Support Coordinators, when completing a Planning Document, must 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.

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.
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
D. Changes to the spending plan.

The Support Coordinator must 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 must 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)
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 must 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 must develop steps to minimize or eliminate the potential risks. The emphasis on prevention must not result in disregard of rights, preferences, or lifestyle choices. Age appropriate developmental skills must be taken into consideration for infants and children when assessing potential risks. The *Risk Assessment* is reviewed at every planning and revised as needed.

**Managed Risk Agreement**

A document that the District Nurse/ Support Coordinator must develop with the member or member’s responsible person which outlines risks to the member’s safety and well-being as a result of choices or decisions made by the member or his/her responsible person. These risk which would require a managed risk agreement may be associated with the member or member’s responsible person’s choices and decisions regarding services, placements or caregivers.

This agreement should document:

A. The amount and type of service the Division can provide cost effectively
B. The placement, service and caregiver options offered to the member
C. The member’s choices regarding those options
D. The risks associated with the refusal of medically assessed services, placement, decrease in service amounts or potential gaps in services
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 or member’s responsible person acknowledge and agree to the service limitations and risks by signing the Managed Risk Agreement. If the member or member’s responsible person refuses to sign the Managed Risk Agreement, the agreement should be placed in the case file with documentation of the refusal.

**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 must have outcomes identified on the Planning Document. If progress on an outcome is not made within the designated timeframe, the team must consider changing the teaching strategy, developing a new outcome, offering a different service, or stopping the service.

The selected provider must develop a teaching strategy for each outcome, which describes the methodology to be used to support the member to achieve the outcome. The strategy must 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

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 their approved rate.

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 their approved rate in previous quarters. When the Support Coordinator identifies the need for a CES, the CES Worksheet should be submitted to the Area Manager or District Designee 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
D. Habilitation, Community Protection.

The Division receives a monthly report from AHCCCS identifying members who had previously been above 80% of their approved rates. 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 (PMMIS/CATS) 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 and their Supervisor (for members below 100%) and 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 CES 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 Area Manager or District Designee and maintained in the member’s case record. The Area Manager or District Designee 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 must be submitted to the Area Manager or District Designee. The Area Manager or District Designee 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.
C. Reconvene the Planning Team to review services.

**Request AHigher 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 must 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


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)

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.

**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.