of a partner with the providers in advocating for adequate funding. Because it's not anywhere near adequate right now."

"First off, yeah, funding, very important. it's really the keystone of what we're talking about. Nothing else can happen without it."

### Central Phoenix

"So I think from a global perspective, with the issues of funding."

"The funding issue really needs to be looked at as well, because that's a part of the overall quality of the service. That I think is a big component to what needs to be improved. It's not DD problem *per se* – the Division problem, but certainly as a state policy, it is one that obviously the Division has to accommodate, the same one that all providers have to navigate as well."

"I do look at employees, and make sure that they have some emotional intelligence before we hire. But with that also, you want to be able to afford them, to retain them. So they don't slip out of your hands and go and move on to other areas. So with finances, I think that could help us to hire more qualified support."

"And [name redacted] says to maintain our current therapists, we need reimbursement rates to be raised to include money for supplies for feeding therapy, OT, PT and SLT. And for additional paperwork time for all the therapists' notes, evals, progress reports. We lose therapists constantly because we can't raise their pay rate if funding doesn't cover the necessary costs to cover all aspects of therapy, not just the time spent directly with the member. I have one more now."

"[Name redacted] says reimbursement rates for OT and PT and SP are less than they were in 2008. We need rate increased."

### Chandler

“Knowing that this information’s going to go to the legislature, I would also want to just advocate for a provider and our rates. Because to hire direct care staff, ever since the minimum wage increase, that has put a significant strain on providers. And also just with the cost of living increase. So in order to keep agencies in business, I definitely would advocate that DDD – and I hope DDD advocates – for higher rates for our providers.”

## **LTSS—Solutions for Improvement**

### **(1) Family Education**

#### West Phoenix

“So that’s concerning to me that families somehow aren’t getting the understanding of what exactly these meetings are for. So maybe it’s a communication thing, maybe they don’t open up the DDD website, because the box that pops up works really well. It pops right up. You can’t get rid of it on the screen without reading it, so that part I like.”

“I just wish that some of the communication out to the families would have been more clear specifically on these meetings, and the slide that you’ll come up on. I think there should have been a huge explanation to that slide, even if it was just here’s what we’re kind of thinking, or here’s some of the discussion, or here’s some ways we could do this. To put up a slide without an explanation as to what that means, most families will have no idea, and that’s even if they show up to the meeting. So this is real concerning to me that this is very poorly attended by families”

#### Flagstaff

“I’d just like to piggy back on that. I think there’s a big issue with DDD and AHCCCS, again saying one thing, but then the health plans really not being as transparent to the families about what the powers that be are saying to DDD. And so it’s great to see that Mercy Care is here. I’m wondering, is anybody from United Health here? Because I think that’s where the powers that be ultimately are going to be the health plans that put pressure on DDD to either cut costs or send notice of actions for denials. And I think the solution is really to be open and transparent with families about what health plan is involved, and then what the health plan is telling DDD. Instead of scapegoating it to DDD.”

“Okay. So along with incentivizing providers that are hard to find, because if it’s a losing proposition for DDD, for a provider to provide in-home services – speech, OT, PT – incentivize the parents for training. There’s a number of things that you could do to incentivize the parents to bridge that gap. Because the parents and the families are with the child, or the individual, life long. Whereas the therapists come and go, the Support Coordinators come and go. But improve the expertise of the parents.”

### Chandler

“And I’m – as many emails as we’ve sent out to our families, they still don’t understand what we’re talking about, and the move that’s going to take place. A lot of us in the room don’t quite grasp it yet. So I would – if there could be a way to explain this to parents. I’m going to send another email this afternoon, and let them know there’s a meeting tonight. But they just don’t get

it. They don't understand the importance, how big of a chance this can be. And I don't know how to explain it differently. We've tried to restate our emails, and re-explain and send different pictures. So we need help with explaining this to our families."

## **(2) Provider Involvement in Decision-Making**

### Tucson

"So having us at the table before decisions are made—oh, the other one is value-based purchasing. So at least to whatever extent possible, ask for input before decisions are made that impact us."

"...getting our input and then also maybe allowing a trial period of changes with like a small group of population to see, like work out the kinks."

"I'm thinking maybe a big group of providers needs to get together like this and look at something like a five year plan."

### Flagstaff

"I would also like to add that I have read several different places, and I could get the information, like Robert Wood Johnson, Anchor, where there are suggestions for how best to design a system like this if you're going to do it. AHCCCS needs to go back and follow that, if they're very serious about this. And it includes a lot of parental and provider input from the beginning, total transparency. And that needs to happen."

### Central Phoenix

"Have smaller meetings, maybe split the districts up to have more input from providers."

"...include providers in decision making for services needed and provided."

## **(3) Increased Funding**

### Tucson

"I was saying that I think that voting for legislation that provides more tax dollars to the Economic Security Division, that's obviously, if they don't have money to give us, where are they going to get it? So we just have to share the cost, provide that."

### Sunnyslope

"I think this would resolve a lot of problems. Upgrade support coordination, upgrade qualifications, and upgrade rate of pay."

### West Phoenix

"So suggestion for improvement, proper funding. Full funding. Full funding. Fund the October rate rebase fully. How about that? I said October, not December. The first one. The first one. The real one, right."

### Flagstaff

“And restoring the funding back to at least the 2008 levels, because the provider issue here in Flagstaff, with the minimum wage issue, is very significant, and it’s impacting our community a great deal. At least we need to get back to the 2008 levels, and then maybe try to compensate for the last 11 years.”

#### Central Phoenix

“[Name redacted] says increase rates for therapies.”

“We need a rate increase for therapies, lobby Congress for more funding.”

“[Name redacted] says maintain a minimum reimbursement rate for therapies that is sustainable to retain consistent therapists for members. Include reimbursement for members meetings, report writing, etc.”

“We could also possibly make a tier kind of payment program, based on teaching strategies and the progress report. What day treatment agencies are actually doing with that time, and increase their pay if it’s showing a lot more activity with our members.”

#### Chandler

“This is really a suggestion for all of us providers. I’m a member of [AAPPD], and they are helping – I would highly recommend that you guys check into that too. What they’re really helping with right now is the legislature’s going in voting on the budget. And we need everybody to send out letters. I just made phone calls last night, I’ve sent my letters. And that’s a way that we can get our rate increased by getting the budget to go through. If you guys can reach out to me, I can connect you with that, or I read a script last night to about 12 legislators, and wrote my letter. So we need to do our work on our end too. DDD had to have the money to reimburse us for those rate increases, so if we can start at the bottom there.”

## **Discussion**

### **Alternate Service Delivery Model Discussion**

The data resulting from the provider forums clearly indicate extensive concerns with the alternate service delivery model. This includes the key themes of Billing Concerns, Eliminating Small Providers, Precedents from Other States in which MCOs have not been effective, Rates/payments, and Concerns with a “Medical Model.” The concerns are extensive and seemed mostly uniform across forum locations. Solicitation of feedback was not difficult for this section, as many providers had a lot to say and were eager to share.

Our facilitators were instructed not to share any opinion or provide any personal viewpoint. However, a significant number of participants posed questions about the potential new model. In these instances, the DDD staff member who facilitated alongside IHD staff would decide if the question was something that ought to be answered (fell into the category of communication) or ought not to be answered (any answer could be construed as biased). It was clear to our facilitators that there was significant confusion among providers where DDD stood with relation to the proposed alternate delivery model (i.e. is this change already in place, has it already been decided that the alternate model will be implemented, is this the only model being considered).

These questions were primarily addressed by the DDD staff member who co-facilitated each session with the IHD facilitator.

The primary theme that arose from the feedback related to the alternate service delivery model was concern over the way in which vendors would be paid. The concern was that payment/billing would become much more difficult and lead to higher costs for providers, lower reimbursement rates from cognizant agencies, and thus thinner margins for the sustainability of their businesses. Some providers already contract directly with MCOs for certain services, so the forum participants had experience to draw from in understanding the potential impacts. The concerns highlighted claim processing, claim denial, and claim appeal processes implemented by MCOs, which were reported to be much slower than the processes used by DDD. There were concerns about increased administrative costs as well as the potential need to recruit and hire new staff to deal with these more complicated processes. There was also a discussion of this feedback which expressed doubt that the actual rates of reimbursements by the MCOs, under the proposed alternate service delivery model, would be lower than that honored by DDD. It was also unclear to providers how much the reimbursements rates offered by MCOs would be transparent and/or the result of complicated negotiation with the MCOs.

Connected to the primary theme, the secondary theme was that under the proposed alternate service delivery model, small providers would be forced out of the field due to economies of scale. In other words, the feedback represents that because vendors will need to contract directly with MCOs, MCOs will choose to contract with providers that have a large array of services, instead of “boutique” providers. Further, this feedback seemed connected to the idea that increased costs and delayed payments, under the proposed alternate service delivery model, would force small vendors to stop operating because they do not have the administrative support nor the cash on hand to remain sustainable.

The third theme to evolve from the forum data was pessimism on the success or value of the proposed alternate service delivery model based on similar implementation in other states. Of course, these sentiments are highly dependent on the definition of “success” or “value” with the proposed system, but most of these vendors expressed that there is evidence from other states that demonstrates that similarly implemented systems lead to worse outcomes for persons with disabilities, their families, the providers, and (for some) the taxpayers. Many of these concerns seemed connected to the understanding that the best outcome for persons with disabilities was appropriate and high quality care, not necessarily maximized cost efficiency. Some providers felt that even the belief that this proposed alternate service delivery model would increase cost-efficiencies for the taxpayers was misguided, since, in the long-term care of persons with disabilities, often short term cost-saving measures lead to unexpected and extraordinary costs when cost-saving measures fall short.

The fourth theme expressed concerns that, under the alternate delivery model, MCOs would view the long term care of persons with disabilities under a different framework, specifically the “Medical Model,” rather than the current system. The “Medical Model,” coined by Scottish psychiatrist R.D. Laing in 1971, is a model for the treatment of persons which defines terms like “injury” and “disease” to articulate deviations from “normal” body functioning. To simplify, the “Medical Model” views persons with disabilities as patients in need of treatment, the treatment of which is designed to help a person with disability return to a “normal” state. Especially

concerning persons with long-term and life-long disabilities, this model stands in opposition to many of the modern academic notions which put forward the notion that disability is something defined by cultural and societal notions (i.e. the “Societal Model,”) and that persons with long-term or life-long disabilities are in need of increased infrastructural access, more accepting attitudes amongst the general public and radical inclusion in all of life’s activities. Linguistic distinctions between these viewpoints can be seen in the use of different terms to define persons with disabilities under care (i.e. “patients” v. “members” or “clients”). It is difficult to define the current model implemented by DDD, however, it seems to be at the very least a blended model, not a pure Medical model. The overall concerns expressed under this theme can be synthesized by the distinction that under a Medical model, providers need to view persons with disabilities under their care as a patient to be treated and discharged, whereas a blended or societal view would be guided by the principle that, for some persons under care, there is no “treatment” and “discharge” is not a goal: some persons under care will remain under care forever and the role of the provider is to provide an optimal quality of life.

### **Governor Ducey’s Executive Order Discussion**

The resulting data, presented below as direct quotes from the transcribed forum sessions, are inclusive of data from note cards and emails. Key themes derived from the data include: (1) Sexual Violence Training and (2) Funding/Rate Increases to Compensate Providers for New Requirements.

Although it seemed as if many providers were familiar with the Executive Order, it was clear that many providers had not actually read the order in full. This segment of the forum involved projecting the content of the actual order and asking for feedback on the content.

The primary theme that arose from the data regarding Governor Ducey’s Executive order was the desire for increased and refined sexual violence training for providers, persons with disabilities, and families. There was an acknowledgement that some training takes place, but the desire was more for official, DDD-sanctioned training and training curricula. There was discussion on the role that DDD may play with the provision of training for persons with disabilities under care. The data reflected a desire for DDD to take a more active role in this kind of education (on topics like consent/good touch vs bad touch, etc.), because many providers felt as if it wasn’t their role to provide this training. Most providers seemed to connect this Executive Order to highly-publicized and disturbing abuse that was uncovered at a residential center in Phoenix.

The secondary theme expressed with regards to the increased protections for persons with disabilities expressed in Governor Ducey’s Executive Order surrounded concerns that these increased protections would end up costing providers money (paying for training, extra staff, compliance costs), and that these costs would not be incorporated into rates of reimbursement, ending up costing providers un-reimbursable expenditures. There was a strong expressed desire to have increased protections as well as compensation for the extra costs associated with these increased protections.

### **LTSS Discussion**

The questions posed to the forum participants associated with LTSS were: What is going well with DDD LTSS? What needs to be improved? Solutions for improvement? The resulting data

are presented by question. It includes direct quotes from the transcribed forum sessions, note cards, and emails.

Feedback on what is going well and what needs to be improved with Long Term Services and Supports provided the least consistent data on themes. We suspect that the broadness of this topic, as well as the diverse needs and experiences of providers, jointly contribute to the diversity in themes presented in the feedback data.

Key themes derived from the data include:

What is working: (1) Options/Choices Available to Members and (2) Person-Centered Planning System.

The primary theme expressed in the feedback on what is working was the contentment regarding the options and choices available to members. Providers spoke about the way in which families have a lot of choice with regard to the care of persons with disabilities. These comments also acknowledged that some of this choice is a result of the diverse kinds of providers available through DDD.

The secondary theme expressed was contentment with the person-centered planning focus of DDD. Providers expressed often feeling like they were succeeding at working collaboratively with DDD, as they felt that the goals of DDD and the goals of the providers are aligned around the experience and care of persons with disabilities.

Regarding the question, “What Needs Improvement as related to LTSS?” the following themes emerged from the data: (1) Communication Between DDD and Providers, (2) Issues with Monitoring Practices, (3) Support Coordinator Training Concerns, (4) Support Coordinator Turnover, (5) Vendor Call Process, (6) Authorizations, and (7) Financial Concerns.

The primary theme expressed was related to the need for improved communication between DDD and Providers. Interestingly, although there was alignment around improved communication, the feedback suggested that there was not alignment around a particular aspect of communication that needs to be improved upon. There were a large number of comments around improved communication with support coordinators and providers (although some providers thought that seasoned support coordinators were better at this and some thought that new coordinators showed better communication skills). The participants indicated a need for more kinds of outreach sessions like the one in which they were participating. There were concerns that similar outreach activities were not being provided to families. There was a common theme about wanting consistent and timely information and communication from DDD on topics relevant to providers.

The secondary theme that arose from the data related to needs for improvement was issues regarding the monitoring of providers by DDD. These concerns ranged from wanting more monitoring and oversight to wanting less monitoring and oversight. There was an expressed concern about the administrative weight of DDD’s oversight as well as a desire for more transparent information about what exactly was being monitored.

The third and fourth themes were related to turnover and training of support coordinators. Many participants expressed frustration at the high rate of turnover of support coordinators as well as the lack of communication about this issue from DDD. Most attributed low wages and an underfunded DDD as the perceived causes for the high turnover. Training issues mostly surrounded a desire for more consistent communication and actions between support coordinators and providers.

The final three themes involved dissatisfaction with the vendor call process, issues with authorization, and financial concerns. Feedback on the vendor call system seemed to vary greatly between vendors (some calling the new system an improvement, some expressing doubts about the new system). Authorization issues seemed to center around misdated authorizations, authorizations timing out too quickly, and emergency authorizations not coming fast enough. Many providers expressed concerns that they are being rated with relation to the timeliness of authorization, but DDD's own staff causes much of the delays relating to authorizations. Financial concerns were mostly about DDD not receiving enough funding, which can be seen as a kind of "cornerstone" issues propagating myriad other problems (turnover, low rates for providers, difficulty recurring staff, etc.).

Regarding the question, "What are solutions for improvement of LTSS?" the following themes arose from the data: (1) Family Education, (2) Provider Involvement in Decision-Making, and (3) Increased Funding. The discussion that resulted in the theme of family education had a strong emphasis on needing to educate families so that they can make informed decisions. This included using language common language and not systems language. Family education further referred to educating families about the importance of attending meetings, including those held by DDD designed to obtain feedback from families about the status of LTSS.

With regard to the second theme of having provider involvement in decision-making, the discussions highlighted the importance of soliciting feedback from providers prior to making decisions that may impact them. Several forums indicated that involving providers in the decision-making process would allow for improving the state of LTSS in Arizona.

Although the need for increased funding was highlighted in all ten of the provider forums, it was only suggested as a solution for improvement in half of those forums. Providers suggested that increased funding would improve LTSS in a number of ways, including decreasing turnover rates, increasing quality of support coordination, and maintaining consistency of therapists.

## **Recommendations**

The following recommendations are provided by topic area in the order of alternate service delivery model, Governor Ducey's executive order, and LTSS. These recommendations are based upon feedback from the sessions and not meant to suggest any kind of overall judgement by IHD personnel on DDD services.

### **Alternate Service Delivery Model**

The data, as provided in the quotes above, support the following recommendations.

- Conduct a thorough review and analysis of the outcomes for individuals with DD from other states that are operating under various models, and utilize the results to make an informed decision about the provision of services in Arizona.
- Ensure the data reviewed from other states are inclusive of models being considered in Arizona.
- Ensure the outcomes data, reviewed from other states, are inclusive of individuals with DD as well as their family members and providers who worked under various models.
- Keep a pulse on individuals with DD and their quality of life outcomes under all model changes.
- Determine options for billing that is supportive of providers of all sizes.
- Improve billing and invoicing practices to be timely and effective for providers of all sizes.
- Review the findings from the forums that were held with individuals with DD and their family members to ensure quality is maintained and improved.
- Assess the impact of the medical model as compared to the current model for persons with DD, if the medical model is implemented.
- Assess the impact of the medical model vs. the societal model as implemented across the U.S.

### **Governor Ducey's Executive Order**

The data, as provided in the quotes above, support the following recommendations.

- Ensure that costs to providers are considered when assigning additional responsibilities to providers for the protection of persons with disabilities.
- Develop division-sanctioned training curricula for providers, staff, and persons with disabilities surrounding the protection of persons with disabilities.
- Provide increased training for providers, staff, and persons with disabilities surrounding the protection of persons with disabilities.

### **LTSS**

The data, as provided in the quotes above, support the following recommendations.

- Increase the provision of uniform training for support coordinators.
- Increase/improve communication with providers and family members.
- Increase involvement of providers and family members on significant decisions.
- Review the effectiveness and success of the vendor call process.
- Clarify the policy regarding the authorization process for DDD staff and providers, including surrounding the dates and speed of authorization.
- Increase funding for DDD and DDD staff.
- Provide higher rates of payment for vendors.

## **Appendix—Transcripts from each Provider Forum**

*Please note: Transcripts from each provider forum facilitated by IHD are attached to this report as an appendix. These transcripts are not the complete record of every word said in every provider forum. The transcripts included below only include the sections of the provider forums where feedback was directly solicited, not the introductions nor the sections of the forums where information was delivered and communicated by the DDD representative to the providers (except where these sections also generated feedback). Further, personally identifying information (PII), including names of persons and vendors and other identifiers have been redacted where appropriate.*

## Tucson (South)

### What is Going Well with DDD LTSS?

Female: I think what is going well is having options to have places that they can try out, so our members can try out. For instance, employment is fantastic, but it's not necessarily everybody's ready for 100%, so they may be able to go to different levels of employment programs as well as [DTA] or other places they can go. But they can transition or adjust whatever the needs are, or whatever their readiness. I think that's working.

Female: I think the fact that it just exists is a good thing. So I'm glad we have it. Yeah, so I'm glad it's there.

Female: Hello. My name is [name redacted], and I am the director for operations in Tucson for [provider name redacted], but I'm also a parent of a special needs daughter. And so DDD has been lifesaving personally for me because my daughter can't reside in our home because she has very highly behavioral. And having an option as a parent to be able to decide on where she's going to live, where she's going to be happy on her employment. She's an AWOL-er, so she runs, and she has a lot of medical needs as far as behavioral goes. And so as an advocate, as a parent, it's really important that I am able to make those decisions and have the option to say yea or nay on certain things that pertain to her hours, to her services.

Right now she is in an amazing placement, the [provider redacted] home. She's in an adult developmental home. And the home that she's in right now has been God's saving grace to me because at one point I was sleeping in the middle of the door just making sure that she wouldn't hurt herself, and she now is working. She has a full-time job. There's no behaviors in two years. She has a steady boyfriend. And so the work that has been accomplished with the people that have been given the opportunity to work in this field has been great. And she is the happiest person that I've seen in such a long time. And that makes me happy.

From a director standpoint, that's what we strive to do. We strive to be able to help the families have these options to be able to accommodate their needs because they're just not a number. It's a family setting, it's a home, and these people need us. To be able to have those choices is great.

Female: Hi, I'm [name redacted] with [provider redacted], and I just have a little feedback for the DDD employees. They're really on top of the needs. When we express a need for a change for an individual they're really quick getting back to us and making sure it happens, and really polite and professional, so we've been having really good experiences with you also. Thank you.

Female: I think that—I'm [name redacted] with [provider redacted]—I think that in our situation I think that timeliness of services is going really well, and authorizations

are going through quickly, and I think the service coordination, especially with the kiddoes that we work with, is going really well.

Female: Collaboration of care when it becomes about behavioral health as well as the medical leave.

Male: Yeah, I think along the collaboration of care again, having one entity to coordinate care I think is important. I mean, people may have issues with DDD and the turnover, and the continuity of staff, and philosophies, and turnover at the top, but I think ultimately there are advantages to having a single entity coordinate over the long-term.

Male: I'm helping establish a new living development in Phoenix called [provider redacted], and I've had a chance to work with the division firsthand and families from all over the nation who are looking to move their children here because we have no waiting list, because we have choices of day services and providers. And the excitement that I get from these families when they hear that there's services available to their children, and how the services work, and to see the way the division has been helping with this entire project is just wonderful. So I just wanted to say that we should be really proud of the services that we have available to us in Arizona.

#### What Needs to be Improved with DDD LTSS?

Male: One of the primary issues that providers are dealing with now are the financial aspect of it. So educating people on the need for the increasing in rates, and the whole impact of Prop 206 is a problem.

Female: I've been working with the same program for 22 years, so I aged together with our folks, and the aging issue that I face for the trainings and support for the family members as well as for the staff members, those are critical, and I don't think we do have enough for those, because as long as we have training in place then we may be able to keep them in the community longer instead of sending them to the skilled nursing. So that is one of my things.

Female: Right.

Female: Right. And also in Arizona the family still cares our members a lot at their home compared to the national average, so it's really important to include the family support as well. The national average is about 54% and Arizona provides support by the family members 80%, so it's a really, really high proportion we have.

Female: I'm [name redacted] with [provider redacted]. I actually have been working in this field for a long time and in Tucson for a long time. And one of the things that I've always felt strongly about is the variance in the communication. I think sometimes it's really good and sometimes it's not so good, and we don't always know what's happening or what's coming next when there's changes in personnel or changes in policy. So I really think there should be a very strong

communication system to all providers, families, individuals being served, everything.

Female: I would say while there are really good support coordinators, there's high turnover in the support coordinator role, which leads to challenges on the provider side because there's not continuity across time, and then when we do have needs, sometimes we don't know the support coordinator's not there anymore, and so we spend a lot of time trying to track down the right person to get the needs met and addressed.

Female: [Yeah, I knew that.]

Female: I think this has already been covered, but just to reiterate and to maybe expand on the money comment. So as a therapy provider—and I'm not as familiar with everyone else's situation—but I know that our rates are very, very low. In fact we lose money for every child we see within our services. And going back to some of the strengths that were mentioned in terms of choice, I think the division is facing a situation where that choice is going to become even more limited because of that rate, because we are choosing to lose money on those kids. And that's not necessarily going to be a choice for very long. So those choices for families to have those providers available could be going away.

Female: How we can make a difference. Well, obviously we all need to be right now down at the legislature because they're making that call right now as we're meeting here. And every day that goes by that we have not been in contact with our state representative or the governor's office, etc., is a day lost. So we're asking for a lot of money above the executive budget, and they need to hear that 42 million. They need to hear it a lot. So that, to me, is probably the biggest way that we can get that message across.

And we need our families down there. You know, they've seen me, they've seen—you know, I'm looking at faces in the room—some of their faces, they've seen us a lot and they know our mantra, but they need to see hundreds and hundreds and hundreds of individuals going down there, members, guardians, their families, community members, advocates, etc.

Some of the shocking things that, some feedback I received that has been kind of shocking to them was that back in the early '90s we were paying 30 to 40% above minimum wage for brand new front line employees and now we're at minimum wage, but we're asking them to deal with feeding tubes, catheters, etc. And those kind of things, I think that there is a perception of what we do that sometimes is a little off base.

And so I think that that communication to those individuals needs to be relayed. And again, I can go on and on and on, but that's what we can do. Because I'm prohibited from doing that, because I'm a state employee, so I'm passing the mike.

Female: [Name redacted] with [provider redacted]. One of our concerns—and this does tie into communication somewhat—is that there are times that we need an elaboration or a clarification on something and we'll send emails, we'll call, and we get back nothing or we get back a couple of answers that don't correspond well to each other, and it's come from DDD. So that's a big concern for us.

Female: I've got the number of the customer service center.

Female: I'll run out and get some brochures, too. The number to customer service is 1-844-770-9500. Again it's 1-844-770-9500. And [name redacted] and I actually work in the same office as them, and they are awesome, and very responsive, and they will get you the answers that you need.

Female: So from what I've experienced a lot of it is that we have a lot of new support coordinators and most of, from a personal basis, most of our issues, we don't have a lot of issues with the old support coordinators, but the newer support coordinators that haven't received the training or the, you know, the experience, that's when it becomes a really big deal, and that's when the communication falls short. I've been in the field for 20...I'm going on 23 years, and so I've seen that. The old support coordinators, I can call them, they'll answer. They reply quickly. The newer ones we have a lot more issues with. But I think it's just because it's a lack of experience and, you know, the training is different from 23 years ago.

Male: The two recent examples are the roll out of the plan document, which is still... And QA being outsourced.

Male: Or not. Or I don't know, did you check today, because I think it's back on.

Male: I mean, just provide us a route in the dark about stuff like that. No matter who you call—it's not like the division isn't willing to answer. They don't know.

Male: Okay, thank you.

Male: I want that on the record. I am correct. Is that on the record? [Laughter.] All right.

Female: It's [name redacted] again. One thing I've noticed just recently with the new case managers is it seems like they're going on another set of rules than the old case managers. For instance, respite has always been kind of an at your, you know, like Mom will maybe decide on respite a few hours on this day, and recently we've been having to actually number the amount of hours on what days and which...it's almost like parents are being expected to do respite on Saturday and Sunday for five hours, and if you don't then you're losing those hours. So that's one thing. It's almost like a new set of rules. So I wondered if maybe it was having something to do with maybe the upcoming changes.

Female: Can I say one more thing?

Female: Also another service that we've been a little getting a roundabout is, for instance, the...we run a summer program every year and that's just in the summertime. However, someone like the [redacted] School District, they're out for like three weeks at a time, and they're actually being authorized for the summer seasonal out of school time program pool or services versus like [redacted] USD who may be out three weeks a year as well, but it's only...it's a week at a time, and families are having to use their respite hours for those things. So I'd like to see a little more consistency with those seasonal summer support hours versus respite.

Female: Could you explain a little bit what seasonal support is? Does everyone else know?

Female: Year round school.

Female: In the summer [DDD] offer[s] what are called day treatment summer programs for children, and what she's saying with the year round schools, there are longer break periods outside of the summer. And it sounds like we [DDD] are inconsistent around what service we may authorize to support a family during that time. Is that a good way of saying it?

Female: Yeah.

Female: And for instance these children might have a shorter summer because they have more time off during the extended school year.

Female: So, each district might have different times off?

Female: Yes.

Female: Might get two weeks for spring break as opposed to one?

Female: [Less] for summer and three weeks during the year, or every three weeks and six weeks in summer, so...

Female: [*Inaudible*] 00:34:56 have any solutions as to what—

Female: And it's probably piggybacking on some of these things that have already been said already, but I don't know, this is kind of a question. Do we all have the same support coordinators? So like does therapy, does like under the age—so we mostly see kids under the age of probably 13. Are the same support coordinators working with our age population as like I have a sister who is also in the system who's 34. So does she have the same, like is it the same pool of support coordinators or do they go by age?

Female: Okay. So a follow-up to that would be we've noticed within our clinic that there's a sparsity—is that a word?—but there's not enough support coordinators. And I really think, and I could be wrong, but I think there might be three that we are dealing with right now for the entire system, and I don't think that's an exaggeration. And so again, it goes back to my other comment about funding and needing more money to be able to provide the services at a level—

Female: For all of it.

Female: Yes. But yes, for support coordination as well, I believe, yes.

Female: Right, thank you. Again, I apologize for being late. There was an accident on the road from Nogales. We're from [provider redacted], and I'm the director there at... And it's just our agency. We don't have any brothers or sisters.

My question or concern is that the new support coordinators that we have, like three or four in Nogales, they're... I don't know if they're not being given the time, if they're given like 50 cases and you've got to start them because you already had your week's training and you've got to get going. But we're in meetings and these people don't know the person. I mean, they haven't read through their file. They haven't looked at their incident reports. It's like, they do? Wow. It's like it's kind of embarrassing because they're the support coordinator. And so that's a concern, big concern.

Female: Hi. It's [name redacted] from [provider redacted]. And I'm going back to the executive order of protection from the governor in a concern that we've had as an agency that's really come to light probably in the last couple years, and that is taking individuals from a day program and putting them in a day program that's run by the residential program or by their ADH provider. And so what we're seeing now is people going to this situation and there's no oversight. So we're kind of seeing this going back to institutions, but on a smaller scale setting. And so I'd kind of like an awareness in the community that this is going on.

I have written a letter to the governor in response to his executive order in relation to this, and we are asking the governor and the attorney general to look at maybe legislation to prevent this from happening. But it is a concern, and it is going on. And like I said, we're seeing it, it's a trend. We've had ten people in the last couple of years leave our agency to go into a residential run day program. And we're a small agency, so I don't know if other agencies are seeing this or if they're even aware that this is going on and that it is a potential concern.

Because now we have people going into situations—and we're not accusing agencies of abuse or anything, but there's no oversight. And right now day programs and residential programs kind of check in on each other and say hey, this person has bruises on him, or this person's lunch is really something for the trash can. And that's not going to happen if it's the same pair of eyes making the lunch as it is working in the day program.

Female: So when we were coming I realized that not just for the training for folks who are caring for the aging individuals, but we do not... we primarily evaluate the services that we could have between DTA, group homes, to the high intense care homes or institution, it's not institution, but skilled nursing, because some folks may need the catheter. That's about it. But then we are not authorized to do medical care at the DTA or group homes, but we cannot get any nurse to come in for 30 minutes. So if we can have that short amount of some additional services,

many folks can stay in the community as long as they want to be. So those little services are not authorized on the current services, but AHCCCS can approve. Is that true or not?

Female: Yeah.

Female: Right, right. Are any person between? Okay, doesn't have to be nurse. I mean, the medical technician can be. But obviously for the direct care provider who do not do the catheter, they may assist. So that is the issue that we face kind of day-to-day.

Female: Right. Beyond the direct care provider tasks. So it doesn't have to be nurses, but maybe between. Some, you know, care. So we have multiple folks, you know, we can combine for two hours for them to come in to help us or, you know, depending on the situation. But I think we need to look into a little bit beyond just the direct provider, but then skilled person who can provide somehow medical services or care, but it's not necessarily doesn't have to be skilled nurses.

Female: Right.

Female: Right. But I don't know if we have that kind of category who can come in between and we can hire them as additional staff or trained staff.

Female: I mean, we do have our own training, but it's not necessarily we can bill that person for, so we need to really coordinate with—

Female: In addition to that, so what we have is our nurses are doing the visits, but our LPNs are doing the hourly schedule, so our LPNs are going out to the programs with the member and assisting them throughout the day program.

Female: Absolutely. And when the member goes back home and the parents are there, then our caregivers will be in the home providing the care with a supervised adult.

Female: Is it easy to find that provider who can really take that role?

Female: In Santa Cruz County, I'm sure you'll agree with me, to recruit an LPN, it's very, very challenging. But I understand in Pima County it may not be as challenging to contract an LPN.

Female: Whatever.

Female: I don't know about that.

Female: [*unintelligible*] 00:44:41. And also as the DPA you're supposed to not provide personal care, right, if it doesn't have [education], right?

Female: I would add a very important one. We have [therapy] [*unintelligible*].

Female: Yeah, therapists as well.

Female: I'm not a parent, but I am a sibling of a person, an older—she's 34, which is crazy. And because of the situation where there are not enough respite providers, I guess, people who come into the home and help my parents be able to care for my sister, who is still at home—she's one of the 80%—and she's in a wheelchair. She needs assistance to transition from wheelchair to sitting, standing, all of that.

My parents are aging. My dad's going to be 66 years old. And so I think not only the aging population of our members, but also the aging population of our parents who have 80% of our members in their home. So my dad is actually taking early retirement to be able to care for my sister. And I feel like that is where the state has fallen down for them. He shouldn't have to quit his job in order to take care of my sister.

Female: I do agree that the therapies are really short. My daughter went—we were looking for a speech therapist for over three years and didn't get one. And it wasn't because the support coordinator didn't try. Vendor calls kept going out. And because of my daughter's situation, she's a two on one, needed to be at our home at the time to receive those services, and we could not get a speech therapist in the home if our life depended on it. And then when we did find one, the turnaround was just, it was insane. It was just speech therapist after speech therapist.

And now she's 26 and didn't ever receive the therapies. And so the support coordinator, well, the team and I last month discussed it and we just decided just to stop searching because at this point she's 26 and what are we going to do? And then she doesn't adjust to change very easily, so having new people coming in the home for our members and for our children, it's really important that the structure is there.

And I do agree with like even the support coordination—well, because I'm a parent and I work in the business, like my rights and I know them, so I will demand that I keep my own support coordinator, and I'll fight for that, because that's my daughter's right, because if she changes, the support coordination changes, then my daughter changes. And then it's a whole roller coaster all over again just to get her stable again.

And so fortunately, since she moved, since I relocated her here to Tucson, I haven't run into those issues. And then the agency she's with is also amazing, so I don't have those issues. But I see it on a daily basis with the members that I try, that we try to support. And so I think therapies are really needed.

Female: Thanks, [name redacted]. I was just sitting here listening and a lot of the things I was listening to in terms of things that need to be improved as a provider, I'm listening and I realize, as people are talking, why some of those things are taking place. And the reason why some of those things are taking place—I don't want to waste a lot of time—but they're complicated reasons. And something as simple as it's the same provider doing the residential, the day program, the other services, and here's what's happening, where's the oversight.

And the reason that things are moving in that direction, that's one example of several that I heard, actually, and it deals more with the system and the changes that have taken place over the past 15 years, I believe, definitely a decade, in the system. And I wanted to add something that requires improvement is we can talk about the rates, and we have a lot, and will continue to do that, hopefully. But it is also this culture, and it's throughout our state, and it's a perception that we need to help change, and the division needs to help us change it, providers need to help us change it, and it is that culture that we can keep asking and asking and asking for improvement and change and different things, but the money doesn't follow.

And this is a population that it's a health and safety issue. And I think that there's a perception that this is like each year going down to the legislature and requesting additional dollars for the, I don't know, some sort of wing at one of the higher education institutions, and it's not. It's health and safety. And yet for some reason we're going down there every year and we're asking. We're asking for our state to find the money, and we're asking them to increase rates. This should be an automatic. It should be this is health and safety of people, and it's not an automatic.

So I think that that is part of the issue, and part of the problem, is that years and years ago, even though it did start out that way, there was more of a statewide culture and more of a perception that this was a duty, this was something, an obligation, something our state needed to do. And now it is not that anymore. And I think that is a problem that, you know, again, if we don't do something or at least try to start tackling that piece, we're going to be back again over and over and over again.

And again, keep in mind what I just said. We are asking for a rate and then we're allowing a group of people, well meaning, probably wonderful people, to understand the complexities of what we do on a day-to-day basis. And they're taking a stab at it, and they're throwing out a 1% increase thinking they're really excited that they really took care of our problem. And we're looking at it going holy crap, I can't do this for 1%, I just can't keep this going. There's not an understanding of it. And that whole mess shouldn't even be happening.

So just to back it up, I do think that that's a big problem and an area that needs improvement, and it's not going to be overnight, but we've got to tackle it. And our state, we also have to recognize that we start over each year also. And every year that we start over—and I say that because our legislature requires that, almost—every year that we start over we forget that piece. And so it almost has to be a commitment of a multiple year situation to get to where we need to go to actually correct the broken system.

And I would like to say that it is broken. And so if we can just put that up there, the system itself is broken. It is not struggling, it is not eroding, it is not all those lovely little terms that I've heard. It is broken and so we need to fix it.

Female: No. I'm talking about we're, the DD system in terms of the Division of Developmental Disabilities, there's some challenges there. Providers have challenges. Those are all over the place. I'm talking about all the pieces that actually affect this population and the rates. That's the legislature, that's the state, that's our funding entity. That whole piece is...it's broken in terms of that maybe is not the appropriate way to do this. You know, going back year after year after year.

And, you know, we just need to take a look at it. And I think people are nervous about taking a look at it because we have a voice, and we don't want to lose our voice. And that's something that is actually working for us. So I get why people get nervous about it. But I think that there's a way, maybe, to deal with it on like a higher scale. And again, I know it gets complicated, but I think that that's the issue. And we're going to keep coming back here over and over again if we don't deal with it.

Female: Right. Absolutely.

Female: I think a lot of the things on the list are just symptoms.

Female: I think they're symptoms of what [name redacted] was just talking about. We have a broken system, we don't value people, we don't... If we valued people we would give them the quality services and supports that they need, not the minimum services and supports that they need. And so so many of these things on this list are symptomatic.

Male: Not now. Go on.

Female: I definitely agree with, was it [name redacted]? I do agree. Back what was it, ten years ago, our families would receive 720 hours of respite and then they just kept taking it away, and now it's at 600. And then I agree with the lady up in the front that it's true. I went to a meeting a couple weeks ago and instead of giving the 12 hours a week, now they told the family we need to know exactly the amount of hours you're going to use and if you do require more, you have to call and ask for those hours to be authorized.

And then as a provider, when I started out 23 years ago, I made what people are making for minimum wage, and the minimum wage was a lot lower. And so how are we going to expect our providers to give their complete self? I mean, the job isn't easy. And I've always told all of my providers don't do this for the money. You have to have the heart to be able to do it. But at some time we do have to show that we appreciate our providers, and the agencies, and the support coordination. I think the lack of support just is across the board.

Female: I think to add onto what [name redacted] was saying about the culture, I think the state of Arizona has to recognize that they have to fully support the individuals as well as the providers. Providers shouldn't have to be doing fundraisers to be making ends meet. And I think it's the state's responsibility to step up and make

sure that the costs of care are being fully covered, and that hasn't happened forever.

And as an administrator I know I spend most of my time trying to figure out how to make ends meet, and how to cover the costs, and counting staff hours, and all of that, when I would really rather be out there trying to develop better and more quality programs. But that's not possible anymore because we are under the gun every single damn day to keep the doors open and/or is there another fundraiser in our mix? No, because who has the time to do that?

So again, I go with the culture, and if the governor's executive order is coming out, then they need to also stand behind that and say we are going to do what we can do to provide the funding that you need.

### What are the Solutions for Improvement?

Male: I'll start, I guess. Yeah, I think forums like this are a start. There's been a couple of disasters, I call them, in DDD recently. One of them is the RFP that tried to include us, right, for long-term services and supports without any input. And I know people can hide behind the procurement veil and not share information. There was that.

There's the whole quality management issue that was, for me, a disaster, and the look behind. I mean, part of the culture is DDD has to understand the impact on providers. So having us at the table, having our input. I mean, we're not the devil incarnate. We're all here for the same thing. We want to have the best services for people. But DDD can go out and hire however many independent contractors you have to re-review 27,000 incident reports or something, and I have the same person.

And for the response to be, well, just ask for more time, I still have to copy an entire file and fact-finding for a hair pull. I mean, we deal with people, and they have incidents. So having us at the table before decisions are made—oh, the other one is value-based purchasing. So at least to whatever extent possible, ask for input before decisions are made that impact us.

Female: And to take that one step further, getting our input and then also maybe allowing a trial period of changes with like a small group of population to see, like work out the kinks. Time and time again I have seen DDD roll out an entire system with n...like it does not work. And if you had tried it on a smaller scale you may have found some of those issues out.

Female: I'm thinking, well, based on the broken system, I mean, I'm thinking maybe a big group of providers needs to get together like this and look at something like a five year plan, what's going to happen, this is how it's growing, this is what we need to see, and maybe go in kind of like that. Because a lot of times people are just going and holding the torch by themselves, and I think that the more people that maybe are on board it might speak a little louder, I guess.

Female: I was saying that I think that voting for legislation that provides more tax dollars to the Economic Security Division, that's obviously, if they don't have money to give us, where are they going to get it? So we just have to share the cost, provide that.

Female: And maybe all the providers maybe do up some simplified little flyer to give to families where they can directly contact their legislator. I think that the language and the reading can be very difficult for a lot of our families, anyway, and so if we could simplify it and make it easy for them. I mean, everybody's got email on their phones now, so I think that if we could simplify it for families, they could be in on it, too.

Male: So along the Prop 206 issue and the funding, I mean, one of the things that the system seems to have done is forget about we're in a system, we're not just the people that supposedly Prop 206 impacted. We have employee related expenses, we have therapists, we have nurses, we have all this other huge set of people that have not had increases for years because of the Prop 206. And they're single-mindedly focusing on just that one problem when it's not just that problem, it's systemic.

Female: I'm just tacking with the high medical need as we age or folks who have the medical needs. If the DDD has a person appointed who assists all the agencies in terms of those medical care and coordination and transitions, who can advise on, because support coordinators themselves cannot provide all the information that we need to place NPL or other options that they have, so they ended up moving that person to a medical intense group home or ICF. So I think we really need a person who can really arrange those or assist us arranging those cares, and also follow through those cases that [highly] needing a person for those medical coordination.

For instance, if someone has a huge surgery and follow through, and the guardians are out of state, and those care often find be neglected, and may not be the quality care that they should receive. I've seen a lot of families struggle because they are managing from out of state. And if they are here, it may be different. But the support coordinators are not necessarily equipped to support that family or providers. So I feel like some intense medical needs to be addressed, and so we could keep them in the community as long as we could.

Female: But more of the coordination, not just the care. I think that part is important.

Male: I guess as far as a solution, one thing that I would suggest, DDD went through a process recently on rate rebase where they had a big long process where I think they got a lot of good input, and I think they did a good job in the process as far as gathering information. And I guess my suggestion would be for DDD to use the results. [Laughter.]

Male: Yeah!

## Thoughts on Alternate Service Delivery Model

Female: Okay, I'll just keep passing it back. So I guess I have a question. So would this, on the right-hand side, the big bubble, the big circle, would that be still one of the contracted health plans, Mercy Care or United Health Community Plan?

Female: Okay.

Female: So that is to be determined?

Female: But it would be that or a similar.

Male: I'm just curious. Did you say that this could expand into [unintelligible] 01:22:44 for another two years?

Male: So in this model what would happen to qualified vendors? Would they subcontract then for United Healthcare or whoever the provider—

Male: So there would be no contract with DDD then?

Male: Well, you asked [for it].

Male: Just to clarify on [name redacted]'s point. So the right-hand side is still three years out?

Male: A minimum three years out. Okay, thanks.

Male: Three years out before they can [unintelligible] 01:23:57.

Male: This is your [forte ], [name redacted].

Male: [name redacted], I know you're acutely aware of where they've done this in other states. You want to hear?

Male: In other states it's been woefully unsuccessful.

Male: You need the microphone.

Male: It's a healthcare plan. They don't know anything about the population.

Male: [name redacted] said... [Laughter.] No, you're contracting with the healthcare plan, so providers will be contracting with Blue Cross, United, who's just used to working with a different population. It is not a lifetime of supports. It's the difference between a disability and an illness. It's all those things we've always talked about. They're just really unfamiliar with the folks we support. They look for us to...for services to kind of step down in terms of they're used to acute medical care. That's different than what we do.

Male: You're welcome.

Female: I've been out of doing things for about a year and a half, but I started providing services here in Tucson 43 years ago, so more than—

Female: Can you put your [mic] up a little bit more?

Female: I don't know if that'll make—I guess it does. [Laughs.] Anyway, one of the things that way back in the olden days that really attracted me was the whole notion that we were helping people to gain and acquire new skills and moving them towards independence. And that's what kept me excited as a direct support person. And over the years, what I've seen is with the whole medical that we're just looking at people as cases and members, yes, thank you. And the whole quality of life part has changed so that we are—and I would agree with [name redacted]—that health and safety.

But there's so much more to life than just health and safety. And somehow I think that's gotten lost over the years. And I just, I see these things and think medical plan, and yes, what are they going to think about. They're going to think about that I'm a fat lady that needs to lose weight and drop your blood pressure, not that I need to go out and do other things, and meet people, and see things, and it just...

Female: Well, I think that the one on the right is just a continuation of the one on the left. It's just a different version, and that in there what gets lost is the people.

Female: My concern is I was around working in EPD when the conversion from county based EPD to MCO based EPD happened, and I watched the number of service and support hours for people be dramatically dropped. I watched our rates be dramatically dropped. And I have a lot of concerns about that relating to what will happen to our people, what will happen to their services. Will they have the services that they need or will a health plan look at an algorithm and say we really can't afford this, this is killing us financially and it's outside of our projected numbers or whatever. Well, so then that person all of a sudden doesn't need whatever services they've been getting. So that's a huge concern for me.

Male: To tag along with [name redacted]. Yeah, I think if you look in other states, I mean, you think about the mission and the culture, as [name redacted] mentioned. I mean, a healthcare plan that's profit driven or at least has to be that way is a total different animal than what DDD, with the philosophy of all of us and all of our providers.

Male: Okay. So the whole culture and values are totally different. And the only way a health plan—again, states look at this transition as a way for the state to save money as opposed to these are people we're dealing with. The only way they can save money is to eliminate providers, cut rates, and reduce services in order to improve their return. And I think as, you know, [name redacted]'s more the expert than I am, but I think that's the examples from other states. There are many fewer providers, much less choice in who's [out there], a longer waiting list.

Male: [Inaudible.] 01:29:23 As imperfect as [Inaudible] is, I can still call and say so-and-so needs an increase in [range] for a week or two weeks. You can't do that with the health plans.

Male: [unintelligible] 01:29:42, [name redacted]. We got...

Male: All right.

Male: Do you want to talk again?

Male: Oh, for God's sake. [Laughter.]

Female: This is crazy. I mean, as a parent, that's taking away my rights, my choices, my daughter's freedom to develop to become more independent. I mean, he's correct. I mean, as we struggle with DDD, we can still call them. We can still get the support system that we need from them. I mean, sometimes it takes a little longer, but they're there. These people are human beings, they're not numbers. They're not numbers. They need these services. And we should be able to still have the rights to make these decisions and not have them taken away.

Female: Just a question. What would DDD's role be then?

Female: So DDD...would DDD have anything to do with establishing the rates and such?

Male: [It depends what you mean] by oversight.

Female: So I just wanted to say that the plan on the right, I'm going to agree with everybody that that one really scares me. I've been around long enough to have seen the transition in employment services go to RSA, who had no idea what population we worked with and how that was an epic fail. It had to go back to DDD because this was an entity, like everybody has said, that has no idea who we work with. And we all remember that healthcare plans look at preexisting conditions and they eliminate people based on those. So our people were born with these conditions. They're not going to get good services. That's reality.

Male: Yeah, part of my concern, so my son receives services. I just got a call a month or so ago when they went to the complete care and everything rolled together, from a case manager in Phoenix, which is three hours away from us, saying she's going to manage his services for behavioral health and physical health, everything that's part of the Arizona complete. So when this rolls out is he going to have a support coordinator out of Phoenix that's going to manage his case three hours away?

Male: You know, I mean...

Female: Wait, [name redacted]. You always have great things to say.

Female: We need a first aid kit.

Male: Absolutely. You know, the focus of health plans obviously is utilization. Utilization is defined differently with our population than it is with behavioral, even the acute medical care. You can look at rates of infection and things like that. In behavioral health you can look at number of admits, length of stay, ER utilization. In our population utilization is actually sometimes more expensive. Health plans just don't get that. Folks are out in the community more, doing more, need higher levels of support. It just, it's a bad fit with traditional insurance company. I think I said the same thing three times.

Male: I know. I've got one more way to say it. [Laughter.]

Female: So sorry, I don't have the mike, but can you elaborate on the utilization, please?

Male: Well, utilization, you know, like [name redacted] was saying, they're looking to reduce—they're looking to save money, so they look at things like utilization. Behavioral health has specific metrics like length of stay at a Level 1 facility, at a hospital, or number of admits, or ER, times people go to an emergency room. And some of their value-based purchasing is based on controlling those metrics. That's how these things work.

In DD there is no such thing. That's why they have such a hard time with value-based purchasing. So what they're going to do is figure out almost an annual cost per person, and if that person's acuity changes, if they need more support or less, the provider—this is why the small providers will disappear, I believe—the larger providers will be able to accommodate folks because they have bigger margins to work on. The small ones will disappear.

Female: I think you're tying it back into that there's not an algorithm to be used for people—

Male: Correct.

Female: With any people, really, would be my—

Male: Correct. Yes, that is correct.

Female: Okay, thank you.

Male: Yeah, not one that's tested in the wild.

Female: So I work out of the medical model, so this is actually what I was hoping would happen October 1, 2019. Because of the rates and how low therapists get reimbursed through DDD, this is actually attractive to me, to be able to go directly to the insurance provider themselves and take kind of DDD out of the mix of it. So this is attractive to me. I can see where the residential piece of it could be more challenging, and the day-to-day piece of it in the actual habilitation services. But from a therapeutic piece of it, this is appealing to me. I find it interesting that the

physical therapy over 21 piece on the October 2019 piece got included. That is typically—

Female: Yeah. That is typically a very profitable provider type, and they lobbied well. So I think that's interesting, and I would like to see therapy services included within that piece of it.

Female: All ages.

Female: You know, the support coordination issue, you know, we have members with varied situations, age and [natural] support, and advocacy skills. And how the healthcare plan support coordinators understand different needs, and what their plans even before they want to take that role? And I think that's a huge piece that DDD provides and continuously. So I think that's...I'd like to know, you know, whoever takes that plan, what their plans are.

Female: Considering varied, you know, natural support, age needs or, you know—

Female: Right.

Female: So this is in existence for three years. This is what is happening October 1<sup>st</sup>. Are we going to be asked to reconvene a meeting like this to confirm that the one on the right is something that's still an option in three years? I mean, it's pretty scary from a vendor. You know, obviously as a qualified vendor we obviously love what we do for a living because we are pinching pennies, and we're not obviously in this for the money. But, I mean, to lose those rights is, it's really sad.

Female: Okay. So as a vendor and as a parent, passing out flyers, getting our families more informed or having them more informed, is that something that...those are all on the website, correct, with all the meetings and everything that's going to be listed?

Female: So I can invite all my families and tell them to go?

Female: I will do so.

Female: I really will.

Male: I don't know what you were going to say, [name redacted], but the... It seems like the forums kind of...I mean, as providers we kind of heard they were coming, and then all of a sudden they were announced literally a day before the first Tucson one, so I don't know how many people showed up, family people showed up to the first Tucson forum.

But I would—it's very important input here, and I would really work hard to get the families involved and that kind of thing. Because we're trying to help, [provider redacted] is, with the families that we deal with, but we were just caught way too...I mean, just timing-wise, we really couldn't have much of an impact at all on the first Tucson forum. So please help us get the word out.

Male: And along those lines, the only feedback I've gotten from a family is someone with a younger person that is not involved with DDD services, so I don't know if DDD has reached out to the special ed departments, because there are that hidden population. And she had no idea that the forums were going on, none at all.

Female: How will the information gathered in all of these forums be shared with people who participated in the forums?

Male: Talking to DD is great, but this is all part of that RFP AHCCCS put out last year, and they have their own agenda going on. They're driving this. They need to be at the table. We need to have forums with them. AHCCCS needs to...you know what I mean? They're the ones that can answer the questions. This is their agenda.

Female: Backing up just a second, [name redacted], is there a place where families can go if they weren't able to attend one of your sessions and provide—

Female: Okay.

Female: That's all on the website, so families can go there, they can call into those, and then—

Female: Okay, thank you. You all got that, to communicate?

Female: The one piece I would add about the AHCCCS—and again, for providers, definitely, that there's been a change in leadership in that area, and [name redacted] is our individual in AHCCCS now, and I would strongly encourage providers to communicate with [name redacted] in written form, not just verbally. She gets the fact that this population is different. There are some things that the wheels have started turning and the ball started rolling, and she's not in a position, I don't believe, to just stand in front of the ball and stop it.

But she is in a position to slow things down, take a look at it, and make sure that we don't make an error and some of those pieces. So I think that she needs to hear from providers across the state, again, in written form, that this is concerning. And it can be a simple three sentences, just wow, this freaks me out, this is concerning, here's the reason why, end of story. Put it in writing so that she has it, she can collect them in files, etc. But it allows her to slow the process down, I believe, and make sure that, again, some of those pieces that you're identifying are truly vetted. So I would strongly suggest that piece.

### Thoughts on Governor Ducey's Executive Order

Female: Monitoring and oversight, yeah.

Female: Yeah, like I said, it's a trend that we've seen quite a bit lately, and that is people from an agency that provides residential care opening or...yeah, opening a day program. So now the individual is with the same agency 24/7. Support coordinators and guardians do not have enough time to visit this person on a

regular basis. And when you have an individual who is in two different agencies, one for residential and one for day program, the agencies communicate with each other and they kind of monitor each other. And I think that is such an important part of keeping people safe.

So when I've seen people go into these same programs 24/7, I have to question where is that oversight. Our program monitors do not have the time or availability to go into these programs on a regular basis. And I'm talking regular as in weekly, or even monthly. Some of us, we don't see our monitor for months at a time. So we had a situation very similar to the situation that was at the [provider redacted] where an individual—

Female: I'm sorry. It's in the executive order. Yeah, and so we have had a situation where a young lady became pregnant by a caregiver, and I am sad to say that this young lady is now in the same day program that is run by the same residential program in which she was raped. This is a real problem. And I don't think that enough attention has been brought to it for people to say oh, wow, red flag here. So that's why I'm bringing it up. And that's why I have written to the governor and asked him to bring this up at all of the task forces or charge them with that to bring this up and spotlight this.

Male: It's not that I'm known to beat a dead horse, but one of the things that I think is lacking in the order is the funding.

Female: Of course.

Male: The majority, by far the majority of our minimum wage staff that are struggling to survive in this environment that the state has created for them, I mean, they have two or three jobs. As [name redacted] mentioned, the culture, it's a disaster waiting to happen. So that's the one comment on the executive order.

The other one is just DDD's perspective on the use of technology. I know that there's some legislation going around that they want to use technology and monitoring and cameras and things in the group home, which is a whole different can of worms. But again, the piece that's missing from that is it doesn't replace a staff, and it's not reimbursed under your Medicaid rates. So if—

Male: —something like this wants to happen or to occur, we can't double, triple staff it 24/7, as [name redacted] points out. I mean, this is a house that we can't have a supervisor there all the time. If we're going to use cameras, then at least include it in the waiver so that we can bill for the service, as to incentive folks.

Female: The only thing I would add in this section is that there are the work groups that I think [name redacted] mentioned, five of them, and they've already identified some people that are on that work group. I'm on that work group. And I think that it would be really helpful. We are allowed to, I think, invite other people to those work groups. And I think that definitely the one that deals with funding for our

direct care providers and our—excuse me, our direct care workers, definitely I think we need to have a lot of voices there.

And so I am perfectly happy, if somebody wants to sit on that work group or participate, to just let me know. The other work groups, there's one that deals with making sure that certifications, licenses, etc. are in line. ICF and [*unintelligible*], I guess, don't have the same kind of requirements that providers do that operate licensed facilities. And there's, I think, prevention. That's the one that has the direct care workforce in it. And I can't remember what the other three are right now, but—

Female: Oh, absolutely, there's one around training. And I'm a little fearful that something that will come out of it will be oh here's another training concept we want you to train individuals on above what we already train. I think most of us train our staff pretty well. It's not that. It's about some of these other dynamics, these unintended things that kind of take place, and the low rates are probably our strongest contributor. But if anybody wants to participate in one of the work groups, I have no problem moving your name forward at all to see if we can get you on there.

Female: I think you raised a really important issue that as providers we work together, you know, whether the residential homes and day programs. And I think we don't want this to turn into the pointing of finger kind of [tools]. So I think we really need to be conscious about how we can work as a team and set the clear guidelines, and also the gray spaces. You can [tell] with abuse, but then you cannot suspiciously accuse anyone because something bad happened. So I think that kind of, you know, should be considered when we develop some guidelines.

Female: Very good.

01:57:12 [*End of recording.*]

## Yuma (South)

### What is Going Well with DDD LTSS?

Male: Who are they?

Female: Yes, to catch up, yeah.

Female: Oh, it's in the window sill.

Female: And employment services as well, correct?

Female: Didn't you mention employment services prior to that as well?

Female: Well, we're more the employment services side of it. We do very little DTA. We have day training, adult, which I think—and then we're not...our housing is separate for the DDD population. It's more geared from the [sabbatical] 00:17:09 behavioral health side of it. So the DTA, we're very small, and what we do is just services with individuals with significant disabilities, but nothing with skills, life skills. Like I think [provider redacted], you guys do that, correct?

Female: Mm-hmm.

Female: And that would probably be based off of what they do.

Female: Right now, for those, I don't have any thoughts on it, unless you do for DTA for employment services.

Male: Nothing, not [for this].

Male: There's a lot of things going well with DDD. I mean, I think there's a lot of people that are interested in making sure that people live as independent a life as possible. Tomorrow there's a provider meeting where they're rolling out the new—

Female: Thursday.

Male: Thursday. I don't particularly care for the new pilot project that they're rolling out. I think it's not necessarily the right tool. But the intention behind it is good.

Male: They're trying to move a more person centered approach to DDD planning meetings, formerly called ISP [team] meetings. Now they're just called, I believe, planning meetings.

Female: Planning meetings, yeah.

Male: And they're trying to do a more person centered approach and the new tool is intended to [meet] in the meetings, and be a more person centered approach. So I

think it's a great intention for what we're trying to accomplish, that being more person centered. Still don't know that I like the tool.

Female: It's just lengthy as far as meetings go as well, and we have so many clients that you're serving, and then so many support coordinators, trying to get into those two, three hour sessions is really difficult for the providers.

Male: They're saying that there can be pre, some integration, was that...?

Female: The initial meeting will take approximately three hours.

Male: Okay, it'll take—

Female: Yes. The first planning meeting, which makes sense if you're doing a person centered approach, because it takes time to engage that individual and the family in order to document exactly what...where you're going, where you need it to go.

Male: It kind of seems like someone dedicated to that in the provider would be a good...because to sort of move it from there you kind of delegate from there or...

Female: Mm-hmm. And the providers need to be a part of that because we can provide some of the services that they would need to be more independent, more employed, more whatever.

Male: I don't know that this is a going well pocket, but I think when you think about people that have various levels of need, the relationship... Many people believe that their relationship is the primary relationship, but that's not in any way the truth. The truth is for the people we serve, the primary relationship is between them and the people that provide their support. That really becomes the primary relationship.

And the provider thinks that they have some relationship in there because they're the employer of the true person that has the relationship. But then there's all kinds of other players in the game. You know, there's a support coordinator, or there's the day program team that they have a relationship, and there's the behavioral health teams, and they think they're primary in the relationship. There's a lot of people that believe that they have this primary relationship with the person receiving services, but in fact the primary relationship is first and foremost between the person and the person that's providing the service.

And then secondarily to that—and I shouldn't say secondarily—but in parallel with that is the relationship between them and their family or their natural support. Because I think that relationship happens without pay. That relationship happens naturally. And so Mom might be willing to care for her child and not getting paid for it for 24/7, and a caregiver might come in for [like relief]. And so—or a direct support professional, as we call them sometimes.

So I think it's important as you go down this road to think about the relationships, and who's primary and secondary in it because when you start doing person centered planning there gets to be a lot of people in the sphere of that plan, and it's not always—like there's been a time that DDD believed that they were in control of something, you know, they were the ones that were having the primary relationship. And I think there are many times nowadays is their recognition that they have not got the primary relationship.

So sometimes, with some factions within DDD—because every office is different, and each office has a different culture, each supervisor breeds a different culture, and so some support coordination people who are the interface between DDD and the member, some of them have a great relationship. They recognize that they're to coordinate services and document plans, and support the person centered approach to this thing, and it's all wonderful. And then there are some people that look at it that they're in control, that they're driving this bus instead of documenting where the bus is going.

And so I think it's important to say that what is going well with DDD is that there are some factions within DDD that do approach this in the right way. But what's going wrong in an entity as large as DDD, that's distributed as much as DDD, with as much middle management and so many layers, there's potential for different cultures to exist inside the same entity, and some people believe they need to control that bus and some people believe they need to invest in that work and coach or support that bus. And I don't know how that fits into this, but it's an important distinction.

Female: Yeah, just thinking back on that, I think support coordination, I've seen a difference in attending all of these ISP meetings that the newer members of those teams, the support coordination teams, are much more open to being the recording side and supporting the direction that the family would like to go and the individual. Whereas some of the older, more seasoned, more veteran support coordinators are more of the let's drive the bus. So I think whatever changes they've done to training for support coordination has been effective. And that's, again, just for district stuff. I don't have experience with any [other] areas.

Male: Agree on this.

Female: Yes, thank you.

Male: [Name redacted]\_[went] through area quite well.

Male: Hi, [name redacted].

Female: Sure.

Female: Can I add to the support coordination complexities? Again, another thing that I see that I'm assuming that it has to do with the training is more invitations to ISP meetings coming from the newer support coordinators versus the older support

coordinators. So those are coming through to me regularly, again, from the more...the less seasoned support coordinators. So I'm assuming that the new training is really putting an emphasis on that and as a provider I really appreciate that.

Female: Yes. [But only at times].

Male: [unintelligible] 00:30:53. [Laughter.] Do you [to just skip that]?

Female: Another thing that's going well, I think, is the district meetings. We have them quarterly.

Female: Yes, they travel down here, and we meet quarterly. Actually, Thursday we have a meeting. And they bring information about what's going on. I understand that they're going to roll out for us on Thursday, let us look at the new planning meeting document, so we'll be getting a peek at that. So yeah, very informational. And then there's an opportunity for us as providers to share what's going on in our own organizations, so that's [awesome], too.

Female: Everybody. There's really every, the whole team. [Name redacted] comes.

Female: Who's the gentleman that's the director? You know him very well.

Female: [name redacted], yes. [Name redacted] comes. He leads the meeting. And then he brings employment. Who else comes? Usually quality assurance. Which, I guess they've gone away, right?

Female: Oh, no? Okay. Because [name redacted] used to come all the time.

Female: [Name redacted] used to come all the time. But he brings a team. And then they meet with support coordination and then with the providers.

#### What Needs to be Improved with DDD LTSS?

Female: I just think that the needs to be improved would be the points where training for the newer support coordinators maybe re-train some of the old guard.

Female: Seasoned, yes.

Male: Sort of a recognition that providers have expertise and that expertise needs to be leveraged for the member, for the team.

Male: And sometimes, in the example that [name redacted]'s talking about, the old guard support coordination, they like to control things. And I think... And that's a broad generalization. It's not the truth all the time.

Male: But I think sometimes providers—so like right now we're trying to roll out our new habilitation curriculum inside [provider redacted]. And it's a very organized and step-based approach to teaching people [things].

Male: And we did this because we watched all that expertise inside of the DDD system, as funding has diminished, a lot of our [minimum] expertise has evaporated inside of provider agencies, and so at [provider redacted] we decided wait a minute, wait a minute, wait a minute, this habilitation that looks too much like babysitting has to stop and we have to turn it into a professional training program, a teaching.

And so we've built the program. Well, and now we're coming to the teams with here, here's our program, and it's like we didn't get taught under this program, what are you doing here? This has no place in our system. And so I think recognizing the expertise and leveraging it for the member is [unintelligible] 00:34:59.

Male: Oh, yeah.

Male: I will say if any of you have gone to the DDD website, take a look at DDD's habilitation curriculum and what they teach support coordinators about habilitation.

Male: It's archaic.

Male: And it's wrong. But we did use it to support our own. We had several training [schedules] that we used.

Male: But I think...

Male: Well, I think you also have to recognize that we're all here to support that person, that member. I mean, our goal is to work ourselves out of a job. So if I can take you and help you be as independent as possible, you're fully functioning in society, you're earning a wage, you feel valued as a member of society and all of a sudden natural support is all you need, wow, what an amazing, awesome thing. So that's our goal, that's our job.

Male: I'm speaking from the employment services side. When we go to planning meetings and stuff—and let me preface it by saying that we have an amazing relationship with DDD here and with support coordinators. Sometimes I think that the goal of the program isn't [unintelligible] 00:36:54. I understand there's a fine line between assisting and the service that we're providing being individual. Of course it's all about the individual and their needs come first. But we also, as a provider, have to look at the program side of it. And part of the program for us in employment is to prepare an individual and get them ready to get competitively employed. And sometimes when we feel that this individual is ready for it, the family says no.

Male: And there doesn't seem to be a lot of support from the coordinators in rolling that through.

Male: Yes. Without a doubt. But a lot of times what we see is the support coordination—

Male: Yeah. That's what the family wants, so we'll just move on.

Male: Right.

Male: And then communication. I think communication can always get better. Sometimes we have meetings that are changed and we never get an email or a call, and then they asked us why we missed it.

Male: Yeah.

Male: I'm just trying to listen.

Male: Timely delivery of planning document things.

Male: It needs to be improved.

Male: I don't know how bad it is in this particular area. Have to rely on [name redacted]. How long does it take?

Female: I would say 15 days, usually.

Male: Statewide our experience is sometimes it goes to more than 30 days. And we're nagging for that. I think in [unintelligible] 00:39:31 providers have an opportunity—

Male: I think provider agencies have the opportunity to not do the program in absence of an [auth] and in absence of a planning document that says what the goals are. How do I—

Male: How do I do habilitation when I don't know what I'm supposed to teach because the document's about that?

Male: I think there's room for improvement in the delivery of that information.

Male: And in this world of technology and our very soon evolution into the EDD environment, I think there's room for the division to deliver that information at the meeting. There can be agreed upon items that occur in the meeting for instant delivery rather than 15 days.

Male: Automated instant delivery of planning documents.

Male: Okay.

Female: Back to the DDD stuff, understanding habilitation also is...we get a mixture of sometimes developing the [half goal] 00:41:09 of the meeting. If we have...the family has input, we have input, and we're actually writing that goal in the meeting, and then others are oh, I'll get you the goal because I have to write it exactly—you have to write it exactly the way I wrote it and put it into the report.

And then we have others that write it and get it to me because we need to move on. So I think it goes back to understanding of habilitation and a training aspect.

Female: Exactly.

Male: Rates. Rates could be improved.

Female: Make that a giant one.

Female: Giant, all caps.

Male: The rates right now, equip, of presence, to—

Male: The rates paid to providers.

Male: I think it's absurd that the division will give you 38 cents for a 50 cent increase in minimum wage. I think whoever is doing that kind of math shouldn't be.

Male: I believe that DDD's in a precarious situation and they work at the pleasure of the governor and the executive, and the legislature is the purse. And so people are in political situations where they can't necessarily publicly advocate for rate increases on the governor's side. And I think it leaves all that burden on the shoulders of providers.

Male: But it also leaves the suffering party to be the member, because the quality of the caregiver is directly proportional to the rate availability. And I think that that's a giant piece that we have seen that's broken in the system. The quality of caregiver has diminished, to some degree.

Female: Because caregiving is now a minimum wage job. It did not used to be that way before the minimum wage went up.

Male: I think what's going well with DDD, another going well piece that we need to recognize is that in the world of Medicaid and in the world of federal mandates coming from CMS, when we have DDD to be...I'm trying to look for the right word. Modified implementer might be a nice word to say. Taking round pegs and shoving them into square holes.

The ability to say okay, we're still trying to operate inside this Medicaid space and we recognize that there's all this stuff we have to do, but we still need to do it differently in the DD population. I think when we provide services for people that get services through the division we have to recognize that it's not going to look like the medical model. And I think we've done a pretty darn good job in Arizona at taking federal dollars and trying to keep us from going to a medical model. So I think that's one thing we've done well, and we need to keep doing well.

Male: It's a good thing you have a recording going on.

Male: Avoiding the medical model through...

Male: DDD interpretation.

Male: I don't know. It's necessary.

Male: Habilitation inside of... I have a contract with United Healthcare. Habilitation at United Healthcare looks very different than habilitation at DDD. And we do habilitation in both MCOs. And I'll tell you, the quality of product inside of DDD is far and away better.

Male: Was that original term modified implementing?

Male: I said modified implementer, but I don't what—

Male: What those words mean, yeah.

Male: You've got some quotes behind it, so it might show up somewhere.

Male: But I think it is working well. I mean, you know, you can't just shove everything through. Our population doesn't typically... It's not a temporary thing. It's not an end of life thing. Oftentimes we see lots of services for seniors at end of life. Well, our folks need it when they're 16, 19, 21, and the rest of their lives. And so there's a whole different look at how we do things.

Male: Far and away, yes, please.

Male: Yes, I did say that. It is unique. And it's more involved, it's more caring, it's more understanding, it's more comprehensive. All of those things.

]Male: Just got to do that in permanent marker, so... [Laughter.]

Female: There you go.

Male: [Close enough] thought. I told [unintelligible] 00:48:37 [Laughter.] There's only 31 more meetings on [this issue].

Female: I think the education of families may need to go over for solutions for improvement.

#### What are the Solutions for Improvement?

Female: It's difficult in here, but we, as well, the [unintelligible] 00:49:05 services, we go out there and we have meetings at our office. We open it up to the public, we open it up to the providers. We [unintelligible] 00:49:15 everyone. And we bring in food and try to discuss it a little bit. But a lot of times there...it's Monday through Friday. That's when they want to work, only during Monday through Friday hours.

Female: Right, absolutely. So then there's all these other things that are happening in the community where they want to go, of course, or go to—

Female: They have other kids, absolutely. That's the hard thing. But I think the best thing is when you do have the ISP, we have the meetings, let the provider, I mean, the providers and the support coordinators, let them know what's going on. Like you said, have the support coordinators be involved in that, and not just say okay, yes, no problem. Well, if you did this, this is what we're here for. We're trying to get them competitively employed. How do we do that? You know, we have all kinds of talks.

Female: What if you had quarterly meetings like you do for the district providers?

Female: A person going [*unintelligible*] 00:50:31.

Female: Absolutely. See? It's in the future.

Female: So they can get involved with it. And not just them, the whole team. As a team.

Male: I think the education gets even further because many of our families don't know what's out there and available to them.

Male: And we at [provider redacted] have been admonished by local support coordination—

Male: By saying, well, have you ever considered habilitation for your child. And we've been told it's not your place to suggest other services.

Male: And we do that anyway.

Female: I have that printed in my office in a binder that I share with families.

Male: It didn't hurt me. [*Laughter.*] It probably [wouldn't] anyway. [*Laughter.*]

Female: I think you can move retrain the old guard and seasoned support coordinators.

Female: Yeah, it's a solution.

Female: Because like I said, the current training seems to be... I think the newer support coordinators are much more open to being a team member.

Female: So whatever you've done with the training has, I think, been effective. And they're the ones I guess [we need] invitations from as well.

Female: I shouldn't say that too loud 'cause I'm like the old guard, too. I'm old.

Male: We're all old.

Female: Being in the business for a while. [*Laughter.*] A little while.

Male: [Make sense of the living] 00:53:00.

Male: There's been variable cultures inside of the Division of Developmental Disabilities over the last several years, and the culture got very closed, and access to people got very restricted. Somehow, somewhere along the way somebody said that as long as you put on your message machine that I'll return calls within so many hours, 48 hours, 24 hours, something, that that just made it okay. Serving our folks is a 24/7 operation.

Male: Accessibility to staff, accessibility to a human being. I mean, I know that I can—so I'll give you an example. A few weeks ago we had an authorization that expired on a Friday—on a Thursday. The authorization didn't [get loaded] and the family was expecting services on the weekend. My agency has a policy that says no authorization, no service. And we log in to Focus, and we make the call, and we call the on call emergency number, and we leave messages. We called the customer service line and followed these new protocols that don't necessarily allow for access. They allow for documentation of your concern, but they don't allow for a solution.

Male: And there's no support coordinator on call, there's no network manager on call that can actually open their laptop and fix your problem. And even to load in a ten unit bridge off to get you through the weekend, there's nobody, there's no access to resolving people's problems. That needs to be improved.

Male: We serve people 24/7 and we're obligated to be available 24/7 to our members. So too should the division.

Female: Don't point at [name redacted]. [*Laughter.*]

Male: I like [name redacted]. For the record, I like [name redacted]. Everybody knows that.

Male: I've liked her for many years.

Male: Very good point.

Male: I think we should be able to get a hold of somebody to resolve problems 24/7.

Male: That's a very specific issue that you had there.

Male: And it involves beyond your agency.

Male: And so what ended up happening, just to share the rest of the story, because it's being recorded, we went ahead and did the service because we have a commitment to our members. We violated the rules—

Male: And we did service in the absence of an auth, only to, on Monday morning, have an auth come in back dated by support coordination. So something needs to be improved because the support coordinator shouldn't be allowed to back date auths. Because that would fix the system. That would force somebody to do their job in a timely manner.

Male: And maybe only [name redacted] gets to go and back date an auth so that [name redacted] knows that something broke down in his system. He's the director.

Male: Yeah, yeah. I was going to say that's two different approaches. The support coordinator should not be able to back date, but what if it's necessary.

Male: In my agency I have certain permissions that I can do things differently than [name redacted] and her staff can do, so sometimes we have to get the job done. But we need to, at the highest levels, recognize this breakdown in the system. And that would allow for a breakdown backup.

Male: Or something.

Male: That would be great. I have a feeling [name redacted] is going to be like I don't even know how to log into Focus. [*Laughs.*] Maybe not say AD. But I'm sure he has people.

Male: [name redacted].

Female: One of the things that needs to be improved is turnover.

Female: I'm sure it has to do with pay, I would assume, I don't know. But the turnover seems to be—and I get this because of our district meetings that they bring staff down, and we don't have someone in employment services, or one person is covering the entire state, which is impossible. So then you get those messages that you leave that [*unintelligible*] 00:58:28, that kind of thing. So I think the turnover rate—and I'm not sure what the reasons are. I'm assuming it's private sector versus government. I'm not really sure.

Female: But the turnover is problematic.

Female: And not only employment services, but I can't remember what the title is, but the individual that works closely with mental health.

Female: Yes. So those two, I know those two positions have had somewhat of a large turnover rate. They get someone on board and then they leave, and you're [baseless], so... I'm not really sure what the...

Female: I'm assuming it has to do with pay. I'm not really sure.

Female: Employment rates, yeah.

Female: Does [*unintelligible*] 00:59:39 have enough staff to do it so they get burned out?

Female: Overwhelmed and overworked.

Female: Maybe.

Female: But it is problematic. For me as a provider, I'm trying to look at doing some different things and when I don't have access to those professionals within the DDD system to talk to and collaborate with it's kind of difficult.

Male: Yeah.

Male: We did that one.

Female: Yes.

Female: It's been a while.

Female: And it's good to see you as well.

Female: [You've dug everything out.] [*Laughter.*]

#### Thoughts on Alternate Service Delivery Model

Female: No, it makes sense. What about the excess part of like the polices, where's that included in there? Because that is like extra, or somebody has to go in and have X-rays done somewhere, or an ultrasound, or something like that.

Female: That is definitely covered under that?

Female: Because I remember a couple years ago that was one of the concerns, is where does that fall under.

Male: So I'll start because, you know, I'm not very—

Male: —shy. We contract with multiple MCOs, including DDD. DDD is a managed care organization just like United Healthcare, just like Banner, just like Mercy Care. And they all work for the single Medicaid agency that draws down federal monies, AHCCCS, and they operate in a capitated rate environment, and each of those MCOs receives a capitation in order to serve their members all in. So basically they get a single dollar amount per member, per day, I think.

Male: Month. Per member per month and they have to provide all the services inside of that capitated rate. To roll this out using the other options example, to me is a very bad idea. The reason it's a very bad idea is what I mentioned earlier over here. The needs of our members—we don't call them members, so it's hard for me to say that. But the people we serve, their needs are not necessarily the same as the people we serve under our EPD contracts.

Male: The respite for a 92-year-old woman who is frail and whose husband has passed, that respite need looks very different than the respite need for a 19-year-old member who lives at home with Mom and Dad. It just looks very different. The attendant care need looks very different.

One primary example is the latest implementation of attendant care supervision to replace false hab. So we have had it at DDD for many years, false hab, habilitation used as observation or supervision. And recently they've made that distinction and they've used attendant care to supplant or to provide security and safety for members while not paying an enhanced rate for teaching them stuff.

Provider agencies like mine would prefer to get larger rate, obviously, because we can pass that on to a higher qualified caregiver. However, there's a distinction in the service specification about what is done. And so we're trying to live into what's done. And so I believe that if we go over to United Healthcare or we go over to a Banner or to a Mercy Care or to another MCO—I shouldn't say their names because Lord knows who it would be—but whatever MCO would be awarded, I believe that they're not going to have the understanding of services to our community, people I grew up with, the people that have been involved in my life for over 40 years.

And I know with a high degree of certainty that it will reflect negatively upon members. DDD, for all of its good parts and all of its bad parts, has a unique view, vision, and understanding of what our people need, and we're not going to be able to replicate that in an MCO that reports to a board of shareholders instead of reporting to the executive branch of government inside of Arizona, funded by the purse strings of the legislature.

Male: It's being recorded, right? Sorry I didn't speak slower.

Male: Most of the MCOs that are involved are for profit organizations and they have shareholders. DDD is hired and works at the pleasure of the governor of the state of Arizona and gets funded based upon revenue appropriated by the legislature. And so there's a two-pronged approach at supervising this MCO called DDD. And constituents and their family members, or members and their family members are constituents of these two groups of people. They can pick up the phone and call the governor if they're not satisfied with services. They can write a letter to their legislator and say hey, I believe I was wronged.

And in both systems there's appeal rights. There's appeal rights over in the EPD side. If you don't feel like your services were properly managed or awarded or authorized, you have those appeal rights. But appeal rights are not necessarily the only solution that fixes it for our members. We have so many anecdotal stories that could be told by family members about how their services got made right by the division. Not because anybody was not forthright in what they were trying to do. Everybody was forthright. But sometimes it just takes a little more explanation. Sometimes it takes a little more understanding. And we have that with DDD. And my thing is if it's not broke, don't fix it. Not that there's not other things we could fix.

Female: Just to piggyback on what [name redacted] said, in the DDD model you have support coordination. You have the ability to, with the appeal process—and here's an example. We had a young man who was receiving—medically involved,

receiving services. He is fragile, and the family was not satisfied with the amount of hours for attending care that were assessed. So we did a time study. We presented that information and his hours were increased. Justification was made for the increase in hours.

When you work with an MCO that is faceless, for one thing, most likely, you are sending information to somewhere and someone is making a decision based upon that information, and you get a letter back that says this has been accepted, or the appeal is granted, or whatever. With support coordination you have that connection with that support coordinator, you know who the APMs are, you have that hierarchy that you're familiar with that is real people. So I don't know how...

Male: [Can't even] help with that one.

Female: Exactly.

Female: It's just faceless, yes. And I don't know how you can make life choices for a family member when you don't have that connection. When it's on paper, someone somewhere in an office is making that decision, whereas with support coordination they can always go back to that support coordinator and say is this what you're seeing? You're in the home, you're seeing the member, what is it that we missed, or the assessment didn't capture. So there is that human element that you don't get with...

Female: Exactly. And with that comes a decrease in services that's detrimental to a member if they're not getting those services. And our job is to make them as independent as possible, and providing those services in that direction, you're not going to get that if you're not getting the amount of services or the types of services that that member might need because they're being denied on appeal, let's say. So it's grave. It could have a huge impact.

Female: I think when you do this you're taking the human factor out of it and putting it into a bureaucracy.

Female: Yeah, that sums it up.

Female: You just take the human factor out. And we experience this in healthcare all the time, all of the hoops you have to jump through to get some kind of service. And you have to prove everything so that you go into a doctor for something, they can't do this test until they do this one, this one, and this one.

And even the DDD patients, I mean, they've got some needs, but you've got some that don't always understand what's going on, and you're putting them... they have to go through all of this right now for their healthcare. So they've got to go through and they've got to have... They're having intestinal problems or something. Okay, we can't do—this test [isn't] probably going to tell us immediately what's wrong. We have to go through an MRI, we have to go

through this. And we have a DDD patient that may have some behavioral issues. You go try to get them—

Female: Delays—

Female: —to lay still in an MRI machine, and you're trying to go through all that. They've got enough to jump through hoops on this other bureaucracy stuff, why are we taking them and putting them into that on their habilitation services and their home and community? And now you've got just one they've got to go through to try to get it. It just doesn't make sense to me.

Male: Here's another thought. [You] talked, so I'll shut up. [*Laughter.*]

Male: Did I make sense?

Female: No, I'm good right now. I'm just kind of taking it all in since...because like I said, we're more of the employment services side of it, so we're just trying to figure out what's going on as well, and how can we help the community, what can we give. That's the kind of thing that we might have. But right now in employment services, I'm okay. I'm just kind of listening.

Male: In the current system where we have basically two MCOs meeting the needs of one member, that's what's happening presently, there's a check and balance inside the system. If a doctor in the acute care plan believes that there are services that DDD is not funding, there's a mechanism where these two MCOs can determine the needs and it can get addressed. If DDD feels like there's a service that a member needs that's funded under the healthcare plan, there's a mechanism to get it done. In the other option scenario where everything's rolled in, it's like the fox guarding the henhouse, and there's no alternate MCO that's checking the other. And I think we lose something in that environment.

Now that's not to say that even in the other options category that there wouldn't be people like [provider redacted] sounding the alarm and making a bunch of noise when something's not going right. But at the division we have a chief medical officer that can get engaged when there's a difference of opinion between the acute care MCO and the DDD MCO, and things can get resolved. So I don't think there's a check and balance inside of a singular MCO environment. And I think that's worth noting. It's just a bad idea. Don't do it.

Male: [*Laughs.*] Of course I'll be saying that at nine more forums. [*Laughter.*]

Female: Get a thesaurus out.

Male: I probably won't make it to all of them. [*Laughs.*]

Female: One thing that hasn't come up, but when it's going through DDD, now even [through where] it is, we're already struggling for dollars. Now [if we're] going to go to a for profit organization, there's going to be less dollars to come down to the

providers to provide these services, and we're already struggling. And no one's really addressed how that's going to affect... I'm the controller for the company, so...

Female: So I'm looking at the bottom line, okay, how much is this going to affect us, and how much can we continue to provide.

Male: Well, and I think to that point where is the money going to come from? The legislature is now funding DDD and its infrastructure, and now we're going to fund this other infrastructure, so we have replicated authorization process, replicated accounting process. Because I'm assuming that it's not going to be an all or nothing, and we're going to switch the light one day and go from one to the other. So I'm assuming we're going to have to fund both systems for a while.

And if there's multiple MCOs chosen, currently DDD has one set of administration that administers services through DDD. Now I'm going to fund the administration of one or more MCOs to do the same thing that I was currently getting all of that efficiency inside of one MCO. So there's another point. I feel bad talking, but... I don't have any group homes in Yuma, but I do have group homes in the Phoenix area. But I'll speak of it because it should be documented somewhere, because I'm sure there's group home providers in Yuma.

Female: There are.

Male: And in this model I have five members or four members in a group home, and one member chooses one MCO and the other three members choose another MCO. Currently the way habilitation services are funded and measured and the rates that are provided are built on a range ratio system. And so how are these MCOs going to perform together in order to fund the needs of the person? What if the rates paid by the MCOs are different?

Currently I have an MCO that pays me 95% of the fee for service schedule and I have an MCO that pays me 90% of the fee for service schedule. So we go to out an MCO where they off the top, from the published rate, take 10% or 5%, depending upon the MCO. DD passes me down the published rate. So first of all the provider agencies get less because the MCO takes a cut, and secondarily, now I have two MCOs funding the same range ratio mix for people inside of the group home, and it creates a problem. I'll just say it creates a problem.

Male: That's one point.

Male: Reimburse at different rates, and in the event of audit, how do you do range ratio billing? Because if I'm Joe Insurance Company and I billed—

Male: Well, there you go.

Male: And that opens up a whole 'nother can of enchiladas because—

Male: They're not very good. [*Laughter.*] Because if you move out of a range ratio billing, which I believe the MCOs would have to do if it wasn't administered through DDD, you lose the flexibility of meeting the needs of members. Our current range ratio billing—and this is something that goes in what works. The current method of range ratio billing for DTA and for a group home, and for—

Male: And for community protection homes and for other homes that bill in a range ratio, that methodology is flexible enough to meet the needs of members without overpaying or underpaying the provider agency. It is the most cost effective method of getting a person's needs met without putting too much money in the provider's pocket and without not having enough. That methodology probably can't be replicated in the MCO environment, especially when more than one MCO is chosen. And I'm sorry that you're trying to interpret this with limited exposure to the system. And I'm not going to say anymore because my cookie's gone. [*Laughter.*]

Female: The only other thing is from my experience with DDD, it pays timely and they pay very well.

Female: They pay timely. I know when the payment's going to be coming and it's there. The others are a little more difficult to collect from. And they'll withhold stuff. They're a lot more on [approval] than dealing with the services that are [on that].

Male: Can we put down what works well is Focus?

Female: It's going to change the Focus. Everybody changes every two years or three years. I agree with that, [name redacted].

Female: Yeah, it's wonderful.

Male: Well, the evolution of Focus is an all-encompassing portal that meets so many needs that would not be replicatable [sic] in an [MSU] 01:33:04 environment. We've worked too hard to build an amazing system of service delivery to screw it up. I can't say this in any other way. We've worked too hard. The division, the providers, we've all been engaged. We've thought about things, we've celebrated things. We didn't get here without any blood, sweat and tears. We got here because we worked hard to get here. And here's not perfect. It's going to get better, it's going to get worse, things are going to happen. Culture changes. Oh, shoot, I was supposed to stop talking.

Female: If minimum wage goes up another dollar.

Male: We have to stop. Our time's coming up.

Male: Lunch is going to be coming soon.

Female: Yes.

#### Thoughts on Governor Ducey's Executive Order

Female: Before we answer, I have a question.

Female: The individual that did this crime, did they have anything in their background that could have ever indicated that this would have been a problem?

Female: This is still an open investigation, so I wish I could answer your question, but I can't.

Female: Okay.

Female: I'm sorry. Until he's convicted I think it's an open situation.

Female: Okay. The reason I ask that is because you can—

Female: [personal information redacted]

Male: It's presumptive that he was a nurse. He was an LPN nurse. And it's presumptive that the nursing board has some criteria in order to hold that certification. And so it's presumptive that he met some sort of background check. I don't know that that's fact, but I can say it out loud because I'm not DDD in this meeting. But that's presumptively true.

Female: I guess the thing is I don't know how much you can go through and we can—I mean, we can do everything possible to safeguard our people. I work in an organization and I have to have a special badge and background check that I have to do to be able to work with kids in a sports deal. And then because we're part of the Olympic thing we have to meet this new deal that the Olympics have put out which is called Safe Sport, and they have to go through that training.

And people can go through all of this background check, they can go through all of it, but how can... I mean, we can put in more and more and more, but there are some times where an individual, for whatever reason, they're going to break. Something's going to break. When you've got that human factor, you cannot get 100% guarantee of safety. And so I think that there has to be an understanding that you're never going to get 100%. You can do everything possible and that's what we can do. We can do everything possible, but we're never going to get 100% because we've got a human factor, the human brain, and—

Female: Be that mandated reporter that we all signed [an autograph] for. Be it to the fullest. That's what you know.

Female: There's a possibility that it might not, but make somebody else make that decision.

Female: Be the mandated reporter we're required to be. Like how many people go well, I'm not sure.

Female: I also think there should be—

Female: Somebody should have known.

Female: Yeah, I think there should be some training associated with identifying behaviors that are associated to abuse. Not just physical abuse, but mental abuse, financial abuse.

Female: Because I belong to the elder abuse coalition here in Yuma, and that's one of the things that we find most often, is even law enforcement isn't quite aware of what that looks like and so—

Female: Yes. Recognition—

Female: I would want to have caregivers trained. All the way down to caregivers.

Female: Family members, everyone. Yes. Especially at a facility like that. Family members may see things, but just sort of brush them off as an anomaly.

Female: But even beyond that, in their own home, if they're going to be left alone as a caregiver, and if it's Uncle Fred or it's cousin Joey that's going to be left alone, and they're going to be the caregiver, they should have to go through the same thing.

Female: I hate to go back to funding, but funding is an issue.

Female: It's real.

Female: And when you have a profession that goes from not being a minimum wage job to now a minimum wage job, not only the quality, but also the quantity of individuals. And when you don't have the funding, as we've had these rate increases, that filters down to the providers, then they have to make changes. And sometimes that's in staffing. And a decrease in staffing, you may have overworked individuals who may be less likely to recognize something that's going on.

Female: [*unintelligible*] 01:43:34 to the providers without us having to pay for it. That would help as well.

Female: Well, it's like the same thing. We go through and we need to have Article [9], we need to have [*unintelligible*] 01:43:47 support training on CPR first aid, so that comes out of our pocket.

Female: So have DDD provide for training?

Female: Absolutely.

Female: That would be good.

Male: This is a very big question, so there's many, many solutions. Some of the solutions trounce on the civil rights of people. It's difficult. I'm a supporter of

something called pre-employment psychological profile. I believe that that's a solution we write up there, pre-employment psychological profiling for people who are going to work with vulnerable citizens.

Male: Well, we played with it at our organization. But I think it was mandated and there was a proven technology that could help weed out people that might have a predilection to do something to someone who's vulnerable. We should leverage it. What we can expect to face in suggesting that is that many civil rights groups will stand up and say how dare you do that to somebody. But it's worth mentioning because it is a solution. Cameras are a solution. So again, in the state of Arizona your voice can't be recorded. At least one person in the space has to be aware that there's a recording going on. So you can collect video, but you can't collect audio.

Male: Collecting video. How does that violate the rights of the person receiving services? There's so many pitfalls inside of this space. But surveillance is a piece where civil rights groups will probably stand up and say well that's great that you're protecting the rights of the member, but what about the rights of the worker. There's lots to consider in this arena. I believe that the most effective one is going to be filtering for people with a predilection to do this. And I believe that that's the most effective method.

This gentleman that—I shouldn't even use that word gentleman—this person that did this thing, allegedly, was credentialed, was a professional, received multiple layers of training, was not an entry level worker. He was not a minimum wage worker. This situation happened when we narrow down our staff to client ratio, for lack of a better phrase, down to one-to-one, or one-to-six, or one-to-30. And when you're the only person in a particular area with a bunch of people that are vulnerable, you have the opportunity to do things.

I think we have to be careful to not just narrow this down to men, because this sexual assault occurred, and we discovered it because a young lady got pregnant. That doesn't necessarily mean that other sexual assaults are not occurring where there's no longstanding evidence. And we need to detect that as well. It's doing whatever damage it's doing to our people. And we need to watch for that.

We really talk heavily about the latest incident, but we have had clients actually die because things weren't done right. We've had clients die at the hands of other clients. Our system is wrought with various levels of exposure inside of what we do. And I think it's horrible what happened to this lady, and I think it's horrible what happened to other people in our system, up to and including those who have died. But my fear is that we'll overreact. And I want to say is that one solution is don't overreact. Let's react appropriately and believe that our solution is going to—measure our solution to prove its effectiveness.

Female: There you go. Perfect.

Male: Whenever that solution comes. There's so many people involved in these work groups. It scares me. I'm going to a meeting in Portland in a few weeks, and one of the topics at the meeting is this particular event.

Male: It will be.

Male: Valid point.

Male: And as leaders of organizations, whatever size, you have to be open to this challenge, because it's a challenge.

Male: Do I have to say all this every time I go?

Female: Yes, you do have to repeat it every time.

Female: It's all right. I go into Phoenix all the time, and I know it sucks.

[*Goodbyes.*]

01:54:22 [*End of recording.*]

## Sunnyslope (Central)

### What is Going Well with DDD LTSS?

Female: You guys know that your list of what needs to be improved will probably be long because we all want to talk about that. I think what's working well for us is that you've gone back to having some of the planning meetings and documents and stuff at the facilities where they attend. When it went to just at the home it was quite difficult for us to go. So that's working well, that they're now back at the facilities.

The only problem is as to what needs to be improved is we're still not getting, as the agency we're not always getting the agenda for what needs to happen with the planning meetings. The families get it, and so sometimes we just have support coordinators show up and be like, well, we scheduled a meeting with the family here at your center. So they don't always include the agency in their information emails. But that it's back at us is great. I think we get a lot more improvement.

Female: As an agency we bill a lot of different payers, and I must say that billing is actually pretty easy and payment is pretty quick, especially in comparison to some of the other payers.

Female: I've got a list. You want to just leave it here with me? Go through a list. Okay, so I have some concerns with oversight. Obviously there's a lot of oversight. We have DTA monitoring now, HCBS monitoring, group home monitoring, we have OLCR, and then we have the quality assurance unit. There's always somebody out monitoring us, always. And sometimes the requests for information and so forth, especially on the QA side, the turnaround is really quick and somewhat over burdensome, and sometimes very much like this was six months ago, but I need it this week kind of thing.

Female: Yes.

Female: Things going well. I would say that actually having a customer service line that you can now call was a huge improvement. It still kind of needs bugs worked out and stuff, but it's a massive improvement. Things not going so well, you can tell from some of the QA inquiries that the folks who are actually inquiring have a real lack of understanding of the service that you're providing, because to ask a day program provider what their home looks like makes you just start to laugh.

Female: Correct. The ones that are asking questions off of an incident report, whether it's something that recently happened or old, are often asking questions that if you understood the service you were asking that question of, you wouldn't ask that question. And then I've recently gotten a lot of questions on things that went wrong in an incident report from an outside contractor that we don't control, and yet we're supposed to submit a bunch of documents on people, and they're not

even our employees, they're [provider redacted]. So I think a little more training for those folks that are asking those questions would be really helpful.

Female: Also on the monitoring, I think something that is going well is now that they've put the OLCR in Focus and keeping everything tracked on there, that's really helped out.

Female: O-L-C-R. Yeah, the online tracking system that DDD uses in Focus now.

Female: I think it's been like this for a while, but the training philosophy is very strong. I know any time I've ever attended Article 9 training or prevention and support it seems like the department gets it about what's important and the focus for the members. And for what needs to be improved, as an agency we spend a lot of time just tracking down trying to get items from support coordinators, whether it's authorizations, ISPs. I mean, it's not uncommon to make two, three attempts, then go to the supervisor, and it's a huge time factor for us and it affects our services as well.

Female: Okay, I would say that the division is pretty responsive when I need something for a member. Pretty good about authorizing a service or increasing a matrix in a group home. Much more responsive than other funders are. They actually take your call and they hear you, so that's good. As far as things that could be improved, I agree on the support coordination. There's a lot of confusion about what is the correct ISP document.

Female: Yeah, that's very frustrating. And the documents that are being used are not necessarily complete enough to meet all the requirements in the residential group homes as far as what we need for rule compliance. And I'm a little disappointed that we're not more—I know AHCCCS had its own project out there to develop an ISP and DDD did its own thing, and I'm a little concerned that we're going to see yet again some more changes—

Female: Yeah. And we don't know what the changes are going to be. And I would really hope that those are communicated really well and that the document is really complete.

Female: Sorry, I thought of something else. The ISP. Having a person centered plan makes me just absolutely thrilled. Welcome to 1986. We're glad you're now on board. However, oftentimes it's not completed very well. And I don't quite understand, and maybe you can explain, I don't quite understand why that document cannot be seen ahead of a meeting, because what's taking so incredibly long is reading every line through that. I understand you want to go through it all.

I still think you can go through it all, but I'd rather have filled that out ahead of time and not have to do it on the fly sitting in a meeting. I think just even releasing it a couple weeks ahead of time and letting people mull some things over would be helpful. But I'm glad it's finally a person centered plan. That was a massive improvement. The service notifications now being online is very helpful.

What I'd like to see improved with them is a lot of coordinators are not providing almost any information. You get date of birth, age, male or female, and what service they're looking for. You may not get the cross roads, you may not get anything about them, and yet you're being asked to make a determination. And then they tell you just email the support coordinator, which you do, and they'll tell you here's the ISP, but would you please accept, go back into the system and put a yes in there. You don't want to put a yes in the system because then you'll get auto assigned, potentially, and you haven't even seen or met the person. So just some bugs need to be worked out of that still.

Female: It's the vendor call process. More information on any one person would be good. They're telling me it's Phoenix, but they're not giving me a cross road.

Female: Yeah.

Male: I think the division does a really good job at supporting our members, the majority of them, more so than a lot of other entities we've worked with, so I'm happy about that. I think they do a really good job. One of the things that we're lacking, we're seeing is there's no modality or system in place to help people with the higher behavioral needs that are dually diagnosed. And I kind of see that they're just kind of being like from company to company to company until something fits. And there should be something in place that can help them more immediately.

Male: Absolutely.

Female: I would ditto what [name redacted] said about the billing and payment system. Works really well in comparison to the MCOs. And I would say that a lot of the problems that have already been voiced in regard to ISPs, the vendor referral system have all stemmed out of DDD inadequately paying support coordinators.

The positions over the last 20 years have...they are no longer the primary gatekeeper, the primary go-to person, the primary support person for people with developmental disabilities. It is a steppingstone to the MCOs who pay about \$20,000 more than what DDD does. So the training requirements, the expectations of that position have lessened. I believe the support coordinator is the most critical position to ensure the long-term supports for people with disabilities, and yet DDD has...it's almost as if they're tried to create systems to go around the support coordinator.

And the vendor referral system is a perfect example. On the EPD side, the support coordinator has 30 days to get a person into the required services, and if they don't get them in they get fined. We have an enormous waiting list in DDD, particularly for people needing evening, weekends, or who have behavioral challenges. And there is no expectation put on the support coordinator to get those services started, whereas in EPD if they don't get them started, those people are out of their jobs. But we can't blame the support coordinators because they come in with very little experience and the turnover is horrific. So I believe that the

support coordinator position needs to be re-looked at, revamped, and truly supported, and recognition for the critical role that it plays in people's lives.

Female: I appreciate the division's partnership. You don't get these kinds of meetings with your MCO. So I appreciate that. We have partnership meetings. I think those are great. I think areas for improvement would be communication. I know the division just recently started a provider newsletter, which is good, but I think there needs to be more communication with the division with different things that are going on. And of course there needs to be a lot more funding in the system.

#### What Needs to be Improved with DDD LTSS?

Male: And just real quickly, to tag onto one earlier thought of [name redacted]'s, was that consistency among monitors. We've had monitors come out and one cite us for a certain issue, and we had the same issue at another home, and it wasn't cited, and then it ended up that it shouldn't have been cited.

Female: There's still a lot of confusion regarding publications from a provider. There's some—

Female: Well, between Chapter 34 of a provider manual, which gives some explanation, and then you go to standard terms and conditions that's in your QVA, the standard terms and conditions in the QVA gathers more pieces that says you have to submit all these things. But the key phrase in one area is that if it's intended for general audience or general public, it doesn't have to go through any vetting.

If it's any piece of information that you're publicizing to look for or look at that could potentially end up in the hands of a potential future person to serve or family to serve, then it has to go through this vetting process. That's pretty much every piece of thing that we do, right? So you send all this stuff in and it falls into a black hole and you don't get a response back.

Female: And I'm sure that person's buried. Is that [name redacted]?

Female: No, it's [name redacted], right?

Female: It also doesn't mention anything about social media. It just says website. There's no Instagram, there's no Twitter. It does definitely need to have a facelift.

Female: But what they'll tell you is that you should have submitted that Twitter before you did it. Well, it doesn't say that.

Female: I just want to reiterate the funding issue. And I really am thankful that DDD is on top of getting us funded. And if there are issues through that with DDD they get right on top of it. In comparison, when I work with some of the MCOs in the past or insurance companies, they can take forever. And it could be just as simple a thing as they say they scan the CMS form in, and I go there six months later after

I've been battling trying to get paid for three or four members, and they say but, you know, it's scanned in here, look at this, look at this. This is an actual incident.

And we look, and they're quote, "scanned in," and I show them a copy of what we sent. They had a copy in front of them of what we sent and when it was, quote, "scanned in" they said the payment date was from January 1, 2014 to January 1<sup>st</sup> of 2014, so we don't get paid for six months because of that error on their, quote, "scanned in" paper. Another thing is when they have a misdiagnosis or they re-diagnose someone, they don't give us the new diagnosis code or they give us only a couple of digits where it needs three or four digits. Again, you don't get paid for months and months and months. And that's optimal for them because they've got to be making interest or something on that money that they've already collected from the state.

It's a big issue. I'm very concerned about having insurance companies come in and bowl our whole state over and our DDD system. We've run a wonderful system for years, and years and years, and now, with these new entities coming in, what's going to happen? Are we going to be paying these insurance companies for their five year contract of what they'll do it for, and then zing, after the five years or whatever the contract is, now they say oh, by the way, all of your fees, state of Arizona, are going to go up, and they're going to go up consistently, year after year after year, until the state's paying them so much more money than they should have been paying originally to our state who's been running a wonderful system. I'm really appalled by the fact of why this is happening. And that's a big question, why is it happening?

Female: I guess the good part is that you have a pretty standard way of getting special staffing ratios during programs. It's pretty standard for every individual, and I think it's pretty clear, at least on our end. The problem is, though, that transportation is a very distinct and separate thing, so they're getting one-on-one support during programming, but it's extremely difficult to get that one-on-one support during transportation. It's very, very difficult, and also impossible, at least from our experience, to have somebody be beside them to give them that one-on-one support while they're receiving transportation. And we can't bill for that, so the agencies are at a loss if they're providing the salary for the employees during transportation.

Male: This is a concern or what can be done better. PRC committees are not always—

Male: We operate a lot in central, and then if we venture out of central, they have so many different things that they have an emphasis on or, you know, yeah, just need to do a better job with consistency.

#### What are the Solutions for Improvement?

Male: Well, without me running them all—

Male: I mean, I guess the PRC chairs should meet frequently to discuss—

Male: The PRC chairs should meet frequently to discuss the point of emphasis, what they're going to be looking at, what's going to be required, what providers are presenting differently and how they're reacting to these things that are presented to them so that there's just consistency across the board.

Female: I think the issue with PRC, the first thing we should do is adopt the proposed changes to Article 9 because in there it said that you wouldn't need a behavior treatment plan if somebody is just on behavior modified medications unless you're implementing a strategy, which violates Article 9, which I think, for the majority of us, that would eliminate the number of behavior plans that need PRC approval. So therefore that would take down the volume that PRC is looking at, so maybe they could be more consistent and more timely when they do their reviews of plans.

Female: Yeah.

Female: Oh, sure. We talked a little bit about OLCR as a positive, but I also think that on the OLCR they could work on their upload for larger providers that are not going to enter people one at a time. If the upload process worked better in the Focus application, that would be very, very helpful.

Female: We as an agency upload a file and then it should, like, hop right in and work. It doesn't work. The upload part of it doesn't work. So then for us to go and manually enter, that's a double system. We have our own system, but now we've got to recreate it in the Focus application.

Male: Well, I just want to say that there's so many things about our contract that we [attest] to do I don't necessarily need OLCR to double check my work. If you want to double check it, come over to my office and double check on my system, but don't cause me to have to upload, or for a smaller provider to key in, keep keeping the thing up, because I get a notation whenever anybody's fingerprints fail. So we act upon it instantly, like everybody does. I don't need another system to keep track. That whole staff matrix thing needs to be pulled out of OLCR, I think. Or perhaps an annual upload where you double check. But not this real time upload that I get emails every day. It's insane.

Female: And if we don't feel comfortable doing an annual upload, depending on the size and the sophistication of the provider, then that's a vetting process. You as an agency have a system that works and notifies you if you have fingerprint problem, or maybe you don't. And then deciding which system the provider needs to use.

Female: Kind of jumping onto that, the QA inquiries on instant reports, one of the things they always ask you is all this information on the person who may have had the unfortunate occurrence of writing the incident report. So now you want all their hiring documents. You already put it into Focus underneath OLCR. You already get it checked in your HR files that are at your office once or twice a year.

Why am I having to re-scan and recopy this person's documents all year long just to send it in to someone, and the person I sent it in on had nothing to do with this incident other than she wrote it. It was all a valid metro driver, but she happened to be the person who reported it, so I've got to pull her HR file and copy and scan everything again. And I did that on her three times in the last two months because something might have changed, and you have to get the new document.

Plus I think now what you have improved on in that system is when you do submit documents to a QA for an inquiry or a fact-finder investigation request, you can now attach everything to that email and send it. It doesn't have that huge restriction on how many documents you can attach to it. That was a real pain. Removing that was a real helpful thing. I'm not sending three emails, I can send one. But it is still very time consuming, and why am I doing that three times? If it's in the Focus system or it's uploaded once a year, and you come out and you check the file, to me that's good enough. Why am I having to answer this all the time? And sometimes fluidly, like [name redacted] said. It's always something every day.

Female: I didn't want to go until what needs to be improved. But I have a problem with incident reporting and turnaround time it takes for them to investigate a staff. And in the meantime we have to find employment for that staff, or office work. And it's like okay, you're being investigated. It's like they just fall off a hill. It can be three, four months.

And that's not fair to the agency and it's not fair to the employee, because most of the time the staff exaggerate things and it's no physical evidence. I think to improve it, if it's investigated by DCS or APS, then we should be probably more involved in it, or have more contact with the person that's doing the investigation. Or let us know. We don't get a notice of their final investigation.

Female: Yes.

Female: Also on the investigations that we get with QA sometimes the medical records requests seem a little excessive as well. For example, we've had somebody who refused to take a medication and sent in an incident report and then we're being asked to pull four months of medication records, four months of nursing assessments. Same thing if somebody has a bruise, months and months of nursing assessments, doctors' visits. It just doesn't always seem like it makes sense that we're being asked for all of this information.

Female: I think overall just looking at the QA process. I have no problem with answering questions, and we're happy to do that, but I guess as a provider we're not always understanding the need for so much time and so much documentation that doesn't always even seem to match with whatever the concern is. So just really examining what providers are being asked to provide.

Female: As far as the monitoring process, at least our agency, I understand that they would like to see you in action without it being planned, but they come and then they

expect hours upon hours of your administrative time on very, very short notice. So if there was a way they could do a drop-in visit with the expectation of it just being their insight for 15 minutes and then schedule a time for it to actually be there, because I don't know if everybody else does it, but when they come it's hours, and I might have a meeting.

I might have things that are quite important, and they just say, well, somebody else should be able to do it. Well, no, nobody else is going to have access to our personnel files and everything. So the importance of them seeing on a drop-in visit, I understand the concept, but if they could just drop in and take their observations and then schedule a time to meet with you for the remainder of the client files and the personnel files and stuff would be great.

Female: Speaking about the QA oversight, I think one of the issues is some of the folks that are coming back and looking at incidents are coming from the medical model and they do not understand that this is not a medical service, this is a...this is someone's life. So they're not very understanding of that.

I think what we report in incidents or what gets QA'd needs to be looked at. Like sometimes I don't think it's germane to have someone QA a bruise. And then I also think on medication errors in particular, they need to look at statistically how many errors folks are having. I think if you compared a DD group home's medication rates to hospitals, you'll find that we do a far better job.

Female: I knew that.

Female: Yeah. And so, you know, and part of it may be changing what is a medication error to where you're only QA'ing—

Female: —things like, you know—

Female: Yes, the wrong med to the wrong person, that kind of thing, or overdosed someone or something on that order. We get QAs that the person missed their medicated mouthwash. Well, what was the effect? Their breath just wasn't as minty. It's kind of...

Female: Right, right.

Female: Yeah, and it really scares me that we're going to this medical model.

Female: Wanted to talk a little bit about the enhanced ratio requests. One of the things going well is we seem to get an email a little more consistent that the person's been approved for their ninth year on their enhanced ratio. [*Laughter.*] However, one thing to improve it is that there's a form that that support coordinator fills out. If you have been a provider who's done a post payment review, the post payment review guys are holding you responsible for that form being filled out and you have no control over it, by the way.

So when it does, when the support coordinator—you submit all the data, you submit a letter that says we'd like to have this person continue for their ninth year on their one-to-one ratio, here's all the data that backs it up, all the incident reports, we submit that. Somewhere in that process the support coordinator who receives it puts it into the 1703A form and sends it on up the line. The response back comes and it comes on a secured email, so you have to go through the process of opening up the secured email. It says here's your enhanced ratio request form, which is the 1703 form back that they filled out. It's not signed.

So now you have to copy the entire email and drop it into a Word document and save it because the email is actually your approval, the form's not, because no one signed it. Why not just sign the damn form and scan it and send it to me? You already scanned it to send it to me. Why don't you just sign it? And then I don't have to go through and copy the email, too, because you're making us do two steps instead of one. It makes no sense.

The other thing about that is I would really like it, it would be really helpful if, on the authorization you would put what ratio they are. It's not a dollar amount, so that shouldn't mess anybody up in case rates change. But on the authorization for service put enhanced ratio one-to-one, or enhanced ratio one-to-two, or regular ration one-to-four, or one-to-six, or whatever it is.

It would be really helpful if it was just on the authorization because on the post payment review side you're going to get asked that question to prove what this person's on, and you have no document to support that. You have an email that says it was approved, but it may not even say in the email that it was a one-to-one approval, it just said it was approved, enhanced ratio, but it didn't tell you which one.

Female: I think it would be great if we could use Focus to access ISPs so when we pull up things if we could just pull up all the other documents on that member.

Female: I think this would resolve a lot of problems. Upgrade support coordination, upgrade qualifications, and upgrade rate of pay.

Female: Training and background

Female: Or if they can't get the ISPs and the planning documents on Focus, where you can download them yourself, have one person at each office be the person that can look up everybody's so that as programs I'm not calling 30 people to get the ISPs, I call one person and say this is who I would like, will you please email me them. I've been told at some of the DDD meetings that some offices have—I forget the title—but a case assistant or something. It's similar to a case aide, but that's not the title they use. That some offices have that. But if you just have one person available to pull up everybody's for each agency, that would be way easier for us, and probably for them, because then we're not bugging the support coordinators during meetings and during other things to simply upload a copy to me or something.

Male: Well, following along on this efficiency drive that we're talking about, monthly progress reporting that you have to submit and you have to break up by case manager and by office, and certain naming protocols, like just send it to monthly progress reports with the secure [FTP] site and just put them all in there, and then you guys can hire somebody to—

Male: It works for me. It's a good solution.

### Thoughts on Alternate Service Delivery Model

Male: Will these remain the same for the same three year period?

Female: [*Inaudible.*]

Female: [*Inaudible*] the support coordination. How is DDD going to handle CMS's rule requirement that support coordination be conflict-free? You can't be a service provider, can't be a funder. And is the deadline of 2022 the same?

Male: Yeah, so—

Male: So my question would be in the model on the right is what exactly is DDD, what exact oversight are they going to be providing?

Female: The model where all long-term services and supports fall under managed care organization concerns me greatly.

Female: Specifically. Okay, let's see. I'm concerned that the MCOs—I mean, part of my issue is the money, that now we've got another layer between us and AHCCCS, and that therefore there will be less money in the system because we're paying for more oversight. So that's one. Two, are MCOs going to contract with every provider currently in network? MCOs tend to like to do one stop shopping. And my concern is that only the large providers are going to survive because they can leverage their rates better. Is it going to be a level playing field as far as rates? I believe every provider's going to be negotiating their own rate.

MCOs operate on a medical model. I don't think they understand the services and supports that we offer for long-term services. They are not very responsive when you come to them and talk about a member needing more services and supports. And I feel that as provider organizations we're going to be forced to kind of fill those gaps, and we're not going to get paid for those gaps.

Their billing is terrible and challenging, and payment is terrible and challenging. It concerns me greatly. And I don't think families understand how things could be under the MCO model. I also understand that while some of the integration has worked in other states, there's real mixed reviews about all long-term services and supports being handled by an MCO.

Female: Less money because the MCO—

Female: Your rate is not going to be based on the service, it's going to be based on the power of your negotiator.

Female: Yes.

Male: And the leverage—

Female: The bigger the organization, the more leverage they're going to have.

Male: To get bigger.

Female: And by actually what results, is that the number [*inaudible*]?

Female: Yes, [*inaudible*] 01:06:10. And it'll limit the individual design of services because it's going to be a...

Female: Right.

Female: When the change of healthcare came into place in the Obama administration, every person who had a health plan through their employer blew a gasket that you weren't going to be able to keep your physician. Oh my god, you're not going to be able to keep your physician. They're not going to be able to keep their provider if you eliminate all the small ones.

Female: Yeah, and maybe that doesn't happen at first, but it will.

Female: That's just as big as making me change my PCP.

Female: It's bigger.

Male: Bigger, yeah.

Female: Put their lives in their hands.

Male: So I think as providers we've got support to figure this all out and to voice our concerns. We're doing it here today. My real concern is that nobody's educating families. DDD's not educating families. They're coming to these forums and unless there are people there to ask insightful questions, and to cause people to think differently, the questions you guys are asking are not adequate to lay a proper foundation for families to make an informed and educated comment in the stakeholder groups. And I think it's problematic. And we have 51 problematic instances.

And I think providers need to go to these forums. They need to drag their families. They need to give as much information to them as they can. But I think it's very shortsighted of DDD, AHCCCS, DES, whoever, [President] Trump, the JLBC, whoever prompted these things to occur to not allow somebody to come in and provide education to the families because they're going to go there and go oh, yeah, no, everything's fine. I like my new support coordinator. And they're going

to be relatively clueless on how to give you feedback. And I'm very concerned about that.

Male: Somebody just needs to educate them. Not steer them. I mean, I'm not trying to change anybody's mind—well, that would be nice.

Male: It is.

Female: But you can provide information and still remain neutral.

Male: Educate their families and get them to come to the forums.

Male: Provide informed feedback.

Female: Yeah, because they don't even know what's going on, so you go to these meetings and families are clueless as to what's going on. I just know because I'm a provider, but then also I have a child. If I wasn't on the provider side I would not know what was going on. So if I went to a meeting I would be just like [name redacted] said. I wouldn't know anything. I would just say oh, I don't like this new planning document that takes too long. They ask questions that, you know, I would say common things like that, but nothing else.

Female: Well, we can share information, but you can only do it verbally, because if you put in writing, then you have to submit it to AHCCCS, and they're going to tell you no. [*Laughter.*] Because that just happened to me, actually.

But I wanted to say one thing. Even though there's tons and tons of pages of where we need to see improvements and what we'd like to see get better, it doesn't mean, and don't ever take it as an entity that none of us don't want DDD to stay in place. All of us want DDD to stay in place. And the reason is that when we get dropped into some outside MCO and suddenly we're all talking to United Healthcare, you're going to lose, and families are going to lose, and providers are going to lose that identity of that advocacy that we do because DDD staff, even though some need more training, they at least get it that we are a zebra among all those horses of United Healthcare's clients.

We're a whole different beast. And I'd rather see DDD stay in place. That's why I raised the question about conflict-free. My biggest fear is that some outside third party company is going to be the support coordinator for all these folks, and they're not going to give a damn about them because there are 1,800 of them. They're trying to keep track of them. They don't even know what they look like. And that, to me, is very scary.

Female: That's the bottom line.

Male: [Name redacted], when you're going around to the family forums, are you showing this slide?

Male: Okay. So I think it's a significant enough change to see the left side of the slide. When you introduce the right side and you say this is just an example, you've clouded the picture. You're portraying the future, even though that may not be met. And I think it's complex enough just to understand the change that's taking place on October 1<sup>st</sup>. That's bad enough. That's difficult enough to get across. To show the example on the right doesn't make it any easier to educate the families. It doesn't make it easier for us, either.

Male: It's not necessary. I think it intentionally confuses or clouds the issue.

Female: There are no separate slides?

Male: Are the purpose of these forums simply to educate, or is there an opportunity to keep what we have currently, to keep the system that we have?

Male: Even in the beginning I saw a slide that was similar to this, but it showed the actual delivery model right now, and it showed the one on the left. And when you showed those present day to the one on the left, you could see clearly that present day was a lot simpler delivery model than the one that's currently on the left, October 1, 2019. So I'm all for just keeping it the same.

Male: No. I mean right now how it is.

Female: Who in fact told you what to put on the slide?

Female: Because my family—is this a form of steering?

Female: Well, it seems like it. I have one other thing. When does it come to the point where these insurance companies, who have a lot of money, let's face it, throughout the world, when it comes to the point where they are actually dictating to the state of Arizona what we are going to be providing for the people we care about in our state. And then they turn around and take all the money that should be going to, where it should be going to our members, and a little to the providers that are helping along, and we for years now, since the recession, give and give and give by reducing everything we have to help our members. I mean, is this all political? And the lives, the souls of our members are the ones that are affected the most.

Female: So are we going to get a choice, we meaning providers, members and families? Are we going to get a choice to vote on one of these?

Female: So why [inaudible]?

Female: It's almost like why have a meeting.

Female: This is going.

Female: The state that I'm most familiar with that has all services putting long-term supports underneath a Blue Cross/Blue Shield, United Healthcare that I'm

familiar with is North Carolina. And North Carolina, for quality of services to people, is a disaster. So much so that they are mandating across the board accreditation because of the quality of service. And a lot of it's driven by their provider, their MCO, is a medical model based provider who doesn't understand this type of service.

Female: Quality goes down tremendously.

Male: I think when I first saw this model, the model on the right, that DDD continued to be an option. Has that gone away?

Female: I just feel like that we are not given any options here. When I saw "we," I mean us—providers, the members, the families. We're not given any—the correct information, because you, as DDD—I don't mean you, [name redacted], I like you—are unable to give our families, the providers and the members, the information they really need for conflict of interest. So we're being dictated by—from who is dictating to us of what they're going to shove down our throats. Why do we bother having any of this, if basically the [side] on the right is not an option?

Female: Well, who are the most [inaudible] 01:21:38 to direct all of our questions and input, AHCCCS?

Male: So I said this in the forum in Yuma, so I want to try to say it in each of the forums. I think it's important that we recognize that we've built a system that works for a lifetime of supports for the people we serve. And unlike services in a typical EPD model, those services are typically provided near end of life, and they're time limited services that are intended to sustain somebody. They're not necessarily intended to enhance somebody's life. So we're about making lives for people that we serve, not about sustaining their life. And our system is built around supporting those people.

And we're taking Medicaid dollars and we're trying to use those dollars to do this with. And we are doing it under the same MCO as somebody that's used to providing these end of life services, we're going to get different interpretations of the same service. It's not going to look like what we have now.

And so I think it's imperative to note that we've worked really hard over many years to build an amazing system of service delivery that has oftentimes rated in the top five, mostly top one, on many different measures, and we need to not throw the baby out with the bathwater here. We need to fix a handful of things that might could be better, but we shouldn't start over, and we shouldn't leave and go—there's a million operational items—maybe not a million—but there's at least thousands of operational items that don't fit in the two systems. And I won't go into them. But we need to keep what we have, and it's amazing.

Female: So are we fixing something that's not broken.

Male: If it ain't broke, don't fix it.

Female: One other thought on that same track is DDD serves 38,000 some odd people.

Female: Okay, so 32,000 long-term care folks. It sounds like a large number, and you wouldn't think that they have personal care, but they do. Considering that a United Healthcare or Blue Cross/Blue Shield is serving millions of people, and here's a story about that. Had a support coordinator chasing a proper measurement with wedges and other supports for a wheelchair for nine months, and are maybe close to getting it done.

How fast do you think a United Healthcare or a Blue Cross/Blue Shield would have done this? I think it would have taken years because there's millions of people doing the same thing. This is one person in a very small system and getting that personal care, even though it's 33,000 people.

Female: I currently and have for a long time worked with the MCOs, all of them, and I think that there is, unfortunately, misinformation about them. And I'm being really blunt. The MCO support coordination is superior to DDD. Most of them have master's degrees and some of them, which came from DDD, have 20 plus years' experience, or even people with Ph.D.s that are support coordinators with the MCOs. And that's because they require those qualifications.

So support coordination is excellent with the MCOs. And even though I would agree that the billing and payment system with DDD is No. 1, the MCOs are...they try to work with you and the difference between them, the MCOs and DDD, is minimal. It's not a horrific system. It's a different system.

Female: I agree.

#### Thoughts on Governor Ducey's Executive Order

Female: I'm actually on one of the work groups, but I have some concerns about the annual training and will there be funding associated with the increased cost for annual training. One of the other things I saw, I believe, in the executive order was about checking the APS registry.

Female: The APS registry is a PDF file. It's not easily searchable. It's not easy to put into any electronic system you currently have to run your employees through there, so that is of concern to me. It would be nice if the system were more robust and easier to search.

Female: There's also the requirement for prominent postage of signage in group homes and day programs. I'm wondering how that prominent postage will play with the HCVS rules that are coming out. I mean, I'm assuming that there's a lot of language in there about a home looking like a home, not an institution, and so here you have two kind of competing sets of direction.

Female: What happened earlier this year was horrific, but it's not isolated. And that's a problem that they... I've been an expert witness that was never called because they settled. And a lot of people, there have been other pregnancies in Arizona, and there have been people that have died, including people that starved to death. But those cases settle and never become public. So there's a problem in the system when the severity of issues are not truly dealt with, but are brushed under the carpet because of a legal settlement.

And being a provider that works with the MCOs and with DDD, there's a very big difference when you call a support coordinator within the MCO. There is genuine care and follow-up on what's going on. With the DDD support coordinators, what I see is they say thank you, recorded it, and unless it's a chronic problem you don't get any follow-up. And again it goes back to the role of the support coordinator and the need to upgrade that position.

Female: I totally agree with that. On a further note, does anybody realize that counts that makes these decisions realize that maybe if they funded the DDD system properly that things would run even better than the, quote, MCOs or insurance companies? I mean, we're doing a damn good job with such lack of funding, and when you think these insurance companies, oh, this is a perfect opportunity to move in and take this over, and make it a huge bundle for themselves as they up their premiums after the initial contracts, putting DDD under, I mean, it's ridiculous.

It's ludicrous of what's happening here. Proper funding, ultimately for the state of Arizona, if they properly fund DDD year after year after year, and bring back the rest of the 15% they took away in 2008 and 2009, maybe, just maybe, we would outperform any insurance company throughout the country or the world.

Female: Yes.

Female: I have another solution, which is I have no idea why this isn't occurring in DDD services across the U.S. When you get down to paying people barely above minimum wage, it is really obvious why it's difficult to get people to do split shifts, evening, weekends and work with people with medical and behavioral challenges. A person with developmental disabilities, they're not all equal. There are some people that have very challenging behaviors, and some people that live rural, and yet the providers are given a flat rate with no recognition of people needing funding for the direct care workers that are not providing your typical services.

And if you look at the waiting lists, where I know down in Tucson there's like 375 people on it, and we went through it, and there was one person that we could find a direct care worker to support because nobody else would do it. They were rural, split shifts, evening and weekend. And like how on earth are group home providers supposed to adequately staff when we know it's all evenings and weekends, and pay a little bit above minimum wage. We're facing a crisis unless there is adequate funding provided for services recognizing how serious the problem is, particularly in the Phoenix area.

Female: I want to add just one thing about what [name redacted] was saying. There is something we don't hardly ever talk about, and that is the provider's inability to provide one-to-one care whenever requested. The majority of it is driven by rate, because without rates you can't hire the qualified person and give them the extra training they need to handle somebody who's very behavior challenging, which puts them on a one-on-one status in the first place.

So as a provider you have a group of four people, you're being paid just over \$41 for that hour for that staff. If it's a one-on-one I'm getting \$21 and I'm not covering the cost of the staff because I could not get that staff at \$11 or \$12 an hour, I had to find somebody who used to be a wrestler in high school and they are getting \$15 and \$16 an hour. And by the time you add on all their employment related costs of the FICA I have to match, the Workers Comp I have to pay, the medical care, the medical health plan I have to offer, and this person is going to take and get their family enrolled and all those things, I'm underwater easily.

Why is that rate only \$21 and some odd cents when I'm getting 41 something for a group of four? And I'm not saying it should be 41 because I'm not buying supplies for four people, I only have to buy supplies for that one person if I'm doing some kind of activity that requires a supply. However, it shouldn't be 21.

Female: And it does go back to the executive order.

Female: I think it does directly relate to the executive order because we have such high turnover in our direct support positions because we can't pay people to do the hard work that they have to do. And because we can't pay people, and because we have high turnover, there's no continuity of care.

So if you have a nonverbal person that you have to pick up on nonverbal cues, how can you do that when you have one staff person today and the next staff person next week, and next month there's somebody else? There's no longevity of care with that person, and so of course they're going to be vulnerable because nobody's going to pick up on those cues that that person is trying to put out and the messages that they're trying to say. So it does absolutely directly relate to this executive order.

Female: [Jump the rates] for one-to-one for at least [seven months].

Male: Well, if you fully fund the rate would go up.

Male: So that could be the solution, easy solution, is fully fund.

Male: Oh, we get [that].

Male: It was a great job and I want to thank you for being here with us today and kind of going through this. It's not easy. It's a tough subject, as you can tell.

Female: It's personal.

Male: Our feedback isn't personal, but it is important.

[*Departure sounds.*]

01:43:37 [End of recording.]

## Prescott (North)

### What is Going Well with DDD LTSS?

Male: I believe that, in my opinion, what is going well, it gives person centered choices, family centered choices, and also gives the members choices whether they will get services in the home, or with DTA, or group home as they desire. What needs to be improved? I believe that what needs to be improved is to stay on the lesser side of giving the family... It seems to be to streamline a lot of red tapes.

And also, when we are saying that consumer driven, I'm with... I'm a grandfather to DDD, so I've been in the system for a long time, so I've been involved in bringing some of the folks back from [provider redacted] back onto the Navajo reservation. Either they were SMI and now I believe a lot of successes has been, so that choice.

And what needs to be improved is that... My question would be if it's—I know that we get federal funds for it, then it mandates us to be governmental driven. It seems to be other involvement comes to play and it begins to be governmental driven by—yeah, by mandates of a lot of things. That used to be improved [quite]. It's not that we're staying away from governmental driven programs. And I think in my opinion, that needs to be rethought.

Female: [Inaudible.] 00:15:43

Male: Yeah, I think the direct care and everything is going well as it is now. Rather than governmental driven. And if they can outsource a lot of these things, then other people come into play, and who are these stranger dangers in our area monitoring our system, the system now?

Female: [Inaudible.] 00:16:10

Male: Right, especially on the... If we're going to be governmental...if we're going to be culturally sensitive, then you come onto the Navajo reservation and provide services. So I think if the federal agency or division really need to take a look at what resources we have available. So that's my pitch. Maybe later on I might say something again.

Female: Good morning. As an owner of a DDD agency, I'm actually very happy with my relationship with DDD. I feel that our needs are being met with the support coordination in District North. I feel that our providers at this time have lots of different choices from various different providers within the network system. I am concerned that the provider list will be limited going with a different system. Also as an agency owner it is very important to get paid on time, and I can say that we are definitely always paid on time. Now I'm going to the other side.

We have partnered with Evercare in the past, and it was like pulling teeth to get paid. And as an agency owner serving the number of people that we serve and the number of employees that we have in this community, waiting to get paid for several months will be very detrimental to our organization. But overall, regarding the long-term services and supports, I feel that our families definitely have the choice at this time. I do definitely feel that it is person centered. I'm very happy with Employment First and the governor's initiative with that as well. We are a big provider with employment services, and so that's my take.

Female: [Inaudible.] 00:19:01

Female: [Inaudible.] 00:19:52

Male: [Laughs.] Nobody. You know, DDD does a lot of stuff amazingly well. The current system of service delivery is flexible, it's person centered. It's... I need to give an example of the flexibility. It's efficient, okay? It's cost effective. And the example that I'll give that you may or may not want to write down has to do with group home and the way group homes are funded. It's a range ratio system of flexibility. And what that allows for is the division doesn't pay more or less than what they need to to properly staff that particular and unique group of people.

The range ratio way of billing for group home services allows for the division to pay not more, but not less than what's necessary to staff the unique configuration of that group of people. [Laughter.] She asked me to go slower. But, I mean, really, it's a unique system. It's just a... it's a very unique way. Arizona is very special in the way that it handles that. I don't know that there's any other states that do it the way we do. And it's pretty grand.

Female: [Inaudible.] 00:22:36

Male: I know. [Laughter.] I'm too old. [Laughs.] I think another thing that we have in DDD is that we have a group of people that's passionately committed to the services and supports for people with DD and IDD. Their focus is specific on that. I think we need to not discount that. Everybody's passionately committed to this. And that's huge. DD and IDD. It's just the PC words we use today. Just the folks we serve. I'll think of some more in a little bit, but [name redacted]'s here. He probably has a lot to say.

Male: [Laughs.] These are good things.

Male: I would like to ditto all of the stuff the gentleman had to say, so you can put your neat star above those. And I would also—are we not doing needs to improve yet?

Female: [Inaudible.] 00:24:20

Male: I think the care and the love of the providers and the agency for our clients is amazing. The concern I have is that when you call or get online to get information that the information may not all be accurate or the individuals you're calling

bounce you around to other individuals that continue to bounce you around before you can get the information that is accurate or needed. Once you find the right person it is a waterfall of amazing, great information. But trying to find the proper person is very difficult. I don't want to say poor access because the information is amazing once you eventually get to the place you're supposed to be.

Male: Yeah, go ahead.

Male: [name redacted]. I'm with the [unintelligible] 00:25:46.

Male: Yes.

### What Needs to be Improved with DDD LTSS?

Male: So I think sometimes the division doesn't follow their own policies. The herd doesn't always go in the same direction. So an example I'll give you is that we're not allowed to provide services in the absence of an authorization for service delivery, and routinely every provider ends up providing services in the absence of an auth. And there needs to be a system that gets those auths loaded preemptively so that providers can follow the rules a little better, and get paid. But all in all, that's going well. DDD has it down as far as payments go. If you bill right, they pay right, typically.

I would add an on call person. They need to have a support coordinator on call. That can actually load an auth for any district, for any client, even if it's just a one or three day auth to get it bridged till the weekend's over. They need to have somebody that has the authority to do something until take an IR. Oh gosh we'll have somebody answer the toll-free number for an IR. But we won't have somebody to toll-free handle an auth that case management didn't load, support coordination didn't load. To check on, yeah, it could be that. [Laughter.] Touché.

Male: I know that there's going to be a transition period. What kind of gives us something, the heads up on is the year 2022, that transition will happen. What's all involved in this is that right now can we counter it to see that that transition does not happen, because it seems to be now, with this forum, is that are we setting for 2020 to make that transition?

Male: You guys aren't prepared to answer questions on the transition plan, is that correct?

Female: It just piggybacks a little bit on the old policies. But sometimes there's new policies that are put into place and it doesn't seem like everyone in the system is trained before they're implemented. So sometimes we feel like we have to train other people, and it's really not our place. But I don't know if there's a system to streamline it a little bit better.

Female: [Inaudible.] 00:31:50

Male: This is a needs to be improved section. The case loads for support coordination are too high. My daughter's planning meeting was yesterday, and my support coordinator's down to 80.

Male: Yeah, he's real excited.

Male: But they're doing that new person centered planning document in my daughter's area, and so it takes a lot longer to get through the program. So doing that with 80 people, could you imagine?

Male: In my, obviously in my opinion I think District North is doing well as far as getting more staff. I feel very sorry for them when they're sitting across my son and for my guys at the ranch, when we're having to sit down and try to go through that packet of information. I feel it's very convoluted. A lot of the information I feel that you don't need. And that's not trying to hid anything, it's just there's a lot of information that goes over and runs over the top of itself as well.

Male: Planning document, 90 day review, annual [inaudible] 00:34:02.

Female: I want one of those. Give me one of those.

Male: I'll give you one. I have lots of good ideas. But I'm just giving her a chance to catch up. So DDD support coordination has lost the knowledge about habilitation and what it is, and how to do it. And so there's a problem, and it needs improvement, and that is around teaching people stuff. And I don't expect them to necessarily be the experts, but I expect them to recognize that providers are the experts.

Male: Has lost knowledge of habilitation, and its purpose to teach people stuff. And then the process on how we do that. To be honest—you don't have to write this down—but to be honest, many providers have lost that as well. And some of us dinosaurs are trying to bring it back.

Male: Well, is it time for one of them? Oh, a what's going well. [inaudible] 00:35:42.

Male: Just a question or either a comment on the new planning packet. Back up north our support coordinator is not using the new packet. And I don't think they are even aware of it.

Male: I am very impressed with the upper management in Northern Arizona, from support coordination on up, very impressed with upper management. I'm not saying that because [name redacted] can hit me in the back of the head with something. [Laughter.] But I'm very impressed. It's the middle management that needs to either be able to have...be allowed to speak more or to not be so gun shy to give us answers that...instead of passing the buck up to the upper management.

Male: Yeah, just the level below there. They're amazing individuals. Amazing individuals. I've got no complaints with any of the individuals I work with or deal

with. They're amazing. But I almost feel there's so many changes going on at DDD that they're scared to answer a question because they could be giving you the wrong information. So that's where I mentioned the bouncing around. You keep getting pushed, pushed, pushed, pushed until finally they give up and then they go to wherever the knowledge is instead of having the confidence to answer a question. And if they don't know the answer to the question, than that's a DDD situation where they need to get their people informed real soon.

Male: [Inaudible.] 00:38:47

Male: [Inaudible.] 00:39:01

Female: [Inaudible.] 00:39:29

Male: [Inaudible.] 00:39:36

Female: [Inaudible.] 00:40:07

Male: [Inaudible.] 00:40:11 Communication breakdown.

#### What are the Solutions for Improvement?

Female: I used to write policy for the state of Ohio for human services, and this is in regards to the training and communication piece. And so I wrote the policy and I actually, it was my job to go out to all the local district offices and actually train on that policy.

We would, the Department of Human Services in Ohio—now mind you this was back in the '90s, so a long time ago—but they had quarterly meetings at the district offices, and even the county Department of Human Services, all levels of employees would come to that training, but it was the actual person that wrote that policy. And again, as an agency owner, there's so many new policies that are coming out through our email, and it might just be a policy change just because they decided to, instead of member they want to use consumer this week. And so it's kind of hard to keep up with those changes.

Female: [Inaudible.] 00:42:48 ...goes to the lower level employees and they would train them on a policy that was written and approved.

Male: One thing that didn't end up on "needs to be improved" is rates. Provider rates need to be improved. And then on solution for improvement—well, I already have I wanted to pay support coordination more. Didn't I put that somewhere? Yeah, I think that was a solution to not enough support coordinators. So I think the solution is to pay them more. So I think it actually belongs on the other one.

Male: So the solution is to pay them more, recognizing that everything happens within an appropriation. So DDD administration is oftentimes capped at what they can spend, but it seems like they've got big, brand new pretty offices all over the state. That's an editorial, by the way. [Laughs.] Have you seen the one in...? Anyway.

They're beautiful. Yeah, that's fine. Anyway, the appropriation is not a solution for improvement because it's flexible and we can't fix the legislature, but you have a...

Male: I [always] vote.

Male: Hi there. Okay, and I'm going to piggyback here a little bit on the after hours individual that can maybe put an emergency auth in even for a short period of time. That same person, to give them something else to do, could go in and be able to push the start date forward on an authorization.

We had an instance where we received an authorization for a member and they were supposed to start on a certain day and they were sick. We've had somebody do a spontaneous vacation, and then suddenly we're getting judged for not starting services on the value-based purchasing at the right time, and nobody seems to want to take and change that date when it's not our fault. We strive to do 100% on all this, and it's way out of our control. But it shouldn't be difficult to change the date.

Male: So a system for improvement would be that only [DDD leadership; name redacted] can backdate an auth.

Male: [Inaudible.] 00:46:40

Male: [Inaudible.] 00:46:50

Male: [Inaudible.] 00:47:28

Male: All electronic, paperless.

Male: [Inaudible.] 00:48:18

Male: The provider forum on May 8<sup>th</sup> is going to be a WebEx from Gompers, so if any providers that you know that can't make it here, please have them look up the WebEx on May 8<sup>th</sup>. There's the link. It's on the DDD website.

#### Thoughts on Alternate Service Delivery Model

Male: What about like my ranch has all of our individuals go to the same place for behavioral and for physical, and there's no other game in town?

Male: [Inaudible.] 00:57:45

Male: [Inaudible.] 00:57:48

Male: [Inaudible.] 00:59:01

Male: Make one distinction. Your families are getting these letters right now. My daughter's already gotten hers. Please make the distinction with your families,

because my families are saying back to us, well, I just got this letter, it's a done deal. Why do I need to go to these forums?

Male: [Inaudible.] 00:59:45

Male: Exactly. So you have to build this distinction with your families. Unfortunately, they don't understand the system well enough and they're getting the letters at the same time we're trying to have the forums, and they're saying to our people why should I go? I just got this letter. It's a done deal.

Male: I know [back] on the four corners our communication email, Internet is pretty much dismal. It's a challenge. And right now as [name redacted] has spoken, the decision's already made. On May 11<sup>th</sup> can I suggest you take a Navajo interpreter? I believe it's going to be in [Kieta].

Male: Okay. Yes, pretty fluent. All right. That way I think that will be well understood because a lot of questions will be posed at the providers, why is this, why. If you had known, why are we not made aware of these changes?

Female: [Inaudible] 01:05:51 ...how we have to get prior auth and everything and the amount of clients that we have, it would be—[name redacted], are you in agreement on this? [Name redacted]? Okay. I mean, I just think it would be a nightmare to keep everybody authorized through the health plan. I mean, we already have a hard enough time staying on top of our authorizations with DDD, and we don't have to go through what you have to with a health plan.

I mean, United Health, too, in my—and I've been working with DDD for 30 years. I've been a speech and language pathologist for over 30 years. Getting payment from them is impossible for me, almost impossible, United Health. I mean, I have to bill and rebill and literally send every little speck of paper that I have. I just think it would be beyond a nightmare for therapy providers.

Female: From an agency point of view it seems like, you know, right now we have one entity that we bill, which is DDD, so like you said, we could have...we could possibly be billing DDD, maybe three separate MCOs. From an admin point of view that is a nightmare to figure out, you know, oh, these members are United Health, these members are Mercy Care, these members are DDD. And just to keep track of that is horrible.

Female: And for me, I have therapists on staff, and when you are contracted with an insurance agency they keep you, I mean, the credentialing that you have to do for each one of those all the time, it is overwhelming. I'm online I can't even tell you how often putting in another certification for this one or that one because they all come in at different times. And if we had to do that, I don't know that...I think you'd have a bunch of providers just jump ship. It wouldn't be worth it. It really wouldn't.

Male: So this goes back to what needs to be improved. It's surprising that therapies didn't come up in this session, that therapy and the access to therapies, especially in rural areas, needs to be improved. So what I would say is that... So I'll wait till you're done there. Yeah, that goes on the other thing. Sorry. But... And I don't know what the solution is. Everything we put on the "needs to be improved" we should be proposing some sort of solution for, and so these are on the other two tabs.

But one of the things it would be is that school districts and other people are paying more, and so a solution might be upgrade the reimbursement structure for therapists so it's worth their while, especially in a rural area where they have to drive three hours to do an hour therapy session. But these folks need services, too. But that wasn't why I grabbed the [mic]. [*Laughs.*] So when you're done putting that over there.

So one of the problems with—before you write maybe you should hear it so you can encapsulate it. That might be easier. In the traditional EPD/APD model of service delivery, the services, the home and community, long-term care supports we provide, many of them are provided, the same [*unintelligible*] codes are provided in that environment to typically seniors that are end of life.

So these services for people with developmental disabilities help them to have and get a life. And oftentimes for seniors we're just helping them hold on to either be non-institutionalized, and so they're getting services in their own home, or we're just trying to give them a satisfactory life until they pass. So these are the same [hic/pic] codes. So you can imagine what it'll be like in the environment where United Healthcare—and I hate to pick on United Healthcare, because they're wonderful.

Female: [*Inaudible.*] 01:11:07

Male: Oh, let's pick on them. I would hate to be in an environment where Mercy Care is authorizing services for seniors and people at end of life in the same [*unintelligible*], and the same case manager is now trying to give somebody a life with the same codes. It doesn't typically mesh in somebody's brain. And I brought it up earlier on what's going well. We have an amazingly dedicated group of people that is coordinating these services through DDD. So this point is, a thought on alternate service delivery model is that the health plans will not be able to separate the services they are coordinating between populations.

Female: [*Inaudible.*] 01:12:00

Male: Well, the services they're authorizing, they're assessing and authorizing.

Female: [*Inaudible.*] 01:13:11

Female: [*Inaudible.*]

Male: To wrap up this thought, moving to an integrated model with a United Healthcare or a Mercy Care is a bad idea because services to people with developmental disabilities are different. The people that coordinate them are different. We need to hold onto that treasure that it is, and all the successes we've had. They are not going to be able to do it well under any scenario, as well under any scenario.

Female: [Since you ask us], so when DDD pays us X amount for our rate of service, with PT and OT and speech in the AHCCCS rates, speech is like less than half is what we get paid. So just an example, PT and OT pays at \$80, speech pays at \$27 or \$32. So is that going to be...will we be getting that rate or will we be getting the DD rate?

Female: [*Inaudible*] 01:15:07, so that's just something we need to take into consideration because you're going to lose a lot of speech therapists if that's the case. And I will say this. I work with the [Azip], too, and so they've changed it to where now we have to bill the AHCCCS plans not just [Azip], and it doesn't roll easily. We don't get special treatment because it's [Azip] kid coming in. And we deal with a lot of different AHCCCS plans. I can't imagine that if we say oh, it's a DD client we're going to get any kind of special oh, let's get up there. It just doesn't work.

Female: I just want to make it [clear] that the health plans [*inaudible*] 01:16:05 lower rate [*inaudible*] 01:16:13. [*Inaudible sentences; completely off mike.*]

Female: So I guess my question... [*Laughter.*]

Male: [*Inaudible.*] 01:18:18

Female: [*Inaudible.*] 01:18:24

[*Off mic conversation.*]

Female: I guess I just kind of have a comment. I'm not actually sure where the alternate service delivery system, where this is actually coming from. Is this a national thing that's happening?

Female: Yeah, so my comment is from what I understand, DDD is either, in the state of Arizona we're either No. 1, I believe, in the country for DDD services, so why are we even changing our system at this time? And my question is where is the study that this system is working, and where is the research that the managed care system is working in other states? From what I understand there has not been any research where MCOs are working in other states for long-term support services.

Male: Other states. [*Laughs.*]

Male: If anybody wants to take pictures of this document before we leave, I only have one copy, but it's got all the URLs to other states with this new...

Female: [*Inaudible*] 01:20:53.

Male: So anybody—share it with your families.

Female: [Inaudible.] 01:20:58

Male: Your families need to go and educate themselves to this issue.

Female: [Inaudible.] 01:21:05

Male: I think Iowa might be one of them, Illinois. Yeah, Iowa.

Female: [Inaudible.] 01:21:18.

Male: Yeah, I was going to talk about something now.

Female: Right now don't really understand the system most of the time, so you're going in with this already basic, like, wait, what? We just, you know, I mean, seriously, they don't—they're just happy that they've got service coordinators that are running it for them and they are, you know, happy to get services, and they really... I mean, so you're starting from the ground up to really, I mean, get them to understand just what they've got now, and the changes will be like... And like you said, if they're getting letters that say nothing needed now, they're going to go okay.

Female: [Inaudible.] 01:22:14

Female: No, I grew up in Iowa, so I have many therapy friends back there.

Female: So you have friends in the states [inaudible] 01:22:21

Female: Yes. They made changes, yes.

Female: [Inaudible.] 01:22:25

Female: Just that I know that they have been unhappy.

Female: I can get specifics, but I don't have them to day. I can call.

Female: Okay.

Female: Right. Yeah.

Female: [Inaudible.] 01:22:52

Male: If it ain't broken, why change it?

Male: I'm sorry. Well, I wanted to—I've been trying to sneak this in. I have contracts with, EPD contracts with Banner and United Healthcare, and my experience is that the MCO keeps 10% or 5%, depending upon the MCO, of the rate. So the published rate, they just decide to keep it. So DDD doesn't keep anything. The

published rate is the rate the providers get paid. And it's all dependent upon how well you negotiated with your MCO. But I've heard stories of 20% going back to the MCO. And I refuse to contract with those particular MCOs because I wasn't going to provide the service 20% less than the AHCCCS fee for service schedule. So why would we want to go play in that sandbox?

Female: This might be more for families, but you're talking, you know, like you said you might not want to contract with the MCO because it's so difficult. So right now a family may be very happy with the agency that is providing services for their child, but you're going to end up...it's going to be poor service for the families because all of a sudden their agency may not be able to service a particular person anymore because of who the family chooses. Because they might not have the contract with that MCO. Right now there's choice.

I mean, that was one of the positive things at the beginning. It's choice for the members, it's choice for the families, and they have a support, they can go to a support coordinator and say hey, I need this, can you help me. So on that model it looks like the members need to deal with these MCOs, but we already know—and I'm sorry that there's a little bit of a breakdown between communication of DDD and getting policy and changes out so everyone's on the same page. How are these families going to be able to cope with this?

Male: So let me give you an example. I have group homes. I have seven of them in Phoenix that I had to move from Flagstaff when Flagstaff raised the minimum wage to some insane amount. And so all my guys are traditionally from the Navajo nation. I have like four people that are not Navajo in my group homes. They had to move away from their land, their families, in some cases. Now to be honest with you, most of them were excited to go to Phoenix because there's a lot more to do there than Flagstaff, so I don't want to say that they weren't excited.

But in that example where I serve a lot of folks, I don't have a contract with Mercy Care. But what happens if we were to go down this road and I never get a contract with Mercy Care because I said bad things today and he doesn't want me to have a contract. [*Laughs.*] I'm just teasing you. So anyway, but let's say I never get a contract with Mercy Care. Well, I've got these guys that have lived together for 28 years, okay, in the same group home. They're a family. Whether they're biologically a family or not. And now, because I don't have a contract with a particular MCO, one of them has to move out? That doesn't make any sense.

Male: [*Inaudible.*] 01:27:33

Male: [*Inaudible.*] 01:27:41

Male: Yeah. Actually, I was going to ask our representative here today. I understand that in limited situations, like [name redacted]'s over here, that the MCOs or some of the MCOs could provide a limited base contract for individuals on a onesie, twosie basis instead of having a full contract. Do you know anything about that?

Male: Well, as in—yeah, on a case by case basis, set up one individual contract, single... [*Inaudible.*] 01:28:43

Male: Well, there's another distinction that everybody needs to get, and that is when MCOs, in some cases they're for profit organizations that work at the pleasure of their CEO and board of shareholders, and they're in business to make money, okay? So my concern about MCOs is that their motive is to make money. DDD's motive at the end of the year is not to have a fund balance in their line item, okay? That's not their motive. Their motive is to spend every single penny the legislature gives them. So I think we have to look at motives here. That's huge.

And then secondarily is—well, I'll let you finish that. I'm sorry. DDD's motive is to spend every penny they have allocated by the legislature on the members. So hard for me to say that word members. I hate it. [*Laughs.*] So the other thing is the safety net that's associated with services presently versus the model on the right. The safety net currently with DDD as a governmental MCO, they are part of the executive branch of government. They work technically at the pleasure of the governor. So if you don't like what's going on, you can call the governor. You can write him a letter. You can go picket outside of his office if you want. It might make a difference.

The governmental MCO known as DDD is funded by appropriations from the legislature. And so if you don't like what DDD's doing, you have all your senators and all your representatives that you can approach about your concerns about the way things are. Now contractually there are remedies built into the DDD contract. There are remedies built into the MCO contracts if members are not satisfied with the services they're getting. But in the environment that we have presently, there are mechanisms that you can complain to outside of the contractual remedy.

And so my concern when we go over to United Healthcare, am I going to write a letter to the shareholders of United Healthcare? Am I going to write a letter to the CEO? Is he going to take my call if I call? The governor won't take your call either, by the way. But the point is that I have mechanisms to achieve satisfaction outside of the contractual remedy. And that's huge. That's huge.

Female: [*Inaudible.*] 01:33:10

Female: [*Inaudible.*] 01:33:54

Female: [*Inaudible.*] 01:34:06

Female: [*inaudible*] 01:34:20

Male: For lack of a better term I'm going to piggyback on what she was saying. I've got, like I say, I've got a son in DDD and I also run the ranch. And I can tell you that there's nothing worse for you to tell me when I ask you a question for my son is I don't know. I'll get back with you. There's nothing worse than telling me that. I

start to levitate off the ground when you tell me I don't know because you're the authority, you should know. And so then for my parents to come and ask me a question and to have to say that is unacceptable. So there needs to be an education period before we do something like that. Turning on a dime will be unacceptable.

Female: [Inaudible.] 01:35:43 ...that's already not fun, so hopefully they'll really take into consideration our comments and look at the providers. You know, speech and language therapy, we can get jobs anywhere. Anywhere. And get paid well. So again, they need to really look at that. And we love working with our clients. We love them. And have been doing it for years. But if it's going to be so difficult to just get payment... And like I said, already with the two AHCCCS plans we have in place right now, it's been incredibly difficult. So have them look at that.

Male: I don't need that.

Male: Oh, really? Capture what I say. What I say, first of all, the governor does take my call, so if you need some help, let me know, okay? And [name redacted], better be careful. You're stepping on the third rail, man. You're stepping on the third rail 'cause a lot of these folks are also for profit institutions and profit motive plays heavy.

And I've worried about this MCO thing because they are going to make—and they have responsibilities, as [name redacted] said, to their shareholders and their owners. And that means utilization and that means rates. And they're going to slice it off both. And as you've alluded to, which prompts my brief remarks, this is so typically top down, going to your excellent—that's the wisest question of all. Now we all have our issues with DDD, but if it ain't broke, why fix it? It's top down.

And 30 years ago I'm at the state legislature going don't fight this Title 19 Medicaid federalization of caring for Arizonans with disabilities. They bought into it then and here's where we are. This is Medicaid money. This is medical insurance. You're not allowed to say day treatment at my place. You're not allowed to use that phrase. We're not treating anybody. We call it developmental activities for independence and integration. Just nomenclature. But that's where we got, and that's where we're going.

So you did ask what's the other solution? No one's listened to mine for a quarter century. DDD does an assessment, a thorough assessment, loads a debit card, gives it to the guardian, to the individual or their caregiver, the person and says here's a list of accredited providers, go have a good life. Go make the most of it.

Male: Well, all right. That's all. All right. Want you guys to come down to our shop. You guys haven't been to our [provider redacted] shop right here, one block away on East Ridge off of Navajo. You just go out to [redacted] Road and go right. It's pretty good. All right.

Male: [Inaudible.] 01:38:58

Male: [Inaudible.] 01:39:46

Male: [Inaudible.] 01:40:01

Female: [Inaudible.] 01:44:22

### Thoughts on Governor Ducey's Executive Order

Male: My observation is that I know the federal government gives the money to AHCCCS. That's where I come from, this, is it governmental driven, and that the [managers] seek state. And then it says they, the federal government says do it this way. And it seems to be dictated by them. And now we're going around and around with the situation we're in right now. And then the state pays into it, and it trickles down to the service provider.

All of a sudden we are alarmed by something is coming up, or by not even being notified. Back on the Four Corners area, we are like that, it seems like. We're a third party to hearing these situations, and where everybody is doing real good down in the valley. And I know when that... I was a part of that when the inter-government agreement was given to the Navajo nation, when the state, and it seems that all the service was available down here until finally, in 1994 or right about then, 1995, we seen services like this on the reservation.

Female: [Inaudible.] 01:46:00

Male: Right. And it's like... it's like we're barely getting services, and we're just barely learning from it, and then these new changes alarms us, hey, what's going on? And all these things are happening. So that's where we're coming from. You know, how can we refer persons back out into the community while they still live in [Ahokun], and no infrastructure, [no things] back home, you know? Like communication is poor, and hey, we have to run a vehicle. Now we're getting a new vehicle to run vehicles back to the home to pick them up to deliver adequate services into those account. And also that the service rate often continues, that why are we getting the urban rate while actually, geographically, we're living in the rural, in the remoteness of Arizona.

Male: [Inaudible.] 01:47:21

Male: I have thoughts on the executive order and for the work groups that have been put together as a part of the governor's order. So I'm worried about us making our response too big. And that sounds callous on its surface because what happened to this young lady was horrific and should have never been allowed to happen. However, we've had people in this situation in our system before and we've had people killed in our system before. This one got national attention and so now we have this big response. But the reality is that if these work groups come together and put together a huge protocol that needs to be followed, it's going to have to be funded. That protocol is going to have to be funded. No protocol without corresponding dollars for its implementation.

Male: [Inaudible.] 01:49:05

Male: Sure.

Male: [Inaudible.] 01:49:10 ...yes, this horrible incident happened, so now we're going to freak out and make this big blanket that everybody's going to have to adapt to when the reality of it is, is after all your work groups and after all of your stuff are done, you're going to bounce back to if jobs were done proper in the first place, this wouldn't have happened. So there shouldn't be funding and all this stuff for new protocols. Protocols are in place. I think DDD, AHCCCS, DES has to get their house in order before they can start making us get our house in order.

And once their house is in order, they can come to us and say okay, this is what we need to see, can you provide this to us. It's just like when they asked us to, when they sent out the whole schedule of when these...your company policies were going to have to be turned in, this one this month, this one this month. Then two weeks later they sent us back a deal that says forego that, we're going a different route. Get your house in order before you come knocking on our door. Then we'll be glad to, and you'll see more of a smile when we do these work groups, more than just a butt kicking contest for the whole day.

Male: I just want to talk about a potential response that could be costly to providers. And let's say that never, ever, ever is a member to be alone with one staff, that there always has to be two staff. Well, if they mandate that, they have to pay for it. Look at therapy. We're having a hard enough time getting therapists. So now a therapist has to have an observer in the room at all times? This could get ridiculous. If you think about the social workers that may or may not be involved in these groups, it could turn into something outrageous. And if it does, they need to recognize the dollars that are associated with it.

Now I don't mean to not protect our people. I've been doing this since I was 16. So I'm all for protecting our people. Maybe even overprotecting them. I overprotect my daughter, and she has to pay the price, because I don't let her have the life she wants. She has to live the life I want her to have. But it's because I want her to be safe. And I think that's just what parents do. But it's what advocates do, too.

Male: Ignorance and evil are going to happen no matter what you do. And the reality of it is being reactionary and Billy Kid in every situation, and shooting from the hip is not going to fix ignorance and evil.

Female: Okay, so I have worked on both sides, as you know. I did work for the state of Ohio and I also worked for the state of Arizona. I understand why the executive order is out, like everyone does. And I do agree with what [name redacted] and [name redacted] are stating also. I'm going to put on my government employee hat that I haven't put on for a while and I am going to say that I feel like whatever is decided and whatever training is developed, I feel like that training should be required of all agencies.

Female: [Inaudible.] 01:53:14

Female: [Inaudible.] 01:53:22

Male: Training and fact-based monitoring of that training, because I'll get a monitor who literally I have to call and appeal because they're saying in my opinion you should have. And this is not a world that opinions [matter]. It has to be fact-based, data driven, accurate information. And so I'm nervous about it.

Male: [Inaudible.] 01:54:23

01:56:21 [End of recording.]

## Mesa (East)

### What is Going Well with DDD LTSS?

- Male: I think sometimes this is unit specific, but there's a lot of good support coordination happening across the state, so we sure appreciate those units that are responsive and they are doing good things for the members.
- Female: I really like the new planning document, even though it's very long. But it certainly has been improved over years and years ago.
- Female: So we still really struggle with finding clients that need services but do not appear on the focus lists that are coming out, I guess, referral list. For speech, OT and PT we have a difficult time finding members that we know exist in the valley that need the services that we're not getting the referrals.
- Female: For us it's oftentimes families not showing up for services, and aren't being held accountable, but we are accountable for continuing to provide services for somebody who doesn't show up.
- Female: Therapy.
- Female: PT, OT, speech? Center based or home or both?
- Female: Both.
- Male: Just the variety of services available to our members. You got to conferences all over the country and when people find out what Arizona is providing it's one of the best in the whole country as far as the needs of the members, and particularly with AAC, there's nothing like it.
- Male: I think one of the best things that Arizona is doing well as it relates to the services is that we're taking Medicaid monies and not turning it into a medical model. We're doing it to enhance people's lives. That's what results in us making true outcomes and making people's lives better. Those dollars are matched, and two-thirds are federal, and we have to follow certain rules, but we've found ways to shove that square peg into a round hole and still get some of our costs covered as a state and produce amazing outcomes that are flexible and help us to meet people's needs.

### What Needs to be Improved with DDD LTSS?

- Female: Support coordination case loads need to go down.
- Male: Times 20.
- Female: Rates, especially with—well, in a variety of programs—but respite and hab. It's now closer to a minimum wage versus it has never been like that, so we don't get an appropriate rate for really any of the services.

Female: Well, I was just saying training for support coordinators.

Female: It's just that sometimes we get different answers for—

Female: Yeah, consistency.

Male: I'm [inaudible] 00:18:53

Male: I am. My perspective has come from—I'm a retired old man now, and a board member, but I spent 20 years in the most recent past integrating behavioral and physical medicine, and having family members qualify for DDD services. I'm looking at what's the difference between long-term care as a state builds a system—it's good Mercy Care is here—as we build the system, how do we match up long-term care with [chronicity].

The behavioral health side and the physical medicine side we talk about chronic conditions, and being an aged person, needing care from—I'm a lifelong asthmatic, use that example, from infancy. Now that I'm 69 years old I'm still asthmatic, I need care. And so how do we build the system to not be piecemeal, age related, and otherwise. How do we better coordinate with filling that triangle in with primary care, the support services, behavioral health, institutional care and otherwise. I want to see the system going to that.

I heard rates. One of the things that has struck me as I'm on the board at UCP, how do we provide speech, language and physical therapy and otherwise under an AHCCCS contract and get paid only 60 cents of the same service on the DDD contract? You can't make that work up on volume. So we're basically subsidizing the state with those services.

Female: [Inaudible.] 00:20:27

Male: Yeah, is there truly a difference in today's integrated model. It's called chronicity in the physical medicine and behavioral health, longstanding chronic condition. Here we call it long-term care. Can we do a blend? Can we make it work so that in fact we don't—I heard the gentleman talk about we're not going to make a medical model. I think if we're going to maximize the benefit of CMS funding all the way down we are going to have to comport to some of the things that in fact come with those federal dollars.

And better coordination in the physical medicine, behavioral health. When we didn't have families show up because it's just lost revenue, you've got a therapist that you're paying dozens of dollars, it's missed opportunity cost. And so we used family support folk that went out, blended that and support, and go in with that. And can what we learned through that system building over 20 years be applied over onto this side of care services, if you will?

And finally, training for support staff. The good news as a nation, we're fully employing persons. The terrible situation as a nation—and this is what we were

looking at in the behavioral health field—is we don't—and this is where I go into advocacy with the state and federal dollars—how do we get money to pay for our professional staff and get licensed, certified clinicians on board so they can direct and coordinate care, and then our support staff. How dare we think they should work for less than a livable wage with human benefits and support benefits that will support their families? So I'm preachy, but just know as long as I live and stay on a board, that's where I'm going to go with my energies.

Male: The rates to support staff at a livable wage.

Male: We think that we can go to a rural community... Because I have on the behavioral health side been with some adult SMI support organizations, we had a question asked in our organization, should we pay our staff in some of the rural areas out past Safford and elsewhere whose families had needs, a lesser salary and a less benefit package than we do in the metro areas.

Female: [*Inaudible.*] 00:23:04

Male: Because we can. And I'm going, well, isn't that just so unfortunate? A person, let's say, living down in Duncan, Arizona has the very same need as somebody living in Goodyear, Arizona. They need the same skill of staff members and training level. So why should we disproportionately pay and not skill up the southern [border] of Arizona community? It's part of my politics, part of my social justice stance, yes, but it's really system building.

Having now gone into a full Medicare system, I'm quite—there was a whole lot of work that my wife, who's a retired LCSW, and I should have been doing as we built our system because there's severe drop offs once a population moves into retirement age. I don't want to see it happen with my family members now with DDD.

Male: That all of the systems don't match, and thus there's not a funding mechanism. There can be a continuity of services. There's just not a pay mechanism and otherwise by not having fully integrated all of the delivery systems and the payment mechanisms. I think we're too encapsulated still.

Male: Every one of the organizations represented here is looking to recruit the very same woman or man in this community especially. That means we're competing with the public school system, we're competing with the local hospitals that are growing their own fully integrated staffing. Those organizations have much richer benefit packages than our organizations can provide. We can't possibly provide health insurance for our employee, yet she or he can't afford to cover health benefits and other benefits offered by other companies, their spouse and/or children. And so we basically make persons dependent on then a public supported system or FQHCs otherwise.

So we need to recruit staff. There's costs then to retain and train those staff and personnel. And what has worked over in private business, in manufacturing and

elsewise is you do that by offering a livable wage salary, you do that by offering benefits. You give job opportunity.

And so go back to my statement of long-term care or chronicity. My nephew is going to have a need, at ten years old, and he will have probably the same needs when he's 49 years old. And so I want to have personnel available, happy to be doing the work, living in the neighborhood close by, and that means we offer livable wages, good training, good staff retention practicums, and wrap it all together. That means that our agencies need to get competitive rates. The DDD rate schedule for clinical services needs to match what AHCCCS is providing, because you're offering the very same service.

Male: I'll let you catch up. You good to go?

Male: I don't know. So I suppose rates have already been talked about. Let me see how this teases out. In my organization we don't treat people. We actually give them a life. That's what we do. And part of my organization, I suppose, does treat people. So we have contracts with EPD MCOs and we serve people. Typically the services are near end of life and they're intended to keep them from being institutionalized.

And so I think one of the positives is that we've managed to take attendant care, for an example, and give somebody with a developmental disability a life because we offered this support so that they could be as integrated in the community as possible. Whereas some of my 92-year-old folks that are getting that attendant care, they're getting it as a component of help me to stay out of the nursing home, help me to continue to live in my home with my Chihuahua. So there's a difference in the way you approach those services.

Male: And I apologize because I'm approaching this as a dad also, because I don't ever want anybody to come in and treat my daughter, okay? I want my daughter to get a life, and I want people to hold her accountable, and I want her to be a positive, happy woman in society. That's what I want. And so when I think about these things, I'm not just thinking about it as a provider. But the last thing...

We do a lot of work with United Healthcare and the last thing I would want is a case manager from United Healthcare in there trying to treat my daughter. It's not a treatment code, it's not a [hic/pic] code, it's about giving her a life and making sure she knows how to catch the bus, and do her own shopping, and get a life. Go on a cruise and maybe do whatever.

But anyway, back on the negative side for DDD, it all comes back down to rates. And I think unfortunately DDD can't... We used to have career ladders inside of provider agencies back when our pay was adequate. And we used to promote from within, and we used to have talent inside of agencies to write behavior plans and talent that used to could write amazing teaching strategies and make a difference for people. We haven't been funded to the degree necessary to have

those expertises anymore. And if you do, please hold onto them, because they're rare.

And I think another negative is that DDD support coordination doesn't know the difference between babysitting and habilitation. And I say that tongue in cheek a little bit because there are people out there that do. But generally speaking, the DDD habilitation curriculum that I pulled down offline has nothing to do with what's really happening in the world, because that's not what we're doing.

And so I think they need to understand, so many of them are so brand new they don't have an opportunity to know what habilitation is and how to teach people something, and all of the prompts, and the chaining, and all of the techniques that are associated with teaching. And if the support coordinator at least doesn't understand those techniques, then they're sure as heck not going to be able to understand our strategies when we talk about them. And that causes poor outcomes for consumers. I hate that word consumers, but it causes poor outcomes. And I'll let someone else talk for a minute.

Female: So I have one of each. Positive, DDD pays quickly, very quickly, if your spreadsheet is correct. So the negative is the "if" because it's such an antiquated system. There's so many possibilities for error, file rejections. Then you're waiting on your money, going through the process of getting the waiver when you shouldn't have had to do that in the first place. It's just antiquated. So they pay quick "if."

Male: So we talked about the vendor call process of getting new members. But sometimes it seems like there wasn't a lot of discussion with providers on how that new system was designed, because in our world we have a therapist that has a time slot available, and if we request that member and it's granted to us, then we have to provide services, but yet if they don't match up to the time slot available, then we're not able to. Because it's not like we have an unlimited number of providers available for any number of members.

And so it's almost like they didn't, when they constructed this new system they didn't understand how it works in the real world. And so there needs to be an ability to find out more information about the member before we commit to be able to...before we know. And even to talk with them to see if it's going to match up personality-wise and schedule-wise.

Male: Yeah, before—because once the support coordinator then sends us the authorization, then we can't send it back, but yet we haven't had any contact with the family yet. We don't know that it's even going to work for that particular member.

Female: So first of all I have a positive. I think that all of our agencies have amazing therapists, so when you look at OT/PT/speech, the majority of them are really doing their jobs because they love what they do. And so many of our therapists I know will rather go unpaid than to not give the service, so when there's a glitch in

authorization they take that chance that the authorization is going to come through like the support coordinator says it's going to come through, even though it didn't come through in a timely manner. So that would be a positive. On the negative side the prior authorization requirements that we are under in billing—

Female: We have amazing therapists, I think agencies, all agencies. And then the second, the negative would be prior authorization requirements that we're all under for billing purposes, the recent change in the requirements. And then I'd also like to say I would like to see teletherapy approved for our members across the state because I think we can do more in especially those outlying areas if we had the ability to do teletherapy.

Female: Yeah, and like five times.

Female: Sorry.

Female: Why are you apologizing?

Female: It's another positive/negative, though. So positive, families have a lot of options in terms of which agency they select. There really are a lot of agencies available to families. The negative of that is it's almost like DDD awarded a contract to anybody who asked and weren't really qualified to do so. At the last DDD therapy meeting somebody in this group of other agencies raised their hand and said why do we need a script, is that a requirement? And they basically said we have an authorization, I don't care about the script. And that's obviously not—

Female: And furthermore with that, no one is checking in on the agencies and making sure that everybody is doing what they're supposed to do. So I'll receive an evaluation that I'm supposed to create a care plan, and the goal is two words, literally two words. And when that went to a coordinator who's not necessarily qualified to do that, but no one is holding that agency accountable for this lack of documentation, and then I have to fight for a new auth for that evaluation. So again, no one's holding an agency accountable for—

Female: Yes.

Female: More so.

Male: I'm going to apologize if I sound too negative. I truly don't. I think I come from a different culture, so it's a language issue. And I think this gentleman and I are really talking about the same thing. I don't provide care. I want life enhancing benefits for everybody. Some of the language that's being used well in the full integration of services is how do the managed care organizations, how does the federal and state government, local community government address social determinants of health. And so when we're looking at how does one get life skills, ride the bus, how does one have housing and shelter and SDOH.

Male: Yes.

## What are the Solutions for Improvement?

Male: I guess I'm struggling with do we have to do negative and positive when we talk about how do we better system build.

Male: I'll wait and you'll hear it again, yes.

Female: Mine is the customer service center, it's a good and a bad, the DDD customer service center. When I call people on the phone they are willing to help, and they want to help you, and they're great to work with. But my negative on it is usually when I get a solution it's already been fixed myself by—

Female: It takes too long. And I—

Female: Just anything with the customer service center, yeah. It's billing—

Female: No, as a provider.

Female: Yeah, okay. And I understand what they're trying to do at the customer service center but it just seems like it's just another step in the way to get your answer. It's like, you know, you need an answer to something right away, but it just takes so long that, you know, it's frustrating.

Male: I'll just ditto on that customer service. The gals that are there—typically gals so far is all that's answered for me—and they don't know anything.

Male: I don't think that's their job to know, really, stuff, but they just like need to know the departments. Like when I say hi, I'm looking for [name redacted]'s number, I can't seem to locate it, they can't find that. [*Laughs.*] Where is she?

Male: Well, I know she's retired now. She's on her Harley right now. [*Laughs.*] But anyway, I just think they're a little bit aloof. And I have the same problem with...we just implemented a communications center, so I'm not being critical, per se, but it's just constructive criticism. But the reason I wanted the mike was to say we have a problem with backdating of auths, and that needs to not happen anymore.

Male: One more thing. And I get auths for people I don't know who they are.

Male: [*Inaudible.*] 00:40:17

Male: It should never happen. Because one of the metrics we're going to be measured on, that we're already being measured on, in case you don't know, is how fast you can get people into service. And so when they backdate an auth 14 days, you're already out of compliance. You have no way to fix that. And they're not using the little date you enter in Focus, and they're not using the date you click "I accept the authorization." They're using the date that the support coordinator put in as the start date of the auth, which I think is crazy. It should be the date I accepted the auth, because maybe I have decided not to accept the auth.

Male: Yes.

Male: But I just went down that road for the [clinician].

Male: The reason I'm standing again on SDOH is it will do what this gentleman and I are both talking about. If we can use those federal and state dollars to in fact do other necessary things. I'm aware of a situation once where we did a liver transplant on a kid, sent her home with all the immunotherapy and otherwise to a family that didn't speak English with no electricity in the house, so we lost that youngster and we lost a good liver. So with money that could pay electric bills, that can put a roof over houses, buy a refrigerator, that's called part of the SDOH formula using healthcare dollars to do these necessary supportive services to make one's life well, not give treatment, but to make one's life well.

Male: Absolutely. Why I say [it with the] coded language is that's [language] being used to treat hundreds and millions of [inaudible] 00:43:12.

Male: So as far as authorizations are concerned is that we need to get... We're being evaluated as a...what's it called? We're being evaluated on getting people into service within the first seven days, timeliness of service delivery. So we can't have backdating of auths. That has to stop. And if there is a reason to have an override it should be at the highest levels of DDD. Yesterday I said [DDD leadership; name redacted] [should have the authority].

Male: They need to stop. And some suggestions for improvement on that are that they use the date that the provider accepted the auth because that's when we made the agreement to do the service instead of the start date of the auth. And if they don't want to use that date, then they need to use the estimated start date that we're required to enter when we accept the auth, because there's an estimated start date field you have to fill in when you accept an auth. And I think either one of those is better than the start date of the auth.

Male: Is there a requirement that [inaudible] 00:44:44. How will that [integrate] with what you're describing?

Male: [EDV] is mandated, and they will know through the aggregator when you started service, and they'll be able to do those calculations much faster and much easier. But moreover, they're going to know how to... They're going to have real time—the goal is to have real time non-provision of service data. So for people that do hard scheduled services, if that service was scheduled at 2:00 on Tuesday and you showed up at 2:15, technically AHCCCS and DDD will know that you were late to the ball game here providing the service. Which is going to be interesting.

Male: [Inaudible.] 00:45:31 ...prior authorization.

Male: Well, it won't because the authorization is about payment. The only distinction would be that if the authorization had a start date of 4/11 and you attempted, in the EVB system, to do the services on 4/10, there's no auth to hit for it. And

secondarily, you know, it's going to show if you started on 4/25 that you missed the seven day.

Male: It's a little out of the scope.

Female: Just utilizing the Focus system more. If DDD had the ability to put all the documents that we needed on Focus, so the script, the recent eval, progress report, ISP, it would really help improve continuity of care and timeliness because we're no longer waiting for five different things, it's all accessible to us right when we get that authorization.

Female: Yes.

Female: Could we each have our own rep that we talk to? That would be awesome.

Female: *[Inaudible.]* 00:47:09

Female: Yeah.

Female: Yeah.

Female: I know there's some flexibility with this right now, but not a ton, and I know we're [DDD] working towards it, but in terms of therapies, just more flexibility with being able to co-treat, because that benefits a lot of our kids. The groups, being able to have more than three and reimbursed. Or if we're not reimbursed more, make the requirements different, because if we have to do a progress report for every single kid, but you're getting paid less for every single kid, therapists, there's still as much paperwork, but they're getting paid less. So maybe formulating a different plan for social skills groups, which our kids really, really need.

Female: It really depends, because some of our kids that are more dependent need a lower ratio. Some of our kids who are less dependent, you could have six kids for one therapist, so it all depends—

Female: Dependent on—

Female: Exactly.

Female: In regards to the staff shortage that we're all experiencing, I'd like to see some different arrangements or models for the IDLA daily service to allow more than one agency to provide that service, kind of like the co-treatment where you would be co providing the services. And I've done that for HIA and it's working out fantastically. I'd like to see that with the daily rate, the HID.

Female: *[Inaudible.]* 00:49:24

Female: There is already a current code for collaboration of care, so being able to use that code so we can attend the ISP meetings and collaborate with everyone on that

team and be paid for it. In addition to letting hab providers get paid while they're sitting in our sessions to see what we're doing in speech and OT so they can actually follow through with the home program accurately.

Female: Yeah. And at ISP meetings, and to have hab providers to be able to get paid while attending therapies.

Male: On that, it allows double dipping. That's basically what you have to say, is allow double dipping.

Male: So with that, particularly in rural areas, where there aren't a lot of therapists available for the members, being able to go into some schools to provide some therapy for kiddos that otherwise they're not going to get. There's no room in schedules. And so there's only 12 hours a day a person can work, and so if they're able to... So for DDD to allow some exceptions to go into schools to work with kiddos that aren't receiving therapy otherwise.

Female: Can I ask a clarifying question? Are you saying go to schools and not have the member present or have the member present?

Male: Provide the therapy at the school for the member.

Female: We want to capture it. [They] are going to see this report.

Female: I would also like to see a separate billing code for feeding so it's separated from speech language, so it could occur on the same day.

Male: I give all the credit to [name redacted] from YEI in Prescott for this. Have a credit card for services and have truly member directed services.

Male: Debit, sorry. Not a credit. So in other words, let the families choose what they need from a menu.

Female: I know this was already said in one of the negatives, but holding families accountable. When it's a free service, they do not think another second when they have a vacation or something else going on about even telling the therapist, hey, I'm not going to be there today, they just don't show up. Multiple, multiple times. And we are required to hold that spot, but they aren't required to come.

Male: A co-pay. Someone was telling me in another state that if they miss it's a \$50, just like when you go to the doctor, you miss an appointment, there's a fine for missing that appointment.

Female: But also just having the...for one, even just during the meeting having the coordinator tell the family that you're required to go, helping them understand that they have to participate, because there's no consequence for not participating. They know that we can't do anything about it, and the support coordinators know that, because they're the ones who don't release the auth. And so there's nothing

even expressed to the family that you're at risk for losing the spot or whatever else.

Female: And we're required to keep that auth out there [*inaudible*] 00:54:09, so yes, I'll offer you a time but I'm not going to sit here until 5:00, and so letting families know they're going to lose the time.

Male: So just on this topic, I believe you might want to check the rate methodologies for therapies because I think there's a productivity adjustment for missed appointments already built into the rate. Not that the rate is adequate, by any means. But I want you guys to be armed, so read that rate methodology, because I think it's in the productivity adjustment. I wanted to say fully fund DDD rate rebase. No 25% of the benchmark, or apparently 73.

Male: The first one.

Male: Not the minimum wage one.

Female: This idea was discussed many, many years ago, and that was to develop a member handbook. And I don't mean the one that's already out, but kind of to go along with some of these things, appointments and your code of conduct, your expectations, your consequences if this doesn't happen as a family member. And even though you're given the handbook that says what your responsibilities are to accept the services, families aren't reading that.

And if you go a little bit further into depth of what the services mean and more of the ins and outs of how to use the services most effectively, I think that would go a long ways to help the families appreciate the services that they're getting, and it kind of gives them more ownership and engagement. And I know that would take a lot of time to develop that, but it was talked about many, many years ago. I remember that, at a provider meeting. And it never went anywhere that I know of. And it would probably take a lot of time to keep it up-to-date.

Male: In Focus it would be helpful if the waiver PDF was, you were able to choose an Excel spreadsheet to download that to instead of just being a PDF because you can't search, you can't plug it into any formulas to try to make sure that all waivers are where they're supposed to be and auth start and end dates are...

Male: Or CSV.

Male: [*Inaudible*] 01:05:47.

Female: No. Just because we don't plan today, you're welcome to take a picture if you need to.

Male: [*Inaudible.*] 01:05:54

Female: You're right. And you're welcome to take a picture. Any questions about the health plans? Yes, sir. I'm coming.

## Thoughts on Alternate Service Delivery Model

- Male: Will we, if we're an HCVS provider now and a qualified vendor, will we be required to contract in addition to that with these managed care organizations?
- Male: I just don't know if it's the right time to make this distinction. We've had a lot of trouble getting families out to the meetings. Last night was an amazing meeting in Prescott, just by the way. [name redacted] did an awesome job. But they're getting confused on this topic because at the same time they're getting letters about this thing that [name redacted] just described and they read it and they think why do I need to go to these forums? It sounds like it's a done deal. So providers need to reach out to your families ASAP and say yeah, that letter you got, you need to pay attention to it. But these forums are so separate and a whole 'nother thing. People are getting confused because of the timing, so providers need to know that. And since this is a provider forum I figured I would say that.
- Male: So will the MCOs or the insurance companies provide some kind of support coordination?
- Male: And what would that requirement look like?
- Male: So is the discussion that the MCOs would provide a similar or identical support coordination service?
- Male: They'd have to follow the guidelines.
- Female: So is this any different than the model that was proposed prior and then they took out the QVA?
- Male: Further explain the three year, right now the three year—
- Male: Okay, but you're saying the right side could be brought into the current contract.
- Male: Okay, that's what I was asking. It would require a whole new RFP.
- Female: So one of our biggest concerns when this was in the RFP process previously was that the member would not necessarily be able to keep their current therapy provider. That's still the biggest—
- Female: Huge concern.
- Male: Is the idea that there would be still some DDD services to certain members that still would fall under the old model, to have a support coordinator?
- Male: So I consider myself pretty involved in the process to not have this implemented on the right-hand side, and the biggest concerns, unanswered questions at the time were continuity of care for the member, who would be able to provides the services, if we were going to need a contract with the MCOs, what the rates were going to look like, what the billing was going to look like—

- Male: Okay, sorry.
- Male: Billing, authorizations. Waivers. The whole process. And specifically the aug comm situation because how the RFP read, it looked like that current payments for—like when we bill United Healthcare, or Mercy Care or whatever, current payments, those same structures would kind of carry over, and that would have essentially destroyed the augmentative communication division because the payments are, the rates are vastly different than... No one could provide—so the concern was no one would be able to provide the services at the current rates, the market rates, outside of what DDD is currently doing.
- Male: Trying to piggyback and echo on this gentleman's. So if we build a system starting October 1<sup>st</sup> that has prior authorization, claims adjudication, other processes already in place and then we jackknife and change that system, how do the providers look at building their own internal structure to do the building properly. And then what I've been hearing over the last few months is that there are new quality management standards that are being put in place by DDD today. Will those change, and then the MCOs [QM] standards that will apply to what their whole AHCCCS and Medicaid, Medicare lines of business are today? Will we as DDD providers comport to those new quality standards and outcomes measures?
- Male: If the MCOs will overarch, and that's the new standards that, a medical record review, a chart review will comport to them to justify billing. It's called that golden thread.
- Male: October 1<sup>st</sup> will every provider under contract October 1<sup>st</sup> with Mercy Care then have to comport their medical records and their billing systems to meet the quality standards as in their manual?
- Male: I do, too.
- Male: It might happen October 1<sup>st</sup> either way.
- Male: No, I get it. Let's change it by timing. So today there is a quality management model that DDD is applying. Come October 1<sup>st</sup> an agency will go under contract with Mercy Care, just as an example, or United Healthcare. And possibly both, because they may have members that have chosen, and so the smart agencies will contract with both. Then does that mean their medical record, that agency's medical record in their billing system will have to comport to the quality measurement standards that that MCO has for all their physical medicine, behavioral medicine and elsewhere? Which are basically cascaded down from CMS. So that's October 1<sup>st</sup>.
- Male: But if that's the payer group and you're going to get payment, you better use their two and a half chart audit.
- Male: So you're working on a bifurcated [different] system.

Male: Different standard.

Male: [Inaudible] 01:21:37 ...because so...so maybe it would be helpful for you to kind of put on a provider hat and how is this going to look different for us, because that's, I think, what's confusing.

Male: Okay, so that's...okay.

Male: Yeah. So I just wanted to make sure, because that's what I understood it to be. Our contract would now go through with Mercy Care and United Healthcare. It wouldn't be through the DDD—

Male: The right-hand column, if they went that way.

Female: So I just wanted to make a comment, and I'm pretty sure that you're already aware of this, but I wanted to make sure that it got captured on the board. I think the biggest issue really is transparency. You have folks on both sides of the system who really want to do the right thing for folks with disabilities, but how do we make sure that it doesn't... I think we've really positioned, as a provider, in a really reactive stance because there are a lot of unknowns, there are a lot of unknown questions. And I'll give you an example, not to pick on you.

Female: So I apologize. But as an example, in theory, I think that you could do an amendment and add long-term services into the contracts. So it's those kind of questions that providers and families and individuals want to know the answer to. And I know they're hot button questions where it's real hard to kind of answer that, so there might be some value really in sitting down doing frequently asked questions and some answers, and maybe soliciting information from providers and families to say here's the mailbox, send them in.

Because I think if you can allay some of those anxiety and concerns, I think it would be a much better position for folks to actually get together and work on the system because the system's changing whether we all like it or not, so we have to be at the table to really talk about what that's going to look like. And so I just wanted to say that so you can put transparency on the board.

Female: I know this was already mentioned, so I'm just going to repeat it. When the first RFP came out my first thought was wow, am I going to stay in business, and am I going to be able to contract with the varying MCOs, and are they going to contract with me. So I still have that concern even with the model on the right-hand side.

Male: So my biggest problem—I'll let you catch up. My biggest problem with this whole idea is that United Healthcare and Mercy Care, and [Centene], and whoever else might be interested in being an MCO in Arizona, they're for profit organizations, and they're in business to make money for their shareholders. Now some of them might not be for profit, I'm not sure, but I know the one that I currently work with is. And they only pay me 90% of the AHCCCS fee for

service schedule. So first of all, they keep 10% of the work that I do through that MCO right off the top for no explicable reason other than profit motive.

And they're in business to make money for their shareholders. You know what DDD, the governmental MCO, is in business to do is to spend every dollar that's allocated to them by the legislature for services to our folks. And if they have a fund balance at the end of the year, that's a bad idea. I think [name redacted] makes a really great point, that we have to figure out a way to make sure that what we're doing inside of DDD fits into this medical model, and we can make it conform to what we have to do to draw down the federal money because there's no way that Arizona wants to pay for these services out of their own pocket.

So my point, for profit versus not-for-profit, is a big deal. It's something that should be alarming all of us. And then second of all, I've been doing this kind of stuff since I was 16 years old, and I feel like we've worked really long and really hard to build a pretty amazing, flexible system to serve people. It's no accident that we rank right up there at No. 1 every year, year after year, with the measures that are compared nationally. And I think that, in many ways, is to the credit of Arizona building their own system from the ground up. So don't take our unique method of getting this done and achieving high level results away, because I don't think that United Healthcare, or Mercy Care, or any of them gets to share the same statistics.

Male: I'm concerned that the outcomes won't be the same. And I'm not talking from an uneducated perspective, because I have contracts with these same people, and quite frankly, if it does happen, these people will just transition under my existing contracts with my MCOs and I'll continue to provide the services, hopefully at the same rate, hopefully with the same quality of service. So there's some point at which I don't get to control this, but I'm going to fight like heck to make sure that this doesn't happen because I don't think they have the same motive.

Male: [Inaudible.] 01:27:55

Male: Because—

Male: Because DDD answers to voters, right, the legislature. We as a people get to be involved in that process where we don't with the MCOs. And the other problem when the RFP came out is the billing side changed their Medicare waiver process at about the same time, where we now have to bill Medicare instead of getting a waiver. And contractually, our contracts say that whatever Medicare pays, that's what we have to accept.

And so all of us that were involved—and they rolled it out kind of agency by agency, and you didn't know when all of a sudden they were going to stop denying your Medicare waivers. And so we saw firsthand pennies on the dollar of what we normally would have received from DDD and now were receiving from Medicare and we're being told you're stuck with that rate. And so that just sent

shock waves for every vendor because if that same thing is going to happen with the MCOs, then yeah, then we're all out of business. And the members suffer.

Female: And the members don't get services.

Male: Yeah, those kids—yeah. So the members, in the end, are suffering because we can't provide the services for them anymore.

Female: I'm going to date myself a little bit. I've been in business 15 years, and so I got on board when the qualified vendor process opened up in 2003, right? So before that—and I've already said that I'm a parent, and my daughter's 36. She's had services since she was three, so I've had DDD services for 33 years, so I've seen a lot of change.

So when the qualified vendor process opened up, I had experienced difficulties with finding quality providers to care for my daughter, so I decided I was going to do something about that and become a qualified vendor. So at that time I really liked that the fair and equitable rates came out because it was fair across the board to all agencies, and that allowed more choice for consumers. So if we're going to this other model, are we taking away some of those choices and we're going to backwards?

Female: I guess I just wanted to ask, with the changes that are going on, how will this affect the DDD support coordinators' jobs?

Female: How many DDD support coordinators do we approximately have?

Female: So that's how many might be affected if they—

Female: So I have two things. One, I think it would be really helpful if DDD could look at all of the questions, concerns and issues that were raised at the first RFP when we had a Q&A open to us and we blasted them with all of these questions, lists and lists and lists of questions and concerns, because if you look back to that, you'd find all of these questions plus a whole lot more.

Female: [*Inaudible.*] 01:32:10

Male: They didn't answer the questions.

Female: No, they didn't answer them, for the most part, but... But all the questions should be available someplace for DDD. And then my second thing is you made the statement that Arizona is nothing new, that we're just going in the way that other states have already been. But if we look at those other states—and I've only looked at Iowa as one—it went really, really bad for the members in Iowa when this transition took over for the LTSS services. Members did not get anything good out of that.

And I really worry about members and us as providers, where that goes if we're going into the same sort of model that these other states have historically already

gone into. We need to learn from those states what worked and what didn't work so that we're not there. We are doing something great in the state of Arizona. We are No. 1 in that area, and it's like the only area that Arizona wins. [Laughter.] We've got to stay there. We can't go backwards.

Female: One of the previous issues was transparency, and families were not really given adequate information about this. And so I anticipate when they try this again that they will attempt to do better. However, I still don't think that DDD sends things to parents in language that everybody could understand because I'm still interpreting, assisting, reading things from DDD for families, and so I don't really think that it goes across all education levels. And even for somebody who has a decent education level still doesn't quite understand what these changes are and how it'll impact their family. And so I do think that DDD or whoever, MCOs, need to do a better job at explaining that to families in language that they can understand.

Male: So as providers, nobody else is going to do it, so we have to make sure that our families know about the links. If any of you are [APAB] providers, you received an email that has links to all the other states that have done this and how it's going. Iowa is one of them, and it is bad. So we need to do that. But the comment I wanted to make was we have... I forgot what I was going to say. It's because I was thinking of something else. I don't remember.

Male: You know, getting old sucks.

Male: Could I ask an off the record question?

Male: I'm just curious is there anyone who is in favor of the right-hand side? Okay, so that's what I would like to [see], is if anybody sees the positive. I haven't. I would love for someone to explain how... Because I'm sure there are people [inaudible] 01:35:48 ...the members. I'm sure they thought it [was going to do more than] include the funding. And so I would love to hear somebody be able to explain how is it going to help the members, how [inaudible] 01:36:03.

Male: If I don't say it quick I'm going to be in trouble. We have a big problem in that we're asking families at this forum tonight to come here and give input on this model on the right and we're expecting them to be able to intelligently contribute to this decision. They're uninformed. And if I have any criticism of this process, it is that DDD can't say anything, Raising Special Kids can't say anything, so nobody gets to have an opinion, so they're really relying on providers to educate the families.

And so when I'm meeting with my families in [location redacted], and I'm sitting here going am I allowed to tell people what my opinion is? Well, yeah, I am. I'm their only resource. And if somebody else wanted to be a resource on educating families, then that would be awesome. But as best I can tell, I agree with you, there is no positives about this in any way, shape or form.

And I feel like the process, gathering all the stakeholder information, is flawed because parents are asked to give input, yet they're uninformed. And that's silly. That's a waste of [name redacted]'s time. And yours, too. But I just feel—and of our time. I mean, we need to be educated. The families need to hear the pros and cons about why we should go down this road or why we shouldn't. It seems like a whole lot of work.

Female: Parents don't even know why we have to ask their further insurance. They fight us on it. Well, I don't understand why you have to [get the] insurance. So you're right, they don't even understand the system. So to ask them, they're just going to look at this and the system [under stake] and they're going to be like I don't know. And so you have to give them the pros and cons. You have to. They can't make a decision otherwise.

Female: Okay, so I was actually raising my hand. I do think that there are some potential benefits, right? I do think use creates some systems efficiencies. I think when you look at the case management line for behavioral health for DDD members and you look at case management support coordination, so you look at both of those, in my opinion that's a huge duplication and that's a big chunk of change that really could be funneled into providing some of these unfunded, underfunded services that people really need. So I do think that there are some benefits.

I also think it really depends—and this is a personal opinion—I think it depends on who the health plan is and who the leadership at the health plan are. I do think there are some really good health plans with good leadership who really do want to do the right thing and are just as concerned as you are. But I think you have to have all those pieces. I think it's a much longer dialogue than maybe six months or a year. I think it will take years to develop. I think you have to develop relationships. I think that there are some benefits.

But if what you're trying to do as a system is to reduce those redundancies so you can create efficiencies, because you have to in order to keep serving people, because we're not just generating more money as a nation, and you know you have more people who are kind of joining the rosters, I think that there are other options that people haven't even looked at.

So, for example, I'm not sure—and not to volunteer anyone—but I'm not sure you couldn't take all of this and put this in-house under DDD. Why can't DDD be their own managed care and manage their budget, and have their behavioral health case manager and their DDD support coordinator be one and the same person? Because case management is a huge line item as far as dollars. So I think if you had just a blank slate and you could make it look however you want, what might that look like?

And I think unfortunately the system didn't start there with the conversation because the system really is pushing for integration because in other areas, in physical and behavioral health, it really is working. So how do we do what

Arizona does best and say hey, you know what, we're going to do something nobody else has done and we're going to make it the best system.

So I don't think the option to not have the conversation is ever optional. I just don't think that's on the table. But how might we create something pretty incredible. And I'm one of those people, I like to be at the table having those conversations because I think Arizona does an exceptional job. So I do have some good things to say about the integration. I do think there are some benefits. But you can't put out an RFP and say if you get it, I think we're going to do really well, and if you get it, not so much, right? It doesn't work like that.

Male: [Inaudible.] 01:41:16

Male: How many of us have said we would love—like when the vendor call thing was changed, like was there a provider at that meeting to give the feedback so that we could improve the system? And so I guess let's record that, is let's have a bottom up conversation and include all involved parties.

Male: Yes, thank you.

Male: Multiple.

Male: Can we add another thing to that?

Male: Uh-huh. Move TPL billing from providers to DDD.

Male: Somebody that has secondary insurance. We have to bill their insurance first and get an EOB, a denial, and so since DDD is the payer of last resort, it can take six months before I finally get paid for those therapy visits. And so as a therapist you're probably more aware than me. And so the point I'm making is that why can't DDD just pay us timely and let them go chase down the secondary insurance. It's not my problem. [Laughter.]

#### Thoughts on Governor Ducey's Executive Order

Female: So this is near and dear to my heart because my daughter was assaulted when she was in high school, and I learned at the time that she didn't know to say no. I'll cut through all the red tape and the little stuff, but eventually what I did is I put together a relationship awareness for individuals with developmental disabilities workshop. That was back in 2001, 2002. And I presented workshops around the metropolitan area. I even presented it [name redacted]'s team at DDD in the hopes that maybe this would become a service or something that DDD would implement.

That did not happen, but I continued to provide the workshops. And I got a copyright on it. This is something that I feel very strongly about, that if my daughter had been taught how to say no that maybe the incident would not have happened. I think that there's a lot of individuals that can be taught this kind of

thing. It starts from not just a review of sexuality and what happened at [provider redacted], going that far, but it starts at a lower level—

Female: Okay, well, I did. So it starts at a lower level where you have to teach them how to say no, you teach them about boundaries, relationship awareness, how to dress, how to talk, how to have relationships, and then you kind of raise the bar a little bit and go to other levels. That would be something that I would recommend that the work groups consider. I'm working with a couple other agencies to kind of spearhead this. And again, it's something very near and dear to my heart, and I'm all in about this.

Female: Yes. Let me say one more thing. Yes. And so you're teaching not just the individual themselves, but you're also training staff, because some staff have really hard times with boundaries, because they want to be the friend, they want to be the whatever, and so you've got to teach staff also how to approach the individual with touch, and boundaries, and personal space and all that. Because we all work together, so it has to be not just the individual with IDD.

Male: I know these work groups are going to come up with all kinds of suggestions, and some of them will be implemented. And my biggest concern as a provider is that there's going to be some suggestion or some change that's not going to be funded. So on this list, the governor and the legislature and all the powers that are considering these suggestions need to make sure that there's dollar signs tied to what we have to implement. Whether that's never having a client alone with somebody—imagine if a therapist always had to have an observer in the room, and they had to pay somebody to cart along with them. That would double your cost almost. And so they can come up with all kinds of suggestions, and who knows what's going to come up. I just want it funded.

Female: Yeah, what is there... I don't know the quality, because we do therapies, but I don't know what the quality management is of some places.

Female: Yeah.

Female: Aren't there already?

Female: Yeah, there you go. Just like the therapy providers, enforce it.

Male: [*Inaudible.*] 01:50:35 ...I mean, I have no problem with very strict penalties for people that abuse those with disabilities. You've got to protect them most vulnerable.

Male: I guess to sum it up, don't go overboard, or don't overreact. I would hate for some of the freedoms and the lifestyles that our folks currently enjoy to get horribly altered. I love [name redacted]'s suggestion of training. If my daughter had had it a long time ago lots of things might be different. So just don't go overboard is my cautionary note.

01:54:50 [End of recording.]

## Phoenix (West)

### What is Going Well with DDD LTSS?

Male: What are we doing first, what's going well?

Male: Well, I'm speaking obviously from the perspective of our agencies. The referral system for the division is done like no other state that I know of, and we have operations in Colorado and versus those states the referrals, you really have to dig and scratch to find them, right? Whereas here, in Arizona, the referral system is really good.

They put them into Focus and you can respond. As long as the [originators] put the relevant information, like the availability and all that. I think it's a good system at least to see the landscape of how many referrals are pending. The other couple states and several states I know of, they don't have a system like that where they really shoot out referrals. We get calls every day from DDD about people waiting for services.

I also think the system is...you know, people from New Mexico and even Colorado, they move here because of the services. We have people that have moved from our agency in New Mexico to our agency in Arizona. So there's definitely, you know, a lot of our members, they do get a lot of services, usually. Sometimes maybe they're, you know, at times we see patients that we attempt to discharge, and they—

### What Needs to be Improved with DDD LTSS?

Male: Yeah, well, they don't need the—well, in our opinion they don't need the services, but here's a negative. They end up back on the wire, right? You do a discharge and... I own a couple agencies here, and we've done a discharge on a member, and next thing you know, my other agency picks it up. So I think that the whole discharge process definitely needs to be improved.

But the biggest negative I think for us is that the division has trouble communicating with providers. I think that the pilot, the therapy pilot is a pretty good example. I'm a member of AAPPD as well, and we had a couple folks from DDD come in and talk about the pilot that's going to happen to therapies, and it's not a bad idea. It's actually, I thought it was very...it definitely has positive benefits. But during the provider meeting that we had a couple weeks ago it was poorly explained, so a lot of providers left the meeting feeling what is this pilot, what is going...? They just didn't understand a lot of it.

And then my second negative has to be just the, unfortunately, the turnover of support coordination. It's not... You know, our software, for example, it links onto a support coordinator and it'll auto email secure emails to them for quarterlies and stuff like that, and evaluations, and a lot of times we find that they're not with the division anymore, or they're in another department. So just

the turnover of support coordination is difficult for providers to constantly juggle. Support coordinators are supposed to be this case manager, right, that knows the child and... But the turnover is just vast, so it's hard to accomplish.

Female: Do you want a [common] one, or a controversial one? [*pause*] Okay, whatever I want. This is, I think, my third one of these.

Female: No, I didn't. So I'm [name redacted] with [provider redacted]. But this is like the third one I've been to. These are really poorly attended, and it's really concerning of me, because how many of you are just plain parents? You're not a provider, you're just a parent.

Female: Correct. So that's concerning to me that families somehow aren't getting the understanding of what exactly these meetings are for. So maybe it's a communication thing, maybe they don't open up the DDD website, because the box that pops up works really well. It pops right up. You can't get rid of it on the screen without reading it, so that part I like.

There's probably no state agency in Arizona that pays as well and as quickly—not as well in terms of dollar rates—but pays as well as DDD does. You turn in your claim, and if your claim is clean you're paid within four or five days, if you have direct deposit. There's probably not a state agency that pays that quickly. That part works well.

The service notifications that come out for referrals in the vendor call system works really well, but it's really dependent on a support coordinator to put in enough information, so most of the time when you see the notification you do have to send an email to the support coordinator and ask for additional information, even the cross roads, because telling me Phoenix doesn't help much. So there's still some education that maybe needs to happen, but I like that at least it's there and you can see it.

The improvements made to the system over the last ten years have actually done really well. I think that they've invested a lot of time, and money, and effort into putting some of their technology to be a little more interactive. The secure messages emails that come out from DDD when you need to respond to something securely works really well coming from DDD.

And maybe there's a spot that I haven't found yet, but there's not a way for a provider to just generate something in the system. You have to email someone to tell you to send you an email through the secure system so you can answer back if the one they originally sent you has expired, and sometimes that happens. They're only in there for so long and then they expire. So then you can't get back to that person, even if you drop back to the previous email. It just won't work. So I would like a way for a provider to just be able to start one from there rather than have to send an email and wait for one to come back. It works okay, but it's another extra couple of steps we'd rather not take if we don't have to.

Other things that go well. Talking to QAs, listening to QAs and actually talking, getting them on the phone and discussing things with them. They're really open to all kinds of ideas and suggestions, and I like that. I think they're feeling a little better in the last couple weeks than they had a month and a half ago. I understand that.

But they're really responsive. They're very open to whatever you suggest. They'll talk things through with you. I really appreciate the time and effort that they put in. And some of your QAs are really...have been in the field before so they know what we're talking about, they know what we're saying. Other things. Not a fan of being censored. I think that's a little on the socialism communist side.

Female: Well, we're always told make sure you let this information out to families. Well, you can let it out to families and talk about timeliness of coming to these meetings, but you have to send it to DDD to get it approved, and then they take my four paragraphs and cut it down to three sentences, and that's all I'm allowed to send out.

Female: Correct. When you have something time sensitive like these meetings, I can't wait 30 days for a family to wait for that notification. Your meetings will be over. So how do you do that? You can call every single one of your families, but man, I'm glad I'm not [provider redacted] or [name redacted] because you'd be calling 1,500 families or 6,000 families, and that's a lot of people to call on the phone when you don't have a lot of time to begin with.

Other things that are... Office locations. I like where DDD's located pretty well throughout the entire valley. It's pretty responsive. No matter where you want to go to a DDD office, you can find one pretty close by.

I just wish that some of the communication out to the families would have been more clear specifically on these meetings, and the slide that you'll come up on. I think there should have been a huge explanation to that slide, even if it was just here's what we're kind of thinking, or here's some of the discussion, or here's some ways we could do this. To put up a slide without an explanation as to what that means, most families will have no idea, and that's even if they show up to the meeting. So this is real concerning to me that this is very poorly attended by families.

Female: Where were you?

Female: If it's Tuesday it must be Cleveland.

Female: Good.

Female: Calling on the phone because [inaudible] 00:24:41.

Female: So [name redacted], you should have got your creative juices flowing.

Female: So a couple things that come to mind that we've heard from our members. On the positive side, DDD's staff understands the services that are being provided and understands that this is life care, this is not healthcare. They understand and have, I think, the same mission as a lot of the providers do of helping individuals be as independent as possible. They understand what that means and understand that it might take five years to get someplace for employment service, but we're going to get there in five or ten years, and we're not going to try and cut an individual off at a certain amount of time just because.

I think we hear a lot about the persons that are planning, that it's the member specific, the family and a team, and we hear a lot about that that's positive, that we should be supporting the member, we should be a team, the provider, DDD, the family, and that that's important for a lot of our providers. I think where we hear a lot of negative is the statewide consistency of implementing rules and policies. We hear a lot of frustration that certain districts might do something one way and another district [might do it a different way], and so trying to get that consistency, especially for some of our statewide providers is frustrating.

Male: In terms of going well, I would say that our relationships with the individual support coordinators is positive, and they're helpful and responsive. What I would say one level up, if there are issues it becomes very—this is a negative, by the way. I'm switching from positive to negative. It becomes very easy to run into some siloed thinking that all institutions do where they are willing to say as much as they are required to say and no further, meaning have you thought about this? There's not a discussion about exploring alternatives for the options or the issues that we raise. It's very by the book, black and white, and you can end up playing phone tag with several people for more of a complex issue.

And this would be in situations that are past the purview of a support coordinator. So that's a positive and a negative. So individually they are great, but if you have a complex issue, you run into not my problem, someone else's problem, and then actually it ends up being no one's problem.

I would say that because we work with individuals in IDLA there is a disconnect between the total vision of having individuals be served in an area that promotes their independence and their independent living skills while constantly putting pressure to minimize the hours of support in the IDLA setting. So it seems like it runs more by cost than actually looking at each person's situation and determining what's best for them.

So since we work with an audience that is all in the IDLA setting, it can be very difficult to demonstrate need because the assumption is they don't need regular care, which is, in our case we've had individuals living in our communities in some way for ten years or so, so we're very familiar with their situation. So that's a constant dance. And there's been some periods where there's been a lot of friction with the state about support hours.

Yeah, so I think somebody wanted to hint about rates, and so we're all waiting for that to return back to earlier directions. And I know that's a complex political machine, so in one way the DDD is just the front person for legislative policy. So I would say yes, the rates continue to be an issue. I would also suggest that I think some of the trade groups are excellent at providing ways in which partnerships can exist, because there are situations where an individual needs perhaps slices of services from different groups, so workplace, employment skills might be from one place, their living community is something distinct.

In my experience—and again, I'm relatively new with [provider redacted] at six months—I have not had the state play any role in partnership development or hey, have you considered talking to this group about these needs with your community. So in my experience it's been all on us to go knock and ask. And that's fine. And I know some of our trade groups are excellent at doing that kind of matchmaking. But it would make sense that the state might know, DDD might have the best awareness of who provides what and where, and how those different services could be added together to boost any one agency's capabilities. So that's what I have to share.

Female: I don't know if this is positive or negative, but I'm kind of happy to see that the division is maybe looking at some more creativity. I mean, that's one of our—

Female: Well, yeah, I'm hoping. I mean, I'm hoping that they take it and really do something with it because there's a lot of different ideas that are out there, but so many times it's just black and white and it's really hard. And with our members. Our members are creative, our families are creative, my staff is creative. And so being able to...we come up with the ideas, but it's always like ooh, how is the division really going to look at this, how is it going to work into that box.

Female: Yeah, that box. You know, it's one of the reasons I don't have any residential. I don't like any of the boxes. I'm not...it wouldn't fit in us. And then the only other thing is group supported employment. Again, it is... It's really... We do a lot of it. I mean, we're pretty successful with it. But the expectations and the real life scenarios are really difficult for all ends, for both members and families, and on [our end] as well.

Female: It's like, you know, I mean, it's kind of like one of those things. When you get a member and you sign on with them, they're yours. To discharge them isn't quite so easy. Even if they're not a good fit. It's not so easy to get them—I don't want to say get them out of your program. It's not—

Female: To release them. Because it's not the best fit for everybody. And so the real life scenarios when it comes to the workplace, you know, it's just the rules are a little different, and it makes it really hard to release them when it doesn't work.

Female: Overall the providers that we hear from in our agency, I think a negative is that the system is not properly funded, and that the 15% cuts that we received during the Great Recession, we didn't get that back. Inflation was cut out, never been

provided. And then you had the minimum wage. And DDD put out that we've only covered half of the cost to the minimum wage, and I think AAPPD would estimate that that's even less than that.

And I think that we need DDD to help us with being properly funded. And I know that there's political issues with that. But helping and being able to talk about what's actually happening out there and what is happening in the community and with services would be helpful so that members' legislators know what's going on in the community.

And I think with that the other negative is we have a direct care workforce shortage. A lot of our providers can't get enough staff and cannot get enough staff that is qualified. We are struggling to get qualified staff, and that's not appropriate for our members. They deserve qualified staff. And so help with that would be appreciated. I know I heard from a couple of our providers they'd appreciate if DDD would stop poaching our staff for support coordination. We know that we need more support coordinators, but we also need our staff. So we'd appreciate if DDD would stop poaching as well.

### What are the Solutions for Improvement?

Male: All right. Well, I'm going to talk about discharges because that's a major issue with my agencies. The best way to describe what happens is basically to give you a real scenario. So this maybe happened a month ago or so. We have a speech therapist down in Tucson, and a client that in the past I think it was 16 months had canceled or no showed 30 times.

And this person, this provider, who's a good provider, very on top of her game, shows up consistently when the appointment happens, and we are paying this person's paycheck and the division screamed bloody murder when I said we're not serving this person, this is ridiculous, like Article 21 violation. Everybody's got them, right? So there was like no understanding. It was like the division really did not hold the parent responsible at all for any of this.

And I feel like, you know, you have 30 plus cancellations and no shows, there comes a time where you have to think about the provider and their ability to make money and work. If people are canceling or no showing all the time, then they're not going to be making any money. So we don't get paid for no shows, right?

So I feel like the division really needs to play both sides of the fence. They need to hold parents responsible and not just kind of throw it all onto the provider. Oh, you have to provide these services. You can't discharge them for missed sessions. And then we're holding onto an authorization that we see this kid maybe once every six weeks, and then obviously with these new timeliness initiatives which are very bad for therapies, they will not work for therapies at all because there's a—

Male: Yeah. Just really quickly about that and therapies. This timeliness initiative that...I can see it working maybe for non-skilled services that don't require outside people involved such as a physician to get a prescription or in this pilot the plan of care. Well, actually the pilot would maybe solve the issue, actually, because we wouldn't get the auth until the plan of care comes down the pipes.

But in the current system the timeliness initiative does not work for therapies. You're at the mercy of support coordination who a lot of the times do not forward the ISPs to you in a timely manner. And we're not going to send a provider out to a home without the ISP. They don't give us the documentation from an evaluation or a quarterly report that maybe came from another agency, again, we're not going to send anybody out without proper documentation. And the authorization just sits in Focus. And support coordinators, at least in my opinion, are sometimes...sometimes you're struggling to get an authorization when you have all the documentation, but other times they are very quick to put it in. And obviously if you're using this timeliness it just doesn't work.

Male: So yeah, my suggestion for improvement. Well, to me—and again, this is just my opinion—the whole timeliness initiative is not... To me that doesn't measure value in a member proving services, or a member getting services. The fact that I can send someone out as quickly as possible doesn't really reflect how I'm going to, or the value in my services that I'm going to provide.

I can tell you that other states use surveys to measure value. And quite honestly, we could talk all day about this. In long-term care there's not a whole lot of research out there that value-based initiatives are the answer, because you have a child with cerebral palsy that's in the system their whole life, and they require a maintenance program, for example, for occupational therapy or physical therapy that's consistent, it's monthly maybe. But how do you...it's difficult to measure value, to me, in the long-term care space, and the research just isn't out there that I can find.

So anyway, going back, I think that surveys potentially could be providing a solution. It's something that maybe the family fills out and the parent fills out. Is this service of value, is the member getting value out of it. Not how quickly is an agency getting out there. And on the whole discharge thing, I really feel that the division just needs to look at having an even playing field. Having the families having some responsibility and not just saying, you know, sorry [provider redacted], you have to stick onto this referral.

Female: There's probably just a little bit of that also with day programs and group supported as well. We seem to have that problem a little bit with group supported. We've gotten real jobs, but the families aren't taking it very seriously that we have these jobs, and they really...we have a contractor. We have to fulfill that. So somehow getting the families and parents—I don't really have a solution for it, but—

Female: And I don't know, this is probably an AHCCCS rule, but—

Female: Yeah, of course. I mean, it is. But is there another way to take like, you know. I mean, there's a lack of support coordination, and there's always a lack of time for everybody. So is there a way to put something into process that it's not every six months, the meetings, that it's maybe once a year and something else is done through a different type of a portal, not taking up as much time. A better communication something—

Female: Yeah. I mean, it takes a lot of time, manpower. It takes a lot. And sometimes they're just... I mean, how many—and we all sit in them—so sometimes they're just a...it's just...it's a formality, and it's boring, and nothing's getting accomplished.

Male: I think a suggestion for improvement might be the right to try for providers to meet people's needs without being held to Article 21. Because we all want to try. Part of that speaks to something that needs to be improved, is that the division, I won't say everybody in the division, but sometimes the division has its own villainizing providers, like we're out to get something. And it bothers me when I'm second guessed like I'm trying to get away with something, or like I'm not trying to follow the rules or like I'm trying to discharge somebody without a valid reason. It's like...it's really disrespectful, and it's crappy, and it needs to be changed.

Female: One possible solution on those value-based purchasing authorization to first day of billing, one of the suggestions would be that there be a mechanism put into the Focus system where the provider can request of the support coordinator to now issue the authorization. I've got five students coming out of high schools. Every single one of those support coordinators want to put the authorization in the system today. They don't graduate for another four weeks. I'm going to tank my score.

A month and a half ago we had an authorization put in the system for a person to start in our program and their pump on their feeding tube broke and the pump that they needed to replace it with was back ordered, and they just started yesterday. I had no control over that. So often that score that you get isn't a reflection of the provider's ability to provide service. It either has to have an explanation behind it with whatever your score is, whether this was in the provider's control or not. It's almost more of a score of the support coordination for DDD than it is for a provider.

I agree that some kind of score or some kind of information about providers, information for service quality or something should be available to families, but dropping a score in there that they will believe, when I had no control over this. And so if there was a mechanism in there that I could now key in and say okay, ready for the authorization, please issue, but I'm going to do that on the 27<sup>th</sup>, 28<sup>th</sup>, 29<sup>th</sup> of May, because they start the 29<sup>th</sup> of May. I don't want it in the system right now. And I've got support coordinators who really just want it off their back and to put it in so they don't forget. I get that. But it can't be sitting in there for 40 days. So to me that's a problem.

Male: I just dealt with it two days ago. Electronic signatures. So I'm not sure what has happened or how the division...or why they continue to ask for wet signatures on quarterly reports, on evaluations. I mean, it's... And every time I respond to them, listen, I have this blurb that I take directly from the CMS website that has approval of electronic signatures. I believe AAPPD was involved in passing the electronic signature legislation. But yet they still continue to ask for them. And I just...I'm just wondering if a memo could maybe go out to all the division staff that it's... But does the division...what is the division's stance on electronic signatures then, I guess?

Male: Yeah, I mean—

Male: And it's not everybody. It seems to be...it goes from basically this particular situation that just happened, I tell my staff to just notify me whenever there's a coordinator that's requesting a wet signature on a document that we have done electronically. It seems to happen when there is a review process that a member has gone—maybe they got two hours of speech, for example, and they're going up for review, and it goes to the medical director, and then the medical director shoots it back saying there needs to be a wet signature here.

And then the therapy coordinator shoots it back to me saying the medical director is stating that there needs to be a wet signature here. And then I send my email with my blurb that I just copy and paste from all the other emails I've sent about this and I never hear from them again. So I just think that they're, you know, it just is something that just continues to kind of linger there that I really believe needs to be addressed, because most people are using an electronic medical record system that captures electronic signatures. And as a matter of fact, when we're on the cusp of going into electronic visit verification that will capture the, you know, everything. So yeah.

Male: Uncharacteristic. I would just add to that that the division is required to accept electronic signatures, so we've been very nice about trying to get a timeline for changes and systems and forms, but it's not really revisit the opportunity, it's revisit implementation of something that's required by statute.

Male: No, I know. I'm not trying to be grumpy with you, [name redacted], but... [Laughs.] But yeah. But I do think that that is an example of a communication issue that is frustrating for providers because you're making the argument at the field level repeatedly. And we get auditors, and it's like, well, what are the auditors trained, where's the audit handbook? So I would just say that generalizes to a much broader concern about transparency and communication, both internally for DDD and externally with providers and families.

Female: One thing I would suggest is putting the ISPs on Focus so you can just draw them down. And then the other item would be that when you submit an incident report that that incident report and its entirety be available to anyone in the division to read, because I do not think they actually see it. I think they get a spreadsheet synopsis of person's name, date, time, organization and fell. Because by the

questions we get on our QA inquiries, they could not have read the document. So I'm wondering if they don't see the whole thing, and if they don't, why can't they?

Female: So suggestion for improvement, proper funding. Full funding. Full funding. Fund the October rate rebase fully. How about that? I said October, not December. The first one. The first one. The real one, right.

Continue with the provider Shout that DDD has started. So AAPPD very much appreciates that. We'd like to continue to see that become more robust. On the communication side, it's having that consistent communication from the division to all providers. We think that's really helpful so we'd love to continue to see that become more robust. And then on the communication, there was some conversation about this. I don't know how to describe it.

But we have these district meetings that providers go to. The information that is shared in those district meetings is never consistent, consistently shared. So is there a way to have a website where all the information that is going to be shared for every district meeting is all in one place so that every provider can see all the information that's shared at all district meetings to help with that?

So, for example, there was a PowerPoint presentation that was provided at a couple of districts that deals with contract actions. That was not provided statewide yet. And so that information should be available to all providers. So there's got to be a consistent way to get that information out for everybody.

Male: Yeah, so I think it would be great to have these DDD provider meetings where there is a central place to go to find the information because I'll give you a really good example. Like I had District Central asking me for agenda items and then District South was asking me for agenda items. Well, they're the same agenda items.

And then just to comment really quickly about the meeting and the consistency, the therapy meeting that was just a couple [weeks ago]. There was, you know, almost just a...it seemed like they were, the people running the meeting, which are therapy coordinators and support coordinators, they didn't even really know a lot of information about stuff. They couldn't answer some of the tough questions, and they even had admitted that they just don't know.

So I think that prior to having these provider meetings, which I believe are mandated by AHCCCS, probably. No? Okay. That there is maybe a group, focus group with the coordinators and the people that are involved running the meetings that they prepare for some of the questions that come up.

And then one last thing. I hate to take all the time here. Last year what happened was very unfortunate. They basically had told all the therapy providers—and this is just something for improvement, I guess it's a communication thing—that you had to become Medicare certified. Yeah. And that was an AHCCCS statute,

basically. Well, it wasn't in the DDD provider handbook. They put it into the DDD provider handbook without really saying anything and said it was retroactive. And then there was confusion on what exactly that meant. Did it mean our agency, which is a home and community based HCBS agency needs to become a home healthcare agency, a proper home healthcare agency that is federally certified by Medicare? And there was so much confusion, and there were no answers.

And eventually we ended up certifying the providers through a very cumbersome process to get them as basically a non-Medicare provider so they could...so we could get a waiver, basically, for our services. So I just think that sometimes that stuff should be communicated. And it's probably coming from AHCCCS, obviously. AHCCCS says get your act together and then DDD kind of push out these things very quickly, and it catches us all like by surprise. And just adding stuff to the provider manual retroactively, it was just...I don't know. There was a lot of animosity around this time last year. It's gotten better, though.

Male: Yes, absolutely. I don't hear about it anymore.

Male: On the heels of what was just talked about, it seems like we should eliminate district provider meetings and they should be put on only by webinar from provider relations, one central point. The provider meetings should come that way. That would ensure consistency. It would eliminate the fiefdoms that exist in South and all the other areas. And everybody has to give a consistent message and they all have to follow the same rules.

Male: [Inaudible.] 01:02:29

### Thoughts on Alternate Service Delivery Model

Female: One of the things that we've asked is that all of the information that you've just explained goes to the providers as well because as a lot of folks have talked about in this room, families come to the providers with questions. And so we just want to make sure that all the same information is available to the providers so in case the family comes we know where to send them. We don't want to answer the questions, but we need to know where to send them, and we need to know what they're talking about, so I just ask the.

Male: So I don't know what happened at last night's forum, but four of our families called this morning asking for an agency that we would recommend since they're with Mercy Care and we don't have Mercy Care. Because they're trying to change their services between now and October. And it's like whatever happened last night they didn't get the message. I was there. I thought it was clear. But anyway, if four of my families called this morning asking that question, then I'm worried about all the other 30 or 40 people that were there. I don't know if you can send a blast to those email addresses on that group.

Female: Maybe it would be helpful if the division would release a statement that we could also provide to our families that is consistent with what you're telling us so that we can also give the memo to the families that may not have email, that may not have a correct address on file, that we can give to our providers to inform the families so everybody is on the same page.

Male: *[Inaudible.]* 01:13:11 ...are you saying that LTSS will not be fully integrated in the managed care contracts for at least three years?

Male: Okay. I've heard some conflicting information.

Male: From the division.

Male: This is the first one of these meetings that I've attended personally, so it sounds to me that the division is regarding these meetings as stakeholder input on a fully integrated model.

Male: Okay, thank you.

Female: *[Inaudible.]* 01:18:24

Female: I'm going to bring up the issue of why are we fixing a system that's not broke. I think the system needs improvement. I think having a meeting like this and talking about solutions such as webinars and putting ISPs online that we can download are great suggestions, and they're things that we can build on in the future, but to totally throw the entire system out and go to that model is pretty scary to most providers because we keep getting information and we keep getting email blasts regarding their healthcare plan changing, which frankly affects almost only 10% of the entire AAPPD nation. Most providers don't do physical therapy, occupational therapy, speech therapy because for most of that it's always been kind of the healthcare plan's responsibility for doing that, especially when they're children.

So it looks to me like you're trying, like it's going to get thrown out when there's nothing broken about the system. It needs improvements, but even that system, if you implemented it, would have a massive number of improvements. It's concerning to me that a healthcare plan that deals a lot with acute types of care, keep bringing up the healthcare plans to us when that's not where we live. So that tells me that they really don't understand us.

That, to me, is a huge red flag. And I'm not so sure they're going to understand the chronic nature and the lifetime nature of our services for most of our folks, because they may only get to volunteering for two hours a week and they're in a day program the rest of the time, but that might be the max for that person to do. And I don't think they're going to understand that. So it's quite concerning to me.

Male: This is my favorite topic. *[Laughs.]* Yeah, to her point, the system as it is right now could definitely use some tweaks, but fundamentally it works well. We have

the best system in the country. People come to the state for this system. This is the privatization of Medicaid. And when you privatize Medicaid, who gets cut? Obviously they make money, they need to make money. They're a private insurance company. The cut is always passed to the provider, always.

And you just have to do a quick Google search of the privatization of Medicaid in other states and it's not going well. It's not going well at all. Texas has—I encourage everybody to follow this page I follow in Texas. It's called, on Facebook, it's called Texas Fragile Children. Now Texas was very irresponsible with their Medicaid program, okay. But they have privatized it and services have been cut, rates have been drastically cut. Iowa is another example. Same thing. Virginia, same thing.

The privatization of Medicaid is burdensome to the provider. A lot of these states, in Virginia, I think, they complained about there's pre-auths, for example, every three months for habilitation, respite, equivalent in home support services for long-term care. Right now we work on a system where our authorization are yearly, for the most part. The administrative burden, along with the rate cuts, would...you would see mass consolidation in the industry because people would just—it's already happening down South.

In the behavioral health model, there's already mass consolidation from the privatization of Medicaid. I think there were two huge, large nonprofits that had to join forces in order to stay afloat in that model. And right now everybody's on an even playing field in terms of reimbursement rates. And when, in this model of privatization, there's no level playing field unless they are going by the fee for schedule AHCCCS rates, which they don't, unfortunately.

So I really think that—actually, you can just look at New Mexico. New Mexico is a prime example. They had their DD waiver program on the chopping block, similar to us last year, and they ended up keeping the DD waiver with the Department of Health in New Mexico. And one of the main driving forces behind that—and I know you have an office in New Mexico, I think—[provider redacted].

I don't know if you're familiar with [provider redacted]. But there was...it was a disaster. [provider redacted], they fired their CEO. They screwed up all the quality control that has to deal with very medically fragile patients and they ended up kicking them out. So I just think that this model of long-term care belongs with the state. Like DDD is doing with the QA, they subcontracted that out, or they're going to. There's an RFP possibly, I think. You probably can't speak about it, right? So—

Male: Yeah. Yet to be determined. But I guess my point is that there's certain avenues to potentially, just shooting from the hip, subcontract out stuff that may be weaker. Maybe that is support coordination, I don't know. But to remove the fundamental nature and the way the system works would be such a drastic change, and there would be cuts to both providers and services, unfortunately. That's my take.

Male: I think we're already seeing what, more than just reimbursement rates or contracted rates, this will shift the risk that the insurers traditionally carry onto providers. And so the current Article 21 revisions are already beginning to do that. You will be involuntarily assigned members who you don't get to, to use the insurance terminology, individually underwrite.

The system we're currently in was built on not only member choice, but provider choice. None of us are large enough to actuarially take on the risk of saying we'll take anybody you send us at this price, or that price is going to have to be really high, a lot higher than it is now. So my concern is not only are the private MCOs going to need to cut costs in the rates, but they're going to be in the position to shift the insurance risk largely onto the providers.

And I think you're absolutely right, [name redacted]. I think the only logical outcome of that is going to be consolidation. And as former Director [name redacted] told me, he said I don't care if there are three or four providers in the state, as opposed to the five or six hundred that the system has become accustomed to over the years. So yeah, let's log those as some real concerns about movement toward one of the proposals that's on the table.

Female: I think my biggest concern with the new model is the authorization portion of it because I have worked on the other end where it's just the Medicaid members versus the long-term care members, where we have to go every three months and get 12 sessions and then be denied by the medical directors at the AHCCCS plans because it's not deemed medically necessary, or they've had too many visits that year.

So is that going to jeopardize our members on getting services, and are we going to be cancelling services, putting them on hold because we're waiting for the AHCCCS plans to respond to our auths, getting the additional information. Just the manpower alone managing those auths is a huge financial burden for any provider, because you have to up your admin, and you're working ten times harder to get additional information. So that's my concern.

Female: Therapy.

Male: Well, [inaudible] 01:28:13 admin.

Male: It'll up everybody's admin because you're dealing with multiple insurers, not just one.

Male: I've been bringing this up at each meeting, but I think we have to look at the motive. I mean, insurance companies are in business to make a profit for their shareholders. I don't expect that Mercy Care or United Healthcare or Banner or any of the traditional MCOs that we currently see here are going to function like DDD. They're in business to make money. And DDD is in business to spend their fund balance each year. And so I contract with United Healthcare and Banner, and they don't give me the published rate. They give me 90% of the published rate.

Banner gives me 95% of the published rate. Is that what I'm to expect in this scenario? It's B.S.

Male: For therapy it's even... So we also contract with United Healthcare and Mercy Care. Some of the rates are fine. But other rates are 10% of what the AHCCCS fee schedule is. Ten percent. And do the math on that. You pay your therapist \$40, which is the going rate, pretty much, for an assistant in the DDD world, and you're getting reimbursed 20. Ten percent of the AHCCCS fee schedule. So there would need to be a... I mean, I just don't see how it's possible. It would wipe out services overnight if they kept the current rates that we get.

Female: Well, do you remember that positive I told you about how quickly DDD pays? [*Laughter.*] It took my medical plan, dental plan 94 days to pay my dentist for a cleaning. And I'm waiting in the 11<sup>th</sup> month for wedges for a person's wheelchair. And I don't know of a provider that can go a year without getting paid.

Male: Wait for him to catch up. The current plan that we have that was built by advocates and families and providers, what we enjoy right now is an amazing system of service delivery that offers flexibility. It allows choice. It allows for the division not to overpay or underpay for services. It's a unique model. It's the, I think, only one of its kind in the nation. We consistency score really high, typically No. 1, in most metrics when you compare outcomes for dollars spent. It's stupid to think about abandoning a system that we worked so hard to build.

And that's just the bottom line. I have some group homes and I don't contract with all the MCOs, so these guys that have lived together for 23 years, if one of their families decides upon the MCO that I don't contract with, are they going to have to break up that family and that person's going to have to move to a different group home that has a contract with that MCO? That just seems kind of silly. So anyway, that was my last.

Male: [*Inaudible.*] 01:32:50.

Male: Just on the...just because I have this agency in New Mexico, so I'm constantly thinking their model versus our model. A lot different. We have what, 35,000 on the waiver? They have 4,000. And a huge waiting list, yeah. Their waiting list is like 13,000. However, they just passed legislation to move 600 of the waiver in New Mexico, or off the waiting list into the waiver every year, so definitely some positive stuff going on in New Mexico.

They do something, though, that I find to be helpful. It probably wouldn't work in Arizona because there's a lot of different software programs and we built our own software, and I know probably a couple people in here built their own software. But they use a software that actually, the physician, the entire team is part of this software. So basically they use one software. But what it does is it's kind of helpful because since the entire team, case managers, the PTs, the OTs, the directors, the physicians, all of them have access to this one software. So what

that provides is almost a team-like, much more streamlined plan of care team approach. And it does great there.

So I think that's kind of what's missing in Arizona in terms of this integrated model. It's more of a team-based type of approach. So I think if there was like, even if you could upload documents to Focus, you could attach different documents that this member has in order to get like a full picture. ISPs uploaded into Focus, and doctor's notes and all of that, so you could have this continuity of care in this industry that is largely home based.

So people are scattered out across the valley. It's an urban sprawl. It takes 30 minutes to go to the grocery store. And it would assist providers in just knowing more about that individual. And I think that's something that DDD should look at. Leveraging Focus more. I think you could put anything in there. You could give the parents a log-in. The parents could upload stuff into it. Doctor's notes. And I think that would just improve care and get everybody on the same page. A lot of the times people aren't on the same page in terms of the care. My OT, or Wheels on the Bus's PT, they never communicate. Ever. So having a way to share information better. So yeah.

Male: Just some continuity of care.

Male: Yeah. [*Inaudible.*] 01:36:32

Male: Thank you. Anyone else?

Female: So AAPPD never took a position with the initial RFP came out, so I just want to start with that. We have no position on good, bad or indifferent. But we did have a lot of questions come up last year, and so there's a few other things that have been raised today that I just wanted to put on the record, I guess. A lot of our members were concerned with if you go to an insurance company that's running the coordination of care are they really going to understand the difference between healthcare and life care? Are they going to understand how, that we're moving towards independence, that we're trying to take care of individuals throughout their entire life.

There is a difference between traditional healthcare and this system. And there was a great concern that an insurance company could not treat our members and our population differently from acute care. There was also concern that was raised last year that—there was a lot of comparison last year between our members and the elderly. And so again it goes back to they're not the same population. Are they going to understand how to do that? And there was a lot of concern that DDD knows how to do that and an insurance company does not.

There was a lot of concern about provider choice and about member choice. When you have a couple of MCOs, what if your healthcare provider is on the MCO, your acute care provider or your behavioral health provider, but your group

home is not? So now you're having to make a decision between do I want my doctor or do I want my group home.

What if, within the group home, as [name redacted] was talking about, I have three or four members in the group home, two have chosen one MCO, the other two have chosen another MCO, how does that work within that model? How does that work for the provider? How does that work for the families? And there was a lot of concern about choice, and that folks wouldn't be able to choose who they wanted.

Male: I'm actually parroting [name redacted]'s statement from Prescott. He made a distinction which is worth making Insurance companies are used to treating people and we don't treat people. We give people a life. We help people get their own life is more accurately stated. And I don't think insurance companies are into getting people a life. They're engaged in treatment. There's procedure codes and it's about a procedure, it's about treatment. And this isn't what we do.

Female: I'm going to be real quick because I would just echo what both of you have said. Those are major concerns for us as well. Yeah, medical model versus an independence model.

Female: So one of the things that came up in the JLBC hearing that you mentioned was why are we doing this. The question was asked and if I recall the answer correctly, it was I don't know. Is there a cost savings? We don't think so. Have you studied this? No, we haven't. Is there going to be a study done more specifically like they did with CMPD, the foster care folks?

#### Thoughts on Governor Ducey's Executive Order

Male: I think I've heard from a number of providers and I agree that it would be nice with respect to training issues if we had a sanctioned curriculum, because it is such a loaded moral and political set of issues that it's going to be very messy if we're training different things at different agencies.

Male: I'm concerned about how big this [can become] and [inaudible] 01:45:57 ...work groups. ...coming into a burdensome implementation for providers. But recognizing that the public expects something to be done, I would insist as a provider that every bit of it be 100% included in my rate. For example, if a client is never to be alone with staff, imagine the cost. Two people on every transport, two people on every awake at night. Two people bathing, two people changing, two people doing everything.

Male: You have to have a third in the house.

Male: It would be incredibly expensive. Every therapist having two people in the room every time. But anyway, it could explode into something that absurd. I doubt it will get that absurd. But that's just an example. And there are going to be many implementations that are going to cost lots of money.

Female: Just a thought. There is a power that's within APS, CPS to substantiate an allegation at any employer or employee that can take them out of this field for the rest of their life, and there's very little recourse, and there is no set of statutes that provide them with credentialing types of criteria to make that determination, so there's not a guideline they have to follow.

This is a subjective opinion. And once it's issued, it's almost impossible to reverse, in which case they've even substantiated that someone being present in a home, just being in the home, had nothing to do with this person, this client being served, but was just present in the home attending to someone else contributed to a person's death. And it's a grandmother who also does in home support for her grandchild with a developmental disability and they have taken away her entire life. That's pretty powerful, and there's very little recourse.

So my concern with this is we're going to have a lot more of these substantiated determinations even if there's no proof to back it up because the burden of proof is different in an APS thing, much like a civil suit compared to a criminal suit. Shadow of a doubt does not exist in a civil suit. It doesn't exist within APS and CPS. And I'm not saying we shouldn't proceed with people who actually do abuse someone. I want them sent to jail, I really do. I'm just saying that when it's not the case, how can someone who is in a home just being present get that slapped on them and they lose their entire career.

Male: Thank you.

Male: I wanted to add one more thing to suggestions for improvement. And that was move TPL billing to DDD.

01:52:30 [End of recording.]

## Flagstaff (North)

### What is Going Well with DDD LTSS?

- Female: What's going well is that we haven't lost the entire provider network in Flagstaff yet.
- Male: *[Inaudible.]* 0:15:01 ...what [name redacted] and I have seen, we've seen it go from kind of a group of people who were just kind of mixed up and didn't know what they were doing. The left hand didn't know what the right hand was doing. And now, more and more, they're starting to get on track, and they're starting actually to listen to what we say in the meetings. Which before, it was no, it's my way or the highway. And that now they're starting to be a little more understanding, and listen to us. Because [name redacted] and I are pretty vocal about what we think.
- Female: Well, and one thing, yeah, one thing I would like to say is it does seem like everybody is more on the same page than what used to be. I'll save my other comment.
- Male: I think one thing powerful about the way the long term care system works, at least related services, is that the family has a lot of say in the IFSP and the direction they want to go. Services aren't always available, they can't always get what they want. But it is an important part of that process and I think that's important.
- Female: It's not directly with the long term care supports and services, but as part of the executive committee of [AAPPD], the provider association, I feel that the dialogue that we have with the management, the leadership of DDD has improved greatly and is much more transparent. And we really appreciate that.
- Male: I think on a national level, Arizona is looked at as a model in a lot of ways, as being a very efficiently ran Medicaid program for its members. its cost per member is significantly lower than any other state's. 600+ providers, you have a nice make up of big/small, rural/urban, for-profit/non-profit providers. you have some diversity there for families to choose from. So those are a couple things off the top of my head.
- Female: Several years back, it seemed like you'd go into one meeting with a family, and the support coordinator would be saying one thing, and then you would go into another meeting with a different family, and a different SC, and that person would say, no, no, that's not how it is. There seems to be more continuity between what they're saying in meetings. And I think education is going on within the division to make that happen. Which is better for agencies, because we go into a meeting thinking this person is going to be on the same board as everyone else.

### What Needs to be Improved with DDD LTSS?

Male: You know, every time we go into a meeting with a client, and it's – I mean every 90 days I think we have an Attendant Care Sheet we have to fill out. You know, there's a lot of redundancy in the agency. the agency, they could just get a lot thinner in what they're doing if they thinned out a lot of the redundancies that we're doing. We go into a meeting, and we're having a meeting, it's like why are we having to do an Attendant Care Sheet whenever we see, they see the client, we see the client every 90 days. And so –

Female: And we're seeing the services being provided.

Yeah, and we're seeing the services being provided. To me there's – that's just one example – but there's a lot of things like that.

Female: The other thing we've seen in meetings – and we're parents, so we kind of can relate to the parents that we're in the meeting with – is depending on the Support Coordinator, they're coming in and they're putting a lot of pressure on families without really listening to the family. Such as, well we're going to reevaluate in six months. We just had this. And the family's like, well what about a year? My wife is under a lot of pressure, why is it now six months? And there's nothing saying it has to be six months, but this SC was really, really pressuring this family. And as parents, that's really hard for [name redacted] and I. Because families are under a lot of stress. You understand this. So –

Male: That's why we attend the meetings that we do with all of our clients, to make sure they understand, and that they're treated the way that they should be treated, rather than trying to be bullied into something. And sometimes that does happen.

Male: A couple things. One initially is, I feel like sometimes, especially over the last five years, the division probably feels like they're watching a tennis match. On one side, they're getting direction from AHCCCS, because that's who they have to respond to. And on the other side they're getting concerns expressed to them from the division. So they're going back and forth a lot of times, where I think they're wondering where their allegiance lies. And my solution that I would offer to that is I think there needs to be more collaboration, where network providers, institutional memory of the Arizona network, DDD staff and AHCCCS are in the same room collaborating on issues that can benefit the members.

Male: I think part of it is the outgrowth of AHCCCS trying to get DDD to act more like an MCO, and be more like an MCO, and walk and talk and look like an MCO. And I think some of the challenges is that the Division and AHCCCS and the network providers, all with institutional memory and knowledge of the network, would be better served if we could collaborate between the triangle of the three of us. I think we'd be in a better position to continue to enhance the supports of the members.

[Inaudible.] 0:22:48

Male: Yeah, DDD, AHCCCS and network providers. There's a lot of very smart people in this room that can lend itself to some wonderful ideas for AHCCCS and for the Division to consider.

Since I have the microphone, I'll throw in another concern that I see. I think that there's a growing disconnect between the care plan process and the rate reimbursement structure. And the answer isn't just more rates. Or higher rates, although that is an issue for some services. But I just think there's an inherent disconnect between the two, and they kind of stand autonomously. And there could be a bridge there, I think. Between the rate reimbursement structure and the members planning teams. Yes ma'am.

Male: I'd just like to piggy back on that. I think there's a big issue with DDD and AHCCCS, again saying one thing, but then the health plans really not being as transparent to the families about what the powers that be are saying to DDD. And so it's great to see that Mercy Care is here. I'm wondering, is anybody from United Health here? Because I think that's where the powers that be ultimately are going to be the health plans that put pressure on DDD to either cut costs or send notice of actions for denials. And I think the solution is really to be open and transparent with families about what health plan is involved, and then what the health plan is telling DDD. Instead of scapegoating it to DDD.

[Inaudible.] 0:24:52

Male: And I'm speaking more from the related services realm. But where I've really seen a deterioration in the amount of services requested, or provided, is in the extreme rural areas. Mostly Navajo and Hopi reservations for us, where we just don't get those requests any more. Oftentimes Support Coordinators will say, well they have services in school, so they don't need services at home. Things like that. And it's been probably five years, where we used to have a pretty large presence on the Navajo and Hopi reservations. We really, for DDD, we don't do anything any more. We're out servicing kids in the schools, but that connection just isn't there any more. And it's really gone down hill quite a bit.

[Inaudible.] 0:26:40

Male: No, there's not even been – if you look, we have vendor calls for Kingman, we have vendor calls for Flagstaff, Prescott. But not for the Navajo Nation or Hopi. There's one, I think in Dilkon right now. But you know the families just aren't really, I think, aware of the services. I think the number of Support Coordinators out there has gone down quite a bit. And so even when we try and help families step through the process, it's really hard for them. Because the Support Coordinator can live 200 miles away. So it's really decreased a lot what's available out there.

Female: A couple of things. What's going well with DDD, I'd like to comment that the Support Coordinators are very vested in the clients. I see them having a lot of

pressure from above, but I do think they're very loving, and I've seen that increase over the years, recently.

One thing I've noticed on what needs to be improved is the audit process. We got a call last year from a DDD office and said, we're going to be there Wednesday to audit you. Two days. And we're like well, can we set a day and time and have a little bit of a notice? Like within a week. But when she came, she said there was a lot of pressure from AHCCCS, and that they had to clean things up, and that was kind of the push. So I think from an agency standpoint, I realize an audit is to come in and check and we always do very well with ours. But that was a lot of pressure. So I think better timing. And it puts those people on the spot too, the auditors.

Male: It's kind of like they think, well your schedule's not important, you're going to operate off of our schedule. And the thing is, we have appointments with clients and stuff that we had to try to keep, or try to shuffle around. But instead, we convinced her to come a few days later.

Female: And they're always very nice when they come. But I think AHCCCS putting pressure on the Division has caused some of that too.

Female: I have a few things. I'm [name redacted], I'm a 28-year special education teacher, and I've worked in 75 schools throughout northern Arizona. I've worked with [name redacted] and I know [name redacted] and a few people in the room. So I need [name redacted], he speaks so well, to put that in layman's terms. And then, layperson's terms.

And then the rotating door with the Support Coordinators. I run into parents all the time in the community, and they're like yeah, we've had – we haven't had the same Support Coordinator for a year, in over five years. There's no way they can actually get to know a person with that much turnover.

The medical model is very frightening to me. DDD, I was told in the spring forum a couple of weeks ago, that DDD is a managed care organization, which is frightening to me. The social model is really going away, and that doesn't serve the human being. And I know this has been an issue since a long time, but people with intellectual disabilities on the mild to moderate level, if they're not long term care, they get nothing. And so someone said in the meeting, oh they get case management. Well they get nothing. They get no support in the community. If they do not have a family member who is taking care of them, or getting them into the community, they are getting nothing. And I said, just send them straight to Corrections, because this is just the pipeline for that. You know that's true. I hope. Okay. So back to you, [name redacted].

[Inaudible.] 0:31:16

Male: Well I think over the years, ever since we got into the Medicaid program, but in particular over the last ten years, there's been a much stronger effort, for lack of a

better word, that AHCCCS is placing on the Division, to walk, talk and act and move like a true managed care organization. And they've struggled with that. And we've struggled, as the network provider, with that as well, and their adjustment. It goes back to my tennis reference, that they are going back and forth trying to build a provider network that meets the needs of the members while still trying to be and comply with and provide encounter data back to AHCCCS as a true MCO, and that creates some challenges. And I think the solution to that sometimes is that collaborative effort between the network providers, AHCCCS representatives and the Division to be in the same room at the same time, since we all are contractually obligated to each other to CMS. There might be some really good opportunities for that.

If I may, on another issue, would be QA/QI would be the same thing. I really think that there's a significant opportunity for provider network, AHCCCS and the Division to thoroughly assess the QA/QI approach to network providers, including incident reporting and fact finding inquiries, and all of the stuff that goes with that. So that we're all on the same page and we can build the infrastructure that will at least mitigate some of the incidents that we see in the network, and build capacity for all three entities – AHCCCS, DDD and network providers.

[Inaudible.] 0:33:20

[Inaudible.] 0:33:27

[Inaudible.] 0:33:41

Male: So one of the issues we have as a related service provider is the – right now we're actually in a good spot. We've been able to hire, we have some staffing for PT. IT looks like OT might also improve. But as everyone knows, it's a chronic shortage, especially in rural areas. One of the problems we have is there's tons of vendor calls in Flagstaff even, right now. But to pick up DDD clients, we know, we're going to try and provide services for as long as the family wants, usually is what it comes down to. And the issue is we know we can provide services now, but we're not sure what will happen down the road. And we often run into issues with that where families and DDD will expect us to continue services for years, which can be beneficial, but at the same time when we have therapists leave, they become very upset that those providers aren't there any more. So now that we're in that good spot of oh, now maybe we can pick up some clients, it's also kind of a negative thing of do we really want to do that, because what happens if someone leaves, or has kids or retires.

Female: Just that there doesn't seem for providers, a way for us to end services.

Male: The process is difficult. There is a process, but the team process is difficult, to get both sides to agree.

[Inaudible.] 0:35:45

Male: Discharge planning and maybe looking at incidents of care, I think is a popular term for it, where you're working on a specific goal for a specific period of time. That it isn't an open-ended we're working forever. And we've been working on that with some families as we pick them up, to make them understand what we can do right now is choose this goal and work on it with you for six months. And I think that can be helpful for the family too, because they're realizing it's not just a service that will go on forever, but it's a service we're here right now, we can help you with these things. And it can create more involvement on the caregiver part too.

[Inaudible.] 0:36:33

Female: I actually have three things that I wanted to bring up, but I'll wait till she's ready. Yes.

Female: You know, there is an assumption, an assumed antagonistic relationship with a lot of DDD employees and providers. You know, we're the bad guys. And it needs to be more collaborative. We're all here for the same thing, and I get really upset when somebody assumes that we hurt a client on purpose. Oh yeah. We're doing the best we can, given our funding and resources. So.

Female: No, but. [Laughs.] I'll wait.

Female: Yeah, and you know I don't have a specific suggestion to fix that, but it has to come from the top down.

Female: The second thing that I wanted to talk about was the funding and the costs in Flagstaff especially. Flagstaff is not considered a rural area, but it certainly is much different than Phoenix or Tucson. And that's not really taken into account in the rates. And the whole minimum wage issue. I understand it's a political issue. But our clients and their families don't get that. This isn't directed at you. And we're being – I hate to use the word punished – but we're just barely, we're not even barely eking by. We're failing. And it doesn't seem like anyone believes that. I've invited people to come look at the books at [provider redacted], and see what it is we're facing, and nobody's taken me up on it. All we hear is, well we can't give Flagstaff too much money, because the people across the street – meaning the legislature – will be upset. And minimum wage isn't the only thing. When you increase the minimum wage, all the costs in Flagstaff went up, and they were high to begin with. So our housing costs are horrible now. I think it's 140%, I think, is what I've heard, of. Yeah. Of the average. I'm not sure if that's national. Anyway, certainly want to stress that. And I would hope that the Division would be more of a partner with the providers in advocating for adequate funding. Because it's not anywhere near adequate right now.

And the third thing I had, which is fixable, is communication. So as an example, yesterday I asked a Support Coordinator to change the start date on an authorization, because it was eight days before we actually started. The Support Coordinators and the Supervisors didn't know anything about the new value

based purchasing initiative, that requires that providers strive to serve people within seven days. So they were refusing to change it. Why wouldn't they know about that? That's something that should have come down from the top. I just think that we need to improve a lot of the communication to Support Coordinators. Maybe it goes through too many channels, I don't know. But it just isn't getting to where it needs to be. And also then, communication from the Division to providers. You know, if it weren't for [AAPPD], we wouldn't know very much at all. So that's important. But the Division has provider meetings up north. They seem to think that, like Havasu or wherever, Kingman, is next door to Flagstaff. So we only end up going to one. And I brought up the suggestion before, we have teleconferencing at DES. We use it for RSA all the time, why can't we use it for the provider meetings?

Female: Well, I don't know. [*Laughs.*] Every one of them.

Female: It did. [*Inaudible.*] 0:41:58

Male: Firstly, I do understand that it's complex, and I know that there's legislative requirements for DDD to make changes. I know there's also policy requirements, and those can be different. But one of my recommendations for solving the communication and sort of the blocked pipes if you will, because we still come across so many time where nobody can make a decision because the right people aren't there. And so my suggestion would be to give Support Coordinators and Regional Supervisors more autonomy, and be able to make and approve decisions, as it relates regionally. That would hopefully involve some rate increases when a certain, specific region requires it. Or certain additional supports like extra staff, or compensation for transportation, when it requires it in their specific regions.

Female: This is kind of as parent thing, but also kind of as an agency thing. For example, [aug comm] devices. My son's breaks. I take it to DDD March 18<sup>th</sup>, it sits there. Not only I had to get a scrip now, saying it needs to be fixed, I had to get a letter from the speech therapist saying that it's used across all environments. That had to go to Phoenix, they didn't like the facts of the letter so I had to get another letter from the speech therapist, send it down. [Name redacted] didn't get it until April 11<sup>th</sup>, so I checked on the repair, and they said, well before we can repair it we have to send the invoice to the state, and then that has to get approved before we can even start a repair. So my point is, what needs to be improved in that aspect, is there has to be – these are individuals that can't speak. They need their device. [Name redacted], you can relate to this, I'm sure. There has to be a quicker way to get that person help, because it's been two months almost, since I dropped off the device, and it still hasn't started repair. So I would say expediting, and going back to the comment of giving SCs and their bosses more autonomy. That's something that where, when it leaves the local DDD office, they should say okay, this is going in, it can get fixed, we're approving it from the get go.

Female: I guess one of the big issues is to incentivize the, I think the gentleman over here said incentivize people serving the rural communities. When I was at the Able

360 Health and Wellness Fair last Friday, the actual line for a lot of these insurance companies, they say they serve Arizona. They say they serve the ten counties below Black Canyon City. And the map actually shows it that way.

And then I met a kid yesterday in a wheelchair at FMC, turns out he's 13 years old, he's from Holbrook, he's been waiting 11 years for his in home therapies. And as a teacher, knowing how we used to work so collaboratively with DDD as a day provider. I attended meetings that the families of my students wanted me to attend and vice versa, we always had a support coordinator in the school at the meeting. And so that should really be – because you know how, when those therapies are carried over, between home and school, I mean you know how effective that is. And to get them early. I mean, this kid had Early Intervention Services from maybe two years, and he's had nothing for 11 years. I find that really – I really can't say it.

I think people outside of Maricopa County, and outside of Pima County need to understand that that's not Arizona. If you look at the highways and then you look – there's only a couple of highways. A lot of our kids live on dirt roads. So there really needs to be some incentive for people to go there. And restoring the funding back to at least the 2008 levels, because the provider issue here in Flagstaff, with the minimum wage issue, is very significant, and it's impacting our community a great deal. At least we need to get back to the 2008 levels, and then maybe try to compensate for the last 11 years.

Female: Thank you. And I'm sorry, I have quite a few. First off, yeah, funding, very important. it 's really the keystone of what we're talking about. Nothing else can happen without it. But I have a few things.

It would be nice to see more health plan accountability. Since everyone was switched to United Healthcare for health insurance, we're drastically lacking on durable medical equipment. it takes a minimum of two years to get a new wheelchair. And I've seen some significant injuries out of insurance not filling scrips.

Another one is about eligibility redetermination. We're encountering situations where people in their 30s are going through eligibility redeterminations, and we're having records be requested from their childhood, but that far surpasses record retention rules for a lot of schools and other places that would have those records. So I think the eligibility redetermination rules need to fit record retention rules, so that we're not asking families to provide things that no longer exist.

And then lastly, I think we need more flexibility in services to suit the many things that people want to do in life. Most people want that American dream. They want a family. Any person with a disability I've known who had a child, had that child taken away from them because they weren't able to provide enough care. I think there needs to be some sort of service for a nanny, or another sort of normative way that anyone seeks help in raising their child.

And then lastly, anyone like to take vacations sometimes? Have a normal part of life when you can afford it? I would love to see service codes that can allow for staff to go with a person on vacation, instead of forcing them to pay that out of their own pocket, so that simple vacations are possible. Thank you.

Male: I was just going to add, [name redacted] was reminding me. Really for us, DDD has almost always been a money losing proposition. I mean, it's something we do because our therapists really like doing it, but especially rural areas – Kingman or Holbrook or Winslow – that is one of the factors that will keep us from providing more, is we have to balance things that will keep us afloat with DDD services. And a lot of it is the tier system really doesn't work, because it doesn't compensate you for the travel. it isn't the same thing.

And then I think there was something else I was going to say related to the equipment. We used to be, as DDD providers, we used to be directly involved with deciding what [DME] equipment was appropriate for kids. And when we had Capstone, which I never really loved Capstone, but I really miss them now. When you had that local insurance provider that you could go to and say, this is why this kid needs that. It took a lot of convincing, but eventually they would realize that. But now with United Healthcare taking care of a lot of that, especially through CRS, I'm seeing a lot of equipment that doesn't get used, that sits out in the yard. Which I would have never ordered, because I know the family would never have used it. And then I'm seeing equipment never getting ordered that the families would really benefit from. Especially if they're older, and they're not in that CRS system, the process for trying to get that equipment ordered is really impossible.

Male: I just wanted to add to the list of things that the Division is doing well. And obviously, this is a reflection of you as well, [name redacted]. You and your colleagues at the Division, there's a lot of great staff at the Division. Whether it's at central office, or in the districts, or in QA, or in support coordination. And they should be applauded for their efforts every single day. Especially you just gave me a list of all the things that are under your umbrella. I don't know how you do that.

But having said that, maybe for the other page, is I think a lot of them are under-leveraged. I think, sometimes I think Division staff who have accomplished a lot in their careers for the last few years are starting to wonder if their voice is still heard in the DDD bureaucracy. So I would say that they're a little bit under-leveraged, but they're prepared to jump back in the game. That's just my own observation.

From a collaborative standpoint, one of the things that I think AHCCCS, DDD and the network needs to really pay a lot of attention to, and I know AHCCCS, it's on their radar. It has to be on ours. And that's workforce development. Workforce development in Arizona is going to be huge, because of our population, our aging population, and how we can recruit and retain and maintain the next generation of direct support professionals and leaders in this network. It's got to be on the radar, I think.

The last part, and hopefully [name redacted], you don't mind me saying this, but I get a little concerned. I'm a Flagstaff guy for 25 years, my wife's a native of Flagstaff. Spent virtually my entire career on the nation. I'm concerned about the loss of traditional Navajo beliefs as we build this and move forward with this system. We have to make sure that we don't lose sight of that.

[Inaudible.] 0:53:25

Male: My balance sheet isn't very even. I think one of the things that's always been strong about Arizona and the long term care system, I remember even back when the boys first moved here. Part of the reason is that a lot of the services are home-based rather than center-based. That most states have a long term care system where you have to go to a center to get services or to get equipment. So I think that's been a strong point, that it is more natural environment, based on what the family or client needs.

Female: So [name redacted] is right. When I relocated to Arizona, I had no services in the Midwest, where we lived. And very minimal respite, which was based on income at that point. And it was a decision to relocate where I had been raised, in the Phoenix area. Brought my boys here. And that's one thing that the state DDD has done, is that they've gotten so many services and supports, and that's a very positive thing. Started out, I was going through a divorce at the time, before I met Don. I was down in the valley, and I applied for services, and I was amazed at the help that they gave me. Now finding providers even at that time, in 2005 down in the valley, I was out at ASU and everywhere else putting up flyers. And I think that's the hard thing with Flagstaff right now, is just finding providers, with the minimum wage increase and the rates. You're kind of in that zone of what you can pay, because of the billable rate and your overhead and stuff. So I applaud the DDD. I think as a parent as an agency. Hopefully we can continue to have the relationships that we've had. Because while it may not be perfect, I think there's a lot of room, and there's a lot of good people there.

Male: Just to kind of add on to that, there's been a lot of articles in the paper about the agencies in town needing to have the increases in order to keep up with the minimum wage. But most of our clients are not there. They're in the rural areas. And since the minimum wage took effect, you could almost hear the door slam on people wanting to work. And because of that, they're not wanting to work, and we're having to pay more money to the minimum wage even though we're not in town. Because it takes them more money to drive out to these rural areas.

Female: And by rural, we're talking ten miles out of Flag. You're not in the city of Flag, you're in – used to, you could go to NAU, to the speech department, physical therapy OT departments, and we could put a flyer over there, they would send it out to their students, we would get calls. It has been very dry. And it's really been a struggle. Which is hard for our members. You know, they're not getting the help they need because we can't as quickly fill those.

Male: I do appreciate those comments. And I think for a recommendation for improvement, and especially as the wind shifts, and more and larger entities are moving in and doing center-based services, I think it really would be important for the health plans, DDD and AHCCCS to all track how many families are being requested to come in to a center, and where their location is. Just to get a read on the pulse of families that might need to come in, or be requested to come in from Window Rock, you know, three times a week to get services. I think that's something that we really need to start taking data on.

Male: I just wanted to add another positive. in the last few years, I've noticed a notable difference in the internal and external capacity that DDD has built to support members with co-occurring conditions. it 's much better than what it was. Still lots of work needs to be done, very complex cases, but I applaud you guys for your efforts.

Female: I guess I, hearing center-based services three times a week from Window Rock. Does anyone else find that ludicrous? But that's what – we're going to center-based services.

Female: No, okay good. Well, and –

Female: Okay. So along with incentivizing providers that are hard to find, because if it's a losing proposition for DDD, for a provider to provide in-home services – speech, OT, PT – incentivize the parents for training. There's a number of things that you could do to incentivize the parents to bridge that gap. Because the parents and the families are with the child, or the individual, life long. Whereas the therapists come and go, the Support Coordinators come and go. But improve the expertise of the parents.

Female: Mine is some things that we need to work on, but also some good things in Flagstaff, when it comes to employment I guess. Because that's my field. I don't know if it's a whole DDD thing, or if it's just specific to our Vocational Coordinator here, Employment Services Specialist through DDD which is [name redacted] [*unintelligible*].1:00:04. He's a major advocate, and I wanted to shout to to him. Yeah. Just because if I ever have a problem, [name redacted] is always there.

And I think the major issues that I see are the connection between DDD and VR, and not having that connection. DDD seems to be really getting on the ball with everything, and with Employment First and wanting to assist people into that transition to employment. But we lack that connection with VR, which is the main source of funding for our folks going through employment. And the education that – what are we doing to educate VR to let them know – some of our folks with higher needs or more severe disabilities, they can work in our community, but what are we doing to show them that you guys might have to spend a little bit more money to help them get there. So that, I think we're lacking in that. but I do think we have some pretty good advocates in Flagstaff to help through that

portion of it. And then there was something else. I don't remember my other one, so that's okay. I'm good.

### What are the Solutions for Improvement?

Male: [Inaudible.] 1:01:37 ...doing the [AZIT] program for Coconino County, we're up from renewal right now so I think we'll continue, we'll see. But I do feel like some things could be learned. DDD has similar idea, but there isn't the structure in place to build that team-based model for providing services, and for really focusing on coaching families. I mean, I think that's the philosophy, the that's the idea of DDD, but that's not reinforced with the whole IFSP process and those kind of things.

[Inaudible.] 1:02:11

Male: No, that's what I'm saying, is actually for the over three population, that moving to more of the, yeah, moving to that idea of coaching, especially, where you're really trying to work with the providers on them providing services, rather than just the therapists being the specialist or the caregiver. And then also with that, maybe moving into really reinforcing that team idea of how to provide services.

Female: Okay, from a transportation point of view, we have Mountain Lift, paratransit services, which many DDD people could be eligible for. Besides the paratransit van, we have a taxi program, and the taxi program does – I'm not sure when DDD does cover Mountain Lift rides, if they also could cover the cost of the taxi program, which the client pays 20%. For instance if they needed \$100 worth of taxi services in a given month, the client or the client's family – or DDD – would pay 20% of that cost. So the taxi program brings down the cost of transportation significantly for us as an agency. And it provides a lot of flexibility. Like if in-home care wasn't possible, that there's transportation through this taxi program, to service providers.

Female: No. That there is a taxi program that involves – yeah, the clients that are eligible for paratransit are also eligible for the taxi program. And it's basically a bank card, it's like a debit card, which is loaded with an amount and it's grant-funded. But 20% would need to be covered by either DDD or the client themselves. So it's a subsidized taxi program. That could be helpful in the big scheme of things.

Female: Right.

Male: I have a suggestion for an improvement, and that's to pull employment supports back from VR and put it back inside of DD.

[Applause.]

Female: [Inaudible.] 1:05:08

Male: I wanted to add to [name redacted]'s comment about the relationship between DD and providers, at least here in Flagstaff. I'd like to suggest some sort of training for Support Coordinators, Supervisors and providers, that get us on the same page. That we're here to help. Like you said, the three legs to the stool. It's really, really important. I think it's gotten really bad up here in Flagstaff.

[*Laughter.*]

Female: That was facetious. [*Laughter.*]

Male: The training that explains to everyone involved. Providers and DD employees, SCs, Supervisors, that basically explain their role, our role, the goals. And the collaboration, yeah. Why we're here.

Female: I'm hearing a lot about the employment aspect of DDD, and I'm so glad that [name redacted]'s still there. Sorry? Yeah. Being a voc rehab client, on the wait list for five and a half years for a device that prevents falls, and then having a bone break and a disability-related fall in January is a little bit of an issue for me. And just the VR system has gotten so convoluted and Byzantine. I can't believe that the two systems aren't working together. But there's this area of DES called the Employment First initiative, and so with the high school transition, school to work, they said, well VR really needs to be able to focus on the individual. Getting the individual ready for work, rather than just saying, you're not ready to work, we don't do anything with you. Until you're ready to work. How do you get ready to work if you don't have the support? And so I would really recommend – it sounds like a lot of people need to come to the table and, sorry, I'm just a client. I'll just say DES needs to get their shit together.

[*Inaudible.*] 1:08:19

Female: I do think anyone can work, like what you're saying. My boys are in high school, they have jobs. And one got pulled out because he had a seizure and was diagnosed with epilepsy. But he's slowly getting back in. These are kids that people would think, well they can't do a whole lot. I have them vacuuming their rooms. They're dusting their rooms. They're progressing. So anyone can work, and I think that needs to be very – it gives them a sense of pride. My one son [name redacted] gets this big smile on his face when he's vacuuming, because he thinks that's cool. And he works over at the [redacted] project here in town. And they love him.

Male: Just to piggy back off those concerns, and also just what I've seen. A suggestion for improvement would be to improve communication so that when there's a concern or a complaint filed with DDD, with VR, with DES, that there's not a way that it's pushed back on the provider. Because I've seen that happen. Where then they'll sort of put it back on the provider, and have the provider receive the complaint.

The other thing that I think would be important is that if there is a concern or a complaint, about a notice of action or a denial, or a delay in the approval of certain services, that DDD gets that, but also the health plan gets that, and also AHCCCS. So that there's a level of accountability, and it's not just one entity that's receiving that communication, but a variety, so others can follow up on where things are in the process.

Male: I think they need – I'll wait till you're done writing. DDD needs to only allow very high level people – [DDD leadership; names redacted] – only them to be allowed to backdate authorizations. Maybe. *[Laughs.]* To backdate authorizations. They should never be able to put an authorization in with a date prior to today's date. Because it's screwing up people's statistics.

### Thoughts on Alternate Service Delivery Model

Male: If a member has, let's say United Healthcare right now for long term care, but Care First for behavioral health, then they will still have Care First if they want? Or they have to choose between United and Mercy? *[pause]* Okay.

Male: Okay, that makes sense. So with that, do providers contract with the DDD, or should they contract directly with Mercy Care or United?

Male: So if there's a 180 day window, and they're switching from a current RBHA up here, who's funding that window? is it through the RBHA, or is it through – ?

Female: I've actually heard of the single case agreement before, but typically they don't get approved, is what I've seen. That they're like oh, it's a single case agreement, we can outsource this psych eval to somebody else instead of it happening here, at the behavioral health home. So if we do a single case agreement, what are the chances of it being approved, and not having to do a notice of action?

Female: Where do dental services fit in all this?

Female: You know, I'm sorry if I missed this point, but what about case management? With the health plan?

*[Inaudible.]* [1:21:50]

Female: I just have a suggestion. All the questions on the single case agreement and the transition, just please don't assume that the health plans know who you are. So come that change, let them know that you're seeing these members, so it won't affect – the lady up in the front with your claims issues and everything, let them know that you have members, and who you are. Don't assume. Because a lot of people think that we get all that information up front, and we don't always get it.

Female: So if somebody is through DDD and behavioral health, but through DDD their health is through Stewart Health instead, can they choose a United or Mercy and go with those plans, or do they have to – ?

Female: I just have a question, would this model mean provider agencies contracting directly with the health plan, as opposed to DDD? That would be riddled with problems.

Female: In my dealings with the health care entities there, it's not specialized enough for people with disabilities. Needs aren't understood, so needs are often overlooked. And privatizing people's lives is a scary thought.

Male: I think related to that, what I – I don't know the way to describe it, but with United Healthcare also running CRS, it's kind of a sticky situation where if families are going to provide services through CRS, they're kind of possessive. They don't want to share. They're not going to contract with us to do home-based. Or they might contract with us, but they're going to encourage people to be bused in from Window Rock, which they're already doing, into the city to get services. Which in some ways now it's filling a hole. Like I said DDD hasn't been able to provide those services. We have families that will come in two times a week for therapy services in Flagstaff, miss a day of school, miss two days of school, and spend all that time in transportation. Which is problematic for the families, because the transportation is unreliable, they're not there. But I see with United Healthcare kind of running CRS, and having that interest of everything going through their clinic, that kind of being forced upon families, or being the only choice. I mean, at least it's services, but I think it would create that model of becoming more center-based rather than less.

And a lot of times, the problems are that those caregivers don't – the therapists are great, the people are great at CRS, I have no problems with them. But they don't really understand the situation at home a lot of times, and that's where we get both some excessive surgeries that I've seen, where they're doing surgeries on kids that will never walk, on their hips. And they're requesting power chairs and standards for kids that the family has no way to transport the power chair. I mean, they're great ideas, but if you were in the home, you might have a better understanding of what actually would work and be more cost effective.

Female: Sorry, I need that bubble on the right explained in a provider who's not medical.

Female: So it's full medical model privatization. Is that right?

Female: That's dangerous.

Female: Do you want to add anything to that, why it's dangerous?

Female: Well, you piecemeal a person, and you take them out of community. And we need our, every one of our persons with a developmental disability in our community. There is no way that a healthcare plan that only cares about the bottom line is going to look at that individual as a human being, in a multi-disciplinary way, with a team understanding of what needs to happen for that individual, and for that community.

- Male: We have a little experience with a similar model right now, with RBHAs, right? RBHA is responsible for health as well as behavioral health. And what they're doing, is they're funding the clinics. And the clinics are responsible for services from A to X or Z. They're not –
- Male: Yes. Just to separate that. And so what we're experiencing is that they're very good at A, B, C services, but they're not very good or proficient with service D or E.
- Male: Let's say employment services.
- Male: Well, yeah, they lack funding in those. But I guess my point is that they're funding these clinics that say they are providing all these services. They're really not providing the employment part. I'm sure their case loads are huge, and they're required to have Case Managers for employment, but they're not doing it. So people are coming to us and saying, I need this help. My point is that the clinics are given a lot of authority and power and funding, but they're not doing everything they're supposed to be doing. And I just see a model like this, where the concentrations are on the, are given to the health insurance, and they're just not going to provide the services that they're not trained to provide. That's what we're seeing.
- Female: I believe there will be a major financial conflict of interest issue in this model. Why would a Support Coordinator authorize services that are going to increase costs for their employer, who's asking them to watch cost?
- Male: You know when you talk about costs, it comes down to motive, for me. United Healthcare and CVS – CVS owns Aetna which owns Mercy Care. So when you start to look at all the organizations, they're for profit entities, and they have an obligation to make profits for their shareholders. That's their purpose. And DDD's purpose it to spend their fund balance down to zero each year and not return anything back to general fund. So when you think about motives, it makes no sense to move these precious dollars over into an arena that their obligation is to make money for their shareholders. it just doesn't make any sense to me.
- And then secondarily, I would say that – I contract with United Healthcare currently to serve the EPD population here in Flag and all over Arizona. Well, the northern half. And they take 10% right off the top, right off the fee for service schedule. So what makes me think they're not going to take 10% off my DDD rate schedule? it 's what they do. And it's not right. And so I'm absolutely opposed to this. it 's a bad idea. If our current system that is flexible and meets the needs of our people in the most cost effective way possible is not broken, then why are we going to fix it? So that's where I'm at with this.
- Female: I've got to say, I'm totally on board with [name redacted]. It doesn't make sense. And if we think we have communication issues now, working with the DDD, what do you think it's going to be like if we're working directly with a United Healthcare entity? It to me doesn't make sense. From a parent standpoint, and

from a provider agency standpoint. I think – what’s it going to look like if you need to get ahold of the person in charge of your support coordination? Is that a local person I can call on the phone?

[Inaudible.] [1:37:16]

Female: Well yeah. I mean a lot of companies are outsourcing worldwide, people who answer their calls. I mean, probably most people see that. If you call into Sears or whatever for a return, that’s what you’re getting. You’re not going to be able to call [name redacted] over at the local DDD office, because your client needs a new wheelchair or a lift seat, and be able to work that out locally. And have it be someone that knows that family, that’s been in their home, that really understands what the parents are going through. Because we serve a lot of families where parents struggle. I have a family right now, here in town, that have had a major employment issue. The last thing they need is being on the phone, trying to get someone that understands their needs. So I agree with [name redacted], and I think I would not support that idea.

Female: Thanks. You know, I have the advantage of having a little bit different perspective of living through when ALTCS was originally set up, and I have a close relative that was in the legislature, and was part of that. And it was set up with DDD as the MCO because the parents demanded that the State have the oversight for this system. And I don’t think feelings about that have changed. I know – I am a guardian now for my brother, and I would be concerned about the quality of services under a private MCO because what you’re hearing is correct. There’s a conflict then, between quality and quantity, for that matter, of service. And of profit perspective. So I think that that’s something we’re really going to have to watch out, and talk a lot about.

I’m also very concerned that these MCOs, these potential MCOs for DD services, have no long term care services and supports experience. When the RFP came out last year, and it was being discussed, I kept saying, please quit calling our clients patients. And they kept doing it anyway. They don’t understand. They don’t get better. Our clients don’t get better. They may improve in some respects and stuff, but it’s different than what can be handled by a medical model. I spent some time looking at what’s happened in other states, and I can’t find any successes. Every state that has tried this is just having all kinds of problems with it. I think that there’s an idea that there is, for the State, that there would be some kind of economies of scale. That in the long run, there would be money to be saved. Well not only do I not believe that, but I don’t believe that this is the place that you want to try to save money. These are people’s lives. This isn’t an acute illness, this isn’t even a long term illness. This is a whole different service, and these MCOs just aren’t set up to handle that at this point.

I would also like to add that I have read several different places, and I could get the information, like Robert Wood Johnson, Anchor, where there are suggestions for how best to design a system like this if you’re going to do it. AHCCCS needs to go back and follow that, if they’re very serious about this. And it includes a lot

of parental and provider input from the beginning, total transparency. And that needs to happen.

Male: She read my mind. But I was actually just going to bring that up. What if we had a model where you can still see the larger entities in control, or sort of at the end of the line, and have different motives. And so that's what I would propose, that we have sort of an equal share. The providers have say, the members have say, equally as DDD and the health plans have say. Because one thing I've run into in the past is a health plan might say, okay we're going to do a single case agreement – and it wasn't with Mercy Care, I want to be clear with that – but they would say, we're going to do a single case agreement, we'll pay you 80% of the AHCCCS rate. And I have to drive three hours each way to provide that service. And so that's where I don't have any sway in if that member gets services. Basically, they're just giving me this ultimatum. And so that's where I feel it should be a shared accountability, but also a shared input into what the rates should be, what supports are needed. And again, there's more autonomy on every level.

Male: I think part of the solution too is what was brought up earlier, more local control. I feel like some of what has happened with the CRS system in town, so many people left CRS when United Healthcare took over. And it basically is similar to what is being proposed here, where CRS became United Healthcare and they had to manage whatever CRS was doing before. And not that they're always trying to save money, I don't think that's necessarily it, but the way they manage the care, and trying to increase profits, has really changed the system and made a lot of people leave. And the interest isn't necessarily in the client's best interest. And so that's kind of what I see as the problem with that system. And I see the solution, if we're going to modify the system as it is, is to go back to more of that local control, where you have people that understand the issues and are more interested in the long term health of the client.

Male: I think the – if you think about Case Managers that work in the EPD space serving seniors on the waiver, and you're trying to help them stay in their own home and not be institutionalized, they're typically at end of life, and the services that they're getting are attendant care, potentially some respite, some personal care. And those kind of services are authorized with the intention to keep somebody in place. For my daughter, and for our folks that we serve, these same services – attendant care, respite, whatever – they're intended to help her get a life, have more of a life. So the mentality is let's make sure you get a life and keep it, rather than towards the end of life, when I'm just trying to keep you stable until you die. I don't want that for anybody in our system, for their whole life. That would be crazy.

Female: Looking at – we're talking about cost and what's effective. There's a lot within the Division that could be looked at. For instance audits. I get like three audits a year. Could there not be one audit that looks at the Office of Licensing, home and community-based, your contract. There are a lot of money saving things that

could really save money within the Division to where we could do more within the Division, and keep that set up the way it is.

Female: Thank you. Yeah, hacienda health care here we come. I mean, this is tragic.

Male: I just want to add, the importance too of, just throughout the life span, making sure that somebody's in their community and not institutionalized. Or worse, especially as behavioral health and integrated health comes into play, we find all the time that the members that don't get the supports up front are put out of state into level one institutions. And when you're looking at cost savings, I mean the short term benefit from cutting costs and not giving the supports is you save money for a month, but in that yearly bill, I mean we've have members cost up to \$200,000 in a hospital, and that's not a life either, and it sort of defeats everyone's purpose.

Female: So that last slide went through very quickly, about qualified vendors. Just from a therapist's stand point, I mean I guess we're going to continue to provide services to our clients after October First, but do I need to look at becoming a United Healthcare provider? Could you walk us through a little bit on that.

Female: Can you give us a sense about when that might change over then to United, and how quickly we may need to change?

Female: Are you saying they will not switch within that, because that contract has already been awarded for three years. So there won't be a change for three years. Because then the next question is, well when will these studies be given to the Governor, and would they then make a quick decision thereafter?

Female: So just for clarification, this is a done deal. Okay. But you're saying by October First this is happening? Okay. Because the timeline with presenting it to the JLBC, the Legislature all of that, they won't be in until next January. Okay.

Female: So right now there is no RFP on the table for the proposed one. When do they expect to have an RFP after they collect – like what is the deadline for collecting the input? is there one?

Female: So I guess one concern I would have then, if this model would be approved – which would not be my option – but if it were, hopefully they're taking in – it took a year and a half for our agency to get approved by the state. Just to go through all the hoops. If my OT has to get a contract with United Healthcare, are my children going to be without services for a period of time because there's that lapse? I mean, there's a whole can of worms and concerns that by going this route, not only will agencies have to get approved by United Healthcare, but there's going to be a lot of families impacted by lack of services if their agency or their therapy company hasn't gotten their approval yet. So that's a huge concern too as well. And then how would the rate schedules look under – and I'm not saying you should have the answer. Have they taken into account though, what are the rates going to look like? Because we're already struggling up here, trying

to find providers at the rates that we get reimbursed. So those are all my concerns when we look at that model, as a parent and a [Inaudible.] 1:54:34.

[Inaudible.] 1:54:39

Female: That's why I was asking, to anticipate how far out do I need to, as a therapist do I need to get a contract with United or mercy or whomever? To make it as seamless as possible, that transition. Because that is going to be an issue. Any therapist that's been providing services that doesn't have United Healthcare, they're either going to have to get United Healthcare or that family is going to lose that therapist, or that person.

Male: [Inaudible.] 1:55:14 ...but part of that process is what's happening more with the behavioral health realm right now, where you won't necessarily be able to get that contract. And if CRS becomes a gatekeeper, they're not necessarily going to promote that home-based part of it. That's kind of what we're seeing happen. I can't predict that would be what would happen, but it seems like that's a concern with the behavioral health part in the existing model. is that you won't have those individual, small providers like [name redacted]'s company, because they can't get a contract that's going to pay them to do the services.

Female: Along those lines, I'd be concerned that one health company would pay providers. We've had wheelchair scrips bounce back for over a year, until they like the wording. Providers wouldn't be able to provide the services and then wait indefinitely for payment. The insurance model doesn't work there.

Female: [Inaudible.] 1:56:22

Female: Well we know that we're going to be paid. We won't have to wait six months or longer to reword things, or – there is a system.

Female: [Inaudible.] 1:56:35

#### Thoughts on Governor Ducey's Executive Order

Female: Thank you. I think the key here is on prevention. And it's great to talk about recognizing abuse, but we need to prevent it before it begins. So my feedback for Governor Ducey would be that he needs to direct our funding where our values are. And back to what [name redacted] was saying – he's not here any more – about workforce development. Our staff need to be paid what they're worth. We can't have minimum wage staff in a revolving door with the most access to our most vulnerable people, and think that that's safe.

Male: This is not a popular comment, but the evidence shows that the most effective way to keep predators out of positions where they can take advantage of people who are vulnerable is pre-employment psychological testing. it is the most effective method. I don't know that we can ever afford to pay for that, and I don't

know how it stomps all over the rights of the employee. But anyway, it's something that needs to be considered.

But my comments on this order are that, coupled with a cautionary note to the work groups to not overreact and create overly burdensome suggestions that could, in fact, pounce on the rights of the people we're trying to serve. It could take away independence, and it could be incredibly costly. Imagine if one of the work groups said that all therapists must have an aide watching them for every session it would cost millions of dollars. And so I would say any suggestions they come up with must be fully funded.

Female: Just to tag on to what [name redacted] was saying about not pouncing on the rights of individuals with disabilities, in a way we're only addressing half of the need here. We need to be working at educating the clients, individuals, as to their sexuality, good touch, bad touch, and we're ignoring that. It's the elephant in the room, and you really can't do one without the other.

Female: The first portion is directly Orwellian to what we're talking about now, because when it becomes about profit, it's not about the person. So when I said [provider redacted] here we come, you are just going to see those things increase. So the community-based, the actual community-based, not speaking with somebody from India to try to get a claim resolved or whatever, there has to be more community involvement for the social aspect of the person, the full person, rather than just their diagnosis or how we think we can fix them. And so I'd like to know if someone from the San Carlos Apache Tribe is at the table. And one of the reasons is when you take someone so far away from their community, one thing to – Governor Ducey should put his efforts behind making sure that everybody can be in their community safely, that their families are supported. And if he really actually cares.

Female: I've spoken with several families lately that have children that are turning into adults, and they're looking at guardianship issues which we've already gone through with our kids. But they're so frustrated at trying to get help for their child, that would it be easier to put that child in a group home or what have you. And I really think, with everything going on, and safety for our kids, we need to be supporting families as much as we can to keep these kids in their home with their loving parents, and give those parents the support that they need. And I think we have some great Support Coordinators out there. But families are just – by the time a child turns 18, and I'm pretty strong and I have a great husband, who's a dad to my boys. He's not the bio dad. But there are a lot of families that by the time the child turns 18, they're like what do I do? And my therapist was at the house yesterday, God bless her, and we had a major melt down. And having a therapist that knows my child for the last seven years, that Support Coordinator – we seem to go through quite a lot of those – but they try. And our families really need the support of us, they need the support of the DDD to keep our kids at home with us as long as we can. These kids need us. Because the only way they're going to continue to grow and learn – my kid vacuuming and my kid dusting is through their parents that aren't broken. And we need to support them.

Female: Kind of going off of what someone was saying, the lack in funding. My sister-in-law works for a skilled nursing facility specifically in the Phoenix area, and I know that one of her biggest complaints is always short staffed. They always have a short staffing of nurses, people are calling off, things like that. And they do get paid enough, each individual who's working there at the time. but because they can't get paid more, it causes it to where they have not a lot of nurses available on staff to check up on the patients. Those are actual patients there. So I would say a lack of funding for more staffing, so we can pay what we have to who we have. For purposes of DDD, we have to have a specific ratio. But that's not required by a skilled nursing facility. You don't have to have 12 nurses per floor, things like that. They're on long shifts and everything. So this specifically of what happened to the individual, I would assume part of it is that there's a lack of staffing and individuals there. Because otherwise he wouldn't have to that. That's my two cents.

*[Inaudible.]* 2:08:52

*[Inaudible.]* 2:09:55

Female: I like it better here.

2:10:12 *[End of recording.]*

## Phoenix (Central)

### What is Going Well with DDD LTSS?

- Female: I will offer, one of the things that I think is a strength in our system is that as providers, most of us have a mission statement, and it's similar to the Division's mission statement. So when we're trying to accomplish something to serve the member, and we come to you – and there's a lot of great people in the room that we know we can go to – you guys have the same mission that we have. And I think that helps us all to be more successful.
- Female: I have to say, one of the things that I've been very appreciative of late is receiving information from the Division to prepare us for the addition of new services. Giving us guidance as to what is expected, and what is required. When I first started ten years ago, I wasn't getting that information. And it was very frustrating. So to be given information in advance is very, very helpful, and I really appreciate that.
- Female: Along those lines is the openness of communication. The ability for us to speak directly to DDD, and have our voices heard.
- Male: You guys pay pretty quickly. Yeah. If there's only several days after we submit an invoice, you pay us very quickly, and I appreciate that.
- Female: [Name redacted] online says the fact that people are able to receive quality services in their own homes is a big plus.
- Male: We've had some incredible Support Coordinators that have really listened, and got the full details of our situation. The one that we have right now is incredible, and she actually went the extra mile and started putting in place some things that we didn't even request. So we're very thankful for that process.
- Female: [Name redacted] online says that DDD provides a minimum payment when the third party liability insurance is less. And [name redacted] online says, I also like the fact that we are able to contact DDD directly, and the focus site that allows for us to view the authorizations immediately, as well as the payment, explanation of benefits and referrals.
- Male: My staff tells me that that customer service line is really working out well. You know, I mean we get a call back, or right there it's answered. And I know it hasn't been in place that long, but it's working very well for us.
- Female: I have to say that restructuring the verbiage in the handbook is very handy. I'm a new DTA, and so I appreciate that. Also, we're given more opportunities to give feedback. So that's been very nice.

Female: To echo the giving feedback, there's a lot of collaboration as we look at the [HCBS] rules, and all these different things that are happening. And we appreciate the collaborative opportunities as we're evolving the system.

Female: We have someone agreeing online that the customer service has improved greatly. Thank you.

Female: I'm going to speak now with the parent's hat on, and that is that I really appreciated the significant improvement in quality standards. The QA division holding providers accountable for raising the bar, to providing excellence in our service delivery, I think makes all of us that much better. And I really appreciate that.

#### What Needs to be Improved with DDD LTSS?

Male: One of the challenges that we have had is just the number of Support Coordinators we've had over the years. And it's even worse with the Nursing Supervisors. The turnover of Support Coordinators and Nursing Supervisors. And our son as a very complex medical history, and having to go through that every single time with a brand new person, to get them to fully understand where he came from, what he's doing, and what we're trying to prevent, is a challenge. And my wife spends a lot of energy going through that every single time. Whereas the times that we've had the same Support Coordinator for three years, things go so smoothly. And she has everything prepared ahead of time, so the meetings are really quick.

Male: So I think from a global perspective, with the issues of funding. And just like the coordinators turnover and the challenges that you're facing, I think the same would be true as well with the turnover that we have with the Direct Care workforce. The turnover rate is so high, and the impacts on the members, the clients, in terms of the behaviors, those sort of things. The funding issue really needs to be looked at as well, because that's a part of the overall quality of the service. That I think is a big component to what needs to be improved. It's not DD problem per se – the Division problem, but certainly as a state policy, it is one that obviously the Division has to accommodate, the same one that all providers have to navigate as well.

Female: [Name redacted] says, we need to think outside the box for living alternatives. Not everyone is able to be successful with the current options available.

Male: I would like to see the system become more flexible overall. Specifically, I think about employment. And we're so siloed in how the services are delivered. I've said for a while now, I would love to see a pre-employment code and an employment code. Do what you need to do within those. Because it's just so rigidly set up, and that's not how people advance, and that's not how people work. So a little bit more flexibility, which allows for the creativity, and some of those outside the box thinking.

Female: Ditto what [name redacted] said, but let me preface my comment by saying we struggle in our 320-person agency, so I know it's hard for you. But your guys' internal communication sometimes is a barrier. We get different messages from executive leadership and provider meetings and actual support coordination, and it's hard to communicate to 2,000 people.

Male: Not just to build on what she said, but monitoring groups to consistency among monitors, we find inconsistent. And so if you could maybe look at that. Actually between all the services, yes.

Female: I just want to say that I really do appreciate the NAU mission. I did go to NAU, and leadership and hospitality was one of the courses I loved. I do look at employees, and make sure that they have some emotional intelligence before we hire. But with that also, you want to be able to afford them, to retain them. So they don't slip out of your hands and go and move on to other areas. So with finances, I think that could help us to hire more qualified support. Also, to try to make – we are, how can I say it? Monitors come out to look at a meaningful day for our members I think to make a meaningful day, there needs to be a little bit more flexibility with finances so that we can do more with them. We have a *folklorico* group, but there's a lot of sacrifice. Trying to get their costumes going. We also have music, but you have to buy those musical instruments. So I mean, that is part of the whole component of their life. I know work is valuable. We try to have our hours go with their work hours, kind of to accommodate, to go around it. But also this is a time when we can be spending valuable time together, so that their life is more meaningful.

Female: [Name redacted] online says therapy services are finally getting more consistent in the home and community. The unknown with the changes in United Healthcare and Mercy Care taking over is scary, as we are trying to navigate how to both service members, and stay afloat as smaller agencies.

Female: I think an improvement could be an enhancement to the self-directed component, of looking at allowing members and then their families to self-direct services. Through more of a budget authority option, where the person gets to choose which services and supports they want, and who provides those services. In other states, that allow that for this population, it's hugely, hugely successful.

Male: All right I'll do two while you do your cough drop. Number one is I'd like to see employment made a priority. I do not feel that employment is a priority within the Division. And with all the changes that are coming, I think it needs to be, and we need to put our money where our mouth is with regards to that. If we're going to move people towards community and away from center-based, we need to do that.

I'd also like to see the Division become more agile. I'm concerned with regards to the amount of changes that we have got to come through. And I use my poster child for this, is the Career Preparation and Readiness Code. Which has taken four years to be fully implemented. And if it's taken us four years to implement one code, how are we going to transform the entire system in two years?

Female: And I think this is something you guys are working on obviously, but when it comes to fact finds and requests for more information. There are a lot of barriers.

Female: [Name redacted] says I agree with [name redacted] too, as these changes have trickled down to AZIP and AZIP DDD is not providing the difference in pay when AHCCCS public third party liability reimburses at a lower rate compared to the difference in reimbursement with private third party liability.

Female: We have a continuing issue with not being appropriately notified of scheduled meetings. The ISP meetings, from Support Coordination. We are proactive, reaching out to coordination to query them as to when the next meeting is. Invariably we're getting notified after the fact. To make matters worse, when we then receive the document, there are goals that are being written that make no sense. With no input from us. And we need to do a better job. There needs to be more collaboration in terms of how one identifies what a goal should be. Is it achievable? Is it measurable? I thought that was the fundamental, core responsibility to have it measurable and achievable, and yet these goals that are coming out of coordination are so far from that.

Female: [Name redacted] says communications can be improved. I'd like to see more provider meetings to keep us updated on the changes that are being made.

Male: This kind of goes back to the goals and stuff. I think we need to do a better job as an entire system, of creating truly person-centered planning. We definitely are not doing that.

Male: And I certainly understand the need for investigations, but it appears as though the pendulum may have swung a little bit too far. We're getting investigations on bruises that we write up, on people who are susceptible to bruises. And so if maybe just a little bit more thought goes into that, because we're spending a lot of time on investigations, which we understand. Investigations sometimes need to be made. But maybe be a little bit more thoughtful in – yeah, absolutely, thank you.

Female: Okay, I have two comments right now. [Name redacted] says, these provider meetings are often given with short notice, and offered during daytime hours, making it hard to have input and ask questions. PS, thanks for the evening on this one.

And [name redacted] says to maintain our current therapists, we need reimbursement rates to be raised to include money for supplies for feeding therapy, OT, PT and SLT. And for additional paperwork time for all the therapists' notes, evals, progress reports. We lose therapists constantly because we can't raise their pay rate if funding doesn't cover the necessary costs to cover all aspects of therapy, not just the time spent directly with the member. I have one more now.

Female: We're getting there [name redacted], hold on.

- Female: [Name redacted] says reimbursement rates for OT and PT and SP are less than they were in 2008. We need rate increased. You guys online are just, whew.
- Female: Fact-finding is really out of control, and the deadlines are becoming unattainable as we often have to request extensions. These requests aren't always acknowledged.
- Female: [Name redacted] says she agrees with [name redacted]'s comment. Retention is hard when there's so much shortage and demand for the therapy in other areas, and we can't keep consistent therapists to support members' needs.
- Male: We had an issue with our physical therapist, who's been seeing our son for ten years now. And the new requirements that she had to sign up with Medicare or something? She just said, I'm not doing it. And so she has left us. And so we no longer have that physical therapy with her. And she also does his school therapy, so we had a good continuity of care there. So now we've lost that because of the additional requirements.

#### What are the Solutions for Improvement?

- Male: As far as nursing services, first of all we need to get somebody in our zip code. We don't even have a nursing supervisor, and so there's a bunch of them that just cover our area. The other thing is to increase the payment for nurses. So we've basically been told by our nursing agency that the only nurses that they're going to get in are new grads that can't get into other positions because they have no experience. So they go to home health, and they come and work for us, and it's very limited that they're with us. Historically, we've usually had our nurses for at least two years. We had one nurse for four and a half years. But now, with the economics of it, we're not getting a lot of nurses coming in to interview.
- Female: [Name redacted] says training and follow up for support coordination, and what is required to meet the needs of each individual. [Name redacted] asks are there specific training topics that you recommend. [Name redacted] says, implement the change to Article 9 would significantly decrease the statewide backlog with PRC. [Name redacted] says increase rates for therapies, [name redacted] says ability for providers to attend meetings to improve collaboration amongst all involved in the client's care. I want to give time to write. Have smaller meetings, maybe split the districts up to have more input from providers.
- [Name redacted] said, we need a rate increase for therapies, lobby Congress for more funding. [Name redacted] says maintain a minimum reimbursement rate for therapies that is sustainable to retain consistent therapists for members. Include reimbursement for members meetings, report writing, etc. And no, we have not gotten a response on specific trainings.
- Male: From the QA standpoint, I've always been surprised that there is not a standardized incident reporting form. I can't imagine the amount of time and energy DDD must go through when [provider redacted] turns in an IR on a

napkin, written in crayon, and [provider redacted] does this very formal, professional, where the information is all over the place. I wonder if that wouldn't assist as well.

Male: I will say this. I've been in Arizona for 15 years. When I was in Michigan, for the previous ten years before that, we had a standardized form. Every agency used the same reporting form.

Male: I couldn't agree more with [name redacted], and I want to offer [provider redacted]'s IR form as the official form. [Laughter.] We actually have a fillable online form. Yeah. But anyways, I think my issue's about the consistency of monitoring, and then also more thoughtful investigations. It really comes down to a bit of training, and standard operating procedures, and check lists and things like that. And I certainly can understand, or feel your pain as far as retention goes. When you don't have much retention, it's very difficult to have consistency. But with that being said, perhaps some more standard procedures and checklists and things like that that everybody uses.

Female: Okay.

Female: [Name redacted] says training in how to communicate in a positive way with families in crisis, training in all the options available for members, training in how to create teams, for example include providers in decision making for services needed and provided.

[Name redacted] says currently, some DDD policy changes with regards to incident reporting requirements should decrease the number of incident reports that require the significant QA follow up.

[Inaudible.] 0:49:03

Female: The trainings again that were mentioned were positive communications for families in crisis, training in all the options available for our members, training in how to create teams to include providers in decision making for services.

Male: With regards to employment – and I know this is being worked on – but a real closer collaboration between VR and DDD. I question whether if someone is entering into an employment program within DDD, that part of that requirement is that you also sign up with Voc Rehab. And I think that there has to be a real discussion about delineation between services on who is serving who. Is this a VR service or is this a DD service? Because it seems like there's overlapping on those services. And we need to kind of say, these are the DDD services, and once you've reached this point, it has to go over to VR.

Female: Okay two things. One, this is awesome, and I feel like you're getting a lot of great information. So these types of things, and then prioritization and you guys have some good processes. You've been doing like [unintelligible] 0:51:05, you're

looking issue by issue. But I love that we're doing this, kind of building the list that hopefully will get prioritized collaboratively.

And secondly – and y'all don't have any control over this, but if you could have an Assistant Director stay three years, it might actually help.

[*Laughter.*]

Female: [Name redacted] says training for providers on how to conduct investigations. What are the Division's expectations?

Female: I do agree with one of the comments that we could help in the monitoring area, where we could stay consistent and not deviate from those specifics. We could also possibly make a tier kind of payment program, based on teaching strategies and the progress report. What day treatment agencies are actually doing with that time, and increase their pay if it's showing a lot more activity with our members. Transparency also on the part of our four-year plan budget that's approaching. Maybe an itemized list of budgeting numbers breaking down, and not so vague, so that we can see and align what we're paying out to what is predicted for that new budget. I did attend that meeting, I did not receive anything that was said to be DDD's information. And even though it had averages, it didn't have the companies disclosed in that paperwork, it still was not available to us. So that could have been helpful. And I think I have it all until later. Thank you.

Female: I'll take responsibility for my own suggestion of improvement, and say with self-direction, it's talking about it more, and beginning to look for ways to gather people, and come up with ideas and then approach this state with ideas of improving that whole program. because I think if we could figure it out at that level – and I understand the waiver issue you pointed out – some of the pay issues get taken care of. Because in that, when you're in charge of a budget, you get to decide the pay of a nurse, of a – you can make lots of decisions of how to manage services for people. So I take on, I see that as a way of improvement, and for sure commit to being involved in that process.

Female: [Name redacted] says provide training for providers on how DDD monitors interpret standards so that there is more consistency.

Female: Great idea. Coming back.

Female: In terms of training of support coordination, an area that again, becomes a repetitive challenge. And that is Support Coordinators who are coming to the ISP meeting without ever reading a progress report. Without ever reading the documentation that is being submitted. And my managers are coming back and saying, oh the Support Coordinator said they don't have time to read it. Then why am I bothering to write these reports? I just – the suggestion being, part of the training program that this is the process that you go through, in preparation for a meeting. Review the documentation that's been submitted so that you can ask

clarifying questions, include that information in the final report. It values then the work that's being done.

Female: Okay, there are three comments from online. And this is the one that got the giggle. [Name redacted] says, I think the Division staff is overworked, based on how quickly my calls/emails are responded to. Do you need to hire more staff? [Name redacted] says –

Female: Sorry. Getting there [name redacted]. [Name redacted] says improvement by Support Coordinators becoming more familiar with different employment services, and improvement in authorizations, both timeliness and accuracy. That was my last one.

### Thoughts on Alternate Service Delivery Model

Male: So regarding the new health plans, and how these services are all being lumped together, are there any changes in the benefits that are being offered?

Female: [Name redacted] asks, when will members know providers who are contracted with Mercy Care or United Healthcare, to allow them to select the plan that's best for them. And hopefully prevent a delay in prescription availability?

[Name redacted] says, why are therapies for children under 21 not included in the change?

Female: So with that said, will we be addition nursing support coordination for members here? I ask that only because I know, years ago, we had nursing coordination in Tucson, yeah. But when my family moved up to Maricopa, it went away, and that was a grave deficit for my son. So I'm wondering is that something that's being discussed?

Female: [Name redacted] wants to know what does limited LTSS look like?

Female: [Name redacted] commented, hopefully the snips will have some staff trained in working with people with IDD.

Male: Could you clarify, when you talk about remains the same, is that, for what period of time does that remain the same?

Male: Maybe more of a point of clarification. And you may not have the answer, but I'm going to ask it anyway. So this got brought up, this idea, this concept, got brought up a year, a couple years ago. And kind of got shot down, if we're all going to be transparent and honest with each other, because this sort of thing did not occur. Provider feedback did not occur. My understanding, from what you've said, is this cannot happen for three years minimum. Could be ten, but three years minimum. Here's where you may not be able to answer, but I'm going to ask the question anyway. Is this the feedback session for three years from now, so that when this happens in three years, the Division can come back and say we did talk

to you back in 2019. Or will there be additional forums and opportunities as it gets closer?

Male: So I think it's worth, when you're looking for feedback. If you look at the other programs that have been integrated by AHCCCS across the board, there have been a series of studies done to identify good and bad approaches. You mentioned earlier that other states have pursued integration. If you look at media reports, some have had better experiences than others. Meaning those members actually receiving services. So I think it's critical to the point, whether it's three years or ten years down the road, or whatever the case may be, of really diving into the experiences of other states, the reporting. Being transparent so that policy makers really can understand what does integration mean in terms of long term service and supports, and most importantly, what does it mean to the members receiving those services.

Female: [Name redacted] asks, what will that look like for agencies? Will qualified vendors have to contract with the health plan, or will qualified vendors be out of a job?

Female: So following what the gentleman said over there – I forget your name, I'm sorry – I think key if this is to happen, is that the RFP has to be really well written, and then the State needs to then hold managed care companies to the deliverables in the RFPs. In states where that happens, I have experienced this future model worked very well. In states where that doesn't happen, it's horrible.

Female: I have five online. [Name redacted] says, what is the vision for how a group home would be funded? Would members who have selected different health plans still be able to live together?

Female: [Name redacted] asks, what are the major changes that occur if LTSS is under the health plan rather than from DDD?

Female: [Name redacted] says, I feel there will be a disconnect with the other option. We are saying today, we need more collaboration, more supports for members, etc. Will the number of services go down because providers credentialing is held up by those awarded the RFP? Will this pull therapists from the homes, and members from necessary services?

Female: Okay, two points I guess. One is, it seems as though this is a path that we are eventually going to go down, but we don't know that. But I think it could be. So I would hope that collaboration and transparency and communication – if we control the process, it doesn't have to be a bad thing. But if it just happens on its own, it will likely be bad.

And the other part would just be a point that yesterday there was an article in Disability Scoop that Senator Bob Casey has asked the Office of Inspector General of Health and Human Services to investigate other states that have already done this, because there are complaints that people are losing services.

Because the other managed care systems have different priorities than DDD and providers have, and they're not often out to get the best services to members. So it'll be interesting to see what those investigations yield.

Male: [Inaudible.] 1:20:44

[Laughter.]

Male: I think to piggy back on something [name redacted] said earlier, obviously this was a process that occurred roughly a year ago. When they released the RFP, there were a host of questions that couldn't be answered. And most of those questions dealt with execution, implementation, how would certain things work. And the response we always got was, well once the RFPs are awarded, then we can talk about it. So I think, whatever the timing is, in addition to the studies that I mentioned earlier, there could be value in having, before the RFP is released, where that point in the procurement process where you can't talk about it, to have a continuing open dialogue like you're doing tonight, with providers, discussing implementation issues. So that when the RFP is issued, the RFP takes those issues into account, as opposed to, we'll deal with it at some point down the road when we can't really affect it.

Female: So seeking some clarification, I'm looking at the screen and it has oversight above DDD, so I'm trying to understand the role that DDD will have relative to provider agencies if provider agencies are contracted through the health plan.

Male: The concern I have in looking at this model is you're requiring lots and lots of services from that health plan, and how many health plans are going to be able to provide those services? So to me, that looks like there's a potential of limiting the options that patients and customers have. Because not all plans are going to be able to offer all those services. Right now we're going down to United and Mercy Care, so we're down to two, right? So we go to this model, and now there's only one.

Male: Okay, right. Okay. A little, but it's still concerning, because I'm not sure that both of those would be able to provide all those things.

Female: The other distinction that I have a concern with is that most of – I would say UHC and Mercy Care, they're for profit, insurance companies are for profit. They have shareholders and stakeholders. So those funds and monies that are going to day, right, they still have to please the stakeholders. Whereas DDD doesn't right now, so that's a concern that they're going to be in business to make a profit, not to help their constituents.

Female: The first online comment is, if Arizona has one of the best community integrated systems in the country, why are we trying to make such a significant change to the system?

The second comment online is, I am in support of option B. I think it would be streamlined for members.

The next comment is, it is concerning that in looking at the medical model of long term care residential models, i.e. nursing homes, there is little to no member choice. That is the opposite of what we want to do in the IDD system.

Does the other option fall upon the responsibility of the therapist and the HCBS providers, rather than a Support Coordinator? Then we are asking for more from our providers than they are already hard to retain and meet members' needs.

Female: And the last comment I have online is, the proposed model appears to just add another layer, or the overall funding would have to go before it reaches the service the member receives.

Male: I just wanted to respond to this gentleman's question here. And that is, the services will be available. I don't think that's the question. I think the question is where [name redacted] was going, is the requirement to provide those services in the RFP? Because there's providers willing to provide those services. It's the RFP, and are they held, is the MCO actually held to provide those services? And that's the critical point I think that [name redacted] was trying to make, that we need to be very careful when we see that RFP, and what is actually in there. And determine what may happen before we actually get to that point of providing that service.

Female: In that comment, that's exactly what I mean when I say we want to be involved in the writing of the RFP, and then look at who is holding the MCOs accountable. And to the support coordination question of it going to the MCOs, North Carolina just awarded managed care contracts, and they did not include support coordination. They kept that private. So just one to take a look at.

Female: Thank you. Anyone anything else? Oh cool. I want to move – oh did you – ?

Female: I have to agree with a lot of comments that we need to review a lot of things before we pass it. I know that was the same problem with Obamacare, that it was kind of, you prove it then you review it. And I think this needs to be reviewed first, before we implement it. Also excessive paperwork, stuff like that, that increases in time. The therapists had brought up some concerns and DTAs. Since I've started a DTA here it's changed a lot. Teaching strategies which I was used to at another DTA, we happened to already do. It was called something else, and it was tied in with an educational institute at the time, it was a 30-year program, grandfathered in as a DTA, so we were used to it. But it was excessive paperwork. And when we found out we were paying rent, it was no longer a building provided with taxpayers money, where I was at another DTA that could afford these extra things. This excessive paperwork became costly, especially because we pay our employees a little bit more, to keep them. So that we don't have to, you know, be concerned about hiring. Who's the next person coming on board?

So these are some interests on my part, just to make sure that all the findings are done ahead of time, before we put something out there. Because it affects us.

### Thoughts on Governor Ducey's Executive Order

Male: [Name redacted] states, mandate pre-employment psychological profiling for those who may serve our people.

Female: I'm all for raising the standards of training for our providers, but it's unfunded. And we need to do something that provides funding to agencies to ensure quality care is being delivered.

Female: I think always we can improve upon our training to signs and symptoms of abuse and neglect. And then the frequency in which we train that. Because you can't do it enough.

Female: I think we also have to remember, we focus a lot on staff – rightly so – to focus on our members, and teaching our members skills. Self-advocacy skills, how to say no, conversations that as an industry, we're not comfortable having directly with our members. We need to start having those conversations.

Male: [*Inaudible.*] 1:36:32

Female: This is a general, can we get copies of these slides, or no? We can't have copies. Okay.

[*Inaudible.*] 1:36:46

Female: I missed opportunities to do that.

[*Inaudible.*] 1:36:51

Female: Okay, cool.

Female: You mentioned that this report will be for AHCCCS and JLBC. Will that be made public?

Female: I've got one chat, if I can go back and add it?

Female: A thought on the Executive Order. It says, this is a difficult conversation. Look at having two staff present with members where they are in vulnerable situations, such as changing, bathing and use of a toilet.

Female: I'm sorry guys. That's what I want to add. Thank you everybody, both here and on the phone lines, thank you.

*Indistinct voices.*] 1:40:05

[*Applause.*]

1:41:44 [End of recording.]

## Chandler (East)

### What is Going Well with DDD LTSS?

Female: I think it's going well how quickly DDD turns around its payments and resolves payment issues.

Female: As a biller, I do like when they answer our ISPs back really quickly, so that we can update our services for our members that we provide. Or so that when adding staff to a house, or updating a matrix, we're very quick to get responses back for that.

*[Inaudible.]* 0:19:41

Female: I know there's been some [provider redacted] meetings going on, and I feel like DDD is trying to listen to us and work with us as providers. So I appreciate that.

Female: DDD is really good about hearing the needs of the member. Extending the services and the service plans that are needed, habilitation, attendant care, respite, moving it back and forth to also balance the State budget, along with meeting the needs of each member. So they're good at listening and working as a team together cooperatively to help one another.

Female: I like how they've implemented the DDD customer service queue. I feel like it gives continuity of care, and they take the issue and they resolve it amongst all divisions.

Female: I think the vendor call system has been working pretty well too. I think communication –

Female: Really, yeah no, I've actually gotten really good response with those for vendor calls.

### What Needs to be Improved with DDD LTSS?

Female: I would say maybe communication with some Support Coordinators. I have noticed even with families, there can be a lack of response and available resources. We do try to refer out if there's a service we can't help with, and guide families. Sometimes we're hesitant to push it back on the Support Coordinator for those kind of things.

Female: We kind of have the same issue of the Support Coordinators, they're very hard to get ahold of, especially when we need to add modifiers to our members and stuff like that. We have to get them approved during different sectors. We used to, when we called into the DDD to call about our billing, they would normally try to filter out what's really easy and quick to take care of, and now that they're for sure like no, first come first serve – which I believe that there should probably be a separate team that kind of filters out something that may take five minutes to

resolve, to that the provider can get their answer, versus something that may take a couple hours of somebody's time to resolve. That is not only an issue that I've said, but a DDD worker as well has pointed that out. That they used to like the old system, where they could get 20 things done because each one would take five minutes, versus making sure they're just going by the queue, they make sure to dial back and get the other ones as well.

As far as the 24 hour turnaround for any type of call back, sometimes I feel like when there's not clarity, again there should be a sector that can answer basic questions, for us to get done. Coming in as a biller for the DDD, my first time in August, there were a couple questions that I needed right away, because my company depends on our billing getting done. The training was good, it was able to get there. There is a lack of communication when you guys update your prices, so that when we put in our billing, there's no – the rate books weren't being updated for providers to implicate the payments. We were submitting it with old prices on it, and then the whole rejections and stuff going on about that. So there needs to be better communication. You know, a month prior, hey we're upping our billing prices as of this date. Please make sure to give us time to update the rate book. Give us time to implement the prices into our system. Stuff like that helps providers a lot when we go to submit our billing. And to be very clear too, okay technically is it for just starting this date, or the entire billing that we submit that time? So there's a lack of communication there as well.

Female: Kind of along the lines of support coordination is the onboarding process that they have. So there's been a lot of turnover, and I feel like any time – I could call five different Support Coordinators and get five different answers. And that's really challenging when we need a clear answer.

Female: Kind of along the same lines, the Support Coordinators, I understand DDD is understaffed, so I would love that to change, where you guys could have more Support Coordinators. Because right now, if you try to get the assigned Support Coordinator on the phone, it's very difficult. Then you try to get the Supervisor on the phone, and try to escalate it, you can't get the Supervisor on the phone. And now it's gotten to where that customer service line is the best way to get a call back. And usually the reason to call is because we're not getting those ISPs back in a timely manner. Which they're not getting back, and then sometimes that delays goals, it delays documentation and so forth.

[Inaudible.] 0:25:37

Female: Okay, so. [Laughs.]

Female: Yeah. So the biggest thing that I think DDD needs improvement on is consistency amongst all the divisions.

Female: The districts, sorry. The reason that I say that is we realize that there's new planning docs, we're all willing to accept them. But what we're finding is that each center is being trained different ways. An example being – this is the biggest

one – they talked and gave an example – and I talked to [name redacted] about this too – they gave an example that there should only be four goals, and that you work intensely on for goals. That was the example given in training. Well these Support Coordinators and Supervisors are running with that. and so when we're in a team meeting, and the family wants more, and it's what's conducive to the member and what's right for the member, they're saying no. So it really does need to go back to team decision with the planning docs, and what's right for the member.

And then the other thing I wanted to talk about was, as far as authorizations, I wish there was a way that SCs could get alerted when an authorization is about to expire, so that they could give us, the authorization, at least a bridge off to cover us while the meetings are taking place.

Female: Okay.

Female: No problem. And I think the timeliness of the documents is another one I want to reiterate. Because we can't roll out a program, and now they're looking at every 90 days, what is the progress that the member's achieving? And if we have not had the planning doc for the last six months, and we keep requesting and requesting, we can't give factual data because we're working off of old goals. So we really do need timeliness of documents.

Female: More of a collaborative relationship between the Support Coordinators and the support team on the vendor side. It seems oftentimes that the team meetings, it's more of a directed format. This is what we need, this is the way it is. And sometimes there's not even a clear understanding on the side of the Support Coordinator as to what the program requirements are for an employment program, for example. What some of the guidelines are in terms of authorizations. What we're able to request in that capacity. Just more of an equalness. That would be nice to see.

Female: So rolling off of the communication with Support Coordinators, a really big issue we have is contact information. We know that Support Coordinators are changing all the time, but Focus is not updated with the correct Support Coordinators, the phone numbers we call are not correct, Supervisors are incorrect. So it takes us a while to get in touch with the right people.

And then also, I know that meeting notices are supposed to go out for the 90-day meetings, and we're never notified when these meetings are happening. So we don't know when to request documents, or to be present at meetings. So that's another issue.

Female: I think there needs to be a way for the Division to work within its own departments, so that information that's submitted to OLCR could also be submitted to contracts consistently. Or with everything that's happening with QA right now, and their requests for fact findings. And instead of providers having to re-submit all of the training, they can just go into the OLCR app and they can

look at the staff roster and verify it. There's a lot of time and effort wasted, on both sides right now. And if there was more transparency in the system, I think that would help.

Female: I just have some concerns about some building codes, the restrooms, all that stuff that gets tied into being in a community. The prices increase, and so since now a DTA is supposed to be established in a community, some other DTAs are in homes, and that is quite sensible and good. With pricing, the only problem is for the new DTAs, there's no compensation for that extra square foot and commercial space. So I think considerations could be accounted for that.

Also the Focus system, I appreciate that DDD is allowing us to give input for changes now. I see that they want the roster updated more, so that it has an accurate account of employees coming in and coming out. However the Focus times you out very quickly, and so you have to work very fast. And so it is tedious, and it is a little bit overbearing too, when you're –

0:31:37

Female: I don't remember, but you have to work fast. No bathroom breaks. *[Laughs.]* Forget that. So Focus could definitely use a little bit of an overhaul right there.

Monitors, I've had a situation in the past where we are surrounded by a community garden, library park, community pool. And a monitor had said that that wasn't enough. So that took a toll on our business, because we had to provide a bus. We've tried doing the [privder redacted] thing, it didn't work. So with those extra expectations cost money. So when you expect, you also have to look at the compensation, if the money is providing for that service or that additional need. So monitor consistency would be very helpful.

Drop ins, member drop ins. I don't have problems now, but I've had that in the past. So when you are trying to have a 4.5 ratio for staff, and you have members that are not consistently coming, it helps to have a Support Coordinator to kind of support and encourage that attendance. Because it does really affect the finances. So we are expected to have that, and so if the member's not there, and reinforcement's not there, it puts us in jeopardy financially. I think I've covered everything.

Female: To jump on the vendor call question, I might be the only person in here who has the habilitation consultation contract, but on those authorizations, the Support Coordinator has an option to check one box, which provides that member absolutely all maladaptive behaviors possible. So a way for them to separate what the member actually has as far as behaviors, versus physical aggression, verbal aggression, self-abuse, inappropriate sexual contact. There's like ten things that apparently every single person has. It's amazing.

Female: Well no, I think it's a system need, within Focus. There's also still a – very, very few of us, between six and eight, habilitation consultation contract holders, and

Support Coordinators are still be told to push the service. I'm based in Mesa, I get calls from Cibecue. I don't even know where that is. Flagstaff, Bisbee. So looking at something as far as – it's rate-based, as far as what the Division reimburses us for. And there's getting RBTs in the service, which right now it's only BCBA's that can provide the service. So if the need is so high, and I've turned down 300 people in the last year, then the Division needs to do something in order to get this fixed so the members can get the service that's been identified.

Female: Okay, so I work on the billing side of things. I just started helping out with the company with this in like October. So this is what I've seen so far that is kind of frustrating. First of all, on the online, DDD online, the documents aren't always accurate. When I went to the training for the billing, she said don't use this one, it's not correct. So they're not getting uploaded, the resources that you have. Those document resources aren't always accurate to what was implemented.

Female: The next one is in Focus, in regards to MCID codes and whatnot. It seems like – I forgot the terminology that they use – but the patient portal, or client portal that they have, Focus isn't always updated. Either it's missing insurance information, the expiration dates aren't correct, it's the wrong insurance, and then it kicks back on billing. We have to wait to get paid, because Focus isn't updated. And so it would be great to see that updated more on a consistent basis, or monitored better. I know it's hard because the families, in most cases, have just, hey I have a new insurance, and I know that's hard. But I never know who to contact – well I think it's benefits or TPL benefits I believe, to contact. So I'm not 100% sure what protocol is on getting that updated.

Female: Fantastic. Okay, good.

Female: AHCCCS slows everything down.

Female: They do, yes. And then in regards to uploading billing, it's Excel. And it has to be extremely accurate, which is fine, but when I first started doing it, I missed like the date. I had a four-digit year. So it kicked back the entire billing, which was frustrating because you have to wait until the next day. It would be great to see some kind of upload like the claim replacement that you have online. It would be great to see – this is more of a suggestion – the claim replacement be similar to that, where you could upload all your line items, your claim lines similar to that. where it was just so easy to get a claim replacement done, and the next day was entered and paid for.

The next item that I'd like to talk about are DDD waivers. We've found it very difficult with the new implementation of the denial code for insurance. They're denying payment from DDD, because of the wrong insurance code, that they're denying insurance for a certain reason. And DDD won't accept that reason.

Female: Like E31 or U – I forget, UX something or other. I don't remember. So whatever insurance is declining, that reason is not good enough or it's not correct based on that DDD will accept to pay the claim. So we're having troubles with DDD

paying claims based off of a denial, but not the correct verbiage from the insurance company. So it's back and forth with the insurance company.

Female: Correct, EOBs, yes. So that's an issue that we're facing where it's a struggle, and we don't know the next steps to really – it says they're not paying because of this reason, but the verbiage is incorrect, so it's a struggle in that respect.

And then also in regards, you guys had talked about Support Coordinators, it is very difficult to get ahold of them, and they are switching. So I just want to reiterate that that is an issue. And I know it's budgets and whatnot, but I just wanted to touch base on that, that it's difficult.

Female: I find an issue with the new vendor call system.

Female: [*Laughs.*] Because of where we're located. Yesterday I went and looked, because we needed new speech clients. And I pulled up all of Maricopa, all of Casa Grand, and there was not one member from Maricopa and Casa Grand in need of speech. And I find that hard to believe, because we actually have a clinic in Casa Grand, and a lot of people don't even know that we're there yet. And we have all the time, members saying, oh I wish I knew you were here, or how long have you guys been here? We have families that, why didn't my Support Coordinator tell me you guys were here.

And then bringing up families, I think that the Support Coordinators need to support us as providers, with families being held accountable to their therapies. We have the three no show policy, and we have the option of dropping services. Which I know that there's changes coming down from that, but we don't get the support from the Support Coordinators holding families accountable. And because we have the clinic, and there's no compensation for no shows, if I'm sitting in the clinic and I've got therapists there, and they don't have clients showing, I can't pay them. Therefore they don't want to do clinic-based therapy. Which is beneficial to some members that don't work well in the home. And then we're paying for rent, or our mortgage and the utilities, and we can't find therapists who want to do clinic-based which is much – from our perspective, for OT services, PT services, we have the equipment that can benefit the members more than in the home. As far as Support Coordinators, the lack of communication and support from them is tremendous. And I just find it hard to believe that there's nobody in the Maricopa/Casa Grand area looking for speech services right now.

Female: I just have a quick suggestion regarding the services, and it being missed. Maybe there needs to be a place where the Support Coordinators can see our brochures. Maybe there needs to be a temporary table set up at DDD, completely where they can see all these different services for these different programs. Because I know it would benefit us as well. We are a smaller hab program, so sometimes when we look on Focus and stuff, it's harder to find members.

I do agree with the reimbursements for when members aren't there, because we do have it sometimes where our members have decided to spend a little vacation

to UPC, and so we are holding a bed for them, and we have to tell one of our staff that okay, well we don't need you temporarily while this person's not there. So some kind of bed hold thing, where we can charge them not even saying super a lot, but something to be reimbursed for holding the bed for that member.

Male: Yeah, I have a couple comments. The first one that you mentioned earlier, about Governor Ducey's focus on making sure all Arizonans are safe. I think this is going to become more of an important issue, even more important maybe than it already is. But the incident reporting system is kind of frightening right now. I mean, there needs to be a really clear understanding of what should be included in an incident, when an incident report should be filed. I mean, in the past I think that I've always thought that it's way to document something that occurred. And in our industry, there are a lot of incidents. I mean simple things, things that are kind of in that intermediate area, and then some serious things. Even the simple things though, you know I've getting fact findings. And my reporting, I mean in a way, the fact findings teach us what the DDD expects in the incident report, so they're good in that sense. But for the most simplest thing, if a medication falls out of someone's mouth after they've taken it, then my incident report shows every step. A pharmacist was contacted, providers, guardians, the whole thing, that I will still get a fact finding. It requires an enormous amount of time for someone. We'd almost have to have a designated person on staff to deal with these incident reports. So just a way to, I don't know, let the serious things follow maybe a certain pathway and then the simpler things that are just for documentation. To have a real clear understanding of how that process should be.

If I can throw in a second comment, this is regarding vocational programs. And I know that there's been a lot of talk, and that there's been a lot of opportunities for us to learn more about how this process works. But there are able accounts, there are special needs trusts, there are ways that families can have their participant or their member earning money and not lose benefits, any more than they would need to. But families, a lot of them are still under the impression that if someone works and loses – a lot of it comes down, there's issues with social security. So yeah, maybe they won't lose this benefit or that benefit, but they do know that if someone earns a certain amount of money, they are going to lose certain benefits that they've worked really hard to get. And so as a provider, our focus is on moving folks toward independence, toward competitive employment. It's an obstacle that we run into a lot.

Female: Knowing that this information's going to go to the legislature, I would also want to just advocate for a provider and our rates. Because to hire direct care staff, ever since the minimum wage increase, that has put a significant strain on providers. And also just with the cost of living increase. So in order to keep agencies in business, I definitely would advocate that DDD – and I hope DDD advocates – for higher rates for our providers.

Female: I just want to expand on a couple things. Going back to the vendor call, I've been dealing with [name redacted] and one of the things we've found is that it's timing out. And so it's not a matter – when the Support Coordinator puts it into the

system, it times out after three days if nobody responds. And so the issue is they're looking at extending that. And what we would like to see – and this is what we've said – is let it extend out as long as it needs to, until the member is served. Once the member has the services assigned, so that way she could find all the people that aren't finding it. Because what's happening right now is it times out. Support Coordinator either one, has to follow up with the family, which they're not doing until the next 90 day, and then they're re-inputting it at the 90 day. So the member is going 90 days without a service.

Female: And then the next one is the incident report. We need somebody following up on them now, versus two years from now. And that's the issue that's happening right now, is we're getting responses, how is this member, on an incident report that happened two years ago. And a lot has changed. And it's hard to follow up on something that happened that long ago.

Female: And then the speed of Focus. So we need to increase the overall speed, because if we go in and we view an authorization, it's taking us sometimes ten minutes to even get into an authorization. And so our speed factor needs to be drastically improved. Because we have people that work our authorizations, and she sits there and it just spins and spins, and then it finally connects, and I mean sometimes it takes ten minutes for one.

Female: The speed of Focus is a great one. And I really dislike, if I can openly speak on that, is that at the end of the auth where you have to input the start date, I've talked to other CEOs and other agencies too, everybody's putting in the beginning date. It's a waste of time. We could actually invest that time into our families, reaching out to more families, getting to those vendor calls, than sitting there ten minutes for this stuff to load, to put in that start date. Because I guarantee you, every agency is putting in the date that it's authorized. It's wasted time. So if we can have the start date removed from Focus for the pending authorizations or the acknowledge. I'll give you some time. And meanwhile say hi to [name redacted] and [name redacted] and [name redacted]. I love IHD.

[Inaudible.] 0:49:39

[Inaudible.] 0:49:46

Female: And then on top of that too, when you go in to closed auths or all auths, it would be really nice if we could see all the auths in date order. Because you have to go in and search, you have to keep clicking, and you could put a window. But then there's that lap of ISP. So if it could actually – I know that we have computer systems that are up to date these days, that you can actually just click and have it go into date order. I know it's so simple, but those are the things that get under my skin. [Laughs.] I'd rather be helping families than spending time on a computer.

Female: We've expressed also a concern, so we want it on the record, that we would like to have the ISPs attached to the Focus authorization.

[Laughter and applause.]

Female: Hi, I just want to say I don't have anything to suggest that needs to be improved, but I really admire your positive attitude in receiving all of this for the last hour, and being positive and helpful instead of getting defensive, which I certainly would in your situation. So.

Female: You have the IOCs, right?

Female: Okay, yes. Any chance that you would be able to go back to having those as typed minutes instead of audio?

Female: Okay. The audio took me three hours and I couldn't understand any of it. And then for talking about the Support Coordinators changing all the time, suggestion. Put a bounce back on their emails when they quit, so when you email somebody it bounces back so you know to move to somebody else.

Female: One more thing. I know somebody else kind of said it too, but utilizing your guys' systems across the board, like between OLCR and DDD, and the double investigation questions and incident report questions. It just seems like you start to repeat yourself over and over again, and even with the census, I'm having to do the census in one spot. And then also, all of our same vendors and sites are in Focus. And you guys see Focus and see all the sites, and we update that all the time. So that is the census, but yet they want it in a whole other census. It's funny, because I've emailed my census for the last six months, and every month it keeps coming back unopened. So DDD isn't even opening our census, but yet they require the census. So just a suggestion.

Female: Another thing I'd like to bring up about the matrixes, when you're entering in the numbers as the biller, for how many staff are there per hour, unfortunately if you don't hit tab fast enough when you're going through the numbers, if you accidentally put a 22 in the box and you didn't save halfway down the list, unfortunately you then have to exit out of the that screen that you've already entered half of your schedule into, and restart from point one. Instead of like turning the box red, saying hey, you can't have 22 staff members in that one hour, and letting us delete it. It has no delete. It says, well you have to exit out and restart over. Instead of going through and being able to just *tch-tch-tch-tch-tch* and be done.

### What are the Solutions for Improvement?

Female: I'm sure it's been addressed a bunch of times, but just from the time perspective, in Focus when we have to update hours and send that information and how many hours are available and left, etc., there's no filter capabilities. We have different districts, because we have multiple families across Arizona and different coordinators. Some way to filter or even see how many hours are used in that filter system. But some way to narrow down from 300 to the 50 in my group for example. Quickly get out the hours, and I'll work on habilitation and people.

- Female: Expanding on authorizations a little bit more as well. Like you mentioned, attaching an ISP, that would be great. And also I know we have an obligation to accept an auth in seven days or we can be penalized. So in those situations where an authorization is mis-assigned, or we don't even know the member, whatever the situation may be, maybe just have a denial section. Exactly. Or if there's a comment field, or if we have to give a reason why, that's something we're more than happy to do.
- Female: It just shoots right back to them instead of that email, lack of communication.
- Female: I was thinking maybe Labor Ready might be able to help people with Article 9, CPR and first aid. Maybe our option would be to reach out to them, so that we can have –
- Female: Like Labor Ready, through DES, where they prep up people for work. That would help us. Because a lot of people find jobs, and you don't really have a sub list, so when people are sick, and you want to keep your ratio good, you have somewhere to call. I thought that might be nice in the social services area.
- Female: This is really a suggestion for all of us providers. I'm a member of [AAPPD], and they are helping – I would highly recommend that you guys check into that too. What they're really helping with right now is the legislature's going in voting on the budget. And we need everybody to send out letters. I just made phone calls last night, I've sent my letters. And that's a way that we can get our rate increased by getting the budget to go through. If you guys can reach out to me, I can connect you with that, or I read a script last night to about 12 legislators, and wrote my letter. So we need to do our work on our end too. DDD had to have the money to reimburse us for those rate increases, so if we can start at the bottom there.

#### Thoughts on Alternate Service Delivery Model

- Female: *[inaudible 1:03:52]*
- Female: For the members that are over 21, and they need physical therapy ongoing, will those members be held to the health plans we give you 15 visits a year, 30 visits a year, whatever. I mean they vary per health plan. But AHCCCS has a limit on how much PT they will provide, and some of the members that are DDD qualified need PT on an ongoing basis. So will those be affected? Change?
- Female: You're saying this part will remain the same, but I've heard rumors that it's going to change.
- Female: Are we at that part yet?
- Female: Okay so my challenge is – and I look at this both as a mom and an agency, okay? We have a Support Coordinator who comes in who we built that relationship with. We will not have that relationship. As a mom, it's very difficult for me to work

with my health care plan to get what I need done, because I don't have a Support Coordinator. It's just a generalized number, I have to call it in, I get my supports and services. With the model of the DDD services – and I've actually done some surveys with the members that we serve and their families – they want that Support Coordinator. They want that one person to manage what it is that they need. So I would say that it's not, from a mom perspective, I don't see it working.

Female: From a billing perspective, for companies across the board, we would like to put this in bold, in big letters please. With changing over the long term services of the hab services, over into the insurance companies, that gives the insurance companies 90 days to process those claims. They do not have to pay you until the 90 day mark. Right now we are getting a five day turnaround from DDD, which helps a lot of us smaller companies. Or just our companies that just do DDD. If we go into that, and heaven forbid you get a denial back, the insurance company then gets 45 days from then. so if they answer you back on the 89<sup>th</sup> day, and say no, we're not paying this for whatever reason, they then get 45 days from that point of saying no. And then not only that, you get two times to get that denial answered, and then you have to write an appeal. And each step you take with that is 45 days. And heaven forbid they get a backlog, they will let you know. And then you get a year to argue that claim denial. That will not help DDD services across the board for us providers who have to consistently pay our staff to come in and deal with the more difficult members, you know. We all do it, because yes, we do like this line of work. We do like helping people. But at the end of the day, our people still need to go home with paychecks.

So from a billing perspective, switching any of the hab services or the 24-hour care over to an insurance that can take 90 days, then 45 twice, then another 45 to answer an appeal. That is not going to help us unless they can guarantee a five day turnaround, just like DDD does. Because I know some of us even bill twice a month compared to once a month, because our companies are smaller. So we don't bill them once a month, we bill them twice a month for DDD. So that will not be a positive thing.

Female: I also come from this aspect as a parent, and providing agency. My issue would be too, when you have a Support Coordinator come in a home, you're dealing with DDD directly, you say, my child needs these services. There is an approval process but it doesn't take that long. We've also dealt with insurance companies on things for like health care for our children, and they deny a lot of things. And I'm afraid that it would be the same thing. I mean, how many of you here are absolutely ecstatic about your health plan? So you know, there are problems with DDD. We know that. but I think working together as a community, we can actually improve what we already have and make it better. It's not horrible. There's great things about it. We can all sit there and say, I have a great Support Coordinator, I have a great support team. Other people say, mine's not so great. But I think working together we can improve that without going down this path.

Male: I just have a simple question but for clarity, the company provides HCBS services. With these models, the new model, do we have to be contracted with United Healthcare? So we have to go through that contract process. Thank you.

Female: Thank you. A couple things. I'm concerned about the rates, when we go to contract with the health providers, with the insurance companies. We have an okay rate now. I know that insurance companies have low rates. And right now, we're doing the best we can with what we have, and I couldn't go any lower as a provider. And to pay our providers, our therapists, they can't go any lower.

I'm concerned about being limited to the number of visits that we may have, that insurance companies may have in place. Our kids have, they're developmentally delayed. They make progress very slowly, they need ongoing for a long time services. The individuals that I work with need services from very young to young adult, to go through all the different stages of life. When they turn 18, they aren't done with services. They need young adult, getting into the job, getting an apartment, developing relationship, they need our support through all of that. And it needs to be recognized, and DDD currently recognizes that.

I'm concerned about the length of service. So if they say you can only see them for a certain amount of time, and showing progress on our progress reports, we don't show a lot of progress with the kinds of individuals we work with. We don't show a lot quickly. We show it over a long period of time. And that's exciting to see. I've been in this field for a long time, and the kids that were three are now driving cars or getting jobs. But that progress has happened over 20 years, it didn't happen in six months.

I know that we've said a lot of things about our Support Coordinators, but overall we've worked with a lot of really good ones. We don't get phone calls back and stuff from some of them, but we also have really good relationships with a lot of them too. They've got our back, and they've got our clients' backs. So those are my concerns.

Female: Okay, I have a question with regards to, since that's going to be their primary insurance, I'm assuming? Just like normal insurance.

Female: Okay. We asked about being contracted, now we have to be contracted with them even though we – like for instance we have speech and occupational therapy. We have to now submit to these insurances, and we have to be contracted with them. So right now I have to get a contract with these providers because we have to submit them first and then go to DDD?

Female: Right, but if they had that service plus a speech. Like for instance –

Female: Yes you are, I apologize.

Female: I thought only because we have primary insurance that we have to bill first, and then if they have two services –

Female: But wouldn't that be, like Care First, wouldn't that be their primary insurance?

Female: Okay, got you.

Female: So if our agency was, say, contracted with United Healthcare, and then once the individuals pick out their health care plans, if they currently live in a developmental home, and I'm only contracted with United Healthcare but they're going to have Care First, then do have to move out? And if their roommate has a different – right.

Female: Yeah. That would be a big concern for individuals that say lived with a provider for 13 years, and yeah. And our agency, they would have to move out because insurance switched and we weren't contracted with that insurance. The other thing would be that, from what I've heard from other states where this has happened, that it just becomes very data-driven, and it's very medical-driven. And they're going off data results, off doctor appointments, and it's a lot more data towards that that I think with all of our concerns over there, unless those things improved, it would become very difficult on the agencies.

Female: So I think the only reason that a state goes to a system like this is to save money, and to make the money that they've got stretch further, which is not a bad goal. But changing to a system like this means that the managed care organization, the insurance company, has to receive money from the system. And believe me, there's no indication the legislature is going to add money to this system. And also, the realities of procurement are that an RFP gets put out, and the lowest bidder is who gets the contract. Which means that that insurance company is now having to conduct this system for the lowest amount of money possible. And since no money is being added to the system, the rates for service won't necessarily go up, so now a greater portion of those rates goes to the insurance companies. And I'm not blaming them, that's how the business work. But the person that said they're concerned about the rate, I think that's a huge concern here. There will be less money flowing to agencies and caregivers, and what happens with that is that you then have fewer agencies and fewer caregivers who want to be in this business.

And I would suggest that if you guys are doing research, Texas went over to this system recently, in the last few years, and you might want to talk to agencies who do business in Texas. And if there's some way to talk to your counterpart organization in Texas to talk to families and actual caregivers, to find out what their experience is with this change. But there's a lot to be gained from efficiencies in the system, and I always applaud that, but I would be very concerned about having more entities in the system who need the existing money.

Female: My concern is we are from an underserved area. We have a hard time getting therapists. It's gotten better over the last few years, but there's a lot of areas still in Arizona that aren't. So if we go to this system, is it going to be one statewide rate? So that tier two, tier three, we don't get those additional rates to entice therapists to come further out.

My next concern is we have a hard time keeping authorizations up to date when we get them a year at a time. A lot of the insurance companies only give 15 or 20, and I'm spending all this time submitting for more authorizations, that takes time away from other things that we could be doing. They get denied, or they didn't – we never received it, all the slew of things that we get back from the insurance companies on a daily basis. So then we have to put member services on hold, and the member's not getting served because our therapists aren't getting paid because we're not getting paid. And it just seems to be that there would be more time on a provider's administrative side that would negatively affect a member.

And I'm a parent also. I have struggled to get physical therapy for my child for four years. because nobody comes out to Maricopa, and we can't find a PT to come out there, because a lot of different things. But PT and OT get the same rates, and a PT has to – they want more money. So as a member, I'm looking at this system, as a parent I'm looking at this system. And I don't see any potential benefits as a provider or a parent. I just see a lot more frustration, a lot more time sitting on hold as a parent, and as a provider.

Female: I was lucky enough to attend a meeting – and I don't know if anybody in here as done it at [provider redacted], when we talked about this. The reality of this, just to kind of alert you guys, to advocate for your agencies, is the MCOs have their own business model. They are for profit. They have clearly said they don't plan on contracting with all 400 agencies. So it's a matter of you submitting your proposal, they're going to look at who has the most services, so if you're just a small HCBS service agency, the chance of you getting that contract are not going to happen. My concern with this after having attended that meeting was, our members have built relationships with the agencies they're with. Whether you're small, whether you're large, there's a relationship. And if that agency is not given that contract, that member now doesn't have service, and they have to go somewhere else. And for some of us, we've served our members for 15 years and they don't want to switch.

The other part of that concern are the rates and I've heard this, this is exactly what they said. Rates are not published rates. They're going to be given based on who – what I got out of it was who is the larger agency's going to have the most negotiations, they're going to get higher rates. The rates are closed, so I'm not going to know what this agency is getting, or they're not going to know what we're getting. So functionality from us on a financial basis is going to be tough.

Female: I'm not sure if you happen to know, but –

[*Laughter.*]

Female: I'm just going to ask though. We do provide [ABA] therapy through insurance, we do have a couple contracts with insurance companies. For those that are eligible for DDD –

Female: And that's not easy.

Female: [Laughs.] For state services, would any of this be an option, the United Healthcare and Mercy Care as a secondary billing? Or do you happen to know.

Female: I just want to say with Mercy Care –

Female: So just to clarify, I'm with Mercy Care, we do also contract with ABA providers. We also look for those that have a DD contract for continuity of care. So you are one of our contracted providers.

Female: Okay. So I've been a biller for the last four years. If the situation switches over to this, from ICD9 to ICD10, there was a 30,000 code upgrade. For this situation, when you go into that, some providers don't know. You have to be contracted for each code, you need to use both your CPT, your [unintelligible] and your diagnosis codes. If you are not contracted with those codes, you cannot help those members under those codes. They also have all inclusive codes, which means your transport, everything else that you do additive, the therapy in the houses, the personal care. Everything. They can put that into an all inclusive code, which means just basic care of what you need to do. Whereas now, we kind of have that flexibility. You also will then have to get approval for modifiers to go through, as we know some of us help people that are nutritional needs, and continent needs, and things like that, will also have to be argued for and then approved via your contract, which has to be set up. They can deny it. There will be AHCCCS rates, so you can fight for a modifier on that. But again, they won't tell you that another agency is getting \$400 for the same code that you're only getting \$200 for. So there is going to be a lot of arguing per the money that needs to go to keep a lot of these programs up for DDD. So as a biller, you guys are going to have to definitely step up your contracts if it goes into these situations.

Male: So what I'm seeing on here. I see qualified vendors and then on this one I see no qualified vendors, on the right. So that would mean to me, no agencies at all.

Male: Okay.

Female: The one thing I'm really concerned about too is if the State is looking at this for their budget and everything overall, what's going to end up happening if we do end up moving to that plan? You're going to end up seeing a lot more unemployment, agencies like you said, I've heard that too, where they're going to have their run of who their pick is. Agencies will lose their contracts, so we're going to have unemployment going with DDD, because the jobs will be cut as well, because they're not going to be able to sustain with this model moving to that model.

But more importantly, my main concern is we're here as IHD knows too, and DDD and all of us, that we're here for the member. The quality of care is going to change, their life is going to change, their day to day living isn't going to be first and foremost, it's going to be a waiting game, waiting for the insurance to approve things. So it's going to be the loss of quality care. And that's my biggest concern, because we are trying to make them advocates and be their own

independent selves and be the best that they can in the community. But this is where it gets lost in translation, where it does come to money. And the lady on the end said, that in itself – it's great if they could actually achieve that, but what ends up happening is we have the Support Coordinators, and like you said too, where we all really know our members by heart. And what they need. And if we're not there to advocate for them, one like you said, they'll still be there but it's going to get lost. And that's the saddest part is that the day to day lives of a member is going to change because of money. And we all know that's what that model's for, it's for money. That to me is the saddest part, so I really hope that's not where we're going.

Female: I want to thank everybody. I think this is constructive criticism. I think that the approach that we're taking is going to help eliminate some of the problems. I thank the Mercy Care representative for being here. I do feel that DDD needs to be practical. They need to delegate duties so this is probably why we're going into this option. Support Coordinators may be more available for others for the needs, and hopefully these little bumps and hurdles will be smoothed out now, since we're coming forward and suggesting all these changes and these concerns.

One thing I do not want, which I'm a little bit concerned, is HUD changed from private to public, so you know, there's always a little concern that DDD might do the same. And so that is my concern. But I do want to thank everybody, because you know we all bounce off of each other. And I do think that we do need to contact our legislators and tell them. We need this financial stability, we need this, to know what we have ahead, in advance. So if they're thinking about going the HUD direction, it would be nice to know. But we would love to stop it, because we are part of this group. And we care and we have a passion for them. Even if we're small. So thank you.

Female: I think it was me. I think a lot of my questions, comments, concerns have been raised already. I know that rates have come up a lot. The fact that it wouldn't be published, a lot of us have no experience negotiating rates, and that's a huge concern. Because we also can't discuss them with one another. We can't say, oh what are you getting, are we even getting a fair rate? We have no clue, so that really puts a lot of us at a huge disadvantage.

The billing multiple MCOs instead of just billing one system is a big concern for the time with that as well. The fact that they don't have to contract with all of us, so we're not guaranteed who we're contracting with, and we could be losing a lot of the members that we currently have. Families also, I'm kind of going off the original IFP that had come out with some of the information on there, where families could switch MCOs as they desired. That also has a lot of impact on the continuity of care, if somebody's going oh, well I was with Mercy Care, but I'm not liking them so I'm going to United. Well I'm not with United now, halfway through the year, three months in maybe, they're switching around to different providers.

Also aside from the money aspect which we've all talked about a lot, the oversight and contract requirements is a concern as well, with the continuity. I know that in the original RFP, it has said that there would be one oversight sort of committee that oversaw everything. Well, even with DDD right now that we're all just going through, we still have program monitors coming in. We still have OLCR licensed safety inspections. A lot of different stuff going on. How many more inspections and monitorings are we going to have once we have multiple MCOs that we're contracted with? And even just having different requirements for what we have to do for each MCO is a big concern as well.

Female: I also see a potential. We already in Arizona have a therapist shortage, providing quality therapies for our members as it is. I see this as another way that will push therapists to move out of the State of Arizona. And that would be a huge deficit.

Female: I have a suggestion. Have the Support Coordinators take out a flyer, a script, to a 90 day review. Have them compile data of the families like this model, and go with what they have to say. Because it's really about them, it's not about us as agencies. It's about the people that are getting the services and the supports. And I can guarantee you, families – I mean I did a survey with my families, and 85% of them wanted to stay with the DDD model.

Female: I have. I actually put that on there to reiterate. We really need them to voice their concerns.

Female: But that's not a lot when you look at we have 30,000.

Female: So why can't the Support Coordinators go out, through training, and talk about it at a 90-day review?

Female: To kind of bounce off what you were saying, I think one of the concerns that we are having is we all know what our providers are required to do to get hired. Is that going to change? Is it going to be different for the credentialing? Are we going to have to credential? That's a whole different thing. I know that our trainers have to get CPR first aid, they have get *duh-duh-duh-duh*. Is that going to be different, is that going to stay the same? I think that's a real concern of ours at our agency. Because again, that's going to be administrative costs to go, okay well – or do we – it's going to be confusing. But it would be nice to know sooner than later what these companies are going to require of our providers.

Female: That was actually going to be my question too. If we're going to the other side, do we need prevention and support? Do we need Article 9? And if we don't, then I'm not going to get re-certified to teach it. [*Laughter.*]

Female: And I'm – as many emails as we've sent out to our families, they still don't understand what we're talking about, and the move that's going to take place. A lot of us in the room don't quite grasp it yet. So I would – if there could be a way to explain this to parents. I'm going to send another email this afternoon, and let them know there's a meeting tonight. But they just don't get it. They don't

understand the importance, how big of a chance this can be. And I don't know how to explain it differently. We've tried to restate our emails, and re-explain and send different pictures. So we need help with explaining this to our families.

### Thoughts on Governor Ducey's Executive Order

Female: Obviously it's a great idea and things we need to do, but some concerns with the annual abuse/neglect monitoring, knowing how to find it, all that bit. Annual training for all staff, is there going to be compensation for this? That costs a lot of money. With our day programs, our employees are already Monday through Friday, getting overtime. They have to do a Saturday overtime training, where's the funding going to come for this?

Also, what programs are going to be used? There isn't a lot out there for adult abuse and neglect, and how to identify it. There's a lot for kids, but for those of us working with adults, we need relevant resources.

Also with the postage of signs in homes and day programs, on how to spot abuse – day programs not as big of a deal, but with group homes, these are supposed to be the individual's personal home. In our homes, we don't have signs posted about how to know if I'm being abused. So how does that come into play with the new HCBS rules, the inclusivity that we're supposed to be going for with these settings?

Female: I think an easy solution would be to modify Article 9. All of our members have to do it, there's an abuse and neglect section, let's expand on it within that section. And they're already being trained on it as well, so.

Female: I'd agree with that, like with the signage. Especially for providers in ACH or CDH homes. It's that family's home, and you and I wouldn't have those signs. And then the other thing is, just another thing to add in keeping people safe, and agencies do their own investigations. But instead having an outside body come, do the investigation. I mean, I know my organization, I know how we conduct, and what we're doing, but maybe there's not a good agency doing investigations, and it just seems contradictory that you should be investigating yourself, like in your own agency. I feel like APS or CPS should be coming in, or just another outside body to conduct those investigations and review those incident reports.

[Inaudible.] 1:45:45

Female: That's okay. When you were talking about redoing Article 9, that's an every three year one, so as far as undoing the abuse and neglect, if that's supposed to be annual then we would have to look at Article 9 as well. As far as being that three-year research.

Female: I did like the suggestion of having an outside entity coming in and investigating and help. Because I have gone to some of those CPS meetings, and it does take a high caliber of reporting, and just to see if someone can even come out and help.

So I do agree with that, absolutely. Maybe a middle man or someone that can help and step in.

[*Applause.*]

1:48:43 [End of recording.]

## Surprise (West)

### What is Going Well with DDD LTSS?

- Female: First of all, I forgot to mention I'm a parent first. I have a 25-year old with autism. DDD has instrumental in everything, all the supports, and anything that we've needed. So I think for me, therapies and I guess the long term supports is ideal. There's a lot of things that we as parents are not able to do, and we have a provider come and help us, and that's been a godsend. So we're very grateful for that.
- Female: I just want to say, I've been doing this 15 years. I'd have to say our relationships that we have with our state Support Coordinators and all of the support and the people we're able to network with throughout this state have been very helpful.
- Male: I think we're able to reach a lot of people that otherwise wouldn't have any resources. [*Pause.*] Yeah that, and the diversity of our providers and all of that.
- Female: I have to say the relationship with some of the Support Coordinators, the communication. The concern for the members, the concern for the whole flow of everything through the services, their interest in the agencies, the qualified vendors, it's appreciated.
- Female: The flexibility with regards to being able to make changes to the members that we're serving through the State. So if we need to make a change in ISP because of certain circumstances, I think it's been really easy to navigate those changes on a state level, within ISPs or other needed resources or services to be added or taken off.

### What Needs to be Improved with DDD LTSS?

- Female: I know it's a really difficult one, but having the same coordinator, or maybe a team of coordinators. Maybe that was two coordinators who were in charge of a family or group of families, that would be ideal because that relationship that we have as a parent with the coordinator, even as an agency with a coordinator, makes all the difference. They know how to work with us, and that makes the flow for everything much more easier.
- Female: Yes. So maybe if you have one – know from my end, if that could be something that be written down. In Avondale. I've been here for 15 years in Arizona. In Avondale, the only coordinator that has been there as many years as we've been here, it's unheard of, is my coordinator, [name redacted]. She is amazing. Maybe if she could partner up or team with somebody else, and make a team with some other coordinators, that would be good.

Also just helping the coordinators, because I see the paperwork that gets involved. Why do we have to have every 90 day meetings? Can it be four months or something like that? Because as a parent, it's overwhelming. We already have all

these therapies, all these appointments. Yeah, I mean why do we have to have every 90 days? Sometimes 60.

Female: I do agree with her, having the ISPs within however many days they do is getting ridiculous. We've had some that are up to, they've already had five this year. How are we supposed to support staff to go to all of that? I think one of the problems we're having is that there is zero consistency from DDD office to DDD office. Even if we stay in the central office. I can call [name redacted] and get one answer, I can call the next one and get a different answer.

We get an ISP it might have 20 pages, the next one will have 60. We get an ISP that says one word. We got an ISP last week, sent to us by a Support Coordinator, that was four months late. How are you doing? Sick. The rest of the ISP was blank. And this was after we've called, we've elevated it three levels, we've done everything we have to do, we've noted, we've called the parent, have you got it? I mean it seems like there's no recourse for that except document, document, document. I could hire 20 staff if that's all I had to do all day long was document every ISP that was requested, giving that 7-day timeline to the Support Coordinators, and then putting it on our fault if you don't have it earmarked yet with licensing. I don't know how we can police DDD. Because that's essentially what you guys had us do, was if you don't have it, we're marking you out in licensing. I didn't do the meeting, I didn't start the paperwork, how can I be responsible for completing the paperwork?

So now I have a girl in my office who used to have way more responsibility, who spends her entire day calling and requesting ISPs. When you have a couple hundred individuals, that takes a long time. And when you're having meetings every 60-90 days – and now we have to have a current 90-day in order to get through licensing, instead of an annual. So I think that's some of our biggest problems. And we don't want to get into rates, or do we? That's why we can't hire anybody.

Female: Okay. Our other problem is not finding providers. Because we're at the pretty high end of the rate, and we still can't get people in the door. So we have families waiting and waiting, and they've tried to go to other agencies, they come back, it's like nobody can find us anybody. It's across the board, and a lot of agencies I know are suffering horribly because of that. I know several that have closed their doors, because they can't find staff to work in their small places. Thank you.

Male: Okay I think this list will probably be longer, because most of the people in this room spend their days working on what's not working, rather than what is working. Squeaky wheel gets the oil, all of that. I want to really second the whole issue with our inability to hire anything beyond a warm body that hopefully will be able to get a fingerprint card at some point. Or continue through the process, make it through all the training and all of that. That is my biggest issue.

My second biggest issue is it's really hard to budget when we're basically, on the rates we pay the providers, every nickel from the rate the agency gets, and then

another nickel goes to that, and the overhead. So what we're seeing is the Prop 206 money, and the nickels and dimes from this and that and the other thing. You can't budget on that, because you don't know how much it's going to be, you don't know when it's coming in.

The last thing that I really spend most of my time on is surveys and audits. You guys are killing me with paperwork. All I do is go to meetings, fill out paperwork, and put out fires.

Female: I just – our agency just came up for renewal, so now most agencies have complete internal systems that we utilize on a daily basis. So now I just found out that not only do we have to keep our employees in compliance within our internal system, but we also get to go on the OLCR system and update everyone as they become – right. So that's taking twice as much time, which we have to pay someone to do.

And I just want to reiterate the point the other gal made in regard to requesting the 90-day ISPs. That again is adding more financial stress on agencies having to hire. We've actually had to hire another full time person, because of having to get these 90-day ISPs in. And I think DDD should know well enough that people's circumstances regarding their needs don't change in 90 days. I have a daughter with special needs, and it's not going to change in 90 days or whatever amount of time. It's unnecessary work for the case worker, and for the agency, and we should be concentrating on more important things.

And I feel like whenever a lapse in DDD – they're not getting their hab reports in time, or they're trying to cut hours, and they come up with these things that they feel are going to help, when in reality they're hindering the system itself. And I don't feel like they ask agencies or involve agencies in this whole 90 day thing. Not one agency was asked.

Or in regards to the inquiries. They changed the entire inquiry system, where we've been doing it the same way for ten years, and it's worked for us, where we've been able to reach out to the family and talk to them. And it's not just about the needs of that individual, it's also about the family dynamics, and the family environment. A lot of times we've been able to place providers with families a lot quicker than we're doing now, because we have to go through this state caseworker to request to get family contact information. We have to wait for that. We could ask on a Monday, and not get an answer until Friday, and by that time we've had two possible providers that we could have placed with that family, that now either went and got another job at Target up the street, or were placed with another agency or another member. So it's putting us in really bad situations, where we're not able to actually do our jobs.

Female: Because we will share with you, we would love to share with you what we do from point A to point B to match a provider with a family. It's intensive. It's not just a warm body. There's so many dynamics in regards to it. And we've love to share this information, because this is what we do, this is our passion.

Male: This is a little bit different from what you're mentioning, but it's all valid. I'm just taking notes and putting check marks on stuff. One of the things that we need to address is the aug comm devices. We have been working with families constantly. Now they get a device, and maybe two, three years, become obsolete. They get a certain program in them, they get what, 12 hours. And sometimes it's not what the child needs. So they've wasted those 12 hours in training. And then they get the right program on the device, and they have no more hours. We have been running ragged this year, trying to work with families and coordinate with either the coordinator or the supervisor, and we have gotten nowhere. That needs to be fixed. Because first of all, there's a language barrier with the families, and so they have to go through us. So we have to extend hours away from what we normally do to assist them, because we coordinate, and help coordinate. So that's been an issue. And so the back end of it is the money that the State is spending on these devices, that could go into other things as far as training. Because we were told – we have a son like you heard, that is on the spectrum and has been getting services from DDD, but we have a couple of devices that just piled up, that never –

Female: It's kind of more of a statement, and it goes with the consistency thing. We know there's been a lot of turnover in Support Coordinators, obviously, and sometimes you'll get a different one every single time. Lately we've gotten, they handed me the file when I walked out the door. I know nothing, I don't know why I'm here, I'm not changing anything, we signed paperwork and we leave. We've had a lot of those. But one of the things that we're getting from the new Support Coordinators are, I just go out of training, so I know. And it's like, well that's good for you, but that's not how this works. Can I fill out the paperwork for you? Well I was told that you have to have the same goals as the DTA. I've been doing it 25 years, and that's never been a fact. Then they argue with you. Then they come back three months later, and they go oh my god, you were right. So the training seems to be really inconsistent. I don't know who's training, but they come out and they're either full steam ahead, like don't tell me, or they walk in and they go, I don't know what I'm doing. Nobody told me anything, they handed me a file and here I am. I've had Support Coordinators hand my Coordinators, here's the assessment, I don't know how to do it, can you fill it out and send it back to me? Sure, we can do that. And it's either that or the family doesn't get attendant care.

And we've had some really – or the changing of the hab goals every 60-90 days. They don't realize that when we get back to the office, we have to type up all new hab goals. Even if they just changed a word. I had a supervisor tell me the other day – I'm like, these aren't the goals we said. And we were at the meeting, and he said, well I thought they sounded stupid. I go really, because the individual themselves chose their goals, and this is her wording. He goes, I don't care, they sounded stupid. She was almost crying when she got her hab goals, because she was so proud of herself for saying, I want to do this and I want to work on this. So we had to do this big old change, but his answer to me was, I thought they were

worded stupidly so I rewrote them. Well good for you. You weren't even at the meeting, we were.

So we're getting a lot of that, and a lot of pushback on, we don't want to keep writing hab goals. By the time we write them, they maybe get a month to run them and we're having another meeting. And they're going, well lack of progress, we have to change these again. Um, I didn't even give you data yet, because we just got them out. Especially when we have to wait a month or two for an ISP. So my Coordinators, that's all we do all day long. Like he said, I go to meetings, I come back, I put out fires, I push paper, I push paper, I push paper. I think there's more of that than anything else to do with the ISPs anymore. It's the constant – they changed two words, well that changes the dynamic of a goal. And then they're like, you guys are putting too much in it. kind of our job. And so they don't understand that every few months when they're changing these, we have to go back, rewrite them, get them back out to the families, get them back out to DDD, get the back out to the providers, hope everybody's on board and starts using the new goals, so we have at least one month of progress to give them at the next meeting. Before they change them again. It's a ridiculous cycle, that's not really, I don't think, helping anybody.

Female: Maybe along the same lines as the goals. When the Coordinator goes in, they usually tell the family – not just us, a lot of families that we've been to at the meetings – the goals cannot go over a year, maybe two years max. I know for sure my son, it took him three years to tie his shoelaces. And he learned, he was probably at 14. He started at maybe 11? Anybody could have said, eh he's not going to learn them any more. Took him a little over three years with the help of us, and with the help of a provider. So we cannot, for sure, say it's going to take two months, three months, six months for a goal, we don't know. We know that they work at a different pace, and we have to support that pace. We're not going to tell how long it's going to take.

Male: Something real quick, as far as the goals, [redacted] office has had something for about the past maybe year and a half, where we've attended meetings, that with the hab goals they're requiring, almost requesting, that the first 90 days it be close to 25, the 180 days close to 50, and then 75% and close to 100. They don't want to repeat the goals. And this is misinformation that's being given. And they said that it was moving West. And that gets us here. I just feel that we get along so well with the Coordinators, and if the training is wrong.

And the other thing is respite. They're trying to regulate respite. And they're giving all of the families that they should stay to 12.5, 50 hours a month. And so I actually called a Supervisor at [redacted], [name redacted], and I asked her, what is going on with this? So she sent me paperwork on the policy. It says nothing. It says nothing. So just so you know that it's not policy. It's not written in policy. So we put out a fire, then we put out another fire, and we still keep putting out fires.

Female: He was saying that the expectation from that office is the member is going to demonstrate 25% progress within the first 90 days, and then 50% progress at six months, and 75% progress at the third –

Male: Correct.

Male: More than one office now, I'm sure.

Female: This isn't from a health plan perspective. I also have ten-year old son who is on the spectrum, non verbal. So to the point with respite, and some of the misinformation you get from Support Coordinators, it then turns into families opting out of services, because it's too restrictive. So respite, we opt out of it. We don't even add it to our service plan, because why? That's not even enough hours to mean anything for my family. And then the turnover. Obviously it's a point that's well taken. I think we've had five or six in the eight years that we've been on DDD. But yeah, I think it's just misinformation.

Female: I know for a really long time, and it's still something that we say in our offices. Why do not case workers have to be, have experience as a care provider? Because if they actually gave someone a shower, *[laughs]* they would know how long it takes. What you have to go through to actually get it done. And that's one thing that we always – we just wish so much that they could experience it first, instead of then just all of a sudden being the person who assesses that they just don't, some of them don't get it. The ones that have kids with special needs usually get it. And then yeah. So some case workers are awesome, they're amazing, they're seasoned. And then you get people that come in and they just have absolutely no compassion at all. And everything is about time. And I almost feel like they're getting some sort of side commission for cutting hours or not giving hours. And I know that sounds pretty blunt, but that's me. But that is the truth. You feel like with this whole, it's almost like a – it's odd. It's very strange. I don't get what the whole hang up is on – it's about the member's needs, and that's it. Period.

Female: Kind of tying into the respite, is companies I know are probably spending a lot of time on authorizations. There's a lot of confusion, especially going way back since the respite change from October to September. And now with no set in stone ISP date, it's changing all the time. Support Coordinators aren't understanding that we put 50 in the first half of the auth, and then the other 550 to move hours back and forth, it's not the same auth, and yes it is. We spend a majority of the day, our billing people, following up on authorizations because there's a lot of confusion or tracking down, the ISP says they're supposed to get hours but nobody's either putting in and authorization, which we have to then tell the family your provider can't work. I'm sorry, they can't. A provider that's been working for four years all of a sudden has to stop because we don't know if we're getting an authorization, and we're being told if there's no auth, do not provide the service. Which there's inconsistency there and things like that.

And then kind of piggy backing on what you said about the appeals. If we're sitting in a meeting and the whole team's not agreeing to something, it shouldn't

even have to go to the appeal process, because if we're not agreeing, it shouldn't go in that ISP. I get if it's an increase in hours or something, where that has to be approved and things. But it's things like I sat in a meeting last week where the Support Coordinator said, I'm putting this person as a one-to-one on the group home. And the rest of the team is like no, they don't need to be a one-on-one, and she sat and argued with us. The guardian was adamant she don't want her a one-to-one, the whole team, day program, everybody. The only person that wanted her one-to-one, and she didn't need it, was the Support Coordinator. And she argued, that's not the way it works. I'm going back to resource, and I'm going to talk to them, and you'll see, and I'm putting it in that ISP. Well I called resource and beat her to the punch, because I had to. It's like, could you explain? And resource is like, what are you talking about? That's not right. And is said exactly, could you please explain it to them?

Because you almost feel going in any more, that you're being threatened, and a lot of our families feel that way. We've had families in tears, that have had to almost leave meetings and things because sometimes you feel like you're being threatened any more. It's very difficult to continue to serve in a positive aspect, when you feel like there's that constant hanging over of the rates, or this paperwork. And you feel like you're not providing the service any more. You're almost just, again, pushing the paper and fighting and fighting and fighting just to maybe get five hours a week, or get the respite, where you're not being told you have to schedule it. And the families feel like they can't utilize it and things like that.

Female: I actually do appreciate you [name redacted] a lot. We've seen you at many meetings, and I see the dedication that you have towards all these system changes. And I think we will see changes. In our personal view, we have seen families. We have a support group as well, and a lot of the group has been helped by the customer service that you guys have. We know [name redacted] very well. [unintelligible 0:48:19] is actually one of the Coordinators that will sit at our meetings every month. And she will take in concerns and she will follow up with them. So the whole unit itself, that's something that we see a one of the really good things. Because we see that person, we see you as customer service. That's the face that we have. And the families can relate, and we know that we can take our concerns and they're valid, you will hear us, and we know that you will be sympathetic to us. So we're very appreciative of that. So we thank you.

Female: I just wanted to bring up some of my points here. When I first came on, having a DTA, I noticed there was some changes. Teaching strategies were taking course. I had come from another DTA, where we had teaching strategies. They weren't called teaching strategies. But expected paperwork increase was just a little bit more than what we expected when we came on board. So in the three years that we've been functioning, a lot of things have been asked extra, in addition to what we already do, and I know we're going to go into solutions later, but I also think that sometimes this excessive paperwork, we should be able to itemize the billing and be able to bill DDD for these things.

Fact findings, sometimes words may trigger these things and it's excessive paperwork that sometimes is totally not needed. Maybe someone to talk to review the situation, so that they understand, we understand, and allowing us to move forward without the excessive paperwork would be great.

Also some other examples, some of the things that we do. Adding the attendance into the progress reports. Wow, that's a great idea, but it takes a lot of time. And it would be so helpful if the Support Coordinators can kind of apply a little bit of accountabilities to some of the members that use the services as drop in. I've mentioned before, I've been at other meetings with these forums. And I've mentioned that we're supposed to provide a ratio of employees. And so when those members just appear once a month or something like that, that puts difficulty on us.

The monitors are a little bit heavy and hard, intimidating at times. We try to please DDD and do our best, but it causes some anxiety and some stress, and there's not that unity of seeing our perspective and trying to resolve the issues. It's just kind of, we have to put up and shut up. And we don't get heard. So I do appreciate these opportunities, these forums.

I do also operate as a for profit business, just to avoid all the audits that I would need to have. But we do offer *folklorico* music, money management, independence skills. We have teachers on staff. We are not related to an institute, and educational institute, but we came from a community college. And we want to continue these services to help them. But with the excessive paperwork, it just puts us, sets us back. And we do have a small non-profit to help them to have costumes, do performing arts, do all these things. But all this paperwork limits us, and I think we need to look at things that are more practical.

Another thing is community outings. Having to ask them, where do you want to go? We get Tombstone, we get Kartchner Cavern, we get Phoenix too, Odyssey. We get all these wonderful suggestions and we feel so bad asking them, and then we have to like get them back down to like okay, the theater has a bargain price going on, Dave & Buster's you liked it last time. Yeah, Dave & Buster's. And luckily, we have a beautiful group that goes with it. But it puts us in an uncomfortable position because we want to help them. And I've even had to talk to Support Coordinators, because their family doesn't extend that money for the admission. And the DTAs make so little, we can't offer those for them to be paid for, because then the family would take advantage of that over and over again, and then you don't want to be biased and help some and don't help the other. So those opportunities that we get with Support Coordinators, if they could help us so that maybe they could have little allowances or whatever worked out, so that they can go to those community outings and they can proudly suggest those ideas and be part of the trip, instead of being left behind because family doesn't give that money. Thank you.

What are the Solutions for Improvement?

Female: For somebody that made a comment about the annual application for certification renewal each year, the system times out. I brought this up in the other concerns. I love the W-9 process through DES, where you fill out paperwork and you can follow up and talk to somebody that inputs it in the system, rather than us directly putting it in the system and trying to troubleshoot and figure out how the system, the Focus works. It is always nice, even registry, when we have to put in emails to check out new employees. We can send those emails out, fill out the form, send it off, and then get a response later. It is very difficult to take the time to have to actually implement and actually put your information into the Focus system, and learn it. In fact I'm in a crisis right now, because my old address, our old location, was deleted with the tech on the phone. Somehow the directions actually deleted our new address, not our old, and contractors – it was very difficult to get them to help. I had to go and talk to our management down south, DDD south, and then helped the situation. It fixed, and now if I find after a fact finding, they had old information of my partner that's been bought out of the company, that they still have my old information. So just recently I looked and I saw the old information back up with the old location, I'm like no, no, no. And that was a headache and now I'm going to have to deal with it again. And I did everything with the technician, the computer tech on the other side, seeing what I was doing, and somehow it just happened from one little thing, and now it's coming up again. So oh, I would love it to just fill out a form, submit it, and they enter it. [Laughs.] Thank you.

Female: No what happened is – somebody brought up the concerns that there's a lot to be put into the system. And what I was trying to point out is if we fill out proper forms, and if we could submit those forms, and then DDD has their representatives put that information in the system, that would be so nice. We've having to put a lot of effort – and maybe perhaps you might want to add to that, so you get a clarification of what we're talking about – and that way she can also let you understand. There's a lot of paperwork, there's a lot of inputting on Focus. Focus is the system that DDD uses. We go in internally and change out information. That information sometimes gets lost or changed. And if we could just submit like we do with the W-9, directly to DES, and they put in our information in the system. If we could be like that and approach things like that, that would be great.

Female: I'll piggy back on that suggestion, because right now, the way the system is, you basically, if they complete a class you better get in there, entered on the same day. Because if they expire tomorrow, you're out of compliance. There's no wiggle room, so there should be a little wiggle room. And then things like fingerprints, DPS is extremely behind. It could take up to six months right now on some of them. And if they're not showing in the system, even if you've reprinted them and put the application in there, the system is kicking them out as non-compliant. And if you don't have 95%, then you're not getting approved. So there's no wiggle room for any of the agencies to either enter things on a weekly basis, or for the fingerprints or things to run the system before we're getting dinged on it. So there needs to be something changed with that system.

The other thing is, there's really – I hate to say this – there's no point of the system. If you're going to put it in, companies could put in bogus information and hit 100%. You could, except for the fingerprints. Everything else could be put in false, and then somebody's still coming out to check those files. So there's extra work. What's the point of that, because they're going to check the files, hard check them anyways. It's really not – something in that system is broken and it needs to be looked at and fixed. I get the theory behind it, but it's really not an effective system the way it's set up. I mean if I wanted to, I could go in and just enter dates that meet the requirement of compliance. And nobody would know any different unless they actually came and checked that file. There's no accountability, I think, on the providers. Because I'd love to say that everybody's honest, but I don't necessarily believe that's true. Probably in some cases, if you're scrambling to meet compliance.

I think one of the suggestions too would be for the authorizations to have a set year. If you're going to have respite, it might as well just be from October to September, and set all the other auths that way. I think that would alleviate a lot of the problems with some of the services and getting services provided. I don't know how that would work with the ever-changing ISP date of now 60 days and whatever. But respite could be put in, essentially October through September since there's no set in stone date any more.

And then the training. I think a suggestion would be for, especially for support coordination training, I really think DDD needs to be doing the training, but I think providers and parents need to be involved in that. Because I think there's a lot of input both ways that that support coordination could really benefit from.

Female: Hi. I think that if the whole process was looked at, that we need a lean process. Like all of us run our business extremely lean, that's the only way that you can run things. If the State will look at things a little differently about a lean process, and how we can spend more time serving the families, and all the extra stuff that's not lean. So whenever decisions are made, if you bring in small business owners, or business owners and have that input, we're used to running things extremely lean, and no all these extra things that are required. So I just think they should be a part of the solutions.

Female: Everything that was mentioned that we extra, things that we do. All the extra things we have to put into Focus, all the IFSPs that happen, that's not lean process. So we still need to, of course, protect the families. Look at what the Federal guidelines are. But we really should be – the State, the Governor's all about the lean process. What lean things can we do to make sure that it runs as a lean process. So if the State was looking at that as lean, and not have all these extra things that are – like they're going to the electronic signatures. What's that going to look like for the providers? They're now requiring that therapy providers have to have signatures on every quarterly report. That's not lean for us. That means that we have to now spend more money on doing paperwork and less on the providers getting paid well so they can continue to see the clients, the consumers.

Male: Just an example of going to the lean process. When we train somebody, we have to put them into the AHCCCS database, we're going to put them into Focus, we probably have our own billing system. That's three different databases and they don't communicate. So that's an opportunity for getting leaner I think, if we can look at how do we do that in one place rather than three or four.

Male: Basically along the same lines, you're by the computer, you start to think a little bit like the computer, right? Folders, subfolders. It's not streamlined. I know what the lean approach is. The State often – and I know it's a big, big operation, with 50 something thousand, 48,000 or something members. At times, it's a meaningful preparation of databases and such, but a lot of times the cart is put before the horse. Now if there's agency requirements, agency compliance issues, why not give us a website? Whenever we need to renew, where we fill out all the information. And if we must – because I know new requirements do come up – make it easy for us where we put everything in a folder, sub-folder. And then whoever needs it from any agency in the state can go in and take whatever files they need. We got to think smarter, we've got to think faster. Because the needs of the families are increasing rather than decreasing. And so I agree, we put a lot of time. We close at four, we close at five, but we actually still answer the phones until nine. I know the State doesn't, but we do, as an agency. I'm sorry, you do. [Laughs.] Thank you.

Female: I know it's already set in stone, is it? The electronic system.

Female: None of the families are happy with it. That's something that I know for sure. A lot of our families are not happy. They play out different scenarios, and it's – it's something that has to be tried I guess, but I'm almost sure it's not going to work because of the families. Every family dynamic is different. A lot of families don't even know how to use it, are not comfortable. Maybe it's a grandma. It's going to be something that's very difficult. So I know that's something in the long run was a waste of time. My opinion.

Female: It's an electronic verification system that AHCCCS is requiring of all the service providers.

Male: I won't say any more. I think we've just taken over the mic here. But the EVV, it's supposed to be free from the State in some form, but I believe it doesn't have all the components. I don't know how many more people here have gotten phone calls from vendors, and I want to quote vendors, that say come with us, because we're complete. It has to have a GPS component, it's connected to the billing, it's connected to their timesheet. Everything is electronics. We need to have a – I think as vendors, we need to have a meeting where the State has a meeting with us. Because every three months I like the meetings, but there's not a lot of meat. There's a lot of veggies, but there's not a lot of meat in these meetings with the State. And we need to be told. Because whenever we're subcontractors, we need to do it right. And we don't have all the information. I've already got three calls from three so-called vendors, and they're saying you know what, we'll match

whatever the other vendor is charging, because the State doesn't have it together yet. It's only one component.

Female: That is my point. I don't feel like – we are going to get information down the road. But we kind of need to know a lot sooner than that and be part of the solution, before it just rolls out. It's sort of like people that don't have an idea of how to run a lean process and run a business is going to make decisions based on these factors. But they don't know how the opposite end works.

Female: And the other thing is, the point with the EVV is to do it all online. But that's just giving us more work again, because somebody's got to police that. And still have to turn in a time sheet that's been signed. So we did not get rid of anything. The EVV added more paperwork again. Because they have to have the system, and then they still have to send in a signed timesheet. So that just put more work on the agency again, it's not helping us streamline anything.

And another suggestion is we need to get these ISPs under control. I know that a lot of the Support Coordinators now are saying that it doesn't really matter, because AHCCCS is rolling out their own ISP by the end of the year. I don't know if anybody else has heard that, but it's kind of like, they're coming in and going, I don't even care any more, let's just get it done. But every 90 days, that every 60-90 day things has to be rectified somehow. We're buried in paperwork.

Female: Can I, just for clarification. You'd like to go back to an annual ISP with reviews?

Female: If possible.

Female: Okay. I'd like to capture it like that. Because I think that how you're saying it might get lost in translation. So the recommendation [you're stating] is to go back to an annual ISP, with 90-day reviews. True 90-day reviews. *[Laughs.]* Any other thoughts, because I kind of – okay. I was going to say, we kind of want to move on so we don't run out of time.

Female: I was just going to suggest some changes to the WIO Act, the Work Innovative Opportunity Act. The last time I checked into it was about a couple years ago, and I have another business that I haven't been able to touch because of all the demands of course with the DTA. But there's a soap business that I have, and I've seen some very good members that could be employed in that side. Although they have some stipulations like, if you were to employ some of the members, there has to be a 50% disabled and abled ratio you have to meet. So that would mean I'd have to have a very big company to meet that. I also see us training them at the DTA. It used to be 50 cents additional per member, to help them. But the problem with that is you have a 20% of the members coming in that need to land a job. So that puts a little bit more strain and legwork on it that I think needs to be looked at.

There's also some liability issues with that, I feel. One of our members had some bruises on the arm, and so we had to do an IR for that. Come to find that the place

where she was working, the woman was handling her rough and pushing her. So I'm foreseeing some liability issues ahead, sometimes when you refer. I'm just asking for more time to look into the WIO Act, and also to allow more possibilities and take some of that red tape away so that it can function more easily with the members. Thank you.

### Thoughts on Alternate Service Delivery Model

Female: I have a daughter that needs a lot of dental all the time because she bites things and breaks things with her teeth. But we have not been able to take advantage of the \$1,000 because we are through Mercy Care. And the dentist that services her has been quite a while, and I don't want to change anything just because of that. So is there any way that maybe that \$1,000 could be helped? I don't want to change the dentist, that's just too much work. Again, paperwork that is inconveniencing for the families. So is there anything that they can help on that?

[Inaudible.] 1:20:52

[Inaudible.] 1:21:01

Female: The screen before, I saw qualified vendors will provide most LTSS. I'm just wondering who and what is most, and if community-based is DTA, then I could assume that Mercy Care or United will be who, if I'm allowed to work with DDD, that I go through?

Female: So would they network with us qualified vendors, or would they have their own? Would they dictate who the DTA is assigned for the members.

Female: I just want to reflect on a past situation. We had to take somebody to a behavior hospital. The Behavior Manager contacted us, said that the aunt was trying to transition this member into another home, because he was giving her problems and he was acting out also at the DTA. So I took him to the hospital, and he was later put in a home. This home was a home that had their own DTA. We loved this member, and the aunt knew that. They found that it was better for transportation purposes that he go to their DTA. So he kind of skipped us, left us, and we missed him. But the reality is, my question, and I know that it's kind of vague, but my question is, if Mercy Care and United come in, and they are the ones that have their own contractors that they deal with for day treatment agencies, are the rest of the qualified vendors going to be left out? Or are we going to be considered? Or are we going to be having to apply and sell ourselves, in other words, to these two that are going to be coordinating these services. These long term services. I'd like that heads up, thank you.

[Inaudible.] 1:27:28

Female: My concern is there's over 500 agencies in Arizona, and we all operate at different levels of, you know, size. So if we integrate, and now we have to become contracted with United and Mercy Care – and I've been in business now

five years, and I'm up against [provider redacted] who's international and been around over 30 years, and we're all trying to get contracted. Yeah, maybe the first year they might just give everyone a contract because of utter chaos, right. But then after that, when it's time to renew, they may just decide to go with the larger agencies, and half of us are going to go out of business.

And for a lot of us, this is what we do. This is our passion. I've worked over ten years just to get to where I am now, and this is all I know how to do. So I think my concern as a business owner and also someone who is very passionate about what I do every day is that there is an absolute possibility that I won't be in business when this takes place, because of the simple fact that United probably already has people they're contracted with that do the same thing that I do. And not only, there's going to be 500 or more of us trying to then get contracted. I love DDD, I love the relationships that I've had. I honestly would love to stay with DDD. If they just tweaked and made a few simple changes, and created a committee with provider agencies on it, where we could come and work together as a team, I think we could definitely make some great positive changes. But this is very scary for a lot of us that are smaller, unless they stipulate the United and Mercy Care need to take a specific amount of small businesses, specific amount of medium size, specific amount of large, this is going to be a very unfair situation for a lot of us who have worked very, very hard to get where we are right now.

And who are amazing providers. There are a ton of small agencies in here alone that I know of that have amazing reputations that work super, super hard and deserve to be contracted just as much as a larger agency.

Female: One of my concerns, we have 54 PT/OT/speech therapists, but the network, we actually dropped our contracts because they pay so poorly for those therapy services. And my fear is that we really don't have a lot of providers for the older population. If this is going to take effect, I know a lot of people will not be accepting the rates or how that's going to look. I've been in provider groups, and a lot of this has been talked about. And the biggest thing is how that reimbursement looks. And what that could possibly be for the therapists. And I know right now that there are no providers out there that are contracted with some of these agencies that – we get calls all the time that families that want services, because they can't get services through Mercy Care or United.

Male: When it comes time in three years to decide if we're going to move to this other option, are we going to be consulted, or are we just going to be told, this is what we've decided?

Male: I've got one on my desk. It doesn't work.

Female: Exactly that was my point is, there's a huge change coming down, and I'm sure there's going to be pros and cons. I'm sure there's going to be good things that are going to come from such a significant change. But change is scary. And if we don't have the answers of how it's exactly going to roll out, we don't even know

how to plan, how to prepare, and so our instinct is going to be to try to prevent it from happening. So, we definitely need lots of communication and transparency with how will this roll out. And we need to have the answers to our questions instead of just, we'll write that down, we'll get to it later. We need to be able to get behind it.

Male: Okay I mentioned earlier that it's really hard to budget when we don't know what the funds are, when they're going to be coming in. This is another example. If I'm looking to make an investment in my business right now, and maybe expand into new services or expand the services that I'm doing, I'm certainly not going to do it today. I'm going to wait and see what happens in three years. Which means I'm not going to be putting that effort, that money, those resources into DDD things.

### Thoughts on Governor Ducey's Executive Order

Female: I'm going to start with, I heard all the agencies you said involved, like DHS and DDD and whoever. Part of the thing right now is, monitoring wise and things, those agencies aren't on the same page. DHS is giving us direction on how a house needs to be, what needs to be set. DDD will come in and tell you the exact opposite. There needs to be that continuity to begin with, of what the rule actually looks like and how it needs to be followed, and things along those lines.

The fact finding, the things in terms of that and abuse and neglect. I could sit and say, this individual got their thumb broke, this happened, it didn't happen. We noticed it, it didn't happen on our program, there is no follow through. I could write a report that somebody fell down and skinned their knee, and I'm having to follow up for five days on a fact finding. There's no consistency with that. You know, just stuff like that. the paperwork. Talking about, I know if you sit and meet, and we've got to put these extra measures in place, I'm afraid it's going to come back to again, us having to do another system to input background checks and things like that. Like I said right now, the OLCR system, if I wanted to, I could go in there – other than the fingerprints – and forge all the information, except for somebody coming out to actually verify. And we're big enough they only check 15 of those 300 files. So as long as I have those 15 in great order, it could be okay. So looking at stuff like that, there needs to be something different in place. There's got to be some other kind of check.

And then DPS might be somebody, I don't know if you said that, that needs to be pulled into that, because these fingerprint background checks are all over the place. We have providers that have worked with us for six years, and we just reprinted them, and it took us four months to get hers back. And a new employee who's never been printed, we got it back in two weeks. It makes no sense. She's been printed for however many years, and hers was taking longer. Of course it came back, there's nothing on it, but it's like what's the point almost?

Female: [Inaudible.] 1:42:20

Female: [Inaudible.] 1:42:24 ... call and call and call [Inaudible] ... call somebody else, they'll just say, call the customer service again. And sometimes you can't get an answer. I actually called customer service, and I got a response that day, but they couldn't give me an answer, even. And I had to call like ten people before I could get an answer, because you call this person and they just say, call customer service. And customer service can't answer it, so who do I call now? I just calling until I got an answer.

Female: I did that. [Inaudible.] 1:43:28 I just had to track it down myself.

[Applause.]

1:45:41 [End of recording.]