1620-D PLACEMENT AND SERVICE PLANNING FOR ALTCS ELIGIBLE MEMBERS

REVISION DATES: 8/2/2023, 2/16/2022, 9/8/2021

EFFECTIVE DATE: July 6, 2021

REFERENCES: Title 42 U.S. Code 1320a-7b, A.R.S. §36-551, AMPM Chapter 1600, Division Medical Policy 1620-B, Division Medical Policy 1620-C, Division Medical Policy Chapter 300, Division Medical Policy Chapter 1200, Division Operations Policy 4002

PURPOSE

This policy applies to Division Members who are eligible for Arizona Long Term Care Services (ALTCS) and all Division staff. It outlines the requirements for Member placement and service planning for Members eligible for ALTCS.

DEFINITIONS

1. "Electronic Visit Verification (EVV)" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and the type of service performed. Services subject to EVV include non-skilled in-home services and home health services pursuant to 42 U.S.C. §1396(b)(l).

2. “Gap in Services Subject to EVV” means the difference between the number of hours of these services documented in each Member’s Planning Document and the hours of the type of these services that are actually delivered to the Member. The following situations are not considered gaps:

   a. The Member is not available to receive the service when the caregiver arrives at the Member’s home as scheduled.

   b. The Member refuses the caregiver when she/he arrives, unless the caregiver is not able to do the assigned duties.

   c. The Member refuses services.

   d. The Member’s home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

3. “Home and Community Based Services (HCBS)” means home and community-based services, as defined in R6-6-1501.

4. “Managed Risk Agreement” means a document developed by the Support Coordinator or District Nurse with the Responsible Person, which outlines potential risks to the Member’s safety and well-being because of choices or decisions made by the

Responsible Person.

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

6. "Out-of-State Services" means services provided to Members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.

7. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a 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).

8. "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.

9. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.

10. "Responsible Person" 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 defined in A.R.S. §36.-551

11. “Share of Cost” means the amount an ALTCS Member is required to pay toward the cost of long term care services.

12. “Support Coordinator” means the same as “Case Manager” under A.R.S. § 36-551

13. “Temporarily Out of State” means A Member is considered temporarily absent from Arizona if

    a. Intends to return to Arizona when the reason for the absence is completed

    b. Has not become a resident of another state. For minors under the age of 18, residency is based on the custodial parent. A resident of another state includes, but not limited to applying for medical assistance in another state; renting or buying a home; getting a job; and/or applying for a driver’s license or identification in another state.

POLICY

A. PLACEMENT AND SERVICE PLANNING STANDARDS

1. The Division shall identify placement goals through a

Member-centric planning process and cost effectiveness standards shall be met in the Home and Community Based setting.

2. The Support Coordinator shall facilitate placement and services based primarily on the Member's choice with additional input in the decision making process from the Planning Team, the Support Coordinator's assessment, and the Pre-Assessment Screening.

3. Support Coordinators shall not use referral agencies to identify placement options for Members in lieu of the Division's contracted network of providers.

4. The Support Coordinator shall discuss the cost effectiveness, as applicable, and availability of needed services with the Responsible Person as part of the Planning Meeting.

5. In determining the most appropriate service placement for the Member, the Support Coordinator and the Responsible Person shall discuss the following as applicable:

   a. The Member's placement choice and preferences,

b. Services necessary to meet the Member's needs in the most integrated/least restrictive setting. Refer to Division Medical Manual Chapters 300 and 1200 for information about the following types of services available:

   i. Home and Community Based Services (HCBS),

   ii. Institutional services,

   iii. Physical health (acute care) services, and

   iv. Behavioral health services.

c. The Member's interest in and ability to direct their own supports and services.

d. The availability of HCBS in the Member's community.

e. Cost effectiveness of the Member's placement and service choice.

f. Covered services that are associated with care in a licensed institutional setting compared to services provided in the Member's Own Home or an HCBS residential setting.

g. The risks that may be associated with the Responsible Person's choices and decisions regarding services, placements, caregivers, which would require the completion of a Managed Risk Agreement (Form DDD-1530A).

h. The Member's financial responsibility as specified in Division Operation Policy 4002.

i. The Member's Share of Cost (SOC) responsibility. The amount of the Member's SOC shall be determined and communicated to the Responsible Person by AHCCCS.

j. The room and board amount to be covered by the Member to be paid towards the cost of the Community Residential Setting.

    i. For Members residing in other alternative residential settings including Community Residential Settings, this is the amount the Member is responsible for paying toward their room and board. Room and board is not an ALTCS covered service in these

settings.

ii. For vendor operated settings that contract directly with the Division, the amount is determined by the Division and shall be communicated to the Responsible Person.

iii. The behavioral health provider shall communicate the room and board amount directly to the Responsible Person for behavioral health residential settings.

iv. The Support Coordinator shall complete an Assisted Living Agreement (Form DDD-1747A) or a DDD Residency Agreement (Form DDD-2176A) for Members who live in Assisted Living or Community Residential Settings prior to the Member's entry into residential services and update the assessment when changes in the Member's income or the provider's rates occur.

6. The Division shall allow any Member who lives in their Own

Home to remain in their Own Home as long as HCBS are cost effective. The Division shall not require Members to enter a residential HCBS placement/setting that is "more" cost effective.

7. The Division shall inform Members that they have the choice to select their spouse to be their paid caregiver for medically necessary and cost effective services, provided the spouse meets all of the qualifications as specified in Division Medical Policy 1240.

8. The Support Coordinator shall complete the Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) with the Member and spouse prior to the authorization of the Member's spouse as the paid caregiver. The Spouse Attendant Care Acknowledgement of Understanding (Form DDD-1469A) form shall be completed at least annually.

9. The Support Coordinator shall coordinate services with the appropriate providers as identified and agreed to in the Member's Planning Document. The Member's assessed needs and corresponding authorization shall not be contingent upon the provider meeting the requirements of the U.S. Department of

Labor, Fair Labor Standards Act.

10. The Support Coordinator shall ensure that the Responsible Person understands that some services and medical supplies require a prescription by the primary care provider (PCP). These include home health services, therapies, and durable medical equipment (DME).

11. The Support Coordinator shall coordinate with the Member's ALTCS Health Plan to obtain a PCP when the Member does not have a PCP or to change the PCP when an ALTCS Member does not have a PCP or wishes to change PCP.

12. The Division shall make a decision regarding the provision of services requested within:

    a. 14 calendar days following the receipt of the request/order, or

    b. Three business days when the Member's life, health, or ability to attain, maintain or regain maximum function would otherwise be jeopardized

13. The Division shall provide appropriate placement and services to

meet the Member's needs within established timelines:

a. Services determined to be medically necessary and cost effective for a newly ALTCS enrolled Member shall be provided to the Member within 30 calendar days of the Member's enrollment.

b. Services for an existing ALTCS Member shall be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

14. The Support Coordinator shall verify the needed services are available in the Member's community and:

c. Shall substitute a combination of other services, when an assessed service is not currently available, to meet the Member's needs until the assessed service becomes available.

d. May assess a temporary alternative placement if services cannot be provided to safely meet the Member's needs.

15. The Support Coordinator shall ensure Members have access to transportation and support for the purpose of visiting potential

residential or non-residential settings prior to making a decision on where to live or receive services.

16. The Support Coordinator shall develop the Planning Document. The role of the Planning Team in developing the Planning Document is communicating and working towards the Member's vision for the future.

17. The Support Coordinator shall document the following in the Planning Document:

    a. The Member's strengths, goals, preferences, needs, and desired outcomes.

    b. The assessed services and supports identified to assist the Member in achieving their established goals. For each ALTCS covered service, the Planning Document shall document the frequency and quantity of the service including any change to the service since the last Planning Meeting.

    c. Every effort shall be made to ensure the Responsible Person understands the Planning Document, including their

agreement or disagreement with each service authorization. The Support Coordinator shall engage in reasonable conflict resolution efforts to resolve any issues when the Responsible Person disagrees with the service(s) authorized.

d. The Planning Document shall be reviewed according to the timeframes specified in Division Medical Policy 1620-A and Division Medical Policy 1620-E. The Planning Document shall be reviewed sooner when there is a change to the Member's functional needs, circumstances, individual goals, or at the Responsible Person's request.

e. The Support Coordinator shall document how the Member communicated their agreement or disagreement when the Member is physically unable to sign the Planning Document.

f. An adult Member enrolled with the Division shall be assumed legally competent to make decisions on their own behalf unless the Court has appointed a legal guardian. The Support Coordinator shall leave the Planning

Document unsigned and document the circumstances when the Member is unable to participate in the planning and decision making process and does not have a legal guardian. When appropriate, a referral to the County Public Fiduciary or resources shall be considered by the Planning Team.

g. The Support Coordinator shall provide a copy of the Planning Document to the Responsible Person and maintain a copy in the case file. The Support Coordinator shall also provide a copy of the Planning Document to the individuals selected by the Responsible Person, as specified in the Planning Document, and to all authorized service providers (vendors).

h. The Support Coordinator shall assess for risks while considering the Member’s right to assume some degree of personal risk. The Planning Document shall also include measures available to reduce risks or identify alternative ways to achieve individual goals based on the Member’s priorities outlined in the Planning Document.

18. The Division shall provide the Responsible Person with a Notice of Adverse Benefit Determination that explains the Member's right to file an appeal regarding the placement or service decisions within the Planning Document when the Responsible Person disagrees with the Planning Document and/or authorization of placement/services including the amount and/or frequency of a service.

19. The Support Coordinator shall provide a copy of the DDD-EVV Member Contingency/Back-Up Plan For the Independent Provider Program (Form DDD-2113A). The contingency plan shall be given to the Responsible Person when developed and at the time of each review visit.

20. For services delivered by an independent provider, the Member's contingency/backup plan shall direct the Responsible Person to contact the Support Coordinator or the Division's Customer Service Center when a Gap in Services Subject to EVV occurs during the Division's business hours. The Member's contingency/backup plan shall direct the Responsible Person to the Division's after-hours telephone number for a Gap in

Services Subject to EVV that occurs after regular business hours.

21. The Support Coordinator shall be responsible for completing the Member Contingency/Back-Up Plan with the Responsible Person when any of the following services will be provided by an Independent Provider (IP):

    a. Attendant care

    b. Respite

    c. Habilitation Hourly

    d. Habilitation Independent

    e. Homemaker (Housekeeping)

22. The Support Coordinator shall encourage and assist members who reside in their Own Home to have an emergency/disaster plan for their household that considers the special needs of the Member. Support Coordinators shall document the discussion in the Planning Document with the Responsible person and document the Member's plan on the Emergency/Disaster Plan (Form DDD-1621A) when the Responsible Person requests

assistance with developing an emergency/disaster plan.

23. The Support Coordinator shall regularly assess Members who reside in out-of-home residential placements to determine if they are in the most integrated setting possible for their needs. Members are permitted to change to a less restrictive placement, if needed services are available and cost effective in that setting.

24. The Support Coordinator shall inform the Responsible Person of the process for voluntary withdrawal and guide the Responsible Person through applying for AHCCCS Complete Care, or other programs, as needed, when the Member does not want or need long term care services.

    a. The Support Coordinator shall advise the Responsible Person that the Member may be disenrolled from the ALTCS program based on the Member’s income.

    b. The Support Coordinator shall continue their attempts to meet with the Member and their Responsible Person until the Member is disenrolled from ALTCS.

25. The Support Coordinator shall include the date range and units

for each service authorized on the Planning Document and in the Member's case file according to the Division's system for tracking service authorizations.

26. The Division shall include the following types of services in its system for tracking authorized services for Members residing in an institutional setting as appropriate based on the Member's needs:

    a. Nursing facility services. The Planning Document shall indicate the Member's acuity (Level I, II, or III) based on the AMPM Exhibit 1620-3, completed by the District Nurse, and the need for specialty care.

    b. Hospital admissions (acute and psychiatric)

    c. Bed holds or therapeutic leave days, refer to AMPM Policy 100 for definitions and limitations

    d. Services in an uncertified nursing facility

    e. DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless of if rented, purchased, or repaired). This requirement shall be waived

for ALTCS/DDD Members.

f. Hospice services

g. Therapies (occupational, physical, and speech)

h. Behavioral health services, refer to the Behavioral Health Service Matrix on the AHCCCS website.

i. ALTCS covered services noted above when provided by other funding sources.

B. TEMPORARILY OUT-OF-STATE HCBS SERVICES

1. The Division shall determine when HCBS Out-of-State Services are appropriate for the Member, medically necessary, and cost effective when requested.

2. The Division shall only cover HCBS Out-of-State Services when they are requested and approved prior to the Member traveling out-of-state.

3. The Division shall not authorize HCBS Out-of-State Services that are requested after the Member has traveled out-of-state.

4. The Support Coordinator shall assess the need for HCBS Out-of-State Services when requested by the Responsible Person. To assess for these services, the Planning Team shall:

   a. Determine if services currently assessed for the Member are appropriate and/or sufficient to meet the Member's needs while out-of-state.

   b. Determine the dates of departure and return.

5. The Division shall notify the Planning Team and the provider/qualified vendor agency of the outcome of the request.

6. The Division shall not authorize Licensed Health Aide (LHA) services for Members traveling Out of State as LHA providers are only licensed to practice in the state of Arizona.

7. The Division shall not cover services for Members who leave the United States and United States Territories.

C. AHCCCS NOTIFICATION REQUIREMENTS

1. The Support Coordinator shall not complete an electronic member change report (eMCR) when reporting a change in the

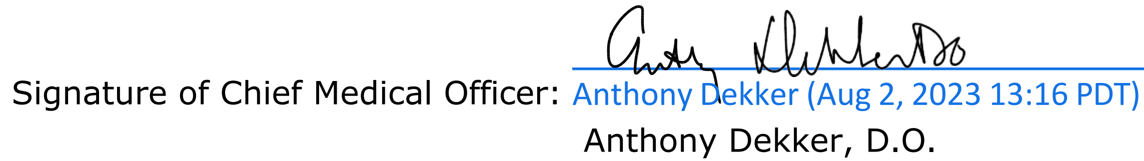
Member's PCP.

2. The Support Coordinator shall complete an eMCR for an evaluation of Long Term Care/Acute Care Only eligibility when the Member refuses long term care services that have been offered or refuses to allow the Support Coordinator to conduct a review visit in accordance with the required timeframes and locations but do not wish to withdraw from the ALTCS program.

3. The Support Coordinator shall complete and send an eMCR and documentation that further describes the circumstances of a Member's refusal to accept ALTCS services or allow a Support Coordinator to conduct a review visit to the AHCCCS Division of Health Care Management Medical Management Unit.

4. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member anticipates being out-of-state or has been out-of-state for more than 30 days.

5. The Support Coordinator shall complete an eMCR to notify AHCCCS when the Member has returned to Arizona when the Member has been out-of-state for more than 30 days.



Signature of Chief Medical Officer: Anthony Dekker (Aug 2, 2023 13:16 PDT)
Anthony Dekker, D.O.