

1620-C COST EFFECTIVENESS STUDY STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/17, 10/01/20

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

I. PURPOSE

This Policy applies to ALTCS E/PD, ALTCS DES DDD (DDD) Contractors, and Fee-For-Service Program including: Tribal ALTCS; excluding Federal Emergency Services (FES). (For FESP, refer to AMPM Chapter 1100). This Policy establishes standards for the cost effectiveness study regarding services provided under Title XIX.

Please note that as a result of the current Public Health Emergency the implementation of the new Person-Centered Service Plan (PCSP) Tool and process has been postponed. AHCCCS intends to postpone PCSP. Contractors and Tribal ALTCS Programs are not required to implement the PCSP requirements noted in this policy until further notification.

II. DEFINITIONS

CASE MANAGERS

Arizona licensed registered nurses in good standing, social workers, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience, or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or have been determined to have an SMI.

CASE MANAGEMENT

A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

CONTRACTOR

An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to ARS 36-2904, ARS 36-2940, ARS 36-2944, or Chapter 34 of ARS Title 36, to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and State and Federal law, rule, regulations, and policies.

DESIGNATED REPRESENTATIVE

A parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs as specified in AAC R9-21-101(B).

**HEALTH CARE
DECISION MAKER**

An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to ARS title 14, chapter 5, article 2 or 3; or ARS 8-514.05, 36-3221, 36-3231 or 36-3281.

**HOME AND COMMUNITY
BASED SERVICES
(HCBS)**

Home and Community-Based Services, as defined in ARS 36-2931 and ARS 36-2939.

**PERSON-CENTERED
SERVICE PLAN
(PCSP)**

A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The Person-Centered Service Plan shall also reflect the member's strengths and preferences that meet the member's social, cultural and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

PLANNING TEAM

A defined group of individuals that shall include the member/Health Care Decision Maker and with the member's/Health Care Decision Maker's consent, his or her family, individual representative, Designated Representative, and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

MANAGED RISK AGREEMENT

A document developed by the Case Manager and the member/Health Care Decision Maker, which outlines potential risks to the member's health, safety, and well-being as a result of decisions made by the member or their Health Care Decision Maker regarding Long Term Care Services and Supports. The Managed Risk Agreement must specify the alternatives offered to the member and must document the member's choices with regard to any decisions involving placement, services, and supports. The Managed Risk Agreement shall be signed by the member/Health Care Decision Maker at each PCSP meeting and kept in the member's case file.

III. POLICY

A. REQUIREMENTS FOR A COST EFFECTIVENESS STUDY

The services provided under Title XIX shall be cost effective whether the placement is in an institutional facility or a Home and Community Based (HCB) setting. Placement in a HCB setting is considered appropriate if the cost of HCBS for a specific member does not exceed 100% of the net cost of institutional care for that member, is the least restrictive setting and HCBS will meet the member's needs.

1. A Cost Effectiveness Study (CES) shall be completed for all Arizona Long Term Care System (ALTCS) and Tribal ALTCS members who are Elderly and/or have a Physical Disability (E/PD) in a HCB setting and for those E/PD members currently placed in an institutional setting who have discharge potential. The timeframes for completion of the CES can be found in AMPM Chapter 1600, Exhibit 1620-1.
2. The Contractor's Annual Case Management Plan shall describe a process used by the Contractor that evaluates the net cost of institutional care that meets the requirements of this policy. This process shall include:
 - a. Calculation on institutional costs stratified for levels of care and specialized needs,
 - b. Annual re-assessment and adjustment of the institutional rates based upon changes in costs associated with the assessed levels of care and specialized needs, and
 - c. Implementation of processes consistent with this policy, for determination and evaluation of CES for each member and processes for resolution of cases where the net HCBS cost exceeds the net cost of institutional care.
3. A CES shall be completed for members with developmental disabilities under the following circumstances:
 - a. Every three months for a member whose service costs exceed 80% of the cost of the appropriate institutional setting for the member,
 - b. When the service costs of a member whose service costs previously exceeded 80% of the cost of the appropriate institutional setting are subsequently reduced to below 80%, and/or
 - c. When discharge is contemplated for any member residing in an Intermediate Care Facility (ICF).

4. The net cost of institutional care for each member takes into consideration the specific member’s assessed Level of Care, the institutional rate appropriate for that Level of Care and the amount of the specific member’s “CES Share of Cost”:
 - a. 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 cost shall be used in calculating the cost effectiveness of HCBS,
 - b. The “CES Share of Cost” is the amount the Division of Member Services/ Arizona Long Term Care System (DMS/ALTCS) eligibility has determined, based on the member’s income and expenses, that member would have to pay monthly **IF** member was placed in a nursing home,
 - c. The net Medicaid cost of institutional care is calculated by subtracting the monthly CES Share of Cost amount for the member from the monthly nursing facility cost based on the specific member’s level of care or other needs. The result is called the Net Institutional Cost,
 - d. If the member has been assessed by the DMS/ALTCS unit, to have an actual Share of Cost that shall be paid in HCBS, that amount is deducted from the total monthly cost of the HCB services the member needs. The result is called the “Net HCBS Cost”,
 - e. If the Net HCBS Cost is more than the Net Institutional Cost, then home care services at that level are not “cost effective” and cannot be provided unless the HCBS costs are expected to decrease to less than the cost of institutional care within six months of the current CES date. At that time, the member shall be issued a Notice of Adverse Benefit Determination (NOA) that explains any decision to not provide services at the level requested/needed by the member/representative and given an opportunity to file an appeal if member does not agree with the decision, and
 - f. The portion of HCBS that are cost effective can be provided if the member/representative still desires HCBS placement and is willing to accept that level of services and to assume the potential risks of remaining at home without all the care that has been assessed as needed. The Case Manager shall complete a Managed Risk Agreement with the member/representative to document this situation:

Example of CES>100%

Total Nursing Home Cost		\$4920.10
CES Share of Cost	-	\$726.90
Net Institutional Cost	=	\$4193.20
SERVICES MEMBER NEEDS		
40 hours of Attendant Care per week		\$2924.00
12 Nursing visits per month	+	\$1341.60
Net HCBS Cost	=	\$4265.60
\$4265.60 DIVIDED BY \$4193.20 = 102% REQUESTED HCBS ARE NOT COST EFFECTIVE		

- g. If the member in the previous example requested all the services that could cost effectively be provided, the Case Manager should determine which services are priorities for the member and recalculate the CES. For example:

Total Nursing Home Cost		\$4920.10
CES Share of Cost	-	\$ 726.90
Net Institutional Cost	=	\$4193.20
SERVICES THAT CAN COST EFFECTIVELY BE PROVIDED		
40 hours of Attendant Care		\$2924.00
11 Nursing visits per month	+	\$1144.00
Net Home Services Cost	=	\$4068.00
\$4068.00 DIVIDED BY \$4193.20 = 97% REQUESTED HCB SERVICES ARE COST EFFECTIVE		

- h. 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).
5. When the cost of HCBS exceeds 80% of the cost of institutional care:
- Contractor Case Managers shall provide written justification of services to their administration for approval, and
 - Tribal ALTCS Case Managers shall provide written justification of services to the AHCCCS/Division of Fee-for-Service Management (DFSM)/Tribal ALTCS Unit as a request for approval.
6. 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:
- A Contractor's administration may approve the HCBS costs. Justification and the approval shall be documented in the case file, and
 - Tribal ALTCS Case Managers shall provide written justification of services to the DFSM/Tribal ALTCS Unit as a request for approval.
7. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months, the Case Manager shall advise the member of the cost effectiveness limitations of the program and discuss other options:
- The Case Manager shall either reduce or not initiate any Title XIX service costs in excess of 100%. Contractors or Tribal ALTCS Program may review individual cases with the appropriate AHCCCS unit (DHCM or DFSM) before the decision to deny or reduce services is made. A NOA shall be issued to the member regarding any decision to deny, reduce, limit or terminate requested services,

- b. If the member chooses to remain in their own home even though the Contractor or Tribal ALTCS Program cannot provide all of the services which have been assessed as medically necessary (including those ordered by the member's Primary Care Provider [PCP]), a Managed Risk Agreement/contract should be written. This agreement should document the services that the Contractor or Tribal ALTCS Program 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/Health Care Decision Maker signature on the agreement documents acknowledgement of the service limitations and risks,
 - c. The cost of HCBS services that will be retroactively approved during prior period coverage enrollment cannot exceed 100% of the cost of institutionalization for that member, and
 - d. The CES shall be updated when there is a change in placement to HCBS or there is a change in services that would potentially place the member's costs at greater than 80% of institutional cost.
8. A CES may be completed indicating "None" for HCBS services needed under the following circumstances:
 - a. The 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,
 - b. The members receiving hospice services only (Placement/Reason code: 10). The members receiving other Long Term Care (LTC) services in combination with hospice shall have a CES completed in accordance with other CES policy explained in this section,
 - c. The members residing in a nursing facility because the cost of HCBS would exceed 100% of institutional costs (Placement/Reason code: Q/01), or
 - d. The members with Acute Care Only status (Placement/Reason code: D/04, D/11 or D/12).
9. The CES data shall be entered into the Client Assessment Tracking System (CATS) system within 10 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 the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

If the initial CES entered in the CATS system also reflects the assessment of the cost effectiveness of HCBS services provided in the Prior Period Coverage (PPC), a comment to that effect shall be added to the case file or system notes if comments are entered in CATS. If the services entered on the initial CES do not reflect those provided during the PPC, a separate hard copy CES shall be completed to demonstrate that PPC services were cost effective and this CES shall be maintained in the case file.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

10. The HCBS that shall be included in the CES:
 - a. Adult day health,
 - b. Attendant care. In addition, if the member chooses to utilize their spouse as the paid caregiver for these services, the spouse shall not be authorized for more than 40 hours of services in a seven-day period. Refer to AMPM Policy1240 for more information on this limitation,
 - c. Habilitation,
 - d. Private Duty Nursing,
 - e. Home delivered meals,
 - f. Homemaker services,
 - g. Personal care,
 - h. Respite, if provided in a repeated pattern, such as weekly,
 - i. Emergency alert systems,
 - j. Behavioral health alternative residential settings, and
 - k. Alternative HCBS settings

11. The services which are not to be included in a CES include:
 - a. Hospice services,
 - b. Customized DME items,
 - c. Physical, speech, occupational and/or respiratory therapies,
 - d. Medical supplies and pharmaceuticals,
 - e. Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support),
 - f. Home modification,
 - g. Community Transition Services,
 - h. Member and/or Direct Care Worker (DCW) Training, authorized as part of a member directed service option,
 - i. Home Health Nursing/Home Health Aide,
 - j. Regularly scheduled medically necessary transportation, and
 - k. Behavioral management (behavioral health personal care, family support and peer support).

12. If the member receives ALTCS-covered HCBS, which are paid for by another funding source, including but not limited to Medicare, tribal entities, or private insurance, a CES shall be completed. The CES shall be completed indicating the services received, but with no unit cost paid by the Contractor or AHCCCS/DFSM for Tribal ALTCS members.