

1620-E - SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

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

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

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 service plan monitoring and reassessment visits.

II. DEFINITIONS

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

SERIOUS MENTAL ILLNESS (SMI) A condition as defined in A.R.S. §36-550 and determined in a person 18 years of age or older.

III. POLICY

1. Case managers are responsible for ongoing assessment and monitoring of the needs, services and placement of each member assigned to their caseload in order to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers.
2. Member needs, placement and services must be reviewed, with the member present, within the following timeframe:
 - a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in non-Medicare certified institutional settings),
 - b. At least every 90 days for a member receiving Home and Community Based Services (HCBS),
 - c. At least every 90 days for a member receiving acute care services only and living in his/her "own home" or an Alternative HCBS setting. Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year. Acute Care Only members residing in a non-contracted or uncertified institutional setting must have an on-site visit at least every 180 days,
 - d. At least every 180 days for DDD members 12 years or older residing in a group home, unless the member is medically involved or Seriously Mentally Ill/Severely Emotionally Disturbed (SMI/SED). For members with medically involved needs or determined SMI/SED, on-site visits must be conducted at least every 90 days.

Refer to AMPM Exhibit 1620-1 for required Case Management Timeframes.

Contractors may develop standards for more frequent monitoring visits of certain members and/or specific types of placements at their discretion. However, at a minimum, Contractors must adhere to the case management review standards outlined in this policy.

Case managers are expected to attend nursing facility care planning meetings on a periodic basis to discuss the member's needs and services jointly with the member/guardian/designated representative and care providers. At a minimum, case managers must consult with facility staff during 180-day visits to assess changes in member Level of Care.

3. Review visits are to be conducted where the member receives services, including the member's home and other service settings as described below. At a minimum, case managers must conduct review visits with a member in his or her home at least twice annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs. If a member receives services in a setting outside of the home, at a minimum, a review visit must be conducted at one of the member's service setting locations. At the election of the member/guardian/designated representative remaining visits may be conducted at an alternate location that is not a service setting. The location of each review visit, whether at a service setting location or an alternate site, must be determined by the member or member/guardian/designated representative and not for the convenience of the case manager or providers. The choice of location by the member/guardian/designated representative must be documented in the case management file.

If a case manager is unable to conduct a review visit as specified above due to the refusal by the member and/or the member/guardian/designated representative to comply with these provisions, services cannot be evaluated for medical necessity and therefore, will not be authorized. A Notice of Adverse Benefit Determination (NOA) must then be issued to the member setting forth the reasons for the denial/discontinuance of services.

4. Member/guardian/designated representative must be able to contact the member's case manager between the regularly scheduled visits to ask questions, discuss changes/needs and/or to request a meeting with the case manager. The case manager must respond to the questions and/or requests made by the member/guardian/designated representative, within 48 hours (not including weekends and holidays).
5. Case managers must take appropriate action when they identify or are notified of an urgent or a potential emergency situation. Case managers must report any urgent or potential emergency situations to their supervisor/manager in order to determine the level of intervention and appropriate action, including referral to quality management.

More frequent case monitoring may be required following the occurrence of an urgent/emergent need or change of condition which will require revisions to the existing service plan.

An emergency visit is required when the situation is urgent and cannot be handled over the telephone or when the case manager has reason to believe that the member's health and/or safety is at risk.

6. Adequate services must be arranged by the case manager prior to the member's discharge to his or her own home or to an Alternative HCBS setting. Additional discharge planning requirements for E/PD and DDD are outlined in AMPM Chapter 1000.

For a member determined to be SMI, and admitted to a behavioral health inpatient facility, the case manager shall participate in Inpatient Treatment and Discharge Plan (ITDP) meetings to assist with coordination of the member's discharge needs. Within three days of the member's admission the case manager must collaborate with the facility treatment team to develop a preliminary ITDP and a full ITDP within seven days of a member's admission. If a member's anticipated stay is less than seven days, the inpatient facility must develop a preliminary ITDP within one day and a full ITDP within three days of a member's admission. Refer to A.A.C R9-21-301.

At a minimum, the facility treatment team, other representatives of the clinical team, the member/guardian/designated representative and the case manager shall review 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 R9-21-301.

7. Case managers must conduct an on-site review within 10 business days following a member's discharge from an inpatient setting or a change of placement type (for example, from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS) or from the date the case manager is made aware of such a change. This review must be conducted to ensure that appropriate services are in place and that the member agrees with the service plan as authorized.

For members enrolled with the Contractor during an inpatient stay in a hospital, case managers must conduct an on-site review within 10 business days post-discharge. This review must be conducted to ensure the provision of services identified through discharge planning, to assess for any unmet needs and to ensure that the member agrees with the service plan as authorized.

8. For members enrolled with an ALTCS E/PD or Tribal ALTCS Contractor, including members determined to have a SMI, once it has been determined that a new behavioral health services is medically necessary and cost effective, the Contractor must ensure the new service(s) are initiated within 14 calendar days.

9. If the case manager is unable to contact a member to schedule a visit, a letter must be sent to the member/guardian/designated representative requesting contact by a specific date (10 business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the case manager must send an electronic Member Change Report (eMCR), indicating loss of contact, to the local Arizona Long Term Care System (ALTCS) Eligibility office for possible disenrollment from the ALTCS program. The eMCR must be sent after 30 days of no contact with a member.

Disenrollment will not occur if the local office is able to make contact with the member or authorized representative and confirm that the member does not wish to withdraw from the ALTCS program.

10. The case manager must meet with the member/guardian/designated representative, according to the established standards, in order to:
 - a. Discuss the type, amount and providers of authorized services. If any issues are reported or discovered, the case manager must take and document action taken to resolve these issues as quickly as possible. The Contractor administration must also be advised of member grievances and provider issues for purposes of tracking/trending,
 - b. 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 outlined in AMPM 1620-B. If the member is assessed to no longer need an institutional level of care, the case manager must refer the case for a medical eligibility Pre-Admission Screening (PAS) reassessment via the electronic Member Change Report process,
 - c. Convene the interdisciplinary team for member's determined to have an SMI to review and discuss the following:
 - i. The outcome of the assessment, the need for further evaluations (as necessary) and any interim services provided (e.g. crisis services),
 - ii. The existing Inpatient Treatment and Discharge Plan (ITDP), according to R9-21-312 (if applicable).

The case manager shall use the HCBS Needs Tool (HNT) found in AMPM Exhibit 1620-17 to review the service hours a member needs when Attendant Care, Personal Care, Homemaker, Habilitation and/or Respite services will be authorized for the member. The HNT must also reflect care that is provided and agreed to by the member's informal support system. This tool must be reviewed at each 90-day service review and must include a discussion with the member and/or the member/guardian/designated representative regarding the voluntary provision of informal support. Case managers must regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care.

The Uniform Assessment Tool (UAT), used to determine the Level of Care for E/PD members, must be updated at least annually, more often as indicated by a change in member condition. Depending on contractual requirements, it may also be updated as requested for nursing facility authorizations.

Case managers must review the UAT every 180 days for nursing facility E/PD members, comparing it with facility documentation such as the Minimum Data Set (MDS) to determine changes in Level of Care. Changes in Level of Care must be communicated to the nursing facility. A copy of the UAT may be found in AMPM Exhibit 1620-3,

- d. Assess the need for an SMI Determination and as appropriate, make a referral to a qualified clinician, as defined in A.A.C. R9-21-101(B) for assessment and evaluation and in accordance with AMPM 320-P,
 - e. Assess the continued appropriateness of the member's current placement and services, including whether the member is residing in the setting of his/her 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,
 - f. Assess the cost effectiveness of services provided and/or requested
 - g. Discuss with the member/guardian/designated representative his/her progress toward established goals,
 - h. Identify any barriers to the achievement of the member's goals,
 - i. Develop new goals as needed,
 - j. Review service delivery options available to the member, including member directed options, at each assessment/ service planning meeting for members living in or preparing to transition to his/her "own home" from an institutional setting or Alternative HCBS setting. These options should be reviewed using the ALTCS Member Service Options Decision Tree (Exhibit1620-18) as a tool to support Members in making an informed decision on the option that works best for them,
 - k. Review and document, at least annually, the member's continued choice of his or her spouse as paid caregiver. Documentation shall include the member's signature on the "Spouse Attendant Care Acknowledgement of Understanding Form" (AMPM Exhibit 1620-12) and
 - l. Review, at least annually, the Contractor's (or the Administration's for members enrolled with a Tribal Contractor) member handbook to ensure member/guardian/designated representatives are familiar with the contents, especially as related to covered services and their rights/responsibilities.
11. The member/guardian/designated representative must be involved for the above if the member is unable to participate due to a cognitive impairment, if the member is a minor child and/or if the member has a legal guardian.

If the member is not capable of making his/her own decisions, but does not have a legal representative or representative available, the case manager must refer the case to the Public Fiduciary or other available resource, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members. If a guardian/fiduciary is not available, the reason must be documented in the file. A

notification for Special Assistance must be completed for members determined to have an SMI who meet the criteria for Special Assistance, in accordance with AMPM 320-R.

12. Members who reside in a residential setting must be regularly assessed to determine if it is possible to safely meet the member's needs in a more integrated setting. Community Transition Services (CTS) may be used to assist members residing in a Nursing Facility (NF) to discharge to his/her "own home" (see AMPM Policy 1240 for definitions and limitations related to CTS).
13. The case manager must complete a written service plan (AMPM Exhibit 1620-13) at the time of the initial visit, when there are any changes in services, and at the time of each review visit (every 90 or 180 days). The member or representative must indicate whether he/she agrees or disagrees with each service authorization and sign the service plan each time. The member must be given a copy of each signed service plan.
14. The case manager must review, with the member/guardian/designated representative the Contractor's process for immediately reporting any unplanned gaps in service delivery at the time of each service review for all members receiving "critical" services in his/her "own home." The AHCCCS/ALTCS Member Contingency/Back-Up Plan (found in Exhibit 1620-14) must also be completed for those members receiving critical services.
15. If problems or issues are identified by the member/guardian/designated representative or case manager, the case manager must make contact with the appropriate HCBS provider to address the concerns. The member's HCBS providers must also be contacted at least annually by the case manager to discuss the on going assessment of the member's needs and status. This shall include providers of services such as personal or attendant care, home delivered meals, homemaker, therapy, etc.

If the member is receiving skilled nursing care from a home health agency, quarterly contact is required with the service provider (refer to AMPM 1620-K).

For members receiving behavioral health services, the case manager may need to make contact with the service provider quarterly in order to complete the behavioral health consultation (refer to AMPM 1620-G).

16. The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order (see AMPM Chapter 1200 for more information on which services require an order from the member's Primary Care Provider [PCP]).

If the case manager and PCP or attending physician disagree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager may refer the case to the Contractor's Medical Director (or the AHCCCS Medical Director for members enrolled with a Tribal Contractor) for review. The

Medical Director is responsible for reviewing the case, discussing it with the PCP and/or attending physician if necessary, and making a determination in order to resolve the issue.

17. If the case manager determines through the reassessment process a change in the member's condition may necessitate a change of placement or services, the case manager must discuss any potential changes with the member/guardian/designated representative prior to the initiation of any changes. This is especially critical if the changes result in a reduction or termination of services.
18. The member or the member's legal representative must be issued a NOA in the event of a denial, reduction, termination or suspension of services, when the member or legal representative has indicated, on the service plan, that s/he disagrees with the type, amount, or frequency of services to be authorized. Refer to A. A. C. 9 A.A.C. 34 and ACOM Policy 414 for more detailed information and specific timeframes.

All grievances and requests for hearings and appeals of members enrolled with a Tribal Contractor are addressed directly to AHCCCS Administration, Office of Administrative Legal Services. A managed care member's request for hearing and/or appeal is initiated through the ALTCS Contractor.

Members determined to have a SMI have the option to choose between the appeal process for members determined to have a SMI or the standard appeal process. Refer to ACOM Policy 444 and ACOM Policy 446-4

19. The case manager must be aware of the following regarding members eligible to receive hospice services:
 - a. Members may elect to receive hospice services. These services may be covered by private insurance or Medicare, if the member has Part A, or by ALTCS if no other payer source is available,
 - b. The Medicare hospice benefit is divided into two 90-day election periods. Thereafter, the member may continue to receive hospice benefits in 60-day increments. A physician must recertify hospice eligibility at the beginning of each election period, and
 - c. The member has 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.

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

The hospice agency is 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 (i.e. Home Health Aide, Personal Care and Homemaker Services) will not be covered. Attendant care is not considered a duplicative service. If the hospice agency is unable or unwilling to provide or cover medically necessary

- services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor may report such cases to Arizona Department of Health Services (ADHS) as the hospice licensing agency in Arizona. Refer to AMPM 1250, for additional information regarding hospice services.
20. All nursing facilities that participate in AHCCCS are dually certified as Medicare and Medicaid facilities. Therefore, beds in these nursing facilities may not be designated as Medicare-only. An ALTCS member may not be asked to leave a Medicaid-participating nursing facility after his/her Medicare benefit days have exhausted.
21. In most cases, members must receive a written 30-day advance notice before discharge from a nursing facility as outlined in 42 CFR 483.12. Exceptions may be made when the health and/or safety of the member or other residents is/are endangered.
- ALTCS Contractors shall set their own rules regarding advance notice of discharge for members who reside in assisted living facilities in the Contractor's contracts with those facilities.
22. Case managers are responsible for using the electronic Member Change Report (MCR) process to notify AHCCCS of a variety of changes in the member's status. Refer to AMPM Exhibit 1620-2 for a hard copy of the MCR form and more information on the circumstances for using this form. Refer to the ALTCS Member Change Report User Guide on the AHCCCS website, for instructions in completing the electronic MCR. The hard copy form should only be used as a last resort when electronic submission is not available (for example when member is no longer enrolled with the Contractor).
23. The case manager is responsible for updating information in the Client Assessment Tracking System (CATS) within 14 business days of the reassessment.