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100 RESERVED

203 CLAIMS PROCESSING

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. §36-2903.01.G

This Policy stipulates requirements for the adjudication and payment of claims.

Administrative Services Subcontracts

An Administrative Services Subcontract (AdSS) is a contract that delegates any of the requirements of the Division's contract with AHCCCS, including, but not limited to the following:

- A. Claims processing, including pharmacy claims
- B. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
- C. Management Service Agreements
- D. Service Level Agreements with any Division or
- E. Subsidiary of a corporate parent owner

Claims Process

The Division develops and maintains claims processes and systems that ensure the correct collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in information on areas including, but not limited to, service utilization, claim disputes and appeals.

The Division ensures there is a mechanism to inform providers of the place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

A. Receipt Date

The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day on which the claim is received at the Division's specified claim mailing address, received through direct electronic submission to the Division, or received by the Division's designated Clearinghouse.

B. Clean Claim

A clean claim is a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

C. Claim Submission Timeliness

Unless a contract specifies otherwise, the Division ensures that, for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

The Division will not pay:

1. Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
2. Claims submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

D. Discounts

The Division applies a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the clean claim was received (A.R.S. §36-2903.01.G).

E. Interest Payments

The Division pays interest on late payments and reports the interest as required.

1. For hospital clean claims, the Division pays slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest is paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.
2. For authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS provider, or a home and community based ALTCS provider, the Division pays interest on payments made after 30 days of receipt of the clean claim. Interest is paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment.
3. For non-hospital clean claims the Division pays interest on payments made after 45 days of receipt of the clean claim. Interest is paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.
4. The Division pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

F. Electronic Processing and Remittance Advices

The Division accepts and generates required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission.

1. Accepted electronic submissions include eligibility verifications, claims, claims status verifications and prior authorization requests.
2. The Division makes claim payments via electronic funds transfer and accepts electronic claim attachments.
3. The Division generates an electronic remittance that includes:
 - a. The reason(s) for denials and adjustments
 - b. A detailed explanation/description of all denials and adjustments
 - c. The amount billed

- d. The amount paid
 - e. Application of Coordination of Benefits (COB) and copays
 - f. Providers rights for claim disputes, and
 - g. Instructions and timeframes for the submission of claim disputes and corrected claims.
4. The Division sends the remittance advice with the payment, unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT is sent no later than the date of the EFT.

G. General Claims Processing

The Division follows all general claims processing requirements as described below.

1. The Division uses nationally recognized methodologies to correctly pay claims; these methodologies include but not limited to:
 - a. Medicaid Correct Coding Initiative (MCCI) for Professional, Ambulatory Surgery Centers and Outpatient services
 - b. Multiple Procedure/Surgical Reductions
 - c. Global Day E & M Bundling standards.
2. The Division's claims payment system assesses and/or applies data-related edits including but not limited to:
 - a. Benefit Package Variations
 - b. Timeliness Standards
 - c. Data Accuracy
 - d. Adherence to AHCCCS Policy
 - e. Provider Qualifications
 - f. Member Eligibility and Enrollment
 - g. Over-Utilization Standards.
3. If a claim dispute is overturned, in full or in part, the Division reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.
4. The Division's claims payment system does not require a recoupment of a previously paid amount when the provider's claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made.

H. Claims Processing by AdSS Contractors

The Division contracts with health plans and delegates the processing of medical claims via an AdSS. The Division:

1. Obtains prior approval from AHCCCS for these AdSSs.
2. Remains responsible for the complete, accurate, and timely payment of all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of administrative service arrangements.
3. Requires its AdSS contractors to submit a monthly claims aging summary.
4. Monitors the performance of the AdSS contractor on an ongoing basis and completes a formal review according to a periodic schedule.
5. Monitors the volume of encounters received from the AdSS contractor.

317 CHANGE IN ORGANIZATIONAL STRUCTURE

EFFECTIVE DATE: May 13, 2016

REFERENCES: AHCCCS ACOM Policy 438, AHCCCS ACOM Policy 103, AHCCCS Contract Attachment F3, Contractor Chart of Deliverables, AHCCCS Contract Section D, Corporate Compliance; 42 C.F.R. 101-106.

Purpose

This Policy identifies the requirements for submitting changes in the Division's organizational structure resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature or resulting from a planned change in a Management Service Agreement (MSA) Subcontractor. This policy also identifies the Division's role in monitoring and evaluating changes in organizational structure, as defined below, for a Management Service Agreement subcontractor.

Change In Organizational Structure

A change in organizational structure includes any of the following:

- A. Acquisition,
- B. Change in Articles of Incorporation,
- C. Change in Ownership,
- D. Change of MSA Subcontractor,
- E. Joint Venture,
- F. Merger,
- G. Reorganization,
- H. Other applicable changes which may cause:
 - 1. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN),
 - 2. Changes in critical member information, including the website, member or provider handbook, and member ID card, or
 - 3. A change in legal entity name.

Transition Plan

The Division submits a summary of all changes in organizational structure and a transition plan to AHCCCS 180 days prior to the effective date of the change.

Items in the transition plan, for which information is not yet available for submission, or is still considered draft, shall be noted and must be submitted, or resubmitted, to AHCCCS no later than 90 days prior to the effective date.

As part of the transition plan, the Division will complete an assessment of the following:

- A. Any potential interruption of services to members including steps to ensure there are no interruptions,
- B. The ability to maintain and support the contract requirements,
- C. Major functions of the Division, as well as Medicaid programs, are not adversely affected, and
- D. The integrity of a fair, competitive procurement process for MSA Subcontractors.

Notification to AHCCCS

When notifying AHCCCS, the considerations listed above, and the following information are included in the summary:

- A. Any material change to operations as specified in AHCCCS Contract, Section D.
- B. The state or federal legislation, rule, or action that necessitates a change in Organizational Structure.
- C. A description of the following:
 - 1. Any changes to the management and staffing of the organization currently overseeing services provided under the contract,
 - 2. Any changes to existing Management Services Subcontracts,
 - 3. Any changes to the administration of critical components of the organizations, information systems, prior authorization, claims processing, or grievances,
 - 4. The plan for communicating the change to members, including a draft notification to be distributed to affected members and providers,
 - 5. The planned changes to critical member information, including the website, member and provider handbook, and member ID card,
 - 6. Any anticipated changes to the network, and

7. Any changes in federal or state funding that directly impact the Medicaid line of business.

Upon AHCCCS approval of the transition plan, any additional information requested by AHCCCS will be submitted within 120 days of the change, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

The Division submits the following via secured FTP server to the Office of Inspector General no later than 45 days prior to the effective date of the change in organizational structure and commencement of operations under the new structure, as specified in Contract, Attachment F3, Contractor Chart of Deliverables:

- A. Information regarding the Disclosure of Ownership and Control,
- B. Disclosure of Information on Persons Convicted of a Crime in accordance with 42 C.F.R. 101-106,
- C. AHCCCS Contract Section D, Corporate Compliance, and AHCCCS ACOM Policy 103.

For a change of MSA Subcontractor, the Division follows the process for the review and approval of the new MSA Subcontractor as outlined in AHCCCS ACOM Policy 438.

Changes in Organizational Structure for a MSA Subcontractor

MSA Subcontractors that also have a contract with AHCCCS shall notify the Division at the same time notification is given to AHCCCS. As appropriate, the Division shall collaborate with AHCCCS in monitoring and evaluating the transition plan.

The Division evaluates and monitors the transition plan for MSA Subcontractors that do not have a contract with AHCCCS.



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404 MEMBER INFORMATION MATERIALS

EFFECTIVE DATE: May 13, 2016

REFERENCES: ACOM Chapter 404, ACOM 404, Attachment A; Member Information Attestation Statement; 42 CFR 438.10(f)(4).

PURPOSE: This policy outlines the requirements for obtaining approval of member information materials from the Arizona Health Care Cost Containment System (AHCCCS).

The Division obtains approval from AHCCCS for all member informational materials (messages) including, but not limited to e-mail, and voice recorded information messages.

Definitions

- A. File and Use - A process whereby the Division submits qualifying member information materials to AHCCCS prior to use, and can proceed with distributing the materials without any expressed approval from AHCCCS within 15 calendar days.
- B. Member Information Materials - Any materials given to Division members or potential enrollees. Member information includes but is not limited to:
 - 1. Informational material such as health and wellness brochures, member newsletters, videos, form letter templates, and mass communications such as voice informational material sent to the member's phone and the Division's website context (Member Information Page),
 - 2. Retention materials sent to current members to target and maintain eligibility, and
 - 3. Instructional material such as member handbooks and provider directories and other new member materials.
- C. Vital Materials - Include at a minimum: notices for denials, reductions, suspensions or terminations of services, consent forms, communication requiring a response from the member, detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, and all grievance and request for hearing information as described in the "Enrollee Grievance System Standards" section of the Division's contract with AHCCCS.

Member Information Materials

- A. The Division complies with ACOM Chapter 404 Member Information, for all materials intended for members including, but not limited to e-mail and voice-recorded messages.
- B. The Division makes every effort to ensure that all information prepared for distribution is easily understood.

- C. The Division makes every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.
- D. All materials are labeled with the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) name and/or logo.
- E. Member information materials are also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of members (e.g., visually limited or have limited reading proficiency.)
- F. The Division shall inform all members of any changes considered to be significant, 30 calendar days prior to the implementation date of the change per the federal law listed in references above. These changes may include:
 - 1. Cost sharing,
 - 2. Prior Authorization,
 - 3. Service delivery, or
 - 4. Covered services.
- G. In addition, the Division will make a good faith effort to give written notice to members within 15 calendar days after receipt or issuance of a provider termination.
- H. The Division will submit the following information to AHCCCS prior to releasing member information materials:
 - 1. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its members or potential members:
 - a. Member information materials must be submitted via electronic mail to AHCCCS 15 calendar days before it is to be released.
 - b. If a 15 day notice is not possible, the Division shall request an expedited review.
 - c. An expedited review request must be clearly marked as expedited, the reason for the shortened timeframe, and a date the material is to be released.
 - 2. A description of the process for disseminating the material.
 - 3. The reading level of the material as measured on the Flesch-Kincaid scale.
 - 4. Translations of the material into other languages are not required to be submitted.

Language and Oral Interpretation Requirements

A. Language

1. All member information materials shall be translated when the language is spoken by 3,000 or 10% (whichever is less) of the members eligible for the Division who also have Limited English Proficiency (LEP).
2. All vital materials shall be translated when the Division is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Division's members speak that language and have LEP.
3. All written notices informing members of their right to interpretation and translation services, are translated when the Division is aware that 1,000 or 5% (whichever is less) of the Division's members speak that language and have LEP.
4. The Division is not required to submit to AHCCCS the member material translated into a language other than English; however, it is the Division's sole responsibility to ensure the translation is accurate and culturally appropriate.

B. Oral Interpretation

1. The Division offers interpretation services available to members free of charge.
2. This service includes interpretation for members using non-English languages or who are hearing impaired.

Materials Not Requiring Submission to AHCCCS

- A. A customized letter, e-mail, or voicemail for individual members.
- B. Information clearly and exclusively related to benefits for non-Medicaid programs.
 1. Health related brochures developed by a nationally recognized organization.
 2. See ACOM 404 Attachment A- National Organizations Recognized by AHCCCS.
- C. The Division is responsible for the content of materials developed by the organizations listed in the AHCCCS ACOM 404 Attachment A National Organizations Recognized by AHCCCS and reviews the materials to ensure:
 1. The information is accurate; and,
 2. The information is culturally sensitive.

- D. In the event the informational material provided by an approved organization references services that are not medically necessary or are not AHCCCS covered benefits. The Division:
1. Will not distribute the organization's informational materials to members.
 2. May use the organization's material only as a reference to develop its own member information materials.
- E. The Division refers to ACOM, Chapter 404 Member Information, for updates when considering using information from a nationally recognized organization.

ALTCS Member Handbook

- A. Members will be provided with a copy of the ALTCS Member Handbook within 10 business days of ALTCS eligibility notification date.
- B. The Support Coordinator will review the Handbook with the member annually and document this review.
- C. The Handbook is available electronically with the option to print from the Division's website.
- D. Members may request a printed version of the Handbook at any time.
- E. The minimum content of the Handbook must include the information provided in Attachment B, Member Handbook Checklist.
- F. The Division will submit a request for review and approval of the Member Handbook as required in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.
- G. The Division will modify or expand content of the Handbook as requested by AHCCCS, and distribute this information in the form of inserts and supply these inserts with subsequently distributed Handbooks.

Member Newsletter requirements

- A. The Division develops and distributes, at a minimum, two member newsletters during the contract year.
- B. The newsletter includes, but is not limited to the following:
1. Educational information on chronic illnesses and ways to self-manage care,
 2. Reminders of flu shots and other preventative measures at appropriate times,
 3. Medicare Part D issues,
 4. Cultural Competency, other than translation services,

5. Division specific issues (in each newsletter),
 6. Tobacco cessation information,
 7. HIV/AIDS testing for pregnant women, and
 8. Other information required by AHCCCS.
- C. The Division will submit draft newsletters to AHCCCS for review and approval as specified in the Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

Website

- A. The Division website shall contain the ALTCS Member Handbook, and all the information required in AHCCCS Attachment C, Contractor Website Certification Checklist and Attestation in the ACOM Policy 404.
- B. The Division website contains the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) name and/or logo.
- C. All of the required content information is located on the Division's website in a manner that members can easily find and navigate.
- D. The Division submits the Contractor Website Certification Checklist and Attestation (Attachment C) annually, as specified in the Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

Additional Requirements

- A. The Division reports member information costs on a quarterly basis as a separate line item in the quarterly financial statements.
- B. The Assistant Director (Chief Executive Officer)/designee shall sign and submit the Member Information Attestation Statement to the designated AHCCCS Operations and Compliance Officer within 45 days of the beginning of the contract year.
- C. The Division shall ensure that the information contained within the material is accurate, updated regularly and appropriately based on changes in benefits, the DES/DDD's Contract with AHCCCS, policy or other relevant updates.
 1. Any updated information shall be re-submitted and tracked on the Division's log, as described in this section,
 2. For resubmissions, the Division identifies the date the material was previously approved, the reason for the update, and clearly identifies all content revisions.
- D. The Division keeps a log of all member material distributed each year; identifying the date the material(s) were originally submitted to AHCCCS and the date of approval.

- E. The Division shall make the log available to AHCCCS upon request.
- F. Member information materials developed for services under contract with AHCCCS are not considered proprietary to the Division, and, must directly relate to the administration of the Medicaid program, or relate to health and welfare of the member.
- G. Member information materials cannot:
 - 1. Directly or indirectly refer to the offering of private insurance,
 - 2. Include inaccurate, misleading, confusing or negative information about AHCCCS or the Division, or any information that might defraud members,
 - 3. Use the word "free" in reference to covered services, or
 - 4. Have political implications.

Incentives

The Division does not participate in member incentive programs.

412 CLAIMS REPROCESSING

EFFECTIVE DATE: May 20, 2016

INTENDED USER(S): Division Claim staff

REFERENCES: DES/DDD AHCCCS Contract, Section D; ACOM Policy 203, 434; AHCCCS Claims Dashboard Reporting Guide; A.R.S. §§ 36-2901, 35-214; A.A.C. R9-22-701 et seq., R9-28-701 et seq., The Deficit Reduction Act of 2005 (Public Law 109-171); 42 CFR 438.600 et seq.

The Division's claims processes, as well as its prior authorization and concurrent review process, minimize the likelihood of having to recoup already-paid claims.

Payment Review

Providers may be selected for a pre or post payment review due to aberrant billing patterns or suspect activities. The following are components that may detect the possibility of aberrant billing practices.

- A. Claims Systems: The Claims Systems prevents/detects payment to providers for services not performed, not authorized, or otherwise inappropriate.
 - 1. Medicare's Correct Coding Initiative (CCI): The system performs CCI edits through the claims process system on all fee-for-service and Long Term Care (LTC) claims. Claims issues such as over utilization, bundling or unbundling, procedure codes and diagnosis codes will trigger CCI edits.
 - 2. Utilization Management (UM): Analyzing the use of authorized services reduces the possibility of abuse by a provider, member, overutilization, and underutilization. UM reports are monitored to determine if a specific provider shows unusually high or low levels of service utilization.

If trends in the initial claims adjudication process identify discrepancies, tests will be conducted to ensure the process is effective for detecting fraud and misuse.

- B. Post Payment Review (PPR):
 - 1. Audit Management System (AMS) completes the Post Payment and Retrospective Reviews for the Division.
 - 2. Refer to the Audit and Management Services-Standard Operating Procedure for; Guiding Principles, Audit Procedures and Audit Planning (phase 1-7).
 - 3. The audit is reviewed by the Division's Compliance Program. If recoupment and a Correction Action Plan (CAP) is required a

recoupment letter is sent to the provider along with a copy of the audit.

Internal Claim Review

The Division utilizes sampling and remediation in internal claim reviews.

- A. Sampling: A selection of claims, which are reviewed for financial or procedural errors, billing trends, units, rates, and services billed. *Reversals and adjustments are excluded for the sample.*
- B. Remediation: an audit team performs the review.

Recoupments

- A. Single recoupments in excess of \$50,000:

Any single recoupment in excess of \$50,000 per Provider Tax Identification Number (TIN), the Division submits a written request including a letter of explanation, electronic file, and provider notification for approval to the designated AHCCCS Operations and Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

- 1. A detailed letter of explanation that describes:
 - a. How the need for recoupment was identified,
 - b. The systemic causes resulting in the need for a recoupment,
 - c. The process that will be utilized to recover the funds,
 - d. Methods to notify the affected Provider(s) prior to recoupment,
 - e. The anticipated timeline for the recoupment,
 - f. The corrective actions that will be implemented to avoid future occurrences,
 - g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted, and
 - h. Other recoupment action specific to this Provider within the contract year.
- 2. An electronic file containing the following:
 - a. AHCCCS Member ID,

- b. Date of Service,
 - c. AHCCCS Original Claim Number,
 - d. Date of Payment,
 - e. Amount Paid, and
 - f. Amount to be Recouped.
3. A copy of the provider notification that includes:
- a. How the need for the recoupment was identified,
 - b. The process that will be utilized to recover the funds,
 - c. The anticipated timeline for the recoupment,
 - d. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped, and
 - e. Listing of impacted claim Claim Reference Number (CRNs.)
- B. Recoupment of payments initiated more than 12 months from the date of original payment:

Retroactive Third Party Recoveries are when the primary insurance was not billed first, as AHCCCS is the payor of last resort, permission from AHCCCS is not needed to adjust for third party liability (TPL).

AHCCCS approval is required when initiating recoupment per Provider TIN more than 12 months from the date of original payment of a clean claim. The Division submits a written request including a letter of explanation, electronic file, and provider notification for approval to the designated AHCCCS Operations and Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
 - a. How the need for recoupment was identified,
 - b. The systemic causes resulting in the need for a recoupment,
 - c. The process that will be utilized to recover the funds,
 - d. Methods to notify the affected Provider(s) prior to recoupment,
 - e. The anticipated timeline for the project,

- f. The corrective actions that will be implemented to avoid future occurrences,
 - g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.
 2. An electronic file containing the following:
 - a. AHCCCS Member ID,
 - b. Date of Service,
 - c. AHCCCS Original Claim Number,
 - d. Date of Payment,
 - e. Amount Paid,
 - f. Amount to be recouped.
 3. A copy of the provider notification that includes:
 - a. How the need for the recoupment was identified,
 - b. The process that will be utilized to recover the funds,
 - c. The anticipated timeline for the recoupment,
 - d. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped,
 - e. Listing of impacted CRNs.
- C. Cumulative recoupments in excess of \$50,000 per provider per contract year

The Division tracks recoupment efforts per Provider TIN. If recoupment amounts for a Provider TIN cumulatively exceed \$50,000 during a contract year (based on a rolling 12 month period by recoupment date), the Division reports the cumulative recoupment monthly to the designated AHCCCS Operations and Compliance Officer as outlined in the AHCCCS Claims Dashboard Reporting Guide.
- D. Recoupment Schedule: If the provider states paying recoupment in full would cause a financial hardship, the Division may request financial statements from the provider to validate the hardship. If the hardship is verified, a recoupment schedule is established.

Post Payment Review Corrective Action Plan (CAP)

A corrective action plan from the provider may be required as a result of a post payment review audit. Recommendations to the Division are provided by AMS in part of their written report and details what is needed for the Provider to meet the Qualified Vendor Agreement and Rate Book Requirements.

Included in the Recoupment letter, the provider is to provide a CAP to the Division within 30 calendar days of the letter.

When the provider does not agree a CAP is warranted, they may file a Claim Dispute.

416 PROVIDER NETWORK INFORMATION

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR.102

This Policy establishes provider information requirements and the content of the Division's website. "Provider" is defined as any person or entity that contracts with the Division to provide a covered service to members in accordance with A.R.S. §36-2901.

Provider Communications

The AHCCCS contract contains requirements for communications between the Division and its provider network. The list below identifies the required content and timing of these communications. The list does not supersede any additional requirements that may be outlined in contract.

A. Provider Manual

The Division develops, distributes and maintains a provider manual, ensuring that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual. The Division also distributes a provider manual to any individual or group that submits claim and encounter data. The Division ensures that all contracted providers meet the applicable AHCCCS requirements with regard to covered services and billing.

The provider manual provides information regarding the following:

1. Division's program and organization
2. Provider responsibility and the Division's expectation of the provider
3. Division's provider service departments and functions
4. Covered and non-covered services, and requirements and limitations including behavioral health services
5. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.
7. Dental services coverage and limitations
8. Maternity/Family Planning services

9. Primary Care Physician (PCP) assignments
10. Referrals to specialists and other providers, including access to behavioral health services
11. Grievance system process and procedures for providers and enrollees
12. Billing and encounter submission information
13. Policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
14. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e. Medicare and Medicaid)
15. Cost sharing responsibility
16. Explanation of remittance advice
17. Prior authorization and notification requirements, including a listing of services which require authorization
18. Claims medical review
19. Concurrent review
20. Fraud, waste, and abuse
21. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.
22. Minimum Required Prescription Drug List (MRPDL) information, including:
 - a. How to access the MRPDL (electronically and hard copy - by request)
 - b. How and when updates are communicated
23. AHCCCS appointment standards
24. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable
25. Eligibility verification
26. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964, and access to interpretation services for members who speak a language other than English (including Sign Language)
27. Peer review and appeal process
28. Medication management services as described in the contract
29. Member's right to be treated with dignity and respect as specified in 42 CFR 438.100

30. Notification that the Division has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102
31. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions
32. Information related to payment responsibilities as outlined in ACOM Policy 432
33. (Acute and ALTCS/EPD) Description of the Change of Contractor policies. See ACOM Policy 401 and 403.

B. Website

1. The Division maintains a website that is focused, informational, functional, and has links to the following:
 - a. RPDL (both searchable and comprehensive listing), which shall be updated twice per year or as needed and within 30 calendar days of AHCCCS notification
 - b. Provider manual
 - c. Provider directory that is current and updated within 15 calendar days of a network change, is user friendly and allows members to search by the following provider information:
 - i. Name of provider or facility
 - ii. Provider or service type
 - iii. Specialty
 - iv. Languages spoken by the practitioner
 - v. Office location (i.e., allow the member to find providers by location such as county, city or zip code)
 - d. Performance Measure Results via link to AHCCCS website
 - e. Medical Determination Criteria and Practice Guidelines
 - f. Contractor provider survey results, as available.
2. For appropriate entities, the Division website also provides the following electronic functionality:
 - a. Enrollment Verification
 - b. Claims Inquiry (adjustment requests; information on denial reasons)
 - c. Accept HIPAA compliant electronic claims transactions

d. Display Reimbursement Information.

See ACOM Policy 404, Attachment C, Contractor Website Certification Checklist and Attestation for other website-related requirements.

Forty-five (45) calendar days after the start of the contract year, the Division submits Annual Website Certification Checklist and Attestation (See ACOM 404, Attachment C, Contractor Website Certification Checklist and Attestation).

C. Required Notifications

In addition to the updates required below, the Division may require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division will provide prior notification as is deemed reasonable or prudent.

The Division provides written or electronic communication to contracted providers in the following instances:

1. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, the Division provides written notice of the reason for declining any written request for inclusion in the network.
2. Division Policy/Procedure Changes - For any change in Policy, process, or protocol (such as prior authorization, retrospective review, or performance and network standards) that affects, or can reasonably be foreseen to affect, the Division's ability to meet Contract performance standards, the Division must notify:
 - a. The designated operations compliance officer to which the Division is assigned, sixty (60) days before a proposed change
 - b. Affected provider, thirty (30) calendar days before the proposed change
3. AHCCCS Guidelines, Policy, and Manual Changes - The Division ensures that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals.
4. Subcontract Updates - If a modification to the AHCCCS Minimum Subcontract Provisions, the Division issues a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.
5. Termination of Contract - The Division provides, or requires its subcontractors to provide, written notice to hospitals and/or provider groups at least 90 calendar days prior to any contract termination without cause. Contracts between subcontractors and individual practitioners are exempted.
6. Disease/Chronic Care Management - The Division disseminates information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

436 NETWORK STANDARDS

REVISION DATE: May 13, 2016
INTENDED USER(S): Network Staff
REFERENCES: ACOM 436, ACOM 415.

The Division maintains a provider network that is sufficient to provide all covered services under the Arizona Long Term Care System to its ALTCS eligible members.

Network Oversight Requirements

The Division:

- A. Ensures networks standards are maintained including network standards delegated to Administrative Services Subcontractors.
- B. Identifies gaps and addresses short and long-term interventions in the Division's Annual Network Development and Management Plan when established network standards cannot be met.
- C. Analyzes compliance each quarter.
- D. Monitors its Administrative Services Subcontractors for compliance with this Policy.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. §36-2901, ACOM Policy 317, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, CMS document SMDL09-001.

Purpose

This policy establishes guidelines and requirements for Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and corrective action plans (CAP).

Administrative Services Subcontracts

An Administrative Services Subcontract is an agreement that delegates any of the requirements of the contract with AHCCCS, including but not limited to:

- A. Claims processing, including pharmacy claims
- B. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
- C. Management Service Agreements
- D. Service Level Agreements with the Division or one of its subcontractors
- E. DDD acute care and behavioral health subcontractors

Providers are not Administrative Services Subcontractors.

Change in Organizational Structure

A change in organizational structure is any of the following:

- A. Merger
- B. Acquisition
- C. Reorganization
- D. Change in Articles of Incorporation
- E. Joint Venture
- F. Change in Ownership
- G. State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature
- H. Change of Management Services Agreement (MSA) Subcontractor

- I. Other applicable changes which may cause:
- J. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)
- K. Changes in critical member information, including the website, member or provider handbook and member ID card
- L. A change in legal entity name

Management Service Agreement

A Management Service Agreement is a type of subcontract in which the Division delegates all or substantially all management and administrative services necessary for the provision of acute or behavioral health services as required in AHCCCS contract.

Provider

A provider is any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. Qualified Vendors are Providers.

Approval of Subcontracts

The Division submits all Administrative Services Subcontracts with the Administrative Services Subcontract Checklist to the AHCCCS Division of HealthCare Management for prior approval, 60 days before the effective date of the subcontract.

- A. The Division retains the authority to direct and prioritize any delegated contract requirements.
- B. The Division requires that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS.
- C. The Division ensures the agreement contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of AHCCCS.
- D. The Division ensures that any reorganization related to an MSA Subcontractor is submitted in accordance with ACOM Policy 317. Additionally, the Division will:
 - 1. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the public including any RFP amendments.
 - 2. Submit final, signed copies of each contract which it enters into with subcontractors and any subsequent amendments within 30 days of signature date.
 - 3. Ensure its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes.

Monitoring And Reporting

- A. The Division monitors the Administrative Services Subcontractor's performance on an ongoing basis and completes a formal review at least annually (42 CFR 438.230).
- B. The formal review includes a review of delegated duties, responsibilities, and financial position. Administrative Services Subcontractors who are state agencies or sovereign nations are not subject to a financial review.
 - 1. The Division prepares written findings of the review.
 - 2. The Division requires the subcontractor to prepare a written response to findings of non-compliance.
 - 3. The Division increases monitoring activities until compliance is achieved and maintained.
 - 4. The Division notifies AHCCCS within 30 days of the discovery of an Administrative Service Subcontractor's non-compliance.
- C. The notification includes:
 - 1. The subcontractor's name
 - 2. Delegated duties and responsibilities
 - 3. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern
 - 4. The scope and estimated impact of the non-compliance upon members
 - 5. The known or estimated length of time that the subcontractor has been in non-compliance
 - 6. The Division's Corrective Action Plan (CAP) or strategies to bring the Administrative Services Subcontractor into compliance
 - 7. Sanction actions that may be taken because of the non-compliance
 - 8. The Division informs AHCCCS of activities that are occurring to bring the subcontractor into compliance.

Administrative Services Subcontractor Evaluation Report

The Division submits the annual Administrative Services Subcontractor Evaluation Report within 90 days of the start of the AHCCCS contract.

- A. The Administrative Services Subcontractor Evaluation Report includes the following:
 - 1. The name of the subcontractor
 - 2. The delegated duties and responsibilities

3. The date of the most recent formal review of the duties, responsibilities and financial position, as appropriate, of the subcontractor.
4. A comprehensive summary of the evaluation of the performance (operational and financial as appropriate) of the subcontractor, including the type of review performed
5. The next scheduled formal review date
6. All identified areas of deficiency; including, but not limited to those which:
 - a. Affect member services; and/or
 - b. Cause a quality of care concern
7. CAP Information, including:
 - a. Any corrective action plans that occurred due to monitoring since the last Administrative Services Subcontractor Evaluation Report
 - b. Any Division or subcontractor CAPs resulting from the annual formal review; and
 - c. Date reported to AHCCCS
 - d. Current status of CAPs

Additional Requirements

- A. All Administrative Services Subcontracts reference and require compliance with the AHCCCS Minimum Subcontract Provisions available on the AHCCCS website.
- B. When a modification to the AHCCCS Minimum Subcontract Provisions occurs, the Division issues a notification and amends Administrative Services Subcontracts.
- C. All Administrative Services Subcontracts must reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and SMDL09-001. Administrative Services Subcontractors disclose to the Division the identity of any excluded person.
- D. All Administrative Services Subcontracts entered into by the Division are subject to review and approval by AHCCCS.
- E. All Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.
- F. The Division maintains a fully executed original or electronic copy of all Administrative Services Subcontracts, which is be accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.

- G. The Division ensures that all member communications furnished by the Administrative Services Subcontractor include the Division's name.
- H. Before entering into an Administrative Services Subcontract, the Division evaluates the prospective Administrative Services Subcontractor's ability to perform the delegated duties.
- I. In the event the Division terminates a subcontract, the Division ensures compliance with all aspects of the AHCCCS Medicaid Contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

Attachment A, Administrative Services Subcontract Checklist

See the ACOM webpage for Attachment A of this policy

Attachment B, Administrative Services Subcontractor Evaluation Report Template

See the ACOM webpage for Attachment B of this policy

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: June 10, 2016

REFERENCES: 9 A.A.C. 22, Article 1; 42 CFR 438.207, 42 CFR 438.10(f) (4), 42 CFR 438.10(f) (5).

The Division ensures that performance and provider network standards are met to support a member's needs, as well as the needs of the membership as a whole. Changes to business operations or to the provider network are evaluated for the impact to members and providers.

Identifying A Provider Network and/or Business Operations Material Change

- A. For changes impacting members and/or providers, the Division evaluates the impact of the change by geographical service area and as a whole using established criteria and/or methodology for determining the impact of the change.
- B. Provider Network changes may include, but are not limited to:
 - 1. Changes in services,
 - 2. Geographic service areas, or
 - 3. Payments.
- C. Changes may also include the addition or change in:
 - 1. Pharmacy Benefit Manager (PBM),
 - 2. Dental Benefit Manager,
 - 3. Acute Health Plan,
 - 4. Provider Contracts (e.g. group homes, nursing facility), and
 - 5. Any other delegated agreements.
- D. Business Operations changes may include, but are not limited to:
 - 1. Policy,
 - 2. Process, and
 - 3. Protocol, such as prior authorization or retrospective review.
- E. Changes may also include the addition or change in:
 - 1. Claims Processing system,

2. System changes and upgrades,
 3. Member ID Card vendor,
 4. Call center system,
 5. Management Service Agreement (MSA), and
 6. Any other Administrative Services Subcontract.
- F. The Division will submit approval for a material change to AHCCCS, at least 60 days in advance of the material change.
- G. Any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided will be communicated to affected providers at least 30 days in advance of the change as identified in Operations Policy Manual Chapter 60, Notification to Providers.
- H. The Division will provide written notice to members within 15 days after receipt or issuance of a provider termination notice.

General Notifications

- A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:
1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration.
 2. For routine changes and updates to Division Guidelines, Policy/Provider Manual.
 3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change.
 4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.
- B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.
- C. Communication with Independent Providers is via US mail.
- D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.

- E. The Division delegates notifications to acute care and behavioral health providers to its Administrative Services Subcontractors.



Chapter 1000	Members and Families
1001	Reserved
1001-A	Basic Human and Disability Related Rights
1001-B	Responsibilities of Individuals Applying for and/or Receiving Supports and Services
1001-C	Rights of Persons with Developmental Disabilities Living in Residential Settings
1002	Voter Registration
1003	District Human Rights Committees
1004-A	Informed Consent
1004-B	Consent to Medical Treatment of Minors, Incapacitated Minors, and Incapacitated Adults
1005-B	Guardianship and Conservatorship or Surrogate Parent
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1005-D	Representative Payee
1006	Healthcare Directives/Advance Directives (AHCD)

1001-A BASIC HUMAN AND DISABILITY RELATED RIGHTS

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S §§ 23-363, 36-551(01)(0), 36-554(A)(0), 36-568(01), 41-3801, 8-533; 41-1492 et seq., 41-1959; A.A.C. R6-6-102(C), R6-6-104, R6-6-107, R6-6-804(9), R6-6-901, R6-6-901-910 et seq., R6-6-1801 et seq., R6-6-2002-2003; 42 CFR 438.420(a).

Arizona Revised Statutes (A.R.S.) clearly recognizes that a person with a developmental disability has the rights, benefits, and privileges guaranteed by the constitutions and laws of the United States and the State of Arizona.

The rights of a person with a developmental disability receiving supports and services through the Division include the:

- A. Right to an initial Individual Support Plan/Individualized Family Services Plan (ISP/IFSP) planning document prior to receiving supports and services;
- B. Right to participate in the ISP/IFSP, periodic evaluations, and whenever possible, the opportunity to select among appropriate alternative supports and services;
- C. Right (once accepted for supports and services) to participate and share in decision making, and to receive a written ISP based upon relevant results of the placement evaluation;
- D. Right to information regarding the supports and services available through a provider and about related charges, including any fees for supports and services not covered by a third-party payor;
- E. Right to a periodic review of the ISP/IFSP planning document;
- F. Right to be given written notice of his/her rights;
- G. Right to exercise his/her rights as a citizen;
- H. Right to live in the least restrictive setting. A least restrictive setting refers to an environment in which a member strives to reach his/her full potential in accordance to the tenets of self-determination;
- I. Right to protection from physical, verbal, sexual, psychological abuse, or punishment;
- J. Right to equal employment opportunity;
- K. Right to fair compensation for labor;
- L. Right to own, rent, or lease property;
- M. Right to marry and have children;

- N. Right to be free from involuntary sterilization;
- O. Right to express human sexuality and receive appropriate training;
- P. Right to consume alcoholic beverages if 21 years of age or older unless contraindicated by orders of his/her primary care provider or the court;
- Q. Right to presumption of legal competency in guardianship proceedings;
- R. Right to be free from unnecessary and excessive medication;
- S. Right to be accorded privacy during treatment and care of personal needs;
- T. Right to confidentiality of information and medical records;
- U. Right of a school age member to receive publicly supported educational services;
- V. Right of a child to receive appropriate supports and services, subject to available appropriations, which do not require the relinquishment or restriction of parental rights or custody, except as prescribed in A.R.S. § 8-533, which describes the grounds needed to justify the termination of the parent-child relationship;
- W. Right to consent to or withhold consent from participation in a research project approved by the Division management team or any other research project; right to knowledge regarding the nature of the research, potential effects of a treatment procedure as part of a research project; right to confidentiality; and the right to withdraw from the research project at any time;
- X. Right of a person who believes his/her, rights have been violated to petition the Superior Court for redress, unless other remedies exist under federal or State laws;
- Y. Right to withdraw from programs, supports and services, unless the member was assigned to the Department by the juvenile court or placed in a secure facility by the guardian and court;
- Z. Right to an administrative review, if in disagreement with a decision made by the Division, by filing a verbal or written request for such with the DDD Office of Compliance and Review, and the right to appeal the decision;
- AA. Right to contact the Human Rights Committee;
- BB. Right to be free from personal and financial exploitation; and,
- CC. The right to have care for personal need provided, except for cases of emergency, by a direct care staff of the gender chosen by the responsible person, this choice shall be specified in the Planning Document.

1001-B RESPONSIBILITIES OF INDIVIDUALS APPLYING FOR AND/OR RECEIVING SUPPORTS AND SERVICES

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

Applying for and/or receiving supports and services individuals with developmental disabilities are to be supported in exercising the same rights and choices and afforded the same opportunities enjoyed by other citizens. The Division provides this support by following the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life shall be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, preferences, strengths and needs. For individuals receiving services through the Division, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support. The Division offers many options for a member wanting to make more choices about services and supports, such as:

- A. Selecting a Support Coordinator;
- B. Selecting and directing their planning process, either an Individual Support Plan and/or a Person-Centered Plan;
- C. Selecting service providers, both qualified vendors and individual independent providers;
- D. Hiring, managing, and firing service providers;
- E. Using a fiscal intermediary to manage the financial aspects of having a service provider who is his/her employee; and,
- F. Having the spouse serve as his/her provider.

1001-C RIGHTS OF PERSONS WITH DEVELOPMENTAL DISABILITIES LIVING IN RESIDENTIAL SETTINGS

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S §§ 23-363; A.A.C. R6-6-901 et seq., R6-6-107; CFR 438.420(a).

Additional rights of persons with developmental disabilities who reside in residential settings such as Group Homes, Adult and Child Developmental Homes, or an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) include the basic human and disability-related rights listed previously. Because of the special circumstances of living in a residential facility, specific rights have been delineated. These rights include the:

- A. Right to be informed of the rules of the residential setting in which he/she is living;
- B. Right to impartial access to treatment and/or accommodations;
- C. Right to a safe, humane, and clean physical environment;
- D. Right to communicate with those responsible for his/her care;
- E. Right to choose his/her personal care provider from the health plan(s) available;
- F. Right to be informed of his/her medical condition, of any technical procedures that will be performed, of the identity of the persons who will perform the procedures, attendant risks of treatment and the right to refuse treatment;
- G. Right to be free from unnecessary drugs and physical restraints, except as authorized in writing by a physician for a specified time period and in accordance with the Division rules regarding behavior supports;
- H. Right to a physical examination, prompt medical attention, and to adequate food and water;
- I. Right to his/her own bed;
- J. Right to personal clothing and possessions as space permits, unless this infringes on the rights of others or is medically contraindicated;
- K. Right to be accorded privacy with regard to written correspondence, telephone communication, and visitors;
- L. Right of a husband and wife who both reside in a facility to share a room;
- M. Right to privacy during visits by a spouse;
- N. Right to refuse to talk with or see someone;
- O. Right to participate in social, religious, and community group activities;

- P. Right to manage his/her own financial affairs and to be taught to do so to the extent of his/her capabilities;
- Q. Right to refuse to perform services for the facility, but if he/she does provide services, right to be compensated at prevailing wages commensurate within state and federal laws and as prescribed by the Industrial Commission;
- R. Right to have the Division supervisors advised of any unusual incident.
- S. Right to file a grievance not only with the Division but also with his/her health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);
- T. Right to the least amount of physical assistance necessary to accomplish a task; and,
- U. Right to have care for personal needs provided, except in cases of emergency, by a direct care staff of the gender chosen by the individual/responsible person. This choice shall be specified in the ISP/IFSP planning document.

1002 VOTER REGISTRATION

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

All support coordination staff must comply with the Arizona Department of Economic Security Policy DES 1-01-24, regarding the National Voter Registration Act of 1993, and applicable state statutes, by offering individuals applying for services the opportunity to register to vote.

Staff will accept the verification of U.S. Citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. Citizenship document.

Staff will sign the acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by new employees within 60 days of hire. The signed copy is maintained in the Supervisor's file.

1003 DISTRICT HUMAN RIGHTS COMMITTEES

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 41-3804.

Human Rights Committees are local groups of citizens who provide independent oversight in matters related to the rights of persons with developmental disabilities who are served by the Division. Each Human Rights Committee must meet at least six times each calendar year, but as often as necessary as determined by the chair in accordance with the bylaws of the committee.

Specifically, the Human Rights Committee reviews the rights of individuals in the following areas:

- A. Administration either of medication, which changes recipient's behavior directly, or as a side effect;
- B. Aversive or intrusive programs;
- C. Research proposals in the field of developmental disabilities, which directly involve individuals receiving supports and services; and,
- D. Incidents of possible abuse, neglect, or violations of an individual's rights.

Any suspected violation of the rights of a person with developmental disabilities should be identified to the appropriate Human Rights Committee.

In addition to protecting the rights of individuals, the Human Rights Committee must:

- A. Submit in writing to the Division Assistant Director any objections it has to actions by employees of the Division or employees of service providers.
- B. Issue an annual report, in concert with the Quality Assurance Unit, summarizing its activities and making recommendations of changes it believes the Division should consider implementing.

There are several Human Rights Committees in the state, each serving one or more counties. For further information on the Human Rights Committee in your area, contact your District Administrative Office.

Membership in Human Rights Committees

Membership in a Human Rights Committee shall occur utilizing the following process:

- A. Candidates for initial membership on a newly developed committee shall be recruited by the District Program Manager/Administrator with input and advice from the local chapter of The Arc, Developmental Disabilities Advisory Council and any other appropriate local advocacy organizations. The director of the Department of Economic Security (DES) shall appoint committee members from the list of

candidates recruited locally.

- B. Each committee shall be comprised of at least seven (7) and not more than fifteen (15) persons with expertise in one or more of the following areas:
1. Psychology;
 2. Law;
 3. Medicine;
 4. Education;
 5. Special education; and, or,
 6. Parents of individuals with developmental disabilities.
- C. No employee of the DES or of a service provider, which is associated with an existing Human Rights Committee, may be a voting member of a committee.
- D. When there is a vacancy in an existing committee's membership, nominees may be presented to the committee by advocacy groups, committee members or the District Program Manager/Lieutenant Program Manager. Upon recommendation by the committee by majority vote, the DES Director shall appoint a person to fill the vacancy.

1004-A INFORMED CONSENT

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36-551 (15) and 36-561.

As one means of protecting the rights of consumers, the Division requires written consent from the individual/responsible person for release of confidential information. Consents may also be required for participation in events, medical treatments, and activities. A.R.S. § 36-551 (15) defines consent as voluntary informed consent. Consent is voluntary if not given as the result of coercion or undue influence.

Consent is informed if the person giving the consent has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of the alternatives to the procedure; and, has been informed and comprehends that withholding or withdrawal of consent will not prejudice the future provision of care and supports and services to the individual. In case of unusual or hazardous treatment procedures performed pursuant to A.R.S. § 36-561, subsection A, experimental research, organ transplantation and non-therapeutic surgery, consent is informed if, in addition to the foregoing, the individual/responsible person giving the consent has been informed of and comprehends the method to be used in the proposed procedure.

All consents must be time or event-limited. Consent may be withdrawn at any time by giving written notification to the individual's Support Coordinator.

Consumer's Competency Questioned

When a consumer's ability to make decisions about medical treatment/ procedures is questioned, the matter must be forwarded to the Division's Medical Director for consideration.

1004-B CONSENT TO MEDICAL TREATMENT OF MINORS, INCAPACITATED MINORS, OR INCAPACITATED ADULTS

REVISION DATE: 9/30/2016, 7/3/2015, 5/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 14-5101, 14-5104, 14-5207, 14-5209, 14-5310, 14-5312, 14-5503, 14-5602 14-5602, 36-2271, 36-3231, 44-133.

Consent to Medical Treatment of Minors

Generally, the parent or guardian of a minor must provide written consent for medical treatment, however, Arizona law allows other individuals to provide consent to medical treatment of a minor when a parent or guardian is unavailable.

- A. A member may consent to the medical treatment of a minor if the member has a properly executed power of attorney from the minor's parent or guardian delegating the power to consent to medical treatment. The delegation of power may be for not more than six (6) months.
- B. If time allows, a temporary guardian may be appointed by the court to consent to medical treatment, but the authority of the temporary guardian is limited to six (6) months. Where no one is available to act as a temporary guardian, a public fiduciary may be appointed by the court.
- C. In cases of emergency, where a parent or guardian cannot be located after reasonably diligent efforts, consent may be given by a person standing *in loco parentis* to the minor. *In loco parentis* means a person who takes the parent's place by undertaking temporary care and control of a minor in the absence of a parent. For example, this might be a person who is a relative, caregiver, or teacher of the minor.
- D. If no one can be located who stands in *loco parentis* to the minor, a physician can determine that an emergency exists, and that a parent or guardian cannot be located or contacted after reasonable diligent effort. The physician can then perform a surgical procedure on the minor if necessary to treat a serious disease, injury, drug abuse, or to save the life of the minor.
- E. As a general rule, the Division Support Coordinators cannot sign a medical consent for treatment of minors except for children in foster care.

Consent to Medical Treatment of Incapacitated Minors

The general rule is that the parent or guardian of a minor must provide written consent for medical treatment, however, Arizona law allows other individuals to provide consent to medical treatment of a minor when a parent or guardian is unavailable.

- A. A member may consent to the medical treatment of a minor if the member has a properly executed power of attorney from the minor's parent or guardian delegating the power to consent to medical treatment. The delegation of power may be for not more than six (6) months.

- B. If time allows, a temporary guardian may be appointed by the court to consent to medical treatment, but the authority of the temporary guardian is limited to six (6) months. Where no one is available to act as a temporary guardian, a public fiduciary may be appointed by the court.
- C. In cases of emergency, where a parent or guardian cannot be located after reasonably diligent efforts, consent may be given by a person standing in *loco parentis* to the minor. In *loco parentis* means a person who takes the parent's place by undertaking temporary care and control of a minor in the absence of a parent. For example, this might be a person who is a relative, caregiver, or teacher of the minor.
- D. If no one can be located who stands in *loco parentis* to the minor, a physician can determine that an emergency exists, and that a parent or guardian cannot be located or contacted after reasonable diligent effort. The physician can then perform a surgical procedure on the minor if necessary to treat a serious disease, injury, drug abuse, or to save the life of the minor.
- E. As a general rule, the Division Support Coordinators cannot sign a medical consent for treatment of minors except for children in foster care.

Consent to Medical Treatment of Incapacitated Adults

An adult cannot consent to medical treatment if he/she lacks the understanding or capacity to make or communicate responsible decisions. One of the duties of a guardian is to make reasonable efforts to secure medical services for a member of the Division who is his/her ward. If a permanent guardian is unavailable (due to death, resignation, etc.), Arizona law allows other identified individuals to sign the consent for medical treatment of an incapacitated adult.

- A. A.R.S. § 36-3231 defines surrogate decision makers priorities and limitations. In the following order of priority, these individuals may act as a surrogate to sign the consent for medical treatment of an incapacitated adult when no guardian is available.
 - 1. The spouse of the incapacitated adult;
 - 2. An adult child;
 - 3. A parent;
 - 4. A domestic partner (assuming the Member is not married and no other person has a financial responsibility for the individual);
 - 5. A brother or sister;
 - 6. A close friend. A close friend means an adult who has shown special care and concern for the individual, who is familiar with the individual's health care views and desires, and who is willing and able to become involved and act in the individual's best interest; and,
 - 7. A health care provider is required to make a reasonable effort to locate and

follow a health care directive. A health care provider shall also make reasonable efforts to locate the above designated individuals. In order to assist the reasonable efforts of health care providers, the Division Support Coordinators should have available, at all times, a complete list of the names, addresses, and phone numbers of these designated individuals who may be contacted for purposes of signing a consent for medical treatment. A copy of the list may be provided to treating medical personnel, as necessary, to assist them in locating a person authorized to sign the consent for medical treatment if a guardian is unavailable. If none of these persons is available, the appointment of a public fiduciary by the court may be requested.

- B. A guardian has authority to execute the consent. If the guardian has executed a health care power of attorney that authorizes another person to make health care decisions on behalf of the incapacitated person, the person named in that power of attorney has authority to execute the consent. The power of attorney is valid for not more than 6 months.
- C. In an emergency, if time allows, a temporary guardian may be appointed by the court to sign a consent for medical treatment or the court may immediately exercise the power to consent to medical treatment prior to notice and hearing. If no one is available to serve as a temporary guardian, the court may appoint a public fiduciary.
- D. When an immediate, life threatening emergency exists and there is neither time to get to court nor time to contact the individuals who may lawfully sign a consent, an attending physician, after consultation with a second physician, may make the health care treatment decision without a signed consent.
- E. The Division Support Coordinators cannot sign a medical consent for treatment of incapacitated adults.
- F. A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall not make decisions to admit the patient to a level one behavioral health facility licensed by the department of health services, except as provided in subsection E of this section or section 14-5312.01, 14-5312.02 or 36-3231. Subsection E: If the admitting officer for a mental health care provider has reasonable cause to believe after examination that the patient is incapable as defined in section 36-3231, subsection D and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in a level one behavioral health facility based on informed consent given by any surrogate identified in subsection A of this section. The patient shall be discharged if a petition for court ordered evaluation or for temporary guardianship, requesting authority for the guardian to consent to admission to a level one behavioral health facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.

1005-A GUARDIANSHIP AND CONSERVATORSHIP OR SURROGATE PARENT

REVISION DATE: 9/30/2016, 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 15-761, 15-763, et seq.; 36-551 (01)(H), 36-551(17), 36-564(D), 14.5101, et seq.; 14-5105, 14-5311, 14-5303-5304, 14-5310; 14-5401, 14-5312; 14-5408(C); 14-5315; A.A.C. R6-6-1401. Public Law 105-17.

REFERENCES: A.R.S. §§

Guardianship is a legal method that is used to insure that a person who is unable to make reasoned decisions has someone specifically assigned to make decisions on his/her behalf. A guardian must be appointed by a court. A conservator refers to a person appointed by a court to manage the estate of a protected person. A person may have a guardian, a conservator or both appointed by the court.

Guardianship or conservatorship for persons with developmental disabilities shall be:

- A. Utilized only as is necessary to promote the well-being of the individual;
- B. Designed to encourage the development of maximum self-reliance and independence in the individual; and,
- C. Ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations.

Appointment of a Guardian or Conservator

Only a court can determine that someone needs a guardian. Neither the family nor a Support Coordinator can unilaterally or jointly make that determination. However, the individual himself/herself, a family member, or any person interested in his/her welfare may petition the court (file a request for a hearing in a State court) for a finding of incapacity and the consequent appointment of a guardian. The court will appoint an attorney to represent the allegedly incapacitated person in the hearing unless the individual has his/her own attorney.

It should be noted that under Arizona law, a person with a developmental disability is presumed legally competent in guardianship proceedings until the court makes a determination to the contrary.

The person alleged to be incapacitated shall be interviewed by a person appointed by the court (called a court visitor) and examined by a court appointed physician, psychologist, or a registered nurse who will submit written reports to the court. In addition, the court visitor shall interview the person seeking appointment as guardian, and visit the home of both the individual and the proposed guardian.

During the hearing, the individual who is the subject of the hearing, has the right to be represented by an attorney, to be present at the hearing, to see or hear all evidence, to present evidence, to cross-examine witnesses, and to trial by jury. If the individual alleged to be incapacitated or his/her counsel requests, the issue may be determined at a closed

hearing.

Before a guardian can be appointed, the court must be satisfied "by clear and convincing evidence" that the appointment of a guardian or conservator is necessary to provide for the demonstrated needs of the individual.

In case of an emergency situation, the court can appoint a temporary guardian and/or a temporary conservator.

If the appointment of a guardian or conservator is required for a American Indian who is a member of an Indian Tribe and who has significant contacts with that tribe, but who is not an Indian child within the scope of federal law, the Arizona Administrative Code requires that the appointment of a guardian or conservator shall first be requested through the appropriate tribal court, if any, unless the request through the tribal court is not in the recipient's best interests as determined by the Individual Support Plan (ISP) team.

Who May be Guardian

Any competent person may be appointed guardian by the Court. Persons who are not disqualified have priority for appointment as guardian in the following order:

- A. Spouse;
- B. Individual or corporation nominated by the person, if in the opinion of the court, the person has sufficient mental capacity to make an intelligent choice for guardian;
- C. An adult child;
- D. A parent, including a person nominated by will or other writing signed by a deceased parent;
- E. A relative with whom the individual has resided for more than six months prior to the filing of the petition;
- F. The nominee of a person who is caring for the person or paying benefits to him/her; or,
- G. A public or private fiduciary, professional guardian, conservator.

The court may give preference for the appointment of a family member unless this is contrary to the expressed wishes of the individual or is not in his/her best interest as determined by the court.

Persons who wish to be considered for appointment as a temporary or permanent guardian or conservator must provide the court with all required information. Specifically, the proposed guardian must disclose any interest in any enterprise providing health care or comfort care services to any individual.

Duties of a Guardian

A guardian's duties include, but are not limited to:

- A. Encouraging the individual to develop maximum self-reliance and independence;
- B. Working toward limiting or terminating the guardianship and seeking alternatives to guardianship;
- C. Finding the most appropriate and least restrictive setting for the individual consistent with his/her needs, capabilities and financial ability;
- D. Making reasonable efforts to secure medical, psychological, and social services for the individual;
- E. Making reasonable efforts to secure appropriate training, education, and social and vocational opportunities for the individual;
- F. Taking care of his/her ward's clothing, furniture, vehicles, and other personal effects;
- G. Giving consents or approvals for medical or other professional care that may be necessary; and,
- H. Completing all reports required by the court.

To encourage the self-reliance and independence of the individual (the ward), the court may grant him/her the right to handle part of his/her money or property without the consent or supervision of a conservator. This may include allowing the individual to maintain appropriate accounts in a bank or other financial institution.

Procedures

As part of the annual review, the ISP team shall evaluate the possible need for a guardian and/or conservator for an individual receiving services through DES/DDD. This information must be noted on the ISP form DD-217 - 2 (Team Assessment Summary, cont) under guardianship status.

When there is serious doubt regarding the ability of the individual applying for services or receiving services to make or communicate responsible decisions, every effort must be made to have a judicial determination made regarding the need for guardianship and/or conservatorship.

In the case of minor child where there is no parent or interested party who is willing and able to serve as guardian, the Support Coordinator should refer the child to Department of Child Safety (DCS).

If an individual is 18 years of age or older, the parents are not the guardians unless they have been so appointed by the court. Thus, parents cannot continue to sign medical consent forms, etc. for their children who have become of legal age. The parents may wish to pursue guardianship status.

If the Support Coordinator and/or the ISP team believes that a determination of legal competency should be pursued, the Support Coordinator should:

- A. Explain the need to the individual and/or family;
- B. Work with the individual/and or family to help them understand the process necessary for obtaining a guardian and/or a conservator;
- C. Refer the individual and/or family for help, if it is needed, in securing an attorney to handle the proceedings; (referrals, for example, to: Arizona Center for Law in the Public Interest, Community Legal Services, The Arc);
- D. If the individual/family is unwilling or unable to seek guardianship, the Support Coordinator must pursue guardianship by:
 1. Writing a letter to the county public fiduciary where the individual receives services explaining the situation; and/or
 2. Contacting Adult Protective Service (APS) for assistance.

Surrogate Parent

Parental involvement in the planning of a child's Individual Education Plan (IEP) is a federal requirement. For a child who is without a parent willing/able to participate in the child's educational process, federal and State laws provide for the appointment, by the court, of a surrogate parent to represent a child in decisions regarding special education.

A petition for a surrogate parent for a child with disabilities may be made if any of the three following conditions have been met:

- A. No parent can be identified;
- B. A public agency cannot determine the whereabouts of a parent after having made three reasonable attempts; or,
- C. The child is a ward of the State and the biological parent is unwilling or unable to consent to special education placement.

A person who is an employee of a State agency which is involved in the education or care of the child is not eligible to be a surrogate parent. Thus, a Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) Support Coordinator cannot be a surrogate parent. Moreover, a DES/DDD Support Coordinator cannot sign an authorization for a special education evaluation or an authorization for services for a child who has a developmental disability.

Procedures

If a child who is receiving services through DES/DDD has a surrogate parent, this information must be noted on the Individual Support Plan (ISP) form *DD-217 - 2 Team*

Assessment Summary, continued under guardianship status and reviewed annually. In addition, the surrogate parent must be part of the ISP team.

A foster parent who wants to be a surrogate parent should work with the Support Coordinator in making a request to the courts. While a foster parent may petition the court to receive an appointment as a surrogate parent, the court is responsible for determining whether a particular individual is able to act as a foster parent, and also represent the best interest of the child as a surrogate parent.

If the Support Coordinator believes a surrogate parent is necessary, e.g., the natural parents have relinquished their rights, the Support Coordinator should seek to have a surrogate parent appointed so that decisions regarding the child's education can be made in a timely manner.

The Arizona Department of Education (ADE) has information regarding surrogate parents and usually has a list of persons who have volunteered to be surrogate parents and have already received the required training.

1005-C AUTHORIZED REPRESENTATIVE FOR ALTCS BENEFITS

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

If there is a legal representative, that person must file the application for Arizona Long Term Care Service (ALTCS) benefits or authorize someone else to be the authorized representative. This is a person who is authorized in writing by an applicant or legal representative to represent him/her in the application process.

The authorized representative signs an affirmation to having knowledge of the applicant's circumstances, has been informed and understands the responsibilities which include:

- A. Providing complete and accurate information to the best of his/her knowledge regarding the applicant's income, resources, household composition, citizenship, residency, and medical insurance coverage;
- B. Providing all documents needed to determine eligibility;
- C. Notifying the local ALTCS office of any change in the applicant's circumstances within 10 working days of their occurrence;
- D. Signing any and all forms necessary for completing the application and verifying eligibility; and
- E. Identifying and filing insurance claims and assigning insurance benefits to Arizona Health Care Cost Containment System (AHCCCS).

Generally, a family member or a legally appointed guardian assumes the responsibility of being an authorized representative for an individual applicant. While a Support Coordinator may assist in the process of making application, the Support Coordinator should not be the authorized representative unless absolutely no one else is available. Before agreeing to becoming an authorized representative for an individual applying for ALTCS benefits, the Support Coordinator must have approval from the Support Coordinator's District Program Manager (DPM) or designee (ALTCS Eligibility Policy and Procedure Manual).

1005-D REPRESENTATIVE PAYEE

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

A representative payee is an individual who handles Social Security payments and Supplemental Security Income (SSI) payments for an individual who is unable to handle his/her own finances. The Social Security Administration makes the final decision on who is best suited to become the representative payee for an individual. A beneficiary who has a payee may be receiving either a Social Security check or an SSI check, or both.

The Social Security Publication No. 05-10076 entitled "*A Guide For Representative Payees: Social Security and SSI*" provides an overview of the duties of a representative payee. This pamphlet can be requested from a local social security office. In general, the duties of a representative payee are to decide how benefits can best be used for the beneficiary's personal care and well-being, to keep an accounting of the funds received, and complete all paperwork and forms required by the Social Security Administration.

In the case of a child with a developmental disability who has been adjudicated a ward of the court and is placed in foster care who is also eligible for SSI, Department of Economic Security (DES) becomes the representative payee. In this one instance, the Support Coordinator is responsible to make the application on behalf of DES to the Social Security Administration as the representative of DES.

In all other situations, DES/Division of Developmental Disabilities (DDD) believes that parents, relatives, public fiduciaries, and advocacy groups may be in less of a conflict of interest situation that the agency in handling funds for an individual for whom it is providing services. DES/DDD may not become a representative payee for individual receiving services unless permission has been granted by his/her District Program Manager (DPM) or designee.

Procedures

If an individual with a developmental disability is receiving services through DES/DDD and has a representative payee, this information must be noted on the Individual Support Plan (ISP) form *DD-217-2 Team Assessment Summary*, contained under guardianship statutes. In addition, the representative payee must be part of the ISP team, and must actively participate in the completion of ISP form *DD-221 Individual Spending Plan*. The ISP form *DD-221 Spending Plan* also must be completed as part of the annual ISP if DES/DDD is the representative payee.

1006 HEALTH CARE DIRECTIVES/ ADVANCE DIRECTIVES (AHCD)

REVISION DATE: 5/13/2016, 7/3/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 36-3221, 36-3222, 36-3223, 36-3224, 36-3231, 36-3261, 36-3262, 36-3251.

Arizona Health Care Cost Containment System (AHCCCS) policy requires the Support Coordinator to ask the adult member if he or she has an advance directive. The Division will prevent discrimination against a member, and will not place conditions on the provisions of care to the member, because of his/her decisions to execute or not execute an advance directive. There are three types of advance directives: (1) a health care power of attorney, (2) a living will, and/or (3) a pre-hospital medical care directive. If the member does not have an advance directive, the Support Coordinator will offer guidance on how the adult member may complete an advance directive.

Health Care Power of Attorney

A health care power of attorney is a written statement executed by an adult who has the capacity to make such decisions naming another person (surrogate) to make health care decisions if that adult cannot make or communicate his/her wishes. A valid health care power of attorney must meet the requirements set forth in:

A.R.S. § 36-3221 – Healthcare Power of Attorney; scope; requirements; limitations;

A.R.S. § 36-3222 – Healthcare Power of Attorney; amendments;

A.R.S. § 36-3223 – Agents; powers and duties; removal; responsibility;

A.R.S. § 36-3224 – Sample Healthcare Power of Attorney; and,

A.R.S. § 36-3231 – Surrogate decision makers; priorities; limitations.

Living Will

A living will is a written document executed by an adult who has the capacity to make such decisions in order to control the treatment/decisions made on that adult's behalf. The living will must meet the requirements set forth in:

A.R.S. § 36-3261 – Living Will; verification; liability; and,

A.R.S. § 36-3262 – Sample living will.

Prehospital Medical Care Directive

A Prehospital Medical Care Directive is commonly known as a Do Not Resuscitate (DNR). A DNR is a document signed by an adult that includes a DNR order written by a physician indicating to health care providers, emergency medical system personnel, and, as provided in A.R.S. § 36-3251(L), direct care staff persons, that the member signing the DNR, who had the capacity to make such decisions at the time of signing the document, does not want cardiopulmonary resuscitation (CPR) if that member suffers from a cardiac or respiratory arrest. A valid DNR must meet the requirements set forth in A.R.S. § 36-3251 – Prehospital Medical Care Directives.

Procedures

- A. The Support Coordinator must offer/provide the member with a copy of the *Decisions about Your Health Care* pamphlet. The member/responsible person must sign an acknowledgment stating that he/she is in receipt of this pamphlet, or has refused the pamphlet. This acknowledgement is to be maintained in the member's case file.
- B. Annually, the Support Coordinator must ask the member if he/she has any of the three advance directives. If the member has completed one or more of these documents, the Support Coordinator must ask the member to provide a copy of all of the documents for his/her case file. The Support Coordinator must note the existence of an advance directive on the annual planning document. The Support Coordinator/member/family/provider agency shall provide a copy of any advance directive to the Primary Care Provider (PCP). If a member moves the Support Coordinator/member/family/provider agency shall send a copy of any advance directive with the member.
- C. If the member/responsible person does not have any advance directives, the Support Coordinator must tell the member/responsible person where to find information, and encourage the member/responsible person to consult with his/her health care provider regarding advance directives.
- D. Pursuant to A.R.S. § 36-3251 (L), when the physician of the member who has a valid Prehospital Medical Care Directive has ordered hospice plan of care, a direct care staff person may comply with a Prehospital Medical Care Directive (commonly known as a DNR). "Direct care staff person" is defined in A.R.S. § 36-3251 (N)(1) as a person who is employed or contracted to provide direct care services pursuant to Title 36, Chapter 5.1.
- E. The provider agency must have a policy in effect indicating whether the direct care staff is required to call 9-1-1 and provide CPR or whether they may follow the DNR in a situation when a member is on hospice, has a DNR, and is found without pulse or respirations. The provider agency's policy must comply with A.R.S. § 36-3251.
- F. The following apply, as appropriate:
 1. Has a DNR and not in Hospice: Direct care staff persons will call 9-1-1 and provide CPR until there is a licensed healthcare provider present to execute a current and known advance directive.
 2. Has a DNR and in Hospice: When the member is on a physician-ordered hospice plan of care and has a properly executed Prehospital Medical Care Directive (DNR), the direct care staff may comply with the Prehospital Medical Care Directive (DNR).
 3. No DNR: Direct care staff persons will call 9-1-1 and provide CPR until there is a licensed healthcare provider present.
- G. Licensed healthcare staff (e.g., Medical Doctor, Registered Nurse, Licensed Practical Nurse, Emergency Medical System Personnel) will follow any advance directive when known.

- H. Except in the case of a court-ordered DNR, the custodial parent of a minor or a legal guardian, if present, may choose to follow the advance directive or may choose to overrule it, and request CPR and 9-1-1. Staff will comply with the custodial parent or legal guardian's request, documenting that request as soon as possible after Emergency Medical System Personnel has taken over care of the member.
- I. These procedures apply to DDD and contracted personnel.

If in doubt, call 911 and start CPR.



Chapter 2000	Support Coordination
2001	Planning Team Members
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2006	Arizona Long Term Care Non-Users
2007	Case Closure

2001 PLANNING TEAM MEMBERS

REVISION DATE: 10/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36.551.01; A.A.C. R6-6-101.

The membership of the Planning Team will vary depending upon the needs and wishes of the member and/or family.

The Planning Team will include at a minimum:

- A. The member;
- B. The member's parent if the member is a minor or legal guardian, if any;
- C. The Division Support Coordinator or other appropriate Division representative, who shall serve as plan facilitator and coordinator;
- D. Representatives of any service currently authorized or assessed;
- E. Any other persons the member/responsible person or the Division select;
- F. Additional team members may participate in the planning team meeting:
 1. Direct support professionals who work directly with the member served in Residential, Employment, or Day Program services;
 2. A person qualified to address the health and medical needs of a member who is medically involved. The Support Coordinator and District/Division nurse will determine which Division staff or providers meet this qualification;
 3. Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID):
 - a. A Qualified Intellectual Disabilities Professional (QIDP), who typically is the Division Support Coordinator;
 - b. The member's Primary Care Provider (PCP), who may participate by means of written reports, evaluations, and recommendations;
 - c. The Division/District nurse assigned to the facility;
 - d. Therapists when there is an indication of need and/or where services are currently being provided; and,
 - e. Providers of direct service in other programs received or needed by the member, such as Day Treatment and Training, or educational programs.

4. Nursing Facilities (NF):
 - a. The member's PCP, who may participate by means of written reports, evaluations, and recommendations;
 - b. The Division/District Nurse assigned to the NF;
 - c. Therapists when there is an indication of need and/or where services are currently provided;
 - d. Staff from NF; and,
 - e. The member's primary caregiver(s).

2002 PLANNING MEETINGS

REVISION DATE: 10/21/16, 10/01/14

EFFECTIVE DATE: July 3, 1993

Member Attendance

The member must be present at all planning meetings unless the responsible person has requested the member not attend. When this occurs, the Support Coordinator must complete a face-to-face visit with the member by the required planning meeting due date, and document the reason the responsible person requested the member not attend the planning meeting.

Initial Planning Meeting (Newly Eligible)

The timeframe requirements for the initial planning meeting are based on the date the Division is notified of the member's eligibility. All initial planning meetings must be completed following the timeframes below.

A. Arizona Long Term Care Service (LTC)

The Support Coordinator will:

1. Contact the responsible person within five days of Focus eligibility notification to schedule the meeting;
2. Hold the planning meeting in person within ten days of Focus eligibility notification;
3. Complete the following documents as appropriate:
 - a. The ALTCS ISP Packet, when Targeted/DD Annual Plan has already been completed;
 - b. The Reassessment of the Planning Document and Service Evaluation, when ALTCS ISP Packet has already been completed;
 - c. The ALTCS ISP Packet when the member is Newly DD eligible and became ALTCS eligible prior to initial meeting.
 - d. Any other required paperwork.

B. Targeted Support Coordination (TSC)

The Support Coordinator will:

1. Contact the responsible person within five days of Focus eligibility notification to schedule the Targeted Planning Meeting;

2. Hold the Targeted Planning Meeting in person within ten days of Focus eligibility notification:
 - a. When the member is newly TSC eligible, and the other scenarios do not apply complete Targeted/DD Annual Plan;
 - b. When Targeted/DD Annual Plan has already been completed and the next scheduled planning meeting is due, complete Reassessment of the Planning Document. When the next planning meeting is not due, complete a narrative of the Targeted Planning Meeting and file with the Targeted/DD Annual Plan;
 - c. When ALTCS ISP Packet has already been completed, and the member becomes eligible for TSC, and the next scheduled planning meeting is not due within the initial 10-day timeframe, complete a narrative of the planning meeting and file with the ALTCS ISP Packet; and,
 - d. Complete any other required paperwork, as appropriate.
- C. DD Only (DDD).

The Support Coordinator will:

1. Contact the responsible person within ten days of Focus eligibility notification to schedule the meeting;
2. Hold the planning meeting in person within 30 days of Focus eligibility notification; and,
3. Complete the Annual Plan for Targeted/DD Only.

Subsequent Planning Meetings

The Support Coordinator will complete all subsequent Planning Meetings following the time frames below.

A. ALTCS

1. Acute Care Only (No long-term care services.)

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

2. Home and Community Based Services (HCBS).

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

3. Child/Adult Developmental Home - regardless of age.

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

4. Group Home – age 12 and under.

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment /Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

5. Group Home – over age 12, no Regional Behavioral Health Authority (RBHA) involvement

The Support Coordinator will:

- a. Hold meetings every 180 days after initial/annual meeting;
- b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, RBHA involvement

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,

- c. Complete any other required paperwork, as appropriate.
7. Group Home – over age 12, medically involved
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
8. Nursing Facility or Intermediate Care Facility
The Support Coordinator will:
 - a. Hold meetings every 180 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
9. Assisted Living Centers
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
10. Foster Care
The Support Coordinator will:
 - a. Hold meetings as required by the member's placement and eligibility;
 - b. Complete required paperwork as required by the member's placement and eligibility; and,
 - c. Complete any other required paperwork, as appropriate.
11. Member starts a new day or employment program; within 30 calendar days of starting new program.
12. Member moves from one placement type to a different placement type; within 10 business days of the move.

13. Member moves from a placement type to the same placement type; within 30 calendar days of the move.

B. Targeted Support Coordination (TSC)

1. All TSC members.

The Support Coordinator will:

- a. Hold face-to-face meetings every 90 days (two visits) for the first six months after initial eligibility; and,
- b. Ask the member/responsible person the preference for type and frequency of ongoing meetings at the second 90-day review.

2. No Long Term Care Services

The Support Coordinator will contact the responsible person by the type and frequency of contact requested:

- a. In-Person Contact

The Support Coordinator will:

- i. Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and,
- ii. Complete any other required paperwork, as appropriate.

- b. Letter Contact

The Support Coordinator will:

- i. Send a letter to the member/responsible person that is appropriate to the member's needs/circumstances. The letter may contain:
 - Follow up questions based on previous meetings.
 - Questions about any changes since the member's last meeting, such as contact information and member's needs;
- ii. Mail the letter by regular and registered mail, return receipt requested; and,
- iii. Update the review/ISP date in Focus with the date the letter was mailed.

c. Phone Contact

The Support Coordinator will:

- i. Complete the Annual Plan – Targeted/DD Only or Reassessment;
- ii. Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call; and,
- iii. Update the review/ISP date in Focus with the date of the phone call.

3. Home and Community Based Services (HCBS)

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

4. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

5. Group Home – age 12 and under

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

6. Group Home – over age 12, no RBHA involvement

The Support Coordinator will:

- a. Hold meetings every 180 days after the initial/annual meeting;
- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,

- c. Complete any other required paperwork, as appropriate.
7. Group Home – over age 12, RBHA involvement
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
8. Group Home – over age 12, medically involved
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
9. Nursing Facility or Intermediate Care Facility
The Support Coordinator will:
 - a. Hold meetings every 180 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
10. Assisted Living Centers
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
11. Foster care
The Support Coordinator will:
 - a. Hold meetings as required by the member's placement and eligibility;

- b. Complete required paperwork as required by the member's placement and eligibility; and,
 - c. Complete any other required paperwork, as appropriate.
12. Member starts a new day or employment program: Within 30 calendar days of starting new program.
 13. Member moves from one placement type to a different placement type: within 10 business days of the move.
 14. Member moves from a placement type to the same placement type: within 30 calendar days of the move.
- C. DD Only (DDD)
1. No Long Term Care services:
The Support Coordinator will:
 - a. Ask the member/responsible person the contact preference for ongoing meetings after one year of eligibility (two face to face 180-day meetings);
 - b. Hold type of preferred meeting at least annually after one year of eligibility; and,
 - c. The Support Coordinator will contact the responsible person by the type of contact requested:
 - i. In-Person Contact
The Support Coordinator will:
 - Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and,
 - Complete any other required paperwork, as appropriate.
 - ii. Letter Contact
The Support Coordinator will:
 - Send a letter to the member/responsible person that is appropriate to the member's needs/circumstances. The letter may include:
 - Follow up questions from previous meetings.
 - Any changes since last meeting?
 - Any changes to contact information?

Mail the letter by regular and registered mail, return receipt requested.

- Update the review/ISP date in Focus with the date the letter is mailed.

iii. By Phone Contact

The Support Coordinator will:

- Complete the Annual Plan – Targeted/DD Only or Reassessment;
- Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call; and,
- Update the review/ISP date in Focus with the date of the phone call.

d. After the first year of eligibility (two face to face 180 day reviews) a file review will be completed 180 days after the annual. The file review is not completed based on the contact preference; however, a phone call may be required to obtain information. A file review shall consist of a review of the Annual Plan and:

- i. Re-determination of eligibility;
- ii. Updating Focus with the date of the file review and any other relevant information. Obtaining school records, if school age;
- iii. Referrals to community resources; and,
- iv. Documentation that the file review was completed.

2. Home and Community Based Services (HCBS)

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

3. Child/Adult Developmental Home - regardless of age

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;

- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
 4. Group Home – age 12 and under
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
 5. Group Home – over age 12, no RBHA involvement
The Support Coordinator will:
 - a. Hold meetings every 180 days after initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
 6. Group Home – over age 12, RBHA involvement
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.
 7. Group Home – over age 12, medically involved
The Support Coordinator will:
 - a. Hold meetings every 90 days after the initial/annual meeting;
 - b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
 - c. Complete any other required paperwork, as appropriate.

8. Nursing Facility or Intermediate Care Facility

The Support Coordinator will:

- a. Hold meetings every 180 days after the initial/annual meeting;
- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

9. Assisted Living Centers

The Support Coordinator will:

- a. Hold meetings every 90 days after the initial/annual meeting;
- b. Complete the Reassessment/ Residential ISP Update Packet, as appropriate; and,
- c. Complete any other required paperwork, as appropriate.

10. Foster care

The Support Coordinator will:

- a. Hold meetings as required by the member's placement and eligibility;
- b. Complete required paperwork as required by the member's placement and eligibility; and,
- c. Complete any other required paperwork, as appropriate.

11. Member starts a new day or employment program: within 30 calendar days of starting new program.

12. Member moves from one placement type to a different placement type: within 10 business days of the move.

13. Member moves from a placement type to the same placement type: within 30 calendar days of the move.

14. Inactive Status: The Support Coordinator will contact the member/responsible person annually by phone.

Scheduling Subsequent Meetings

With the exception of the initial planning meeting, subsequent meetings shall be scheduled and written notice given at the end of each planning meeting. The date and time of the meetings should be at the convenience of the responsible person. In addition, the Support Coordinator shall provide the team members written notice of upcoming annual planning meetings at least 10 days in advance. The Support Coordinator shall document all attempts

to schedule planning meetings at the required or requested TSC intervals. The Support Coordinator shall document the reason in the progress note when the responsible person delays, cancels, or reschedules the meeting.

Focus ISP Date (Set in stone date)

The meeting date on which the initial plan was developed becomes the Focus ISP date. The annual planning meeting may be held up to 5 working days before the Focus ISP date every subsequent year. An annual meeting held more than five working days prior to the Focus ISP date is considered a review meeting, not the annual planning meeting. Review meetings may be held at any time prior to their due date. All planning meeting due dates are based on the mandated review cycle.

Meeting Location

(Reference: Arizona Health Care Cost Containment System Medical Policy Manual [AMPM] Chapter 1620 - E)

Review visits are to be conducted where the member receives services, including service settings both inside and outside of the member's home as described below. At a minimum, Support Coordinators will conduct review visits with a member in his or her home at least once annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs. If a member receives services outside of the home, at a minimum, a review visit must be conducted at one of the member's service setting locations. At the election of the member or member's representative, remaining visits may be conducted at an alternate location that is not a service setting. The location of each review visit, whether at a service setting location or an alternate site, must be determined by the member or member's representative and not for the convenience of the Support Coordinator or providers. The choice of location by the member/representative must be documented in the member file.

If a Support Coordinator is unable to conduct a review visit as specified above due to the refusal by the member and/or the member's representative to comply with these provisions, services cannot be evaluated for medical necessity and therefore will not be authorized. A Notice of Action must then be issued to the member setting forth the reasons for the denial/discontinuance of services.

Special Meetings

The Planning Team may meet to review and revise the Planning Document at any time when there is change. The planning team must reconvene in the following circumstances:

- A. When there is a change in the member's medical treatment or physical condition that significantly affects daily living and is not of a short term or emergency nature;
- B. Prior to any transfer to/from a residential setting operated or funded by the Division;
- C. When there is a change that affects the continued implementation of the planning document;

- D. When the results of a grievance/appeals process require a review and/or revision of the current Planning Document; and,
- E. For members living in a licensed residential setting, when an emergency measure, including a one-time emergency use of behavior modifying medication ordered by a Doctor, is used to manage a behavior two or more times in a 30 day period or with any identifiable pattern, or when required by the results of Program Review Committee (PRC) or Human Rights Committee (HRC) reviews of behavior plans.

Mandatory Reporting

A. Abuse/Neglect

If, during the course of a Plan Review or any other contact with the member, the Support Coordinator identifies any instance of abuse or neglect, she/he is required, by law, to report this to a police officer or protective services worker.

B. Quality Assurance

Support Coordinators may become aware of quality assurance issues during the course of their work, i.e., residential licensing standards that are out of compliance; inappropriate implementation of individual programs; untimely medical check-ups; or serious incidents not have not being reported. The Support Coordinator must verbally report problems to provider relations or quality assurance staff.

2003 PLANNING DOCUMENT

REVISION DATE: 6/10/2016, 2/12/2016, 7/3/2015, 3/2/2015,

EFFECTIVE DATE: July 31, 1993

Support Coordinators, when completing a Planning Document, shall use a person-centered approach, taking into consideration natural and community resources, acute care services, home and community based services, behavioral health services, and what is important to the member now (priorities) and in the future (vision), and:

- A. Provide information to assist members/responsible persons in making informed decisions and choices;
- B. Provide members with flexible and creative service delivery options;
- C. Provide service options that support the member's priorities and outcomes;
- D. 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;
- E. Provide necessary information to providers about any changes in the member's functioning to assist the provider in planning, delivering, and monitoring services;
- F. Review all professional evaluations;
- G. Assume responsibility for completion of all components of the planning document in conjunction with the team; and,
- H. Provide copies of the completed Planning Document (e.g., Annual Plan, Reassessment of the Planning Document, Changes in the ISP, cover sheet) to all team members and service providers within 15 working days of the date of the Planning Team meeting, or revision resulting in a change in the Planning Document, and ensuring that copies of the Planning Document are available in all settings where the individual receives services.

A critical component of the person-centered approach is the assessment process. This process involves the member and their family as appropriate in the identification of support needs and includes their participation in decision-making. In designing the plan, the Planning Team must consider the unique characteristics of the member as expressed by the member or documented by others who know the member. For the member, the planning process will:

- A. Recognize and respect rights;
- B. Encourage independence;
- C. Recognize and value their competence and dignity;
- D. Promote social inclusion;

- E. Preserve integrity;
- F. Support strengths;
- G. Maintain the quality of life;
- H. Enhance all areas of development; and,
- I. Promote safety and economic security.

Annual Plans

An annual plan is required for all members. The member's eligibility and placement determines the type of plan to be completed.

Reassessment of the Planning Document

Reassessments of the planning document are completed based on the member's eligibility and placement. The reassessment is a review of the annual plan.

Changes to the Planning Document

Any team member may recommend changes in the Planning Document/Individual Support Plan (ISP) by forwarding the proposed change to the Support Coordinator using the *Changes in the ISP* form. Examples may include:

- A. New or changes to outcomes;
- B. New action items;
- C. Changes in medications; or,
- D. Changes to the spending plan.

The Support Coordinator shall sign the *Changes in the ISP* form signifying that the recommended change does not require a Planning Team meeting as outlined in this policy manual, obtain the member/responsible person's signature, file the original with the ISP/Planning Document in the member's file and forward a copy of the form to each team member. Any team member who disagrees with the change may request a special team meeting.

Attendance Sheet

The *Attendance Sheet* is required at every planning meeting to record who was present. Signatures are required from all team members. If a team member refuses to sign or is unable to sign, the Support Coordinator will print their name and indicate they were present. Signing the *Attendance Sheet* does not indicate agreement or disagreement with the planning document.

Acknowledgement of Publications/Information

Acknowledgement of Publications/Information highlights important information the Division is required to provide to members/responsible persons. Based on the member's eligibility, the Support Coordinator shall provide or offer the following publications annually:

- A. Statement of Rights;
- B. Notice of Privacy Practices;
- C. Arizona Long Term Care Service (ALTCS) Member Handbook (for ALTCS members);
- D. Decisions About Your Healthcare (for members age 18 and older); and,
- E. Voter Registration (for members who do not have a legal guardian and who are or will be 18 by the next general election).

Additionally, there are acknowledgements the member/responsible person shall make when reviewing this form. This form is reviewed at the initial planning meeting and annually thereafter and signed by the member/responsible person.

Team Assessment Summary/Working With Me

The *Team Assessment Summary* captures a complete picture of the member's capacities, resources, challenges, and supports needed. The Support Coordinator obtains this information through a discussion with the team at the annual planning meeting.

Support Information

The *Support Information* page captures adaptive equipment, behavioral health information, and medications for members. Advance directive and burial plans information is captured on this page for members age 18 and older.

Risk Assessment Plan

Every member enrolled in the Division must be assessed for potential risks. The *Risk Assessment* identifies behaviors or conditions that may compromise the member's health, safety, well-being, or quality of life. The Planning Team shall develop steps to minimize or eliminate the potential risks. The emphasis on prevention shall not result in disregard of rights, preferences, or lifestyle choices. Age appropriate developmental skills shall be taken into consideration for infants and children when assessing potential risks. The *Risk Assessment* is reviewed at every planning and revised as needed. The *Risk Assessment* is the Division's *Managed Risk Agreement* as required in AHCCCS policy.

Vision and Priorities

The member's *Vision and Priorities* page provides direction for the plan. The Vision identifies the desired future for the member. The Priorities are what the member/responsible person would like to focus on in the upcoming year to help members reach their vision for the future.

Service Considerations/Evaluation

The *Service Considerations* page assists the team in evaluating the appropriate services a member may need. The *Service Evaluation* documents a member's abilities, current needs, and future support needs. Outcomes identified for members assessed for Habilitation Hourly are also documented on this form. Services other than Habilitation Hourly are documented on the *Additional Service Outcome* page.

Service Outcomes

Based on the person's *Vision and Priorities*, the Support Coordinator facilitates the development of attainable, observable, measurable, and time-limited outcomes. Members who receive Habilitation, Day Treatment and Training, employment-related programs, behavioral health supports, or therapy shall have outcomes identified on the *Planning Document*. If progress on an outcome is not made within the designated timeframe, the team shall consider changing the teaching strategy, developing a new outcome, offering a different service, or stopping the service.

The selected provider shall develop a teaching strategy for each outcome, which describes the methodology to be used to support the member to achieve the outcome. The strategy shall identify the time needed to implement the methodology described and define the data to be recorded regarding progress. Support Coordinators are responsible for ensuring continuity of teaching strategies related to outcomes that occur in more than one setting.

Service Plan

The *Service Plan* document assesses the services to be authorized, other services requested by team members, and/or indirect services. A *Service Plan* is completed at every meeting for all members eligible for the Division, excluding children who are Non-ALTCS Arizona Early Intervention Program (AzEIP) eligible.

Contingency Plan (Back-up Plans)

Development of the *ISP - AHCCCS/ALTCS/DDD Member Contingency/Back-Up Plan (Contingency Plan)* is required when any of the following critical services are authorized:

- A. Attendant Care;
- B. Homemaker;
- C. Respite;
- D. Habilitation – Individually Designed Living Arrangement; and,
- E. Nursing.

Contingency Plans ensure continuous provision of services when the direct care worker is unable to work when scheduled. Family members should not be considered as a substitute for a *Contingency Plan*. The agency authorized must offer a substitute direct care worker.

The member/family may decline a substitute direct care worker and not receive the critical service from an agency direct care worker or may elect to provide the service informally. When only Independent Providers are authorized to provide services, the Planning Team must consider an agency as a backup. The *Contingency Plan* should include the back-up person identified and a reasonable option for alternative supports. Multiple back-ups must also be identified.

The *Contingency Plan* requires a member to select and document their preference level. The preference level is the time a critical service needs to be provided when the scheduled provider is unable to work a scheduled shift. The preference level may be changed by the responsible person at any time.

The *Contingency Plan* is completed annually and reviewed at each meeting.

Action Items

Each *Planning Document* includes action items to be completed, the person responsible for completing each action item, and the date by which the action item must be completed. This form is completed annually and reviewed at each planning meeting.

Summary of Professional Evaluations

The *Summary of Professional Evaluations* captures medical appointments and medical issues. This form is required annually for members who live in licensed residential settings.

Rights, Health and Safeguards

The *Rights, Health and Safeguards* form documents exceptions to residential licensing. This form is required annually for all members residing in licensed residential settings.

Spending Plan

The *Spending Plan* determines how the member's money will be spent in the upcoming year. The form is required annually for all members for whom the Division is the Representative Payee and for all members living in licensed residential settings.

Transfer Plan

Prior to transfer of a non-medically involved member from a residential setting operated or financially supported by the Division, the Planning Team must meet to plan the transfer. The transfer plan will be documented on the *Residential Transfer Checklist*.

Cost Effectiveness Studies

Home and Community Based Services (HCBS) provided under the ALTCS Program must be cost-effective when compared to the cost of providing care to the member in an institutional setting. It is the responsibility of the Planning Team to identify if the member's costs will exceed 100% of the institutional cost and develop a plan to reduce ALTCS costs. Written Cost Effectiveness Studies (CES) are also required by Arizona Health Care Cost Containment

System (AHCCCS), for ALTCS eligible persons whose costs exceed 80% of the institutional cost.

The CES is a three-month projection of costs. The Support Coordinator must complete a *Cost Effectiveness Study Worksheet (CES Worksheet)* if the member's name appears on the quarterly report "Client_0060 – Members Exceeding 80% Cost Effectiveness." This report identifies members whose costs exceeded 80% of the institutional rate in previous quarters. When the Support Coordinator identifies the need for a CES, the *CES Worksheet* should be submitted to the ALTCS Specialist within 30 days. A copy is maintained in the member's file. Collaboration should take place with identified District staff to obtain information. Completion of a *CES Worksheet* must be done quarterly until costs are reduced below 80%.

In addition, a CES is required within 30 calendar days for the following services:

- A. Nursing services (including nursing respite) in excess of 200 hours monthly;
- B. Habilitation – Nursing Supported Group Home;
- C. Concurrent services of residential Habilitation (Individually Designed Living Arrangement or Group Home) when the staff ratio is 1:1 or 1:2 at either program; and,
- D. Habilitation, Community Protection.

The Division receives a monthly report (CATS) from AHCCCS identifying members who had previously been above 80% of the institutional cost. For these members who are now below 80%, a new *CES Worksheet* must be completed and entered on the CA160 screen in the AHCCCS computer system within 60 days of the report. The CA160 screen will be printed and placed in the member file.

Each *CES Worksheet* must be signed by the Support Coordinator Supervisor (for members below 100%) or the District Program Manager/Lieutenant Program Manager (for members above 100%). This signature assures that all appropriate CES policies and procedures have been followed.

When a member is discharged from an institutional placement (e.g., an ICF/IID, the Arizona State Hospital or, a Skilled Nursing Facility) the Support Coordinator must complete a CES prior to the move. The costs used for the study should be those proposed for the new placement, not from the institutional placement.

The completed *CES Worksheet* will be reviewed by District placement personnel. If the costs are below 100% of the appropriate institutional level and the move is approved, copies will be sent to ALTCS Specialists and maintained in the member's case record. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system at CA160.

In addition to the CES, a *Discharge Plan* consistent with Division policy must be in place prior to any move.

Note: It is advisable to complete an analysis of costs prior to any and all placement changes (e.g., Group Home, Developmental Home).

The completed *CES Worksheet* and the cost reduction plan must be maintained in the member's case record. A copy of the *CES Worksheet* shall be submitted to the ALTCS Specialist. The ALTCS Specialist will ensure that the CES is entered in the AHCCCS computer system.

Until the CES is brought below 80%, the Support Coordinator will be required to complete and submit a *CES Worksheet* quarterly. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

When the completed *CES Worksheet* generates a result over 100%, the following options should be pursued:

- A. Request a higher medical rate;
- B. Request a higher behavioral health rate; or,
- C. Reconvene the Planning Team to review services.

Request A Higher Medical Rate Through The Health Care Services Office

Support Coordinators and ALTCS Specialists submit documentation for the Division's Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinators and ALTCS Specialists must complete a justification packet that includes the following:

- A. Narrative describing how the person meets the criteria.
- B. Current *CES Worksheet*
- C. Plan To Reduce Costs

Request A Higher Behavioral Health Rate Through The Behavioral Health Unit

The Support Coordinator submits documentation for the Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinator must complete a justification packet that includes the following:

- A. Narrative describing how the person meets the criteria. This narrative shall contain the person's psychiatric diagnosis, most recent psychiatric and psychological evaluations, description of how the person has difficulty adapting to community life, description of substance abuse issues (if applicable) and a description of criminal offenses (if applicable);
- B. Current *CES Worksheet*;
- C. Plan To Reduce Costs;
- D. Current *Behavior Plan*;

- E. Any other information that will assist the Behavioral Health Unit in evaluating the request; and,
- F. *Current Planning Document.*

The Division's Health Care Services or the Behavioral Health Unit will inform the ALTCS Specialist of authorizations for higher institutional rates (medical and/or behavioral) with the approval time period. If costs continue at the higher level, a request should be resubmitted in advance of the approval expiration. Should the approval expire or be denied, the institutional rate will revert back to the regular institutional rate. The Support Coordinator must initiate review of the other remaining options listed above.

Procedures for Reducing Cost Below 100% within 6 months

The AHCCCS Medical Policy Manual provides that when the cost is expected to be below 100% within the next six months, justification must be added to the *CES Worksheet* and documented in the case file.

When/if services are reduced, the Support Coordinator must follow the Notice of Action (NOA) requirements in policy. If it is unlikely that costs can or will be reduced in the next six-month period, the Support Coordinator is responsible for initiating a review of other options.

Once the Support Coordinator completes the *CES Worksheet* and costs are found to exceed 100%, the Support Coordinator must submit the calculation to the District ALTCS Specialist so it can be entered in the AHCCCS computer system at CA160. In addition, the Support Coordinator should immediately consult with their supervisor, area manager, nurse, contract staff, etc. The Support Coordinator may need to call special team meetings to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced by the end of the six-month period. The Planning Team may discuss the following:

- A. Reducing service units (reducing staffing levels); and,
- B. Alternative placements.

If, at the end of six months, costs have not been reduced below 100%, the Support Coordinator must notify the ALTCS Specialist, the District Program Manager (DPM)/Lieutenant Program Manager (LPM), and the ALTCS Program Administrator.

If the DPM/LPM approves home and community based services above 100% of the cost of serving the member in an institutional setting, these costs must be paid with State funds. The Support Coordinator will advise the CES Manager/Business Operations to adjust payments accordingly. The revised *CES Worksheet* (below 100%) is filed in the case record, and a copy is submitted to the ALTCS Specialist. The *CES Worksheet* calculation previously entered in the AHCCCS computer system at CA160 will be adjusted to reflect Medicaid approved costs up to, but not exceeding 100% of institutional cost.

State funds may be available for members residing in licensed residential settings such as Group Homes and Child or Adult Developmental Homes.

If District administration denies the use of State funds, the Support Coordinator should initiate termination of service costs in excess of 100%. The Support Coordinator must advise the member/responsible person of the cost effectiveness limitations and discuss other options. The Support Coordinator must also follow the NOA requirements in policy. If the member chooses to remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member's Primary Care Provider), a *Managed Risk Agreement* is completed. This agreement should document:

- A. The amount and type of service the Division can provide cost effectively;
- B. The placement/service options offered to the member;
- C. The member's choices regarding those options;
- D. The risks associated with the decrease in service amounts; and,
- E. Any plans the member/responsible person has to address those risks (e.g., paying privately for services above 100%, using volunteer services).

The member/responsible person acknowledge and agree to the service limitations and risks by signing the *Managed Risk Agreement*.

Considerations for Possible Institutional Placement

When considering institutional placement, the Support Coordinator must first document all other options considered and reasons why these options were not chosen, and submit for review by the DPM/LPM. The Planning Team must discuss the lack of appropriate, cost - effective alternatives for the member and discuss the potential placement.

The Support Coordinator will submit a completed *CES Worksheet* to the ALTCS Specialist. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

District administration may continue current costs while any of the above options are being pursued. After six months, if costs continue beyond 100% without AHCCCS approval, the CES calculation in the AHCCCS system must be adjusted to reflect AHCCCS approved costs up to, but not exceeding, 100% of institutional cost.

2004 SERVICE AUTHORIZATION

REVISION DATE: 6/10/2016, 7/3/2015

EFFECTIVE DATE: July 31, 1993

All services funded by the Division require authorization prior to delivery. Support Coordinators may authorize services in certain circumstances. Some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services, which require prior authorization by Health Care Services (HCS). Other services may require authorization by the Assistant Director or designee.

Authorization by the Division Support Coordinator shall be documented by the Support Coordinator's signature on the service plan.

For members who are eligible for Arizona Long Term Care System (ALTCS), the Support Coordinator shall authorize long term care services only when the assessment and planning process outlined in this policy manual determines the services to be medically necessary, cost effective, and federally reimbursable. Services are cost effective when the total cost does not exceed 100% of the cost of an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID). Non-covered services and services provided to members who are not ALTCS-Long Term Care shall be authorized only when the same processes determine them to be developmentally necessary and cost effective and state funding is available.

Prior to authorization, the Support Coordinator shall ensure that other potential resources for meeting the identified needs have been explored, and are either not available or not sufficient to meet the documented need for both ALTCS and non-Long Term Care services. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in this policy manual.

Support Coordinators shall follow the steps outlined below in authorizing services:

- A. Members who are eligible for ALTCS receive identified services within thirty (30) days of eligibility. The Focus system will be updated within 5 days of the team meeting, unless a Utilization Review is required;
- B. A Utilization Review is required for any new or increase in service including Attendant Care, Respite, Habilitation and Day Treatment and Training. This Utilization Review process must be completed within 10 days;
- C. Entry of approvals in Focus shall be approved or denied following Support Coordinator authorization, other District management staff authorization if needed, and HCS authorization or other Division staff, if needed; and,
- D. Within five days of approval by the appropriate authority, the Support Coordinator ensures authorization information for the needed service, the amount of units, the start/end dates, and the preferred provider are entered in Focus.

Other Authorizations

Therapies require prior authorization through the District Administration and the Central Office. Home Health Aide, Home Health Nurse, Hospice, and Respiratory Therapy services require prior authorization through Health Care Services. Home modifications require prior authorization through the Home Modification unit.

2005 REFERRAL AND PLACEMENT IN SERVICES

REVISION DATE: 7/15/2016, 10/1/2014

EFFECTIVE DATE: July 3, 1993

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to a member starting a service, the Support Coordinator shall send a copy of the Planning Documents to the identified provider.

Preschool-age children shall not be placed in a Child Developmental Home without a stay-at-home parent, unless all other alternatives have been exhausted and the Assistant Director has given approval. There may be exceptions to this requirement for children whose cases have been transferred to the Division from Department of Child Safety (DCS). All other alternatives include currently available Child Developmental Homes.

The Division staff shall also make every attempt to develop an appropriate home if one is not available. The Assistant Director will consider the need for expansion of a Child Developmental Home after the family's situation and family dynamics have been thoroughly explored. Child Developmental Home expansion will not occur unless it is determined that the child can fully benefit from this placement, and that the quality of care and supervision of other members who reside in the home will not be adversely affected.

For members being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

- A. Demographic information that includes the member's name, address, telephone number, date of entry into the Division system, Focus identification number, legal competency status, language spoken and understood, name of parent/responsible person or next of kin (with address and telephone number), physician's name, address and telephone number, and Third-Party Liability (TPL) information (e.g., company, policy number). Printouts of the appropriate Focus documents and/or Planning Documents should contain most of this information, and will be acceptable documentation for referral purposes;
- B. Current and appropriate consents and authorizations;
- C. Description of special needs and how these should be met (e.g., medical or behavioral), if not thoroughly documented on the most recent Planning Documents;
- D. A copy of most recent physical examination;
- E. Medical history, including results of Hepatitis B, tuberculosis tests, and immunization records, if available;
- F. Current medications and medication history, if not thoroughly recorded on the most recent Planning Documents; and,

- G. Copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, or psychological evaluations.

In the event these records are not available, the Support Coordinator should assist the provider in scheduling appointments or obtaining the records needed to meet minimum residential licensing requirements.

For members being placed in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), a physician's order, and the approval of the Assistant Director shall accompany the above information. The Assistant Director may delegate selective authority.

The Planning Team shall schedule a pre-placement meeting with the provider to introduce the member, review the Planning Documents and other records, and discuss any other information necessary to provide safe and effective services. The Support Coordinator shall coordinate and attend pre-placement meetings for residential and day program settings. The Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on the circumstances of each case.

2006 ARIZONA LONG TERM CARE NON-USERS

REVISION DATE: 7/3/2015

EFFECTIVE DATE: July 31, 1993

The Support Coordinator shall offer the member/responsible person the option to voluntarily withdraw from Arizona Long Term Care System (ALTCS) and seek services through an Arizona Health Care Cost Containment (AHCCCS) Acute Care Plan through other programs when there is no assessed service need, or no intent to pursue ALTCS services. If the individual voluntarily withdraws from ALTCS, the Support Coordinator shall inform the responsible person of the right to reapply for ALTCS at any time.

If the individual/responsible person chooses not to voluntarily withdraw from the ALTCS program, Acute Care status may be appropriate. The Division will notify the member/responsible person that a change from ALTCS to Acute Care status is being requested and AHCCCS may contact them to complete a financial redetermination.

2007 CASE CLOSURE

REVISION DATE: 3/25/2016, 7/3/2015

EFFECTIVE DATE: July 31, 1993

Causes for Division Case Closure

The following situations may require Division case closure. The member:

- A. No longer meets the eligibility requirements defined in this policy manual;
- B. Requests case closure verbally, in writing, or the responsible person requests such action;
- C. Reaches the age of eighteen (unless an application for continuation of services has been filed);
- D. Moved from previous residence and cannot be located via a certified letter, return receipt requested;
- E. Moved out of state; or,
- F. Has passed away.

All contact attempts must be documented in the case file. Prior to case closure, the Support Coordinator/Supervisor shall ensure due diligence to make contact and determine why attempts were unsuccessful. Additionally, the following must be considered:

- A. *Arizona Long Term Care Services (ALTCS) eligibility* – These cases cannot be closed until the Division receives a roster disenrollment from Arizona Health Care Cost Containment System (AHCCCS); and,
- B. *Inactive Status* – An option to consider if the person has a history of being unable to contact.

If the Support Coordinator/Supervisor determines case closure will be necessary, this should occur within 30 calendar days. Any Focus authorizations must be end dated when a case closure occurs.

Members who are eligible for the ALTCS cannot be placed in inactive status or discharged from the Division until the AHCCCS dis-enrolls them via a roster transmission. As long as the person remains ALTCS eligible, the Support Coordinator must continue attempts to schedule a meeting. AHCCCS will not dis-enroll the member if AHCCCS is able to contact with the member.

Notification of Case Closure

A *Notice of Service System Discharge* must be sent by certified mail, return receipt requested, to the member/responsible person informing him/her of the case closure at least

35 days prior to the date of the case closure. A copy shall also be sent to the local ALTCS office if the member is ALTCS eligible. The notice shall also discuss the opportunity for administrative review as described in this policy manual. If the member is ALTCS eligible, a case cannot be closed until AHCCCS dis-enrolls the member.

A *Notice of Service System Discharge* shall not be sent in instances where the member has passed away.

Documentation of Case Closure

The following steps shall be taken at the time a member's case is closed:

- A. Include a copy of the applicable *Notice of Service System Discharge* in the case record;
- B. Close the record in Focus including the appropriate reason code. If the member is ALTCS eligible, the case cannot be closed until AHCCCS dis-enrolls the member; and,
- C. Store the record in accordance with this policy manual.



Chapter 3000	Network
3001	Family Members as Paid Providers
3002	Home and Community Based Service Delivery
3003	Selection of Providers
3004	Reserved
3005	Notification of Network Changes
3006	Short Term Emergency Situations (Residential and Day Programs)
3007	Service Provider Information, Authority, and Notification

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

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

EFFECTIVE DATE: June 30, 1994

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*.

Chapter 4000 Business Operations

Third Party Liability

4001 Third Party Liability

Client Billing

4002 Client Billing

Administrative Review/Appeal and Hearing Rights

4003 Administrative Review/Appeal and Hearing Rights

Management of Member Funds

4004 Overview

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4004-K Use of Member Funds

4004-L Reviewing Member’s Accounts

4004-M Changes in a Member’s Status

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4001 THIRD PARTY LIABILITY

REVISION DATE: 9/1/2014

EFFECTIVE DATE: January 1, 1996

Third party liability (TPL) is any funding source other than the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). It includes medical insurance, e.g. Medicare, CHAMPUS, TriCARE, or Blue Cross/Blue Shield. It also includes any benefits or settlements a person has as the result of an accident. It may also include eligibility for other programs such as Children's Rehabilitative Services (CRS), Arizona Health Care Cost Containment System (AHCCCS), or county funded services.

DES/DDD is required to bill any third party for all covered services for all individuals eligible for services through DES/DDD. A member/responsible person is required to provide third party insurance information when requested.

4002 CLIENT BILLING

REVISION DATE: 9/1/2014

EFFECTIVE DATE: January 1, 1996

REFERENCES: A.A.C. 6-6-18, with appeal rights as described by A.A.C. 6-6-22.

Financial Contribution

Members receiving Home and Community Based Services (HCBS) may be required to make a financial contribution to the cost of their care.

Members receiving state funded services who have a trust, annuity, estate, or assets exceeding \$2000 will be required to make a financial contribution for the actual cost of programs and services provided by the Division. When billing a trust, the Division is not limited to trust income and can also bill the trust corpus.

Members who meet the financial eligibility requirements for federal Social Security Supplemental Income benefits or the financial eligibility requirements for Arizona Long Term Care Service (ALTCS), are not affected by this requirement.

Members and responsible parties affected by this financial contribution requirement may make applications to Arizona Health Care Cost Containment System (AHCCCS) for ALTCS eligibility determination. If eligible for ALTCS, the member will not receive a bill for the cost of programs and services, except a member may be billed for room and board.

Financial Contributions and Billing for Residential Services

- A. The financial contribution for a member receiving residential services is based on the total amount of income and monthly benefits the member receives. For purposes of this policy, "residential services" means room and board.
 1. The required financial contribution is a maximum of 70% of the member's income and monthly benefits the member receives, but shall not exceed the actual cost of room, and board.
 2. When the member's personal savings exceeds the maximum limit allowed by the federal agency providing the monthly federal benefits, the billing amount is:
 - a. For the ALTCS member, the actual cost of room, and board services until the member's personal savings drops below the maximum allowable limit; and,
 - b. For the non-ALTCS member, the actual cost of all services, including room and board, until the member's personal savings drops below the maximum allowable limit.
- B. The Department will notify the financially responsible person of the amount the member is required to pay each month for room and board costs.

- C. The financially responsible person shall pay the monthly bill, or may contact the Division to request one or more of the following: a financial review, an Administrative Review, or a reduction in the amount billed based on hardship to the member.

Financial Review

- A. The financially responsible person may contest the figures or method used by the Division in calculating the amount by requesting, verbally, or in writing:
1. An informal business review. An informal business review is conducted by the Division's Business Office, and may be requested at any time ten (10) or more business days prior to the payment due date; the Division will make its best efforts to respond within ten (10) business days from receipt of the request. There is no right to appeal the response to an informal business review, only the decisions that results from of an Administrative Review may be appealed as described below; or
 2. An Administrative Review as prescribed by Arizona Administrative Code (A.A.C.) Title 6, Chapter 6, Article 18, with appeal rights as prescribed by A.A.C. Title 6, Chapter 6, Article 22. The financially responsible person may request an Administrative Review at any time within thirty-five (35) days of the date payment is due by submitting a request to the Divisions Office of Compliance and Review.
- B. The financially responsible person may request an Administrative Review without requesting an informal business review.
- C. Any request for consideration based on the member's personal obligations or expenses shall be resolved under a Hardship Reduction Request described below.

Hardship Reduction Request

- A. Any person financially responsible for the cost of care of a member may submit a *Hardship Reduction Request* to the Assistant Director. The request must be accompanied by supporting documentation as described below.
- B. Consideration for a hardship reduction will be given for the following expenses:
1. Medicare Part D prescription drug co-payments, when submitted with proof of out-of-pocket expenses;
 2. Amounts ordered by a court for restitution, child or spousal support, when documentation of the order is submitted;
 3. Amounts paid for services provided by and items prescribed by a licensed health care professional, when documentation of the expenses supporting the request and denial(s) from third party payers, or other potential sources of assistance are submitted;

4. Expenses for an extraordinary circumstance that affects the member's health and safety when documentation of the amount of the expense, and the effect on the member's health and safety if the expense is not incurred is submitted; and,
 5. Cost of a prepaid burial or cremation plan when supported by documentation of the cost and the length of the payment period.
- C. The Division will review requests that include current documentation of the expenses supporting the request and will issue a written determination that:
1. Approves a temporary reduction of the billing amount for up to 12 months; or,
 2. Denies the request.
- D. The financially responsible person who disagrees with the hardship determination may request an Administrative Review. This request must be received by the Division within 35 days after the date of the Division's hardship determination.
- E. The Division reserves the right to amend or rescind a reduction of costs if the member's financial circumstances change or have been misrepresented.
- F. Upon request by the Division, the financially responsible person shall provide verification that the expense for which a hardship is granted has been paid.

4003 ADMINISTRATIVE REVIEW/APEAL AND HEARING RIGHTS

REVISION DATE: 9/1/2014

EFFECTIVE DATE: January 1, 1996

REFERENCES: A.A.C. 6-6-22 (R6-6-2201 et seq.).

- A. The Division will issue a written decision within thirty (30) calendar days from receipt of the request for Administrative Review. Appeal of this decision is available as prescribed by A.A.C. Title 6, Chapter 6, Article 22 (R6-6-2201 et seq.).
- B. If Administrative review is based on notice of an increase in the monthly billing amount, the billing amount shall not increase until the Department has issued its final decision.
- C. If the Administrative Review decision or an appeal of an Administrative Review decision results in affirmation of the original order in whole or in part, the monthly billing liability shall be retroactively effective from the date of the original notice of the billing amount. The person liable for the cost of care shall pay all amounts as stated in the original notice, as adjusted (if any adjustment in the amount is made by Administrative Review or the appeal). The Department's final decision on the billing amount will be retroactively effective beginning with the month in which the request for Administrative Review was made. Failure to pay the amounts owed may result in termination of services.

4004 OVERVIEW

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

This chapter explains Department of Economic Security (DES) policies for safeguarding, using, and investing funds for members in the Division of Developmental Disabilities (DDD).

4004-A DEFINITIONS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.A.C. R6-6-1204.

- A. Member Funds - Funds entrusted to an individual or agency for safeguarding and investment. The requirements for this are found in the instrument establishing such funds, and by Division Policy and Internal Instruction Manuals. Funds include;
1. cash;
 2. checks;
 3. money orders;
 4. petty cash funds;
 5. change funds;
 6. bank accounts; or
 7. savings accounts and investments.
- B. Member Fund System - The systems used by the Division to maintain and track member funds.
- C. Fiduciary Capacity - A person who also handles member funds is acting in a fiduciary capacity. He/she is responsible to properly and faithfully account for all member funds received by him/her. They may include any employee of the State of Arizona or private provider under contract.
- D. Individual Spending Plan - A plan designed for each member living in a community residential setting or for whom the Division is the representative payee. The Planning Team process creates the plan. This plan dictates the amounts and purposes for which each member's money is spent.
- E. Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) - A document developed by a Planning Team identifying needed services. It also includes the goals and objectives to be attained. The Planning Document directs the provision of safe, secure, and dependable active treatment in areas necessary for individuals to achieve full social inclusion, independence, and personal and economic well-being.

- F. Personal Spending Money - Discretionary funds and allowances provided to members.
- G. Railroad Retirement Annuities and Pensions - A comprehensive benefit program for railroad employees that have retired and includes their families and survivors. It was created in the 1930's. For more information on this benefit, contact the Railroad Retirement Board and request form IB-2.
- H. Representative Payee - A representative payee is an individual or organization that receives Social Security and/or Supplemental Security Income (SSI) payments or other benefits for someone who cannot manage or direct the management of his/her money.
1. When no one is willing or able to perform the duties of the representative payee, the Division shall request that the Social Security Administration appoint them to become the representative for the member. When the Division is the representative payee, the Support Coordinator is responsible for the management of the member funds as directed by the Planning Team (Individual Support Plan/Person Centered Plan).
- I. Residential Services - Includes Room and Board and daily Habilitation. Examples include: Habilitation Services - with Room and Board; Habilitation, Child, or Adult Developmental Home; Habilitation; Nursing Group Home; Habilitation, Community Protection; Residential Room and Board, etc.
1. Because Residential Room and Board is not a reimbursable service under Title XIX, it is the only residential service that is billable under Administrative Rule R6-6-1204. (http://www.azsos.gov/public_services/Title_06/6-06.htm)
- J. All other services that a member might receive in out-of-home care such as therapies, hourly support programs, day programs, etc. are not considered residential services.
- K. Social Security Benefits:
1. Social Security (SSA, Title II) is a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner. A worker's spouse or children may become eligible for Social Security if the worker becomes disabled or dies. The amount someone receives depends upon the age of the wage earner, the length of time worked and the amount they earned from which Federal Insurance Contributions Act (FICA) taxes withheld.
- Benefits are based on the insured's earnings. Persons receiving benefits cannot be disqualified because of income or resources. Persons become Medicare eligible after two years. Benefits are not affected by whom you live with or where you live.

2. SSI, Title XVI is a federal income maintenance program for the aged, blind, and disabled persons with few or no resources. The person must be blind, or disabled, or 65 or older, have limited income, and cannot have over \$2,000 in allowable resources.
- L. Veterans' Benefits - Benefits payable to surviving spouses and dependents of military personnel who die while in active military service and to survivors of veterans who die after active service.

4004-B MEMBER FUNDS SYSTEM

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

When members need assistance in handling their funds, but no other responsible party is available, the Division applies to be the representative payee for these members. The responsibility of being representative payee requires the Division to have policies and procedures that direct the Division on how to maintain these funds and how these funds are to be used.

The Member Fund System Manager acts in a fiduciary capacity and is responsible for the funds under his/her control. Black's Law Dictionary, sixth edition states:

"One is said to act in a fiduciary capacity or to receive money or contract a debt in a fiduciary capacity, when the business which he/she transacts, or the money or property which he/she handles, is not his/her own or for his/her own benefit, but for the benefit of another person, as to whom he/she stands in a relation implying and necessitating great confidence and trust on the one part and a high degree of good faith on the other part. The term is not restricted to technical or express trusts, but includes also such offices or relations as those of an attorney at law, a guardian, executor or broker, a director of a corporation and a public officer."

When the Division becomes the representative payee for the member funds, the Division sets up special accounts for these funds. These accounts are called the "Member Fund System" and are composed of:

- A. Social Security Benefits (SSA);
- B. Social Security Income (SSI);
- C. Wages earned by the member;
- D. Railroad Retirement (RR);
- E. Veteran's benefits (VA);
- F. Revenue from personal trust funds and estates;
- G. Monetary gifts and other sources; or,
- H. Earned interest.

4004-C POLICY

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

This policy applies to all Division and contracted provider personnel involved with Division member funds if the Division is representative payee.

The Division will not be the representative payee when:

- A. The Planning Team (Individual Support Team/Person Centered Plan team) determines that the member can learn to manage their own funds; or,
- B. There is a guardian, family member, or other interested payee other than a paid provider, willing and able to serve in that capacity and who is approved by the Social Security Administration.

A paid provider shall not be representative payee for a member.

As an exception to this, Independent Providers who are also family members may be a representative payee for a member.

Service provider and Division contracts specify that providers develop internal policies regarding member funds. These provider policies must be consistent with Division policies and appropriate state and federal regulations. These provider policies are subject to Division approval during contract negotiations and subject to periodic review by Division staff.

This policy specifically prohibits a provider from establishing a bank account (other than the standard provider/member personal ledger) for a member.

The provider shall not establish or be included on a joint account for a member, nor establish any account where the provider or provider staff has access to the member's funds.

Money paid out of the member accounts administered by the Division is by specific direction of the Support Coordinator as developed by the Planning Team. Supervisory and management approval is required. Member Fund System disbursements require a *Request for Funds* form.

The Division should not maintain an account for the member's benefits while another person (relative, or friend, but not a provider) maintains an additional account for the member's wages. Separate accounts make it difficult to assure that the individual's financial eligibility level for benefits or Title XIX services is not exceeded.

If someone other than the Division is maintaining an additional account (i.e. wages) for the member, the Division shall recommend that this person should become the representative payee to keep all the member's funds in one account, unless there are reasons why this person cannot or should not be the representative payee.

4004-D RESPONSIBILITIES

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

- A. District Program Administrators/Mangers are ultimately responsible for the proper use of the member funds.
- B. The Division of Developmental Disabilities Business Operations will:
 - 1. Ensure training, assistance, and technical guidance is provided to all employees responsible for member funds;
 - 2. Exercise good judgment and due diligence in the administration of member funds; and,
 - 3. Audit and provide administrative assistance to review activity related to member funds.
- C. Confidentiality will be maintained in accordance with Chapter 1800 of the Policies and Procedures Manual.
- D. No Division employee shall offer assistance or in any way help an individual complete income tax forms, unless they are the legal guardians for the member.

4004-E SAFEGUARDING MEMBER FUNDS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

A. Separate accounts:

1. A separate accounting shall be maintained for each member. This will show all funds received, or disbursed, and remaining balances.
2. Transactions posted to a member's account shall be traceable to an original source document, such as a *Request for Funds* form, a receipt, invoice/bill, etc.
3. Electronic transfers in or out of member accounts are not allowed.

B. Fund Transactions:

1. All funds received will be documented through the Member Fund System.
2. When a member transfers from one district to another, accountability for inter-district fund transfers will be documented. Signed receipt forms shall be used. This shall be documented in the case record, See Chapter 900 for instructions.

The District Member Fund Manager is to be notified in writing/e-mail of the transfer. The names of the sending and receiving responsible persons and the effective date of the transfer shall also be included.

3. Checks and other negotiable instruments received must be immediately endorsed with the restrictive statement, as follows:

AZ DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF
DEVELOPMENTAL DISABILITIES (insert District identifier here)
ACCOUNT NUMBER (insert District Account Number here)
FOR DEPOSIT ONLY

4. Funds received are to be deposited in the designated bank account in a timely manner. Appropriate safeguards should be present while funds are being transported between the Division's facility and the bank.
5. The same person will not handle a transaction from beginning to end. If personnel and other cost considerations permit, cash and check handling and record keeping functions will be separated.
6. The Member Fund System Manager acts in a fiduciary capacity, which includes responsibility to account for all funds in the Member Fund System.

7. Insurance purchased for members in the Member Fund System such as life or burial insurance shall not list as beneficiary:
 - a. The Division;
 - b. An employee of the Division;
 - c. A paid contracted provider; and,
 - d. An employee of a provider.

However, a family member who is also an employee of the Division or a provider may be listed as a beneficiary.
 8. All transactions and record keeping will be done confidentially. Only those with a need to know are allowed to review and to work with the member's records.
- C. The Support Coordinator shall submit a request to establish any new accounts. These requests are to be submitted to:
1. The District Business Operations Manager or the District Program Manager for approval.
 2. The request shall include the member's demographic data, effective dates, income sources, and any requests for funds.
 3. The District Member Fund Manager or designee will be notified once all the approvals are obtained.

4004-F MEMBER FUNDS SECURITY

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

Member funds will be kept in a secure safe or locked location until deposited. When the Fund Manager leaves the work area, the safe or other location shall be locked.

Funds shall not be stored in desks, unlocked files, purses, or other places that are not secure.

Computer access to member information shall be restricted by secure passwords. No one other than the fund manager and/or designee shall have knowledge of the safe key/combination or the password to secure files.

The District Business Operations Manager or designee shall reconcile member accounts monthly. The administrator of business operations must approve any exceptions.

4004-G DISBURSING MEMBER FUNDS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

- A. All disbursements will be by pre-numbered checks.
- B. All disbursements, except by authority of the District Program Manager/Lieutenant Program Manager (DPM/LPM), must be authorized in the Individual Spending Plan.
- C. All disbursements require the following:
 - 1. Disbursements shall be documented by written requests for funds; or,
 - 2. Any request over \$500 must be approved by the District Program Administrator/Manager or designee;
 - 3. Documentation of the amount of each ongoing deduction for residential billings;
 - 4. Excess funds are not to be used for non- approved purchases. If disbursed funds exceed the cost of the approved purchase, these excess funds shall be returned to the member's account with a reconciliation statement accounting for purchases. Anything under \$5.00 may be returned to the member for personal use, unless the Support Coordinator requests otherwise; and,

The person processing an expenditure shall not be the payee of the check. Nor will the person maintaining accounting records or preparing checks also sign the checks.
- D. All pre-numbered checks will be accounted for monthly in the following categories to aid in the bank reconciliation process:
 - 1. Paid by bank (cancelled);
 - 2. Void;
 - 3. Outstanding; and,
 - 4. Suspense File: Cash or checks in the hands of third parties for the purchase of goods and services for members will be signed for and a suspense file established pending paid receipts. Suspense files will be cleared within thirty days after full payment for goods and services.
- E. It is the policy of the Social Security Administration that individuals shall be provided at least \$30 monthly for their personal needs.
 - 1. Member personal spending money does not require receipts.

2. However, any personal spending money not paid directly to the member requires supporting documentation verifying the use of these funds. Those entities required to account for members funds shall maintain a log of all expenditures for each member.
- F. All non-personal spending money disbursed from the member's account for any good(s) or service(s) in excess of \$50.00, shall be verified within 30 days, by an itemized receipt. The receipt must show:
1. The vendor name;
 2. Date of purchase; and,
 3. A written description of the individual item(s) or services. District Program administrators/Managers may establish a receipt limit of less than \$50.00.
- G. Until the properly supported receipt form is submitted, no further requests for that vendor or individual will be processed unless specifically approved by the District Program Administrator/Manager or designee.
- H. It is permissible for a request to designate that several disbursements be made in the name of a member over a period of time. Examples include: monthly personal allowances, or rent subsidy. Such requests remain in effect until the Support Coordinator submits paperwork to change or cancel the request.
- I. A disbursement request charging a member's account will not be honored unless that account has sufficient funds to pay the entire amount requested. The requesting party will be so notified and a modified request can be submitted.
- J. All requests will be processed by the payment deadline set by the district business office or designated member fund system personnel.

4004-H MEMBER FUNDS - PROVIDER RESPONSIBILITIES

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

A person or agency providing out-of-the-home services for members may receive and maintain funds on behalf of the member for personal spending. These funds shall be recorded in a ledger maintained in the member's residence or agency's business office.

The agency or caregiver shall be required to provide proof of how the funds designated for the member were expended, at the Division's discretion.

4004-I LEDGERS MAINTAINED BY PROVIDERS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 41-1345.

When the individual or service provider receives spending money from the Division, family, employment, or other sources on behalf of a member, they are to open and maintain a separate ledger for each member receiving these funds. The ledger is a financial record for each member, composed of a separate log and balance sheet with running totals. The balance is not to exceed \$200. Funds in excess of \$200 shall be returned to the District Member Fund Manager and deposited into the Member Funds System.

- A. Funds can only be obligated and utilized for the member's personal needs; all funds received and expended must be accounted for in the ledger.

This ledger, maintained by the provider, will show:

1. All funds received: sources of those funds and the dates received;
2. All expenditures: what they were spent for, receipts, and dates funds were expended; and,
3. A running balance.

These records must be maintained for a minimum of seven years.

- B. The ledger is to be sent to the member's Support Coordinator quarterly and provided for review at each Individual Spending Plan meeting or as frequently as requested by the Division and/or the guardian. Member funds are also subject to review by the assigned support coordinator and/or member's guardian.

The Support Coordinator shall adjust the spending plan to assure that the Member funds that are maintained by the individual or provider do not exceed \$200. Any funds in excess of \$200 shall be returned to the district Member Fund System Manager or designee for deposit into the member's account.

Member funds cannot be loaned, given, or provided in any way or manner to other members, provider staff, relatives, or friends. Member funds cannot be used to purchase anything that is ordinarily required to be supplied by the service provider or the Division.

Member funds cannot be used to purchase insurance, burial plans, pay medical expenses, etc. for other members, providers, staff, relatives, or friends.

The funds of several members may be pooled to make group purchases provided the Social Security Administration approval is obtained prior to the purchase (an example of a group purchase would be a large TV for a group home). The request for group purchases is to be submitted to the local Social Security Office for approval.

The provider must ensure that the member funds are used to meet the beneficiary's acceptable day-to-day personal needs, including recreation and miscellaneous expenses as required by the Social Security Administration. The federal publication: Representative Payment Program, Guide for Organizational Representative Payees, Publication No. 17-013 is an excellent resource.

- C. Member funds shall be kept in a secure locked location.

Any funds discovered stolen or missing from the member's ledger or personal cash shall be the responsibility of the Provider or Qualified Vendor to replace within 10 working days of the discovery of the theft or missing funds. It shall also be reported to the member's Support Coordinator within 10 working days of the discovery.

- D. These member funds are subject to audit. Any audit exceptions are the responsibility of the service provider for resolution and/or repayment.
- E. The Support Coordinator shall follow Division and Social Security Administration policy and is responsible for the use of these funds. The Member Fund Manager will provide technical assistance to the Support Coordinator when the member dies, moves to another setting, or returns home. Obligations to the Division shall be the first consideration. The final disbursement of these funds will be processed by the Member Funds System Manager or designee as directed by the Support Coordinator.
- F. Service providers shall not be representative payees for a member's benefits.
- G. The Member Funds System Manager, or designee, shall notify the chain of command of the Division of Developmental Disabilities (DDD) of any mismanagement, or suspected mismanagement, of member funds. The Administrator shall determine whether it is appropriate to refer issues to the Department of Economic Security (DES), Office of Special Investigations (OSI), and the Social Security Administration (SSA).

4004-J BANK RECONCILIATION

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

Bank and checkbook balances shall be reconciled monthly. The duties of reconciling the bank and Member Fund System balances and maintaining the accounting records will be separated. Bank, petty cash, and change fund balances shall be reconciled in member accounts monthly.

The Member Funds System Manager or designee shall send Monthly Member Fund reconciliation reports to the Division of Business and Finance, Accounting Office.

Summaries of these reports are to be sent to the Business Operations Administrator.

A report on the number of Title XIX eligible individuals shall be sent monthly to local Arizona Health Care Cost Containment System (AHCCCS) office:

- A. Those with balances over \$1,500; and,
- B. Those with balances over \$2,000.

A report including all accounts with balances over \$2,000 shall be sent to the District Program Administrator/Manager. This report shall be reviewed by management staff to ensure that District staff are working towards a spend down plan.

4004-K USE OF MEMBER FUNDS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.A.R. § 6-6-1204.

Member funds are administered in accordance with the intent of the individual or entity providing the funds.

- A. For economy and efficiency of administration, member funds should be pooled into one bank account. Separate records shall be maintained that identify each Member funds.
- B. Funds in the pooled bank account in excess of current requirements shall be invested in accordance with the provisions of Management of Consumer Funds of the Policy and Procedures Manual.
- C. Member funds shall not be loaned to other members, state employees, or any other agency or person. Nor shall the member accept any loan from other members, state employees, or any other agency or person.
- D. Member funds may be used to pay for the extraordinary expenses of an escort/attendant when the member is traveling, on vacation, or participating in community activities. These expenses may include the cost of transportation, admission fees, meals and/or lodging, but not souvenirs or other personal purchases for the escort/attendant.

Recommendations from the Individual Spending Plan, along with estimated expenses and availability of funds, shall be submitted to the Lieutenant Program Manager/Manager for approval.

Member funds that are advanced shall be reconciled against receipts for all expenditures. Any personal expenditure beyond the original funds that were advanced, which are over \$5.00 must be evidenced by an original receipt to be eligible for reimbursement.

State employees cannot volunteer to be an escort/attendant when that activity is part of their job description.

Exceptions to part "d" require approval in the Planning Documents (Individual Support Plan/Person Centered Plan) and by the District Program Manager/Administrator.

- E. The Individual Spending Plan (ISP) is developed as part of, and during, the member's Individual Support Plan/Person Centered Plan meeting. The spending plan is to include the fiscal planning for the member, what items are to be purchased, monthly expenditures, projected needs, current income, billing by the Division for residential services (room and board), etc., and is to be acknowledged and signed by those present.

During this fiscal planning the support coordinator shall inform the representative payee of his/her obligation to report to the Division the amount of benefits they receive and any changes in these benefits. They are also to be informed that the Division will bill up to 70% of the benefits to be used to offset a portion of the member's residential costs. It is especially important that the representative payee be informed that if he/she receives a large, lump sum payment from the benefit source, that they are to notify the Division, as the Division is required by Administrative Rule R6-6-1204 to bill a portion of those funds.

- F. Unless allowed by law, member funds, including interest earnings, will not be used to defray the cost of administration, supplies, equipment, or services. However, bank and investment institution service charges for administering pooled checking and investment accounts may be offset against interest earnings.
- G. Member funds can only be used for expenditures authorized in the ISP, except upon written approval of the Lieutenant Program Manager/Manager or designee.

If the ISP recommends that the member be issued a Debit Card, these recommendations from the ISP for the use of a Debit Card along with the plan on oversight and accounting of the use of the debit card shall be submitted for approval to the District Business Operations Manager and then to the Lieutenant Program Manager/District Program Manager for final approval.

The use of a credit card shall not be approved.

The purchase of gift cards shall not be approved. The use of gift cards does not allow for the level of accountability required by the Social Security Administration or the Division.

- H. Unexpended member funds that have been advanced to a third party for purchases or allowances will be re-deposited in the bank and credited to the appropriate member's account. However, unexpended funds of less than \$5.00 may be retained, provided they are expended for the member's incidental needs.
- I. Funds belonging to members no longer requiring financial management from the Division shall be disposed of as noted in this chapter.
- J. If the member is a child receiving Foster Care Services (Child Developmental Home), the Office of Accounts Receivable and Collections maintains his or her account, including dedicated accounts as required by the Social Security Administration.
- K. Individual accounts may be established in the Member Fund System to receive and distribute monthly personal spending allowances for members in Foster Care.

4004-L REVIEWING MEMBER'S ACCOUNTS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

- A. The District Member Funds Managers or designee shall conduct random reviews of individual member accounts
- B. The service provider shall make an up-to-date ledger sheet available for review quarterly or upon request by the Support Coordinator as required in this chapter.
- C. A balance sheet shall be sent to the assigned Support Coordinator monthly.
- D. The Support Coordinator shall be notified when the individual's account exceeds \$1,500 and when it exceeds \$2,000. The Support Coordinator shall make every effort to assure that eligibility for Social Security benefits and Title XIX are maintained.
- E. When the State *is not* the Representative Payee: the Division does not have the authority to require the representative payee to inform the Division of the balances in member's accounts.

The exception to this is when the member and/or representative payee is applying for Community Living Service funds, Client Services Trust Funds or other financial assistance, or eligibility for services.

When the Support Coordinator becomes aware that a member's account exceeds the maximum amount to maintain eligibility for Arizona Health Care Cost Containment System (AHCCCS) and/or Social Security benefits and the Division is not the representative payee, the Support Coordinator shall ensure that this is noted at the time of the Planning Meeting (Individual Support Plan/Person Centered Plan meeting) and that it is documented in the Spending Plan.

The support coordinator shall remind/notify the representative payee that anytime the member's funds/resources meet or exceed \$2,000, as described by the Social Security Administration (SSA) for eligibility determination that they are to notify the SSA and AHCCCS.

This notification by the representative payee is required to be made within 30 days of the member's funds/resources meeting or exceeding the \$2,000 limit. An immediate spend-down plan shall then be developed with the representative payee in accordance with the SSA's definition of the proper use of these benefits.

The Support Coordinator shall work with the representative payee to develop a spend down plan, where the Division will bill the member's account at a higher rate until it goes below the eligibility limits for benefits and services. See part "F" below for 100% bill down procedures.

- F. When the State is Representative payee; when a member account exceeds the maximum to maintain eligibility for (AHCCCS) and/or Social Security benefits, the Support Coordinator and the member team will develop a reasonable spend-down plan to bring the account below the current \$2,000 limit.

4004-M CHANGES IN A MEMBER'S STATUS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

If the member experiences any change in status, the Division of Developmental Disabilities (DDD), District Member Funds Unit/staff must be notified. If the member is a social security beneficiary, the Social Security Administration must also be notified. This notification is to be done by the Support Coordinator or designee. These changes include the following:

- A. The member dies;
- B. The member moves;
- C. The member marries;
- D. The member starts or stops working, even if the earnings are small;
- E. A member's condition improves;
- F. The member starts receiving another government benefit or the amount of that benefit changes;
- G. The member plans to leave the United States for 30 days or more;
- H. The member is imprisoned for a crime that carries a sentence of over one month;
- I. The member is committed to an institution by court order for a crime committed because of mental impairment;
- J. Custody of a child changes or a child is adopted; and the parents' divorce;
- K. You can no longer be payee; or,
- L. The member no longer needs a payee.

Additional events that you must report for Supplemental Security Income (SSI) beneficiaries:

- A. The member moves to or from a hospital, nursing home, or other institution;
- B. A married member separates from his or her spouse, or they begin living together after a separation;
- C. Somebody moves into or out of the member's household;
- D. The member has any change in income or resources (i.e., a child's SSI benefit check may change if there are any changes in the family income or resources); or,

- E. The member has resources that exceed \$2000.

The Support Coordinator will report any changes in the residential settings where room and board is paid to the provider, including both permanent or temporary placement changes. These reports are to be sent to Central Office, Site 791A Residential Billing, on the Division of Developmental Disabilities *Billing and Benefit Information* form.

These will then be forwarded to the Division of Business and Finance - Office of Accounts Receivable and Collections. A copy is to be placed in the member's file and a copy sent to the Member Funds Manager. A DDD *Billing and Benefit Information* form is required on all new placements and changes to all out-of-home placements within five (5) working days of placement, and *Benefit Information* form, is also required for all the following:

- A. Member leaves care;
- B. Member moves out-of-state;
- C. Member transfers to another District;
- D. There is a change in billing information;
- E. Member dies;
- F. There is a change representative payee;
- G. There is a request for a billing waiver;
- H. There is change in income (earned or unearned);
- I. Member has a change of address; or
- J. Member enters/leaves acute care facility.

4004-N INVESTING MEMBER FUNDS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

Interest earnings, minus any bank charges on Member funds that are invested in the State Treasurer's Office, will be apportioned to member's accounts quarterly based on account period ending balances.

4004-O TERMINATION OF A MEMBER'S ACCOUNT OR CHANGE IN REPRESENTATIVE PAYEE

REVISION DATE: 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887.

Generally, a member's account is made up of Social Security benefits, earned money, family gifts, and other payments. Social Security benefits make up the largest percentage of these accounts; therefore all applicable Social Security laws and rules are applied first to terminate a member account. These are outlined in the Social Security publication: "Understanding the Benefits", Pub. No. 10024. (www.ssa.gov/pubs).

Fund balances will be returned to the member, Social Security Administration (SSA), guardian, or other authorized entity by check. But this will only be done after all outstanding debts are paid including residential billing in accordance with appropriate rule and law regarding terminated accounts statements. See Policy and Procedures Manual, Chapter 1100 – Case Closure.

- A. When a member dies, and there is no entity to receive money from the member's account, and there is no family, guardian, custodian, executor or beneficiary, the following Arizona Revised Statutes will apply in the disbursement of the account: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887 www.azleg.gov.
- B. Funds not attributed to Social Security benefits as identified on parts 3 and 4 of this section and not able to be assigned to a family member, estate, guardian, custodian, executor, or beneficiary will be paid to the Arizona Department of Revenue, Unclaimed Property Unit. (See their publication #601 for details www.azunclaimed.gov).
 1. Funds of deceased individuals may be used to pay for funeral expenses and shall be used for other outstanding debts, including residential room and board costs, before closing the account.
 2. Accounts having been determined to be inactive (having no transactions for a year or more) will be terminated after reasonable efforts to dispense funds have failed. The account will be closed and funds sent to the Arizona State Treasurer after five (5) years. (Unclaimed Property – Arizona Department of Revenue, Unclaimed Property Unit.)
 3. Social Security (SSA, Title II) is paid after the month of eligibility. Any funds received from the SSA the month after the death of a member receiving SSA, shall not be spent, but shall be returned to the SSA.

For example, – If the member dies on May 30th, the last day of the month, and the SSA check received the first of May was for April the check is due and payable as the member was alive and eligible for the entire month of April.

However, if a check is received the first of June for May, The Support Coordinator or designee shall return the check as the member was not eligible for SSA for the entire month of May, the month the member died.

4. Supplemental Security Income (SSI) is paid in anticipation of eligibility. Any funds received from the SSA during the month of the member's death remain the property of the member's estate. Funds received the month after a member's death shall not be spent, but shall be returned to the Social Security Administration.

For example, if a SSI check comes May 1, and the member was alive during some portion of May, the check is due and payable. If a Check comes in June, the Support Coordinator or designee shall return it as the member was not alive or eligible in June.

For additional information regarding SSI resources, refer to – *Pub No. 05-10029 - Disability Benefits and 05-11011 – "What You Need to Know When You Get SSI Benefits"* (www.ssa.gov/pubs).

To report changes to the SSA, call or visit your local Social Security office. The Support Coordinator or designee shall document the phone call in the case record including information on who they talked with, the date and the outcome.

To report changes to the Division, contact your local District Member funds Unit/staff.

- C. When a change in representative payee is made from the Division to another entity, after all debts incurred while the Division was Representative Payee are paid, all of the Member Funds that can be identified as Social Security Benefits are to be returned to the SSA. The new representative payee is then to request these funds from the SSA. They are not to be transferred directly from the Division to the new representative payee. Providers shall not be representative payees for members. Additionally, agency board members are prohibited from being representative payees except for members of their own families who are members.
- D. If the new representative payee is not the Division, any funds remaining in the "Member's Personal Allowance Fund" that were generated as a foster child shall be sent back to the Social Security Administration. The Social Security Administration may then transfer these funds to the new representative payee.

If the Division becomes the new representative payee, these funds are transferred to the new account that is set up in the local District Business Office for the member's personal use.

- E. A person willing to become the representative payee must file a SSA form (www.ssa.gov/about.htm) requesting a change in payee.

If no one else is available, the Division may request to become the representative payee. Or, Social Security may request/require the Division to become the representative payee. A Member Fund System account is set up in the local district Business Office.

The Social Security Administration is to be notified of the change of address to the local Business Office for the District.

5000 RESERVED

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6001-A CONFIDENTIALITY

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 36-568(01), 36-551(07), 41-1346, 41-1959, 36-568(01), and, 36-551(01); A.A.C. R6-6-102, et seq., and, R6-6-102.

Confidential Information

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, Social Security Number (SSN), ASSISTS or Arizona Health Care Costs Containment System (AHCCCS) I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

- A. The right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;
- B. The right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;
- C. The right to receive one copy of their medical record free of charge annually;
- D. The right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;
- E. The right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;

- F. The right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;
- G. Subpoenas are not court orders. Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F;
- H. The right to file complaints;
- I. The right to seek correction of records; and
- J. Should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.

6001-B RELEASE OF INFORMATION

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-104; 42 CFR 483.410(c) (3).

An authorized list of persons or titles, who may have access to personally identifiable information, shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

- A. Obtained from the member or responsible person in writing and dated); and,
- B. Maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.

6001-C ACCESS TO PERSONALLY IDENTIFIABLE INFORMATION

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.A.C. R6-6-103.

A *Record of Access* documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a *Record of Access* is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with ALL personally identifying information deleted.

While Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) do not require a standardized *Record of Access*, all *Record of Access* documents shall include:

- A. Requestor's name;
- B. Date information copied/sent;
- C. Purpose for request;
- D. Specific information released;
- E. Where information was sent; and
- F. Verification of consent.

A *Record of Access* is not required for the following:

- A. Member/responsible person or their written designee;
- B. Federally authorized members including AHCCCS and DHS staff; or
- C. Direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must maintain a Log Book which documents the names of persons, other than Support Coordinators, or supervisors reviewing the case record and date/time of the review is maintained. The *Record of Access* is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the *Record of Access* (See Master Folder Access Log).

6001-D **LAWFUL DISCLOSURE OF CONFIDENTIAL INFORMATION**

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 8-105, 11-2, 36-29, 36-568(01).

Confidential information shall not be released by any Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) or contract provider staff except as defined below:

- A. When the responsible person designates in writing to whom records/information may be disclosed;
- B. Pursuant to court order;
- C. To the extent necessary to make claims on behalf of a member for public/private assistance, insurance, or health or medical assistance to which the member may be entitled;
- D. In oral/written communications between professional persons in the provision of services or the referral to services;
- E. When disclosure of otherwise confidential information is necessary to protect against a clear and substantial risk of imminent or serious injury to a member;
- F. To the superior court when a petition to establish guardianship for the person is filed;
- G. To other State agencies or bodies for official purposes. All information shall be released without the designation of the name of the member, unless such name is required by the requestor for official purposes. The State agency or body receiving such information shall regard the information as confidential and shall not release it unless a consent to release information has been obtained from the member/responsibility person;
- H. To foster parents and/or persons certified to adopt if necessary to assist in the placement with or care of a child(ren) by such persons;
- I. To an officer of the superior court, the Department, or any agency required to perform an investigation, if the information is pertinent to the investigation. All information received by the officer, the department or agency pursuant to this paragraph may be disclosed to the court but shall otherwise be maintained as confidential; and,
- J. A standing committee of the legislature, a committee appointed by the President of the Senate, or the Speaker of the House of Representatives may obtain the information upon written notification to the director.

Any receiver of confidential information is prohibited from using/releasing the information except in the performance of his/her duties, as defined by statute. Any questions should be referred to the Office of Compliance and Review (OCR).

6001-E VIOLATIONS AND PENALTIES

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-204

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE'S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.

6001-F CASE RECORDS

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.A.C. R6-6-202(B), R6-6-110(B)(8)(9), R6-6-114(14); 42 CFR 483.410(c)(1)(6).

Central Case Records

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), maintains a central (main) case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to a member, and is kept in a location designated by the local confidentiality officer/designee, but usually in the Support Coordinator/QIDP's office. Main case records are available to the member or responsible person upon request, verbally or written.

The Support Coordinator is responsible for making sure that all information generated regarding services to the member, is documented in the central case record. Central case records are required to contain the following:

- A. A copy of the member's ISP/Individual Education Plan (IEP);
- B. Program data and progress notes;
- C. The member's identifying information and a brief social history;
- D. Pertinent health/medical information;
- E. Current evaluative data/assessments;
- F. Authorization for emergency care, if appropriate;
- G. Visitation records, if appropriate;
- H. Record of financial disbursements, if appropriate;
- I. Active treatment schedule (ICF/IID);
- J. Resident fact sheet, if appropriate;
- K. Periodic dental records, if appropriate;
- L. ICAP, if appropriate;
- M. Documentation regarding the protection of member rights;
- N. An accepted diagnosis/diagnostic scheme;
- O. Documentation of an evaluation that identifies the member's specific needs;

- P. Reviews/modifications to the ISP/IFSP/IEP;
- Q. Communication among persons involved with the member and his/her program;
- R. Documentation of protection of the legal rights of each person served, staff the Department, or contract providers by recording all actions that may significantly affect these rights;
- S. Documentation to furnish a basis of review, study and evaluation of overall programs provided by DES/DDD;
- T. Member primary data from ASSISTS; and,
- U. For members residing in a Nursing Facility (NF) placed on termination status, a Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs, documentation of the member's choice of placement and the reason for non-placement in a NF placed on termination status for a new placement.

Case records, where applicable, shall contain the following additional documentation:

- A. Of Arizona Long Term Care System (ALTCS) eligibility;
- B. Utilization review report;
- C. Current photograph of the member;
- D. Physician's statement of need;
- E. Pre-Admission Screening;
- F. Psychological evaluations/social history;
- G. Medication history;
- H. Immunization record;
- I. Incident, injury, illness and treatment reports including hospital stays;
- J. Seizure reports;
- K. Records of contacts/referrals, etc.;
- L. An accounting ledger;
- M. Authorization for emergency care;
- N. Behavioral health records as described in this Policy Manual; and

- O. Other pertinent information.

Program/Service Records

Occasionally the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records. The Confidentiality Officer, Support Coordinator or QIDP is responsible for assuring that files are available at each site where the member receives services, as appropriate, that the Support Coordinator/QIDP has access to such files, and that a summary of information contained in such records is entered into the member's main record. These files shall also contain:

- A. The name/address and phone number of the physician or health facility providing medical care;
- B. Reports of accidents, illness, and treatments;
- C. Reports of significant behavioral incidents;
- D. Current medication treatment plan;
- E. A description of the member's specialized needs;
- F. A copy of the ISP/IEP;
- G. Program data/progress notes;
- H. Identifying information/social summary;
- I. Pertinent health/medical information;
- J. Current evaluative data/assessments;
- K. Authorization for emergency care;
- L. Visitation records;
- M. Records of financial disbursements;
- N. Active treatment schedule (ICF/IID);
- O. Resident fact sheet; and where applicable
- P. Periodic dental reports.

Each member's case record must include current consents. A medical consent signed by the member or the responsible person shall be required in the event of emergency medical care, routine medical care, and special procedures.

6001-G DOCUMENTATION REQUIREMENTS

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

All documentation entered into a case record must be in ink or typed, legibly written in non-technical terminology if possible, and dated, and signed by the person making the entry. In case of an error in documentation, cross out the error with a single line and initial it. Do not erase or use "White Out". If room remains on a Progress Note page, draw a line through the remaining spaces after your signature. Each case record shall include a legend for explaining symbols, and abbreviations.

The Support Coordinator has primary responsibility for assuring that case records contain all of the required documentation, and that such documentation meets the criteria set forth in this Chapter by being complete, accurate, timely, and reflective of the member's programmatic, social, medical, developmental, educational, or vocational status.

6001-H RECORDS STORAGE AND SECURITY

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297.

Internal

Case records for members currently eligible for services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) are considered active records. Active files may contain too much information to be confined to one case record. Overflow files may be established, and utilized to store non-essential, out-dated information.

Once established, overflow files are considered inactive, and can contain progress notes, Individual Support Plans (ISP), correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, Qualified Intellectual Disabilities Professional (QIDP), or the Confidentiality Officer must note in the most current active record that there is an overflow(s) file, and indicate where it is stored.

Although these case records can be maintained within DES/DDD in a place designated by the confidentiality officer for a period of time, the Support Coordinator/QIDP should coordinate the transfer of overflow/inactive files to the State of Arizona Records Management Center (813Z), for storage and retention. See this chapter for procedural information.

External

The Records Center is the DES official depository for inactive case records. The Records Center provides storage, retrieval and re-file services for DES.

To transfer inactive files for storage/retention, staff must:

- A. Review the records retention schedule to determine that the records are appropriate for retention at this time;
- B. Pack records into standard boxes 15" L X 12" W X 10" H leaving a minimum of two (2) inches of space to permit retrieval;
- C. Complete a J-239, *DES Records Storage Transmittal (Appendix 1800.C)*, and forward it to the DES Records Center at 813Z;
- D. Assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up; and,
- E. Upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, complete a J-240, *Records Reference Request* and send it to DES Records Center at 813Z.

Destruction of Records

Records will be destroyed in accordance with the records retention schedule in compliance with A.R.S. § 12-2297.

6001-I MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

REVISION DATE: 9/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 12-2297; 45 CFR 164.530(j)(2).

The Division will maintain all records for a period of five years from the date of final payment under contract with Arizona Health Care Cost Containment System (AHCCCS) unless a longer period of time is required by law.

For retention of the member's medical records, the Division will ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider shall retain the member's medical records according to the following:

- A. If the member is an adult, the Division will retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the Division.
- B. If the member is under 18 years of age, the Division will maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j) (2).

If the Division's contract with AHCCCS is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Division's contract with AHCCCS, or costs and expenses of the Division's contract with AHCCCS to which exception has been taken by AHCCCS, shall be retained by the Division for a period of five years after the date of final disposition or resolution thereof.

6002-A DEFINITIONS OF INCIDENTS AND SERIOUS INCIDENTS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

An Incident is defined as an occurrence, which could potentially affect the health and well-being of a member enrolled with the Division or poses a risk to the community. If the incident is determined to be "serious" as defined in this policy, the "Serious Incident" section of this policy shall be followed.

Incidents

Incidents include, but are not limited to:

- A. Death of member;
- B. Potentially dangerous situations due to neglect of the member;
- C. Allegations of sexual, physical, programmatic, verbal/emotional abuse;
- D. Suicide threats and attempts;
- E. Member missing;
- F. Accidental injuries which may or may not result in medical intervention;
- G. Violation of a member's rights as stated in this policy manual;
- H. Provider and/or member fraud;
- I. Complaints about a community residential setting, resident or the qualified vendor;
- J. Allegations of inappropriate sexual behavior;
- K. Theft or loss of member's money or property;
- L. Use of emergency measures;
- M. Medication errors such as:
 - 1. Wastage of a Class II substance;
 - 2. Giving medication to the wrong member;
 - 3. Wrong method of medication administration;
 - 4. Wrong dosage administered; or,
 - 5. Missed medications;

- N. Community disturbances in which the member or the public may have been placed at risk;
- O. Serious work related illnesses or injuries (Division employees). (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee] ;)
- P. Threats to Division employees or state property (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee]); and accidents on state property involving non-member/non-employees. (See DES Policy # DES 1-07-02B, Unusual Incident Reporting [Client] ;)
- Q. Environmental circumstances which pose a threat to health, safety or welfare of members such as loss of air conditioning, loss of water or loss of electricity;
- R. Unplanned hospitalization or emergency room visit in response to an illness, injury, medication error;
- S. Unusual weather conditions or other disasters resulting in an emergency change of operations; or,
- T. Provider drug use.

Serious Incidents

A Serious Incident is an extraordinary event involving a member, facility, or employed/contracted worker. A serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media.

Serious incidents include, but are not limited to the following:

- A. All deaths;
- B. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a member or staff member;
- C. Severe physical injury that:
 - 1. Creates a reasonable risk of death;
 - 2. Causes serious or permanent disfigurement: or,
 - 3. Causes serious impairment of a member's or worker's health;
- D. Property damage estimated in excess of \$10,000;
- E. Theft or loss of a member's money or property of more than \$1,000;
- F. Reporting to law enforcement officials because a Division enrolled member is missing and presumed to be in imminent danger;

- G. Reporting to law enforcement officials due to possession and/or use of illegal substances by members or staff/providers;
- H. A 9-1-1 call due to a suicide attempt by a member; or,
- I. An incident or complaint from the community that could be or is reported by the media.

6002-B INCIDENT MANAGEMENT SYSTEM (IMS) DEFINITIONS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

The following definitions are used when entering incidents into the Incident Management System (IMS) database. Incidents are entered by the type which is the main reason for the incident and category which is the main classification for the incident.

- A. *Accidental Injury*: a non-intentional or unexpected injury.
- B. *Member Missing*: an incident in which a member without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides.
- C. *Community Complaint*: a complaint from the community that puts a member or the community at risk of harm.
- D. *Death*: "expected" (natural), "unexpected" (unnatural) or "no provider present".
 - 1. *Expected deaths*: may include deaths from long-standing, progressive medical conditions, or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer's/Parkinson's Disease, severe congenital malformations that have never been stabilized.
 - 2. *Unexpected deaths*: include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions, (i.e. seizures, pneumonia, falls) that progress to rapid deterioration.
 - 3. *No provider present*: refers to deaths of members living independently or with family and no provider is present at the time of the death. The "expected" or "unexpected" categories shall be used if a provider is present at the time of death.
- E. *Emergency Measure*: the use of physical management techniques (Client Intervention Techniques [CIT] level II) or behavior modifying medications in an emergency to manage a sudden, intense or out of control behavior.
- F. *Fact-finding*: a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident. The process could include: interviews with the member; Provider and/or Division staff; collection and/or review of member and provider documentation; and coordination with investigatory agencies.

- G. *Human Rights Violation*: a violation of a member's rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the State of Arizona. Human rights are defined in A.R.S § 36.551.01. as a violation of a member's dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one's own money, choosing what to eat.
- H. *Member*: a person enrolled with the Division of Developmental Disabilities.
- I. *Investigation*: collection of facts/information for the purpose of describing and explaining an incident. An investigation may be completed by law enforcement, Child Protective Services, Adult Protective Services, or other state agencies.
- J. *Legal*: an incident of alleged provider fraud/inappropriate billing, member exploitation through using a member to gain monetary or personal rewards, the possession or use of illegal drugs by provider or state staff.
- K. *Medication Error*: the administration of medication in an incorrect manner. This includes: giving medication to the wrong member, administering medication in the wrong method, giving the wrong dosage, or not administering the medication.
- L. *Neglect*: a pattern of conduct resulting in a deprivation of food, water, medication, medical services, shelter, or other services necessary to maintain physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty, or failure to carry out a prescribed treatment plan.

For example: in the case of children, the definition includes the substantial risk of harm due to inability or unwillingness of a parent, guardian or custodian to care for the child. This includes; supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child's health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

- M. *Other*: incidents which involve behavioral episodes without the use of physical restraints, hospitalizations or treatment at an emergency medical facility/urgent care facility due to medical conditions or illness.

Other Abuse: programmatic abuse, verbal/emotional abuse and sexual abuse.

1. *Programmatic Abuse*: aversive stimuli techniques not approved as part of a person's plan. This can include isolation, restraints, or not following an approved plan and/or treatment strategy.
2. *Verbal/Emotional Abuse*: remarks or actions directed at a member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory, or profane.
3. *Sexual Abuse*: any inappropriate interactions of a sexual nature toward or

solicited from a member with developmental disabilities.

- N. *Physical Abuse*: intentional infliction of pain or injury to a member.
- O. *Property Damage/Theft*: damage or theft of state property in a member-related incident, or the theft or damage of a member's property.
- P. *Provider*: any person, entity or person hired by the entity, who is paid, through contract or agreement to deliver services to any member.
- Q. *Suicide*:
 - 1. Attempted suicide with medical and/or police involvement; or,
 - 2. Threatened suicide with a statement from a member that they want to commit suicide.
- R. *A Health Care Acquired Condition (HCAC) inclusive of the Hospital Acquired Condition (HAC)*: as described under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.
 - 1. Foreign object retained after surgery;
 - 2. Air embolism;
 - 3. Blood incompatibility;
 - 4. Pressure ulcers stage III and IV;
 - 5. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burn, electric shock);
 - 6. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity);
 - 7. Catheter associated urinary tract infections (UTI);
 - 8. Vascular catheter-associated infection;
 - 9. Surgical site infection following: after coronary artery bypass surgery (CABG), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery) and orthopedic procedures (spine, neck, shoulder and elbow);
 - 10. Deep venous thrombosis or pulmonary embolism (DVT/PE) after total knee or hip replacement (does not include pediatric and obstetric patients);or,

11. Other Provider Preventable Conditions (OPPC) means a condition occurring in the inpatient and outpatient health care setting which Arizona Health Care Cost Containment (AHCCCS) has limited to the following;
 - a. Surgery on the wrong member;
 - b. Wrong surgery on a member; and,
 - c. Wrong site surgery.

6002-C REPORTING REQUIREMENTS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

When an incident occurs, take whatever actions are necessary to resolve the emergency and implement protective measures immediately for the person's safety, which may include calling 9-1-1 or taking other emergency action.

- A. As designated by law, medical professionals, psychologists, social workers, support coordinators, peace officers, and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters.

Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred are required to report such information immediately to a peace officer or protection services worker, (i.e., Adult/Department of Child Safety, Tribal Social Services.) Refer to Support Coordination and Incident Reporting in this Policy Manual for additional information regarding mandated reporting.

- B. Serious Incidents, as described in this chapter, are to be reported and written as soon as possible, but no later than 24 hours after the incident.

Within 24 hours of a serious incident, the following actions must be taken:

1. The provider shall notify the District of the serious incident;
 2. District personnel must enter the incident into the Incident Management System (IMS) database within 24 hours or the next business day if the incident occurs over a weekend or holiday;
 3. Notification to Responsible Person, i.e., guardian or family member - The responsible person shall be notified unless otherwise specified in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan). The procedures for notification of the responsible person shall be coordinated between the service provider and the Support Coordinator. The Support Coordinator or designated District staff member shall ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person shall also be notified of any follow up actions that occurs.
- C. All other incidents listed in the definitions section of this policy must be reported to the District by close of the next business day following the incident, and be entered by designated District personnel into the IMS database within 48 hours of notification (if applicable).
- D. Incidents occurring after normal business hours must meet the above reporting requirements.

6002-D MEMBERS AT-RISK IF MISSING

REVISION DATE: 5/20/16, 3/2/2015

EFFECTIVE DATE: July 31, 1993

The actions in this section are required when a vulnerable member leaves a Division funded setting without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in their Planning Document is missing longer than the plan provides.

A vulnerable member is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may be a danger to self or others require medication to control a condition such as diabetes, seizure disorder, or lack essential survival skills (such as the ability to communicate or move safely about the community). The Individual Support Plan team shall assess the potential risk of a member who may leave his or her service site without supervision and shall note the results of that assessment in the Individual Support Plan. If the member has prescribed medication, the Team shall contact the primary care physician and/or psychiatrist to determine if a potential medical risk may arise if the member goes without prescribed medication for any length of time; this shall be noted in the plan.

Provider Responsibilities:

- A. When a vulnerable member leaves a Division funded setting without planned alone time is missing and is at-risk of harm, or when a member with alone time as defined in their Planning Document is missing longer than the plan provides, the provider staff will:
 1. Conduct a search of the immediate area,
 2. If the member is not located within 15 minutes, provider staff will notify the program supervisor/other staff to assist with the search,
 3. If the member is not found within thirty minutes, the provider must notify law enforcement agencies (e.g., Police, Sheriff's Office) in both the immediate and surrounding communities and the parent/guardian,
 4. To assist in locating the member, also contact the following entities during the search: hospitals, shelters, jails and bus stations,
 5. If the member is not located within one hour, the provider must notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends, or
 6. The provider will report the following information to the Division and submit a written incident report within 24 hours:
 - a. Age of member,

- b. General description of the person,
 - c. Time and location of disappearance,
 - d. Efforts to locate member,
 - e. Vulnerability,
 - f. Means of communication,
 - g. Medical or special needs,
 - h. Precursors to disappearance,
 - i. Time police and parents/guardian notified,
 - j. Other entities contacted, and
 - k. Legal status (e.g., foster care, probation).
- B. If the member is located within one hour, the provider will notify the parent/guardian immediately and provide notification to the Division within 24 hours.

Media Involvement

The decision to contact the media for assistance in locating a member will be a collaborative agreement between the Division, law enforcement officials, the parent/guardian and the provider.

- A. Prior to contact with the media, the provider will obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.
- B. As authorized, the provider will work directly with law enforcement officials by providing essential information about the member to be released to the media. Law enforcement will make the request for release of the vulnerable member's information to the media.
- C. Support Coordination will immediately notify the District's Program Manager or designee when a media release is requested.
- D. District Program Manager/designee will notify the Division's Assistant Director or designee for notification to the Department's Director and Public Information Officer.

Planning Team Responsibilities

The member's Planning Team will meet to discuss the incident within 30 days or as designated in the Behavior Plan to review the appropriateness of the current plan and Risk Assessment Tool.

6002-E INCIDENT REPORTS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

The Incident Management System (IMS) is the computerized database for incidents and reports.

- A. All incidents meeting the criteria of the IMS including serious incidents must be entered into the IMS as defined in this policy.
- B. Reporting an incident
 - 1. Provider's may use the Division's *Incident Report* Form to report incidents, or,
 - 2. A provider's own internal incident report form may be used to record incidents as defined in this policy.
- C. Incident Reports shall:
 - 1. Be written clearly, objectively, and in order of occurrence without reference to the writer's opinion. Incident reports may be available to family/guardians and are considered legal documentation.
 - 2. Include demographic information (i.e., full name, address, date of birth and Focus ID number) about the member.
 - 3. Include the names and job titles of staff that witnessed or were involved in the alleged incident.
 - 4. Include a description of the incident including all known facts, location, and the date and time the incident occurred.
 - 5. Include causes of injury (if applicable).
 - 6. State whether the responsible person was notified and, if not, why.
 - 7. Include whether or not law enforcement, Adult/Department of Child Safety or Tribal Social Services were contacted.
 - 8. Include signatures and names of the person completing the report and his/her supervisor and any additional comments.
 - 9. Be completed for each individual involved in the incident and reference other individuals by initials only.
 - 10. Be included in the member's primary record maintained by the Support Coordinator and by the provider completing the report.

6002-F FACT FINDING

REVISION DATE: 10/1/2014

EFFECTIVE DATE: July 31, 1993

The Division may initiate a fact-find of any incident. Except when such action would compromise the legal investigation by law enforcement, Protective Services, or another State Agency (i.e., DES Office of Licensure, Certification, and Regulation, an Office of the Inspector General (OIG)) the Division should notify the service provider of the onset of a fact find.

Service providers shall ensure that any service provider worker alleged to have endangered the health or safety of an individual shall not have direct contact with any individual served by the Division, pending the outcome of the Division's fact finding activities.

Division staff is responsible for notifying and assigning appropriate personnel to initiate fact-finding.

The District Program Manager is responsible to assign only qualified Division personnel to complete a fact-finding. Division personnel assigned to conduct a fact finding will meet the following qualifications:

- A. Have demonstrated ability to be objective;
- B. Can maintain confidentiality;
- C. Can complete the task within the assigned period;
- D. Have expertise regarding the particular situation; and,
- E. Have no conflict of interest involving the situation.

The staff assigned to complete fact finding of any incident must have successfully completed fact-finding training offered by the Division.

When a fact-finding of an incident occurs, the following apply:

- A. Protective measures must be taken immediately for the person's safety.
- B. Initiation of the fact-finding occurs within 24 hours of notification or the next business day for the following incidents:
 - 1. Allegations of physical abuse which results in medical treatment or police involvement;
 - 2. Allegations of sexual abuse;
 - 3. High risk incidents of member missing;

4. Attempted suicide;
 5. Unexpected deaths;
 6. Allegations of neglect that involve imminent danger; or,
 7. Accidental injuries involving hospitalization.
- C. Fact-Findings are initiated within 10 days of notification for:
1. Allegations of physical abuse which do not result in medical/police intervention;
 2. Allegations of verbal/emotional or programmatic abuse;
 3. Community complaints;
 4. State property damage or theft above \$100;
 5. Member property damage or theft over \$25;
 6. Expected deaths;
 7. Allegations of human rights violations;
 8. Allegations of neglect that involve potential danger;
 9. Accidental injuries that resulted in medical intervention; or,
 10. Legal issues involving allegations of fraud, member exploitation, or provider drug use.

The fact-finding may involve a review of the provider's incident reports, as well as a review of other records maintained in the provision of services. A fact-finding will typically include interviewing the person reporting the incident, the service provider, and/or members who might have additional information or insight regarding the incident.

If an external investigation is initiated, the Division may delay its fact-finding until Office of Special Investigations, Department of Child Safety (DCS), Adult Protective Services, Tribal Social Services, law enforcement personnel, or other State Agencies (e.g.,: DES Office of Licensing Certification and Regulation [OLCR], OIG) have completed their investigation, to avoid potential conflicts. If another state agency is involved, the assigned Division employee must coordinate efforts with that agency.

Conclusion of the Division's fact-finding shall be within 30 days from notification date of the incident. A fact-finding can be extended an additional 30 days twice for a total of 90 days if more time is needed to allow DCS, Adult Protective Services, Tribal Social Services, law enforcement or, other state agencies to complete their investigation and provide the results to the Division.

6002-G ABUSE AND NEGLECT

REVISION DATE: 10/1/2014

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 36-561(B), 13-3620, 46-454, 46-451.

Definitions

Abuse:

- A. Intentional infliction of physical harm;
- B. Injury caused by negligent acts or omissions;
- C. Unreasonable confinement or unlawful imprisonment; or,
- D. Sexual abuse or sexual assault.

Abusive treatment:

- A. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or any sexual abuses;
- B. Emotional abuse which includes ridiculing or demeaning a member, making derogatory remarks to an member or cursing directed towards an member; or,
- C. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Individual Support Plan (ISP) and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

Child, youth or juvenile: a member who is under the age of eighteen years.

Exploitation: the illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

Incapacity: an impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

Neglect: a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health. Neglect also means:

- A. Intentional lack of attention to physical needs of members such as toileting, bathing, meals, and safety;
- B. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse;

- C. Sleeping on duty or abandoning work station; or,
- D. Intentional failure to carry out a prescribed treatment plan for a member.

Physical injury: the impairment of physical condition includes, but shall not be limited to any skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

Serious physical injury: physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, serious impairment of health or loss, or protracted impairment of the function of any bodily organ or limb.

Vulnerable adult: a member who is eighteen 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.

Department of Child Safety

When a Support Coordinator suspects abuse or neglect, as a mandated reporter, the Support Coordinator must immediately report to Department of Child Safety (DCS). Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator shall cooperate during investigations, and follow-up as required.

Reports made regarding American Indians will be in accordance with tribal procedures.

Reports

Reports made to DCS shall contain:

- A. The names, and addresses of the minor and his/her parents or person or persons having custody of such minor;
- B. The minor's age, and the nature, and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect; and,
- C. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

A copy of the *Incident Report*, and the *Child Abuse Reporting Form* will be forwarded to the DCS Hotline within 24 hours.

Incident Report

When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator shall complete an Incident Report (IR) in the Incident Management System. The District will ensure the DCS Program Manager receives an information copy of all IRs on DCS referrals from Division staff.

When DCS staff reports alleged abuse or neglect made by someone other than Division staff, the Support Coordinator will complete and forward an IR.

Investigative Procedures

It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. The Support Coordinator shall receive the results of the investigative decision by DCS. If, subsequent to an investigation, DCS opens a case, the Support Coordinator shall participate in a team staffing to develop a collaborative plan.

Working with Department of Child Safety

The Support Coordinator shall work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

Whenever possible, the Support Coordinator shall meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information. The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

Adult Protective Services

In accordance with A.R.S. §46-454, as a mandated reporter, the Support Coordinator or other Division staff shall immediately report any suspicions/allegations of abuse, neglect or exploitation of an adult to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements the person:

- A. Is 18 years of age or older; and,
- B. Is a vulnerable adult as defined in A.R.S. § 46-451.

Reports

Reports made to APS shall contain:

- A. The names and addresses of the adult and any persons having control or custody of the adult, if known;

- B. The adult's age, and the nature, and extent of his/her incapacity or vulnerability;
- C. The nature, and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property; and,
- D. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

A written follow-up report shall be mailed or delivered to the police officer or local adult protective services worker within 48 hours or on the next working day if the 48 hours expire on a weekend or holiday.

When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together with the Support Coordinator or other Division staff as appropriate. Specific responsibilities are decided on a case-by-case basis. The APS worker will remain involved until the abuse or problem situation has been resolved.

When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS, and notification of the fact finding process. DES/DDD staff, as appropriate, will conduct a fact- find to determine program, and contract compliance issues.

Incident Report

When a report is made to Adult Protective Services, the Support Coordinator shall complete an Incident Report (IR), following procedures established in this policy manual.

Working with Adult Protective Service

The Support Coordinator shall work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

Whenever possible, the Support Coordinator shall meet in person with the APS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator shall notify his/her immediate supervisor whenever issues cannot be quickly, and satisfactorily resolved at the Support Coordination level. The Support Coordinator shall cooperate during investigations, and follow-up as required. Supervisory and/or management staff shall immediately pursue the steps necessary to resolve the issues.

6002-H REFERRAL TO OTHER INVESTIGATIVE AGENCIES

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

The Assistant Director or the Office of Compliance and Review may refer incidents for investigation to the Department of Economic Security (DES) Office of Special Investigations. An external investigation request may be made for incidents involving:

- A. Potential criminal activity;
- B. Possible misconduct by a Division or service provider's employee; or,
- C. Fraud (this type of incident will also be referred to Arizona Health Care Cost Containment System (AHCCCS), as appropriate).

6002-I INCIDENT CLOSURE AND CORRECTIVE ACTIONS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

A. An incident is complete when:

1. The fact finding if needed is reviewed and approved by the Division;
2. Recommendations for corrective action are identified and provided to appropriate Division and provider personnel;
3. Corrective action plans, if needed, are requested, and received from the provider and approved by the Division; or,
4. Designated District personnel have verified the information entered into the Incident Management System (IMS) database and have verified that all corrective actions have been completed no later than 60 days from the acceptance of for a plan.

B. Corrective actions may be member-specific or systemic.

An example of a member-specific corrective action would be requiring the person's Planning Team to reconvene to discuss the incident and review the need for any changes in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan) to ensure the health and safety of the member.

Systemic corrective actions may require the provider to rewrite or clarify agency policy, procedure, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of members served.

- C. The member's Planning Team shall review all incidents for the effectiveness of services and assess risk as part of the Planning Document and update the process.
- D. The Division's Program Monitoring staff (at the Central Office and District Level) shall review all incidents for residential placements and Day Treatment & Training programs to be monitored prior to the visit to identify any areas that may warrant extra monitoring.

6002-J TRENDING FOR QUALITY IMPROVEMENT

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Trending is an essential component of the Incident Management System (IMS).

District Quality Management lead will compile District specific quarterly data analysis reports and submit to the Quality Management unit. The content will include at a minimum:

- A. Total incidents by type and category, provider and member;
- B. Trends by provider and member including:
 - 1. Total allegations of abuse, neglect, and exploitation, and,
 - 2. Information of whether or not the allegation was substantiated; and,
- C. A narrative analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

The Division's Central Office designee will prepare a Statewide Incident Summary Report monthly and annually and will include at a minimum:

- A. Total incidents by type and category by district;
- B. Trends by provider and member including:
 - 1. Total allegations of abuse, neglect and exploitation;
 - 2. Information of whether or not the allegation was substantiated.
- C. In a narrative format an analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

Incident Summary Reports will be provided to the Quality Administrator, the Assistant Director and to designated personnel.

The Division Management Team and Statewide Quality Management Committee will formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, focus studies will be completed by the Central Office designee, District Quality Management leads or designee. If the focus study confirms any areas of concerns or patterns, corrective actions will be recommended for quality improvement.

6002-K INFORMATION SHARING

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Incident reports may be made available to:

- A. The Human Rights Committees as prescribed in this policy manual;
- B. The member/responsible person(s);
- C. Others who are bound by confidentiality on a need to know basis; and, or,
- D. All requests should be directed to the Office of Compliance and Review.

Fact finding reports and action plans are confidential. Fact-finding and corrective action plans are summarized in the Incident Management System (IMS) Fact Finding screens.

6002-L MORTALITY REVIEW AUDITS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations, and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, i.e., entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance, or management information system change.

6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 11-597

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will forward the information to their District Quality Unit's Incident Report (IR) Central for entry into the Incident Management System (IMS) database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, they will notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance Manager or designee will also immediately notify the appropriate District Manager or designee within 24 hours of the Division's notification of a member's death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support coordination (Department of Child Safety) and Bereavement Counseling offered to the family may remain authorized after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member's death, it should be reported into the IMS.

If Health Care Services staff is notified of a death, they will notify the Central Office on-call person within 24 hours.

The District Manager or designee will notify the Assistant Director/designee or the Division's on-call line within 24 hours of being notified of a death, as well as the Adult or Department of Child Safety agency as required by statute. The District Manager or designee will also notify the Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk Management if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. All deaths are to be reviewed jointly by the Support Coordinator and his/her supervisor within 30 days, to identify apparent issues relating to care or cause of death.

2. The Support Coordinator or designee will enter the following information, as applicable, relating to the death into the IMS database:
 - a. Member's underlying primary medical conditions.
 - b. Detailed circumstances of the death Date of Death? What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?
 - c. Was Hospice involved?
 - d. Did the member have an Advance Directive in place?
 - e. Had Department of Child Safety/Adult Protective Services (DCS/APS) been involved within the last year?
 - f. Is there litigation pending?
 - g. Is there further fact-finding pending?
 - h. Was the family/guardian notified?
 - i. Did the Division offer support/grief counseling for the family?
 3. The District will send the primary case file to Central Office Health care Services within 60 days after being notified of the death.
- B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review
1. The Health Care Services Quality Assurance (QA) Nurse reviews the mortality information documented in the IMS database and requests further information, as necessary.
 2. The Chief Medical Officer assigns the death into one of the following categories:
 - Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.

- Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/9-1-1 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and problems with emergency or other medical care.
- C. The HCS QA Nurse requests death certificates and when indicated, autopsy reports.
 - D. The HCS QA Nurse gathers additional medical records for review when indicated.
 - E. The HCS QA Nurse tracks mortality information in a database specifically designed to collect information related to member deaths.
 - F. The Chief Medical Officer communicates via IMS the status of the mortality review and when the case is considered closed. The Chief Medical Officer shares any recommendations in the summary.
 - G. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting; the selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made.

Mortality Committee Review

- A. The Committee shall discuss each case selected and identify changes to practice e, training, or processes that may positively affect care and treatment. The Committee shall report in writing their recommendations to the Management Team.
- B. Within 30 days of receiving a recommendation from the Committee, the Management Team shall report their disposition and intended steps to respond to recommendation(s).
- C. Following the Mortality Review Committee review, the case shall be closed unless it is referred for Level C review.

Review Level C – Root Cause Analysis Review

- A. Root Cause Analysis, which will follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, will be arranged by the Chief Medical Officer and will be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.
- B. No more than 3 Root Cause Analyses shall be conducted in a fiscal year.

- C. The HCS QA Nurse shall monitor the implementation of recommendations from a Root Cause Analysis.

Process

- A. The Mortality Review Committee shall meet at least quarterly.
- B. The Chief Medical Officer shall issue annually a Mortality Review and Analysis, which will aggregate, analyze, and summarize mortality data and actions taken for system improvements.
- C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.
- D. Autopsies should always be requested for children in foster care. For all other deaths, requests should be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved. A request for an autopsy should follow these steps in priority order:
1. Arizona Revised Statute 11-597 (www.azleg.gov/) provides for County Medical Examiners to complete an autopsy and outlines when this is required.
 2. When the Medical Examiner does not identify a need for an autopsy, the Division can request the family to authorize an autopsy, at the expense of the Division, when the Division's Chief Medical Officer believes there are unanswered questions surrounding the death.
 3. Autopsy reports will be requested by the HCS QA Nurse.
- E. Death Certificates will be requested by the HCS QA Nurse.
- F. Reviewers and all others involved with these processes shall in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.

6002-N FRAUD AND FALSE CLAIMS

REVISION DATE: 6/10/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: ARS §§ 13-1802, 13-2002, 13-2310, 13-2311, 36-2918;
Arizona Administrative Code Title 6, Chapter 6, Articles 8, 10, 11, and 15; 42 CFR 455.2.

Overview

This section defines fraud and describes the procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

- A. Prevent or detect fraud and abuse,
- B. Delineate reporting requirements,
- C. Define investigative procedures,
- D. Explain corporate compliance,
- E. Describe training requirements, and
- F. Specify policy requirements for providers.

Definitions

Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary or which fail to meet professionally recognized standards for health care.

Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

- A. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.
- B. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

- C. Conspires with others to get a false or fraudulent claim paid by the Federal Government.
- D. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government.

Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention - Keep something from happening.

Primary Contact - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS in the manner prescribed in this policy.

Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual, All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

Remit Advice - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pending. Reason codes are attached and summarized for those lines denied.

Prevention and Detection

The Division has established internal controls on the member payment system including claim edits and prior authorization requirements. The Division produces reports to review high utilization by members (CLT_0060), underutilization by members (CLT_0150), service cost, and units by service title, month by month over the fiscal year, and other reports for analysis. The Business Operations Unit as outlined below conducts a post-payment review process.

A. Claims Edits

All claims are edited through a computerized system. When a claim is entered in the system for payment the system checks to ensure that a completed authorization is in place. System edits prevent payment for incomplete or absent authorizations and/or duplicate claim submittals.

The Division also segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

The Division reviews detailed "remit advices". Additionally, the Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services are prior authorized. Prior authorization occurs within the guidelines set forth in this policy manual and the AHCCCS Medical Policy Manual.

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

E. Contract Provisions

All providers shall comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement".

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff. Fraud can be reported to the Division by anyone in writing or by phone reports can be made by calling the appropriate District Office. The Office of Compliance and Review can be contacted directly to report fraud as well as by calling 1.866.229.5553 or submitting information to:

Division of Developmental Disabilities
Office of Compliance and Review
1789 W. Jefferson St
Phoenix, AZ 85007

All the Division employees and providers shall comply with this chapter. The Manager of the Division Office of Compliance and Review shall report potential incidents to AHCCCS utilizing the AHCCCS prescribed form.

False Claims Act

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of \$5,500 to \$11,000 for each false claim.

An individual can receive an award for “blowing the whistle” under the FCA. In order to receive an award the person must file a “qui tam” lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government’s participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The “whistle blower” is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

Any provider receiving at least \$5,000,000 in annual payments through the Division; shall establish written policies for all employees regarding Fraud and the FCA requirements.

Corporate Compliance

The Corporate Compliance Officer implements, oversees, and administers the Division’s compliance program including fraud and abuse control. The Corporate Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the monthly Corporate and Quality Data Analysis Committee. The committee includes the Chief Medical Officer, Quality Management Administrator, Quality Assurance staff, Office of Compliance and Review Manager, Resolution Unit, Arizona Long Term Care System (ALTCS) Administrator and Business Operations Administrator. The monthly agenda includes a review of all Incident Management System data for the past month (including suspected fraud); Resolution System data for the past month; Program Monitoring reviews for the past month; claim disputes, appeals, and state fair hearings for the past month; and any other data available, including results from post-payment reviews. The committee will make recommendations for improvement of the compliance program as identified through the analysis and review of reports. The Division’s Compliance Unit reports any suspected fraud or false claims incidents to the appropriate AHCCCS entity as required by contract and/or AHCCCS policy.

Training

The Division has available training through both the continuous core curriculum as well as Computer Based Training regarding the FCA. In addition, the Office of Compliance and Review provides on-going standalone training to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

6002-O HEALTH CARE ACQUIRED CONDITIONS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Identification and Reporting

Any Health Care Acquired Conditions (HCAC) occurrence that has been identified and verified will be entered into the Division's Information Management System (IMS) by the Health Care Services (HCS) Quality Assurance Registered Nurse/designee who has the final determination of confirmed HCAC occurrence and will enter each confirmed HCAC as an Incident Report (IR) within twenty-four (24) hours of confirmation. These IR's will be reviewed on a daily basis for reporting to Arizona Health Care Cost Containment System (AHCCCS), by the Division's HCS Quality Assurance Registered Nurse. In addition, a report could be made to the appropriate regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, and Arizona State Board of Nursing).

6003-A DEFINITIONS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Action: a written decision made by the Division not agreed upon by the member/responsible person, when Arizona Long Term Care System (ALTCS) actions include:

- A. Service denial or a limited authorization (an authorization in an amount, duration or scope less than what is ordered or requested) of a requested service, including the type or level of service, is granted; or
- B. A previously authorized service is reduced, suspended, or terminated;
- C. Payment for a service, in whole or in part, is denied in accordance with the Arizona Administrative Codes;
- D. Authorization of services not initiated in a timely manner; or,
- E. A request by a member, who resides in a rural area with only one health plan, is denied his/her right to obtain services outside the network.

ALTCS Notice of Action: the written notice to the affected member regarding an action by the Division.

Appeal: formal process under ALTCS to request a review of an action taken by the Division.

Administrative Decision: the formal decision made by the Office of Compliance and Review (OCR) related to a state funded service, including eligibility.

Administrative Review: formal review and investigation of the stated issues conducted by the OCR or assigned designee.

Grievance: a member/responsible person's expression of dissatisfaction with any aspect of a member's care not involving an action.

Notice of Intended Action: a letter from the Division related to a state funded service informing the member/responsible person of the decision and the member/responsible person's due process rights.

Notice of Appeal Resolution: the formal written decision made by the OCR regarding an ALTCS covered service.

6003-B INFORMAL RESOLUTION/GRIEVANCE PROCESS NON-ARIZONA LONG TERM CARE SERVICES

REVISION DATE: 7/22/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

A member/responsible person may have a grievance or expression of dissatisfaction with any aspect of his/her care such as a quality of care issue or problems related to communication or courtesy. A member or his/her responsible person will be encouraged to discuss any problems with the Support Coordinator as soon as they arise to seek resolution. The Support Coordinator is responsible for reviewing the grievance(s) and attempting to resolve it informally before the grievance is elevated to the Office of Family and Community Resources.

If necessary, the Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution. At any time, the member or his/her responsible person may contact the Support Coordinator's Supervisor or Program Manager.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone, or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the progress notes.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Office of Family and Community Resources will advise the member or his/her responsible person in writing of the resolution of the grievance no later than ninety (90) calendar days from the receipt of the grievance and will record all results in the Resolution System .

6003-C APPEAL PROCESS FOR MEMBERS WHO RECEIVE STATE FUNDED SERVICES

REVISION DATE: 2/26/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the Department of Economic Security (DES) Office of Appeals. The appeal request must be made in writing and received by Office of Compliance and Review (OCR) no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OCR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and the record supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified by the Hearing Officer of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than 15 calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-D NOTICE OF INTENDED ACTION (STATE ONLY)

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1802

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

- A. Service denial, change, reduction, termination; or,
- B. Eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action* or *Service System Discharge*, and include the following information:

- A. The name and address of the responsible person;
- B. The date that the notice is mailed;
- C. The name of the member affected by this action;
- D. The action that is being taken;
- E. The effective date of the action;
- F. The reason for the action;
- G. What the member/responsible person can do if he/she does not agree with the action being taken; and,
- H. The signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with interpretation.

6003-E ADMINISTRATIVE REVIEW PROCESS (STATE ONLY)

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1803

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Compliance and Review (OCR). Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

- A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.
- B. Responsible person's name, relationship, and telephone number.
- C. Support Coordinator's name and telephone number.
- D. Physician's name, if applicable.
- E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Site Code 016F
Phoenix, Arizona 85012

OCR will complete a review and investigation of the stated issues. OCR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OCR within 5 calendar days. OCR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if necessitated by a change in health status).

6003-F FAIR HEARINGS AND APPEALS

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Further appeal options depend on whether the member is Arizona Long Term Care Service (ALTCS) eligible or whether he/she receives state funded services. There are common components to the two appeal processes, which include:

- A. The hearing must be held at the established hearing location that is most convenient for the member or responsible person. The member and his/her responsible person must be informed of the date, time, and location of the hearing no less than 20 calendar days in advance for standard requests. At the discretion of the hearing officer, the hearing can be conducted by telephone.
- B. The hearing notice must state that the member or responsible person has the right to:
 - 1. Present his/her case in person or by telephone;
 - 2. Receive a copy of all case file documents, and any material that the Division will use in the hearing at a reasonable time before the hearing;
 - 3. Obtain assistance from the Division local office in preparing his/her case;
 - 4. Make inquiry at the Division local office concerning the availability of free legal resources; and
 - 5. Request a change of the hearing officer.
- C. Hearings must be conducted in an orderly manner by the hearing officer. The hearing officer can rule on the admissibility of evidence, and include or exclude witnesses. Parties may present evidence, cross examine witnesses, and present arguments.
- D. A complete record is made of all hearings. The member and his/her responsible person may inspect the record at a location that is accessible to them.
- E. The hearing decision must be based solely on the evidence and testimony presented at the hearing, appropriate state and federal law, and applicable Department of Economic Security (DES) rules.

6003-G ARIZONA LONG TERM CARE SERVICE GRIEVANCE PROCESS

REVISION DATE: 6/10/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

State Only

A member or his/her responsible person may have a complaint regarding an issue unrelated to a Notice of Intended Action, such as a quality of care issue or problems related to communication or courtesy. Members and their responsible persons will be encouraged to discuss any problems or complaints with the Support Coordinator as soon as they arise. The Support Coordinator is responsible for reviewing and investigating complaints and attempting to resolve them informally before they reach the grievance stage. The Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or his/her responsible person of the process for filing a grievance in person, by telephone, or in writing. The Support Coordinator's responsibilities do not extend to preparing the document for the member or the responsible person.

Arizona Long Term Care Service Members

The Support Coordinator must document the member's complaint, the Support Coordinator's attempts to resolve the complaint, and the fact that the member or his/her responsible person was advised of his/her right to file a grievance and the process for doing so. This documentation should be included in the case notes.

The Division will acknowledge receipt of a grievance orally or in writing. Receipt of grievances will be recorded in the Resolution Tracking System.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will provide written or oral notice of the grievance decision within 90 calendar days after the Division receives the grievance and will record all results in the Resolution Tracking System.

6003-H ARIZONA LONG TERM CARE SERVICE NOTICE OF ACTION

REVISION DATE: 3/2/2015

EFFECTIVE DATE: July 31, 1993

Reasons for Use

A Support Coordinator/designee or health plan representative must issue a written Notice of Action to any member/responsible person or authorized legal representative who receives services from the Division when the member or responsible person is not in agreement to an action that results in a requested service not being authorized in the amount, duration, or scope which was ordered/requested.

Standard Request

A Support Coordinator/designee or health plan representative will issue a written Notice of Action within 14 calendar days of the request for authorization of a service for a standard request to reduce, suspend, or terminate an authorized service.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within 3 working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.

A Notice of Action will be issued within 3 working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Action will be issued.

If a service request does not seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person orally to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than 2 calendar days to the member/responsible person. If the member/responsible person disagree, he/she is allowed to submit additional documentation to support the expedited request.

Notice of Extension

A Notice of Extension may be issued for up to 14 additional days if the Division requires further information to make a decision and it is in the member's best interest. When additional information is not received within the timeframes allowed, the service request will be denied.

Format

The notice must be issued on Division or health plan letterhead, written in an easily understood manner, and available in alternate formats. The notice must include the following information:

- A. The name and address of the responsible person;
- B. The date that the notice is mailed;
- C. The name of the member affected by this action;
- D. The action that has been taken or intends to be taken;
- E. The effective date of the action. A Notice for a previously authorized service must be sent at least 10 days before the date of the proposed termination, suspension, or reduction;
- F. The reason for the action;
- G. What the member/responsible person can do if he/she does not agree with this action;
- H. How to request an expedited resolution of the appeal;
- I. The circumstances under which services can be continued pending resolution of the appeal; and,
- J. The signature of the person authorized to make the decision regarding the determinations noted previously.

6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

REVISION DATE: 6/10/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.A.C. R9-34-209, R9-34-216.

Filing an Appeal

When a Notice of Action is given by the Division or health plan representative with whom the member/responsible person does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person. The Division will not take punitive action against a service provider who requests a resolution of the appeal or who supports the member's request for a resolution of the appeal.

The member/responsible person/authorized representative must file the appeal within 60 calendar days after the date of the Notice of Action either orally or in writing with the Office of Compliance and Review (OCR) at:

DDD Office of Compliance and Review
3443 N Central Ave, 9th Floor
Suite 916
Phoenix, Arizona 85012
602-771-8163 or 1-855-888-3106

At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal. OCR will acknowledge receipt of standard appeals in writing within five calendar days.

The Division will assist the member/responsible person with the completion of forms and other procedural steps, upon request. The member/responsible person/authorized representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/authorized representative is included as a party to the appeal process.

Standard Appeal Resolution Timeframe

The Division will respond to the standard appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within thirty (30) calendar days after the date the Division receives the appeal. The Division will extend the 30-day time frame up to an additional 14 calendar days upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 30-day time-frame if additional information is needed and the extension is in the best interest of the member. The OCR will provide the member/ responsible person written

notice of the reason for the decision to extend the 30-day time frame.

Expedited Appeals

The member/responsible person/authorized representative may request an expedited resolution of the appeal. The Division will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, OCR will promptly contact the member/responsible person orally to advise him/her of the denial. OCR will send written notice of the denial no later than 2 calendar days to the member/responsible person. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, OCR will promptly contact the member/responsible person orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/authorized representative within 3 working days after the day the Division receives the request for an expedited appeal. The Division will extend the 3-day time frame up to an additional 14 calendar days upon request by the member/responsible person. The Division may request a 14 calendar day extension of the 3-day time frame if additional information is needed and the extension is in the best interest of the member. OCR will provide the member/responsible person written notice of the reason for the decision to extend the 3-day time frame.

Appeal Decisions and Timeframes

The Division will ensure that the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 3 working days for an expedited, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/authorized representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

- A. The member's right to request a fair hearing and how to do so;
- B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;



- C. The factual and legal basis of the decision; and,
- D. The member/responsible person's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) decision.

If the Notice of Appeal Resolution is reversed, OCR will notify Support Coordination and the Health Plan, as appropriate. Upon notification services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division has the right to recover the cost of services from the member.

6003-J ARIZONA LONG TERM CARE SERVICES FAIR HEARING PROCESS

REVISION DATE: 6/10/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings (OAH). The fair hearing request must be filed in writing and received by Office of Compliance and Review (OCR) no later than 30 calendar days after receipt of the Notice of Appeal Resolution. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916, Phoenix, Arizona 85012

Once the hearing request is filed, OCR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OCR staff will submit the file to AHCCCS within five days. This file will include a cover letter, copy of the entire file, copies of the Notice of Action, request for fair hearing, investigative materials, and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is formal and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence, and the record supplied by OCR and the appellant, the ALJ will prepare written findings of fact and conclusions of law, and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and/or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services (OALS) no later than 30 calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The rehearing will be decided by the AHCCCS Director or designee and a final written decision on the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-K CLAIM DISPUTES

REVISION DATE: 6/10/2016, 1/15/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 36-2903.01(.8) (.4), 41.1 092; A.A.C R9-34-402, R9-34-405

Claim Dispute Process

A Division representative or health plan representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division or a Division subcontracted health plan.

When a notice is given by the Division or a Division subcontracted health plan with which the service provider does not agree, the service provider may file a claim dispute. A claim dispute will be accepted by the Division or the Division subcontracted health plan only if the dispute involves a payment of a claim, denial of a claim, an imposition of a sanction, or reinsurance.

The service provider must file the claim dispute in writing with either the Division or the Division subcontracted health plan. The claim dispute must be filed within 12 months after the date(s) of service, within 12 months after the date that the member's eligibility is posted or within 60 days after the date of the denial of a timely claim submission.

If the service provider submits the claim dispute directly to the Division subcontracted health plan, the Division subcontracted health plan will forward a copy of the claim dispute to the Division upon receipt. The Division or the Division subcontracted health plans date all claim disputes upon receipt. The Division or the Division subcontracted health plan will send the service provider a written notice acknowledging receipt of the claim dispute within five working days from the date the claim dispute is received. The Division or Division subcontracted health plan will advise the service provider that any additional information the service provider wishes to submit to the Division for consideration must be done so in 10 calendar days.

Office of Compliance and Review (OCR) staff may contact the service provider and the Division subcontracted health plan to obtain additional information. Division subcontracted health plans are required to provide all information related to their recommendation to deny or approve the claim dispute to OCR no later than 10 days after the Division subcontracted health plan receives the claim dispute. Relevant policies will be reviewed and Central Office staff will be consulted as necessary.

All claim disputes are thoroughly investigated using applicable authorities and facts obtained from all parties. The Division will issue a letter to the provider if there is a mutual agreement to extend the decision due date to allow the Division to make a decision or allow the provider additional time to submit supporting documentation. All extensions must be agreed upon by both parties. Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within 30 calendar days of receipt of the services provider's claim dispute unless the provider and the contractor agree to a longer period.

The Notice of Decision complies with regulatory and contractual requirements and includes:

- A. The date of the decision;
- B. The factual and legal basis for the decision; and,
- C. The service provider's right to request a fair hearing and how to do so.

State Fair Hearings for Claim Disputes

When a service provider does not agree with a Notice of Decision by the Division on a claim dispute, the service provider may file a request for a fair hearing by the Department of Economic Security (DES) Appellate Services Administration/Arizona Long Term Care System (ALTCS). The request for fair hearing must be made in writing and received by the OCR no later than 30 calendar days after receipt of the Notice of Decision. The request should be sent to:

DES/DDD
Office of Compliance and Review
3443 North Central Avenue, 9th Floor
Suite 916
Phoenix, Arizona 85012

Once the hearing request is made, OCR staff will prepare a duplicate file along with the hearing request for submission to the DES Appellate Services Administration/ALTCS and the Attorney General's Office. This file will include copies of the claim dispute, investigative materials, and the Notice of Decision.

The hearing will be scheduled by a DES Appellate Services Administration/ALTCS representative, and the service provider will receive written notification of the date and time. The DES Appellate Services Administration/ALTCS representative will also notify the Attorney General's Office and OCR of the scheduled hearing.

At the hearing, the service provider, a DES/Division of Developmental Disabilities (DDD) representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/ALTCS Hearing Officer. The rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and other records supplied by OCR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision. The DES Appellate Services Administration/ALTCS representative will forward a copy of the decision to the Arizona Health Care Cost Containment Service (AHCCCS) Office of Administrative Legal Services, the service provider, DES/DDD and the Attorney General's Office.

Petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the DES Appellate Services Administration/ALTCS Administrative Law Judge. The petition must completely explain the grounds on which rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If it is decided that a review will not be petitioned, the OCR will arrange with the appropriate Division staff and/or subcontracted health plan staff to authorize and make payment for the services as expeditiously as possible.

If the service provider is still not satisfied with the decision, the service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overtured or Reversed Claim Disputes

The Division or its subcontractors shall reprocess and pay overturned or reversed claim disputes within 15 business days of the date of the decision. The Division or its' subcontractors will make payments in a manner consistent with the decision.

6003-L ATTORNEYS AT PLANNING MEETINGS

REVISION DATE: 5/20/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

The member/responsible person may invite anyone to participate at planning meetings, including his/her attorney. It is recommended that the member/responsible person notify the Support Coordinator, at least two business days before the meeting is scheduled to occur, that legal counsel will participate with the responsible person at the planning meeting.

If prior notice is not given, the planning meeting may be postponed. If the Division's legal counsel is not present at the meeting and Division staff determines that legal counsel is needed, Division staff may temporarily stop the meeting in an effort to obtain legal counsel. In addition to Division staff, the Division may have an Assistant Attorney General at a meeting. Any meeting may be audio recorded.

6003-M CONDUCTING ALL MEETINGS

REVISION DATE: 2/26/2016, 1/15/16, 3/2/2015
EFFECTIVE DATE: July 31, 1993

To provide defined objectives and to allow for adequate meeting facilities complete the following:

- A. Clarify the purpose of the meeting;
- B. Check with the member/responsible person as to how many people they will have in attendance so adequate space will be provided and clarify with the family the names and titles of those attending from the Division; and,
- C. Schedule space appropriate for the number of people in attendance.

Tape Recording Meetings

Unless there are either pending grievances or legal actions, there is no prohibition for members/responsible persons to tape record Individual Support Plan (ISP) meetings. Canceling a meeting for this reason is not acceptable.

Requests for Member Information

In order to ensure uniformity and conformity, all requests for member information must be cleared through the Office of Compliance and Review (OCR). Situations include, but are not limited to:

- A. Any circumstance where staff may deem it necessary to initiate contact with an attorney or his/her staff; or,
- B. Any request for member records or communication regarding a member's services unless prior authorized by the OCR.

6004-A QUALITY MANAGEMENT

REVISION DATE: 8/30/2013

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§ 36-550, 36-595 et seq.; A.A.C. R6-6, R9-28, R9-33, R6-18; 42 CFR 438.66

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

- A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.
- B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.
- C. Oversight for determining quality, efficiency, and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division's contracted Health Plans; and oversight of a variety of services; and settings such as:

- A. Assisted living facilities;
- B. Individual's home (not contracted with the Division);
- C. Day programs (Day Treatment and Training (child and adult));
- D. Employment programs;
- E. Nursing facilities;
- F. Provider's home; or,
- G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes).

6004-B INTERNAL OVERSIGHT

REVISION DATE: 8/30/2013

EFFECTIVE DATE: July 31, 1993

Monitoring

The Division's program and contract monitoring activities provide oversight of services around a set of minimum expectations as documented in statute, rule, and contract. The Division's Program Monitors review all residential settings as required for programmatic and contractual compliance as well as compliance with licensing and certification requirements. Additional monitoring of services may occur depending on Division requirements.

Continued Stay Reviews

Continued Stay Reviews ensure the appropriateness and necessity of an ICF/ID level of care through reviews of health and programmatic records. The review also assesses the quality of care and assists in discharge planning.

Quality Management staff must review each individual within six (6) months of admission and at least every six (6) months thereafter. Reviewers evaluate the physician's certificate of need for care, medical evaluations, the plan of care, and the facility's Utilization Control Plan in relation to the individual's community integration and placement in the least restrictive environment.

Program Operations and Business Operations

Prior to receiving a contract, Division staff will ensure applicants have completed all the necessary steps, and qualify as a provider for the Division. Division employees at the District and Central Office are required to provide oversight of contracted providers to ensure contract compliance.

Support Coordination

Support Coordination serves as the first level of oversight to ensure Division funded settings and services are meeting the individual's needs. This oversight can take place during a review and/or annual planning meeting and includes an assessment of the placement and/or provider's ability to meet the individual's needs. On-site reviews shall be conducted while the individual is present.

Support Coordination is responsible for reporting any concerns regarding the setting or the provider's ability to meet individual's needs using the incident reporting system. See Chapter 2100 for further details.

Support Coordination is also responsible for ensuring the implementation of the Arizona Long Term Care System (ALTCS) program as described in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual. This includes oversight of all services in all settings.

Health Care Services

Health Care Services serves as the first level of oversight to ensure contracted health plans comply with their contract.

In addition to the reviews completed by the Support Coordinator, Health Care Services nurses complete utilization/concurrent reviews to ensure individuals are receiving the appropriate level of nursing care. This oversight can be provided in all settings.

Arizona Long Term Care System Administrator/Specialists

The ALTCS Administrator oversees the entire ALTCS program including oversight of the ALTCS Specialists/designees who audit case files to monitor support coordination compliance with the ALTCS program.

The Division monitors implementation of the ALTCS and Targeted Support Coordination (TSC) programs through the use of specific audit tools. Data gathered is analyzed to identify Support Coordination system issues and corrective action plans are developed as appropriate.

Arizona Long Term Care System

- A. An ALTCS audit monitors completion of timely planning meetings by a review of case files. Documentation in the case file must establish the following:
 - 1. The member's presence and participation with support as needed in the development of the planning document.
 - 2. The meeting occurred at the member's home unless documentation indicates the member/responsible person has chosen an alternate location. At least one ISP/review must occur in the individual's home every twelve months.
 - 3. An acceptable reason when the planning meeting occurs after the due date.
- B. The ALTCS On-Site and Timeliness Audit are used to monitor timeliness of planning meetings. To achieve timeliness, a planning meeting must have occurred:
 - 1. Within the required interval based on a comparison of the date of the most current and the previous review (prior timeliness); and,
 - 2. On the date of the audit, all planning meetings must be current. (Current timeliness).

The Division completes this audit on 100% of the ALTCS cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

- C. The Support Coordinator ALTCS Audit is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM.) Quarterly, the District must complete a minimum of two Support Coordinator ALTCS audits for every Support Coordinator position allocated, including vacant positions. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

Targeted Support Coordination

- A. The TSC audits monitor completion of a timely planning meeting through a review of documentation contained in a member's file. Documentation must establish the following:
1. The planning meeting was held at the frequency requested by the member/responsible person using the contact type requested; and,
 2. An acceptable reason if the planning meeting occurred after the due date.
- B. The Targeted Timeliness Audit is used to monitor completion of a timely planning meeting through a review of documentation contained in a member's file. Documentation must establish the following:
1. At least annually, the type and frequency of contact chosen;
 2. When the member receives a service that has a "mandated minimum review cycle" requirement, the chosen contact type and frequency do not exceed the "mandated minimum review cycle."
 3. The planning meeting is within requested/required intervals based on a comparison of the date of the most current and the previous review (prior timeliness).
 4. The most current planning meeting is within the required interval when compared to the date of the audit (current timeliness).

The Division completes audits on 100% of the Targeted cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

- C. The Targeted Support Coordination Audit is used to monitor the Division's compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM). Quarterly, each District completes audits on 10% of their Targeted Support Coordination cases. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

Other

Additional Division employees are responsible for oversight activities such as tracking, trending, and reporting issues related to Quality Management.

Additional oversight of Support Coordination occurs at the District and Central Office level.

6004-C EXTERNAL OVERSIGHT

REVISION DATE: 8/30/2013

EFFECTIVE DATE: July 31, 1993

Licensing/Certification

For settings that require licensing and/or certification, the entities that provide the license and/or certification also have oversight responsibilities. Entities responsible for oversight include:

- A. U.S. Department of Labor;
- B. Arizona Department of Health Services (DHS);
- C. Arizona DHS, Division of Behavioral Health Services (DBHS);
- D. Arizona DHS, Division of Licensing Services, Office of Long-Term Care Licensing; and,
- E. Arizona Department of Economic Security (DES), Office of Licensing, Certification and Regulation (OLCR).

Arizona Health Care Cost Containment System

Arizona Health Care Cost Containment System (AHCCCS), as the Single State Medicaid agency, has the authority to inspect Arizona Long Term Care System (ALTCS) funded settings at any time. The purpose of AHCCCS oversight is to ensure compliance with the standards set forth in the AHCCCS Medical Policy Manual (AMPM). The Division, as an ALTCS program contractor, is required to ensure that all ALTCS eligible individuals are receiving services as medically needed. This process typically involves review of support coordination functions as they relate to the Planning Document. AHCCCS may or may not actually visit the site during the review.

Advocacy

Advocacy agencies have the authority to review residential settings in the community at reasonable times. This authority was granted because of the Arizona Training Program Coolidge lawsuit (*Griswold vs. Riley*) and is noted in Arizona Revised Statutes. This includes the Developmental Disabilities Advisory Council.

Financial Audit

All agencies with a contract are subject to the programmatic and fiscal monitoring requirements of the Department to ensure accountability of the delivery of all goods and services. Specific requirements are delineated in the provider's contract.

6004-D DIVISION OVERSIGHT FINDINGS

REVISION DATE: 8/30/2013

EFFECTIVE DATE: July 31, 1993

When deficiencies are identified, the scope and severity of the deficiencies as well as the oversight activity, will determine the next steps. At a minimum, the Division may request a Corrective Action Plan from the Provider.

6004-E OPERATIONAL REVIEWS

EFFECTIVE DATE: May 20, 2016

REFERENCES: 42 CFR Part 438, AHCCCS 1115 Waiver

Purpose of Operational Reviews

The purpose of the Division performing an Operational Review (OR) is to:

- A. Know the Contractor's system and operation.
- B. Support Contractor compliance with Division requirements.
- C. Improve Contractor's compliance with Division requirements.
- D. Recognize Contractor accomplishments.
- E. Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with the Arizona Health Care Cost Control System (AHCCCS) 1115 Waiver.
- F. Determine whether the Contractor satisfactorily meets:
 - 1. Division contract requirements
 - 2. Division policies
 - 3. Arizona Revised Statute
 - 4. Arizona Administrative Code
 - 5. 42 CFR Part 438, Managed Care.
- G. Determine progress made in implementing recommendations made during prior reviews.
- H. Determine Contractor compliance with its own policies and procedures.
- I. Evaluate the effectiveness of Contractor policies and procedures.

Types of Operational Reviews

The following are types of Operational Reviews:

- A. Full Review, which includes a review of all standards
- B. Focused Review, which includes review of specific:
 - 1. Areas across all Contractors, e.g., implementation of value based purchasing
 - 2. Standards related to individual Contractor performance.

Prior to Onsite Review Timeline

The timeline for performing Operational Reviews is as follows:

- A. Three (3) weeks before onsite review, the Division provides formal notification of the onsite review to the Contractor.
- B. Two (2) weeks before onsite review, the Contractor submits the first documents, which include Populations for Samples, e.g., Prior Approval (PA) Logs.
- C. Within three (3) days of receipt of above documents, the Division notifies Contractor of which samples will be reviewed.
- D. One (1) week before onsite review, the Contractor uploads all documents to the Division's File Transfer Protocol (FTP) site.

After Onsite Review Timeline

After the onsite review occurs, the following occur:

- A. Six (6) weeks after the onsite review, the Division forwards a draft of its findings to the Contractor.
- B. Within one week after above action, the Contractor may challenge The Division's finding by submitting a Challenge Letter to the Division.
- C. Nine (9) weeks after the onsite review, the Division issues its Final Report.
- D. Eleven (11) weeks after the onsite review, the Contractor Corrective Action Plan(s) (CAP) is due to the Division.
- E. Six (6) months after the Division approves the CAP approval – CAPs must be completed and closed.

The Process – Document Review

The Division reviews documents at the Contractor's place of business (on-site), off-site, or a combination of both.

When the Division requests additional documents:

- 1. Before noon, the Contractor supplies the documents by close of business on the same day.
- 2. After noon, the Contractor supplies the documents by 9:00 a.m. on the following day.

OR Categories

OR Categories are:

- A. Case Management (CM)
- B. Claims and Information Systems (CIS)
- C. Delivery Systems (DS)
- D. General Administration (GA)
- E. Grievance System (GS)
- F. Maternal/Child Health and EPSDT (MCH)
- G. Medical Management (MM)
- H. Member Information (MI)
- I. Quality Management (QM)
- J. Reinsurance (RI)
- K. Third Party Liability (TPL)
- L. Corporate Compliance (CC).

6004-F COMPLIANCE PROGRAM

EFFECTIVE DATE: June 10, 2016

REFERENCES: [42 CFR 438.230\(b\)](#), [42 CFR 438.608](#), [ACOM Policy 103](#)

Compliance Program Overview

The Division Compliance Program consists of the development, maintenance, and implementation of Policies and Procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Qualified Vendors, and Administrative Services subcontractors) meet all legal and regulatory requirements in the performance of their duties.

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

- A. 42 Code of Federal Regulation (CFR)
- B. Health Insurance Portability and Accountability Act (HIPAA)
- C. Arizona Revised Statutes (ARS)
- D. Arizona Administrative Code (AAC)
- E. The Division's Contract with the Arizona Health Care Cost Containment System (AHCCCS).

Responsibility for Compliance Program Structure

The following personnel monitor, review, and assess the effectiveness of the compliance program and the timeliness of reporting to ensure that the Compliance Program structure facilitates compliance with all legal and governmental requirements:

- A. The Compliance Officer
- B. Compliance Committee (consisting of Compliance Officer, a budgetary official, Executive Management and others with the ability to commit resources).

Responsibility for Compliance Program Implementation

The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

- A. The Compliance Officer, and all other Division management
- B. Human Resources personnel
- C. All other employees.

Compliance Program Components

The Division Compliance Program is based on the Division's Corporate Compliance Plan, policies, procedures, training/updates, monitoring, oversight of compliance to law and contractual obligations, and enforcement.

A. Corporate Compliance Plan

Implementation of the Division's Corporate Compliance Plan prevents and detects fraud, waste, and abuse; the Plan:

1. Identifies the location of written criteria for selecting a Compliance Officer
2. Includes the Compliance Officer job description, clearly outlining the responsibilities and authority of the Compliance Officer, who reports directly to the Division's Assistant Director and whose office is located at the Division's Central Office
3. Is administered and monitored by the Compliance Officer/delegate.
4. Describes:
 - a. Lines of communication between the Compliance Officer and Division employees
 - b. Enforcement through well-publicized disciplinary guidelines
 - c. Internal and external monitoring/auditing and related reporting
 - d. Division compliance with the Deficit Reduction Act of 2005
 - e. Training requirements for the Division, subcontractors and providers
 - f. Notification requirements pertaining to CMS compliance issues related to HIPAA transaction and code set complaints.
5. Adheres to ACOM Policy 103 and the Division's contract with AHCCCS
6. Is submitted annually to AHCCCS Office of Inspector General (OIG).

B. Policies and Procedures

The Compliance Program is based on written Policies, Procedures, and material that facilitate compliance with federal and state laws, regulations, and contractual requirements.

Pursuant to the Deficit Reduction Act of 2005, written Policies address the Federal False Claims Act, administrative remedies for false claims/statements, civil and criminal penalties for false claims/statements, and whistleblower protections under law. See Operations Manual Policy 6002-N Fraud and False Claims, Provider Manual Chapter 20 Fraud, Waste and Abuse, and Provider Manual Chapter 21 False Claims Act.

C. Training and Updates

1. Mandatory Training

- a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:
 - i. Compliance
 - ii. Article 9
 - iii. HIPAA
 - iv. Standards of Conduct for State Employees
 - v. Fraud Awareness
 - vi. Business Continuity
 - vii. Diversity
 - viii. AHCCCS Overview
- b. The Division trains employees as appropriate to their job functions, including but not limited to:
 - i. Support Coordination/Member Services
 - ii. Network/Provider Relations
 - iii. Medical Management
 - iv. Quality Management
- c. The Division provides refresher training to all employees, and to employees as appropriate to their job functions, as needed

2. Training Materials

The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by Division employees.

3. Updates

- a. The Division may provide updates, to Division personnel, communicated in the following formats:
 - i. Unit meetings
 - ii. Statewide meetings
 - iii. E-mails
 - iv. Policies and procedures.
- b. The Division may provide updates to contract providers in the following formats:
 - i. Provider/coordination meetings
 - ii. Vendor Blasts/e-mails
 - iii. Policies and procedural manuals
 - iv. Contract amendments.

D. Contracts with Administrative Services Subcontractors

The Division:

- 1. Evaluates the ability of prospective providers to perform the activities to be delegated.
- 2. Establishes a written agreement (as defined by the Division's contract with AHCCCS) that:
 - a. Specifies activities and reporting responsibilities delegated to the contractor
 - b. Provides for revocation of such delegation, and application of sanctions
 - c. Includes other specific requirements, as stated in the Division's contract with AHCCCS.
- 3. Retains authority to direct delegated contract requirements
- 4. Communicates deficiencies to the provider so that the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Compliance Monitoring and Enforcement

1. Monitoring

The Division monitors compliance via:

- a. Compliance-related reports based on Division and provider data
- b. Investigations of allegations of non-compliance
- c. Review of functional areas and related systems
- d. Assessment of mechanisms to facilitate detection of non-compliance
- e. Internal and external audits.

2. Reporting of Noncompliance to the Division

The Division maintains open lines of communication and supports Division personnel, contract providers, members, and all other individuals in reporting non-compliance. Means of reporting non-compliance to the Division include:

- a. Toll-free telephone hotlines identified in Division publications
- b. Email addresses identified in Division publications and accessible via the Division website.

3. Division Reporting of Noncompliance to AHCCCS

Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:

- a. May conduct a preliminary fact-finding to determine the nature of the incident
- b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases)
- c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.

4. Enforcement

The Division:

- a. Responds to compliance issues to the extent required by law and within the mandated timeframes
- b. Enforces compliance and takes corrective actions as appropriate.

5. Reports

The Division generates regular compliance-related reports that include, but are not limited to:

- a. Grievance System Report
- b. Resolution System Report
- c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims
- d. Claims Dashboard
- e. Support Coordination Reports.