1620-B - NEEDS ASSESSMENT/CARE PLANNING STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/17, 06/01/21

APPROVAL DATES: 10/01/04, 02/01/05, 09/01/05, 10/01/06, 10/01/07, 05/07/10, 01/01/11, 05/01/12, 03/01/13, 01/01/16, 07/20/17, 05/28/20

I. PURPOSE

This Policy applies to ALTCS E/PD and DES/DDD (DDD); and Fee-For-Service (FFS) Tribal ALTCS as delineated within this Policy. Where this Policy references Contractor requirements the provisions apply to ALTCS E/PD, DES/DDD and Tribal ALTCS unless otherwise specified. This Policy establishes requirements regarding needs assessment and care planning.

II. DEFINITIONS:

CASE MANAGERS	Arizona licensed registered nurses in good standing, social workers, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience, or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or have been determined to have an SMI.
CASE MANAGEMENT	A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
DESIGNATED REPRESENTATIVE	A parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs as specified in A.A.C. R9-21-101(B).
HEALTH CARE DECISION MAKER	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

PERSON-CENTERED SERVICE PLAN (PCSP)	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 Person-Centered Service Plan shall 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 rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.
PLANNING TEAM	A defined group of individuals that shall include the member/Health Care Decision Maker and with the member's/Health Care Decision Maker's consent, his or her family, Health Care Decision Maker, individual representative, 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 like Department of Child Safety (DCS). 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.
PRIOR PERIOD COVERAGE (PPC)	For Title XIX members, the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, Prior Period Coverage for the member will be covered by AHCCCS Fee For Service and the member will be enrolled with the Contractor only on a prospective basis.

III. POLICY

1. Case Managers are expected to use a person-centered approach regarding the member assessment and needs identification, taking into account not only ALTCS covered services, but also other needed community resources as applicable. Case Managers shall:

a. Respect the member and the member's rights,
b. Support the 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 teaching to support the member/Health Care Decision Maker to make informed decisions and choices,
d. Be available to answer questions and address issues raised by the member/Health Care Decision Maker and Designated Representative (as applicable), including between regularly scheduled PCSP meetings,
e. Provide a continuum of service options that supports the expectations and agreements established through the PCSP process,
f. Educate the member/Health Care Decision Maker and Designated Representative (as applicable), on how to report unavailability or other problems with service delivery to the Contractor to ensure unmet service needs can be addressed as quickly as possible. Refer to AMPM Policy 1620-D and AMPM Policy 1620-E regarding specific requirements,
g. Facilitate access to non-ALTCS supports and services available throughout the community, as well as Non-Title XIX services for members with an SMI designation,
h. Advocate for the member and/or family/significant others as the need occurs,
i. Allow the member/Health Care Decision Maker and Designated Representative to identify their role in interacting with the service delivery system, including the extent to which the family/informal supports will provide uncompensated care,
j. Provide members/Health Care Decision Makers and Designated Representatives with flexible and creative service delivery options,
k. Educate members/Health Care Decision Makers and Designated Representatives about member directed options for delivery of designated services in accordance with AMPM Chapter 1300. These options shall be reviewed with members/Health Care Decision Makers for members living in their own homes at every PCSP meeting. The ALTCS Member Service Options Decision Tree found in AMPM Chapter 1600, Exhibit 1620-18, is a tool that may be used by Case Managers to have discussions with members,
l. Educate members/Health Care Decision Makers on the option to choose a spouse as the member's paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs,
m. Provide necessary information to providers about any changes in 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 member,
o. Educate the members/Health Care Decision Makers and Designated Representatives on End of Life Care and Advanced Care Planning, services and supports including covered services and assist members in accessing those services as specified in AMPM Policy 310-HH,
p. Assist members to identify their independent living goals and provide them 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 (refer to the section below which outlines additional requirements for individualized member goals), and

q. Refer member cases, via Electronic Member Change Report (EMCR), to the AHCCCS Division of Member/Provider Services for a medical eligibility re-assessment if a member is assessed to no longer require an institutional level of care. Refer to the AHCCCS ALTCS Member Change Report Guide for MCR instructions.

2. The involvement of the member/Health Care Decision Maker and Designated Representative in strengths/needs identification as well as decision-making is a basic tenet of ALTCS Case Management practice. For the PCSP meetings, the Planning Team may include anyone, as requested by the member/Health Care Decision Maker. The member/Health Care Decision Maker and Planning Team partner with the Case Manager in the development of the PCSP, with the Case Manager generally functioning as the facilitator.

3. The Case Manager shall complete a Uniform Assessment Tool (UAT) based on information from the member's PCSP to determine the member's current level of care. E/PD Case Managers shall utilize AMPM Chapter 1600, Exhibit 1620-3. DDD Case Managers shall utilize the Contractors Level of Care Assessment Tool to determine the member's current level of care.

4. PCSP is based on face-to-face discussion with the member/Health Care Decision Maker and other members of the Planning Team in order to develop a comprehensive PCSP, as defined in this policy. The PCSP shall include recommendations of the member's Primary Care Provider (PCP), as well as input from ALTCS service providers, as applicable. Case Managers shall complete the HCBS Needs Tool (HNT) to determine the amount of service hours a member needs when Attendant Care, Personal Care, Homemaker, Habilitation, and/or Respite services will be authorized for members living at home. Refer to AMPM Chapter 1600, Exhibit 1620-17.

5. As part of the development of the member's PCSP, Case Managers shall assist in identifying meaningful and measureable individualized goals for members, including long-term and short-term goals (e.g. in the areas of recreation, transportation, friendships, family and other relationships) to assist the member in attaining the most self-fulfilling, age-appropriate goals consistent with the member's needs, desires, strengths, and preferences.

   Goals shall include steps that the member will take to achieve the goal(s). Goals shall be written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes. Goals shall be reviewed at each PCSP meeting.

6. For members who have been receiving Home and Community Based Services (HCBS) during the Prior Period Coverage (PPC) timeframe as specified in AMPM Policy 100, 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.

   If all three of these criteria are met, the services are eligible for reimbursement by the ALTCS Contractor, or, for FFS members, the AHCCCS Administration, as specified in the member's PCSP. Services that will be retroactively approved based on this assessment shall be marked as "Retroactive" in the PCSP. If any of the services provided during the PPC are not approved by the ALTCS Contractor, the member must be provided a written Notice of Adverse Benefit Determination (NOA) and given an opportunity to file an appeal. Refer to A.A.C. 34, for more detailed information on this requirement.

   In addition to the grievance and appeals procedures described above, the Contractor shall also make available the grievance and appeals processes described in ACOM Policy 444 and ACOM Policy 446 and in 9 A.A.C 21, Article 4 for individuals determined to have a SMI under Arizona law.

   Assisted Living Facilities are encouraged to bill/accept Medicaid payment for services for members who are eligible under PPC, but are not required by regulations to do so. If the facility chooses to, or is required by contract to bill the Contractor, 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 facility must refund private payments made by the member or family, less the amount of room and board assigned by the Contractor, prior to billing the Contractor for Medicaid reimbursement.