1620-B NEEDS ASSESSMENT/CARE PLANNING STANDARD

REVISION DATE: XX/XX/24
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REFERENCES: ~~AHCCCS AMPM Chapter 1620-B;~~ A.R.S. § 36-401; A.R.S. § 36-551; 9 A.A.C. 22 Article 1; 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101); AHCCCS AMPM Chapter 1620-B.

PURPOSE

This Policy establishes requirements regarding needs assessment and care planning.

DEFINITIONS

1. **"Member" means the same as "Client" as defined in A.R.S. § 36-551.**

~~1.~~2. "Own Home" ~~A~~means a residential dwelling that is owned, rented, leased, or occupied by a ~~m~~Member, at no cost to the ~~m~~Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

a. Health care institution under A.R.S. § 36-401.

b. Residential care institution under A.R.S. § 36-401.

c. Community residential setting under A.R.S. § 36-551, or

d. Behavioral health facility under 9 A.A.C. 20, Articles 1, 4, 5, and 6 (A.A.C. R9.101).

~~2. "Person-Centered Service Plan (PCSP)" means A~~a collaborative ~~process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost effective outcomes.~~

3. "Person Centered" means An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.

~~3.~~4. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports. ~~A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Person Centered Service Plan (PCSP). The member/Responsible Person (as~~

~~defined in A.R.S. §36-551) has final decision-making authority unless there is legal documentation that confers decision-making authority to a legal representative~~.

~~4.~~5. "Planning Team"~~-~~**means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems**~~A group of individuals that shall include the member, Responsible Person (when applicable), Support Coordinator, and a representative from the agency for member's living in a licensed setting and with the member's consent, their Health Care Decision Maker, Designated Representative and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/ spiritual organizations, and agents from other~~

~~service systems. The size, scope, and intensity of involvement of the team members are determined by the objectives of the planning team to best meet the needs and individual goals of the member~~.

~~5.~~6. "Prior Period Coverage" or "(PPC)" means ~~F~~for Title XIX ~~m~~Members, the period of time prior to the ~~m~~Member's enrollment, during which a ~~m~~Member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a ~~m~~Member is enrolled with a ~~C~~Contractor. Refer to 9 A.A.C. 22 Article 1. If a ~~m~~Member made eligible via the Hospital ~~P~~Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via ~~t~~the full application process, Prior Period Coverage for the ~~m~~Member will be covered by ~~A~~AHCCCS Fee-For-Service and the ~~m~~Member will be enrolled with the Contractor only on a prospective basis.

~~6.~~7. "Responsible Person" ~~M~~means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for

whom no guardian has been appointed as cited in A.R.S 36-551.

~~7.~~8. "Support Coordination" **means the same as "Case Manager" under A.R.S. § 36-551.** ~~A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the member's needs through communication and available resources to promote quality, cost effective outcomes.~~

POLICY

A. PERSON CENTERED APPROACH

1. **The Division shall** ~~Support Coordinators are expected to~~ use a person-centered approach regarding the ~~m~~Member assessment and needs identification, considering not only ALTCS covered services, but also other needed community resources as applicable.

~~1.~~2. The Support Coordinator shall ~~Support Coordinators shall~~:

a. Respect the Member and the ~~m~~Member's rights.

b. Support the ~~m~~Member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible.

c. Provide adequate information and education to support the ~~member/R~~Responsible Person to make informed decisions and choices.

d. Be available to answer questions and address issues raised by the ~~member/R~~Responsible Person, including between regularly scheduled ~~P~~planning ~~M~~meetings.

e. Provide a continuum of cost-effective~~cost effective~~ service options that supports the expectations and agreements established through the planning process.

f. Educate the ~~member/R~~Responsible Person~~,~~ on how to report unavailability or other problems with service delivery to ensure unmet service needs can be addressed as quickly as possible as outlined ~~. Refer to~~in Division Medical Policy 1620-D and 1620-E, and 540 regarding specific requirements.

g. Facilitate access to non-ALTCS supports and services available throughout the community and~~, ("natural supports") as well as~~ Non-Title XIX services for ~~m~~Members with a Serious Mental Illness (SMI) designation.

h. Advocate for the ~~m~~Member including their ~~and/or~~ family,

~~/~~and significant others as needed~~the need occurs~~.

i. Allow the ~~member/R~~Responsible Person to identify their role in interacting with the service delivery system, including the extent to which the family and other informal~~other/informal~~ supports will provide uncompensated care.

j. Provide the ~~member/~~Responsible Person with flexible and creative service delivery options.

k. Educate the ~~member/~~Responsible Person about ~~m~~Member directed options for delivery of designated services. These options will be reviewed with the ~~member/~~Responsible Person for ~~m~~Members living in their ~~o~~Own ~~h~~Home~~s~~ at every ~~P~~planning ~~M~~meeting.

l. Educate the ~~member/~~Responsible Person on the option to choose a spouse as the ~~m~~Member's paid attendant caregiver.

m. Provide necessary information to providers about any changes in the ~~m~~Member's goals, functioning and~~/or~~ eligibility to assist the provider in planning, delivering, and monitoring services.

n. 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 ~~m~~Member.

o. Educate the ~~member/~~Responsible Person on End-of-Life Care and Advanced Care Planning, services and supports. See Division Operations Policy 1006 for additional guidance regarding health care directives.

p. Assist ~~m~~Members to identify their independent living goals and provide the Responsible Person~~m~~ with information about local resources that may help them transition to greater self-sufficiency in the areas of housing, education, and employment, including volunteer opportunities. ~~(r~~Refer to ~~the s~~Section B of this policy ~~below~~ which outlines ~~-~~additional requirements for individualized ~~m~~Member goals~~)~~.

~~p.~~**B. PLANNING MEETING**

1. The Support Coordinator shall facilitate a face-to-face planning meeting, to develop the Planning Document, that includes ~~the~~ the Member, the Responsible Person, if applicable, and all other requested members of the planning team.

2. The Support Coordinator shall include recommendations from the Member's Primary Care Provider (PCP), as well as input from service providers, as applicable, in the Member's Planning Document.

3. The Support Coordinator shall complete the (Form - DDD-2039A) HCBS Member Needs Assessment Tool and the Member Weekly Schedule (Form DDD-2111A) to determine the amount of service hours a Member needs when Attendant Care/Homemaker, Habilitation Hourly, and/or Respite services will be authorized for Members living in their own home.

4. The Support Coordinator shall complete the Respite Assessment Tool (Form DDD-2042A) when Respite services are assessed.

~~1.~~5. The Support Coordinator shall complete the Division's Member Level of Care Tool (MLOC) (Form DDD-2096A) based on information from the ~~m~~Member's Planning Document to determine the ~~m~~Member's current level of care.

~~2. If a member's status has improved that s/he may no longer be medically eligible for ALTCS, t~~The Support Coordinator shall complete an Electronic Member Change Report (EMCR), for a medical PAS Reassessment when a Member's status has improved that s/he may no

~~longer be medically eligible for ALTCS.~~

~~2. The involvement of the member/Responsible Person in strengths/needs identification as well as decision-making is a basic tenet of Support Coordination practices. For the Planning Meetings, the Planning Team may include anyone, as requested by the member/Responsible Person. The member/Responsible Person and Planning Team partner with the Support Coordinator in the development of the Planning Document, with the Support Coordinator generally functioning as the facilitator.~~

~~3. The Support Coordinator shall will complete the Division's Member Level of Care Tool (MLOC) (Form DDD-2096A) based on information from the mMember's Planning Document to determine the mMember's current level of care.~~

~~4. Person-centered plan is based on face-to-face discussion with the member/Responsible Person and other members of the Planning Team in order to develop a comprehensive Planning Document, as defined in this policy. The Planning Document will include recommendations of the member's Primary Care Provider (PCP), as well as input from service providers, as applicable. Support Coordinators will complete the (DDD-2039A) HCBS Member Needs~~

~~Assessment Tool to determine the amount of service hours a member needs when Attendant Care/Homemaker, Habilitation Hourly, and/or Respite services will be authorized for members living at home. If the member has been assessed for Respite, the Respite Assessment Tool must also be completed.~~

6. ~~In development of the member's Planning Document,~~The Support Coordinator~~s~~ shall assist in identifying meaningful and measurable individualized goals for ~~m~~Members, including long-term and short-term goals. ~~(e.g., in the areas of recreation, transportation, friendships, family and other relationships)~~

7. The Support Coordinator shall assist the Planning Team in writing goals for the Member that outline clear expectations about what is to be achieved through the service delivery and care coordination processes.

8. The Support Coordinator shall assist the Planning Team in identifying goals that:

   a. ~~to a~~Assist the ~~m~~Member in attaining the most self-fulfilling, age-appropriate goals consistent with the ~~m~~MN~~m~~ember's needs, desires, strengths, and preferences.

   b. ~~1. Goals will i~~Include steps that the member will take to

achieve the goal(s),

~~(s). 2. Goals will be Goals aAre written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.~~

9. The Support Coordinator shall review the Member's goals~~3. Goals will be reviewed at each~~ at each ~~P~~planning ~~M~~meeting.

~~a.~~10. The Support Coordinator shall complete an Electronic Member Change Report (EMCR) for a medical PAS Reassessment when a Member's status has improved that the Member may no longer be medically eligible for ALTCS.

C. PRIOR PERIOD COVERAGE (PPC)

1. The Support Coordinator shall complete a retrospective assessment ~~F~~for ~~m~~Members who have been receiving Home and Community Based Services (HCBS) during the Prior Period Coverage (PPC) timeframe~~ a retrospective assessment must occur~~ to determine whether those services were:
   a. Medically necessary,
   b. Cost~~-~~effective, and
   c. Provided by a registered AHCCCS provider.

2. The Support Coordinator shall document in the Planning Document when all ~~If all~~ three of these criteria are met to signify that ~~,~~ the services are eligible for reimbursements. ~~specified in the member's Planning Document. Services that will be retroactively approved based on this assessment will be marked as "Retroactive" in the Planning Document.~~

~~2.~~3. The Division shall provide a Notice of Adverse Benefit Determination to the Responsible Person for ~~If~~ any of the services provided during the PPC that are not approved as outlined in Division Operations Policy 414. ~~The Division shall allow the Respon, the member must be provided a written Notice of Adverse Benefit Determination (NOA) and given an opportunity to file an appeal.~~

4. ~~For a new member residing in an Assisted Living Facilities (ALF) during PPC, t~~The Division ~~support coordinator~~ shall inform the Assisted Living Facilities (ALF), for a new Member residing in an ALF, that they are encouraged to bill or accept~~or/accept~~ Medicaid payment for services for ~~m~~Members who are eligible under PPC but are not ~~-~~required by regulations to do so.

~~3.~~5. ~~If the facility chooses to, or is required by contract to bill the~~

~~Division, the facility must accept the Medicaid payment as full payment and is not permitted to bill the member or family for the difference between the Medicaid and private pay rate.~~ The Division~~support coordinator~~ shall ensure that the facility refunds private payments made by the ~~m~~Member or family, less the amount of room and board assigned by the Contractor, prior to billing the Division for Medicaid reimbursement.

~~4. In addition to the grievance and appeals procedures described above, Division of dDevelopmental Disabilities (DDD) will also make available the grievance and appeals processes described in Division Operations Policy 446.~~