1620-E SERVICE PLAN MONITORING AND REASSESSMENT STANDARDS

REVISION DATE: 07/19/2023
EFFECTIVE DATE: July 6, 2021
REFERENCES: A.R.S. §36-551, AMPM Chapter 1620-E

PURPOSE

This policy establishes the requirements for service plan monitoring and reassessment visits for Members who are eligible with Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Home and Community-Based Services (HCBS)" means home and community-based services, as defined in R6-6-1501.
2. "Member" means the same as "client" as defined in A.R.S. § 36-551.
3. "Own Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the 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).

4. “Person-Centered Service Plan (PCSP)” means a written plan developed through an assessment of functional need 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. The PCSP will also reflect the Member’s strengths and preferences that meet the Member’s social, cultural, and linguistic needs, individually identified goals and desired outcomes and reflect risk factors (including risks to Member)

5. “Planning Document” means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), or Person-Centered Service Plan (PCSP).

6. “Planning Team” means a group of individuals that shall include the member, responsible person (as applicable), support coordinator, and a representative from the agency for Members

living in a licensed setting and with the Member’s consent, 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.

7. “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 cited in A.R.S 36-551
8. “Serious Mental Illness (SMI)” means a designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older
9. “Serious Mental Illness Determination” means a determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual’s eligibility for SMI services.

10. “Special Assistance” means the support provided to a Member designated as Seriously Mentally Ill (SMI) who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.
11. “Support Coordinator” means the same as “Case Manager” under A.R.S. § 36-551.

POLICY

A. SERVICE PLAN MONITORING AND REASSESSMENT VISITS FOR MEMBERS ELIGIBLE FOR LONG TERM CARE SERVICES (ALTCS)

1. The Support Coordinator shall be responsible for the ongoing assessment and monitoring of the needs, services, and residential service setting of each Member they are assigned to assess including, but not limited to:
    a. The continued suitability and cost effectiveness of the services and residential service setting in meeting the Member's needs, and
    b. The quality of the care delivered by the Member's service

providers.

2. The Support Coordinator shall complete the Planning Meeting with the Member present as the Planning Document is about the Member being served.
3. The Support Coordinator shall encourage the Member to actively engage and participate in the development of their Planning Document to the greatest extent possible.
4. The Support Coordinator shall conduct the Planning Meetings where the Member receives services, including the Member's Own Home and other service settings.
    a. The Support Coordinator shall conduct the Planning Meetings with the Member and the Responsible Person, if applicable, in the Member's Own Home at least twice annually to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs.
    b. The Support Coordinator shall conduct the Planning Meeting once a year at one of the Member's service setting locations when a Member receives services in a setting outside of the home.

c. The Support Coordinator shall conduct the remaining Planning Meetings at an alternate location that is not a service setting when the Responsible Person chooses an alternate location for the Planning Meeting.

i. The Support Coordinator shall conduct the Planning Meeting at a service setting or an alternate service setting site, when it is convenient for the Responsible Person and not for the convenience of the Support Coordinator or providers.

ii. The Support Coordinator shall document the Responsible Person's choice of location in the Member's case file.

5. The Support Coordinator shall complete a Planning Document:

a. At the time of the initial Planning Meeting,

b. When there are any changes in services, and

c. At the time of each Planning Meeting, as specified in section B of this Policy.

6. The Support Coordinator shall provide a copy of the signed Planning Document that includes the Responsible Person's indication of whether they agree or disagree with each service

authorization.

B. TIMELINES FOR COMPLETING AND MONITORING THE PLANNING DOCUMENT

1. The Support Coordinator shall complete a Planning Meeting every 90 days for Members in the following scenarios:
   a. Living in their “Own Home”.
   b. Residing in a Child or Adult Developmental Home.
   c. Residing in a group home and the Member is under the age of 12 years old.
   d. Residing in a group home and the Member is medically involved, regardless of age.
   e. Members receiving behavioral health services and/or medication monitoring from a behavioral health provider through their DDD health plan regardless of the Member’s living arrangement.
2. The Support Coordinator shall complete a Planning Meeting every 180 days for Members in the following scenarios:
   a. The Member is 12 years or older, residing in a group home, and not receiving behavioral health services through the Member’s ALTCS health plan, and not medically involved.

b. The Member is residing in a Skilled Nursing Facility (SNF), Intermediate Care Facility/Intellectually Disabled (ICF/ID), or other institutional setting, and not receiving behavioral health services from a behavioral health provider through their DDD health plan.

   i. The Support Coordinators shall attend the facility's care planning meetings on a periodic basis to discuss the Member's needs and services jointly with the Responsible Person and the assigned District Nurse when the Member is in an SNF.

   ii. The Support Coordinator shall consult with facility staff, the Responsible Person, the assigned District Nurse, and when appropriate, the Division's health plan representative during Planning Meetings to assess changes with the Member and whether discharge from the SNF should be considered.

   iii. The Support Coordinator shall request a copy of the facility's Care Planning Meetings to be included as part of the Member's Planning Document and as part of the Member's file.

c. The Member is receiving hospice services in an institutional setting, even if it is a non-Medicare-certified institutional setting.

3. The Support Coordinator shall complete the 90-day Planning Meeting on-site or by telephone, as requested by the Responsible Person when the Member is in Long Term Care and Acute Care Only (LTC/ACO) status and is living in their Own Home and currently does not want or does not need Long-Term Services and Support in LTC/ACO status.

   a. The Support Coordinator shall document in the Member's file the Responsible Person's request to conduct the meeting, other than in the Member's Own Home.

   b. The Support Coordinator shall complete an on-site home visit with the Member at least once every 12 months.

C. ADDITIONAL MONITORING

1. The Support Coordinator shall respond to the Responsible Person's questions and requests, within 48 hours, not including holidays and weekends, when the Responsible Person contacts the Support Coordinator between regularly scheduled Planning Meetings to ask questions, discuss changes or needs, and to

request a meeting with the Support Coordinator.

2. The Support Coordinator shall take appropriate action when they identify or are notified of an urgent or a potential emergency situation.

    a. The Support Coordinator shall conduct an emergency visit when the situation is urgent and cannot be handled over the telephone.

    b. The Support Coordinator shall be required by law to report to a police officer or protective service worker, when the Support Coordinator identifies any instance of abuse or neglect during the course of a Planning Meeting or during any other contact with the Member.

    c. The Support Coordinator shall report urgent or potential emergencies to Support Coordination management to determine the level of intervention and appropriate action, including referral to quality management.

3. The Support Coordinator may provide more frequent case monitoring following the occurrence of an urgent or emergent need or change of condition, which may require revisions to the existing Planning Document.

4. The Support Coordinator, in conjunction with the Division’s Health Care Services and Member’s DDD health plan, shall assess and authorize adequate services prior to the Member’s discharge to the Member’s Own Home, community residential setting, or assisted living setting.
   a. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days following a Member’s discharge from an inpatient setting or a change of placement type or from the date the Support Coordinator is made aware of such a change.
   b. The Support Coordinator shall conduct the Planning Meeting to ensure that appropriate services are in place and that the Responsible Person agrees with the Planning Document as authorized.
   c. The Support Coordinator shall conduct a post-discharge Planning Meeting within 10 business days when a Member is discharged from the hospital to a new SNF. A post-discharge Planning Meeting shall not be required for Members discharged from an inpatient hospital stay and returning to the SNF from which they were admitted.

d. The Support Coordinator shall conduct an on-site Planning Meeting within 10 business days post-discharge for Members who are enrolled with ALTCS during an inpatient stay in a hospital.

e. The Support Coordinator shall ensure the provision of services identified through the discharge planning, assess for any unmet needs, and ensure that the Responsible Person agrees with the Planning Document.

5. The Support Coordinator shall work in coordination with the District's Complex Care Specialist and the Member's behavioral health provider to assist with coordination of the Member's discharge needs when a Member has been admitted to a behavioral health inpatient facility.

a. The Support Coordinator shall participate in all scheduled Inpatient Treatment and Discharge Plan (ITDP) Meetings within three days of the Member's admission.

b. The Support Coordinator, with the facility's treatment team and representatives of the Planning Team, shall develop a preliminary ITDP within one day and a full ITDP within seven days of a Member's admission when a Member's

anticipated stay is less than seven days. Refer to A.A.C R9-21-312.

c. The Support Coordinator shall review and participate in the review of the ITDP as frequently as necessary, but at least once within the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent year that the Member remains in the inpatient facility. Refer to A.A.C R9-21-312.

6. The Support Coordinator shall conduct an on-site Planning Meeting within 30 calendar days when a Member:

a. Moves from a placement type to the same placement type.

b. Starts a new day treatment program or an employment program.

D. ADDITIONAL PLANNING MEETING REQUIREMENTS

1. The Support Coordinator shall meet with the Responsible Person, according to the established standards:

a. The Support Coordinator shall discuss the type, amount, and providers of authorized services.

b. The Support Coordinator shall take and document action taken, when issues are reported or discovered, to resolve

these issues as quickly as possible. The Division shall also be advised of Member grievances and provider issues for purposes of tracking and trending.

c. The Support Coordinator shall assess the Member's current functional, medical, behavioral, and social strengths and needs, including any changes to the Member's informal support system, in accordance with the Needs Assessment and Care Planning Standards as specified in Division Medical Policy 1620-B.

d. The Support Coordinator shall use the Division's, HCBS Member Needs Assessment Tool to review the service hours a Member needs when Attendant Care, Homemaker, and/or Habilitation services shall be authorized for the Member.

e. The Support Coordinator shall utilize the HCBS Member Needs Assessment (Form DDD-2039A) to assess and document the care that is provided and agreed upon by the Member's informal support system.

f. The Support Coordinator shall review the HCBS Member Needs Assessment (Form DDD-2039A) at each Planning

Meeting and include a discussion with the Responsible Person regarding the voluntary provision of informal support.

g. The Support Coordinator shall regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care to the Member.

h. The Support Coordinator shall use the Division's Member Level of Care (MLOC) Tool (Form DDD-2096A) to determine the level of care for all Members not residing in an institutional setting.

i. The Support Coordinator shall complete the Member Level of Care (MLOC) Tool (Form DDD-2096A) every 12 months and review the MLOC Tool at least every 180 days or more often as indicated by a change in Member's condition.

j. The District Nurse, in coordination with the Support Coordinator, shall review and complete the AHCCCS Uniform Assessment Tool (UAT) at least once every 180 days for Members residing in an SNF.

    i. This review shall include a comparison with facility

documentation. In addition, for Nursing Facilities, this review shall include documentation from the Minimum Data Set (MDS) to determine changes in the Member's acuity level.

ii. The UAT may be updated more frequently than 180 days as requested by the provider for authorization purposes or when there has been a change in the Member's condition.

k. The Support Coordinator shall assess the continued appropriateness of the Member's current placement and services, including whether the Member is residing in the setting of their choice and whether there are any goals that need to be developed and/or risks to manage related to the Member's service or placement decisions and identify risks that may compromise the Member's general health condition and quality of life. The Support Coordinator shall:

i. Assess the cost effectiveness of services provided or requested,

ii. Discuss with the Responsible Person the progress

toward established goals

iii. Identify any barriers to the achievement of the Member's goals,

iv. Develop and prioritize new and/or existing goals as needed

v. Review service delivery options available to the Member, at each Planning Meeting for Members living in or preparing to transition to their Own Home from an institutional setting or to a community residential setting or Assisted Living setting.

vi. Review and document, at least annually, the Member's continued choice of the Member's spouse as the paid caregiver. Documentation shall include the Member's signature on the Spousal Attendant Care Acknowledgment of Understanding (Form DDD-1469A).

vii. Review, at least annually, the Division ALTCS Member Handbook to ensure the Responsible Person is familiar with the contents, especially as related to covered services and their rights and responsibilities.

2. The Support Coordinator shall coordinate with the Member's behavioral health provider for a referral to a qualified clinician, as specified in A.A.C. R9-21- 101(B) for assessment and evaluation when the Planning Team has identified the need for a Serious Mental Illness Determination. See the Division's Medical Policy 320-P for further details.
3. The Support Coordinator shall coordinate with the assigned advocate from the Office of Human Rights (OHR) assigned to provide the notification for Special Assistance Members with a Serious Mental Illness Determination in accordance with AMPM Policy 320-R.
4. The Support Coordinator shall coordinate with the behavioral health provider to review and discuss the following items for Members who have a Serious Mental Illness Determination:
    a. The outcome of the assessment, the need for further evaluations, as necessary, and any interim services provided.
    b. The existing Inpatient Treatment and Discharge Plan (ITDP), according to A.A.C. R9-21-312, when applicable.
5. The Support Coordinator shall be responsible for following up

with the behavioral health provider for Members receiving behavioral health services to ensure newly assessed services are initiated within 14 calendar days.

6. The Support Coordinator shall refer the case to the Public Fiduciary or other available resources, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members when the Member is not capable of making their own decisions, but does not have a guardian and is not capable of making their own decisions, The Support Coordinator shall document in the case file the reason a Responsible Person is not available.

7. The Support Coordinator shall regularly assess using the Planning Document, Members who reside in a community residential or Assisted Living setting to determine if it is possible to safely meet the Member’s needs in a more integrated setting.

8. The Support Coordinator shall review, at each Planning Meeting, with the Responsible Person, the process for immediately reporting any unplanned gaps in service delivery for Members receiving services in their Own Home.

9. The Support Coordinator shall reconvene the Planning Team to

address the gap and, if needed, identify additional strategies to prevent future occurrences when a gap occurs in one or more of the following services.

a. Attendant Care
b. Respite
c. Nursing
d. Homemaker
e. Habilitation Hourly, and
f. Habilitation – Individually Designed Living Arrangement

10. The Support Coordinator shall contact the appropriate provider to address problems or issues identified by the Responsible Person.
11. The Support Coordinator shall contact the Member’s HCBS provider, at least annually, if they are not present at the time of the Planning Meeting, to discuss the ongoing assessment of the Member’s needs and status.
    a. The Support Coordinators shall review Provider Progress Reports and follow-up if issues or concerns are identified.
    b. The District Nurse shall contact the Home Health Agency quarterly when the Member is receiving skilled nursing

care and document any input received from the Home Health Agency on the Quarterly Nursing Assessment.

c. The Support Coordinator may need to contact the service provider quarterly, for Members receiving behavioral health services, to complete the behavioral health consultation. Refer to Division Medical Policy 1620-G for further details.

12. The Support Coordinator shall refer the case to the Division's Medical Director for review when the Support Coordinator and PCP or attending physician disagree regarding the need for a change in acuity, placement, or physician's orders for medical services. The Medical Director shall be responsible for reviewing the case, discussing it with the PCP or attending physician if necessary, and making a determination to resolve the issue.

13. The Support Coordinator shall discuss with the Responsible Person any potential changes that may necessitate a change of placement or services, determined through the planning process, prior to the initiation of any changes.

14. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person in the event of a denial, reduction, termination, or suspension of services, when the

Responsible Person has indicated, on the Planning Document, that they disagree with the type, amount, or frequency of services to be authorized. Refer to 42 CFR 438.404 and Division Operations Policy 414 for more detailed information and specific timeframes regarding the Notice of Adverse Benefit Determinations.

15. The Division shall provide Members who have a Serious Mental Illness Determination the option to choose between the appeal process for Members who have received a Serious Mental Illness Determination or the standard appeal process. Refer to Division Operations Policy 446.

16. The Support Coordinator shall be aware of the following regarding Members eligible to receive hospice services:

    a. The Responsible Person may elect for the Member to receive hospice services which may be covered by private insurance or Medicare, or by ALTCS if no other payer source is available.

    b. The Medicare hospice benefit shall be divided into two 90-day election periods. Thereafter, the Member may continue to receive hospice benefits in 60-day increments.

A physician shall recertify hospice eligibility at the beginning of each election period, and

c. The Responsible Person shall have the right to revoke the election of Medicare hospice care at any time during the election period and resume ALTCS coverage; however, any remaining days of coverage are then forfeited for that election period.

d. A Responsible Person may also, at any time, again elect to receive Medicare hospice coverage for any other hospice election periods for which they are eligible.

e. The hospice agency shall be responsible for providing covered services to meet the needs of the Member related to the Member's hospice-qualifying condition. Medicaid services provided to Members receiving Medicare hospice services that are duplicative of Medicare hospice benefits shall not be covered.

f. The Support Coordinator may assess and authorize attendant Care services in conjunction with hospice services.

i. The Division shall provide the attendant care service

when the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis. Refer to the Division's Medical Policy 310-J, for additional information regarding hospice services.

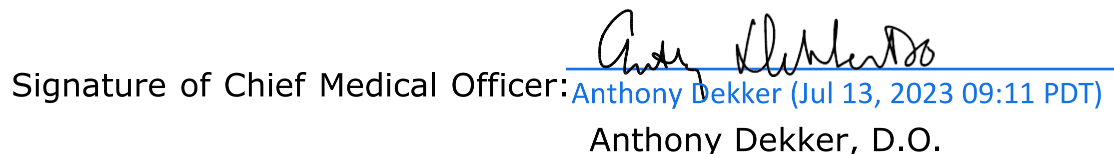
17. The Support Coordinator shall only complete a Member Change Report (eMCR) for Members who are ALTCS. The Support Coordinator shall be responsible for using the eMCR process to notify AHCCCS of a variety of changes in the Member's status. Refer to AMPM 1620-2 for a hard copy of the eMCR form and refer to the ALTCS Member Change Report User Guide on the AHCCCS website, for instructions on completing the eMCR.
18. The Support Coordinator shall update the information in Focus as the Division electronically transmits some data fields to AHCCCS.

E. RESPONSIBLE PERSON'S REFUSAL TO COOPERATE

1. The Division shall issue a Notice of Adverse Benefit Determination to the Responsible Person, indicating the reason(s) for the denial or discontinuance of services when a Support Coordinator is unable to conduct a Planning Meeting, as specified above, due to the Responsible Person's refusal to

cooperate with the provisions, services cannot be evaluated for medical necessity and therefore shall not be authorized.

2. The Support Coordinator shall send a letter to the Responsible Person requesting contact by a specific date within 10 business days to schedule a Planning Meeting.
3. The Support Coordinator shall contact the local ALTCS office to see if they have the Member's current contact information when there is no response by the designated date on the letter.
4. The Support Coordinator shall send an eMCR after 30 days of no contact with a Responsible Person indicating loss of contact to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program.
    a. The Division shall not disenroll a member when the local ALTCS office is able to contact the Responsible Person and confirm the Responsible Person does not wish to withdraw from the ALTCS program.



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