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1600 CHAPTER OVERVIEW

Chapter 1600 provides process and administrative standards for ALTCS and targeted case management. These standards must be included in policies and procedures developed by Contractors for case management of their enrolled members. Standards set forth in this chapter may be exceeded in order to meet the needs of enrolled members.

For the purpose of this chapter, the following definitions apply:

1. "Contractor(s)" – unless otherwise specified, means Program Contractors for ALTCS managed care members, Tribal Contractors for ALTCS fee-for-service (FFS) members and the Targeted Case Management Contractor for acute care members with developmental disabilities (DD).

    a. Tribal case management for on-reservation FFS members may be provided by the Tribal government through an Inter-Governmental Agreement (IGA) with AHCCCS or, if there is no IGA between AHCCCS and a Tribal government, case management is provided through a special Tribal case management Contractor.

    b. Program Contractors and the Targeted Case Management Contractor have formal contracts with AHCCCS.

2. "Member(s)" – those individuals who are eligible for ALTCS or targeted case management and are enrolled with a Contractor.

    a. Eligible individuals who are elderly and/or have a physical disability (E/PD) and are enrolled with a Program Contractor

    b. Eligible individuals who have a DD and are enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)

    c. Eligible E/PD individuals who are Native American and living on a reservation (or lived on a reservation immediately prior to placement in an institutional facility that is located off-reservation) and are enrolled in the ALTCS FFS program and receive ALTCS services through a Tribal Contractor

d. Eligible individuals with DD who qualify financially for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program, may receive targeted case management services through ADES/DDD. These members receive their acute care services through an AHCCCS acute care Contractor.

3. "Service plan" – for ALTCS, a uniform system of tracking member services, date ranges and units of services authorized by the ALTCS Contractor. It does not specifically refer to the CA165 screen in the Client Assessment and Tracking System (CATS), except for ALTCS Tribal Contractors.

Information regarding other ALTCS topics, such as acute care services, provider qualifications and FFS quality and utilization management, is also included in this manual. Refer to the Manual Table of Contents for guidance.

Refer to the AHCCCS FFS Provider Manual and the Encounter Reporting User Manual for complete information regarding claims and encounter reporting procedures for covered services, the provider registration process, rate determination methodologies used for ALTCS services, required financial reporting for nursing facilities and general billing information. Both of these manuals are available from the AHCCCS Web site at www.ahcccs.state.az.us.

Refer to the Eligibility Manual, available from the AHCCCS Division of Member Services, for information on the financial and medical eligibility determination processes for ALTCS members.

1610 COMPONENTS OF ALTCS CASE MANAGEMENT

Description. Case management is the process through which appropriate and cost effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. Each individual enrolled as an ALTCS member must receive case management services as specified in the chapter and provided by a qualified case manager.

The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon, appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting. The case manager must foster a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice. Case management begins with a respect for the member's preferences, interests, needs, culture, language and belief system.

Amount, Duration and Scope. ALTCS case management components include the following:

1. Service planning and coordination to identify services that will effectively meet the member's needs in the most cost effective manner and to develop and maintain the member's service plan. Development of the service plan must be coordinated with the member and/or member's family/representative to ensure mutually agreed upon approaches to meet the member's needs within the scope and limitations of the program, including cost effectiveness. Service planning and coordination also includes ensuring members/representatives know how to report unplanned "gaps" in service and that these will be addressed as quickly as possible when reported.

2. Brokering of services to obtain and integrate all ALTCS services to be provided to the member, as well as other aspects of the member's care, in accordance with the service plan. If certain services are unavailable, the case manager may substitute combinations of other services, within cost effectiveness standards, in order to meet the member's needs until the case manager is able to obtain such services for the member. The case manager must also consider and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs.

3. Facilitation/Advocacy to resolve issues which impede the member's progress and access to needed services (both ALTCS and non-ALTCS covered services) and to ensure that services are provided that are beneficial for the member. The case manager will assist the member in maintaining or progressing toward his/her highest functional level through the coordination of all services.

4. Monitoring and reassessment of services provided to ALTCS members and modifying/reviewing member service plans and goals as necessary based on changes in the member's condition.

5. Gatekeeping to assess and determine the need for, and cost effectiveness of, ALTCS services for assigned members. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.

1620 CASE MANAGER STANDARDS

I. INITIAL CONTACT/VISIT STANDARD

A. Within seven (7) business days of a new member's enrollment, the assigned case manager, or designee, must initiate contact with the member or member representative. If the member resides in a nursing facility or other residential setting, the case manager will contact the facility to inform the facility of the member's enrollment. Initial contact may be made via telephone, a face-to-face visit or by letter, if the case manager is unable to contact the member by other approaches.

An on-site visit to initiate service planning must be completed by the case manager within 12 business days of the member's enrollment. If the member is ventilator dependent, the on-site visit must be completed within seven (7) business days of enrollment.

The interview must be conducted at the member's place of residence in order to develop the member's service plan. Confirmation of the scheduled interview is recommended prior to the meeting.

If the visit cannot be made at the member's place of residence, the rationale for the alternate site must be documented in the case management file. A visit made to a site other that the member's place of residence must be at the request of the member or member's representative, not just for the convenience of the case manager.

The member must be present for, and included in, the on-site visit. The member representative must be contacted for care planning, including establishing service needs and setting goals, if the member is unable to participate due to cognitive impairment, the member is a minor child and/or the member has a legal guardian.

Refer to Exhibit 1620-1 for a chart of Case Management Timeframes.

B. If the case manager is unable to locate/contact a member via telephone, visit or letter, or through information from the member's relatives, neighbors or others, another letter requesting that the member contact the case manager should be left at, or sent to, the member's residence. If there is no contact within 30 calendar days from the member's date of enrollment, the case must be referred to the member's Arizona Long Term Care Services (ALTCS) eligibility worker, via the Member Change Report (MCR) form, for potential loss of contact. A copy of the MCR may be found in Exhibit 1620-2.

   If AHCCCS Division of Member Services staff are also unable to contact the member or representative, the process of disenrolling the member will be initiated.

C. All contact attempted and made with, or regarding, an ALTCS member must be documented in the member's case file.

D. The case manager is responsible for explaining the member's rights and responsibilities under the ALTCS program to the member or member representative, including the procedures for filing a grievance and/or an appeal. A copy of these rights and responsibilities must also be provided in writing (generally via the Member Handbook). The member or member representative must sign and date a statement indicating that they have received the member rights and responsibilities in writing, that these rights and responsibilities have been explained to them and that they clearly understand them.

II. NEEDS ASSESSMENT/CARE PLANNING STANDARD

A. Case managers are expected to use a person-centered approach regarding the member assessment and needs, taking into account not only ALTCS covered services, but also other needed community resources as applicable. Case managers are expected to:

   1. Respect the member's rights

   2. Provide adequate information and teaching to assist the member/family in making informed decisions and choices

3. Provide a continuum of service options that supports the expectations and agreements established through the care plan process

4. Educate the member/family on how to report unplanned gaps or other problems with service delivery to the Contractor in order that unmet needs can be addressed as quickly as possible. See also subsections IV and V in this policy.

5. Facilitate access to non-ALTCS services available throughout the community

6. Advocate for the member and/or family/significant others as the need occurs

7. Allow the member/family to identify their role in interacting with the service system

8. Provide members with flexible and creative service delivery options

9. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering and monitoring services, and

10. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact to the member.

B. The involvement of the member and member's family in strengths/needs identification as well as decision making is a basic tenet of ALTCS case management practice. The member, family, and/or significant others are partners with the case manager in the development of the plan with the case manager in the facilitating mode.

C. The case manager must complete a Uniform Assessment Tool (UAT) based on information from the strengths/needs assessment to determine the Level of Care. The UAT and guidelines for completion can be found in Exhibit 1620-3.

D. Care planning is based on:

1. Face-to-face discussion with the member and/or member representative that includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas:

   a. Functional abilities

   b. Medical conditions

   c. Behavioral health

   d. Social/environmental/cultural, and

   e. Existing support system.

2. Recommendations of the member's primary care provider (PCP)

3. Input from ALTCS service providers, as applicable, and

4. Preadmission screening (PAS), as appropriate.

E. The case manager and member together must develop goals that address the issues that are identified in the care planning process. Goals should be built on the member's strengths and include steps that the member will take in achieving the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.

F. Member goals must:

1. Be member specific

2. Be measurable

3. Specify a plan of action/interventions to be used to meet the goals

4. Include a timeframe for the attainment of the desired outcome, and

5. Be reviewed at each assessment visit and progress must be documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.

III. COST EFFECTIVENESS STUDY STANDARD

A. A Cost Effectiveness Study (CES) must be completed for all E/PD members with potential for placement in a home and community based (HCB) setting and for those E/PD members currently placed in an institutional setting who have discharge potential.

B. A CES must be completed for DD members under the following circumstances:

   1. Every three months for any DD member whose service costs exceed 80% of the cost of the appropriate institutional setting for the member

   2. When the service costs of a DD member whose service costs previously exceeded 80% of the cost of the appropriate institutional setting are subsequently reduced to below 80%

   3. All DD ventilator dependent program members, and/or

   4. When discharge is contemplated for any member residing in a ICF/MR.

C. Services provided under Title XIX must be cost effective whether the placement is in an institutional facility or a HCB setting.

D. Placement in a HCB setting is considered appropriate if the cost of HCBS does not exceed 100% of the net cost of institutional care and HCBS will meet the member's needs.

The cost of HCBS is compared against an amount equal to the net Medicaid cost of institutional care for the specific member. If the member has needs that would necessitate a specialized rate in an institutional setting (for example, Alzheimer's or behavioral unit, residential treatment center, extensive respiratory care), this net cost should be used in calculating the cost effectiveness of HCBS.

Existing HCBS units cannot be reduced if there is an increased cost of services incurred to fill a service gap (for example, if personal care and homemaker services are provided to substitute for a gap in attendant care services).

E. When the cost of HCBS exceeds 80% of the cost of institutional care:

1. Program Contractor case managers must provide written justification of services to their administration for approval.

2. Tribal Contractor case managers must provide written justification of services to the AHCCCS Division of Health Care Management (DHCM)/ALTCS Unit for approval.

F. When the cost of HCBS exceeds 100% of the cost of institutional care, but the cost is expected to drop below 100% within the next six months because of an anticipated change in the member's needs:

1. A Program Contractor's administration may approve the HCBS costs. Justification and the approval must be documented in the case file.

2. Tribal Contractor case managers must provide written justification of services to the DHCM/ALTCS Unit for approval.

G. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months, and the member's needs could not be appropriately met in an institutional setting (for example, a member with significant behavioral health needs that would be more appropriately addressed by a behavioral health group home), Contractors must refer the case to the DHCM/ALTCS Unit for review and potential approval.

The case manager must submit adequate documentation to demonstrate that a nursing facility placement would not be suitable for the member because of his/her special needs.

H. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months and the member's needs could be appropriately met in an institutional setting, the case manager should advise the member of the cost effectiveness limitations of the program and discuss other options. The case manager should either reduce or not initiate any Title XIX service costs in excess of 100%. Appropriate notification must be given to the member regarding any decision to deny or reduce requested services.

   If the member chooses to remain in his/her own home even though the Contractor cannot provide all of the services which have been assessed as medically necessary (including those ordered by the member's PCP), a managed risk agreement/contract should be written. This agreement should document the services the Contractor can cost effectively provide, the placement/service options offered to the member, the member's choices with regard to those options, the risks associated with potential gaps in service and any plans the member has to address those risks (for example, volunteer services or paying privately for services). The member's or member representative's signature on the agreement documents his/her acknowledgement of the service limitations and risks.

I. The CES must be completed prior to the initiation of ALTCS services. However, if services are already in place at the time of the member's enrollment, the CES must be completed within 12 business days of the enrollment.

J. The CES should be updated when there is a change in placement to HCBS or there is a change in services which would increase the cost significantly (for example, an increase to >80% of institutional cost that would require approval). **All HCBS E/PD members must have a CES completed at least annually.**

K. A CES may be completed indicating "NONE" for HCBS services needed under the following circumstances:

1. Members residing in nursing facility who have no potential for HCBS placement (Placement/Reason code: Q/05). Documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement.

2. Members receiving hospice services (Placement/Reason code: 10)

3. Members residing in a nursing facility because the cost of HCBS would exceed 100% of institutional costs (Placement/Reason code: Q/01)

4. Members residing in a nursing facility because the member or family requests that placement (Placement/Reason code: Q/03), or

5. Members with Acute Care Only status (Placement/Reason code: D/04, D/11 or D/12).

L. CES data must be entered into the CATS system within 14 business days of the date the action took place (for example, initial on-site visit to determine service needs, placement changes or significant increase in cost of services). Refer to Appendix F of this manual for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

M. HCBS which must be included in the CES include:

1. Adult day health

2. Attendant care

3. Habilitation

4. Home health nurse

5. Home health aide

6. Home delivered meals

7. Homemaker

8. Personal care

9. Respite, if provided on a regular basis

10. Regularly scheduled medically necessary transportation. These costs do not need to be included if similar costs would be incurred while in a nursing facility. For example, if dialysis transportation costs for a HCBS member would be similar if the member were in an institutional setting, these costs would not be included on the CES.

11. Emergency alert systems

12. Non-customized durable medical equipment (DME) included in the nursing facility per diem and having a value exceeding $200, regardless of purchase or rental (for example, standard wheelchairs, walkers, hospital beds). DME items covered under other insurance may be omitted from the CES until the Contractor assumes responsibility for partial or full payment.

13. Partial care (supervised, therapeutic and medical day programs)

14. Behavioral management (behavioral health personal assistance, family support and peer support)

15. Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)

16. Assisted living facilities, and

17. Behavioral health alternative residential settings.

N. Services which are not to be included in a CES include:

1. Hospice services
2. Customized DME items
3. Physical, speech, occupational and/or respiratory therapies
4. Medical supplies and pharmaceuticals
5. Behavioral health services which are not listed above, and
6. Home modification.

O. If the member only receives ALTCS-covered HCBS that are provided by another funding source (Medicare, Children's Rehabilitative Services, tribal entities), s/he may still be in a HCBS placement and therefore must have a CES completed. The CES should be completed indicating the services received, but with no unit cost paid by the Contractor.

IV. PLACEMENT/SERVICE PLANNING STANDARD

The case manager is responsible for facilitating placement/services based primarily on the member's choice. Additional input in the decision-making may come from the member's guardian/family/significant other, the case manager's assessment, the Pre-Assessment Screening, the members PCP and/or other service providers.

A guiding principle of the ALTCS program is that members are placed and/or maintained in the most integrated/least restrictive setting. This needs to be the placement goal for ALTCS members as long as cost effectiveness standards can be met in the HCB setting.

A. After the needs assessment is completed, the case manager must discuss the cost effectiveness and availability of needed services with the member and/or member representative.

B. In determining the most appropriate service placement for the member, the case manager and the member and/or the member representative should discuss the following issues:

1. The member's placement choice

2. Services necessary to meet the member's needs in the most integrated setting. See Chapter 1200 of this manual for information about the following types of services available:

   a. Home and community based services (HCBS)

   b. Institutional services

   c. Acute care services, and

   d. Behavioral health services.

3. The availability of HCBS in the member's community

4. Cost effectiveness of the member's placement/service choice

5. Covered services which are associated with care in a nursing facility compared to services provided in the member's home or another HCB setting as defined in Chapter 1200

6. The member's Share of Cost (SOC) responsibility. The SOC is the amount of the member's income that s/he must pay towards the cost of long term care services. The amount of the member's SOC is determined by and communicated to the member by the local ALTCS Eligibility office.

7. The member's room and board (R & B) responsibility. Since AHCCCS does not cover R & B in a HCB alternative residential setting, this portion of the cost of the care in these settings must be paid by the member or other source (such as the member's family). The monthly R & B amount is determined by and communicated to the member by the ALTCS Contractor.

C. Any member who lives in his/her own home must be allowed to remain in his/her own home as long as HCBS are cost effective. Members cannot be required to enter an alternative residential placement/setting that is "more" cost effective. Refer to Chapter 100 of this manual for a definition of "own home".

D. Upon the member's or member representative's agreement to the service plan, the case manager is responsible for coordinating the services with appropriate providers.

   Placement within an appropriate setting and/or all services to meet the member's needs must be provided as soon as possible. A decision regarding the provision of services requested must be made within 14 calendar days following the receipt of the request/order (3 business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized). Refer to Title 42 of the Code of Federal Regulations (42 CFR) 438.210 for more information.

   Services determined to be medically necessary for a newly enrolled member must be provided to the member within 30 calendar days of the member's enrollment. Services for an existing member must be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

   Program Contractors shall develop a standardized system for verifying the delivery of services with the member or representative after authorization.

E. The case manager must ensure that the member or representative understands that some long term care services (such as home health nurse, home health aide or DME) must be ordered by the PCP. These services cannot be provided until the PCP approves them. All orders for medical services must include the frequency, duration and scope of the service(s) required, when applicable.

F. If an ALTCS member does not have a PCP or wishes to change PCP, it is the case manager's, or designee's, responsibility to coordinate the effort to obtain a PCP or to change the PCP.

G. The case manager must also verify that the needed services are available in the member's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of personal care or home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.

H. The case manager is responsible for developing a written service plan that reflects the agreed upon placement and services. The member or representative must sign this plan at initial development, when there are changes in services and at least annually thereafter. The case manager should provide a copy of the service plan to the member or representative and maintain a copy in the case file.

   The case manager is responsible for providing to HCBS in-home members or member representatives the Important Member Rights Notice form (Exhibit 1620-10) informing them of their rights pursuant to the Ball vs. Biedess order.

I. A written contingency or back-up plan must also be developed for those members who will receive any of the following critical services in their own home:

   1. Attendant care

   2. Personal care

   3. Homemaker, and/or

   4. In-home respite.

   The term "critical services" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

A gap in critical services in defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the member.

The following situations are not considered gaps:

1. The member is not available to receive the service when the caregiver arrives at the member's home at the scheduled time

2. The member refuses the caregiver when s/he arrives at the member's home, unless the caregiver's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (for example, drug and/or alcohol intoxication)

3. The member refuses services

4. The provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes unavailable.

5. The member and regular caregiver agree in advance to reschedule all or part of a scheduled service, and/or

6. The caregiver refuses to go or return to an unsafe or threatening environment at the member's residence.

The contingency plan must include information about actions that member and/or representative should take to report any gaps and what resources are available to the member, including agency providers and the member's informal support system, to resolve unforeseeable gaps (e.g., regular caregiver illness, resignation without notice, transportation failure, etc.) within two hours. **The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice.** An out-of-home placement in a NF or ALF should be the last resort in addressing gaps.

The plan must include the telephone number(s) for the provider and/or contractor that will be responded to promptly 24 hours per day, 7 days per week. The member or member representative should also be provided the Critical Service Gap Report form (Exhibit 1620-11) that can be mailed to the Contractor rather than calling in the service gap. The member or member representative should be encouraged to call the provider and/or Contractor rather than mailing the Critical Service Gap Report form so that the service gap can be responded to more timely.

In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the Program Contractor to ensure that critical services are provided within two hours of the report of the gap. However, if the provider agency or case manager is able to contact the member or representative before the scheduled service to advise him/her that the regular caregiver is unavailable, the member or representative may choose an alternative time to receive the service from the regular caregiver and/or an alternate caregiver from the member's informal support system instead of a substitute caregiver from the provider agency's back-up staff. **The member or representative has the final say in how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.**

When the provider and/or Contractor is notified of a gap in services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to

- The reason for the gap, and
- The alternative plan being created to resolve the particular gap and any possible future gaps.

J. The written contingency plan for members receiving those critical services described above must include a Member Service Preference Level from one of the four categories shown below:

1. Needs service within two hours

2. Needs service today

3. Needs service within 48 hours, or

4. Can wait until the next scheduled service date.

Member Service Preference Levels must be developed in cooperation with the member and/or representative and are based on the most critical in-home service that is authorized for the member. The Member Service Preference Level will indicate how quickly the **member chooses** to have a service gap filled if the scheduled caregiver of that critical service is not available. The member or representative must be given the final say about how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

The case manager should assist the member or representative in determining the member's Service Preference Level by discussing the member's caregiving needs associated with his/her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs, such as housekeeping, meal preparation and grocery shopping), abilities and cognitive, behavioral and medical status. The case manager should ensure the member or representative has considered all appropriate factors in deciding the member's Service Preference Level, including the availability of the member's informal support system. However, it should not be assumed that the presence of an informal support system will determine the member's Service Preference Level.

The case manager must document the Member Service Preference Level chosen in the case file. This documentation should clearly indicate the member's or representative's involvement in contingency planning.

A member or representative can change the Service Preference Level from a previously determined Service Preference Level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor should discuss the current circumstances with the member or representative at the time the gap is reported to determine if there is a change in the Service Preference Level. The plan to resolve the service gap must address the **member's choice** at the time the gap is reported.

The contingency plan must be discussed with the member/representative at least quarterly. A copy of the contingency plan must be given to the member when developed and at the time of each review visit. The member/representative may change the member Service Preference Level and his/her choices for how service gaps will be addressed at any time.

K. The case manager must explain the member's right to file an appeal regarding a placement or service plan determination if the member disagrees with the assessment and/or authorization of placement/services. Refer to Arizona Administrative Code, Title 9, Chapter 34 (9 A.A.C. 34) for additional information.

L. Members who reside in a nursing facility should be regularly assessed for HCB discharge potential and allowed to or encouraged to change to a HCB service placement, as long as needed services are available and cost effective in the HCB setting.

M. When a member will be admitted to an assisted living center (ALC), the case manager must ensure that the member has the right to exercise his or her choice for single occupancy within that facility. The Single Occupancy form must be completed and signed by the member or member representative indicating his/her choice. Refer to Exhibit 1620-5 for a copy of this form.

The only exception to this requirement is for an ALC that has been granted an AHCCCS waiver for single occupancy. Refer to the AHCCCS Division of Health Care Management policy "Assisted Living Center Occupancy Exception" for more information.

N. If the member will be admitted to a nursing facility, the case manager must ensure that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and Level II evaluation, if indicated, have been completed prior to admission. See Chapter 1200 of this manual for more information.

O. If the member does not intend to pursue receiving HCBS or institutional services, the member needs to be encouraged to withdraw from the ALTCS program voluntarily and seek services through an AHCCCS acute care Contractor or other programs.

If the member refuses long term care services that have been offered, but does not wish to withdraw from the ALTCS program, the case must be referred for an evaluation of Acute Care Only eligibility via a Member Change Report (MCR) form. The member/representative must be advised that s/he could be disenrolled from the ALTCS program depending on his/her income. The MCR and a copy of the case notes or other documentation regarding the member's refusal to accept ALTCS services should be sent to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit.

Refer to Exhibit 1620-2 for a copy of the MCR form and to the Eligibility Manual for more information on the procedure.

Exhibit 1620-2 also provides guidelines on circumstances for which a MCR is needed and Exhibit 1620-4 describes member situations for which an Acute Care Only "D" placement is appropriate.

P. The service plan must include the date range and units for each service authorized in the member's case file according to the Contractor's system for tracking service authorizations. Tribal Contractor case manager must enter those services authorized for the member on the CA165/Service Plan in the CATS system.

Q. Service plans for members residing in an **institutional setting** must include the following types of services, as appropriate based on the member's needs:

1. Nursing facility services. The service plan must indicate the Level of Care (Level I, II, or III) based on the Uniform Assessment Tool or Ventilator Dependent status (Level IV)..

2. Hospital admissions (acute and psychiatric)

3. Bed hold or therapeutic leave days (refer to Chapter 100 of this manual for definitions and limitations)

4. Services in an uncertified nursing facility

5. DME outside the institutional facility per diem (item/items with a value exceeding $200 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DD members.

6. Hospice services

7. Therapies (occupational, physical and speech)

8. Medically necessary non-emergency transportation (**required for Tribal Contractors only**)

9. Behavioral health services (only those provided by behavioral health independent billers – see definition in the Glossary of Appendix G in this manual)

10. Title XIX covered services as noted above if provided by other funding sources, for example, Medicare, Tribes, Children's Rehabilitative Services, other insurance sources.

R. Service plans for members residing in a **HCB setting** must include the following types of services, as appropriate, based on the member's needs:

1. Adult day health or group respite

2. Hospital admissions (acute and psychiatric)

3. Attendant care

4. DME outside the institutional facility per diem (item/items with a value exceeding $200 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DD members.

5. Emergency alert systems

6. Medical supplies that have a monthly cost in excess of $50.00 (**required for Tribal Contractors only**)

7. Habilitation

8. Home delivered meals

9. Home health aide

10. Homemaker

11. Hospice

12. Personal care

13. Respite care, including nursing facility respite

14. Therapies (occupational, physical, speech, and/or respiratory)

15. Behavioral health services (only those that are authorized with HCPCS codes)

16. Medically necessary non-emergency transportation (**required for Tribal Contractors only**)

17. Home modifications

18. Assisted living facility services

19. Behavioral health alternative residential facility services, and

20. Title XIX covered services as noted above, if provided by other funding sources, for example, Medicare, Tribes, Children's Rehabilitative Services, other insurance sources.

S. Service plans for members designated as **"Acute Care Only (ACO)"** must include the following types of services, as appropriate, based on the member's needs:

1. DME

2. Medically necessary non-emergency transportation (required for Tribal Contractors only)

3. Rehabilitative therapies (physical, occupational and speech), and

4. Behavioral health services.

Members who are enrolled as "ACO" due to financial reasons (such as a transfer of resources) are eligible to receive all medically necessary behavioral health services as listed in Chapter 300, Policy 310 of this manual, including those typically considered as HCBS.

T. Refer to Chapter 1200 for descriptions of the amount, duration and scope of ALTCS services and settings, including information about restrictions on the combination of services.

U. The CA161/Placement Maintenance screen in the CATS system must be updated with the following information within 14 days of the initial visit:

1. ID number of case manager currently assigned to the case

2. Date of last case management review visit with the member

3. Placement code(s) and begin/end dates since enrollment

4. Residence code that corresponds with each Placement

5. Placement Reason code that corresponds with each Placement, and

6. Behavioral health code that reflects member's current status

Refer to Appendix F of this manual for information on the codes and procedures for entering the above data into the CATS system.

V. Program Contractors are not required to enter service authorizations on the CA165/Service Plan in the CATS system. Tribal Contractors are required to enter this information within 10 business days of the initiation of the service(s) authorized.

Refer to Appendix F of this manual for information on the codes and procedures for entering service plan data into the CATS system.

V. SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

A. Case managers are responsible for ongoing monitoring of the services and placement of each member assigned to their caseload in order to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers.

B. Member placement and services must be reviewed on-site, with the member present, within the following timeframes:

1. At least every 180 days for a member in an institutional setting (this includes ventilator dependent program members, members receiving hospice services and those in uncertified institutional settings)

2. At least every 90 days for a member receiving home and community based services (HCBS)

3. At least every 90 days for a member residing in an alternative residential setting

4. At least every 90 days for a community-based member receiving acute care services only. Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year. Acute Care Only members residing in a non-contracted or uncertified institutional setting must have an on-site visit at least every 180 days, and

5. At least every 180 days for DD members 12 years or older residing in a group home, unless the member is medically involved or seriously mentally ill/severely emotionally disturbed (SMI/SED). If medically involved or SMI/SED, on-site visits must be made at least every 90 days.

Refer to Exhibit 1620-1 for a chart on Case Management Timeframes.

Contractors may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion.

Case managers should attend nursing facility care conferences on a periodic basis as an opportunity to discuss the member's needs and services jointly with the member, care providers and the family.

C. Review visits must be conducted at the member's residence. If an alternate site is used, the rationale must be documented in the case management file. A visit made to a site other than the member's place of residence must be at the request of the member or representative, not just for the convenience of the case manager.

D. Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action. More frequent case monitoring is required when the case manager is notified of an urgent/emergent need or change of condition which will require revisions to the existing service plan.

An emergency visit is required when the situation is urgent and cannot be handled over the telephone and when the case manager has reason to believe that the member's well being is endangered.

E. Case managers must conduct an on-site review within ten business days following a member's change of placement (for example, from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS) or from the date the case manager is made aware of such a change. This review should be conducted to ensure that services are in place and appropriate and that goals are updated to correspond with the current placement, services and other needs.

   Whenever possible, discharge to a member's own home should be delayed until adequate services can be arranged. In-home services must be initiated within ten business days following a member's discharge to HCBS.

F. If the case manager is unable to contact an enrolled member to schedule a visit, a letter must be sent to the member or representative requesting contact by a specific date (ten business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the case manager must complete a Member Change Report form (Exhibit 1620-2) indicating loss of contact and forward this, along with a copy of the letter, to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program.

   NOTE – Disenrollment will not occur if the local office is able to make contact with the member or representative and confirm that the member does not wish to withdraw from the ALTCS program.

G. The case manager must meet with the member and/or representative, according to the established standards, in order to:

   1. Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the case manager must take and document action taken to resolve these as quickly as possible. The Contractor administration must also be advised of member grievances and provider issues for purposes of tracking/trending.

2. Assess the member's current functional, medical, behavioral and social strengths and needs, including any changes to the member's informal support system.

   The Uniform Assessment Tool (UAT), used to determine the member's Level of Care, must be updated at least annually, more often as indicated by a change in member condition. Depending on contractual requirements, it may also be updated as requested for nursing facility authorizations. A copy of the UAT may be found in Exhibit 1620-3.

3. Assess the continued appropriateness of the member's current placement and services

4. Assess the cost effectiveness of services provided and/or requested

5. Discuss the member's perception of his/her progress toward established goals

6. Identify any barriers to the achievement of the member's goals, and

7. Develop new goals as needed.

H. The member representative must be involved for the above if the member is unable to participate due to a cognitive impairment, if the member is a minor child and/or if the member has a legal guardian.

   If the member is not capable of making his/her own decisions, but does not have a legal representative or member representative available, the case manager must refer the case to the Public Fiduciary or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file.

I. Members who reside in an institutional setting should be regularly assessed to determine if it is possible to safely meet the member's needs in a HCB setting.

J. The member's or representative's signature on the service plan is required for the initial service plan, when there are any changes in services, or at least on an annual basis thereafter. The member should be given a copy of the signed service plan at the time of each review visit (every 90 to 180 days).

K. At the time of each HCBS member's (not including those residing in and assisted living facility) service review, the case manager must review, with the member and/or representative, the Contractor's process for members to immediately report any unplanned gaps in service delivery.

L. The member's HCB service providers must be contacted at least annually to discuss their assessment of the member's needs and status. Contact should be made as soon as possible to address problems or issues identified by the member/representative or case manager. This should include providers of such services as personal or attendant care, home delivered meals, homemaker, therapy, etc.

   If the member is receiving skilled nursing care from a home health agency, contact is required with the service provider more frequently (see Standard XI, Skilled Nursing Need, in this Chapter).

   For members receiving behavioral health services, the case manager may need to make contact with the service provider quarterly in order to complete the behavioral health consultation.

M. The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order (see Chapter 1200 of this manual for more information on which services require an order from the member's PCP).

   If the case manager and PCP or attending physician disagree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager may refer the case to the Contractor's Medical Director for review. The Medical Director is responsible for reviewing the case, discussing it with the PCP and/or attending physician if necessary, and making a determination in order to resolve the issue.

N. If the case manager determines during the reassessment process that changes in placement or services are indicated, this must be discussed with the member and/or representative prior to the initiation of any changes. This is especially critical if the changes result in a reduction or termination of services.

O. The member or member representative must be notified in writing of any denial, reduction, termination or suspension of services. Refer to 9 A.A.C. 34 for specific time frames.

All grievances and requests for hearings and appeals of members enrolled with a Tribal Contractor are addressed directly to AHCCCS Administration, Office of Legal Assistance. A managed care member's request for hearing and/or appeal is initiated through the member's Program Contractor.

P. The case manager must be aware of the following regarding members eligible to receive hospice services:

1. Members may elect to receive hospice services. These services may be covered by private insurance or Medicare, if the member has Part A, or by ALTCS if no other payer source is available.

2. The Medicare hospice benefit is divided into two 90-day election periods. Thereafter, the member may continue to receive hospice benefits in 60-day increments. A physician must recertify hospice eligibility at the beginning or each election period.

3. The member has the right to revoke the election of Medicare hospice care at any time during the election period and resume ALTCS coverage; however, any remaining days of coverage are then forfeited for that election period.

A member may also at any time again elect to receive Medicare hospice coverage for any other hospice election periods for which they are eligible.

The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. ALTCS services which are duplicative of the services included in the hospice benefit should not be provided. Attendant care services are not considered duplicative. If, however, the hospice agency is unable to provide or cover medically necessary services, the Contractor must provide those services. The contractor may report such cases to the Arizona Department of Health Services (ADHS) as the hospice licensing agency in Arizona. Refer to Chapter 1200, Policy 1250, for additional information regarding hospice services.

Q. All nursing facilities that participate in AHCCCS are dually certified as Medicare and Medicaid facilities. Therefore, beds in these nursing facilities may not be designated as Medicare-only. An ALTCS member may not be asked to leave a Medicaid-participating nursing facility after his/her Medicare benefit days have been exhausted.

R. In most cases, members must receive a written 30-day advance notice before discharge from a nursing facility as outlined in 42 CFR 483.12. Exceptions may be made when the health and/or safety of the member or other residents is/are endangered.

   ALTCS Contractors set their own rules regarding advance notice of discharge of members who reside in assisted living facilities in their contracts with those facilities.

S. Case managers are responsible for using the Member Change Report to notify the local ALTCS office of a variety of changes in the member's status. Refer to Exhibit 1620-2 for a copy of this form and more information on the circumstances for using this form. Refer to the Eligibility Manual for detailed information on the completion of this form. The Eligibility Manual is available from the AHCCCS Division of Member Services.

T. The case manager is responsible for updating information in the CATS system within 14 business days of the reassessment.

VI. VENTILATOR DEPENDENT STANDARD

ALTCS members who meet the medical criteria of ventilator dependency as defined in Chapter 100 of this manual are enrolled in the Ventilator Dependent program (VDP). Covered services may be provide in the member's own home, a HCB alternative residential setting, a hospital or a nursing facility.

In addition to all other ALTCS case management standards, the following standards also apply to VDP members:

A. AHCCCS members enrolled in the ALTCS VDP may receive any medically necessary institutional or HCB services described in Chapter 1200 of this manual.

Private duty skilled nursing services are available, if determined to be medically necessary, for VDP members residing in their own home or a HCB approved alternative residential setting.

If respite care is determined to be necessary, it must be provided at the member's level of medical need.

B. If skilled nursing personnel are unavailable to provide ventilator dependent care or respite care, services may be provided by a licensed respiratory therapist when all of the following conditions are met:

   1. The member's PCP must approve/order the care by the licensed respiratory therapist, and

   2. The member's care requirements must fall within the scope of practice for the licensed respiratory therapist (as defined in Arizona Revised Statutes §32-3501), and

   3. An orientation to the care needs unique to the member must be provided by the usual caregiver.

C. The case manager should also ensure that essential medical supplies are ordered for and received by the member in a timely manner.

D. The case manager must notify the AHCCCS Division of Member Services (DMS) Medical Eligibility Quality Control Supervisor, via Member Change Report, within five business days of learning that an existing non-VDP member has become dependent on a ventilator and has been dependent for 30 consecutive days.

   A PAS will be completed to determine whether the member meets the VDP criteria or not. The results of this assessment are communicated back to the case manager by DMS.

Ventilator Dependent Weaning Period

ALTCS provides for a weaning period during which a VDP member may be weaned from dependence on the ventilator and remain enrolled in the VDP despite the fact that s/he no longer meets the VDP enrollment criteria (requiring ventilator services for a minimum of six hours per day for at least 30 consecutive days).

Generally, the weaning period provides up to 30 additional days of VDP enrollment. If the member enters the weaning period and does not require ventilator services 30 days later (even if s/he became dependent on the ventilator again during the weaning period), s/he is disenrolled from the VDP on the 31st day.

If, during the weaning period, a member again becomes ventilator dependent and continues to require ventilator services for six hours or more per day, s/he will remain enrolled in the VDP.

If a member's medical condition deteriorates and ventilator services are again necessary after the member has successfully completed the weaning period and been disenrolled from the VDP, s/he must meet the requirement of 30 consecutive days of ventilator dependence for six hours per day prior to re-enrollment in the VDP.

If weaning is successful, the case manager will complete and send a Member Change Report form to the AHCCCS Division of Member Services (DMS) Medical Eligibility Quality Control Supervisor within two business days from the end of the 30-day weaning period to request a Pre-Admission Screening reassessment.

The Member Change Repost form may be found in Exhibit 1620-2.

VII. BEHAVIORAL HEALTH STANDARD

In addition to all other ALTCS case management standards, the following standards also apply to members who need or receive behavioral health services:

A. Direct referral for a behavioral health evaluation may be made by any health care professional in coordination with the case manager and PCP.

B. Requests for behavioral health services made by the member or member representative must be assessed for appropriateness within three business days of the request. If it is determined that services are needed, the referral for evaluation must be made within one business day.

C. Behavioral health services which have been determined to be medically necessary by a qualified behavioral health professional (as defined in 9 A.A.C. 20) may be provided.

D. Behavioral health appointments must be provided within the following timeframes:

   1. Within 24 hours of referral for emergency appointments, or

   2. Within 30 days of referral for routine appointments.

E. Case management for a member receiving behavioral health services must be provided in consultation/collaboration with a qualified behavioral health professional in those cases where the case manager does not meet the qualifications of a behavioral health professional. The consultation does not have to be with the provider of behavioral health services. It may be with the Contractor's behavioral health coordinator or other qualified designee.

F. An initial consultation between the ALTCS case manager and the behavioral health professional is required for all members receiving/needing behavioral health services. Quarterly consultations are required thereafter as long as the member continues to receive/need behavioral health services.

G. Initial and quarterly consultations are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.

H. The case manager must document the content and results of the initial and quarterly consultation with the behavioral health professional. The consultation must be a communication between the case manager and a behavioral health professional about the member's status and plan of treatment. It must not simply be a report from the provider that has been received by the case manager and put in the case file.

I. As part of the service plan monitoring, the case manager must review the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this monitoring. Examples of medication uses that do not require this special monitoring are: sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms and anticonvulsants used to treat a seizure disorder.

   Documentation of the medication review must be clearly evident in the member case file. The review must take place at each reassessment and include the purpose of the medication, the effectiveness of the medication and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, multiple medications apparently prescribed for the same diagnosis) must be discussed with the behavioral health consultant and/or prescribing practitioner. Case notes must reflect this discussion.

J. The behavioral health code that reflects the member's current behavioral health status must be updated at the time of each review visit on the CA161/Placement Maintenance screen in CATS. Refer to Appendix F for a list and description of these codes.

VIII. TRANSITIONAL PROGRAM STANDARD

The ALTCS Transitional program is a program for currently eligible ALTCS members who have improved either medically, functionally or both, to the extent that they are no longer at risk of institutionalization at a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) level of care. These members continue to require some long term care services, but at a lower level of care. The ALTCS Transitional program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. NF and ICF/MR services are excluded, since reassessment has determined that institutional services are not medically necessary.

In addition to all other ALTCS case management standards, the following standards also apply to Transitional program members:

A. The case manager, upon being notified of the change of a member to the Transitional program, must discuss the change in level of care with the member or representative to ensure understanding of the change.

B. The case manager must ensure that the member in a HCB setting meeting transitional criteria continues to receive all covered HCBS as necessary.

C. While institutional services are no longer considered medically necessary for transitional eligible members, a short-term stay in a NF or ICF/MR is available. ALTCS Transitional program members whose medical condition temporarily worsens to the extent that NF services are medically necessary may receive up to 90 continuous days of care at any one admission.

D. The case manager must ensure that the member, or the representative of a member, already residing in a NF or ICF/MR who becomes eligible for the Transitional program., understands that discharge from the NF or ICF/MR is necessary within 90 days from the Transitional program effective date. The case manager must work with the member or representative towards HCBS placement as soon as possible.

E. A PAS reassessment must be requested, via Member Change Report, within 45 days of institutional admission for any Transitional program member who has had a deterioration of condition and who is expected to need NF services for greater than 90 continuous days. A PAS reassessment is not needed if a Transitional program member will remain in or return to a HCB setting.

   The case manager should follow up with the local ALTCS office after the PAS reassessment has been requested if there has been no response by the 60th day. Alternate placement options may need to be explored in case the member continues to meet the transitional program criteria.

   Case file documentation should demonstrate that the case manager has taken appropriate and timely action either to pursue discharge to a HCB setting or facilitate a PAS reassessment as indicated.

   The Member Change Report form may be found in Exhibit 1620-2.

IX. HIGH COST BEHAVIORAL HEALTH REINSURANCE STANDARD

The ALTCS program for high cost behavioral health reinsurance is specifically designed to provide payment assurance for members who are elderly and/or physically disabled, enrolled with ALTCS Contractors (as specified by contract), and who meet all of the following criteria:

A. Have significant behavioral problems or a history of these behaviors which have been documented as difficult to manage, and

B. Require a specialized service regimen for the management of his/her behavioral challenges, and

C. Would be inappropriate for placement in a locked Alzheimer's or dementia unit.

In addition to all other ALTCS case management standards, the following standards also apply to members covered under the ALTCS Reinsurance program for high cost behavioral health:

1. A request for reinsurance authorization must be submitted to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-6. Additional provider documentation that supports the member's behaviors and need for intervention must also be submitted.

   AHCCCS will provide the Contractor with written verification of authorization or denial. Authorization will be granted for the member's current placement and setting only. If there is a subsequent change of placement or setting, information and documentation to describe the reason for the change must be submitted as a new reinsurance request.

2. If the Contractor believes the member continues to require a specialized treatment program and placement, a re-authorization request and supporting documentation must be submitted in writing to DHCM within ten business days prior to the expiration of the current approval.

3. The service plans for E/PD members who receive specialized services covered under the High Cost Behavioral Health Reinsurance program must be coordinated with the member's PCP <u>and the Contractor's Medical Director</u>.

4. Covered services may be provided in the member's own home, in a HCB approved alternative residential setting, an unclassified health care facility licensed by the Arizona Department of Health Services or a nursing facility if the provider offers specialized services necessary for individuals with significant behavior management problems. Services provided in a residential treatment center (RTC) are not covered under this reinsurance program.

5. All institutional and HCBS services described in Chapter 1200 of this manual, including non-emergency transportation, are included in the High Cost Behavioral Health Reinsurance program. Behavioral health services, except as noted below, are also covered. The following services are excluded from behavioral health reinsurance coverage under this program as they are included as a part of regular reinsurance:

   a) Individual and group behavioral health counseling

   b) Acute care hospitalization, including psychiatric hospitalization

   c) Durable medical equipment and medical supplies

   d) Pharmaceuticals

   e) Physician services, and

   f) Therapies, including physical therapy, occupational therapy, speech therapy and respiratory therapy.

Refer to the Encounter Reporting User Manual and the AHCCCS Reinsurance Claims Processing Manual for information regarding reporting and payment issues. These manuals are available on the AHCCCS Web site at www.azahcccs.gov.

X. OUT-OF-STATE PLACEMENT STANDARD

Out-of-state services are covered as provided for under 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.

This section of the manual is intended to address the standards related to the long term placement of members in out-of-state settings. It does not apply to situations in which the member is temporarily absent from the State.

Out-of-state placements may be approved in licensed/certified residential-type settings only (for example, nursing facilities, residential treatment centers, group homes). Personal residences outside the State of Arizona are not approved placements. Out-of-state facility providers must be registered with AHCCCS.

Written authorization from AHCCCS is required prior to the placement of an ALTCS member in an out-of-state placement.

In addition to all other ALTCS case management standards, the following standards also apply when the Contractor seeks an out-of-state placement:

A. A request for out-of-state placement must be submitted to AHCCCS when it is determined that an ALTCS member's need for services cannot be met by existing providers within the State of Arizona.

B. Tribal Contractors requesting out-of-state placement approval for members being placed in one of the nursing facilities in Utah or New Mexico must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-7.

C. Program Contractors requesting out-of-state placement approval must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit. The request must include at least the following information:

1. Member name and AHCCCS ID#

2. Name and location of the facility where the Contractor intends to place the member

3. Description of the member's medical/behavioral condition that necessitates this placement

4. Description of facility's program(s) that makes this placement appropriate for the member

5. Information about other in-state placement options ruled out for the member, and

6. Plan for member's return to an Arizona placement

D. When justified, AHCCCS approvals are generally given for six month intervals. The case manager must submit appropriate documentation to request a renewal if the out-of-state placement is expected to continue beyond the initial approval time period. Requests for renewals must be submitted prior to the expiration of the previous approval.

XI. SKILLED NURSING NEED STANDARD

The case manager is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet his/her individual needs.

Non-Institutional Settings

A. The member's initial needs assessment must be conducted by an AHCCCS registered home health agency if the member is at risk of compromising his/her skin integrity (for example, the member is bed bound, quadriplegic) or if the member has a history of medical instability (for example, frequent seizures, unstable diabetes, COPD). If a registered home health provider is not available, an independent registered nurse may conduct the assessment for skilled nursing needs. Thereafter, the member will be monitored for skilled nursing needs, by the home health agency or independent registered nurse, within established timeframes and as otherwise necessary. DES/DDD may utilize its district nurses in performing these assessments and making recommendations to the PCP for continued monitoring.

B. A member who has skilled nursing needs for conditions (for example, pressure ulcers, surgical wounds, tube feedings, pain management and/or tracheotomy) must be referred to a home health agency for the initial assessment and the ongoing provision of skilled nursing care as well as monitoring determined necessary by the assessment. An independent registered nurse may provide these services if an AHCCCS registered home health agency is not available.

C. The case file must reflect quarterly consultations with the provider of the skilled nursing care and documentation of the member's condition and progress until the member no longer requires skilled nursing care.

D. If the member or member representative refuses skilled nursing care, the case manager must inform the member or representative of the possible risks of refusing such care. The case manager must, at a minimum, document in the case management file the reason given for refusing the recommended care and that the member or representative has been informed of the risks. The member's PCP must also be informed of the refusal.

Institutional Settings

A. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromising his/her skin integrity (for example, the member being bed bound, quadriplegic, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.

B. Every six months, the case manager must consult with the appropriate facility staff and review treatment record documentation related to the member's condition and progress. The member's progress related to the specific skilled nursing need(s) must then be documented in the case management file.

C. If the member or member representative refuses skilled nursing care, the case manager must coordinate with facility staff to ensure the member or representative has been informed of, and understands, the possible risks of refusing the care. The case manager must, at a minimum, document in the case management file that the member or representative has been informed of such risks and the member's reason for refusing care. The member's PCP must also be informed of the refusal of care.

XII. CASE FILE DOCUMENTATION STANDARD

A. Case file documentation must be complete and comprehensive. It may be written by hand or typewritten. Each case file page should indicate the member's name and identification number. Each entry made by the case manager must be signed and dated. If electronic records are utilized, the Contractor must ensure the integrity of the documentation. AHCCCS may request that documentation kept in an electronic system be printed out for purposes of a case file review.

B. Contractors must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).

C. Case files must be kept secured.

D. Program Contractors are expected to maintain a uniform tracking system for documenting the begin and end dates of those services listed in the Placement/Service Planning Standard section of this chapter (excluding transportation), as applicable, in each member's chart. This documentation is inclusive of renewal of services and the number of units authorized for services.

E. Tribal Contractors must show authorization of services on the CA165/Service Plan.

F. Case files must include, at a minimum:

1. Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number

2. Identification of the member's PCP

3. Uniform Assessment Tool (UAT), completed at least annually

4. Information from 90/180 day on-site assessments that addresses at least the following:

   a. Member's current medical/functional/behavioral health status, including strengths and needs

   b. The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of an institutionalized member

   c. The cost effectiveness of ALTCS services being provided

   d. Identification of family/informal support system or community resources available to assist member

e. Identification of service issues and/or unmet needs and the actions to be taken to resolve these

f. Member-specific goals that will allow the member to gain functional skills or maintain/increase their current functioning level. Goals must be evaluated for appropriateness at each review with progress towards each goal documented and adjustments to goals/services made as necessary. Documentation should reflect member involvement in the development of goals.

g. Member's ability to participate in the review and/or who case manager discusses service needs and goals with if the member was unable to participate, and

h. Environmental and/or other special needs.

5. Copies of the member's Cost Effectiveness Studies (CES), placement history and service plans/authorizations. The service plan must be signed by the member or member representative at least annually and a copy kept in the file.

6. Documentation that the member/representative has been advised of how to report unplanned gaps in authorized services

7. Copies of current CATS screens (CA160, CA161, CA165) for Tribal Contractors. CATS screens or comparable forms for Program Contractors.

8. Notices to the member regarding denial or changes of services (discontinuance, termination, reduction or suspension)

9. Member-specific correspondence

10. Physician's orders for medical services and equipment

11. Copy of the completed PASRR level II evaluation, if applicable

12. Evaluations and/or progress reports (for example, home health, therapy, behavioral health)

13. Case notes including documentation of the type of contact made with the member and/or all other persons who may be involved with the member's care (for example, providers)

14. Documentation of the initial and quarterly consultation/collaboration with a qualified behavioral health professional, if applicable

15. Copy of the annual pulmonology consultation for Ventilator Dependent Program members, and

16. Other documentation as required by the Contractor.

G. Screen prints may be used to replace hard copy service plans or CES, especially for updates which do not always require a member signature. If screen prints are used, the case manager must sign and date the document signifying the copy is accurate.

H. ALTCS member file information must be maintained by the Contractor for a minimum of five years.

XIII. PROGRAM CONTRACTOR CHANGE STANDARD

For purposes of this section, the term "E/PD Contractor" refers to all Program and Tribal Contractors, but not the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD).

Members may be transferred between E/PD Contractors or between an E/PD Contractor and DES/DDD. Transfers between E/PD Contractors are generally as a result of the member moving out of one Contractor's service area into another's. Transfers between an E/PD Contractor and DES/DDD are the result of a change in DDD eligibility, as determined by DES/DDD. The service area of DES/DDD includes the entire state. When a DDD eligible member moves from one area of the state to another, a change of Contractors does not occur; there is just a change of DES/DDD case managers.

A. The case manager is responsible for the transition of and discharge planning for members transferred to another Program Contractor. Refer to Chapter 500, Policy 520, of this manual regarding member transitions for further information on standards set forth for the transition of ALTCS members.

B. A change of E/PD Contractors due to member movement to another service area or member choice where multiple Contractors are available may be initiated by:

   1. The E/PD member or his/her representative

   2. The current Program/Tribal Contractor, or

   3. AHCCCS Administration.

C. The case manager is responsible for initiating action when the request is made by the member or member representative. Case managers must not assume, or allow the member to assume, that a change of Contractor is automatic.

D. E/PD case managers are responsible for explaining that there may be service limitations and exclusions when the member moves into another Program Contractor's service area.

E. For E/PD members in Maricopa County, a change of Contractor may occur on the anniversary date of the member's enrollment or at any time when one of the following conditions exists:

   1. For medical continuity of care reasons

   2. Erroneous network information or agency error

   3. Lack of initial enrollment choice

   4. Lack of annual enrollment choice

   5. Family continuity of care, or

   6. Continuity of institutional or residential setting.

Refer to the AHCCCS Division of Health Care Management operational policies on enrollment choice in a choice county and changes of Program Contractor for more information on these conditions.

F. For transfers within or into Maricopa County, the E/PD member must make a choice of Contractors before any change can be processed. This choice should be discussed with the member/representative and processed by the local ALTCS office.

G. Case managers must discuss the potential transfer of a member with the Transition Coordinator or case manager of the potential receiving Contractor to ascertain availability of services in that area. This information will assist the member/family with planning.

H. The relinquishing case manager must also provide adequate member information (case documentation and/or medical records) to the potential receiving contractor to assure continuity of care. The ALTCS Enrollment Transition Information (ETI) form to be used for this purpose can be found in Exhibit 1620-9.

I. Tribal members are considered to have on-reservation status even though they are admitted to a nursing facility within a Program Contractor area of service off the reservation. Tribal members who move to HCB settings off reservation will be transitioned to the Program Contractor serving that area.

J. In Maricopa County, the member will be given a choice of Contractor by the local ALTCS office upon notice (from either the member/representative or case manager) that the member intends to move or has moved to Maricopa County.

K. Member Change Reports (MCRs) are to be used under the following transition circumstances:

1. E/PD Program Contractor out-of-service area transfers from HCBS to HCBS own home or from institution to HCBS own home

   Note: Refer to Chapter 100 of this manual for a definition of “own home”.

2. Tribal Contractor to Tribal Contractor transfers from HCBS to HCBS own home or from institution to HCBS own home. This applies when the Tribal Contractor enrolled E/PD member will reside on a different reservation from that with which s/he had been enrolled (for example, a Navajo Nation member who will now reside on the Tohono O'Odham reservation in his/her "own home" should be enrolled with Tohono O'Odham Nation).

3. Program Contractor to Program Contractor within Maricopa County when requested by the E/PD member (HCBS only), except for medical continuity of care reasons. Program Contractor Change Request (PCCR – see Exhibit 1620-8) is used in that circumstance.

4. Native American E/PD member who is enrolled with an E/PD Program Contractor who moves to his/her own home on the reservation. The member will be enrolled with the Tribal Contractor responsible for case managing that reservation, or

5. E/PD Tribal member requesting a transfer from a Tribal Contractor service area (HCBS or institutional setting) to off-reservation status within an E/PD Program Contractor's area of service (HCBS only, not including alternative residential settings).

If no specific date is requested, the member becomes the responsibility of the new Contractor or Tribe on the first day of the next month. The MCR is mailed to the local ALTCS office.

When a specific date of transfer will be requested due to specific care issues or to ensure no service lapse, the PCCR process should be followed.

L. An MCR is also used by DES/DDD to notify AHCCCS that a DD member no longer meets the DDD eligibility criteria and will require a PAS assessment to determine if the member meets ALTCS eligibility criteria as an E/PD member.

M. PCCRs (Exhibit 1620-8) are to be used under the following transition circumstances:

1. For E/PD Contractors, transfer from any setting to an institutional or alternative residential setting in another E/PD Contractor's service area

2. For enrollment changes between E/PD Contractors in Maricopa County when medical continuity of care reasons are cited by the member's PCP

3. For E/PD Contractors, transfers from any setting to HCBS for which a specific effective date will be requested for continuity of services, or

4. For E/PD Contractors, when the member who is a minor child transfers from the service area where his/her parents reside to another service area and a change of Contractors is requested.

Medical continuity of care requests must be reviewed and approved by the Medical Directors of both Program Contractors before the relinquishing Contractor can complete the PCCR.

The potential receiving Contractor is responsible for reviewing the request and notifying the relinquishing Contractor within ten business days of the request for transfer decision.

The current/relinquishing Contractor must notify the member's case manager and the member within seven days of receiving decision notification from the potential receiving Contractor. The relinquishing Contractor must arrange and pay for transporting the member, if necessary.

N. If the potential receiving Contractor denies the request for enrollment change, the relinquishing Contractor may request a review by the AHCCCS Medical Director after the Medical Directors of both receiving and relinquishing Contractors have discussed the request and not been able to come to agreement.

A written decision will be sent to the member and both Contractors by AHCCCS following this review. If the request is denied, AHCCCS will notify the member of his/her appeal rights.

O. Both the relinquishing and receiving Contractions are responsible for ensuring a safe transition for the member.

P. The CA161 (Placement Screen) and service plan must be updated to reflect any changes in placement, services and/or Contractor enrollment dates.

XIV. SERVICE CLOSURE STANDARD

A. Closure of a member's service(s) may occur for several different reasons. The following is a list of the most common reasons. This list is not meant to be all-inclusive:

1. The member is no longer ALTCS-eligible, as determined by AHCCCS/Division of Member Services/ALTCS Eligibility Administration (DMS/AEA)

2. The member dies

3. The case manager and/or physician determine that a service is no longer necessary

4. The member or representative requests discontinuance of the service(s)

5. The member moves out of the Contractor service area

6. The member leaves the Contractor service area temporarily and the Program Contractor is unable to continue services

7. For E/PD members in Maricopa County only – the member's Contractor has been changed due to member request, and/or

8. Contact has been lost with the member.

B. Case managers are required to provide community referral information on available services to meet the needs of members who are no longer eligible for ALTCS.

C. If the member has been determined ineligible for ALTCS, the member or member representative will be informed of this action and the reason(s), in writing, by DMS/AEA. This notification will provide information about the member's rights regarding that decision.

D. If a service is closed because the ALTCS Contractor has determined that it is no longer medically necessary, the member must be given written notice of the plan to discontinue the service and information about his/her rights with regards to that decision. Refer to 9 A.A.C. 34 for specific information and timeframes.

Written notice is also required when services are closed due to the death of a member when the member has not yet been disenrolled by AHCCCS.

Contractors are not required to send a written notice of action to the member if the member's PCP has determined that a service which requires a physician's order (for example, home health nursing or therapy) is not medically necessary and therefore will not be authorized by the Contractor.

Notice is also not required if the member/representative requests the closure of a service in writing.

E. When the member's enrollment will be changed to another Contractor, the case manager must coordinate a transfer between the Contractors. Refer to Standard XIII, Program Contractor Change, in this Chapter, as well as to Chapter 500 of this manual for more detailed information.

F. The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process.

G. If a member is disenrolled from ALTCS, but remains eligible for AHCCCS acute care benefits, the case manager must provide informational materials (available from AHCCCSA) to the member regarding available acute care health plans. The case manager must obtain from the member his or her choice of health plans and convey this information to the AHCCCS Communication Center at 1-800-334-5283.

H. Case notes must be updated to reflect service closure activity, including, but not limited to:

   1. Reason for the closure

   2. Member's status at the time of the closure, and

   3. Referrals to community resources if the member is no longer ALTCS eligible.

I. The case manager must update placement history (CA161) and service plan information in the case file and CATS, as applicable. When a service is closed, the end date and service units must be adjusted accordingly.

J. A member who is disenrolling from ALTCS will generally remain enrolled through at least the end of the month in which the eligibility is terminated. If the member voluntarily withdraws and wants ALTCS benefits to stop immediately, the disenrollment will be effective with the processing of the withdrawal by DMS/AEA.

K. **The member continues to be the responsibility of the Contractor until the disenrollment is processed by ALTCS and appears on the Contractor's roster.** Members are eligible to receive medically necessary services through their disenrollment date.

L. When the reason for termination is the member's death, the case manager must end date the service authorization(s) with the actual date of death.

XV. ABUSE/NEGLECT REPORTING STANDARD

A. Suspected cases of abuse and/or neglect must be reported to the appropriate authorities by the case manager. Case manager are responsible for identifying the agency in their area that handles these issues for adults and/or children, as applicable.

B. Adult abuse is defined as:

1. Intentional infliction of physical harm

2. Injury caused by criminally negligent acts or omissions including pressure sores and dehydration

3. Unlawful imprisonment, as defined in A.R.S. §13-1303

4. Sexual abuse or sexual assault, and/or

5. Intentionally subjecting or permitting a vulnerable adult to be subjected to emotional abuse.

C. Vulnerable adult is defined as an individual who is 18 years of age or older who is unable to protect himself/herself from abuse, neglect or exploitation by others because of a mental or physical impairment.

D. Child abuse is defined as:

1. The infliction or allowing of physical injury

2. Impairment of bodily function or disfigurement

3. Infliction of or allowing another person to cause serious emotional harm, and

4. Inflicting or allowing sexual abuse and/or sexual exploitation to occur.

E. Adult Protective Services (APS) – a program within the Arizona Department of Economic Security, which is governed by A.R.S. §§46-451 through 46-454 and 14.5310.01, to protect vulnerable adults from abuse or neglect.

   APS workers also serve as a part of Arizona's Ombudsman Program to act as an advocate, investigate reports of abuse, neglect or exploitation and assist in problem resolution for individuals residing in long term care facilities.

F. Child Protective Services (CPS) – a program within the Department of Economic Security which functions to ensure the safety of children. A.R.S. Title 8 Article 3 (§§8-546 through 8-546.10) requires that the agency investigate reports of suspected child abuse, neglect, and/or abandonment.

   The program also assists parents/caregivers in receiving available services which will help improve family relationships and strengthen their ability to provide good child care. If this is not possible, alternative solutions and placement are sought.

G. For Tribal members – the APS and CPS programs do not have jurisdiction on the reservations to intervene in cases of abuse, neglect or exploitation. Case managers must determine which Tribal program is responsible for handling these issues in their area.

H. Documentation related to the suspected abuse or neglect, including the reporting of such, should be kept in a file, **separate** from the member's case file, that is designated as confidential. The confidentiality of this information is protected under A.R.S. §§36-441, 36-445, 36-2401 through 2404, 36-2917, and 42 CFR 434.34.

I. Member quality of care issues must be reported to and a resolution coordinated with the Contractor's Quality Management Unit and/or AHCCCS/Division of Health Care Management/Clinical Quality Management Unit. Refer to Chapter 900, Policy 960, of this manual for more information on the Contractor's responsibilities related to these issues.

EXHIBIT 1620-1

CASE MANAGEMENT TIMEFRAMES

EXHIBIT 1620-1

CASE MANAGEMENT TIMEFRAMES

INITIAL CONTACT/VISIT	TIMEFRAME
Initial Contact (CM or designee)	Within 7 business days of enrollment
Initial on-site visit (non-Vent Dependent)	Within 12 business days of enrollment
Initial on-site (Vent Dependent)	Within 7 business days of enrollment
Initial service start-up (non-Vent Dependent)	Within 30 days of enrollment
Initial service start-up (Vent Dependent)	Within 12 business days of enrollment
CASE FILE UPDATES	**TIMEFRAME**
Initial CES	Prior to placement/services
Initial CES, when services in place at enrollment	Within 12 business days of enrollment
CES update	Prior to placement change to HCBS **and** at least once a year for all HCBS members, **and** when changes of services increases % to > 100%
CES when no discharge potential	No updates required, CES will reflect "NONE"
CATS ENTRIES	**TIMEFRAMES**
CES/CA160	Within 14 business days of date of action
Placement/CA161	Within 14 business days of date of action
Service Plan/CA165 (Tribal only)	Within 14 business days of date of action
REASSESSMENT VISITS	**TIMEFRAMES**
HCBS member	At least every 90 days
NF member	At least every 180 days
Ventilator Dependent members	At least every 90 or 180 days depending on placement as above (HCBS or NF)
Hospice members	At least every 90 days (every 90 or 180 days depending on placement beginning 10/2000)
Acute Care Only members – may be phone contact but on-site visit required at least once a year	▪ At least every 90 days for home based members ▪ At least every 180 days for institutionalized members*
DD members 12 years or older residing in a group home, unless the member is medically involved or seriously mentally ill/severely emotionally disabled (SMI/SED)	At least every 180 days*

*The "Next Review Date" on the CA161/Placement Maintenance screen in CATS will be calculated at 90 days for these members.

EXHIBIT 1620-2

ALTCS MEMBER CHANGE REPORT

EXHIBIT 1620-2

ALTCS MEMBER CHANGE REPORT

Date ___/___/___	ALTCS Program Contractor:	Reported By:	Phone #:

Member Name:	AHCCCS ID:	
Sent To: ❑ ALTCS Local Office ❑ DHCM ❑ Medical QC Supervisor	DOB:	Customer #:
Verification Attached? ❑ YES ❑ NO	Verification Type: ❑ DE-130 ❑ Case Notes ❑ Other: _____	

PART I - Demographic/Miscellaneous **(Send DE-701 to ALTCS local office)**

❑ **Address Change:**
- ❑ Residential
- ❑ Move to Home in Different Fiscal County
- ❑ Mailing
- ❑ Move Out of State

For: ❑ Representative ❑ Member

Effective Date: ___/___/___

❑ Name ❑ Sex ❑ DOB
❑ Phone # ❑ SSN ❑ DOD ❑ Other:

Explain Change:

PART II - Placement/Living Arrangement **(Send DE-701 to ALTCS local office)**

FROM: (previous residence) Enter facility name (if applicable), address and phone number. **TO:** (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, phone number. Enter comments.

FROM:		Phone: ( )	
Address:	City:	State:	Zip Code:

TO: Living Arrangement
- ❑ NF/ICF-MR
- ❑ Home
- ❑ Adult Foster Care Home *
- ❑ Assisted Living Home *
- ❑ Assisted Living Center *
- ❑ Assisted Living Center Room
- ❑ Alzheimer's Pilot Facility
- ❑ Level I or II Behavioral Health Center
- ❑ Level III Behavioral Health Center
- ❑ DD Group Home/Adult Development Home
- ❑ Child Developmental Foster Home/Large Group Setting
- ❑ Alternative Acute Living Arrangement
- ❑ Other _____

Effective Date: ___/___/___

Length of Stay:
- ❑ Permanent
- ❑ Temporary Until: ___/___/___
- ❑ Unknown

Facility Status:
- ❑ Medicare Certified
- ❑ Not Medicare Certified
- ❑ Licensed
- ❑ Unlicensed
- ❑ Contracted with PC
- ❑ Not Contracted with PC

Note to Local Office:

To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE.

* If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.

Facility Name:	Provider ID:	Phone: ( )	
Address:	City:	State:	Zip Code:

Comments:

Member Name:	AHCCCS ID:

PART III - Client Status

Send the DE-701 to the ALTCS local office to report the following changes:	Date From:	Comments:
❑ Member requests voluntary withdrawal from ALTCS (DE-130 attached) ❑ Change Contract Type from LTC to Acute for retroactive period (refusing services) ❑ Temporarily Absent from Arizona ❑ Returned to Arizona ❑ Tribal Enrollment Change – DHCM was contacted ❑ On-Reservation ❑ Off-Reservation	___/___/_____	
Send the DE-701 to DHCM for the following changes:	**Date To:**	
❑ From LTC to Acute– (Attach case notes) ❑ Services not available ❑ Temporarily out of service area ❑ Refusing Services (DE-130 not signed) ❑ From Acute to LTC ❑ Services are available ❑ No longer out of service area ❑ No longer Refusing Services	___/___/_____	

PART IV - Change PC Within Maricopa County (Send DE-701 to ALTCS local office)

❑ Member Requests Enrollment Change to: _____(Program Contractor)

Reason:
❑ Erroneous Information/Error ❑ Family Continuity ❑ Lack of Choice ❑ Continuity of Placement

Comments:

PART V - Medicare/Other Health Insurance (Send DE-701 to ALTCS local office)

Medicare Part A ❑ YES ❑ NO Effective Date: ___/___/_____ Medicare Number:

Medicare Part B ❑ YES ❑ NO Effective Date: ___/___/_____ Disenrollment Date: _____

Other Insurance ❑ YES ❑ NO Effective Date: ___/___/_____ ___/___/_____ Policy Number:

Insurance Carrier: _____

PART VI - Share of Cost (Send DE-701 to ALTCS local office)

❑ Reduce Share of Cost Due to Death of Member ❑ Other (Specify):	Effective: Month/Year _____/_____

PART VII - Income/Resource Change (Send DE-701 to ALTCS local office)

❑ Income ❑ Resources Explain the change:

Source or Type: _____

PART VIII - Ventilator Status Change/PAS Reassessment Request (See form instructions)

❑ Ventilator Dependent ❑ Non-Ventilator Dependent Effective date: _____

❑ PAS Reassessment Request – Check Reason for Assessment and provide comment

❑ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.

❑ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)

❑ Other (Explain):

Comments:

RESPONSE - (Completed by AHCCCS Employee)

❑ Refer to Part(s) _____

❑ Change Completed
Date Completed ___/___/_____
Effective Date ___/___/_____
❑ Member no longer eligible
Effective Date ___/___/_____

❑ Failed PAS
❑ Other Reason _____

❑ Member still eligible
❑ Passed PAS Reassessment

❑ DHCM has determined LTC status should continue

❑ Contract Type Change from _____ to _____
Begin date _____ End date _____

❑ SOC increased to $ _____ Effective Date: ___/___/___

❑ SOC decreased to $ _____ Effective Date: ___/___/___

❑ Income Changed

❑ Resources Changed

❑ Member eligible for acute care only
Effective Date ___/___/_____
❑ ALTCS Acute care
❑ Health Plan _____

❑ No Action Taken (see comments)

Comments:

Signature of AHCCCS Staff Person _____ Date Returned ___/___/_____

EXHIBIT 1620-2 (CONTINUED)
GUIDELINES ON WHEN TO USE A MEMBER CHANGE REPORT FORM

A Member Change Report (MCR) form should be sent to the local ALTCS eligibility office (except where noted) to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.)
- To report a change in the member's financial status (or that of his/her household) which may affect their ALTCS eligibility
- To report a change in an ALTCS member's placement
- To report a change in the contract or certification status of the facility where a member resides if the member chooses to remain in the facility
- To report a change in the member's Ventilator Dependent status and request a PAS reassessment
- To report a change in the member's DD status and request a PAS reassessment
- To report he closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program)
- To initiate a Contractor change when an E/PD member moves into another Contractor's service area in a HCB setting (does not include alternative residential settings
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to an institutional setting and is expected to stay more than 90 days
- To request Acute Care Only determination for a member who refuses ALTCS services but who has not signed a Voluntary Withdrawal. Also, change from Acute Care Only back to full LTC when the member accepts services. **MCRs for these situations must be sent to AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit.**
- To request a change in Contract Type when a member has received no LTC services for a full calendar months doe to LTC service provider not available or member is temporarily out of the contractor's service area. **MCRs for these situations must be sent to DHCM/ALTCS Unit along with case notes.**
- To inform ALTCS when a member is temporarily out-of-state (>30 days)
- For Maricopa County E/PD members only – to report the member's request to change Program Contractors and the need for an enrollment choice.

NOTE – members who are temporarily out of the Contractor's service area may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor.

EXHIBIT 1620-3

UNIFORM ASSESSMENT TOOL
AND
GUIDELINES

AHCCCS/ALTCS UNIFORM ASSESSMENT TOOL – ACUITY DETERMINATIONS

MEMBER NAME: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

DETERMINED CLASS: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

DATE CLASS DETERMINED: _____ **REVIEW DATE:** _____ **CLASS** _____ **CM:** _____

Acuity determinations are based on this UAT matrix which describes characteristics of clients in each level. Information will be gathered through assessment of the client, interview with nursing facility staff, and medical record review, with particular attention to documentation regarding the past 30 days and updates within the MDS. *If the CM is uncertain regarding client's level of care, he/she will review case with their manager.*

	CLASS 1 **CLIENT HAS THREE OR MORE OF THE FOLLOWING**	**CLASS 2** **CLIENT HAS FOUR OR MORE OF THE FOLLOWING:**	**CLASS 3** **CLIENT HAS FIVE OR MORE OF THE FOLLOWING:**
BATHING, DRESSING, GROOMING	Independent or may participate in care, but requires assistance with bathing, dressing, and/or grooming.	Requires moderate assistance with bathing, dressing, and/or grooming.	Requires maximum assistance with bathing, dressing, and grooming.
FEEDING/ EATING	Independent or requires minimum set up/prompting assistance with feeding/eating.	Requires moderate assistance with feeding/eating.	Requires maximum assistance with feeding/eating (for example, tube feeding).
• **MOBILITY**	Independent or requires minimum or stand by assistance to move from one location to another with or without assistive devices.	Requires moderate assistance to move from one location to another with or without assistive devices.	Requires maximum assistance to move from one location to another with or without assistive devices.
• **TRANSFERRING**	Can transfer to some or all surfaces independently. Requires the assistance of no more than one person to transfer from one surface to another with or without assistive devices.	Requires hands-on physical guidance or assistance of one person for all transfers with or without assistive devices. The client may participate by being able to bear weight and pivot.	Requires assistance of 2 or more people to be physically lifted or moved from one surface to another with or without assistive devices.
BOWEL/ BLADDER	Continent or occasionally incontinent (*less than 7 times per week*) of bowel and/or bladder or may be continent at times with a training program.	Moderately (daily but some control) incontinent of bowel and/or bladder	Totally incontinent of bowel and/or bladder, receives scheduled toileting on a daily basis to avoid incontinence and/or receives care of a catheter or ostomy.
ORIENTATION/ BEHAVIOR	Requires no intervention or requires minimum staff intervention for episodes of confusion, memory deficits, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.	Requires moderate staff intervention. May have periodic emotional or mental disturbances, including combativeness.	Requires maximum staff intervention. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.
MEDICAL CONDITION	Stable, with no or some routine nursing/medical monitoring and care.	Conditions require more frequent monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).	Conditions require intense professional intervention to maintain stability (for example, unstable diabetes, come, terminal medical condition).
MEDICAL/ NURSING TREATMENTS	None or routine, such as range of motion and injections, as well as routine medication administration and routine catheter care. **ANYTHING MORE WOULD COUNT UNDER CLS 2**	Skilled nursing treatment in addition to routine medication administration. (Such as a treatment for skin condition.)	Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 decubitus, deep suctioning or an extensive rehab regime.

For ADLs: Minimum means some or less than half of the task, moderate means approximately one-half to less than three-quarters of the task, and maximum means extensive or approximately three-quarters of the task or more.

GUIDELINES FOR THE USE OF THE UNIFORM ASSESSMENT TOOL

I. PURPOSE

The purpose of the Uniform Assessment Tool (UAT) is to assess the acuity of Nursing Facility (NF) residents. The UAT will also be used on HCBS members when determining the NF rate to use when developing a Cost Effectiveness Study.

The use of the UAT is not intended to impact how Contractors determine authorizations for specialty levels of care (for example, wandering dementia and medical sub-acute).

II. DEFINITIONS

The following definitions apply for **most** situations. Exceptions are noted within this document and on the UAT.

- **Minimum** = means less than half the task.
- **Moderate** = means approximately 50% to less than 75% of the task.
- **Maximum** = means extensive or approximately 75% of the task or more.

III. ASSESSMENT CATEGORIES

The following information is for the purpose of assisting the case manager in completing the UAT. The information that follows is not intended to be all-inclusive. Case managers should consult with their supervisor/manager when a Characteristic does not clearly fall within a specific level.

The UAT is made up of eight (8) Characteristics:

A. Bathing/Dressing/Grooming
B. Feeding/Eating
C. Mobility
D. Transferring
E. Bowel/Bladder
F. Orientation/Behavior
G. Medical Condition
H. Medical/Nursing Treatment

Each Characteristic is assessed for one of three acuity levels. The cumulative levels determined for each Characteristic will determine the overall Class level for the member (Class 1, Class 2 or Class 3).

A single UAT form is designed to allow the case manager to document up to four (4) assessments. The case manager shall document the assessment-related date in the box associated with a Characteristic's determined acuity. When the eight (8) Characteristics are assessed, determine the Class level as summarized on the UAT. Finally, document, at the top of the tool, the review date, Class and the case manager's initials. The first assessment is documented in the upper left corner. Subsequent assessments would be documented in the upper right corner.

A. BATHING/DRESSING/GROOMING

Bathing - the process of washing, rinsing and toweling the body or body parts and transferring in/out of the tub or shower. This includes the ability to get the bath water and/or equipment, whether this is in bed, tub, shower, or sink. Use of assistive devices such as tub/shower chair, pedal/knee controlled faucets, or long-handled brushes does not disqualify the client from being independent. If the client has a problem getting to and from the bathroom to bathe, that should be reflected in the Mobility section and should not affect the score for bathing.

Assessment Considerations:

- When taking a bath/shower, can the person get their own towel, washcloth, soap, and run the water?
- Can the person tell if the water is too hot or too cold?
- Is the person able to get in and out of the shower or tub by themselves?
- Does the person need a bath bench, shower seat or hand held shower to assist with bathing?
- What kind of problems does the person have with bathing him/herself?

Minimum = the client requires up to minimal supervision, verbal cueing, assistance in and/or out of the shower, and may need assistance with washing back or lower extremities.

Moderate = the client requires step by step cueing with the entire bathing process, one person assist getting in and out of the tub/shower, and/or hands-on assistance with approximately 50% to 75% of the bathing process.

Maximum = the client is dependent on others for assistance with approximately 75% or more of the bathing process or requires assistance of two or more persons to get in and out of shower/tub or requires the use of a Hoyer lift.

Dressing - dressing includes laying out, putting on and fastening of clothing and footwear. Use of assistive devices such as reachers, sock pullers, shoe horns, Velcro fasteners does not disqualify the client from being independent.

Assessment Considerations:

- Can the person choose their own clothes, get them from the closet or drawer, put them on and button the buttons, fasten/close the zipper or tie their shoes?
- If someone lays out the clothes, can the person put them on?
- Does the person have assistive devices to assist in dressing, such as reachers, sock pullers, shoe horns, Velcro fasteners?
- How does the person get dressed if help is needed?

Minimum = the client may need some supervision or reminding (for example, laying out clothes, giving advice or being available.

Moderate = the client required hands-on physical assistance of another person or supervision with approximately 50% to 75% of the dressing activities.

Maximum = the client needs assistance with dressing approximately 75% or more of the time.

Grooming - grooming activities include combing hair, shaving, brushing teeth, washing hands/face, nail care and/or menses care. Obtaining the water and supplies necessary to complete the task are included in grooming.

Assessment Considerations:

- Can the person run the sink water and wash their face, comb their hair and brush their teeth?

Minimum = the client needs up to minimal supervision or reminding (for example, setting up grooming implements, giving advise, being available, menses care.

Moderate = the client requires some physical assistance or supervision or step by step cueing with approximately 50% to 75% of their grooming activities.

Maximum = the client is dependent on others for assistance with approximately 75% or more of their grooming activities.

B. EATING/FEEDING

Eating/Feeding – the process of getting nourishment by any means from a receptacle (dish, plate, cup, glass, bottle, etc.) into the body. Use of mechanical aids such as modified utensils or plate guards does not disqualify the client from being independent.

Assessment considerations:

- Can the person effectively get food and beverages into his/her mouth?
- Can the person cut his/her own meat?
- Does the person use any mechanical aids to assist with eating?
- Is the person receiving an intravenous or tube feeding as a means of total nutrition?
- Does the person need cueing or supervision to ensure an adequate intake?

Minimum = client requires some supervision, reminding, set-up or cutting, including alteration of food (for example, pureeing) or hands-on assistance with less than half of the meal task.

Moderate = client requires hands-on physical assistance, cueing or reminding with approximately 50% to 75% of the meal task, but can participate physically.

Maximum = client requires hands-on physical assistance with approximately 75% or more of the meal task or is totally dependent for nutritional needs (for example, tube feeding or TPN).

C. MOBILITY

Mobility – the extent of the client's purposeful movement within their residence. The use of assistive devices such as a wheelchair, walker or quad cane does not disqualify the person from being independent.

Assessment Considerations:

- Can the person purposely move about in his/her current environment independently?
- Does the person have an unstable gait or balance?
- Could the person avoid an obstacle in his/her path?
- Does the person use any assistive devices such as a cane, walker, wheelchair or handrails?
- Is the person unsafe without the assistance of another person in ambulating?

Minimum = approximately 50% or less of the time the client requires supervision, standby or hands-on assistance by one person for safety, including adjustment of assistive devices or restraints.

Moderate = approximately 50% to 75% of the time the client requires supervision, standby assistance or hands-on assistance of one person, including adjustment of assistive devices or restraints.

Maximum = approximately 75% or more of the time the client requires hands-on assistance of one or more persons or may be totally dependent on others for mobility (for example, cannot self-propel wheelchair).

D. TRANSFERRING

Transferring – the client's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc.

Assessment Considerations:

- Can the person move horizontally or vertically between the bed, chair, wheelchair or commode independently?
- Does the person display any weakness or unsteady balance, which would require assistance when transferring?
- Does the person use any mechanical devices such as a walker, cane, handrails or wheelchair to assist with transfers?
- Can the person physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver?

Minimum = can transfer to some or all surfaces independently. If needed, the assistance of no more than one person to transfer from one surface to another with or without assistive devices. The client may require some supervision or reminding or standby assistance for safety.

Moderate = the client requires hands-on physical guidance or assistance of one person for all transfers. The client may participate by being able to bear weight and pivot.

Maximum = the client requires assistance of 2 or more people to be physically lifted or moved.

E. BOWEL/BLADDER CONTINENCE

Continence – the ability to voluntarily control the discharge of body waste from bladder or bowel. Incontinence means the involuntary loss of bowel and bladder contents. Stress incontinence means the inability to prevent escape of small amounts of bowel/bladder contents during certain activities such as coughing, lifting or laughing.

Those who willfully toilet in inappropriate places will not necessarily be assessed as being incontinent. These behaviors may be assessed in other parts of this instrument (for example, Behaviors). Those who receive dialysis and do not urinate will be rated as continent of bladder.

Clients who have no voluntary control secondary to physiological conditions and rely upon dilatation, indwelling catheters, intermittent catheterization, ostomies, condom catheters or placed urinals for evacuation should be rated as totally incontinent in the applicable function.

Bladder Continence – the ability of the client to voluntarily control the discharge of body wastes from the bladder. A client with a Foley catheter or ostomy will be scored maximum.

Assessment Considerations:
- Does the person have any episodes of incontinence?
- Can the person "hold their urine" until they get to the toilet?
- Does the person have accidents when they sneeze or cough?
- How frequently does the person have accidents – once or twice a week, every day, once a month?

Minimum = the client may be incontinent less than 7 times a week.

Moderate = the client may be frequently incontinent or incontinent daily, but some control is present (for example, daytime, or if toileted frequently).

Maximum = the client is totally incontinent of bladder, receives scheduled toileting on daily basis to avoid bladder incontinence and/or receives care of a catheter or ostomy.

Bowel Continence - the ability of the client to voluntarily control the discharge of body wastes from the bowel. A client with an ostomy will be scored maximum.

Assessment Considerations:
- Does the person have bowel accidents?
- Does the person ever soil their clothing?
- How often does the person accidents?

Minimum = the client may be continent less than 7 times per week.

Moderate = the client may be frequently incontinent (7 times or more per week) or incontinent daily, but some control is present.

Maximum = the client has no voluntary control of bowel and/or receives care of an ostomy.

F. ORIENTATION/BEHAVIOR

Behavior – identify the presence of certain behaviors that may reflect the level of an individual's emotional functioning and need for intervention. Behaviors should be assessed based on the last 90 days (with particular attention to the past 30 days), or since the last review. Documentation should include frequency and type of behavior and if there has been or will be a request for mental health services.

Wandering is defined as moving about with no rational purpose and with a tendency to go beyond physical parameters of the environment in a manner that may jeopardize safety of self or others.

Repeated behaviors that cause injury to self (for example, biting scratching, picking behaviors; putting inappropriate objects into the ear, mouth or nose; head slapping or banging) or others (for example, physically attacking another person, throwing objects, punching, biting, pushing, pinching, pulling hair and physically threatening behavior).

Other repeated behaviors that interferes with the activities of others or the individuals own activities: for example, putting on or removing clothes inappropriately, stubbornness, sexual behavior inappropriate to time, place or person, excessive crying or screaming, persistent pestering or teasing; constantly demanding attention and urinating or defecating in inappropriate places, or threats and or attempts to take one's own life.

Minimum = requires staff intervention less than 50% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.

Moderate = requires staff intervention approximately 50% to 75% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May have periodic emotional or mental disturbances, including combativeness.

Maximum = requires staff intervention approximately 75% or more of the time. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.

G. MEDICAL CONDITION

Medical Condition – refers to the degree of stability of health care needs that may require nursing and/or medical monitoring of treatment(s) and/or therapy to restore and/or maintain function. This does not include maintenance regimens (monthly weights and blood pressure checks).

Minimum = stable, with routine nursing/medical monitoring and care.

Moderate = conditions require more frequent professional monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).

Maximum = conditions require intense professional intervention to maintain stability (for example, unstable diabetes, coma, terminal medical conditions).

H. MEDICAL/NURSING TREATMENTS

Medical/Nursing Treatments – refers to level of nursing and/or medical care that is required to perform medical assistance and interventions with current health care needs.

Minimum = Routine treatments, such as range of motion and injections, as well as routine medication administration and routine catheter care. Anything more would be considered at least "moderate".

Moderate = Skilled nursing treatment in addition to routine medication administration (for example, treatment of stage 1 to 3 pressure ulcer, tube feeding).

Maximum = Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 pressure ulcer, deep suctioning or an extensive rehab regimen.

EXHIBIT 1620-4

APPROPRIATE "D" PLACEMENT SCENARIOS
(ACUTE CARE ONLY)

EXHIBIT 1620-4

APPROPRIATE "D" PLACEMENT SCENARIOS

The following is a list of the common scenarios for which a member's placement is designated as Acute Care Only, "D" placement. This list is not all-inclusive.

- Member has refused both institutional and/or HCB services but does not want to withdraw from ALTCS.
- Member resides in a non-contracted setting and does not want to move.
- Member resides in an uncertified nursing facility.
- Member was determined eligible for acute care services under the ALTCS program due to financial reasons. Member will be enrolled with Contract Type designated as Acute Care Only.
- Member has received no LTC services for a full calendar month (for example, member receives services until June 12th when he leaves the state, receives no services at all in July, returns to the area and begins to receive services on August 20th. The member would be in a "D" placement for the month of July.)
- Member receives no LTC services for a full calendar month due to a lack of any available provider.
- Member receives no services, has signed a Voluntary Withdrawal and disenrollment is pending.

NOTE – members whose income is greater that 100% of the current Supplemental Security Income (SSI) amount who are in one of the above situations may not be eligible to remain enrolled in the ALTCS program. If the Contract Type of a member in one of those situations does not already indicate Acute Care Only, the case must be referred to AHCCCS (as described in Exhibit 1620-2) for an eligibility determination.

EXHIBIT 1620-5

ASSISTED LIVING CENTER/SINGLE OCCUPANCY FORM

ASSISTED LIVING CENTER/SINGLE OCCUPANCY

☐ Assisted Living Center

☐ Alzheimer's Pilot Facility

Member Name: _____ AHCCCS ID#: _____

Program Contractor: _____

I understand that, as an ALTCS member, I can choose to live by myself or have a roommate in an Assisted Living Center.

MY CHOICE FOR STAYING AT _____ IS (CHECK ONE CHOICE BELOW):
ASSISTED LIVING CENTER NAME

☐ Single Occupancy (one person per room)

☐ Shared Occupancy (at least 2 persons per room)

☐ Shared Occupancy until Single Occupancy becomes open

I understand that I may change my decision at any time and still remain at this facility.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Member

I hereby CHANGE my choice. My new choice is (check one choice below):

☐ Single Occupancy

☐ Shared Occupancy

☐ Shared Occupancy until Single Occupancy becomes open

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Member

cc: ALTCS Case Management File
Member/Representative
Assisted Living Center (original)

EXHIBIT 1620-6

HIGH COST BEHAVIORAL HEALTH REINSURANCE FORM

DIVISION OF HEALTH CARE MANAGEMENT
HIGH COST BH REINSURANCE REQUEST FORM

REQUEST/NOTIFICATION TYPE

Member Name: _____ AHCCCS #: _____

☐ Initial authorization

☐ Renewal authorization

☐ Placement Change Effective Date: _____

Reason: _____

_____

☐ Termination Effective Date: _____

Reason: _____

☐ Other _____

_____

Signature: _____ Date: _____

Program Contractor Name: _____

MEMBER DEMOGRAPHIC INFORMATION

Member Name:	AHCCCS #:
Facility Name and Type:	DOB:
Placement Date:	Daily Rate:

DIAGNOSES

Include Psychiatric and Medical, as relevant

CURRENT BEHAVIORAL ISSUES

Describe member's current behaviors and the frequency and intensity of those behaviors; how behaviors impact ability to reside in facility with lower level of intervention

FACILITY PROGRAMMING DESCRIPTION

What is unique about this facility's program that enables it to manage/minimize the occurrence of behaviors the member has exhibited in the past and without which those behaviors would persist. *This information not required for renewal authorization requests if unchanged.*

BEHAVIORAL TREATMENT PLAN

Goals as well as both behavioral and chemical interventions in place to actively manage member's current behavioral issues.

Member Name:	AHCCCS #:

PLACEMENT HISTORY

Brief description of prior placement history, to include specific information regarding reason(s) placement(s) were unsuccessful. *This information not required for renewal authorization requests.*

RE-EVALUATION OF PLACEMENT

Results of periodic re-evaluation of the member's ability to function with a lower level of intervention than provided under current treatment plan (not just attempts at placement change). *This information not required for initial authorization requests.*

Signature: _____ Date: _____

Program Contractor Name: _____

EXHIBIT 1620-7

FFS OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM

EXHIBIT 1620-7
FFS OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM

SECTION A: TO BE COMPLETED BY THE CASE MANAGER

Member Name: _____ Tribal Contractor: _____

AHCCCS ID #: _____ Date of Birth: _____

Current Residence/Placement: _____

Diagnosis/Condition: _____

Location of/Distance to nearest family: _____

Level of involvement by family: _____

Names of AZ nursing facilities contacted for availability:

Indicate requested nursing facility:

☐ **San Juan Manor**
806 W. Maple
Farmington, NM 87401
AHCCCS ID: 562050

☐ **Four Corners Care Center**
818 North 400 West
Blanding, UT 84511
AHCCCS ID: 161406

☐ **Red Cliffs Regional**
1745 East 280 North
St. George, UT 84770
AHCCCS ID: 579039

☐ **St. George Care Center**
1032 East 100 South
St. George, UT 84770
AHCCCS ID: 449810

PCP Name: _____ AHCCCS Provider ID: _____

Case Manager: _____ Date: _____

SECTION B. TO BE COMPLETED BY AHCCCS

Comments: _____

Approved _____ Signature _____ Date _____
(Name and Title)

Denied _____ Signature _____ Date _____
(AHCCCS Medical Director or designee)

Init. Eff. Date 04/01/2004

EXHIBIT 1620-8

PROGRAM CONTRACTOR CHANGE REQUEST FORM

Exhibit 1620-8
Program Contractor Change Request

Member/Recipient's Name:	AHCCCS ID #:

I. CURRENT PROGRAM CONTRACTOR INFORMATION

Person Requesting Change:		Phone #:
Contractor Name:		
Fiscal County Name:	Fiscal County #:	Provider ID #:
Transfer: ❑ Approved ❑ Denied	Date:	

Reason: ❑ Member/Recipient Leaving Service Area ❑ Member/Recipient Resides Out of Service Area ❑ Within Service Area for Medical Continuity of Care ❑ Family Request ❑ Other – Specify:	Comments/Current Medical Condition: (Attach Medical Release, Current Plan of Care and Other Necessary Information)	
Authorized Signature:	Title:	Date:

II. RECEIVING PROGRAM CONTRACTOR INFORMATION

Contractor Name:		
Fiscal County Name	Fiscal County Number:	Provider ID #:
Transfer: ❑ Approved ❑ Denied	Effective Enrollment Date:	
Authorized Signature	Title	Date

If approved, complete member/recipient information below and send this form to the AHCCCS Administration. If request denied, return form to originator.

III. MEMBER/RECIPIENT INFORMATION

Is this a change in Program Contractors within Maricopa County? ❑ YES ❑ NO

Is the change due to a move to a new county of fiscal responsibility? ❑ YES ❑ NO

Has the member/recipient physically moved to a new county of fiscal responsibility? ❑ YES ❑ NO
If YES, provide the new address below.

Effective Date of the Move:

Residential Address:	Facility Name (if applicable)			
Phone #:	Street	City	State	Zip
Mailing Address (if different):	Street	City	State	Zip

Type of Placement: ❑ Home & Community Based – Specify:
❑ Nursing Home ❑ Other – Specify:

IV. AHCCCS PROGRAM CONTRACTOR CHANGE REQUEST COORDINATOR USE ONLY

❑ Local Office Contacted:	NAME:	Date:	Initials:
❑ Local Office Changes Made:		Date:	Initials:
❑ MFIS Referral Completed		Date:	Initials:
❑ Enrollment Effective Date Adjusted in PMMIS		Date:	Initials:

Comments:

EXHIBIT 1620-9

ALTCS ENROLLMENT TRANSITION INFORMATION FORM (ETI)

ALTCS ENROLLMENT TRANSITION INFORMATION (ETI) FORM

SENDING PC: _____ **RECEIVING PC:** _____

Transition Date: _____ **Rate Code:** _____

Member Name: _____ **DOB:** _____

PRIMARY LANGUAGE SPOKEN:

AHCCCS ID: _____ **M or F (circle one)**

Rep or Contact Person (include phone #): _____

PRIMARY HEALTH INSURANCE

Medicare #: _____ **Part A B Both (circle one)**

Medicare +Choice Plan: _____ **Other:** _____

LOCATION
Current Address: _____

_____ **Member Phone Number:** _____

Facility Name: _____ **Type of Facility:** _____

Nursing Facility Level of Care: _____ **Specialty Unit:** _____

Alternative Setting Level of Care: _____

Alternative Setting Level of Care: _____

MEDICAL INFORMATION

Diagnosis: _____

_____

PCP Name: _____ **PCP Phone #:** _____

Specialists (Including out of area)

Name: _____ **Type:** _____ **Phone #:** _____

Name: _____ **Type:** _____ **Phone #:** _____

Scheduled appointments/procedures: _____

_____

Special Medications/Treatments (For example: IV, tube feedings, chemotherapy, IM's, BH):

_____

CRS Services: _____

Member Name: _____ **ETI Page 2**

DIALYSIS
Site Name and Address: _____

Days: M T W Th F Sat Sun Time: _____ **Phone Number:** _____

Transportation Provided by: _____

Assistance and/or Type of Transportation Required: _____

_____

HCBS SERVICES **Circle all that apply (See attached listing of services for details)**

Adult Day Health	Home Modification	Homemaker	Personal Care
Attendant Care	Home Delivered Meals	Hospice	Respite
Emergency Alert	Home Health Aide	Nursing	Other_____

BEHAVIORAL HEALTH SERVICES (SEE LISTING OF SERVICES FOR PROVIDERS AND UNITS)

COT?: _____ **Named on Court Order:** _____

Behavioral Health Diagnosis: _____

DME/SUPPLIES **(SEE ATTACHED LIST OF SERVICES FOR ITEMS AND PROVIDERS)**

Customized DME: _____**Supplies needed regularly:** _____

_____

PENDING GRIEVANCE **Yes** **No** **Expected Resolution Date:** _____

HOSPITALIZED MEMBERS (COMPLETE IF MEMBER IS HOSPITALIZED ON DATE FORM IS COMPLETED)

Hospital: _____**Phone:** _____

Admission Date: _____ **Admitting Diagnosis:** _____

Inpatient Treatments: _____

Expected Discharge Date: _____ **D/C To:** _____

REQUIRED ATTACHMENTS

_____ CM Assessment _____ CM Summary
_____ List of Medications _____ List of all Diagnosis
_____ Last Quarterly Behavioral Health Consult (if applicable)
_____ Listing of Services (including DME, all services, providers, and units)

Case Manager Name: _____**Phone:** _____

EXHIBIT 1620-10

SAMPLE
IMPORTANT MEMBER RIGHTS NOTICE FORM

Janet Napolitano, Governor
Anthony D. Rodgers, Director

AHCCCS
Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

801 East Jefferson, Phoenix AZ 85034
PO Box 25520, Phoenix AZ 85002
phone ***602 417 4000***
www.ahcccs.state.az.us

[Must use Times New Roman and 14 point font, and be on AHCCCS letterhead]
AHCCCS Contractors may obtain an electronic copy of this form by contacting AHCCCS Division of Health Care Management.

IMPORTANT MEMBER RIGHTS NOTICE

As a result of the lawsuit *Ball v. Biedess*, the AHCCCS Administration is sending you this notice about your rights to receive "critical" long term care services at home when you are enrolled in the ALTCS Program.

You have the right to receive all the services in your care plan to help you with bathing, toileting, dressing, feeding, transferring to or from your bed and wheelchair and other similar daily activities. These services are called "critical services." Your program contractor or tribal contractor must make sure that you receive these critical services without delays. If there is a delay and you do not receive these services on time, your program contractor or tribal contractor must provide them within 2 hours of the time they are notified of the gap. (A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual's care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.) Your other long term care services cannot be reduced to make up for the critical services that you did not receive on time.

If you do not receive your critical services on time, call your provider to report the issue. In addition, you may also call your program contractor or tribal contractor at the telephone numbers listed below to report the problem. Your case manager will also provide you with phone numbers to call if there are delays in getting your critical services. You can also call your case manager or speak with an operator during normal business hours. Your program contractor or tribal contractor will also give you a form to fill out and mail back when there is a gap in critical services. You will get an answer by phone or in writing. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again.

AHCCCS will collect reports on gaps in critical services from each program contractor on a monthly basis. AHCCCS will also collect information to help determine how to set rates to pay workers who provide critical services. The program contractors will also give information to AHCCCS every 6 months about home care workers' current wages and benefits. This information will be made public once a year beginning August 15, 2005.

AHCCCS has hired experts to look at the amount of critical services available for AHCCCS members and the general population. This information will be available on October 15, 2005.

We will send you another Notice if a Court makes changes to this information. If you have any questions about this Notice, please call your program contractor or tribal contractor, your case manager or AHCCCS. Telephone numbers are listed below.

[CONTRACTOR INSERTS THEIR SPECIFIC CONTACT INFORMATION HERE]

Arizona Health Care Cost Containment System (AHCCCS)
(602) 417-4086 or 1 (800) 654-8713, extension 74086

Revised August 16, 2005

EXHIBIT 1620-11

SAMPLE
CRITICAL SERVICE GAP REPORT FORM

LOGO AND ADDRESS OF CONTRACTOR HERE

[Must use Times New Roman and 14 point font]

CRITICAL SERVICE GAP REPORT FORM

All ALTCS members have the right to receive all critical services in their care plan to help with bathing, dressing, toileting, feeding, transferring to or from your bed or wheelchair and other similar daily activities. If you do not receive your critical services as specified in your care plan, you should report this as quickly as possible. You should immediately call the service provider or our phone numbers listed on the Contingency Plan Form your case manager filled out with you. You may also call your case manager to help you receive these critical services.

In addition, you can mail this form to us at the address listed above telling us the services you have not received. As your program contractor, we will respond to you either by telephone or by the mail. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again. Please fill in the following:

Your Name:_____

AHCCCS ID Number (if available)_____

Date of Birth:_____

Date(s) you did not receive your services:_____

Critical Service(s) not received:_____

Comments:_____

_____

_____

Revised August 16, 2005

1630 ADMINISTRATIVE STANDARDS

Administrative responsibilities related to case management of enrolled members include the following:

- **CASE MANAGER QUALIFICATIONS**

Individuals hired as case managers must be either:

A degreed social worker

A licensed registered nurse, OR

A person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities.

- **CASE MANAGEMENT PROCEDURES**

Contractors are responsible for maintaining case management procedures that are reflective of AHCCCS policy, as defined in this Chapter.

Contractors may develop their own standardized forms and tools for assessing and recording information regarding members' needs and services.

Refer to Exhibit 1630-1 for guidelines to be used in developing and implementing an assessment tool or process for attendant care, personal care and/or homemaker services.

- **TRAINING**

Case managers must be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used must be maintained.

A. Contractors must ensure that there is a structure in place to provide uniform training to all case managers. This plan should include formal training classes as well as mentoring-type opportunities for newly hired case managers.

B. Newly hired case managers must be provided orientation and training in a minimum of the following areas:

1. The role of the case manager in utilizing a member-centered approach to ALTCS case management, including involving the member and their family in decision-making and service planning

2. The principle of most integrated, least restrictive settings for member placement

3. Member rights and responsibilities

4. Case management responsibilities as outlined in this Chapter

5. Case management procedures specific to the Contractor

6. An overview of the AHCCCS/ALTCS program

7. The continuum of ALTCS services, including available service settings and service restrictions/limitations

8. The Contractor provider network by location, service type and capacity. Included in this should be information about community resources for non-ALTCS covered services.

9. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect and/or exploitation

10. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the ALTCS population service by the Contractor

11. General social service information, such as family dynamics, care contracting, dealing with difficult people

12. Behavioral health information, including identification of behavioral health needs, covered behavioral health services and how to access those services within Contractor's network

13. Pre-Admission Screening and Resident Review (PASRR) process

14. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for members under the age of 21, and

15. ALTCS management information system (CATS) that maintains member-specific data such as Cost Effectiveness Studies, Placement/Residence codes, behavioral health codes, review dates and, for Tribal Contractors, service authorizations. The level of orientation to CATS will be dependent on the level of usage by the Contractor case managers.

C. All case managers must be provided with regular ongoing training. The following are examples of topics that could be covered:

1. Policy updates and refresher training for areas found deficient through the monitoring process

2. Interviewing skills

3. Assessment/observation skills

4. Cultural competency

5. Medical/behavioral health issues, and/or

6. Medications.

D. Training may also be provided by external sources, for example:

1. Consumer advocacy groups

2. Providers (for example, medical or behavioral health), and

3. Accredited training agencies.

- **CASELOAD MANAGEMENT**

Adequate numbers of qualified and trained case managers must be provided to meet the needs of enrolled members.

Contractors must have written protocols to ensure newly enrolled ALTCS members are assigned to a case manager immediately upon enrollment.

Elderly and/or Physically Disabled (E/PD) members.

Each case manager's caseload must not exceed a weighted value of 96. The following formula represents the maximum number of members allowable per E/PD case manager:

A. For institutionalized members, a weighted value of **0.8** is assigned. Case managers may have up to 120 institutionalized member (120 x 0.8 = 96).

B. For HCBS (own home) members, a weighted value of **2.0** is assigned. Case managers may have up to 48 HCBS members (48 x 2.0 = 96).

C. For assisted living facility (ALF) members, a weighted value of **1.6** is assigned. Case managers may have up to 60 ALF members (60 x 1.6 = 96).

D. For Acute Care Only (ACO) members, a weighted value is 1.0 is assigned. Case managers may have up to 96 ACO members (96 x 1.0 = 96).

E. If a mixed caseload is assigned, there can be no more that a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

(# of HCBS members x 2.0)
+
(# of ALF members x 1.6)
+
(# of ACO members x 1.0)
+
(# of NF members x 0.8)
96 or less

F. **Developmentally Disabled members** – Each case manager's case load must not exceed an average ratio of 1:40 members, regardless of setting.

Caseload Exceptions – Program Contractors must receive authorization from AHCCCS/Division of Health Care Management prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established at the discretion of the Contractor and do not require authorization.

The Contractor's annual Case Management Plan must describe how caseloads will be determined and monitored.

- **ACCESSIBILITY**

Members and/or member representatives must be provided adequate information in order to be able to contact the case manager or Contractor office for assistance, including what to do in cases of emergencies and/or after hours.

A system of back-up case managers must be in place and members who contact an office when their primary case manager is unavailable must be given the opportunity to be referred to a back-up for assistance.

There must be a mechanism to ensure members, representatives and providers are called back in a timely manner when messages are left for case managers.

- **TIME MANAGEMENT**

Contractors must ensure that case managers are not assigned duties unrelated to member-specific case management for more than 15% of their time if they carry a full caseload.

- **TECHNICAL**

Contractors will establish a mechanism to ensure that CATS data is entered accurately and within established timeframes (14 business days of the date the action took place).

Contractors must ensure that case managers do not provide direct, reimbursable services to ALTCS members enrolled with the Contractor.

- **SUPERVISION**

A supervisor to case manager ratio must be established that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers.

A system of internal monitoring of the case management program (for example, case file audits) must be established and applied, at a minimum, on a quarterly basis. Results from this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, must be documented and made available to AHCCCS upon request.

- **INTER-DEPARTMENTAL COOPERATION**

The Contractor should establish and implement mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with medical management and quality management.

The Contractor should ensure the Medical Director is available as a resource to case management and that s/he is advised of medical management issues as needed.

- **REPORTING REQUIREMENTS**

A Case Management Plan must be submitted annually to AHCCCS on or before November 15th by all Program Contractors. Tribal Contractors are not required to submit a plan. The plan must address how the Program Contractor will implement and monitor the case management and administrative standards outlined in this Chapter, including specialized caseloads.

An evaluation of the Contractor's Case Management Plan from the previous year must also be included in the plan, highlighting lessons learned and strategies for improvement.

EXHIBIT 1630-1

ATTENDANT CARE GUIDELINES

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ATTENDANT CARE GUIDELINES

In developing and/or implementing an Attendant Care assessment tool or process, the following guidelines should be used:

1. The process must assess the member's total need for care.

2. The assessment must be done with direct involvement of the member and/or representative.

3. There must be a discussion about what care is needed, the average amount of time needed to complete that care and the availability of informal caregivers to assist with that care. Consideration must be given to the stressors the informal caregivers are under in providing care and how the provision of ALTCS services to relieve them may increase their ability to continue with that care.

4. The assessment must allow for individual member needs. Pre-determined/maximum time limits or task frequencies (for example, maximum of ten minutes for eating or no more than 1x/week for laundry) cannot be established. Guides may be used as a starting point, but the case manager must have the freedom to vary from those with adequate justification.

5. The assessment must address the member's need for general supervision as well as specific tasks. If the member is not safe to be alone, this must be considered. For example, if the member needs around the clock care due to dementia, and has a history of unsafe behaviors, but the family is unavailable to provide this care 7 AM to 6 PM (11 hours) Monday through Friday, then the attendant care need in this case begins at 55 hours/week.

6. There can be no differentiation or discrimination in the types of frequencies of service authorized simply because the member's caregiver will be a family member or other live-in person.

7. There must be adequate case file documentation to support the assessment and hours authorized.

8. After the member's needs are assessed, the CES must be calculated to determine what can be provided within the ALTCS cost effectiveness standards. Services whose cost is at or below 100% of the cost of institutionalization or those that are expected to be at this level within 6 months may be authorized.

These same guidelines, with the exception of #5, may be used in assessing a member's need for personal care and homemaking services.

1640 TARGETED CASE MANAGEMENT STANDARDS

Targeted case management (TCM) is a covered service provided by the Arizona Department of Economic Security/Division of Developmental disabilities (ADES/DDD) to members with developmental disabilities (DD) who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program. ADES/DDD provides the TCM services to these members; however, the members receive their acute care services through the AHCCCS acute care Contractors. Members must be given a choice of available Contractors and primary care providers registered with AHCCCS and a choice of case managers from ADES/DDD. Members are not required to accept case management services.

Members receiving TCM may reside in any of the ADES/DDD approved settings and may choose the type (on-site visit, telephone, letter) and frequency of case management contact except under the following circumstances:

1. New ADES/DDD members eligible for TCM must be visited every 90 days for the first six months. Thereafter, them may choose the frequency of contact.

2. Members receiving non-medically related services funded by the Arizona Early Intervention Program (AzEIP) must be visited every 90 days.

3. Members residing in any licensed residential setting must be visited every 180 days.

4. Members receiving attendant care provided by the family must receive an initial 30 day visit and a visit every 90 days thereafter, and

5. Members receiving State-funded services must be seen at the time of the annual Individual Service Plan (ISP).

Targeted case manager responsibilities include, but are not limited to, the following components:

1. Informing the member of service options including medical services from Contractors based on assessed needs

2. Coordinating and participating in the plan of care ISP meetings including developing, revising and monitoring of the ISP.

3. Locating, coordinating and arranging social, educational and other resources to meet the member's needs

4. Providing necessary information to assist the provider in planning, delivering and monitoring services regarding the member's functioning level and any changes in the member's level of functioning

5. Providing family members, or other caregivers, the support necessary to obtain optimal benefits from available services/resources

6. Providing assistance to strengthen the role of family as primary caregivers

7. Providing assistance to reunite families with children who are in an alternative setting whenever possible

8. Preventing costly, inappropriate and unwanted out-of-home placement, and

9. Identifying services provided by other agencies to eliminate costly duplication.

ADES/DDD administrative responsibilities include, but are not limited to, the following components:

1. Ensuring staff are qualified and employed in sufficient numbers to meet case management needs and responsibilities

2. Ensuring that staff receive initial and ongoing training regarding case management responsibilities for the TCM program

3. Identifying new members who are eligible for TCM services and assign case managers

4. Ensuring the member is informed of the assignment of the case manager, when the case manager is changed and how the case manager can be contacted

5. Assisting the member with requesting a new case manager from those available if s/he is dissatisfied with the assigned case manager

6. Informing ongoing DD members receiving TCM of visit options and request their decision on the options, and

7. Following ADES/DDD prescribed timeframe guidelines for Inventory for Client and Agency Planning (ICAP) and ISP.

   a. The ICAP must be done at the initial visit and upon re-determination.

   b. The ISP must be developed within 12 business days of enrollment to ADES/DDD and TCM, and completed annually thereafter.

   c. The ISP must consist of a narrative including, but not limited to:

      1) Identification of member as enrolled in TCM

      2) A description of the type and frequency of contact requested or required

      3) Identification of TCM contacts

      4) Demonstration of attempts made to contact member, including certified letter (when applicable)

      5) A description of member abilities, supports and needs, and

      6) Member refusal, when applicable.

   The completed ISP must be signed by the member or representative and a copy of it sent to the member or representative within 15 business days following its completion. The ISP may be completed by telephone if the member is not receiving ADES/DDD funded services. When completed by telephone, the ISP must be send to the member or representative for signature within 15 business days of the telephone conversation.

8. Establish and maintain an internal monitoring system of the TCM program, and make results available at the time of annual review, to include a summary/analysis and corrective action plan, when applicable.