1620-D - PLACEMENT AND 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, 06/01/21, 10/01/22, 07/26/24, 10/01/25, 10/01/26

APPROVAL 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, 07/20/17, 06/18/20, 04/07/22, 05/16/24, 08/26/25, 08/18/26

I. PURPOSE

This Policy applies to ALTCS E/PD and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Program Tribal ALTCS; excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy establishes requirements for ALTCS member placement and service planning. Where this Policy references ALTCS or Contractor requirements, the provisions apply to ALTCS E/PD, DES DDD, and Tribal ALTCS unless otherwise specified.

II. DEFINITIONS

Refer to the AHCCCS ACOM and AMPM Dictionary for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

CASE MANAGER	Arizona licensed Registered Nurses (RNs) 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 individuals with a Serious Emotional Disturbance (SED) identification or Serious Mental Illness (SMI) designation.
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 (DR)	An individual parent, guardian, relative, advocate, friend, supporter, or other individual, designated orally or in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs.

HEALTH CARE DECISION MAKER (HCDM)	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in ARS Title 14, Chapter 5, Article 2 or 3; or ARS 8-514.05, 36-3221, 36-3231 or 36-3281.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and Community Based Services, as specified in ARS 36-2931 and ARS 36-2939.
HOME AND COMMUNITY BASED SERVICES NEEDS TOOL (HNT)	A tool used by ALTCS Case Managers to assess ALTCS member's specific needs related to direct care services (AMPM Policy 1240-A) and habilitation service (AMPM Policy 1240-E) needs. The tool has two tabs for assessment purposes: one for minor children aged 0-17 and one for adults aged 18+. The HNT is a stand-alone document found in AMPM Exhibit 1620-17.
MANAGED RISK AGREEMENT	A document developed by the Case Manager and the member/Health Care Decision Maker (HCDM), which outlines potential risks to the member's health, safety, and well-being as a result of decisions made by the member or their HCDM regarding Long Term Care Services and Supports. The Managed Risk Agreement shall specify the alternatives offered to the member and shall document the member's choices with regard to any decisions involving placement, services, and supports. The Managed Risk Agreement shall be signed by the member and or the HCDM at each Person-Centered Service Plan (PCSP) meeting and kept in the member's case file.
OWN HOME	A residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a: 1. Health care institution under ARS 36-401. 2. Residential care institution under ARS 36-401. 3. Community residential setting under ARS 36-551. 4. Behavioral health facility under 9 AAC 20, Articles 1, 4, 5, and 6.
PARENT AS PAID CAREGIVER (PPCG) SERVICE MODEL OPTION	Permits legally responsible parents, including legal guardians, with formal physical and/or legal custody to receive compensation for providing paid direct care and habilitation services to their minor child, an ALTCS member.

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 PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified and prioritized goals, 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 (HCDM) and with the member's/HCDM's consent, their individual representative, Designated Representative (DR), 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.

III. POLICY

A guiding principle of the ALTCS program is that members live in the most integrated and least restrictive setting. A member's placement goals shall be identified through the Person-Centered Service Plan (PCSP) process, and cost effectiveness standards shall be met in the home and community-based setting.

The ALTCS Case Manager is responsible for facilitating placement and services based primarily on the member's choice and with additional input in the decision-making process from the member/Health Care Decision Maker (HCDM) and/or Designated Representative (DR), the Case Manager's assessment, the Pre-Admission Screening (PAS), and other members of the planning team.

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

The Case Manager shall adhere to placement and service planning standards as follows:

1. After the PCSP (refer to AMPM Policy 1620-B) is completed, the Case Manager shall discuss the cost effectiveness and availability of needed services with the member/HCDM/DR.

2. In determining the most appropriate service placement, the Case Manager and the member/HCDM/DR shall discuss the following as applicable:
   a. The member's placement choice and preferences,
   b. The services necessary to meet the member's needs in the most integrated/least restrictive setting, Refer to 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 their own supports and services, an HCDM/DR may be appointed to direct the member's care. Member-directed options for service delivery of designated services are specified in AMPM Policy 1320-A,
   d. The availability of HCBS in the member's community,
   e. The cost-effectiveness of the member's placement and service choice,
   f. The covered services which are associated with care in a Nursing Facility (NF) compared to services provided in the member's home or another alternative HCBS setting as specified in AMPM Chapter 1200,
   g. The risks that may be associated with the member/HCDM's choices and decisions regarding services, placements, caregivers, which would require a Managed Risk Agreement signed by the member/HCDM to document the situation. For additional information regarding Managed Risk Agreements for the purpose of cost-effectiveness, refer to AMPM Policy 1620-C. If a Managed Risk Agreement is required and the member or the member's HCDM refuses to sign the Managed Risk Agreement, the Managed Risk Agreement shall be placed in the case file with documentation of the refusal,
   h. The member's share of cost responsibility. The share of cost is the amount of the member's income that the member shall pay towards the cost of long-term care services. The amount of the member's share of cost is determined and communicated to the member by the local ALTCS eligibility office,
   i. 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 shall be paid by the member or other source such as the member's family because AHCCCS is prohibited from covering R&B in these settings,
      ii. The monthly R&B amount is determined by, and will be communicated to the member by, the ALTCS Contractor or Tribal ALTCS Program for Tribal ALTCS members,
      iii. Once the member has selected an Assisted Living Facility (ALF) placement option and prior to the member residing in the facility, review and signature by all parties of the ALF Residency Agreement is required. Refer to AMPM Exhibit 1620-15. Whenever the member's income or LOC changes, the Contractor shall complete the Assisted Living Facility Financial Change Agreement to update the reimbursement rate and/or R&B amount as appropriate. Refer to AMPM Exhibit 1620-16, and

iv. Once the member has selected a Community Residential Setting (refer to AMPM Policy 1230-C) placement option and prior to the member residing in the setting, review, and signature by all parties of the residency agreement is required. Refer to AMPM Exhibit 1620-14 (DDD settings) and AMPM Exhibit 1620-15 (EPD ALF settings).

For documents requiring a member/HCDM signature, an electronic signature in lieu of a wet signature is an acceptable method for obtaining consent and/or acknowledgement.

3. Any member who chooses to live in their own home may receive services in their own home in the amount, scope, and duration of services that are medically necessary and cost effective. Members cannot be required to enter an alternative HCBS placement/setting that is "more" cost-effective.

4. The members/HCDM/DR shall be informed that they have the choice to select their 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-A. The Case Manager shall be available to assist the member and spouse with this decision, but the Case Manager 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. The Spouse Attendant Care Acknowledgement of Understanding form (AMPM Exhibit 1620-12) shall 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. The members and their families shall be informed of caregiver options for minors including the Parents as Paid Caregiver service model (PPCG) in accordance with AMPM Policy 1240-A and 1240-E. The ALTCS Case Manager shall support and document informed decision making on the selection of caregiver option(s) utilizing the Minor Caregiver Options Discussion Guide and Decision Roadmap found in AMPM Exhibit 1620-21. The discussion shall occur only after the members' needs have been identified in the PCSP process and the Home and Community Based Services (HNT) Needs Tool has resulted in a determination that a minor member has assessed needs that meets 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). The frequency of the discussion shall be no less than on an annual basis or when the following circumstances apply:
   a. After an initial service assessment for newly eligible ALTCS members,
   b. When a member experiences a change in conditions that necessitates either a reduction or increase in assessed and authorized services and hours, or
   c. When the parent/guardian of an existing member expresses interest in a service model change.

   The parent(s) shall review and sign the Parents as Paid Caregiver Acknowledgement of Understanding and Agreement to Follow Service Model Requirements form found in AMPM Exhibit 1620-22. The service delivery model shall also be noted in the PCSP.

For members utilizing PPCG, the parent(s) shall review and sign the Parents as Paid Caregiver Acknowledgement of Understanding and Agreement to Follow Service Model Requirements form found in AMPM Exhibit 1620-22. The service delivery model shall also be noted in the PCSP.

Also, for members utilizing PPCG, there must be at least one member-directed, individualized goal in the PCSP focused on engagement with peers in community settings. This goal may be a personal goal that does not necessitate paid services.

6. Upon the member's/HCDM/DR agreement to the PCSP, the Case Manager is responsible for coordinating the services with appropriate providers in accordance with AMPM 1620-B.

   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 shall be provided as soon as possible. A decision regarding the provision of services requested shall be made within seven calendar days following the receipt of the request/order (if the member's life, health, or ability to attain, maintain, or regain maximum function would otherwise be jeopardized, the timeframe is reduced to three business days). Refer to Title 42 CFR 438.210 for more information.

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

   The Contractor and Tribal ALTCS Programs shall develop a standardized system for verifying and documenting the delivery of services with the member/HCDM/DR after authorization.

7. The Case Manager shall ensure that the member/HCDM/DR understands that some long-term care services (such as home health services or Durable Medical Equipment [DME]) shall be prescribed by the member's 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 shall include the frequency, duration, and scope of the service(s) required, when applicable.

8. If an ALTCS member does not have a PCP or wishes to change their PCP, it is the Case Manager or designated staff's responsibility to coordinate the effort to obtain a PCP or to change the PCP.

9. The ALTCS Case Manager shall also verify that the services needed are available in the member's community. If a service is not currently available, the Case Manager shall substitute a combination of other services 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 attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the members' needs.

10. The ALTCS Case Manager shall ensure members have access to transportation and support for the purpose of visiting potential licensed residential or non-residential settings specified in AMPM Policies 1230-A, 1230-C, 1240-B, 1240-E and 1240-J prior to making a decision on where to live or receive services.

11. The ALTCS Case Manager is responsible for developing the PCSP utilizing AMPM Exhibit 1620-10. The PCSP shall identify the member's strengths, goals, preferences, needs, and desired outcomes. The role of the planning team in developing the PCSP is to support the member in communicating the member's vision for the future. The PCSP shall include the full range of assessed services and supports identified to assist the member in achieving their established goals. For each ALTCS covered service, the PCSP shall document the frequency/quantity of the service, including any change to the service since the last PCSP meeting. Every effort shall be made to ensure the member/HCDM understands the PCSP, including if the member/HCDM agrees or disagrees with each service authorization. The Case Manager shall engage the Contractor in reasonable conflict resolution efforts to resolve issues related to a member's disagreement with the PCSP.

    The PCSP shall be reviewed according to the timeframes specified in AMPM Exhibit 1620-1 or sooner if there is a change to the member's functional needs, circumstances, individual goals, or at the member's request. If the member is physically unable to sign, the ALTCS Case Manager shall document how the member communicated their agreement/disagreement. If the member is unable to participate due to cognitive limitations and the member does not have a HCDM/DR, the PCSP shall remain unsigned, and the ALTCS Case Manager shall document the circumstances. The ALTCS Case Manager shall provide a full copy of the PCSP to the member/HCDM upon initial development and subsequently anytime the PCSP is updated. A copy of the PCSPs shall be maintained in the member's case file. The ALTCS Case Manager shall also provide a copy of the PCSP to the individuals including a DR selected by the member/HCDM, as specified in the PCSP.

    The Case Manager shall assess for risks while considering the member's right to assume some degree of personal risk and include measures available to reduce risks or identify alternate ways to achieve individual goals.

12. If the member/HCDM disagrees with the PCSP and/or authorization of placement or services (including the amount and/or frequency of a service), the Case Manager shall provide the member/HCDM with a Notice of Adverse Benefit Determination (NABD) that explains the member's right to file an appeal regarding the placement, services, or PCSP determination. In addition to the appeals procedures described in the NABD the Contractor shall also make available the grievance and appeals processes as specified in 9 AAC 21 Article 4, ACOM Policy 444, and ACOM Policy 446 for persons determined to have a Serious Mental Illness (SMI) under Arizona law. Refer to AMPM Policy 1620-E for additional information.

The Contractor shall ensure that all issues presented by the member in the appeal are fully addressed and explained in the Notice of Appeal Resolution (NOAR). It is further expected that the Contractor shall communicate with the member's provider(s) before issuing the NOAR 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 NOAR shall 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, relevant to the appealed matter, supports the Contractor's determination. The Contractor shall also promptly evaluate any new information that is submitted with the request for a 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.

13. For contingency planning requirements of provider agencies, refer to AMPM Policy 540.

14. For contingency planning requirements of case managers for members utilizing the self-directed attendant care member-directed option, refer to AMPM Policy 1320-A.

15. The 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. ALTCS Case Managers shall document the discussion with the member/HCDM/DR. Informational materials are available at the Federal Emergency Management Agency's (FEMA) website at www.fema.gov or www.ready.gov.

16. The members who reside in out-of-home residential placements shall be regularly assessed to determine if they are in the most integrated setting possible for their needs. Members are permitted to change to a less restrictive placement, as long as needed services are available and cost-effective in that setting.

17. If the member will be admitted to a NF, the Case Manager shall 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. Refer to AMPM Policy 680-C for more information.

18. If the member/HCDM/DR does not intend to pursue receiving HCBS or institutional services, the Case Manager shall review the applicable ALTCS member handbook and inform the member/HCDM/DR on the process for voluntary withdrawal and guide the member/HCDM on seeking services through an AHCCCS Complete Care (ACC) Contractor or other programs.

    If the member/HCDM/DR refuses long term care services that have been offered or refuses to allow the ALTCS 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 shall be referred for an evaluation of Acute Care Only (ACO) eligibility via the electronic Member Change Report (eMCR) process. The member/HCDM shall be advised that the member may be disenrolled from the ALTCS program depending on the member's income.

The eMCR and documentation that further describes the circumstances of the member's refusal to accept ALTCS services shall be sent to AHCCCS via the AHCCCS eMCR website.

Refer to AMPM Exhibit 1620-2 for a hard copy of the ALTCS Member Change Report (MCR) form. AMPM Exhibit 1620-2 also provides guidelines on circumstances for which an eMCR is needed, and AMPM Exhibit 1620-4 describes and gives examples of member situations for which an Acute Care Only "D" placement is appropriate.

19. The PCSP shall 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 ALTCS programs Case Manager shall enter those services authorized for the member on the CA165/Service Plan in the Client Assessment Tracking System (CATS) system.

    For members residing in an institutional setting, the Contractor's system for tracking authorized services or the CA165/Service Plan (for Tribal ALTCS Programs) shall include the following types of services, as appropriate based on the member's needs:
    a. Nursing Facility (NF) services. The PCSP shall 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,
    d. Services in an uncertified NF,
    e. A DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless of whether the item is 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 ALTCS Programs only),**
    i. Behavioral health services (only those provided by behavioral health independent providers – see the AHCCCS Covered 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 (CRS), and 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 ALTCS Programs) shall 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,
    d. A DME outside the institutional facility per diem (item/items with a value exceeding $300 regardless of whether 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 ALTCS Programs only**),

g. Habilitation, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as Agency With Choice (AWC),
h. Home delivered meals,
i. Home health aide,
j. Licensed Health Aide (LHA),
k. Community transition services that will be authorized in order to transition the NF member to HCBS "own home". Refer to AMPM Policy 1240-C for limitations. This service may be authorized while the member is still in an institutional placement,
l. Homemaker, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as AWC,
m. Hospice,
n. Personal care, including when provided through a member directed option. The U7 service code modifier shall be used to designate when the service is provided as AWC,
o. Respite care, including NF respite,
p. Therapies (occupational, physical, speech, and/or respiratory),
q. Behavioral health services (only those that are authorized with Healthcare Common Practice Coding System [HCPCS] codes),
r. Medically necessary non-emergency transportation when the round-trip mileage exceeds 100 miles (**required for Tribal ALTCS Programs only**),
s. Home modifications,
t. Assisted Living Facility (ALF) services,
u. Member and/or Direct Care Worker (DCW) training authorized as part of a member directed service option,
v. Behavioral health alternative residential facility services, and
w. Title XIX covered services as noted above, if provided by other funding sources (for example, Medicare, Tribes, CRS, and other insurance sources).

21. For members designated as **"ACO,"** the Contractor's system for tracking authorized services or the CA165/Service Plan (for Tribal ALTCS Programs) shall include the following types of services, as appropriate, based on the member's needs:
    a. 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 ALTCS Programs only**),
    c. Rehabilitative therapies (physical, occupational, and speech), and
    d. Behavioral health services.

    The 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-B.

    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.

22. The CA161/placement maintenance screen in the CATS system shall be updated with the following information within 10 business days of the initial PCSP meeting:
    a. ID number of ALTCS Case Manager currently assigned to the case,
    b. Date of last case management review visit with the member,
    c. Placement code(s) and begin/end dates since enrollment,
    d. Residence code that corresponds with each placement,
    e. Placement reason code that corresponds with each placement, and
    f. Behavioral health code that reflects member's current status.

23. The CA162/community first choice screen in the CATS shall be entered with the following member's information within 10 business days of the PCSP meeting and updated at least annually:
    a. Agency with choice indicator,
    b. Self-directed attendant care indicator,
    c. Employment status,
    d. Educational level,
    e. Level of care,
    f. Incontinence status,
    g. Whether member receives any antipsychotic medications, and
    h. Major diagnosis (at least one but up to three diagnoses).

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

24. The Contractors are not required to enter service authorizations on the CA165/Service Plan in the CATS system; however, the Contractors are expected to maintain a uniform tracking system.

25. The Tribal ALTCS Programs are required to enter this information on the CA165/Service Plan within five business days of the initiation of the service(s) authorized.