

**1620-B - NEEDS ASSESSMENT/CARE PLANNING STANDARD**

EFFECTIVE DATES: 02/14/96, 10/01/17, 06/01/21, 10/01/25

APPROVAL DATES: 10/01/04, 02/01/05, 09/01/05, 10/01/06, 10/01/07, 05/07/10, 01/01/11,  
05/01/12, 03/01/13, 01/01/16, 07/20/17, 05/28/20, 08/26/25

**I. PURPOSE**

This Policy applies to ALTCS E/PD and DES DDD (DDD) Contractors; and Fee-For-Service (FFS) Tribal ALTCS Programs. Where this Policy references ALTCS or Contractor requirements the provisions apply to ALTCS E/PD, DES DDD, and Tribal ALTCS unless otherwise specified. This Policy establishes requirements regarding needs assessment and care planning.

**II. DEFINITIONS**

Refer to the [AHCCCS Contract and Policy Dictionary](#) for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

**HOME AND COMMUNITY  
BASED SERVICES NEEDS TOOL  
(HNT)**

A tool used by ALTCS Case Managers to assess ALTCS member’s specific needs related to direct care services (AMPM 1240-A) and habilitation service (AMPM 1240-E) needs. The tool has two tabs for assessment purposes; one for minor children aged 0-17 and one for adults aged 18+. The HNT is a stand-alone document found in AMPM Exhibit 1620-17.

**PARENT AS PAID CAREGIVER  
(PPCG) SERVICE MODEL OPTION**

Permits legally responsible parents, including legal guardians, with formal physical and/or legal custody to receive compensation for providing paid direct care and habilitation services to their minor child, an ALTCS member.

**III. POLICY**

1. ALTCS Case Managers are expected to use a person-centered approach regarding the member assessment and needs identification, taking into account not only ALTCS-covered services, but also other needed community resources as applicable. ALTCS Case Managers shall:
  - a. Respect the member and the member’s rights,
  - b. Support the member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible,
  - c. Provide adequate information and teaching to support the member/Health Care Decision Maker (HCDM) to make informed decisions and choices,
  - d. Be available to answer questions and address issues raised by the member/HCDM and/or Designated Representative (DR) (as applicable), including between regularly scheduled Person-Centered Service Plan (PCSP) meetings,

- e. Provide a continuum of service options that supports the expectations and agreements established through the PCSP process,
  - f. Educate the member/HCDM and DR on how to report unavailability or other problems with service delivery to the Contractor to ensure unmet service needs can be addressed as quickly as possible. Refer to AMPM Policy 1620-D and AMPM Policy 1620-E regarding specific requirements,
  - g. Facilitate access to non-ALTCS supports and services available throughout the community, as well as Non-Title XIX/XXI services for members with a Serious Mental Illness (SMI) designation and SED identification,
  - h. Advocate for the member, HCDM/DR and/or family/significant others as the need occurs,
  - i. Allow the member/HCDM and DR to identify their role in interacting with the service delivery system, including the extent to which the family/informal supports will provide uncompensated care,
  - j. Provide members/HCDMs and DRs with flexible and creative service delivery options,
  - k. Educate members/HCDMs and DRs about member directed options for delivery of designated services in accordance with AMPM Chapter 1300. The member directed options shall be reviewed with members/HCDMs for members living in their own homes at every PCSP meeting. The ALTCS Member Service Options Decision Tree found in AMPM Exhibit 1620-18 is a tool that may be used by Case Managers to have discussions with members,
  - l. Educate members/HCDMs/DR on the option to choose a spouse as the member's paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs,
  - m. Provide necessary information to providers about any changes in member's goals, functioning and/or eligibility to assist the provider in planning, delivering and monitoring services,
  - n. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member including actively assist in transitions such as identifying alternate providers, making referrals and coordinating care,
  - o. Educate the members/HCDMs and DRs on End of Life (EOL) Care and Advanced Care Planning (ACP) services and supports, including covered services, and assist members in accessing those services as specified in AMPM Policy 310-HH,
  - p. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education and employment, including volunteer opportunities (refer to the section below which outlines additional requirements for individualized member goals), and
  - q. Refer member cases, via Electronic Member Change Report (EMCR), to the AHCCCS Division of Member Provider Services (DMPS) for a medical eligibility re-assessment if a member is assessed to no longer require an institutional level of care. Refer to the AHCCCS ALTCS Member Change Report Guide located on the AHCCCS website for EMCR instructions.
2. The involvement of the member/HCDM and DR in strengths/needs identification as well as decision-making is a basic tenet of ALTCS Case Management practice. For the PCSP meetings, the Planning Team may include anyone, as requested by the member/HCDM. The member/HCDM and Planning Team partner with the Case Manager in the development of the PCSP, with the Case Manager generally functioning as the facilitator.

3. The Case Manager shall complete a Uniform Assessment Tool (UAT) based on information from the member's PCSP to determine the member's current level of care. The ALTCS Case Managers shall utilize AMPM Exhibit 1620-3. The DDD Case Managers shall utilize the Contractors Level of Care Assessment Tool to determine the member's current level of care.
4. The PCSP is an in-person meeting with the member/HCDM and other members of the Planning Team in order to develop a comprehensive PCSP, as defined in this policy. The PCSP shall include recommendations of the member's Primary Care Provider (PCP), as well as input from ALTCS service providers, as applicable. Case Managers shall complete the Home and Community Based Services (HCBS) Needs Tool (HNT) to determine the amount of service hours a member needs when direct care services, and/or Habilitation, services may be authorized for members living at home. The member/HCDM may request for an assessment using the HNT at any time. Refer to AMPM Chapter 1600, Exhibit 1620-17. When the results of the HNT determine that a minor member has assessed needs that meet the extraordinary care criteria as defined by developmental milestones and age appropriate tasks outlined on the Child Tab of the HNT (AMPM Exhibit 1620-17), the Case Manager shall support informed decision making on the selection of caregiver options for minors including the Parents as Paid Caregiver (PPCG) Service Model Option in accordance with AMPM Policy 1240-A and 1240-E. The Minor Caregiver Options Discussion Guide and Decision Roadmap found in AMPM Exhibit 1620-21, is the tool that shall be used by Case Managers to facilitate and document these discussions.
5. As part of the development of the member's PCSP, Case Managers shall support the member in identifying meaningful and measurable individualized goals, including long-term and short-term goals (e.g. in the areas of recreation, transportation, friendships, family and other relationships, self-advocacy and decision making, skills to promote greater independence). Each goal should be written to reflect on how the member determines successful achievement and should align with their vision of a meaningful and fulfilling life. Therefore, goals should consider what is important to and for the member, and be based on their preferences, strengths, and support needs.

The goals should be developed collaboratively and written in plain language with an action plan that outlines steps the member will take to achieve them including support offered by their circle of support. Goals shall be reviewed at each 90-day PCSP meeting.

6. For members who have been receiving HCBS during the Prior Period Coverage (PPC) timeframe, a retrospective assessment must occur to determine whether those services were:
  - a. Medically necessary,
  - b. Cost effective, and
  - c. Provided by an AHCCCS registered provider.

If all three of the above criteria are met, the services are eligible for reimbursement by the ALTCS Contractor, or, for FFS members, the AHCCCS Administration, as specified in the member's PCSP. Services that will be retroactively approved based on this assessment shall be marked as "Retroactive" in the PCSP. If any of the services provided during the PPC are not approved by the ALTCS Contractor, the member must be provided a written Notice of Adverse Benefit Determination (NOA) and given an opportunity to file an appeal. Refer to ACOM Policy 414 for more detailed information on this requirement.

In addition to the grievance and appeals procedures described above, the Contractor shall also make available the grievance and appeals processes described in ACOM Policy 444 and ACOM Policy 446 and in 9 AAC 21, Article 4 for individuals determined to have an SMI under Arizona law.

The Assisted Living Facilities (ALFs) are encouraged to bill/accept Medicaid payment for services for members who are eligible under PPC but are not required by regulations to do so. If the facility chooses to, or is required by contract to bill the Contractor, the facility must accept the Medicaid payment as full payment and is not permitted to bill the member or family for the difference between the Medicaid and private pay rate. The facility must refund private payments made by the member or family, less the amount of room and board assigned by the Contractor, prior to billing the Contractor for Medicaid reimbursement.