

1620-D - PLACEMENT/SERVICE PLANNING STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/04, 02/01/05, 09/01/05, 01/01/06, 05/01/06, 10/01/07, 02/01/09, 03/01/10, 05/07/10, 01/01/11, 02/01/11, 05/01/12, 03/01/13, 01/01/16, 10/01/17

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I. PURPOSE

This Policy applies to ALTCS/EPD, DES/DDD; 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 for placement and service planning.

II. DEFINITIONS

HOME AND COMMUNITY BASED SERVICES Home and community-based services, as specified in A.R.S. §36-2931 and §36-2939.

OWN HOME The ALTCS Member's residential dwelling, including a house, a mobile home, an apartment, or similar shelter. An ALTCS HCB approved alternative residential setting as specified in 9 A.A.C. 28 Article 1.

III. POLICY

A guiding principle of the Arizona Long Term Care System (ALTCS) program is that members live in the most integrated/least restrictive setting. Placement goals must be identified through the service planning process and cost effectiveness standards must be met in the Home and Community Based setting.

The case manager is responsible for facilitating placement/services based primarily on the member's choice with additional input in the decision-making process from the member/guardian/designated representative, the case manager's assessment, the Pre-Assessment Screening, the members Primary Care Provider (PCP) and/or other service providers.

Case managers are prohibited from using referral agencies to identify placement options for member in lieu of the Contractor's contracted network of providers. Refer to Title 42 U.S. Code 1320a-7b.

The case manager shall adhere to the placement/service planning standards as follows:

1. After the needs assessment (refer to AMPM Policy 1620-B) is completed, the case manager must discuss the cost effectiveness and availability of needed services with the member and/or the member's family/representative.
2. In determining the most appropriate service placement for the member, the case manager and the member and/or the member's family/representative should discuss the following as applicable:
 - a. The member's placement choice,
 - b. Services necessary to meet the member's needs in the most integrated/least restrictive setting. See AMPM Chapter 1200 for information about the following types of services available:
 - i. Home and Community Based Services (HCBS),
 - ii. Institutional services,
 - iii. Acute care services, and
 - iv. Behavioral health services.
 - c. The member's interest in and ability to direct their own supports and services. If the member is unable to direct his/her own supports and services, a legal guardian or Individual Representative may be appointed who can choose to direct the member's care. Member directed options for service delivery of designated services are outlined in AMPM Policy 1322,
 - d. The availability of HCBS in the member's community,
 - e. Cost effectiveness of the member's placement/service choice,
 - f. Covered services which are associated with care in a nursing facility compared to services provided in the member's home or another Alternative HCBS setting as defined in AMPM Policy 1230,
 - g. The risks that may be associated with the member/guardian/designated representative choices and decisions regarding services, placements, caregivers, which would require a managed risk agreement signed by the member/legal guardian to document the situation,
 - h. If a managed risk agreement is required and the member or the member's legal guardian refuses to sign the managed risk agreement, the agreement should be placed in the case file with documentation of the refusal,
 - i. The member's Share of Cost (SOC) responsibility. The SOC is the amount of the member's income that he/she must pay towards the cost of long term care services. The amount of the member's SOC is determined and communicated to the member by the local ALTCS Eligibility office,
 - j. The member's Room and Board (R & B) responsibility, including the following:
 - i. The portion of the cost of the care in an Alternative HCBS setting that must be paid by the member or other source (such as the member's family), since AHCCCS does not cover R&B,
 - ii. The monthly R&B amount is determined by and will be communicated to the member by the ALTCS Contractor, and
 - iii. Once the member has selected Assisted Living Facility placement option and prior to the member residing in the facility, review and signature by all parties of Exhibit 1620-15, Assisted Living Facility Residency Agreement is required. Review and completion by the Contractor of Exhibit 1620-16, Assisted Living Facility Member Financial Change Agreement is required,

when appropriate to update the R&B amount whenever the member's income or facility rate changes.

3. Any member who lives in his/her own home must be allowed to remain in his/her own home as long as HCBS are cost effective. Members cannot be required to enter an Alternative HCBS placement/setting that is "more" cost effective.
4. Members must be informed that they have the choice to select his/her spouse to be the member's paid caregiver for medically necessary and cost effective services (provided the spouse meets all the qualifications as specified in the attendant care section of AMPM Policy 1240.) The case manager must be available to assist member/spouse with this decision but is not expected to contact the applicable agencies for the member to determine the impact of the change in the spouse's income on eligibility for programs. Exhibit 1620-12, Spouse Attendant Care Acknowledgement of Understanding must be signed by the member and spouse prior to the authorization of the member's spouse as the paid caregiver and at least annually thereafter.
5. Upon the member's or member representative's agreement to the service plan, the case manager is responsible for coordinating the services with appropriate providers.

A provider's compliance with the U.S. Department of Labor, Fair Labor Standards Act, has no bearing on a member's assessed needs and corresponding authorized services and service hours.

Placement within an appropriate setting and/or all services to meet the member's needs must be provided as soon as possible. A decision regarding the provision of services requested must be made within 14 calendar days following the receipt of the request/order (three business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized). Refer to Title 42 CFR 438.210 for more information.

Services determined to be medically necessary for a newly enrolled member must be provided to the member within 30 calendar days of the member's enrollment. Services for an existing member must be provided within 14 calendar days following the determination that the services are medically necessary and cost effective.

Contractors shall develop a standardized system for verifying and documenting the delivery of services with the member/guardian/designated representative after authorization.

6. The case manager must ensure that the member/guardian/designated representative understands that some long term care services (such as home health services or Durable Medical Equipment [DME]) must be prescribed by the PCP. A decision about the medical necessity of these services cannot be made until the PCP writes an order for the service. All orders for medical services must include the frequency, duration and scope of the service(s) required, when applicable.

7. If an ALTCS member does not have a PCP or wishes to change PCP, it is the case manager or designated staff's responsibility to coordinate the effort to obtain a PCP or to change the PCP.
8. The case manager must also verify that the needed services are available in the member's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of personal care or home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.
9. The case manager is responsible for developing a written service plan (Exhibit 1620-13) that reflects services that will be authorized. It must be documented for each ALTCS covered service whether the frequency/quantity of the service has changed since the previous service plan. Every effort must be made to ensure the member or representative understands the service plan. The member or representative must indicate whether he/she agrees or disagrees with each service authorization and signs the service plan at initial development, when there are changes in services and at the time of each service review. If the member is physically unable to sign, the case manager must document how the member communicated his/her agreement/disagreement. If the member is unable to participate due to cognitive limitations and there is no representative, the case manager must leave the service plan unsigned and document the circumstances. The case manager must provide a copy of the service plan to the member or representative and maintain a copy in the case file.

The Contractor must engage in reasonable conflict resolution efforts to resolve issues related to member's disagreement with the service plan.

10. If the member disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the member with a Notice of Adverse Benefit Determination (NOA) that explains the member's right to file an appeal regarding the placement or service plan determination. 9 A.A.C. 34 ACOM Policy 414 for additional information.

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 for persons determined to have an SMI under Arizona law.

Contractors shall ensure that all issues presented by the member in the appeal are fully addressed and explained in the Notice of Appeals Resolution (NAPR). It is further expected that the Contractor shall communicate with the member's provider(s) before issuing the NAPR to ensure the Contractor has thorough, timely, and accurate information to adjudicate the appeal. For service-related decisions in which the appeal is not upheld, the NAPR must clearly explain the specific treatment alternatives and services that are available for the member to consider such as step therapies or more cost effective, clinically appropriate treatment alternatives. Upon receipt of a request

for hearing, Contractors are required to thoroughly review their determination to ensure that the decision is complete, is legally and factually accurate as well as relevant to the appealed matter, and that it supports the Contractor's determination. The Contractor must also promptly evaluate any new information that is submitted with the request for hearing. Sufficiently in advance of the date of the hearing, the Contractor shall contact the member to explain the reasons for the Decision and make reasonable efforts to resolve the member's concerns outside of the hearing process.

11. The AHCCCS/ALTCS Member Contingency/Back-Up Plan (found in Exhibit 1620-14) must also be completed for those members who will receive any of the following critical services in their own home:
- Attendant care, including spouse attendant care, Agency with Choice and Self-Directed Attendant Care,
 - Personal care, including Agency with Choice,
 - Homemaker, including Agency with Choice and/or
 - In-home respite.

The term "critical services" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.

A gap in critical services is defined as the difference between the number of hours of critical services scheduled in each member's Service Plan and the hours of the scheduled type of critical services that are actually delivered to the member.

The following situations are not considered gaps:

- The member is not available to receive the service when the Direct Care Worker (DCW) arrives at the member's home at the scheduled time,
- The member refuses the DCW when he/she arrives at the member's home, unless the DCW's ability to accomplish the assigned duties is significantly impaired by the DCW's condition or state (for example, drug and/or alcohol intoxication),
- The member refuses services,
- The provider agency or case manager is able to find an alternative DCW for the scheduled service when the regular DCW becomes unavailable,
- The member and regular DCW agree in advance to reschedule all or part of a scheduled service, and/or
- The DCW refuses to go or return to an unsafe or threatening environment at the member's residence.

The contingency plan must include information about actions that the member and/or representative should take to report any gaps and what resources are available to the member, including on-call back-up DCWs and the member's informal support system, to resolve unforeseeable gaps (e.g., regular caregiver illness, resignation without notice, transportation failure, etc.) within two hours. **The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice.** An out-of-home placement in a Nursing Facility (NF) or Assisted Living Facility (ALF) should be the last resort in addressing gaps.

The contingency plan must include the telephone numbers for the toll-free AHCCCS line and provider and/or contractor that will be responded to promptly 24 hours per day, seven days per week. The member or member representative should be encouraged to call the toll-free AHCCCS line and provider and/or Contractor so that the service gap can be responded to in a timely manner.

In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the Contractor to ensure that critical services are provided within two hours of the report of the gap. If the provider agency or case manager is able to contact the member or representative before the scheduled service to advise him/her that the regular caregiver will be unavailable, the member or representative may choose to receive the service from a back-up substitute caregiver, at an alternative time from the regular caregiver or from an alternate caregiver from the member's informal support system. **The member or representative has the final say in how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.**

12. The written contingency plan for members receiving those critical services described above must include a Member Service Preference Level from one of the four categories shown below:
 - a. Needs service within two hours,
 - b. Needs service today,
 - c. Needs service within 48 hours, or
 - d. Can wait until the next scheduled service date.

Member Service Preference Levels must be developed in cooperation with the member and/or representative and are based on the most critical in-home service that is authorized for the member. The Member Service Preference Level will indicate how quickly the **member chooses** to have a service gap filled if the scheduled caregiver of that critical service is not available. The member or representative must be given the final say about how (informal versus paid caregiver) and when care to replace a scheduled caregiver who is unavailable will be delivered.

The case manager should assist the member or representative in determining the member's Service Preference Level by discussing the member's caregiving needs associated with his/her Activities of Daily Living (ADL, such as mobility, transferring, toileting, bathing, grooming, and eating) and Instrumental Activities of Daily Living (IADL, such as housekeeping, meal preparation and grocery shopping), abilities and cognitive, behavioral and medical status. The case manager should ensure the member or representative has considered all appropriate factors in deciding the member's Service Preference Level. The member/representative is not required to take into account the presence of an informal support system when determining the Service Preference Level.

The case manager must document the Member Service Preference Level chosen in the case file. This documentation must clearly indicate the member's or representative's involvement in contingency planning.

A member or representative can change the Service Preference Level from a previously determined Service Preference Level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor must discuss the current circumstances with the member or representative at the time the gap is reported to determine if there is a change in the Service Preference Level. The plan to resolve the service gap must address the **member's choice** at the time the gap is reported.

The contingency plan must be discussed with the member/representative at least quarterly. A copy of the contingency plan must be given to the member when developed and at the time of each review visit. The member/representative may change the member Service Preference Level and his/her choices for how service gaps will be addressed at any time.

13. Members who reside in “own home” settings should be encouraged, and assisted as indicated, by the case manager to have a disaster/emergency plan for their household that considers the special needs of the member. Informational materials are available at the Federal Emergency Management Agency’s (FEMA) website at www.fema.gov or www.ready.gov.
14. Members who reside in out-of-home residential placements must be regularly assessed to determine if they are in the most integrated setting possible for their needs. Members should be allowed or encouraged to change to a less restrictive placement, as long as needed services are available and cost effective in that setting.
15. If the member will be admitted to a nursing facility, the case manager must ensure and document that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and Level II evaluation, if indicated, have been completed prior to admission. See AMPM Chapter 1200 for more information.
16. If the member does not intend to pursue receiving HCBS or institutional services, the member needs to be encouraged to withdraw from the ALTCS program voluntarily and seek services through an AHCCCS Acute Care Contractor or other programs.

If the member refuses long term care services that have been offered or refuses to allow the case manager to conduct a review visit in accordance with the required timeframes and locations, but does not wish to withdraw from the ALTCS program, the case must be referred for an evaluation of Acute Care Only eligibility via the electronic Member Change Report (MCR) process. The member/representative must be advised that he/she could be disenrolled from the ALTCS program depending on his/her income. The electronic MCR and documentation that further describes the circumstances of the member’s refusal to accept ALTCS services should be sent to the AHCCCS/Division of Health Care Management (DHCM) Medical Management (MM) Unit.

Refer to Exhibit 1620-2 for a hard copy of the MCR form. Exhibit 1620-2 also provides guidelines on circumstances for which an MCR is needed and Exhibit 1620-

- 4 describes and gives examples of member situations for which an Acute Care Only “D” placement is appropriate.
17. The service plan must include the date range and units for each service authorized in the member’s case file according to the Contractor’s system for tracking service authorizations. Tribal Contractor case manager must enter those services authorized for the member on the CA165/Service Plan in the CATS system.

For members residing in an institutional setting, the Contractor’s system for tracking authorized services or the CA165/Service Plan (for Tribal Contractors) shall include the following types of services, as appropriate based on the member’s needs:

- a. Nursing facility services. The service plan must indicate the Level of Care (Level I, II, or III) based on the Uniform Assessment Tool or other contractor method for determining specialty care (for example, behavior management, wandering/dementia or sub-acute),
 - b. Hospital admissions (acute and psychiatric),
 - c. Bed hold or therapeutic leave days (refer to AMPM Chapter 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 if rented, purchased or repaired). This requirement is waived for ALTCS/DDD members,
 - f. Hospice services,
 - g. Therapies (occupational, physical and speech),
 - h. Medically necessary non-emergency transportation (**required for Tribal Contractors only**),
 - i. Behavioral health services (only those provided by behavioral health independent billers – see definition in the Glossary of the Behavioral Health Services Guide), and
 - j. Title XIX covered services as noted above if provided by other funding sources, for example, Medicare, Tribes, Children’s Rehabilitative Services, other insurance sources.
20. For members residing in an HCBS setting the Contractor’s system for tracking authorized services or the CA165/Service Plan (for Tribal Contractors) must include the following types of services, as appropriate, based on the member’s needs:
- a. Adult day health or group respite,
 - b. Hospital admissions (acute and psychiatric),
 - c. Attendant care – including when provided through a member directed option. One or more service code modifiers must be used to distinguish the type of Attendant Care when /if provided as follows:
 - i. By the member’s spouse (U3),
 - ii. By family living with the member (U5),
 - iii. By family not living with the member (U4),
 - iv. As Self Directed Attendant Care (U2),
 - v. As Agency with Choice (U7),

- d. DME outside the institutional facility per diem (item/items with a value exceeding \$300 regardless if rented, purchased or repaired). This requirement is waived for ALTCS/DDD members,
 - e. Emergency alert systems,
 - f. Medical supplies that have a monthly cost in excess of \$100.00 (**required for Tribal Contractors only**),
 - g. Habilitation, including when provided through a member directed option. The U7 service code modifier must be used to designate when the service is provided as Agency with Choice,
 - h. Home delivered meals,
 - i. Home health aide,
 - j. Community Transition Services that will be authorized in order to transition the Nursing Facility (NF) member to HCBS “Own Home”. Refer to AMPM Policy 1240 for definitions and limitations. This service may be authorized while the member is still in an institutional placement,
 - k. Homemaker, including when provided through a member directed option. The U7 service code modifier must be used to designate when the service is provided as Agency with Choice,
 - l. Hospice,
 - m. Personal care, including when provided through a member directed option. The U7 service code modifier must be used to designate when the service is provided as Agency with Choice,
 - n. Respite care, including nursing facility respite,
 - o. Therapies (occupational, physical, speech, and/or respiratory),
 - p. Behavioral health services (only those that are authorized with Healthcare Common Practice Coding System [HCPCS] codes),
 - q. Medically necessary non-emergency transportation when the round trip mileage exceeds 100 miles (**required for Tribal Contractors only**),
 - r. Home modifications,
 - s. Assisted Living Facility services,
 - t. Member and/or DCW Training, authorized as part of a member directed service option,
 - u. Behavioral health alternative residential facility services, and
 - v. Title XIX covered services as noted above, if provided by other funding sources, for example, Medicare, Tribes, Children’s Rehabilitative Services, other insurance sources.
21. For members designated as “**Acute Care Only (ACO)**” the Contractor’s system for tracking authorized services or the CA165/Service Plan (for Tribal Contractors) must include the following types of services, as appropriate, based on the member’s needs:
- a. DME (this requirement is waived for ALTCS/DDD members),
 - b. Medically necessary non-emergency transportation when the round trip mileage exceeds 100 miles (required for Tribal Contractors only),
 - c. Rehabilitative therapies (physical, occupational and speech), and
 - d. Behavioral health services.
- Members who are enrolled as “ACO” due to financial reasons (such as a transfer of resources) are eligible to receive all medically necessary behavioral health services as listed in AMPM Policy 310.

22. Refer to AMPM Chapter 1200 for descriptions of the amount, duration and scope of ALTCS services and settings, including information about restrictions on the combination of services.
23. The CA161/Placement Maintenance screen in the Client Assessment Tracking System (CATS) system must be updated with the following information within ten days of the initial visit:
- ID number of case manager currently assigned to the case,
 - Date of last case management review visit with the member,
 - Placement code(s) and begin/end dates since enrollment,
 - Residence code that corresponds with each Placement,
 - Placement Reason code that corresponds with each Placement, and
 - Behavioral health code that reflects member's current status.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management for information on the codes and procedures for entering the above data into the CATS system.

24. The CA162/Community First Choice screen in the Client Assessment Tracking System (CATS) must be entered with the following member information within ten business days of the service visit and updated at least annually:
- Agency With Choice indicator,
 - Self-Directed Attendant Care indicator,
 - Employment Status,
 - Educational Level,
 - Level of Care,
 - Incontinence Status,
 - Whether member receives any Antipsychotic Medications, and
 - Major Diagnosis (at least one but up to three diagnoses).

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management for information on the codes and procedures for entering the above data into the CATS system.

25. Contractors are not required to enter service authorizations on the CA165/Service Plan in the CATS system. Tribal Contractors are required to enter this information on the CA165/Service Plan within five business days of the initiation of the service(s) authorized.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management, for information on the codes and procedures for entering service plan data into the CATS system.