1620-E - SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

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

APPROVAL DATES: 10/01/04, 02/01/05, 09/01/05, 10/01/07, 02/01/09, 01/01/11, 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; Fee-For-Service (FFS), Tribal ALTCS as delineated within this Policy. Where this Policy references Contractor requirements the provisions apply to ALTCS E/PD, ALTCS DDD and Tribal ALTCS unless otherwise specified. This Policy establishes requirements for service plan monitoring and reassessment visits.

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.

DESIGNATED REPRESENTATIVE (DR) 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 A.A.C. R9-21-101(B).

HEALTH CARE DECISION MAKER (HCDM) 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 A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. § 8-514.05, 36-3221, 36-3231 or 36-3281.

HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. § 36-2931 and § 36-2939.
PLANNING TEAM	A defined group of individuals that shall include the member/Health Care Decision Maker (HCDM) 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.
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 PCSP 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.
SERIOUS MENTAL ILLNESS (SMI)	A designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.
SERIOUS MENTAL ILLNESS DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.
SPECIAL ASSISTANCE	The support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

III. POLICY

1. Case Managers are responsible for ongoing assessment and monitoring of the needs, 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.

2. A PCSP shall be completed with the member present, within the following timeframe:
   a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in non-Medicare certified institutional settings),
   b. At least every 90 days for a member receiving HCBS,
   c. At least every 90 days for a member receiving acute care services only and living in their "own home" or an Alternative HCBS setting. Acute care service monitoring for members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member shall be completed at least once a year. Acute Care Only members residing in a non-contracted or uncertified institutional setting shall have an on-site PCSP meeting at least every 180 days,
   d. At least every 180 days for ALTCS DDD members 12 years or older residing in a group home, unless the member is medically involved or determined to have a Serious Mental Illness/Severely Emotionally Disturbed (SMI/SED). For members with medically involved needs or determined SMI/SED, a PCSP shall be conducted at least every 90 days.
   e. Refer to AMPM Chapter 1600, Exhibit 1620-1 for required Case Management Timeframes.

   Contractors may develop standards for more frequent monitoring visits of certain members and/or specific types of placements at their discretion. However, at a minimum, Contractors shall adhere to the Case Management PCSP standards as specified in this Policy.

   Case Managers are expected to attend nursing facility care planning meetings on a periodic basis to discuss the member's needs and services jointly with the member, Health Care Decision Maker (HCDM) and Designated Representative (DR) (as appropriate). At a minimum, Case Managers shall consult with facility staff during 180-day PCSP meetings to assess changes in member Level of Care.

3. PCSP meetings are to be conducted where the member receives services, including the member's home and other service settings as described below. At a minimum, Case Managers shall conduct PCSP meetings with a member in the member's home at least twice annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs. If a member receives services in a setting outside of the home, at a minimum, a PCSP meeting shall be conducted at one of the member's service setting locations. At the election of the member/HCDM remaining PCSP meetings may be conducted at an alternate location that is not a service setting. The location of each PCSP meeting, whether at a service setting location or an alternate

site, shall be determined by the member or Health Care Decision Maker and not for the convenience of the Case Manager or providers. The choice of location by the member/Health Care Decision Maker shall be documented in the Case Management file.

If a Case Manager is unable to conduct a PCSP meeting as specified above due to the refusal by the member/Health Care Decision Maker to comply with these provisions, services cannot be evaluated for medical necessity and therefore, will not be authorized. A Notice of Adverse Benefit Determination (NOA) shall then be issued to the member setting forth the reasons for the denial/discontinuance of services.

4. The member/Health Care Decision Maker shall be able to contact the member's Case Manager between regularly scheduled PCSP meetings to ask questions, discuss changes/needs and/or to request a meeting with the Case Manager. The Case Manager shall respond to the questions and/or requests made by the member/Health Care Decision Maker, within 48 hours (not including weekends and holidays).

5. Case Managers shall take appropriate action when they identify or are notified of an urgent or a potential emergency situation. Case Managers shall report any urgent or potential emergency situations to their supervisor/manager in order to determine the level of intervention and appropriate action, including referral to quality management.

   More frequent case monitoring may be required following the occurrence of an urgent/emergent need or change of condition, which will require revisions to the existing PCSP.

   An emergency visit is required when the situation is urgent and cannot be handled over the telephone or when the Case Manager has reason to believe that the member's health and/or safety is at risk.

6. Adequate services shall be arranged by the Case Manager prior to the member's discharge to the member's own home or to an Alternative HCBS setting. Additional discharge planning requirements for ALTCS E/PD, ALTCS DDD, and Tribal ALTCS as specified in AMPM Chapter 1000.

   For a member determined SMI and admitted to a behavioral health inpatient facility, the Case Manager shall participate in Inpatient Treatment and Discharge Plan (ITDP) meetings to assist with coordination of the member's discharge needs. Within three days of the member's admission, the Case Manager shall collaborate with the facility treatment team to develop a preliminary ITDP and a full ITDP within seven days of a member's admission. If a member's anticipated stay is less than seven days, the inpatient facility shall develop a preliminary ITDP within one day and a full ITDP within three days of a member's admission. Refer to A.A.C R9-21-312.

   At a minimum, the facility treatment team, other representatives of the Planning Team, the member/Health Care Decision Maker and Designated Representative (if applicable) and the Case Manager shall review the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first

year, and every 90 days thereafter during any subsequent year that the member remains in the inpatient facility. Refer to A.A.C R9-21-312.

7. Case Managers shall conduct an on-site PCSP meeting within 10 business days following a member's discharge from an inpatient setting or a change of placement type (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. The PCSP meeting shall be conducted to ensure that appropriate services are in place and that the member/Health Care Decision Maker agrees with the PCSP as authorized. For members discharged from an inpatient hospital stay and returning back to the Nursing Facility (NF) from which they were admitted, a post discharge PCSP meeting is not required. However, if a member is discharged from the hospital to a new NF, a post discharge PCSP meeting is required within 10 business days.

   For members enrolled with the Contractor during an inpatient stay in a hospital, Case Managers shall conduct an on-site review within 10 business days post-discharge. This review shall be conducted to ensure the provision of services identified through discharge planning, to assess for any unmet needs and to ensure that the member agrees with the PCSP as authorized.

8. Once it has been determined that a new behavioral health service(s) is medically necessary and cost effective, the Contractor shall ensure the service(s) are initiated within 14 calendar days.

9. If the Case Manager is unable to contact a member to schedule a visit, a letter shall be sent to the member/Health Care Decision Maker requesting contact by a specific date (10 business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the Case Manager shall send an Electronic Member Change Report (eMCR), indicating loss of contact, to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program. The eMCR shall be sent after 30 days of no contact with a member.

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

10. The Case Manager shall meet with the member/Health Care Decision Maker, according to the established standards, in order to:
    a. Discuss the type, amount, and providers of authorized services. If any issues are reported or discovered, the Case Manager shall take and document action taken to resolve these issues as quickly as possible. The Contractor's administration shall also be advised of member grievances and provider issues for purposes of tracking/trending,
    b. Assess the member's current functional, medical, behavioral and social strengths and needs, including any changes to the member's informal support system, in accordance with the Needs Assessment and Care Planning Standards as specified in AMPM Policy 1620-B. If the member is assessed to no longer need an institutional level of

care, the Case Manager shall refer the case for a medical eligibility Pre-Admission Screening (PAS) reassessment via the eMCR process,

c. Convene the interdisciplinary team for member's determined to have an SMI to review and discuss the following:
   i. The outcome of the assessment, the need for further evaluations (as necessary) and any interim services provided (e.g. crisis services),
   ii. The existing Inpatient Treatment and Discharge Plan (ITDP), according to A.A.C. R9-21-312 (if applicable).
d. The Case Manager shall use the HCBS Needs Tool (HNT) found in AMPM Chapter 1600, Exhibit 1620-17 to review the service hours a member needs when Attendant Care, Personal Care, Homemaker, Habilitation, and/or Respite services will be authorized for the member. The HNT shall also reflect care that is provided and agreed to by the member's informal support system. This tool shall be reviewed at each PCSP meeting and shall include a discussion with the member and/or Health Care Decision Maker regarding the voluntary provision of informal support. Case Managers shall regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care.
e. A Uniform Assessment Tool (UAT), used to determine the Level of Care for members, shall 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 or Intermediate Care Facility for individuals with Intellectual Disability (ICF/ID) authorizations.

   At a minimum, Case Managers shall review the UAT every 180 days for nursing facility or ICF/ID members, comparing it with facility documentation. For nursing facilities, this would include documentation from the Minimum Data Set (MDS) to determine changes in Level of Care. Changes in Level of Care shall be communicated to the nursing facility or ICF/ID. Contractors are required to administer a UAT tool specific to the applicable program, ALTCS E/PD, Tribal ALTCS, or ALTCS DDD. A copy of the UAT for E/PD members may be found in AMPM Chapter 1600, Exhibit 1620-3,

f. Assess the need for an SMI Determination and as appropriate, make a referral to a qualified clinician, as specified in A.A.C. R9-21-101(B) for assessment and evaluation and as specified in AMPM Policy 320-P,
g. Assess the continued appropriateness of the member's current placement and services, including whether the member is residing in the setting of their choice and whether there are any goals that need to be developed and/or risks to manage related to the member's service or placement decisions and identify risks that may compromise the member's general health condition and quality of life.
h. Assess the cost effectiveness of services provided and/or requested
i. Discuss with the member/Health Care Decision Maker the member's progress toward established goals,
j. Identify any barriers to the achievement of the member's goals,
k. Develop new goals as needed,

l. Review service delivery options available to the member, including member directed options, at each PCSP meeting for members living in or preparing to transition to their "own home" from an institutional setting or Alternative HCBS setting. The ALTCS Member Service Options Decision Tree (AMPM Chapter 1600, Exhibit1620-18) is an optional tool that is available for use by the Case Managers when reviewing member directed options in order to support Members in making an informed decision on the alternatives,
m. Review and document, at least annually, the member's continued choice of the member's spouse as the paid caregiver. Documentation shall include the member's signature on the "Spouse Attendant Care Acknowledgement of Understanding Form" (AMPM Chapter 1600, Exhibit 1620-12) and
n. Review, at least annually, the Contractor's (or the Administration's for members enrolled with a Tribal ALTCS Program) member handbook to ensure member/Health Care Decision Maker are familiar with the contents, especially as related to covered services and their rights/responsibilities.

11. The member/Health Care Decision Maker shall 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 their own decisions, but does not have a Health Care Decision Maker, the Case Manager shall refer the case to the Public Fiduciary or other available resource, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members. If a Health Care Decision Maker is not available, the reason shall be documented in the file. A notification for Special Assistance shall be completed for members determined to have an SMI who meet the criteria for Special Assistance, in accordance with AMPM Policy 320-R.

12. Members who reside in a residential setting shall be regularly assessed using the PCSP to determine if it is possible to safely meet the member's needs in a more integrated setting. Community Transition Services (CTS) may be used to assist members residing in a Nursing Facility (NF) to discharge to their "own home" (refer to AMPM Policy 1240-C for definitions and limitations related to CTS).

13. The Case Manager shall complete a PCSP (AMPM Exhibit 1620-10) at the time of the initial visit, when there are any changes in services, and at the time of each PCSP meeting (every 90 or 180 days). The member/Health Care Decision Maker shall indicate whether they agree or disagree with each service authorization. The member/Health Care Decision Maker shall be given a copy of the signed PCSP.

14. The Case Manager shall review, with the member/Health Care Decision Maker the Contractor's process for immediately reporting any unplanned gaps in service delivery at each PCSP meeting for all members receiving "critical" services in their "own home." The AHCCCS/ALTCS Member Contingency/Back-Up Plan (found in AMPM Chapter 1600, Exhibit 1620-14) shall also be completed for those members receiving critical services.

15. If problems or issues are identified by the member/Health Care Decision Maker, Designated Representative or Case Manager, the Case Manager shall make contact with the appropriate HCBS provider to address the concerns. The member's HCBS providers shall also be contacted at least annually by the Case Manager to discuss the ongoing assessment of the member's needs and status. This shall include providers of services such as personal or attendant care, home delivered meals, homemaker, therapy, etc.

    If the member is receiving skilled nursing care from a home health agency, quarterly contact is required with the service provider as specified in AMPM Policy 1620-K).

    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 as specified in AMPM Policy 1620-G.

16. The Case Manager is responsible for coordinating physician's orders for those medical services requiring a physician's order as specified in AMPM Policy 1620-20 for more information on which services require an order from the member's Primary Care Provider [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 shall refer the case to the Contractor's Medical Director (or the AHCCCS Medical Director for members enrolled with a Tribal ALTCS Program) 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.

17. If the Case Manager determines through the PCSP process a change in the member's condition may necessitate a change of placement or services, the Case Manager shall discuss any potential changes with the member/Health Care Decision Maker prior to the initiation of any changes. This is especially critical if the changes will result in a reduction or termination of services.

18. The member/Health Care Decision Maker shall be issued a NOA in the event of a denial, reduction, termination, or suspension of services, when the member/Health Care Decision Maker has indicated, on the PCSP, that they disagree with the type, amount, or frequency of services to be authorized. Refer to 42 CFR 438.404 and ACOM Policy 414 for more detailed information and specific timeframes.

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

    Members determined to have a SMI have the option to choose between the appeal process for members determined to have a SMI or the standard appeal process. Refer to ACOM Policies 444 and 446 .

19. The Case Manager shall be aware of the following regarding members eligible to receive hospice services:
    a. 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,
    b. 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 shall recertify hospice eligibility at the beginning of each election period, and
    c. 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. Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (i.e. Home Health Aide, Personal Care and Homemaker Services) will not be covered. Attendant care services may be provided in conjunction with hospice services. If the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services shall be provided by the Contractor. The Contractor may report such cases to Arizona Department of Health Services (ADHS) as the hospice-licensing agency in Arizona. Refer to AMPM Policy 310-J, for additional information regarding hospice services.

20. 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 their Medicare benefit days have exhausted.

21. In most cases, the member/Health Care Decision Maker shall receive a written 30-day advance notice before discharge from a nursing facility as outlined in 42 CFR 483.15. Exceptions to this 30-day timeframe are provided under specific circumstances including but not limited to when the health and/or safety of the member or other residents is/are at risk.

    ALTCS Contractors shall set their own rules regarding advance notice of discharge for members who reside in assisted living facilities in the Contractor's contracts with those facilities.

22. Case Managers are responsible for using the eMCR process to notify AHCCCS of a variety of changes in the member's status. Refer to AMPM Chapter 1600, Exhibit 1620-2 for a hard copy of the eMCR form and more information on the circumstances for using

this form. Refer to the ALTCS Member Change Report User Guide on the AHCCCS website, for instructions in completing the eMCR. The hard copy form shall only be used as a last resort when electronic submission is not available (for example when member is no longer enrolled with the Contractor).

23. The Case Manager is responsible for updating information in the Client Assessment Tracking System (CATS) within 14 business days of the PCSP meeting.