1620-D PERSON-CENTERED SERVICE PLANNING STANDARDS

REVISION DATES: 10/1/2025, 9/3/2025, 12/4/2024, 8/2/2023, 2/16/2022, 9/8/2021
REVIEW DATES: 12/13/2024, 5/3/2024, 10/20/2023
EFFECTIVE DATE: July 6, 2021
REFERENCES: Title 42 U.S. Code 1320a 7b; A.R.S. § 36-551; AMPM Chapter 1600; 2024 National Committee for Quality Assurance Case Management Long Term Services and Supports (NCQA CM-LTSS) Standard 2, Elements D and E and Standard 3, Elements A and B; Division Medical Policies Chapter 300, Chapter 1200, 1620-A, 1620-B, 1620-C, 1620-E; and Division Operations Policy 4002.

PURPOSE

This policy establishes the requirements for Person-Centered service planning for Division of Developmental Disabilities (Division) Members enrolled in Arizona Long Term Care Services (ALTCS).

DEFINITIONS

1. "Alternative Home and Community Based Services Settings" means living arrangements where Members reside and receive Home and Community Based Services, and includes:
    a. Community Residential Settings,
    b. Group foster homes,
    c. Adult Behavioral Health Therapeutic Homes (ABHTH), and
    d. Behavioral health respite homes.

2. "Attendant Care" means a service which provides a trained attendant to provide assistance with homemaking, general supervision and personal care.
3. "Business Day" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. § 1-301.
4. "Calendar Day" means every day of the week including weekends and holidays.
5. "Community Residential Setting" means:
    a. A residential setting in which persons with developmental disabilities live and are provided with appropriate supervision by the Service Provider responsible for operating the residential setting; and
    b. Includes a child developmental home or an adult developmental home operated or contracted by the department or the department's contracted vendor, a group home operated or contracted by the department or a behavioral-supported group home or nursing-supported group home contracted by the department.

6. "Cost Effective" means Home and Community Based Services provided under the ALTCS program that are determined to be Cost Effective when compared to the cost of providing care to the Member in an Institutional Setting, as specified in Division Medical Policy 1620-C.
7. "Electronic Visit Verification" or "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).
8. "Extraordinary Care" means care that exceeds the range of activities that a spouse or a legally responsible Parent of a minor child would ordinarily perform in the household on behalf of the ALTCS Member if the Member did not have a disability or chronic illness, and which is necessary to assure the health and welfare of the Member.

9. "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 the caregiver arrives, unless the caregiver is not able to do the assigned duties;
    c. The Member refuses services; and
    d. The Member's Home is seen as unsafe by the agency or caregiver, so the caregiver refuses to go there.
10. "Habilitation" means a service encompassing the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other Habilitation services.

11. "Habilitation, Hourly Support" means a habilitative service that supports Members to maximize their independent living skills in their Homes and communities.
12. "Home" means a residential dwelling in which the Member is currently living.
13. "Home and Community Based Services" or "HCBS" means, as defined in A.R.S. § 36-2939, services that may be provided in a Member's Home, at an alternative residential setting as prescribed in A.R.S. § 36-591 or at other behavioral health alternative residential facilities licensed by the Arizona Department of Health Services and approved by the Director of AHCCCS.
14. "Home and Community Based Services Needs Tool" or "HNT" means a tool used by the Support Coordinator to assess the Member's specific needs related to Attendant Care and Homemaker services and Habilitation needs.
15. "Independent Provider" means an individual who has a service agreement with the Division to provide Attendant Care (ATC),

Homemaker (HSK), Respite (RSP), or Habilitation, Hourly Support (HAH/HAI) and who is a DCW.

16. "Institutional Setting" means the following:
    a. A nursing facility as specified in 42 USC 1396 r(a);
    b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;
    c. An Intermediate Care Facility for the Mentally Retarded (ICF-MR) for an individual with intellectual or developmental disabilities; or
    d. A hospice free-standing, hospital, or nursing facility subcontracted beds as specified in ARS 36-401.
17. "Managed Risk Agreement" means a document completed 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.
18. "Medically Necessary" means a service prescribed by a doctor or licensed health practitioner that helps with health problems, stops disease, disability, or extends life.

19. "Member" means the same as "Client", a person receiving developmental disabilities services from the Division, as specified in A.R.S. § 36-551.
20. "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.
21. "Person-Centered" means an individualized approach to planning designed to assist the Member to plan their life and supports that enables individuals to increase their personal self-determination and improve their own independence.
22. "Person-Centered Needs Assessment" means a comprehensive process to identify a Member's strengths, needs, and interests by gathering and analyzing information from a variety of sources regarding multiple areas of a Member's life to understand the Member from a whole-person perspective.

18. "Planning Document'' means a written plan developed through a Person-Centered Needs Assessment 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.
19. "Planning Meeting" means an in-person on site meeting with the Planning Team for purposes of conducting a Person-Centered Needs Assessment and ongoing re-assessment, development of the Planning Document; and ongoing monitoring of implementation of the Planning Document, the quality of services and the Member's progress towards goals utilizing Person-Centered practices and guiding principles.
20. "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 or spiritual organizations, and agents from other service systems.

21. "Private Residence" means a residential dwelling in which the Member is currently residing, that is not an Alternative Home and Community Based Services Setting, facility, institution, or a portion of any of the following that are 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).
22. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
23. "Responsible Person" means an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed, the parent or guardian of a minor with a

developmental disability, or the guardian of an adult with a developmental disability.

24. "Service Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.
25. "Share of Cost" or "SOC" means the amount an ALTCS Member is required to pay toward the cost of long term care services.
26. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. SERVICE PLANNING STANDARDS

1. The Support Coordinator shall complete a full Planning Document on an annual basis in the Member's home with the Member present.
2. The Support Coordinator shall assist the Member in identifying goals through a Person-Centered Needs Assessment and Person-Centered planning process.

3. The Support Coordinator shall ensure Cost Effectiveness standards are met in settings where Home and Community Based Services (HCBS) are delivered, as specified in Division Medical Policy 1620-C.
4. The Support Coordinator shall facilitate services based primarily on the Member's choice with additional input in the decision making process from the:
    a. Planning Team,
    b. Person-Centered Needs Assessment, and
    c. Pre-Assessment Screening.
5. The Support Coordinators shall not use referral agencies to identify service options for Members in lieu of the Division's contracted network of Service Providers.
6. The Support Coordinator shall discuss the Cost Effectiveness, as applicable, and availability of needed resources and services to support progress towards achieving goals with the Responsible Person as part of the Planning Meeting.

7. The Support Coordinator and Responsible Person shall discuss the following to determine the most appropriate service and service setting options for the Member:
    a. The Member's choice and preferences toward lifestyle, living situation and how care is provided;
    b. Services necessary to meet the Member's needs in the most integrated and least restrictive setting, including:
        i. 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 service and service setting choices;
    f. Covered services that are associated with care in a licensed Institutional Setting compared to services

provided in the Member's Private Residence or an Alternative HCBS Setting;

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

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

i. The Member's SOC responsibility which is:

   i. The amount of the Member's income that the Member pays towards the cost of long-term care services; and

   ii. 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 Alternative HCBS Setting.

   i. For Members residing in Alternative HCBS Setting, 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.

iii. The room and board amount to be communicated by the behavioral health provider to the Responsible Person for behavioral health residential settings.

8. The Support Coordinator shall complete:

a. Assisted Living Agreement (DDD-1747A) for Members who have elected to receive services in an assisted living facility prior to the Member's entry into the residential setting;

b. DDD Residency Agreement (DDD-2176A) for Members who have elected to receive services in Community Residential Settings prior to the Member's entry into the residential setting; and

c. An updated agreement when changes in the Member's income or the Service Provider's rates occur.

9. The Support Coordinator shall place the Managed Risk Agreement (DDD-1530A) in the case file with documentation of the refusal if the Responsible Person refuses to sign the Managed Risk Agreement.
10. The Division shall accept an electronic signature as a method for obtaining consent or acknowledgement in lieu of a wet signature when documents require the Responsible Person's signature.
11. The Division shall approve services that are Cost-Effective and medically necessary for Members who live in a Private Residence.
12. The Division shall not require Members to enter an Alternative HCBS Setting that is "more" Cost Effective.
13. The Division shall inform the Responsible Person that they have the choice to select the Member's 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 Operations Policy 3001.
14. The Support Coordinator shall complete the Spouse Attendant Care Acknowledgement of Understanding (DDD-1469A) at least

annually with the Member and spouse prior to the authorization of the Member's spouse as the paid caregiver.

15. The Support Coordinator shall inform the Member and their family of caregiver options for minors including the PPCG Service Model Option in accordance with Division Operations Policy 3001.
16. The Support Coordinator shall support and document informed decision making on the selection of caregiver options utilizing the Minor Caregiver Options: Discussion Guide and Decision Roadmap.
17. The Support Coordinator shall assess if the Member has needs that meet the Extraordinary Care criteria as defined by developmental milestones and age appropriate tasks outlined in the Child Tab of the HNT, AMPM Exhibit 1620-17.
18. The Support Coordinator shall have the discussion above in (14) only after the Member's needs have been identified in the PCSP process and the following forms have been completed:
    a. HCBS Needs Assessment Tool, and
    b. Home and Community Based Scheduling Tool.

19. The Support Coordinator shall have the discussion listed in (14) no less than on an annual basis or when the following circumstances apply:
    a. After an initial service assessment for newly eligible ALTCS Members; or
    b. When a Member experiences a change in condition that necessitates either a reduction or increase in assessed and authorized services and hours.
20. The Support Coordinator shall review and obtain parental signature on the Parents as Paid Caregiver Acknowledgement of Understanding and Agreement to Follow Service Model Requirements form, AMPM Exhibit 1620-17.
21. The Support Coordinator shall ensure the service delivery model of (19) is also noted in the Planning Document.
22. The Support Coordinator shall ensure that there is at least one Member-directed and individualized personal outcome in the Planning Document that fosters community integration and relationships with peers in community settings for Members utilizing the PPCG Service Model Option.

23. The Support Coordinator shall communicate with and coordinate services with the appropriate Service Providers as identified and agreed to in the Member's Planning Document.
24. The Division shall not make the Member's assessed needs and corresponding authorization contingent upon the Service Provider meeting the requirements of the U.S. Department of Labor, Fair Labor Standards Act.
25. The Division shall provide all services to meet the Member's needs as soon as possible.
26. The Division shall provide services determined to be Medically Necessary for a newly enrolled Member within 30 Calendar Days of the Member's enrollment.
27. The Division shall provide services for an existing Member within 14 Calendar Days following the determination that the services are Medically Necessary and Cost Effective.
28. The Support Coordinator shall notify the Responsible Person that home health services, therapies and durable medical equipment require a prescription by the primary care provider (PCP).

29. The Support Coordinator shall educate the Responsible Person about fraud, waste, and abuse, and provide information to the Responsible Person, including how to report abuse, neglect, exploitation, and other critical incidents as specified in Division Medical Policy 1620-O.
30. 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 wishes to change their PCP.
31. The Division shall ensure decisions regarding the provision of services funded by ALTCS are:
    a. Made within:
        i. 14 calendar days following the receipt of the request or order; or
        ii. Three business days when the Member's life, health, or ability to attain, maintain or regain maximum function would otherwise be jeopardized.
    b. Based on information provided during the Person-Centered planning process by the Member or Responsible Person

and other individuals invited by the Member to participate in planning;

c. Based on individually assessed needs and consistent with the Member's assessed level of care;

d. Representative of ensuring services are Medically Necessary, Cost Effective and delivered in the least restrictive, most integrated settings possible to meet the Member's individually assessed needs;

e. Based on where they exist;

i. Available research findings;

ii. Practice guidelines;

iii. Best practices; and

iv. Standards of practice issued by professionally recognized organizations or government agencies.

f. Documented in the Planning Document.

32. The Division shall verify and document the delivery of service with the Member or Responsible Person after authorization.

33. The Support Coordinator shall ensure that the Responsible Person understands that some long-term services need to be

prescribed by the Member's PCP and a decision about whether a service is medically necessary cannot be made until the PCP writes an order for the service.

34. The Division shall ensure all orders for medical services include the frequency, duration, and scope of the services requested, when applicable.
35. The Division shall provide appropriate services and service settings to meet the Member's needs within the following timelines:
    a. Services determined to be medically necessary and ~~c~~Cost ~~e~~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.
36. The Support Coordinator shall verify the needed services are available in the Member's community and:

a. 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; or

b. Assess a temporary alternative service or service setting if services cannot be provided to safely meet the Member's needs.

37. 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.

38. The Support Coordinator shall facilitate the Planning Team in developing the Planning Document by supporting, communicating, advocating, and working towards the Member's vision for the future.

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

a. The Member's assessed strengths, needs, interests, goals and outcomes, service needs, and preferences toward lifestyle, living situation and how care is provided;

b. Prioritized meaningful and Person-Centered individualized goals that:

   i. Assist the Member in attaining the most self-fulfilling, age-appropriate goals based on the Member's assessed needs, desires, strengths and preferences;

   ii. Include outcomes and the smaller manageable steps the Member will take to achieve the goal;

   iii. Are specific, measurable, attainable, relevant and time-bound (SMART); and

   iv. Outline actions to be taken by the Planning Team to support the Member in achieving their goals and outcomes.

c. The assessed supports and services needed to assist the Member in achieving their established goals and meet their assessed needs;

d. The frequency and quantity of each ALTCS covered service including any change to the service since the last Planning Meeting;

e. Life planning activities;

f. The Member's preferred method of communication;

g. Assessed risks while considering the Person-Centered guiding principle of dignity of risk for the Member;

h. Measures available to reduce assessed risks or identify alternative ways to achieve individual goals based on the Member's priorities outlined in the Planning Document;

i. The Member's self-management plan;

j. How identified barriers to meeting the Member's goals and preferences or implementing the Planning Document will be resolved, including:

   i. Language or literacy levels;

   ii. Access to transportation;

   iii. Understanding of diagnosis or condition;

   iv. Physical Health;

   v. Lack of motivation;

vi. Insurance coverage or lack of coverage for specific services or amounts;

vii. Health beliefs or health literacy;

viii. Spiritual beliefs;

ix. Visual or hearing impairment;

x. Behavioral Health; or

xi. Any other identified barriers.

k. How the Member communicated their agreement or disagreement when the Member is physically unable to sign the Planning Document.

l. The frequency for Planning Meetings to review and follow up on the Planning Document according to the timeframes specified in Division Medical Policy 1620-E.

40. The Support Coordinator shall ensure the Planning Document is reviewed sooner than the timeframes specified in Division Medical Policy 1620-E when there is a change to the Member's functional needs, circumstances, individual goals, or at the Responsible Person's request.

41. The Support Coordinator shall make every effort to ensure the Responsible Person understands the Planning Document, including their agreement or disagreement with each service authorization.
42. The Support Coordinator shall engage in reasonable conflict resolution efforts to resolve any disagreements that arise during the needs assessment or planning processes, including when the Responsible Person disagrees with the services authorized.
43. The Division shall uphold the Person-Centered guiding principle of presumption of competence by assuming an adult Member enrolled with the Division is legally competent to make decisions on their own behalf unless the Court has appointed a legal guardian.
44. 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 due to cognitive limitations and does not have a legal guardian.

45. The Support Coordinator shall discuss the option of making a referral to the County Public Fiduciary or other community resources, when appropriate.
46. The Support Coordinator shall provide a full copy of the Planning Document upon initial development and subsequently any time the Planning Document is updated, to the following individuals within 10 calendar days of the Planning Meeting and maintain a copy in the case file:
    a. Adult Members;
    b. The Responsible Person, if other than the Member;
    c. Individuals selected by the Responsible Person, as specified in the Planning Document; and
    d. All authorized Service Providers, including behavioral health providers.
47. The Support Coordinator shall document in the case file when the Planning Document was sent to the individuals identified in Section (A)(26) of this policy.
48. 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 service decisions within the Planning Document when the Responsible Person disagrees with the Planning Document or authorization of services including the amount or frequency of a service.

49. The Division shall provide the Responsible Person with information regarding grievance and appeals processes available for Members with a Serious Mental Illness designation as specified in 9 A.A.C. 21 Article 4, ACOM Policy 444, and ACOM Policy 446.33.

50. The Support Coordinator shall complete the Member DDD-EVV Member Contingency/Back-Up Plan for the Independent Provider Program (DDD-2113A) 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 Support;

    d. Habilitation Independent; or

    e. Homemaker.

51. Upon completion of Member DDD-EVV Member Contingency/Back-Up Plan For the Independent Provider Program (DDD-2113A) listed above in (44), the Support Coordinator shall provide a copy to the Responsible Person.
52. The Support Coordinator shall review form DDD-EVV Member Contingency/Back-Up Plan for the Independent Provider Program (DDD-2113A) listed above in (44) during each Planning Meeting.
53. The Support Coordinator shall ensure form DDD-2113A listed above in (44):
    a. Directs 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; and
    b. Directs 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.
54. The Support Coordinator shall encourage and assist Members who reside in a Private Residence to have an Emergency/Disaster Plan (DDD-1621A) for their household to

ensure the Member's safety and that their needs are met in the event of a natural disaster, power outage, required evacuation, or other emergency.

55. The Support Coordinators shall document the discussion with the Responsible Person and indicate if the Responsible Person agreed or declined to develop the Emergency/Disaster Plan (DDD-1621A) in the Planning Document.
56. The Support Coordinator shall document the Member's emergency or disaster plan on the Emergency/Disaster Plan (DDD-1621A), when the Responsible Person requests assistance with developing an Emergency/Disaster Plan.
57. The Support Coordinator shall request a copy of the Electronic Visit Verification (EVV) Member Contingency/Back Up Plan (DDD-2099A), from the Qualified Vendor for Members residing in a Qualified Vendor setting.
58. The Support Coordinator shall attach the following to the Planning Document:
    a. The DDD-EVV Member Contingency/Back-Up Plan For the Independent Provider Program, (DDD-2113A) for Members

residing within an Independent Provider setting, when applicable; and

b. The Emergency/Disaster Plan (1621-A) for Members residing in a Private Residence, when applicable.

59. The Support Coordinator shall complete referrals for services and community resources identified in the Planning Document within one business day of the Planning Document being completed.
60. The Support Coordinator shall monitor and follow up on the referrals made to ensure services are initiated as specified in the Person-Centered Principles Handbook.
61. If the Responsible Person is responsible for acting on a referral, the Support Coordinator shall monitor if they have followed through with referrals.
62. The Support Coordinator shall monitor, verify, and document that the Member receives the services included in the Planning Document at the frequency specified in Division Medical Policy 1620-E.
63. The Support Coordinator shall regularly assess if the Member is residing in the most integrated setting possible for the Member's

needs to be met. Members are permitted to change to a less restrictive service setting, if needed services are available and Cost Effective in that setting.

64. 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 to meet with the Member and their Responsible Person until the Member is disenrolled from ALTCS.
65. 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.

66. 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 where the Planning Document indicates the Member's acuity level based on the AMPM Exhibit 1620-3, completed by the District Nurse, and the need for specialty care;
    b. Acute and Psychiatric Hospital admissions;
    c. Bed holds or therapeutic leave days, refer to AMPM 100 for definitions and limitations;
    d. Services in an uncertified nursing facility;
    e. DME outside the institutional facility per diem with a value exceeding $300 regardless of if rented, purchased, or repaired which will be waived for Members;
    f. Hospice services;
    g. Occupational, Physical, and Speech therapies;
    h. Medically necessary non-emergency transportation;
    i. Behavioral health services as indirect services; and

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

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

a. Group respite;

b. Attendant care;

c. Habilitation;

d. Home delivered meals;

e. Licensed health aide;

f. Community transition services that are to be authorized in order to transition a Member from an institution to a Private Residence;

g. Homemaker;

h. Respite care;

i. Occupational, Physical, Speech, or Respiratory therapies;

j. Behavioral health services as an indirect services;

k. Home modifications;

l. Assisted living facility services; and

m. Title XIX covered services as noted above, if provided by other funding sources, or insurance sources other than Title XIX.

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 Effectiveness 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 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 or sufficient to meet the Member's needs while out-of-state, and
   b. Determine the dates of departure and return.

4. The Division shall notify the Planning Team and the Qualified Vendor of the outcome of the request.
5. 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.
6. The Division shall not cover services for Members while the Member is outside of the United States and United States Territories.

C. AHCCCS NOTIFICATION REQUIREMENTS

1. The Support Coordinator shall complete an electronic member change report (eMCR) for an evaluation of long term care or 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.
2. 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.

3. 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.
4. 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.
5. The Support Coordinator shall not complete an eMCR when reporting a change in the Member's PCP.

Coralyn Lingwall

Signature of System and Practice Improvement Administrator

Coralyn Lingwall

Name

Sep 2, 2025

Date