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### **3001 FAMILY MEMBERS AS PAID PROVIDERS**

REVISION DATE: 2/26/2016, 7/3/2015

EFFECTIVE DATE: June 30, 1994

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

- A. Natural Child;
- B. Natural Sibling;
- C. Adoptive Child;
- D. Adoptive Sibling;
- E. Stepchild or Stepsibling;
- F. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law;
- G. Grandparent or Grandchild; and, or,
- H. Spouse of Grandparent or Grandchild.

Immediate relatives not permitted to provide services for children under age 18 include:

- A. Natural Parent;
- B. Adoptive Parent ; and,
- C. Step Parent.

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

- A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services;
- B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse (See Attendant Care section for exception);
- C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources;

- D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or Habilitation (skilled care includes, but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers, or suctioning tracheostomy care) (See Appendix D – Skilled Nursing Matrix);
- E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service;
- F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws, and rules;
- G. Primary caregivers/parents may not be paid to provide Respite;
- H. Services shall not replace care provided by the person's natural support system;
- I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division;
- J. Qualified family members may become certified home and community based service providers by meeting the certification requirements, as applicable; and,
- K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

## 3002 HOME AND COMMUNITY BASED SERVICE DELIVERY

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Member directed service options allow members to have more control and flexibility over how some of their services are provided. The options are not a new service, but rather a way of providing services, which offers the member the ability to play a more active role in directing their own care. Member directed service options are available to Arizona Long Term Care System (ALTCS) members who live in their own home.

### Traditional

Traditional is a way of providing Home and Community Based services which offers members the ability to select a Qualified Vendor.

### Agency with Choice

Agency with Choice is a way of providing Attendant Care (ATC), Homemaker (HSK) or Habilitation (HAH/HAI) services which offers members the ability to play a more active role in directing their own care. The Agency with Choice service option allows ALTCS members living at home to enter into a partnership agreement with the provider agency. This gives the member more control over assigning duties and schedules for the caregiver but leaves the hiring, firing, and minimal training requirements as the responsibility of the provider agency.

If a member is unable to fulfill the partnership roles and responsibilities for the above listed services on their own, an Individual Representative may be appointed to assist them in directing their care. If a member has a legal guardian, that guardian automatically serves in the capacity of an Individual Representative. The role of an Individual Representative is to act on the member's behalf in choosing and directing care, including representing the member during the service planning process and approving the service plan. Arizona Administrative Code Title 9, Chapter 28, Section 509 (A.A.C. R9-28-509) and Section 1915 (k) of the Social Security Act prohibit an Individual Representative from serving as a member's paid Direct Care Worker.

### Individual Independent Providers

Individual Independent Providers may provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP) and Habilitation (HAH/HAI). This type of service delivery offers members and their families the ability to direct their care and gives the member control over assigning duties and schedules for the direct care worker including hiring, firing, and minimal training requirements. The member/responsible person must enroll with the Division's Fiscal Intermediary agency as the employer of record. The member or responsible person can change Individual Independent Providers at any time. This method of service delivery mainly differs from Traditional and Agency with Choice in that the member does not have to choose a direct care worker employed by a Qualified Vendor to deliver these services.

An Individual Independent Provider is limited to 40 hours per week in combination of all services to all members.

### **3003 SELECTION OF PROVIDERS**

REVISION DATE: 6/10/2016, 10/1/2014

EFFECTIVE DATE: July 3, 1993

REFERENCES: (A.A.C.) R6-6-2101 - R6-6-2115.

The Division does not discriminate against providers who serve high-risk populations or providers who specialize in conditions that result in costly treatment.

Selection of providers occur when:

- A. A new service is authorized.
- B. A change in a Qualified Vendor (QV) is requested by the responsible person at the time of the annual planning meeting and documented in the Planning Document. The Division accommodates the request, to the extent appropriate and practical.
- C. The responsible person requests a change of a QV outside an annual planning meeting. The responsible person must state in writing or must report to the Support Coordinator for incorporation into the member record the following:
  1. The rationale for changing QVs; and,
  2. A description of the opportunities given to the current QV to address the member's concerns.

When a service has been identified and approved in Focus the Support Coordinator may assist the member or responsible person in selecting a QV or Independent Provider (IP) in one of the following ways:

- A. Family choice: When the member or responsible person already knows of a contracted QV or contracted IP, they may notify the Support Coordinator of their selection.
- B. Provider Search: This option is available on the Division's website.
- C. Provider Directory: The Support Coordinator may provide a copy of the QV or IP directory to the member or responsible person to assist them in making a selection.

While it is unacceptable for the Support Coordinator to select providers for the family/member, the Division is responsible for assisting the family/member with identifying criteria that will help narrow the list of available providers. The criteria are based on the needs and preferences of the family/member. It is acceptable for the Support Coordinator to contact the provider to help determine availability.

- D. Vendor Call: The Vendor Call for Services invites QVs to submit a response indicating their availability to provide an identified service. At the request of the member or responsible person, a vendor call may be sent. The results of the vendor call will be provided to the member or responsible person to make a selection.
1. Residential Services
    - a. The Division may transmit or post a Vendor Call for Residential Services that includes:
      - i. Only non-identifying information about the member or group of members;
      - ii. A summary of service needs as outlined in the Planning Document;
      - iii. Any special accommodations that the member(s) requires, including behavioral health, transportation, physical health care, and personal preferences;
      - iv. Positive attributes and strengths of the member, such as hobbies, favored activities, and preferences;
      - v. The desired timeframe for delivery of services;
      - vi. The date when the Vendor Call Response is due; and,
      - vii. To whom the response is submitted.
    - b. Upon receipt of a vendor call, the QV shall submit a written response that includes:
      - i. The experience and background to provide the requested service(s);
      - ii. A written plan to meet identified needs described in the member's Planning Document;
      - iii. A description of how any special accommodations will be met;
      - iv. A timeframe by which the service will be delivered; and,
      - v. Any additional information responsive to the Vendor Call for Services.

- c. Upon receipt of a written response from a QV, the Division:
    - i. Reviews all Vendor Call Responses received within the requested timeframe.
    - ii. Evaluates the responses based on the QV's written response as to how they will meet the member's service needs and special accommodations included in the Vendor Call for Services.
    - iii. Notify each QV in writing whether or not the submitted response fulfills the need specified in the Vendor Call for Services within fourteen (14) days of the response due date.
  - d. Upon request of a QV responding to a vendor call, the Division shall provide the following redacted, non-identifying information to the QV:
    - i. The current Planning Document;
    - ii. Any historical and behavioral information;
    - iii. Summary information from the Program Review Committee;
    - iv. Serious incidents reviewed by the Human Rights Committee within the past year;
    - v. Behavior treatment plans; and,
    - vi. Additional information specific to the member and his/her support needs.
2. Hourly Services
- a. Upon receipt of a vendor call the QV contacts the member/member responsible person directly to make a selection based on member preference.
  - b. The Division shall provide the member/responsible person with a list of providers that meet the needs of the member. Prior to making a selection, the member/responsible person may request to meet with one or more of the QVs listed. The Division or member / member responsible person shall provide at least 48 hour notice to the QV when scheduling the meeting.
  - c. The Division shall provide the following redacted, non-identifying information to the QV:
    - i. The current Planning Document;
    - ii. Historical and behavioral information necessary for the provider to anticipate the member's needs;
    - iii. Any Additional information specific to the member and his/her support needs as outlined by the member's Planning Document.

3. Redaction is not required if the Division has a Health Insurance Portability and Accountability Act (HIPAA) release signed by the member/responsible person in the member's case file. Providers who request to review additional information that exceeds the list(s) above, may do so with the written permission of the member/responsible person.
  4. A QV may withdraw its response to a Vendor Call for Services at any time prior to when the member/responsible person or the Division makes a final selection. The final selection will be documented by the District in an authorization transmitted formally to the vendor, noting service codes, rate of reimbursement, level of staffing, target dates,. After a final selection has been made, the QV may not refuse to provide the authorized services for the member based on the difficulty of supports needed by the member.
- E. **Emergency Need:** When there is an emergency need for services to protect the health and safety of a member, and an abbreviated vendor call is not practical, Network staff may seek permission for Direct Calls from the Network Administrator or Designee to contact one or more QVs to meet the emergency need.
- If no QV is available, Network staff will contact providers not on the QV list to identify a provider to meet the emergency need.
- F. **Random Auto-Assignment Process**
- When the member/responsible person is unwilling or unable to choose a provider, the Division's Business Operations Unit will randomly assign a QV.

#### QV Selection Process

Support Coordinators and Division staff are not permitted to recommend any specific provider. If the Support Coordinator or Division staff is asked to make a recommendation regarding a provider, this request cannot be granted. The Support Coordinator must explain to the member/responsible person that the QV directory lists all of the providers who are certified as QVs for the service needed. If the Support Coordinator or designee is delegated to confirm availability, he or she must be unbiased in contacting providers.

When a member/family identifies or wishes to choose a QV, the following process is implemented:

- A. The planning process identifies the need for services funded by the Division;
- B. The responsible person indicate whether they will contact the potential providers to assess availability or if the Support Coordinator or designee will assist. The Support Coordinator documents the responsible person's choice;

- C. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval within five (5) working days from the date of identified need. If services are denied, a *Notice of Action* form must be completed and processed;
- D. The District maintains a QV directory that includes objective and factual attributes. This information will be used to assist the member/responsible person in selecting a QV;
- E. The responsible person identifies the chosen QV;
- F. The member/responsible person or Support Coordinator/designee will notify the provider of the service need and the member's preferences. The provider must make contact with the responsible person or express interest in delivering services to the member within five working days;
- G. The provider selected by the member/family is documented in the Planning Documents. If the provider is identified outside of the Planning Meeting, this must be recorded on the *Change in the ISP* form;
- H. For AzEIP eligible children the chosen provider is recorded directly on the *Individualized Family Services Plan (IFSP)*, with the date and the responsible person's signature; and,
- I. The Support Coordinator/designee verifies or provides contact information to the available provider and member/responsible person to facilitate the introduction of member and provider.

When the member/responsible person notifies the Support Coordinator of an approved provider:

1. The Support Coordinator confirms the provider and member/responsible person match; and,
  2. The Support Coordinator documents the member/responsible person's choice of provider and follows the District's authorization process.
- J. Once the service need has been assessed by the planning team, the QV shall not offer an alternative service to the member/ member responsible person. If there is a request to change the service type, the support coordinator will initiate the service evaluation process.

#### Individual Independent Provider Selection Process

- A. The Division requires the use of a fiscal agent to manage the tax responsibilities and other employer obligations related to IP selection.

- B. When a member/family chooses an IP to provide authorized supports as cited in the Planning Documents the member/family shall:
1. Use a fiscal intermediary to act as their agent for payroll and tax purposes;
  2. Hire, orient, and train each IP to deliver the support as authorized in the Planning Documents;
  3. Review and sign each IP time sheet;
  4. Track the hours of service used against the hours of service authorized; and,
  5. Report any concerns to the Support Coordinator, and work with the fiscal intermediary and Division staff toward resolution.
- C. The fiscal intermediary for the member and family shall:
1. Work with the Division and the Arizona Health Care Cost Containment System (AHCCCS) to develop appropriate informational materials to assist members and their families with choosing an IP;
  2. Work with the Division to successfully transfer funds and any necessary confidential information;
  3. Maintain member and family information in a confidential manner and in compliance with HIPAA regulations (See Records Management in this Policy Manual);
  4. Provide direct easy access to customer representatives who can assist with answering questions and resolving concerns;
  5. Pay claims submitted by IPs, including tax obligations;
  6. Maintain a declining balance for each service for each member that is submitted to the member regularly;
  7. Maintain a system that ensures that the member/family has an available reserve of support hours for each service provided; and,
  8. Work with members, families, and the Division to resolve any financial concerns.
- D. The IP for each service shall:
1. Have a contract with the Division;
  2. Work with the fiscal intermediary chosen by the member/family to complete all requirements; and,
  3. Work with the fiscal intermediary and the Division to resolve concerns.

- E. Although provider selection is intended to be self-directed by the member; service delivery, and provider selection is further determined by:
1. The planning process initiated by the Planning Documents that identifies the need and timelines for services funded by the Division;
  2. The Planning Team has the option of completing the *Individual Support Plan /Individualized Family Service Plan Individual Attributes Checklist* to assist in the IP match process. This checklist will be filed in the referral section the member's case file;
  3. Services are reviewed and approved per the Division's statewide service approval process. The Support Coordinator initiates the service approval process within five working days from the date of identified need and within the timelines of service need specified in the Planning Document;
  4. The District will maintain a list of IPs for the member/responsible person's consideration. Identification of the Individual IP is recorded on the Planning Documents;
  5. The District designee completes the Rate Assessment with the member/responsible person. The assessment is filed in the referral section of the member's case file; and,
  6. Once the service is approved, the Support Coordinator or designee documents the member/responsible person's choice of provider and follows the District's authorization process.

**3004    RESERVED**

### **3005 NOTIFICATION OF NETWORK CHANGES**

REVISION DATE: 10/1/2014  
EFFECTIVE DATE: July 3, 1993

The Division will notify members/families who receive services of discontinued contracts for personal care providers, attendant care agencies, etc. The Division will send a letter to the member/family fifteen (15) days after receipt of the termination notice by the Division.

### **3006 SHORT TERM EMERGENCY SITUATIONS (RESIDENTIAL AND DAY PROGRAMS)**

REVISION DATE: 10/1/2014  
EFFECTIVE DATE: July 3, 1993  
REFERENCES: A.A.C. R6-6-2110

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include, but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee *and* the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, or e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen ([15]) calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

#### Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.

Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

- A. The change in behavior or condition that precipitated an emergency situation;
- B. The actions being taken to assist member (e.g., medical or psychiatric appointment, arranging for positive behavioral support, grief counseling);

- C. The projected date of completion for each step; and,
- D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

#### Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within (21) calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV's request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.

### **3007 SERVICE PROVIDER INFORMATION, AUTHORITY, AND NOTIFICATION**

REVISION DATE: 10/1/2014

EFFECTIVE DATE: July 3, 1993

The Division shall disclose to a service provider in the Planning Document, and in all meetings resulting from a response to a Vendor Call for Services, any historical and behavioral information necessary for the provider to anticipate the member's future behaviors and needs. This includes summary information from the Program Review Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and Behavioral Health Treatment Plans. The Division shall redact the member's identification from this information.

Service providers are authorized to engage in the following activities in accordance with the member's Planning Document:

- A. Administer medications, including assisting the member's self-administration of medications;
- B. Log, store, and dispose of medications; and,
- C. Maintain medications and protocols for direct care.

The Division may establish procedures for items "A" through "C" listed above.

To protect the health and safety of a member, a provider must notify the Division within 24 hours if an emergency situation exists in which the provider is unable to meet the health or safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15 days after notification to recommend any changes, including whether there is a need for temporary additional staffing to provide appropriate care for a member, and shall develop a plan within 30 days after notification to resolve the situation.

#### Other Safety Considerations for Placements

Prior to any out-of-home respite or residential placement (including emergencies), the *Pre-Service Provider Information*, *Residential Transfer Checklist*, and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the member, other residents, staff, and the public.

The Planning Team shall complete the *Case Transfer* form as part of the pre-placement meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the Department of Child Safety (DCS), or other members/agencies as appropriate, will identify

planned responses to known problems prior to placement, and document them on the *Risk Assessment*.