

CHAPTER 1600

CASE MANAGEMENT

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1600 CHAPTER OVERVIEW

REVISION DATES: 05/01/12, 04/01/11, 01/01/11, 10/01/04

INITIAL

EFFECTIVE DATE: 02/14/1996

Chapter 1600 provides process and administrative standards for Arizona Long Term Care System (ALTCS) and targeted case management. These standards must be included in policies and procedures developed by Contractors for case management of their enrolled members. Standards set forth in this chapter may be exceeded in order to meet the needs of enrolled members.

For the purpose of this chapter, the following definitions apply:

1. “Contractor(s)” – unless otherwise specified, means Program Contractors for ALTCS managed care members, Tribal Contractors for ALTCS Fee-For-Service (FFS) members and the Targeted Case Management Contractor for acute care members with Developmental Disabilities (DD).
 - a. Tribal case management for on-reservation FFS members may be provided by the Tribal government through an Inter-Governmental Agreement (IGA) with AHCCCS or, if there is no IGA between AHCCCS and a Tribal government, case management is provided through a special Tribal case management Contractor.
 - b. Program Contractors and the Targeted Case Management Contractor have formal contracts with AHCCCS.
 - i. “Member(s)” – those individuals who are eligible for ALTCS or targeted case management and are enrolled with a Contractor.
 - (a) Eligible individuals who are Elderly and/or have a Physical Disability (E/PD) and are enrolled with a Program Contractor
 - (b) Eligible individuals who have a DD and are enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)
 - (c) Eligible E/PD individuals who are Native American and living on a reservation (or lived on a reservation immediately prior to placement in an institutional facility that is located off-reservation) and are enrolled in the ALTCS FFS program and receive ALTCS services through a Tribal Contractor
 - (d) Eligible individuals with DD who qualify financially for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program, may



receive targeted case management services through ADES/DDD. These members receive their acute care services through an AHCCCS acute care Contractor.

- (i) “Service plan” – for ALTCS, a uniform system of tracking member services, date ranges and units of services authorized by the ALTCS Contractor. It does not specifically refer to the CA165 screen in the Client Assessment and Tracking System (CATS), except for ALTCS Tribal Contractors

Information regarding other ALTCS topics, such as acute care services, provider qualifications and FFS quality and utilization management is also included in this manual. Refer to the [Manual Table of Contents](#) for guidance.

Refer to the AHCCCS FFS Provider Manual and the Encounter Reporting User Manual for complete information regarding claims and encounter reporting procedures for covered services, the provider registration process, and rate determination methodologies used for ALTCS services, required financial reporting for nursing facilities and general billing information. Both of these manuals are available from the AHCCCS Web site at www.azahcccs.gov.

Refer to the Eligibility Manual, available from the AHCCCS web site at www.azahcccs.gov for information on the financial and medical eligibility determination processes for ALTCS members.

Forms requiring a member’s signature are available in Spanish. Refer to Appendix K, Select ALTCS Case Management Forms in Spanish, for these forms.



1610 COMPONENTS OF ALTCS CASE MANAGEMENT

REVISION DATES: 05/01/12, 05/01/10, 02/01/05, 10/01/04

REVIEW DATES: 10/01/13, 01/01/11

INITIAL

EFFECTIVE DATE: 02/14/1996

Description

Case management is the process through which appropriate and cost effective medical, medically related social and behavioral health services are identified, planned, obtained and monitored for individuals eligible for Arizona Long Term Care System (ALTCS) services. Each individual enrolled as an ALTCS member must receive case management services as specified in the chapter and provided by a qualified case manager.

The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon, appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting. The case manager must foster a person-centered approach and maximize member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice. Case management begins with a respect for the member's preferences, interests, needs, culture, language and belief system.

Amount, Duration and Scope

ALTCS case management components include the following:

1. Service planning and coordination to identify services that will effectively meet the member's needs in the most cost effective manner and to develop and maintain the member's service plan. Development of the service plan must be coordinated with the member and/or member's family/representative to ensure mutually agreed upon approaches to meet the member's needs within the scope and limitations of the program, including cost effectiveness. Service planning and coordination also includes ensuring members/representatives know how to report the unavailability of or other problems with services and that these issues will be addressed as quickly as possible when they are reported.
2. Brokering of services to obtain and integrate all ALTCS services to be provided to the member, as well as other aspects of the member's care, in accordance with the service plan. If certain services are unavailable, the case manager may



substitute combinations of other services, within cost effectiveness standards, in order to meet the member's needs until the case manager is able to obtain such services for the member. The case manager must also consider and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs.

3. Facilitation/Advocacy to resolve issues which impede the member's progress and access to needed services (both ALTCS and non-ALTCS covered services) and to ensure that services are provided that are beneficial for the member. The case manager will assist the member in maintaining or progressing toward his/her highest functional level through the coordination of all services.
4. Monitoring and reassessment of services provided to ALTCS members and modifying/reviewing member service plans and goals as necessary based on changes in the member's condition.
5. Gatekeeping to assess and determine the need for, and cost effectiveness of, ALTCS services for assigned members. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.



1620 CASE MANAGER STANDARDS

1620-A INITIAL CONTACT/VISIT STANDARD

REVISION DATES: 05/01/12, 01/01/11, 10/01/07, 09/01/05, 02/01/05, 10/01/04

REVIEW DATES: 10/01/13, 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

1. Within seven business days of a new member's enrollment, the assigned case manager, or designee, must initiate contact with the member or member representative. If the member resides in a nursing facility or other residential setting, the case manager, or designee, will contact the facility to inform the facility of the member's enrollment. Initial contact may be made via telephone, a face-to-face visit or by letter, if the case manager is unable to contact the member by other approaches.

An on-site visit to initiate service planning must be completed by the case manager within 12 business days of the member's enrollment. If information obtained during the initial contact or from the Pre-Admission Screening Tool completed by AHCCCS during the eligibility determination indicates the member has more immediate needs for services, the on-site visit should be completed as soon as possible.

The interview must be conducted at the member's place of residence in order to develop the member's service plan. Confirmation of the scheduled interview is recommended prior to the meeting.

The member must be present for, and be included in, the on-site visit. The member representative must be contacted for care planning, including establishing service needs and setting goals, if the member is unable to participate due to cognitive impairment, the member is a minor child and/or the member has a legal guardian.

Refer to Exhibit 1620-1 for a chart of Case Management Timeframes.

2. If the case manager is unable to locate/contact a member via telephone, visit or letter, or through information from the member's relatives, neighbors or others, another letter requesting that the member contact the case manager should be left at, or sent to, the member's residence. If there is no contact within 30 calendar days from the member's date of enrollment, the case must be referred to the member's Arizona Long Term Care Services (ALTCS) eligibility worker, via the electronic Member Change Report (MCR) process,



for potential loss of contact. A hard copy of the MCR may be found in Exhibit 1620-2.

Only when AHCCCS Division of Member Services staff are also unable to contact the member or representative, will the process of disenrolling the member be initiated.

3. All contact attempted and made with, or regarding, an ALTCS member must be documented in the member's case file.

The case manager is responsible for explaining the member's rights and responsibilities under the ALTCS program to the member or member representative, including the procedures for filing a grievance and/or an appeal. A copy of these rights and responsibilities must also be provided in writing (generally via the Member Handbook). The member or member representative must sign and date a statement indicating that they have received the member rights and responsibilities in writing, that these rights and responsibilities have been explained to them and that they clearly understand them.



1620-B NEEDS ASSESSMENT/CARE PLANNING STANDARD

REVISION DATES: 03/01/13, 05/01/12, 01/01/11, 05/07/10, 10/01/07, 10/01/06, 09/01/05,
02/01/05, 10/01/04

INITIAL
EFFECTIVE DATE: 02/14/1996

1. Case managers are expected to use a person-centered approach regarding the member assessment and needs, taking into account not only Arizona Long Term Care System (ALTCS) covered services, but also other needed community resources as applicable. Case managers are expected to:
 - a. Respect the member's rights
 - b. Support the member to have a meaningful role in planning and directing their own care to maximum extent possible.
 - c. Provide adequate information and teaching to assist the member/family in making informed decisions and choices. This information must be reviewed until such time as the member/representative indicates s/he understands it.
 - d. Be available to answer questions and address service issues raised by the member or representative, including between regularly scheduled review visits.
 - e. Provide a continuum of service options that supports the expectations and agreements established through the care plan process
 - f. Educate the member/family on how to report unavailability or other problems with service delivery to the Contractor in order that unmet needs can be addressed as quickly as possible. See also subsections 1620-D and 1620-E in this policy regarding specific requirements.
 - g. Facilitate access to non-ALTCS services available throughout the community
 - h. Advocate for the member and/or family/significant others as the need occurs
 - i. Allow the member/family to identify their role in interacting with the service system, including the extent to which the family/informal support system will provide uncompensated care



- j. Provide members with flexible and creative service delivery options
 - k. Educate members about member directed options for delivery of designated services (see Chapter 1300 of this manual for more details). Review these options, at least annually, with members living in their own homes.
 - l. Educate members on their option to choose their spouse as their 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 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. 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, and
 - p. Refer member cases, via electronic Member Change Report (MCR), to the AHCCCS Division of Member Services for a medical eligibility re-assessment if a member is assessed to no longer require an institutional level of care. See Exhibit 1620-2 for the MCR form and the AHCCCS Contractor Operations Manual, Chapter 400, Policy 430 for MCR instructions.
2. The involvement of the member and member's family in strengths/needs identification as well as decision making is a basic tenet of ALTCS case management practice. The member, family, and/or significant others are partners with the case manager in the development of the plan with the case manager in the facilitating mode.
 3. The case manager must complete a Uniform Assessment Tool (UAT) based on information from the strengths/needs assessment to determine the member's current Level of Care. The UAT and guidelines for completion can be found in Exhibit 1620-3.
 4. Care planning is based on:



- a. Face-to-face discussion with the member and/or member representative that includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas:
 - i. Functional abilities
 - ii. Medical conditions
 - iii. Behavioral health
 - iv. Social/environmental/cultural factors, and
 - v. Existing support system.

The case manager shall use the HCBS Needs Tool (HNT) found in Exhibit 1620-17 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 the member.

- b. Recommendations of the member's Primary Care Provider (PCP)
 - c. Input from ALTCS service providers, as applicable, and
 - d. Preadmission Screening (PAS), as appropriate.
5. The case manager will assist the member to identify meaningful and measureable goals for him/herself. Goals should be built on the member's strengths and include steps that the member will take to achieve the goal(s). Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes.
 6. Member goals must:
 - a. Be member specific
 - b. Be measurable
 - c. Specify a plan of action/interventions to be used to meet the goals
 - d. Include a timeframe for the attainment of the desired outcome, and
 - e. Be reviewed at each assessment visit and progress must be documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.
 7. For members who have been receiving Home and Community Based Services (HCBS) during the Prior Period Coverage (PPC) timeframe (as defined in



Chapter 100 of this Manual), 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 Fee-For-Service (FFS) members, the AHCCCS Administration, as specified in the separate care/service plan.

A separate care/service plan must be developed and documented to indicate those services that will be retroactively approved based on this assessment. If any of the services provided during the PPC are not approved by the ALTCS Contractor or, for FFS members, the AHCCCS Administration, the member must be provided written notice of this decision and given an opportunity to file an appeal. Refer to Arizona Administrative Code 9 A.A.C., Chapter 34, for more detailed information on this requirement.

Assisted Living Facilities are encouraged to bill/accept Medicaid payment for services for members who are eligible in the PPC but they are not required by regulations to do so. If the facility chooses to, or is required by contract to bill the Contractor, they must accept the Medicaid payment as full payment and are 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.



1620-C COST EFFECTIVENESS STUDY STANDARD

REVISION DATES: 03/01/13, 05/01/12, 04/01/12, 07/01/11, 02/01/11, 01/01/11, 10/01/07,
10/01/06, 07/01/06, 01/01/06, 09/01/05, 02/01/05, 10/01/04

INITIAL

EFFECTIVE DATE: 02/14/1996

1. A Cost Effectiveness Study (CES) must be completed for all Elderly and/or Physically Disabled (E/PD) members with potential for placement in a Home and Community Based (HCB) setting and for those E/PD members currently placed in an institutional setting who have discharge potential.
2. A CES must be completed for Developmentally Disabled (DD) members under the following circumstances:
 - a. Every three months for any DD member whose service costs exceed 80% of the cost of the appropriate institutional setting for the member
 - b. When the service costs of a DD member whose service costs previously exceeded 80% of the cost of the appropriate institutional setting are subsequently reduced to below 80% and/or
 - c. When discharge is contemplated for any member residing in an Intermediate Care Facility (ICF).
3. Services provided under Title XIX must be cost effective whether the placement is in an institutional facility or an HCB setting.
4. Placement in an HCB setting is considered appropriate if the cost of Home and Community Based Services (HCBS) for a specific member does not exceed 100% of the net cost of institutional care for that member and HCBS will meet the member's needs.

The net cost of institutional care for each member takes into consideration the specific member's assessed Level of Care, the contracted or approved institutional rate for that Level of Care and the amount of the specific member's "CES Share of Cost."

If the member has needs that would necessitate a specialized rate in an institutional setting (for example, Alzheimer's or behavioral unit, residential treatment center, extensive respiratory care), this cost must be used in calculating the cost effectiveness of HCBS.



The “CES Share of Cost” is the amount the Division of Member Services/Arizona Long Term Care System (DMS/ALTCS) eligibility has determined, based on the member’s income and expenses, that s/he would have to pay monthly **IF** s/he was placed in a nursing home.

The net Medicaid cost of institutional care is calculated by subtracting the monthly CES Share of Cost amount for the member from the monthly nursing facility cost based on the specific member’s Level of Care or other needs. The result is called the Net Institutional Cost.

If the member has been assessed, by the Division of Member Services/Eligibility, to have an actual Share of Cost that must be paid in HCBS, that amount is deducted from the total monthly cost of the HCB services the member needs. The result is called the “Net Home and Community Based Services (HCBS) Cost.”

If the Net HCBS Cost is more than the Net Institutional Cost, then home care services at that level are not “cost effective” and cannot be provided unless the HCBS costs are expected to decrease to less than the cost of institutional care within six months. The member must be provided a written notice that explains any decision to not provide services at the level requested/needed by the member/representative and given an opportunity to file an appeal if s/he does not agree with the decision.

The portion of HCB services that are cost effective can be provided if the member/representative still desires HCBS placement and is willing to accept that level of services and to assume the potential risks of remaining at home without all the care that has been assessed as needed. A managed risk agreement should be completed to document this situation.

Example of CES>100%

Total Nursing Home Cost		\$4920.10
CES Share of Cost	-	\$ 726.90
Net Institutional Cost	=	\$4193.20
SERVICES MEMBER NEEDS		
40 hours of Attendant Care per week		\$2924.00
12 Nursing visits per month	+	\$1341.60
Net HCBS Cost	=	\$4265.60
\$4265.60 DIVIDED BY \$4193.20 = 102%		
REQUESTED HCB SERVICES ARE NOT COST EFFECTIVE		



If the member in the previous example requested all the services that could cost effectively be provided, the case manager should determine which services are a priority for the member and recalculate the CES. For example:

Total Nursing Home Cost		\$4920.10
CES Share of Cost	-	\$ 726.90
Net Institutional Cost	=	\$4193.20
SERVICES THAT CAN COST EFFECTIVELY BE PROVIDED		
40 hours of Attendant Care		\$2924.00
11 Nursing visits per month	+	\$1144.00
Net Home Services Cost	=	\$4068.00
\$4068.00 DIVIDED BY \$4193.20 = \$4193.20 = 97% REQUESTED HCB SERVICES ARE COST EFFECTIVE		

Existing HCBS units cannot be reduced if there is an increased cost of services incurred to fill a service gap (for example, if personal care and homemaker services are provided to substitute for a gap in attendant care services).

5. When the cost of HCBS exceeds 80% of the cost of institutional care:
 - a. Program Contractor case managers must provide written justification of services to their administration for approval.
 - b. Tribal Contractor case managers must provide written justification of services to the AHCCCS Division of Health Care Management (DHCM)/ALTCS Unit as a request for approval.
6. When the cost of HCBS exceeds 100% of the cost of institutional care, but the cost is expected to drop below 100% within the next six months because of an anticipated change in the member's needs:
 - a. A Program Contractor's administration may approve the HCBS costs. Justification and the approval must be documented in the case file.
 - b. Tribal Contractor case managers must provide written justification of services to the DHCM/ALTCS Unit as a request for approval.
7. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months the case manager must advise the member of the cost effectiveness limitations of the program and discuss other options. The case manager must either reduce or not initiate any Title XIX service costs in excess of 100%. Contractors may review individual cases with DHCM/ALTCS before the decision to deny or reduce services is made. Appropriate notification must



be given to the member regarding any decision to deny or reduce requested services.

If the member chooses to remain in his/her own home even though the Contractor cannot provide all of the services which have been assessed as medically necessary (including those ordered by the member's Primary Care Provider [PCP]), a managed risk agreement/contract should be written. This agreement should document the services the Contractor can cost effectively provide, the placement/service options offered to the member, the member's choices with regard to those options, the risks associated with potential gaps in service and any plans the member has to address those risks (for example, volunteer services or paying privately for services). The member's or member representative's signature on the agreement documents his/her acknowledgement of the service limitations and risks.

8. The CES must be completed prior to the initiation of ALTCS services. However, if services are already in place at the time of the member's enrollment, the CES must be completed within 12 business days of the enrollment.

The cost of HCBS services that will be retroactively approved during prior period coverage enrollment cannot exceed 100% of the cost of institutionalization for that member.

9. The CES must be updated when there is a change in placement to HCBS or there is a change in services that would potentially place the member's costs at greater than 80% of institutional cost. **All HCBS E/PD members must have a CES completed at least annually.**
10. A CES may be completed indicating "NONE" for HCBS services needed under the following circumstances:
 - a. Members residing in nursing facility who have no potential for HCBS placement (Placement/Reason code: Q/05). Documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement.
 - b. Members receiving only hospice services (Placement/Reason code: 10).

NOTE: Members receiving other Long Term Care (LTC) services in combination with hospice must have a CES completed in accordance with other CES policy explained in this section.
 - c. Members residing in a nursing facility because the cost of HCBS would exceed 100% of institutional costs (Placement/Reason code: Q/01) or



- d. Members with Acute Care Only status (Placement/Reason code: D/04, D/11 or D/12).
11. CES data must be entered into the Client Assessment Tracking System (CATS) system within ten business days of the date the action took place (for example, initial on-site visit to determine service needs, placement changes or significant increase in cost of services). Refer to the AHCCCS Contractors Operations Manual (ACOM), Chapter 400, Policy 411, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

If the initial CES entered in the CATS system also reflects the assessment of the cost effectiveness of HCBS services provided in the PPC, a comment to that effect must be added to the case file, or system notes if comments are entered in CATS. If the services entered on the initial CES do not reflect those provided during the PPC, a separate hard copy CES must be completed to demonstrate that PPC services were cost effective and this CES must be maintained in the case file.

Refer to the AHCCCS Contractor Operations Manual, Chapter 400, Policy 411, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

12. HCBS which must be included in the CES include:
- a. Adult day health
 - b. Attendant care, including when provided through a member directed option. See Chapter 1300 of this manual for information on member directed options. If the member chooses to utilize his or her spouse as the paid caregiver of these services, the spouse shall not be authorized for more than 40 hours of services in a seven day period. Refer to Policy 1240 for more information on this limitation.
 - c. Habilitation, including when provided through a member directed option. See Chapter 1300 of this manual for information on member directed options.
 - d. Home health nurse
 - e. Home health aide
 - f. Home delivered meals



- g. Homemaker, including when provided through a member directed option. See Chapter 1300 of this manual for information on member directed options.
 - h. Personal care, including when provided through a member directed option. See Chapter 1300 of this manual for information on member directed options.
 - i. Respite, if provided in a repeated pattern, such as weekly.
 - j. Regularly scheduled medically necessary transportation when the round trip mileage exceeds 100 miles. These costs do not need to be included if similar costs would be incurred while in a nursing facility. For example, if dialysis transportation costs for an HCBS member would be essentially the same as if the member were in an institutional setting; these costs would not be included on the CES.
 - k. Emergency alert systems
 - l. Non-customized Durable Medical Equipment (DME) included in the nursing facility per diem and having a value exceeding \$300, regardless of purchase or rental (for example, standard wheelchairs, walkers, hospital beds). DME items covered under other insurance may be omitted from the CES until the Contractor assumes responsibility for partial or full payment.
 - m. Partial care (supervised, therapeutic and medical day programs)
 - n. Behavioral management (behavioral health personal assistance, family support and peer support)
 - o. Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)
 - p. Assisted living facilities, and
 - q. Behavioral health alternative residential settings.
13. Services which are not to be included in a CES include:
- a. Hospice services
 - b. Customized DME items



- c. Physical, speech, occupational and/or respiratory therapies
 - d. Medical supplies and pharmaceuticals
 - e. Behavioral health services which are not listed above, and
 - f. Home modification
 - g. Community Transition Services
 - h. Member and/or DCW Training, authorized as part of a member directed service option.
14. If the member only receives ALTCS-covered HCBS that are provided by another funding source (Medicare, Children's Rehabilitative Services, tribal entities), s/he may still be in an HCBS placement and therefore must have a CES completed. The CES should be completed indicating the services received, but with no unit cost paid by the Contractor.



1620-D PLACEMENT/SERVICE PLANNING STANDARD

REVISION DATES: 03/01/13, 05/01/12, 02/01/11, 01/01/11, 05/07/10, 03/01/10, 02/01/09,
10/01/07, 05/01/06, 01/01/06, 09/01/05, 02/01/05, 10/01/04

INITIAL

EFFECTIVE DATE: 02/14/1996

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

A guiding principle of the Arizona Long Term Care System (ALTCS) program is that members are placed and/or maintained in the most integrated/least restrictive setting. This needs to be the placement goal for ALTCS members as long as cost effectiveness standards can be met in the Home and Community Based (HCB) setting.

1. After the needs assessment is completed, the case manager must discuss the cost effectiveness and availability of needed services with the member and/or member representative.
2. In determining the most appropriate service placement for the member, the case manager and the member and/or the member representative should discuss the following issues as applicable:
 - a. The member's placement choice
 - b. Services necessary to meet the member's needs in the most integrated setting. See [Chapter 1200](#) of this manual 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 care. If the member is unable to direct his/her own care, 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 Chapter 1300 of this manual.



- 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 HCB setting as defined in Chapter 1200.
 - g. The risks that may be associated with any service and/or placement decisions made by the member/representative, including the decision to direct one's own care. The case manager must develop a managed risk agreement with the member to document these risks, alternatives offered to the member and the member's choices with regard to those risks. The signed managed risk agreement should be kept in the case file.
 - h. The member's Share of Cost (SOC) responsibility. The SOC is the amount of the member's income that s/he 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.
 - i. The member's Room and Board (R & B) responsibility. Since AHCCCS does not cover R & B in an HCB alternative residential setting, this portion of the cost of the care in these settings must be paid by the member or other source (such as the member's family). The monthly R & B amount is determined by and communicated to the member by the ALTCS Contractor. See Assisted Living Facility Residency Agreement and Assisted Living Facility Member Financial Change Agreement in Exhibits 1620-15 and 1620-16. The Change Agreement should be used 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 residential placement/setting that is "more" cost effective. Refer to [Chapter 100](#) of this Manual for a definition of "own home".
4. Members must be informed that they have the choice to select their spouse to be their paid caregiver for medically necessary and cost effective services (provided the spouse meets all the qualifications as specified in the attendant care section of Policy 1240 of this Manual) not to exceed 40 hours in a seven day period. The case manager must inform and be available to discuss with member and spouse the financial impact that this choice could have on the eligibility of their household for publicly funded programs, including AHCCCS. The "Spouse Attendant Care Acknowledgement of Understanding" Form



(Exhibit 1620-12) must be signed by the member and spouse prior to the authorization of the member's spouse as the paid caregiver. 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.

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.

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 of the Code of Federal Regulations (42 C.F.R.) 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.

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

6. The case manager must ensure that the member or representative understands that some long term care services (such as home health nurse, home health aide 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 them. 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 designee'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 noted 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 they agree or disagree with each service authorization and sign the service plan at initial development, when there are changes in services and at the time of each service review (every 90 or 180 days). 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 case manager is responsible for providing and explaining to HCBS in-home members or member representatives the Important Member Rights Notice Form (Exhibit 1620-10), which informs them of their rights pursuant to the Ball v. Betlach (also known as Ball v. Biedess) order.

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 written notice of action that explains the member's right to file an appeal regarding the placement or service plan determination. Refer to Arizona Administrative Code, Title 9, Chapter 34 (9 A.A.C. 34) and the AHCCCS Contractors Operations Manual (ACOM) Policy 414 for additional information.
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:
 - a. Attendant care, including spouse attendant care, Agency with Choice and Self-Directed Attendant Care
 - b. Personal care, including Agency with Choice
 - c. Homemaker, including Agency with Choice and/or
 - d. 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 home care worker critical service scheduled in each member's HCBS



care plan and the hours of the scheduled type of critical service 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 at the scheduled time
- b. The member refuses the caregiver when s/he arrives at the member's home, unless the caregiver's ability to accomplish the assigned duties is significantly impaired by the caregiver's condition or state (for example, drug and/or alcohol intoxication)
- c. The member refuses services
- d. The provider agency or case manager is able to find an alternative caregiver for the scheduled service when the regular caregiver becomes unavailable.
- e. The member and regular caregiver agree in advance to reschedule all or part of a scheduled service, and/or
- f. The caregiver 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 caregivers 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 must also be provided the Critical Service Gap Report Form (Exhibit 1620-11), which can be mailed to the Contractor as an alternative to calling in the service gap. The member or member representative should be encouraged to call the toll-free AHCCCS line and provider and/or Contractor rather than mailing the Critical Service Gap Report form so that the service gap can be responded to more timely.



In those instances where an unforeseeable gap in critical services occurs, it is the responsibility of the Program 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.**

When the AHCCCS, provider or Contractor is notified of a gap in services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to

- i. The reason for the gap, and
 - ii. The alternative plan being created to resolve the particular gap and any possible future gaps.
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) 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 [Chapter 1200](#) of this manual 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, 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 s/he 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)/ALTCS 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.
18. Service plans for members residing in an **institutional setting** must 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 [Chapter 100](#) of this manual 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/DD 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)
 - 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. Service plans for members residing in an **HCB setting** 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/DD 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 Policy 1240 of this manual 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. Community Transition Services that have been authorized in order to transition a NF member to HCBS “Own Home”. Refer to Policy 1240 of this manual for definitions and limitations.
 - u. Member and/or 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, Children’s Rehabilitative Services, other insurance sources.
21. Service plans for members designated as **“Acute Care Only (ACO)”** must include the following types of services, as appropriate, based on the member’s needs:
- a. DME (this requirement is waived for ALTCS DD 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 [Chapter 300](#), Policy 310 of this manual, including those typically considered as HCBS.

- 22. Refer to [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:
 - a. ID number of 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

Refer to the AHCCCS Contractors Operations Manual (ACOM), Chapter 400, Policy 411, 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 updated with the following member information within ten business days of the service visit:
 - 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
- h. Major Diagnosis (at least one but up to three diagnoses).

Refer to the AHCCCS Contractors Operation Manual (ACOM), Chapter 400, Policy 411, for information on the codes and procedures for entering the above data into the CATS system.

25. Program 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 AHCCCS Contractors Operations Manual, Chapter 400, Policy 411, for information on the codes and procedures for entering service plan data into the CATS system.



1620-E SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

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

INITIAL

EFFECTIVE DATE: 02/14/1996

1. Case managers are responsible for ongoing monitoring of the 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 placement and services must be reviewed on-site, with the member present, within the following timeframes:
 - a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in uncertified 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 residing in an alternative residential setting
 - d. At least every 90 days for a community-based member receiving acute care services only. 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, and
 - e. At least every 180 days for Developmentally Disabled (DD) 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). If medically involved or SMI/SED, on-site visits must be made at least every 90 days.

Refer to Exhibit 1620-1 for a chart on Case Management Timeframes.

Contractors may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion but may not determine members to need less frequent visits.



Case managers should attend nursing facility care conferences on a periodic basis as an opportunity to discuss the member's needs and services jointly with the member, care providers and the family. Case managers should at least consult with facility staff during 180-day visits to assess changes in member Level of Care.

3. Review visits must be conducted at the member's residence. A visit made to a site other than the member's place of residence must be at the request of the member or representative, not just for the convenience of the case manager. If an alternate site is used, the rationale must be documented in the case management file. Every effort should be made to see members in their homes in order for the case manager to assess the living environment and evaluate potential barriers to quality care. Visits to an alternative site should be the exception.
4. Members must be able to contact their case manager, or designee 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 promptly to the questions and/or requests.
5. Case managers must be able to quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action. More frequent case monitoring is required when the case manager is notified 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 well-being is endangered.

6. Case managers must conduct an on-site review within ten business days following a member's 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.

Whenever possible, discharge to a member's own home should be delayed until adequate services can be arranged. In-home services must be initiated within ten business days following a member's discharge to HCBS.

7. If the case manager is unable to contact an enrolled member to schedule a visit, a letter must be sent to the member or representative requesting contact by a specific date (ten 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, indicating loss of contact, to the local Arizona Long Term Care System (ALTCS) Eligibility office for possible disenrollment from the ALTCS program.

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

8. The case manager must meet with the member and/or 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 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. 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.

The case manager shall use the HCBS Needs Tool (HNT) found in 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.

The Uniform Assessment Tool (UAT), used to determine the Level of Care for EPD 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 EPD 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 Exhibit 1620-3.



- c. 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 risks to manage related to the member's service or placement decisions
 - d. Assess the cost effectiveness of services provided and/or requested
 - e. Discuss the member's perception of his/her progress toward established goals
 - f. Identify any barriers to the achievement of the member's goals
 - g. Develop new goals as needed
 - h. Review service delivery options available to the member, including member directed options, on at least an annual basis
 - i. 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" (Exhibit 1620-12) and,
 - j. Review, at least annually, the Contractor's (or the Administration's for members enrolled with a Tribal Contractor) member handbook to ensure members/ representatives are familiar with the contents, especially as related to covered services and their rights/responsibilities.
8. The member 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 member representative available, the case manager must refer the case to the Public Fiduciary or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file.

9. Members who reside in an out-of-home 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 Nursing Facility (NF) members with discharge to an HCBS "Own Home" setting (see Policy 1240 of this manual for definitions and limitations related to CTS).
10. The case manager must complete a written service plan (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 they agree or disagree with each service authorization and sign the service plan each time. The member must be given a copy of each signed service plan.

11. The case manager must review, with the member and/or representative, the Contractor's process for immediately reporting any unplanned gaps in service delivery at the time of each service review for each HCBS member receiving "critical" services.
12. The member's HCB service providers must be contacted at least annually to discuss their assessment of the member's needs and status. Contact should be made as soon as possible to address problems or issues identified by the member/representative or case manager. This should include providers of such services as personal or attendant care, home delivered meals, homemaker, therapy, etc.

If the member is receiving skilled nursing care from a home health agency, contact is required with the service provider more frequently (see Standard XI, Skilled Nursing Need, in this Chapter).

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.

13. The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order (see [Chapter 1200](#) of this manual 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.

14. If the case manager determines during the reassessment process that changes in placement or services are indicated, this must be discussed with the member and/or representative prior to the initiation of any changes. This is especially critical if the changes result in a reduction or termination of services.
15. The member or member representative must be notified in writing of any denial, reduction, termination or suspension of services, when the member or



representative has indicated, on the service plan, that s/he disagrees with the type, amount, or frequency of services to be authorized. Refer to Arizona Administrative Code 9 A.A.C. 34 and the AHCCCS Contractors Operations Manual (ACOM) policy 414 for more detailed information and specific time frames.

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 member's Program Contractor.

16. 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.
 - 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 [Chapter 1200](#), Policy 1250, for additional information regarding hospice services.



17. 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 been exhausted.

18. In most cases, members must receive a written 30-day advance notice before discharge from a nursing facility as outlined in Code of Federal Regulations 42 C.F.R. 483.12. Exceptions may be made when the health and/or safety of the member or other residents is/are endangered.

ALTCS Contractors set their own rules regarding advance notice of discharge of members who reside in assisted living facilities in their contracts with those facilities.

19. 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 Exhibit 1620-2 for a hard copy of the MCR form and more information on the circumstances for using this form. Instructions for completing the electronic MCR can be found in the AHCCCS Contractor Operations Manual (ACOM), Chapter 400, Policy 411 available on the AHCCCS Website. The hard copy form should only be used when an electronic version is not possible (for example when member is no longer enrolled with the Contractor).

20. The case manager is responsible for updating information in the Client Assessment Tracking System (CATS) within 14 business days of the reassessment.



1620-F TRIBAL FEE-FOR-SERVICE STANDARDS

REVISION DATE: 07/01/12 (RELOCATED FROM CHAPTER 1200, CHAPTER OVERVIEW)

REVIEW DATE: 03/01/13

In addition to all other Arizona Long Term Care System (ALTCs) case management standards, the following standards also apply for members who are enrolled with a Tribal Fee-For-Service (FFS) contractor:

1. For the following services, the tribal case manager must assist in obtaining the documentation and must coordinate with the Division of Fee-For-Service Management (DFSM) Prior Authorization (PA) unit for approval prior to the tribal case manager entering the service authorization on the CA165/Service Plan;
 - a. Specialty rates for facilities (nursing facilities and alternative residential settings) and above level of care facility rates, and
 - b. Home Modifications (refer to Exhibit 1240-4 in Chapter 1200 of this Manual).
2. For the following services, the tribal case manager must obtain medical review by the DFSM PA unit before the tribal case manager provides authorization and enters the service authorization on the CA165/Service Plan:
 - a. Durable Medical Equipment (DME), when the cost exceeds \$500 (items between \$300 and \$499 must be authorized by the FFS case manager and included on the CA165/Service Plan).
 - b. Medically necessary incontinence supplies (e.g., diapers and Chux). This does not include catheters, ostomy supplies, etc. and
 - c. Specialty beds and wound care treatments.



1620-G BEHAVIORAL HEALTH STANDARD

REVISION DATES: 10/01/13, 05/01/12, 10/01/11, 01/01/11, 10/01/07, 09/01/06, 09/01/05,
02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

In addition to all other Arizona Long Term Care System (ALTCS) case management standards, the following standards also apply to members who need or receive behavioral health services:

1. Direct referral for a behavioral health evaluation may be made by the member or by any health care professional in coordination with the case manager and Primary Care Provider (PCP).
2. Requests for behavioral health services made by the member or member representative must be assessed for appropriateness within three business days of the request. If it is determined that services are needed, the referral for evaluation must be made within one business day.
3. Behavioral health services which have been determined to be medically necessary by a qualified behavioral health professional (as defined in Arizona Administrative Code 9 A.A.C.10) may be provided.
4. The case manager must ensure there is communication with the PCP and behavioral health providers involved in the member's care and that care is coordinated with other agencies and involved parties.
5. The case manager must ensure the timely involvement of a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). Refer to the "Policy for Management of Acute Behavioral Health Situations" found in Appendix H of this manual for more detailed information on that process.
6. Information from the Pre-Admission Screening and Resident Review (PASRR) Level II Evaluation for determination of mental illness (completed by the Arizona Department of Health Services when indicated by PASRR Level I screening) regarding a member's need for specialized services (see definition in Chapter 1200, Policy 1220 of this Manual) must be incorporated into the member's service plan.



7. Behavioral health appointments must be provided within the following timeframes:
 - a. Within 24 hours of referral for emergency appointments, or
 - b. Within 30 days of referral for routine appointments.
8. Case management for a member receiving behavioral health services must be provided in consultation/collaboration with a qualified behavioral health professional in those cases where the case manager does not meet the qualifications of a behavioral health professional (as defined in 9 A.A.C. 10). The consultation does not have to be with the provider of behavioral health services. It may be with the Contractor's behavioral health coordinator or other qualified designee.
9. An initial consultation between the ALTCs case manager and the behavioral health professional is required for all members receiving/needing behavioral health services. Quarterly consultations are required thereafter as long as the member continues to receive/need behavioral health services.
10. Initial and quarterly consultations are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.
11. The case manager must document the content and results of the initial and quarterly consultation with the behavioral health professional. The consultation must be a communication between the case manager and a behavioral health professional about the member's status and plan of treatment. It must not simply be a report from the provider that has been received by the case manager and put in the case file.
12. As part of the service plan monitoring, the case manager must review the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this special monitoring. Examples of medication uses that do not require this monitoring are sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms and anticonvulsants used to treat a seizure disorder.

Documentation of the medication review must be clearly evident in the member case file. The review must take place at each reassessment and include the purpose of the medication, the effectiveness of the medication and any adverse side effects that may have occurred. Any concerns noted (for example, medication appears to be ineffective, adverse side effects are present, multiple medications apparently prescribed for the same diagnosis) must be discussed



with the behavioral health consultant and/or prescribing practitioner. Case notes must reflect this discussion and a plan of action to address these issues.

13. Case managers are responsible for identifying, assisting with and monitoring the special needs and requirements related to members who are unable or unwilling to consent to treatment (i.e. petitioning, court ordered treatment and judicial review). Case file documentation must reflect this activity.

14. The behavioral health code that reflects the member's current behavioral health status must be updated at the time of each review visit on the CA161/Placement Maintenance screen in Client Assessment Tracking System (CATS). Refer to the AHCCCS Contractors Operations Manual (ACOM), Chapter 400, Policy 411, for a list and description of these codes.



1620-H TRANSITIONAL PROGRAM STANDARD

REVISION DATES: 05/01/12, 04/01/12, 10/01/11, 10/01/07, 09/01/06, 09/01/05, 02/01/05,
10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

The Arizona Long Term Care System (ALTCS) Transitional program is a program for currently eligible Arizona Long Term Care System ALTCS members who have improved either medically, functionally or both, to the extent that they are no longer at immediate risk of institutionalization at a Nursing Facility (NF) or Intermediate Care Facility (ICF) for persons with Intellectual Disabilities level of care. These members continue to require some long term care services, but at a lower level of care. The ALTCS Transitional program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. NF and ICF services are excluded, since reassessment has determined that institutional services are not medically necessary.

In addition to all other ALTCS case management standards, the following standards also apply to Transitional program members:

1. The case manager, upon being notified of the change of a member to the Transitional program, must discuss the change in level of care with the member or representative to ensure understanding of the change.
2. The case manager must ensure that the member in a Home and Community Based (HCB) setting meeting transitional criteria continues to receive all covered Home and Community Based Services (HCBS) as necessary.
3. While institutional services are no longer considered medically necessary for transitional eligible members, a short-term stay in a NF or ICF is available. ALTCS Transitional program members whose medical condition temporarily worsens to the extent that NF services are medically necessary may receive up to 90 continuous days of care at any one admission.
4. The case manager must ensure that the member, or the representative of a member, already residing in a NF or ICF who becomes eligible for the Transitional program, understands that discharge from the NF or ICF is necessary within 90 days from the Transitional program effective date. The case manager must work with the member or representative towards HCBS placement as soon as possible.



5. A PAS reassessment must be requested, via electronic Member Change Report (MCR), within 45 days of institutional admission, for any Transitional program member who has had a deterioration of condition and who is expected to need NF or ICF services for greater than 90 continuous days. A PAS reassessment is not needed if a Transitional program member will remain in or return to a HCB setting within 90 days.

The case manager must follow up on the MCR with the local ALTCS office after the PAS reassessment has been requested if there has been no response by the 60th day following admission. Alternate placement options may need to be explored in case the member continues to meet the transitional program criteria.

Case file documentation must demonstrate that the case manager has taken appropriate and timely action either to pursue discharge to a HCB setting or facilitate a PAS reassessment as indicated.



1620-I HIGH COST BEHAVIORAL HEALTH REINSURANCE STANDARD

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

INITIAL

EFFECTIVE DATE: 2/14/1996

The Arizona Long Term Care System (ALTCS) program for high cost behavioral health reinsurance is specifically designed to provide supplemental payment for members who are elderly and/or physically disabled, enrolled with ALTCS Contractors (as specified by contract), and who meet all of the following criteria:

1. Have significant behavioral problems or a history of these behaviors which have been documented as difficult to manage,
2. Require a specialized service regimen for the management of his/her behavioral challenges,
3. Would be inappropriate for placement in a locked Alzheimer's or dementia unit, and
4. Behavioral health reinsurance was approved by AHCCCS prior to October 1, 2007 and the case was active on September 30, 2007.

A member's temporary absence from the approved placement (e.g. for hospitalization) will not impact the continuation of the approval upon the member's return. However, a previously approved reinsurance case where the member has been terminated for the circumstances described below cannot be reapproved at a later date.

1. Contractor's activity to transfer the member to a lower level of care.
2. AHCCCS determines through the review process at renewal that the member no longer meets the criteria.

In addition to all other ALTCS case management standards, the following standards also apply to members covered under the ALTCS reinsurance program for high cost behavioral health:

1. A request for renewal of a reinsurance authorization must be submitted to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-6, within ten business days prior to the expiration of the current approval. Additional provider documentation that supports the member's behaviors and need for intervention must also be submitted.



AHCCCS will provide the Contractor with written verification of authorization or denial. Authorization will be granted for the member's current placement and setting only. If there is a subsequent change of placement or setting, information and documentation to describe the reason for the change must be submitted as a new reinsurance request. Contractors must also notify AHCCCS when a reinsurance member is disenrolled from ALTCS, transferred to another Contractor and/or discharged from a specialized treatment setting.

2. The service plans for Elderly and/or Physically Disabled (E/PD) members who receive specialized services covered under the High Cost Behavioral Health Reinsurance program must be coordinated with the member's Primary Care Provider (PCP) and the Contractor's Medical Director.
3. Covered services may be provided in the member's own home, in a Home Community Based (HCB) approved alternative residential setting, an unclassified health care institution licensed by the Arizona Department of Health Services or a nursing facility that is licensed to provide behavioral health services.
4. All institutional and Home Community Based Services (HCBS) described in [Chapter 1200](#) of this Manual, including non-emergency transportation, are included in the High Cost Behavioral Health Reinsurance program. Behavioral health services, except as noted below, are also covered. The following services are excluded from behavioral health reinsurance coverage under this program as they are included as a part of regular reinsurance:
 - a. Individual and group behavioral health counseling
 - b. Acute care hospitalization, including psychiatric hospitalization
 - c. Durable medical equipment and medical supplies
 - d. Pharmaceuticals
 - e. Physician services, and
 - f. Therapies, including physical therapy, occupational therapy, speech therapy and respiratory therapy.

Refer to the Encounter Reporting User Manual and the AHCCCS Reinsurance Claims Processing Manual for information regarding reporting and payment issues. These manuals are available on the AHCCCS Web site at www.azahcccs.gov.



1620-J OUT-OF-STATE PLACEMENT STANDARD

REVISION DATES: 05/01/12, 01/01/11, 10/01/07, 01/01/06, 09/01/05, 02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

Out-of-state services are covered as provided for under Code of Federal Regulations 42 C.F.R., 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 (as defined in Chapter 300) are not covered.

This section of the manual is intended to address the standards related to the long term placement of members in out-of-state settings. It does not apply to situations in which the member is temporarily absent from the State.

Out-of-state placements may be approved in licensed/certified residential-type settings only (for example, nursing facilities, residential treatment centers, group homes). Personal residences outside of the State of Arizona are not approved placements. Out-of-state facility providers must be registered with AHCCCS.

Written authorization from AHCCCS is required prior to the placement of an Arizona Long Term Care System (ALTCS) member in an out-of-state placement.

In addition to all other ALTCS case management standards, the following standards also apply when the Contractor seeks an out-of-state placement:

1. A request for out-of-state placement must be submitted to AHCCCS when it is determined that an ALTCS member's need for services cannot be met by existing providers within the State of Arizona.
2. Tribal Contractors requesting out-of-state placement approval for members being placed in one of the nursing facilities in Utah or New Mexico must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-7.
3. Program Contractors requesting out-of-state placement approval must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit. The request must include at least the following information:
 - a. Member name and AHCCCS ID#



- b. Name/location of facility where the Contractor intends to place the member, include the facility's AHCCCS provider ID#
 - c. Description of the member's medical/behavioral condition that necessitates this placement
 - d. Description of facility's program(s) that makes this placement appropriate for the member
 - e. Information about other in-state placement options ruled out for the member, and
 - f. Plan for member's return to an Arizona placement
4. When justified, AHCCCS approvals are generally given for six month intervals. The case manager must submit appropriate documentation to request a renewal if the out-of-state placement is expected to continue beyond the initial approval time period. Requests for renewals must be submitted prior to the expiration of the previous approval.



1620-K SKILLED NURSING NEED STANDARD

REVISION DATES: 05/01/12, 01/01/11, 10/01/07, 09/01/05, 02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

The case manager is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet his/her individual needs.

A. NON-INSTITUTIONAL SETTINGS

1. The member's initial needs assessment must be conducted by an AHCCCS registered home health agency if the member is at risk of compromising his/her skin integrity (for example, the member is bed bound, quadriplegic) or if the member has a history of medical instability (for example, frequent seizures, unstable diabetes, Chronic Obstructive Pulmonary Disease [COPD]). If a registered home health provider is not available, an independent registered nurse may conduct the assessment for skilled nursing needs. Thereafter, the member will be monitored for skilled nursing needs, by the home health agency or independent registered nurse, within established timeframes and as otherwise necessary. Department of Economic Security/Division of Developmental Disabilities (DES/DDD) may utilize its district nurses in performing these assessments and making recommendations to the Primary Care Provider (PCP) for continued monitoring.
2. A member who has skilled nursing needs (for example, pressure ulcers, surgical wounds, tube feedings, pain management and/or tracheotomy) must be referred to a home health agency for the initial assessment and the ongoing provision of skilled nursing care as well as monitoring determined necessary by the assessment. An independent registered nurse may provide these services if an AHCCCS registered home health agency is not available.
3. The case file must contain documentation from the initial nursing assessment. In addition there must be evidence of quarterly consultations with the provider of the skilled nursing care and documentation of the member's condition and progress until the member no longer requires skilled nursing care.
4. If the member or member representative refuses skilled nursing care, the case manager must inform the member or representative of the possible risks of refusing such care. The case manager must utilize a managed risk agreement to document the reason given for refusing the recommended care and that the



member or representative has been informed of the risks. The member or representative should sign this agreement. The member's PCP must also be informed of the refusal.

B. INSTITUTIONAL SETTINGS

1. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromising his/her skin integrity (for example, the member being bed bound, quadriplegic, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.
2. Every six months, the case manager must consult with the appropriate facility staff and review treatment record and other Level of Care documentation related to the member's condition and progress. The member's progress related to the specific skilled nursing need(s) including compliance with prescribed treatments, must then be documented in the case management file.



1620-L CASE FILE DOCUMENTATION STANDARD

REVISION DATES: 03/01/13, 05/01/12, 01/01/11, 10/01/07, 10/01/06, 09/01/05, 02/01/05,
10/01/04

INITIAL

EFFECTIVE DATE: 02/14/1996

1. Case file documentation must be complete and comprehensive. It may be written by hand or typewritten. Each case file page should indicate the member's name and AHCCCS identification number. Each entry made by the case manager must be signed and dated. If electronic records are utilized, the Contractor must ensure the integrity of the documentation. AHCCCS may request that documentation kept in an electronic system be printed out for purposes of a case file review.
2. Contractors must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).
3. Case files must be kept secured.
4. Program Contractors are expected to maintain a uniform tracking system for documenting the begin and end dates of those services listed in the Placement/Service Planning Standard section of this chapter, as applicable, in each member's chart. This documentation is inclusive of renewal of services and the number of units authorized for services.
5. Tribal Contractors must show authorization of services on the CA165/Service Plan.
6. Case files must include, at a minimum:
 - a. Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number
 - b. Identification of the member's Primary Care Provider (PCP)
 - c. Uniform Assessment Tool (UAT), completed at least annually
 - d. Information from 90/180 day on-site assessments that addresses at least the following:
 - i. Member's current medical/functional/behavioral health status, including strengths and needs



- ii. The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of residentially placed member
 - iii. The cost effectiveness of Arizona Long Term Care System (ALTCS) services being provided
 - iv. Identification of family/informal support system or community resources and their availability and willingness to assist the member as uncompensated caregivers, including barriers to assistance
 - v. Identification of service issues and/or unmet needs, an action plan to address them and documentation of timely follow-up and resolution
 - vi. Member-specific goals that will allow the member to gain functional skills or maintain/increase their current functioning level. Goals must be evaluated for appropriateness at each review with progress towards each goal documented and adjustments to goals/services made as necessary. Documentation should reflect member involvement in the development of goals
 - vii. Member's ability to participate in the review and/or who has been designated for the case manager to discuss service needs and goals with if the member is unable to participate, and
 - viii. Environmental and/or other special needs.
- e. Information from the initial on-site assessment that includes all items listed in 4 above, as well as, for those members with HCBS services already in place at the time of enrollment, an assessment of the medical necessity and cost effectiveness of those services and a care/service plan that indicates which Prior Period Coverage (PPC) services will be retroactively authorized by the Contractor.
 - f. Copies of the member's Cost Effectiveness Studies (CES), placement history and service plans/authorizations. The service plan must be signed by the member or member representative at each service review visit (every 90 or 180 days) and a copy kept in the file.
 - g. A copy of the HCBS Needs Tool (HNT) completed for all members receiving Attendant Care, Personal Care, Homemaker, Habilitation and/or Respite services that indicates how the service hours were assessed and which portions of care, if any, are provided by the member's informal support system.
 - h. A copy of the contingency plan and other documentation that indicates the member/representative has been advised regarding how to report unplanned gaps in authorized "critical" services.
 - i. A copy of the "Spouse Attendant Care Acknowledgement of Understanding" Form (Exhibit 1620-12) signed by any member choosing



- to have his or her spouse as the paid caregiver, both before that service arrangement is initiated and annually to indicate the member's continued choice for this option.
- j. Copies of Agency with Choice (AWC) or Self Directed Attendant Care (SDAC) related forms requiring case manager signature for all members choosing a member directed option, including the AWC Individual Representative form. Member directed forms can be found in Chapter 1300 of this manual.
 - k. A copy of the managed risk agreement, if indicated for the member, that identifies potential risks associated with service and/or placement decisions the member has made
 - l. Copies of current Client Assessment Tracking System (CATS) screens (CA160, CA161, CA165) for Tribal Contractors. CATS screens or comparable forms for Program Contractors.
 - m. Notices of Action sent to the member regarding denial or changes of services (discontinuance, termination, reduction or suspension)
 - n. Member-specific correspondence
 - o. Physician's orders for medical services and equipment
 - p. Documentation that a Pre-Admission Screening and Resident Review (PASRR) Level I screening and PASRR Level II evaluation, if applicable, have been completed for members in nursing facility placements and that copies are in the facility chart. A copy of the PASRR Level II evaluation, if applicable, must also be retained in the case manager's file.
 - q. Provider evaluations/assessments and/or progress reports (for example, home health, therapy, behavioral health)
 - r. Case notes including documentation of the type of contact made with the member and/or all other persons who may be involved with the member's care (for example, providers)
 - s. Documentation of the initial and quarterly consultation/collaboration with a qualified behavioral health professional, if applicable, and
 - t. Other documentation as required by the Contractor.
7. ALTCS member file information must be maintained by the Contractor for a minimum of five years.



1620-M PROGRAM CONTRACTOR CHANGE STANDARD

REVISION DATES: 05/01/12, 01/01/11, 07/01/08, 10/01/07, 09/01/05, 02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

For purposes of this section, the term “Elderly and/or Physically Disabled (E/PD) Contractor” refers to all Program and Tribal Contractors, but not the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD).

Members may be transferred between E/PD Contractors or between an E/PD Contractor and DES/DDD. Transfers between E/PD Contractors are generally as a result of the member moving out of one Contractor’s service area into another’s. Transfers between an E/PD Contractor and DES/DDD are the result of a change in DDD eligibility, as determined by DES/DDD. The service area of DES/DDD includes the entire state. When a DDD eligible member moves from one area of the state to another, a change of Contractors does not occur; there is just a change of DES/DDD case managers.

1. The case manager is responsible for the transition of and discharge planning for members transferred to another Program Contractor. Refer to [Chapter 500](#), Policy 520, of this manual regarding member transitions for further information on standards set forth for the transition of Arizona Long Term Care System (ALTCS) members.
2. A change of E/PD Contractors due to member movement to another service area or member choice where multiple Contractors are available may be initiated by:
 - a. The E/PD member or his/her representative
 - b. The current Program/Tribal Contractor, or
 - c. AHCCCS Administration.
3. The case manager is responsible for initiating action when the request is made by the member or member representative. Case managers must not assume, or allow the member to assume, that a change of Contractor is automatic.
4. E/PD case managers are responsible for explaining that there may be service limitations and exclusions when the member moves into another Program Contractor’s service area.
5. E/PD members in Maricopa County are given an opportunity to change Contractors once a year, on the anniversary date of the member’s enrollment



(called Annual Enrollment Choice [AEC]). Additionally, these members may request a change of Contractor at any time when one of the following conditions exists:

- a. For medical continuity of care reasons
- b. Erroneous network information or agency error
- c. Lack of initial enrollment choice
- d. Lack of annual enrollment choice
- e. Family continuity of care, or
- f. Continuity of institutional or residential setting.

Contractor change requests for all of the above reasons, except medical continuity of care, can be completed and submitted to the local ALTCS eligibility office for processing. Refer to the AHCCCS Contractor Operations Manual (ACOM) Policy 403 for more information on these conditions and changes of Contractor.

6. For transfers within or into Maricopa County, the E/PD member must make a choice of Contractors before any change can be processed. The member will be given a choice of Contractors by the local ALTCS office upon notice (from either the member/representative or the case manager) that the member intends to move or has moved to Maricopa County.
7. Tribal members are considered to have on-reservation status even though they are admitted to a nursing facility or alternative residential setting within a Program Contractor area of service off the reservation. Tribal members who move to own home HCBS settings off reservation will be transitioned to the Program Contractor serving that area.
8. Case managers must discuss the potential transfer of a member with the Transition Coordinator or case manager of the potential receiving Contractor to ascertain availability of services in that area. This information will assist the member/family with planning. A list of current Transition Coordinators for the Contractors is available from the AHCCCS Division of Health Care Management/Case Management Unit.
9. The Program Contractor Change Request (PCCR) form (found in Exhibit 1620-8) is used for all member transfers. In some cases, as noted below, the transfer will first require the receiving Contractor's agreement to accept enrollment of the member. In others because of a change in the county of fiscal responsibility



or reservation status, the relinquishing and receiving Contractor only need to agree on the effective date of the transfer that will occur.

- a. E/PD members who move from any setting to Home and Community Based Services (HCBS) own home in another Contractor's service area will have a change of fiscal county and therefore Contractor. The relinquishing and receiving Contractor must agree to the effective date of transfer.

NOTE: Refer to Chapter 100 of this Manual for definition of "Own Home".

- b. Native American members who move from any setting type to HCBS own home in another Tribal Contractor's service area/reservation will have a change of reservation status and therefore Tribal Contractor. This applies when the Tribal Contractor enrolled E/PD member will reside on a different reservation than where s/he lived at enrollment (for example, A Navajo Nation member who will now reside on the Tohono O'Odham reservation in his/her "own home" should be enrolled with Tohono O'Odham Nation). The relinquishing and receiving Tribal Contractors must agree to the effective date of transfer.
- c. Native American E/PD members who are enrolled with an E/PD Program Contractor who move to HCBS own home on the reservation will have a change of reservation status and therefore will be enrolled with the Tribal Contractor responsible for case managing that reservation. The relinquishing and receiving Tribal Contractors must agree to the effective date of transfer.
- d. E/PD Tribal members who move from a Tribal Contractor's reservation/service area (HCBS or institutional setting) to HCBS own home off-reservation within an E/PD Program Contractor's area of service will have a change of reservation status and therefore Contractor. The sending and receiving Contractors must agree to the effective date of transfer.
- e. Transfers of E/PD members who move from any setting to an institutional or alternative residential setting in another E/PD Contractor's service area will require the receiving Contractor to agree to the transfer. The sending and receiving Contractors must agree to the effective date of transfer.
- f. Transfers of E/PD members in Maricopa County for whom medical continuity of care is cited by the member's Primary Care Provider (PCP) as the reason for a change of Contractors must be reviewed and approved by the Medical Directors of both Program Contractors before the relinquishing Contractor can submit the PCCR. The sending and receiving Contractors must agree to the effective date of transfer.



- g. Transfers of E/PD members who are minor children that are moved/placed out of the service area where their parents reside to another service area will require the receiving Contractor to agree to the transfer. The sending and receiving Contractors must agree to the effective date of transfer.
10. DES/DDD must notify AHCCCS (via electronic Member Change Report) if a DD member no longer meets the DDD eligibility criteria. AHCCCS would need to complete a PAS assessment to determine if the member meets ALTCS eligibility criteria as an E/PD member. If the member is determined to be E/PD, DES/DDD must coordinate the transition to an E/PD Contractor through the PCCR. Both sending and receiving Contractors must agree to the effective date of transfer.
11. The relinquishing case manager must provide adequate member information (case documentation and/or medical records) to the receiving Contractor to assure continuity of care. The ALTCS Enrollment Transition Information (ETI) form (found in Exhibit 1620-9) is used for this purpose.
12. The potential receiving Contractor is responsible for reviewing the request and notifying the relinquishing Contractor within ten business days of the request for transfer decision.

The current/relinquishing Contractor must notify the member's case manager and the member within seven days of receiving decision notification from the potential receiving Contractor. The relinquishing Contractor must arrange and pay for transporting the member, if necessary.

13. If a change of Contractor is agreed to by both Contractors, a scanned copy of the completed/signed PCCR form, or at least the information listed below must be sent via **secure email** to the AHCCCS PCCR mailbox (pccr@azahcccs.gov).
- a. Member's Name
 - b. Member ID#
 - c. Address and county of member's new residence
 - d. Phone number of member or representative (this is needed to allow AHCCCS eligibility to confirm the new residence before processing the transfer)
 - e. Effective date of transfer to new Contractor.



If the PCCR form was not used, the email chain between the relinquishing and receiving Contractors that indicates agreement to the transfer by both Contractors must be included when sending the email to AHCCCS.

14. If the potential receiving Contractor denies the request for enrollment change, the relinquishing Contractor may request a review by AHCCCS after both receiving and relinquishing Contractors representatives have discussed the request and have not been able to come to agreement.

AHCCCS will notify the relinquishing Contractor of its decision. The Contractor will be responsible for informing the member of that decision.

15. Both the relinquishing and receiving Contractions are responsible for ensuring a safe transition for the member.
16. The CA161 (Placement Screen) and service plan must be updated to reflect any changes in placement, services and/or Contractor enrollment dates.



1620-N SERVICE CLOSURE STANDARD

REVISION DATES: 05/01/12, 01/01/11, 01/01/10, 10/01/07, 09/01/05, 02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

1. Closure of a member's service(s) may occur for several different reasons. The following is a list of the most common reasons. This list is not meant to be all-inclusive:
 - a. The member is no longer Arizona Long Term Care System (ALTCS)-eligible, as determined by AHCCCS/Division of Member Services/Field Operations Administration (DMS/FOA)
 - b. The member dies
 - c. The case manager and/or physician determine that a service is no longer necessary
 - d. The member or representative requests discontinuance of the service(s) or refuses services.
 - e. The member moves out of the Contractor service area
 - f. The member leaves the Contractor service area temporarily and the Program Contractor is unable to continue services
 - g. For Elderly and/or Physically Disabled (E/PD) members in Maricopa County only – the member's Contractor has been changed due to member request, and/or
 - h. Contact has been lost with the member.
2. Case managers are required to provide community referral information on available services and resources to meet the needs of members who are no longer eligible for ALTCS.
3. If the member has been determined ineligible for ALTCS, the member or member representative will be informed of this action and the reason(s), in writing, by DMS/FOA. This notification will provide information about the member's rights regarding that decision.



4. If a service is closed because the ALTCS Contractor has determined that it is no longer medically necessary, the member must be given a written Notice of Action regarding the plan to discontinue the service that contains information about his/her rights with regards to that decision.

A Notice of Action is not required if the member/representative agrees with the closure of a service on the service plan (Exhibit 1620-13).

Refer to Arizona Administrative Code 9 A.A.C. 34 for specific information and timeframes about written member notices. The AHCCCS Contractor Operations Manual (ACOM) policy 414 provides additional guidelines on and examples of Notices of Action.

5. When the member's enrollment will be changed to another Contractor, the case manager must coordinate a transfer between the Contractors. Refer to Standard XIII, Program Contractor Change, in this Chapter, as well as to [Chapter 500](#) of this manual for more detailed information.
6. The case manager is responsible for notification of and coordination with service providers to assure a thorough discharge planning process.
7. If a member is disenrolled from ALTCS, but remains eligible for AHCCCS acute care benefits, the case manager must direct the member to the AHCCCS website for information regarding available acute care health plans and encourage the member to convey their choice of health plans to the AHCCCS Communication Center at 1-800-962-6690.
8. Case notes must be updated to reflect service closure activity, including, but not limited to:
 - a. Reason for the closure
 - b. Member's status at the time of the closure, and
 - c. Referrals to community resources if the member is no longer ALTCS eligible.
9. The case manager must update placement history (CA161) and service plan information in the case file and Clients Assessment Tracking System (CATS), as applicable. When a service is closed, the end date and service units must be adjusted accordingly.
10. A member who is disenrolling from ALTCS will generally remain enrolled through at least the end of the month in which the eligibility is terminated. If the member voluntarily withdraws and wants ALTCS benefits to stop



immediately, the disenrollment will be effective with the processing of the withdrawal by DMS/FOA.

11. **The member continues to be the responsibility of the Contractor until the disenrollment is processed by ALTCS and appears on the Contractor's roster.** Members are eligible to receive medically necessary services through their disenrollment date.
12. When the reason for termination is the member's death, the case manager must end date the service authorization(s) with the actual date of death.



1620-O ABUSE/NEGLECT REPORTING STANDARD

REVISION DATES: 05/01/12, 01/01/11, 10/01/07, 09/01/05, 02/01/05, 10/01/04

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 02/14/1996

1. Suspected cases of abuse neglect and/or exploitation must be reported to the appropriate authorities by the case manager. Case managers are responsible for identifying the agency in their area that handles these issues for adults and/or children, as applicable.
2. Adult abuse includes:
 - a. Intentional infliction of physical harm
 - b. Injury caused by negligent acts or omissions (including pressure sores and dehydration)
 - c. Unreasonable confinement
 - d. Sexual abuse or sexual assault,
 - e. Neglect (a pattern of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health), and/or
 - f. Exploitation (the illegal or improper use of vulnerable adult or his resources for another's profit or advantage).
3. Vulnerable adult is defined as an individual who is 18 years of age or older who is unable to protect himself/herself from abuse, neglect or exploitation by others because of a mental or physical impairment. Vulnerable adult includes an incapacitated person (defined in Arizona Revised Statute A.R.S. 14-5101 as any person who is impaired by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person).
4. Child abuse includes:



- a. The infliction or allowing of physical injury including that which results from permitting a child to enter or remain in a dangerous environment or setting
 - b. Impairment of bodily function or disfigurement
 - c. Infliction of or allowing another person to cause serious emotional harm,
 - d. Inflicting or allowing sexual abuse and/or sexual exploitation, including incest, molestation and child prostitution to occur and
 - e. Unreasonable confinement.
5. Adult Protective Services (APS) – a program within the Arizona Department of Economic Security, which is governed by A.R.S. §§46-451 through 46-459 and 14.5310.01, to protect vulnerable adults from abuse or neglect.

APS workers also serve as a part of Arizona’s Ombudsman Program to act as an advocate, investigate reports of abuse, neglect or exploitation and assist in problem resolution for individuals residing in long term care facilities.

6. Child Protective Services (CPS) – a program within the Department of Economic Security which functions to ensure the safety of children. A.R.S. Title 8 Chapter 10 (§§8-800 through 8-819) requires that the agency investigate reports of suspected child abuse, neglect, and/or abandonment.

The program also assists parents/caregivers in receiving available services which will help improve family relationships and strengthen their ability to provide good child care. If this is not possible, alternative solutions and placement are sought.

7. For Tribal members – the APS and CPS programs do not have jurisdiction on the reservations to intervene in cases of abuse, neglect or exploitation. Case managers must determine which Tribal program is responsible for handling these issues in their area.
8. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, **separate** from the member’s case file, that is designated as confidential. The confidentiality of this information is protected under A.R.S. §§36-441, 36-445.01 through 445.02, 36-2401 through 2404, 36-2917, and 42 Code of Federal Regulations C.F.R. 431 Subpart F.
9. Member quality of care issues must be reported to and a resolution coordinated with the Contractor’s Quality Management Unit and/or AHCCCS/Division of Health Care Management/Clinical Quality Management Unit. Refer to [Chapter](#)



[900](#), Policy 960, of this manual for more information on the Contractor's responsibilities related to these issues.

EXHIBIT 1620-1

CASE MANAGEMENT (CM) TIMEFRAMES

EXHIBIT 1620-1

CASE MANAGEMENT (CM) TIMEFRAMES

INITIAL CONTACT/VISIT	TIMEFRAME
Initial Contact (CM or designee)	Within seven business days of enrollment
Initial on-site visit	Within 12 business days of enrollment
Initial service start-up	Within 30 days of enrollment
CASE FILE UPDATES	TIMEFRAME
Initial Cost Effective Study (CES)	Prior to placement/services
Initial CES, when services in place at enrollment	Within 12 business days of enrollment
CES update	Prior to placement change to HCBS and at least once a year for all Home and Community Based Services (HCBS) members, and when changes of services increases % to > 100%
CES when no discharge potential	No updates required, CES will reflect "NONE"
CATS ENTRIES	TIMEFRAMES
CES/CA160	Within ten business days of date of action
Placement/CA161	Within ten business days of date of action
Service Plan/CA165 (Tribal only)	Within five business days of date of action
REASSESSMENT VISITS (Includes service plan review and signature)	TIMEFRAMES
HCBS member	At least every 90 days
Nursing Facility (NF) member	At least every 180 days
Acute Care Only members – may be phone contact but on-site visit required at least once a year	<ul style="list-style-type: none"> ▪ At least every 90 days for home based members ▪ At least every 180 days for institutionalized members*
Developmentally Disabled (DD) members 12 years or older residing in a group home, unless the member is medically involved or Seriously Mentally Ill/Severely Emotionally Disabled (SMI/SED)	At least every 180 days*

*The "Next Review Date" on the CA161/Placement Maintenance screen in Client Assessment Tracking System (CATS) will be calculated at 90 days for these members.

EXHIBIT 1620-2

**ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CHANGE REPORT
HARD COPY EXAMPLE ONLY – CHANGES MUST BE REPORTED
ELECTRONICALLY**

VIA WEBSITE: [HTTPS://MCR.STATEMEDICAID.US/](https://mcr.statemedicaid.us/)

EXHIBIT 1620-2

ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CHANGE REPORT

Date ____/____/____	ALTCS Program Contractor:	Reported By:	Phone #:
MEMBER NAME:		AHCCCS ID:	
Sent To: <input type="checkbox"/> ALTCS Local Office <input type="checkbox"/> DHCM <input type="checkbox"/> Medical QC Supervisor		DOB:	Customer #:
Verification Attached? <input type="checkbox"/> YES <input type="checkbox"/> NO	Verification Type: <input type="checkbox"/> DE-130 <input type="checkbox"/> Case Notes <input type="checkbox"/> Other: _____		
PART I - DEMOGRAPHIC/MISCELLANEOUS (SEND DE-701 TO ALTCS LOCAL OFFICE)			
<input type="checkbox"/> Address Change: <input type="checkbox"/> Residential <input type="checkbox"/> Move to Home in Different Fiscal County <input type="checkbox"/> Mailing <input type="checkbox"/> Move Out of State		For: <input type="checkbox"/> Representative <input type="checkbox"/> Member	Effective Date: ____/____/____
<input type="checkbox"/> Name	<input type="checkbox"/> Sex	<input type="checkbox"/> DOB	
<input type="checkbox"/> Phone #	<input type="checkbox"/> SSN	<input type="checkbox"/> DOD	<input type="checkbox"/> Other:
Explain Change:			
PART II - PLACEMENT/LIVING ARRANGEMENT (SEND DE-701 TO ALTCS LOCAL OFFICE)			
FROM: (previous residence) Enter facility name (if applicable), address and phone number. TO: (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, phone number. Enter comments.			
FROM:		Phone: ()	
Address:	City:	State:	Zip Code:
TO: LIVING ARRANGEMENT		EFFECTIVE DATE:	LENGTH OF STAY:
<input type="checkbox"/> NF/ICF <input type="checkbox"/> Home <input type="checkbox"/> Adult Foster Care Home * <input type="checkbox"/> Assisted Living Home * <input type="checkbox"/> Assisted Living Center * <input type="checkbox"/> <input type="checkbox"/> Behavioral Health Residential <input type="checkbox"/> Behavioral Health Supportive Home <input type="checkbox"/> DD Group Home/Adult Developmental Home <input type="checkbox"/> Child Developmental Foster Home/Large Group Setting <input type="checkbox"/> Alternative Acute Living Arrangement <input type="checkbox"/> Loss of Contact <input type="checkbox"/> Other _____		_____/____/____ <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Until: ____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Medicare Certified <input type="checkbox"/> Not Medicare Certified <input type="checkbox"/> Licensed <input type="checkbox"/> Unlicensed <input type="checkbox"/> Contracted with PC <input type="checkbox"/> Not Contracted with PC
		NOTE TO LOCAL OFFICE: To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE. * If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement.	
Facility Name:		Provider ID:	Phone: ()
Address:	City:	State:	Zip Code:
Comments:			

EXHIBIT 1620-2

ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CHANGE REPORT

MEMBER NAME:		AHCCCS ID:	
PART III - CLIENT STATUS			
SEND THE DE-701 TO THE ALTCS LOCAL OFFICE TO REPORT THE FOLLOWING CHANGES:		Date From: ____/____/____	Comments:
<input type="checkbox"/> Member requests voluntary withdrawal from ALTCS (DE-130 attached) <input type="checkbox"/> Change Contract Type from LTC to Acute for retroactive period (refusing services) <input type="checkbox"/> Temporarily Absent from Arizona <input type="checkbox"/> Returned to Arizona <input type="checkbox"/> Tribal Enrollment Change – DHCM was contacted <input type="checkbox"/> On-Reservation <input type="checkbox"/> Off-Reservation			
SEND THE DE-701 TO DHCM FOR THE FOLLOWING CHANGES:		Date To: ____/____/____	
<input type="checkbox"/> From LTC to Acute– (Attach case notes) <input type="checkbox"/> Services not available <input type="checkbox"/> Temporarily out of service area <input type="checkbox"/> Refusing Services (DE-130 not signed) <input type="checkbox"/> From Acute to LTC <input type="checkbox"/> Services are available <input type="checkbox"/> No longer out of service area <input type="checkbox"/> No longer Refusing Services			
PART IV - CHANGE PC WITHIN MARICOPA COUNTY (SEND DE-701 TO ALTCS LOCAL OFFICE)			
<input type="checkbox"/> Member Requests Enrollment Change to: _____(Program Contractor)			
REASON:			
<input type="checkbox"/> Erroneous Information/Error <input type="checkbox"/> Family Continuity <input type="checkbox"/> Lack of Choice <input type="checkbox"/> Continuity of Placement			
COMMENTS:			
PART V - MEDICARE/OTHER HEALTH INSURANCE (SEND DE-701 TO ALTCS LOCAL OFFICE)			
Medicare Part A <input type="checkbox"/> YES <input type="checkbox"/> NO	Effective Date: ____/____/____	Medicare Number: _____	
Medicare Part B <input type="checkbox"/> YES <input type="checkbox"/> NO	Effective Date: ____/____/____	Disenrollment Date: _____	
Other Insurance <input type="checkbox"/> YES <input type="checkbox"/> NO	Effective Date: ____/____/____	_____ / ____ / ____	Policy Number: _____
INSURANCE CARRIER: _____			
PART - SHARE OF COST (SEND DE-701 TO ALTCS LOCAL OFFICE)			
<input type="checkbox"/> Reduce Share of Cost Due to Death of Member		Effective: Month/Year	
<input type="checkbox"/> Other (Specify): _____		____/____/____	
PART VII - INCOME/RESOURCE CHANGE (SEND DE-701 TO ALTCS LOCAL OFFICE)			
<input type="checkbox"/> Income <input type="checkbox"/> Resources		Explain the change:	
Source or Type: _____			
PART VIII - VENTILATOR STATUS CHANGE/PAS REASSESSMENT REQUEST (SEE FORM INSTRUCTIONS)			
<input type="checkbox"/> Ventilator Dependent <input type="checkbox"/> Non-Ventilator Dependent		Effective date: _____	
<input type="checkbox"/> PAS Reassessment Request – Check Reason for Assessment and provide comment			
<input type="checkbox"/> Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.			
<input type="checkbox"/> Transitional member now in NF; expected to exceed 90 days:		(Complete Part II)	
<input type="checkbox"/> Other (Explain): _____			
Comments: _____			
RESPONSE - (COMPLETED BY AHCCCS EMPLOYEE)			
<input type="checkbox"/> Refer to Part(s) _____		<input type="checkbox"/> Contract Type Change from _____ to _____	
<input type="checkbox"/> Change Completed		Begin date _____ End date _____	
Date Completed ____/____/____		<input type="checkbox"/> SOC increased to \$ _____ Effective Date: ____/____/____	
Effective Date ____/____/____		<input type="checkbox"/> SOC decreased to \$ _____ Effective Date: ____/____/____	
<input type="checkbox"/> Member no longer eligible		<input type="checkbox"/> Income Changed	
Effective Date ____/____/____		<input type="checkbox"/> Resources Changed	
<input type="checkbox"/> Failed PAS		<input type="checkbox"/> Member eligible for acute care only	
<input type="checkbox"/> Other Reason _____		Effective Date ____/____/____	
<input type="checkbox"/> Member still eligible		<input type="checkbox"/> ALTCS Acute care	
<input type="checkbox"/> Passed PAS Reassessment		<input type="checkbox"/> Health Plan _____	
<input type="checkbox"/> DHCM has determined LTC status should continue		<input type="checkbox"/> No Action Taken (see comments)	
Comments: _____			
Signature of AHCCCS Staff Person _____		Date Returned ____/____/____	

EXHIBIT 1620-2
ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CHANGE REPORT
GUIDELINES ON WHEN TO USE A MEMBER CHANGE REPORT FORM

An electronic Member Change Report (MCR) should be sent to AHCCCS to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their Arizona Long Term Care System (ALTCS) eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the member's Developmentally Disabled (DD) status and request a Pre-Admission Screening (PAS) reassessment.
- To report the closure of a member's service plan for reasons other than financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).
- To initiate a Contractor change when an Elderly and/or Physically Disabled (E/PD) member moves into another Contractor's service area in a Home and Community Based (HCB) setting (does not include alternative residential settings).
- To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.
- To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to a nursing home or Intermediate Care Facility (ICF) and is expected to stay more than 90 continuous days (this request must be sent within 45 days of admission to the institutional setting).
- To request an Acute Care Only determination for a member who has received no Long Term Care (LTC) services for a full calendar month because s/he refuses ALTCS covered services but s/he has not signed a Voluntary Withdrawal. "Refusing" includes being unwilling or unavailable to receive services offered or covered by the Contractor (examples: member is not home whenever provider comes to deliver care, member unwilling to move out of non-contracted alternative residential setting or member temporarily out of contractor's service area). This determination could result in the member being disenrolled from ALTCS if his/her income exceeds 100% of the Federal Benefit Rate.
- To request a change in a member's status from Acute Care Only back to full LTC when the member begins to accept LTC services.
- To request a change in Contract Type when a member has received no LTC services for a full calendar month, due to no LTC service provider being available. This change will not cause a member to be disenrolled.

EXHIBIT 1620-2
ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CHANGE REPORT
GUIDELINES ON WHEN TO USE A MEMBER CHANGE REPORT FORM

- To inform ALTCS when a member is temporarily out-of-state (>30 days).
- For Maricopa County E/PD members only – to report the member’s request to change Program Contractors and the need for an enrollment choice.
- To report loss of contact with the member.

NOTE – members who are temporarily out of the Contractor’s service area including out of state, may be provided with LTC services if these are available, in the member’s best interests and are approved by the contractor. No AHCCCS services may be provided while a member is outside of the United States.

A hard copy MCR may be needed if, at the time of submission, the member is no longer enrolled with the Contractor that is attempting to send the report.

EXHIBIT 1620-3

**UNIFORM ASSESSMENT TOOL
AND
GUIDELINES**

EXHIBIT 1620-3

UNIFORM ASSESSMENT TOOL AND GUIDELINES

MEMBER NAME: _____

REVIEW DATE: _____ CLASS _____ CM: _____

DETERMINED CLASS: _____

REVIEW DATE: _____ CLASS _____ CM: _____

DATE CLASS DETERMINED: _____

REVIEW DATE: _____ CLASS _____ CM: _____

Acuity determinations are based on this UAT matrix which describes characteristics of clients in each level. Information will be gathered through assessment of the client, interview with nursing facility staff, and medical record review, with particular attention to documentation regarding the past 30 days and updates within the MDS. *If the CM is uncertain regarding client's level of care, he/she will review case with their manager.*

	CLASS 1 CLIENT HAS THREE OR MORE OF THE FOLLOWING	CLASS 2 CLIENT HAS FOUR OR MORE OF THE FOLLOWING:	CLASS 3 CLIENT HAS FIVE OR MORE OF THE FOLLOWING:
BATHING, DRESSING, GROOMING	Independent or may participate in care, but requires assistance with bathing, dressing, and/or grooming.	Requires moderate assistance with bathing, dressing, and/or grooming.	Requires maximum assistance with bathing, dressing, and grooming.
FEEDING/EATING	Independent or requires minimum set up/prompting assistance with feeding/eating.	Requires moderate assistance with feeding/eating.	Requires maximum assistance with feeding/eating (for example, tube feeding).
MOBILITY	Independent or requires minimum or stand by assistance to move from one location to another with or without assistive devices.	Requires moderate assistance to move from one location to another with or without assistive devices.	Requires maximum assistance to move from one location to another with or without assistive devices.
TRANSFERRING	Can transfer to some or all surfaces independently. Requires the assistance of no more than one person to transfer from one surface to another with or without assistive devices.	Requires hands-on physical guidance or assistance of one person for all transfers with or without assistive devices. The client may participate by being able to bear weight and pivot.	Requires assistance of two or more people to be physically lifted or moved from one surface to another with or without assistive devices.
BOWEL/BLADDER	Continent or occasionally incontinent (<i>less than seven times per week</i>) of bowel and/or bladder or may be continent at times with a training program.	Moderately (daily but some control) incontinent of bowel and/or bladder	Totally incontinent of bowel and/or bladder, receives scheduled toileting on a daily basis to avoid incontinence and/or receives care of a catheter or ostomy.
ORIENTATION/BEHAVIOR	Requires no intervention or requires minimum staff intervention for episodes of confusion, memory deficits, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.	Requires moderate staff intervention. May have periodic emotional or mental disturbances, including combativeness.	Requires maximum staff intervention. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.
MEDICAL CONDITIONS	Stable, with no or some routine nursing/medical monitoring and care.	Conditions require more frequent monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).	Conditions require intense professional intervention to maintain stability (for example, unstable diabetes, come, terminal medical condition).
MEDICAL/NURSING TREATMENTS	None or routine, such as range of motion and injections, as well as routine medication administration and routine catheter care. ANYTHING MORE WOULD COUNT UNDER CLS 2	Skilled nursing treatment in addition to routine medication administration. (Such as a treatment for skin condition.)	Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 decubitus, deep suctioning or an extensive rehab regime.

For ADLs: Minimum means some or less than half of the task, moderate means approximately one-half to less than three-quarters of the task, and maximum means extensive or approximately three-quarters of the task or more.

EXHIBIT 1620-3
UNIFORM ASSESSMENT TOOL AND GUIDELINES

GUIDELINES FOR THE USE OF THE UNIFORM ASSESSMENT TOOL

I. PURPOSE

The purpose of the Uniform Assessment Tool (UAT) is to assess the acuity of Nursing Facility (NF) residents. The UAT will also be used on HCBS members when determining the NF rate to use when developing a Cost Effectiveness Study.

The use of the UAT is not intended to impact how Contractors determine authorizations for specialty levels of care (for example, wandering dementia and medical sub-acute).

II. DEFINITIONS

The following definitions apply for **most** situations. Exceptions are noted within this document and on the UAT.

1. **Minimum** = means less than half the task.
2. **Moderate** = means approximately 50% to less than 75% of the task.
3. **Maximum** = means extensive or approximately 75% of the task or more.

III. ASSESSMENT CATEGORIES

The following information is for the purpose of assisting the case manager in completing the UAT. The information that follows is not intended to be all-inclusive. Case managers should consult with their supervisor/manager when a Characteristic does not clearly fall within a specific level.

The UAT is made up of eight Characteristics:

1. Bathing/Dressing/Grooming
2. Feeding/Eating
3. Mobility
4. Transferring
5. Bowel/Bladder
6. Orientation/Behavior
7. Medical Condition
8. Medical/Nursing Treatment

Each Characteristic is assessed for one of three acuity levels. The cumulative levels determined for each Characteristic will determine the overall Class level for the member (Class 1, Class 2 or Class 3).

A single UAT form is designed to allow the case manager to document up to four assessments. The case manager shall document the assessment-related date in the box associated with a Characteristic's determined acuity. When the eight Characteristics are assessed, determine the Class level as summarized on the UAT. Finally, document, at the top of the tool, the review date, Class and the case manager's initials. The first assessment is documented in the upper left corner. Subsequent assessments would be documented in the upper right corner.

EXHIBIT 1620-3
UNIFORM ASSESSMENT TOOL AND GUIDELINES

A. BATHING/DRESSING/GROOMING

Bathing - the process of washing, rinsing and toweling the body or body parts and transferring in/out of the tub or shower. This includes the ability to get the bath water and/or equipment, whether this is in bed, tub, shower, or sink. Use of assistive devices such as tub/shower chair, pedal/knee controlled faucets, or long-handled brushes does not disqualify the client from being independent. If the client has a problem getting to and from the bathroom to bathe, that should be reflected in the Mobility section and should not affect the score for bathing.

Assessment Considerations:

1. When taking a bath/shower, can the person get their own towel, washcloth, soap, and run the water?
2. Can the person tell if the water is too hot or too cold?
3. Is the person able to get in and out of the shower or tub by themselves?
4. Does the person need a bath bench, shower seat or hand held shower to assist with bathing?
5. What kind of problems does the person have with bathing him/herself?

Minimum = the client requires up to minimal supervision, verbal cueing, assistance in and/or out of the shower, and may need assistance with washing back or lower extremities.

Moderate = the client requires step by step cueing with the entire bathing process, one person assist getting in and out of the tub/shower, and/or hands-on assistance with approximately 50% to 75% of the bathing process.

Maximum = the client is dependent on others for assistance with approximately 75% or more of the bathing process or requires assistance of two or more persons to get in and out of shower/tub or requires the use of a Hoyer lift.

Dressing - dressing includes laying out, putting on and fastening of clothing and footwear. Use of assistive devices such as reachers, sock pullers, shoe horns, Velcro fasteners does not disqualify the client from being independent.

Assessment Considerations:

1. Can the person choose their own clothes, get them from the closet or drawer, put them on and button the buttons, fasten/close the zipper or tie their shoes?
2. If someone lays out the clothes, can the person put them on?
3. Does the person have assistive devices to assist in dressing, such as reachers, sock pullers, shoe horns, Velcro fasteners?
4. How does the person get dressed if help is needed?

Minimum = the client may need some supervision or reminding (for example, laying out clothes, giving advice or being available).

Moderate = the client required hands-on physical assistance of another person or supervision with approximately 50% to 75% of the dressing activities.

EXHIBIT 1620-3

UNIFORM ASSESSMENT TOOL AND GUIDELINES

Maximum = the client needs assistance with dressing approximately 75% or more of the time.

Grooming - grooming activities include combing hair, shaving, brushing teeth, washing hands/face, nail care and/or menses care. Obtaining the water and supplies necessary to complete the task are included in grooming.

Assessment Considerations:

1. Can the person run the sink water and wash their face, comb their hair and brush their teeth?

Minimum = the client needs up to minimal supervision or reminding (for example, setting up grooming implements, giving advise, being available, menses care.

Moderate = the client requires some physical assistance or supervision or step by step cueing with approximately 50% to 75% of their grooming activities.

Maximum = the client is dependent on others for assistance with approximately 75% or more of their grooming activities.

B. EATING/FEEDING

Eating/Feeding – the process of getting nourishment by any means from a receptacle (dish, plate, cup, glass, bottle, etc.) into the body. Use of mechanical aids such as modified utensils or plate guards does not disqualify the client from being independent.

Assessment considerations:

1. Can the person effectively get food and beverages into his/her mouth?
2. Can the person cut his/her own meat?
3. Does the person use any mechanical aids to assist with eating?
4. Is the person receiving an intravenous or tube feeding as a means of total nutrition?
5. Does the person need cueing or supervision to ensure an adequate intake?

Minimum = client requires some supervision, reminding, set-up or cutting, including alteration of food (for example, pureeing) or hands-on assistance with less than half of the meal task.

Moderate = client requires hands-on physical assistance, cueing or reminding with approximately 50% to 75% of the meal task, but can participate physically.

Maximum = client requires hands-on physical assistance with approximately 75% or more of the meal task or is totally dependent for nutritional needs (for example, tube feeding or TPN).

C. MOBILITY

Mobility – the extent of the client's purposeful movement within their residence. The use of assistive devices such as a wheelchair, walker or quad cane does not disqualify the person from being independent.

EXHIBIT 1620-3 UNIFORM ASSESSMENT TOOL AND GUIDELINES

Assessment Considerations:

1. Can the person purposely move about in his/her current environment independently?
2. Does the person have an unstable gait or balance?
3. Could the person avoid an obstacle in his/her path?
4. Does the person use any assistive devices such as a cane, walker, wheelchair or handrails?
5. Is the person unsafe without the assistance of another person in ambulating?

Minimum = approximately 50% or less of the time the client requires supervision, standby or hands-on assistance by one person for safety, including adjustment of assistive devices or restraints.

Moderate = approximately 50% to 75% of the time the client requires supervision, standby assistance or hands-on assistance of one person, including adjustment of assistive devices or restraints.

Maximum = approximately 75% or more of the time the client requires hands-on assistance of one or more persons or may be totally dependent on others for mobility (for example, cannot self-propel wheelchair).

D. TRANSFERRING

Transferring – the client’s ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc.

Assessment Considerations:

1. Can the person move horizontally or vertically between the bed, chair, wheelchair or commode independently?
2. Does the person display any weakness or unsteady balance, which would require assistance when transferring?
3. Does the person use any mechanical devices such as a walker, cane, handrails or wheelchair to assist with transfers?
4. Can the person physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver?

Minimum = can transfer to some or all surfaces independently. If needed, the assistance of no more than one person to transfer from one surface to another with or without assistive devices. The client may require some supervision or reminding or standby assistance for safety.

Moderate = the client requires hands-on physical guidance or assistance of one person for all transfers. The client may participate by being able to bear weight and pivot.

Maximum = the client requires assistance of two or more people to be physically lifted or moved.

EXHIBIT 1620-3
UNIFORM ASSESSMENT TOOL AND GUIDELINES

E. BOWEL/BLADDER CONTINENCE

Continence – the ability to voluntarily control the discharge of body waste from bladder or bowel. Incontinence means the involuntary loss of bowel and bladder contents. Stress incontinence means the inability to prevent escape of small amounts of bowel/bladder contents during certain activities such as coughing, lifting or laughing.

Those who willfully toilet in inappropriate places will not necessarily be assessed as being incontinent. These behaviors may be assessed in other parts of this instrument (for example, Behaviors). Those who receive dialysis and do not urinate will be rated as continent of bladder.

Clients who have no voluntary control secondary to physiological conditions and rely upon dilatation, indwelling catheters, intermittent catheterization, ostomies, condom catheters or placed urinals for evacuation should be rated as totally incontinent in the applicable function.

Bladder Continence – the ability of the client to voluntarily control the discharge of body wastes from the bladder. A client with a Foley catheter or ostomy will be scored maximum.

Assessment Considerations:

1. Does the person have any episodes of incontinence?
2. Can the person “hold their urine” until they get to the toilet?
3. Does the person have accidents when they sneeze or cough?
4. How frequently does the person have accidents – once or twice a week, every day, once a month?

Minimum = the client may be incontinent less than seven times a week.

Moderate = the client may be frequently incontinent or incontinent daily, but some control is present (for example, daytime, or if toileted frequently).

Maximum = the client is totally incontinent of bladder, receives scheduled toileting on daily basis to avoid bladder incontinence and/or receives care of a catheter or ostomy.

Bowel Continence - the ability of the client to voluntarily control the discharge of body wastes from the bowel. A client with an ostomy will be scored maximum.

Assessment Considerations:

1. Does the person have bowel accidents?
2. Does the person ever soil their clothing?
3. How often does the person accidents?

Minimum = the client may be continent less than seven times per week.

Moderate = the client may be frequently incontinent (seven times or more per week) or incontinent daily, but some control is present.

Maximum = the client has no voluntary control of bowel and/or receives care of an ostomy.

EXHIBIT 1620-3
UNIFORM ASSESSMENT TOOL AND GUIDELINES

F. ORIENTATION/BEHAVIOR

Behavior – identify the presence of certain behaviors that may reflect the level of an individual’s emotional functioning and need for intervention. Behaviors should be assessed based on the last 90 days (with particular attention to the past 30 days), or since the last review. Documentation should include frequency and type of behavior and if there has been or will be a request for mental health services.

Wandering is defined as moving about with no rational purpose and with a tendency to go beyond physical parameters of the environment in a manner that may jeopardize safety of self or others.

Repeated behaviors that cause injury to self (for example, biting scratching, picking behaviors; putting inappropriate objects into the ear, mouth or nose; head slapping or banging) or others (for example, physically attacking another person, throwing objects, punching, biting, pushing, pinching, pulling hair and physically threatening behavior).

Other repeated behaviors that interferes with the activities of others or the individuals own activities: for example, putting on or removing clothes inappropriately, stubbornness, sexual behavior inappropriate to time, place or person, excessive crying or screaming, persistent pestering or teasing; constantly demanding attention and urinating or defecating in inappropriate places, or threats and or attempts to take one’s own life.

Minimum = requires staff intervention less than 50% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May require temporary (24 hours or less) restraints to control a behavioral or medical problem and restraints for personal safety.

Moderate = requires staff intervention approximately 50% to 75% of the time for episodes of confusion, memory defects, impaired judgment, or agitation. May have periodic emotional or mental disturbances, including combativeness.

Maximum = requires staff intervention approximately 75% or more of the time. May be disoriented, confused, combative, withdrawn, or depressed. May need restraints (physical/chemical) for personal safety or protection of others.

G. MEDICAL CONDITION

Medical Condition – refers to the degree of stability of health care needs that may require nursing and/or medical monitoring of treatment(s) and/or therapy to restore and/or maintain function. This does not include maintenance regimens (monthly weights and blood pressure checks).

Minimum = stable, with routine nursing/medical monitoring and care.

Moderate = conditions require more frequent professional monitoring to maintain stability (for example, unstable hypertension needing frequent assessment and medication adjustment).

Maximum = conditions require intense professional intervention to maintain stability (for example, unstable diabetes, coma, terminal medical conditions).

EXHIBIT 1620-3
UNIFORM ASSESSMENT TOOL AND GUIDELINES

H. MEDICAL/NURSING TREATMENTS

Medical/Nursing Treatments – refers to level of nursing and/or medical care that is required to perform medical assistance and interventions with current health care needs.

Minimum = Routine treatments, such as range of motion and injections, as well as routine medication administration and routine catheter care. Anything more would be considered at least “moderate”.

Moderate = Skilled nursing treatment in addition to routine medication administration (for example, treatment of stage one to three pressure ulcer, tube feeding).

Maximum = Relatively complex, with more than one professional or technical treatment, such as IV therapy, tube or parenteral feeding, care of recent wound, care of infected or stage 4 pressure ulcer, deep suctioning or an extensive rehab regimen.

EXHIBIT 1620-4

ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

EXHIBIT 1620-4
ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

- Members should be placed in a “D” placement in the following situations:
 - The member has refused both institutional and/or Home and Community Based (HCB) services but does not wish to withdraw from the program. “Refused” includes circumstances where the member/representative is unavailable or unwilling to receive services offered by the Contractor.
 - The member receives no Long Term Care (LTC) services because a provider for the service(s) requested/needed is not available in the member’s area.
 - The member resides in an Alternative Residential Setting that is not contracted with the member’s Program Contractor, or in Maricopa County is not contracted with any available Program Contractors and s/he does not want to move.
 - The member resides in an Alternative Residential Setting that is not registered with AHCCCS and s/he does not want to move.
 - The member is not eligible for full LTC benefits due to an uncompensated transfer of resources/property. A member under these circumstances will be approved by AHCCCS as Acute Care Only (ACO) at the time of enrollment.
 - The member receives no services, has signed a Voluntary Discontinuance and is pending disenrollment.
 - The member resides in an uncertified nursing facility
- “D” placements are generally for a full calendar month only. See exceptions to this rule in case examples #5, #7 and #9-10 to follow.
- If HCB services are provided to the member for any portion of a month, that member should be in an “H” placement code for the entire calendar month.
- “Q” placement begin and end dates however, must match the actual date of admission and/or discharge. This is because member Share of Cost is assessed based on date of admission and/or discharge.
- Placements do not need to be changed to “D” when a member is hospitalized and not receiving LTC services for a full calendar month. The placement code should remain the same as it was prior to hospitalization until it is known what placement member will be discharged to.
- Member Change Reports (MCR) should be submitted electronically for changes of member status from LTC to ACO as well as ACO back to LTC.
- MCRs are sent electronically after at least one full calendar month has passed in which no LTC services were provided.
- MCRs for changes from LTC to ACO must be sent electronically with adequate information to describe the reason for the change.
- Members whose income is greater than 100% of the current Federal Benefit Rate will not be eligible for ALTCS if/when they refuse LTC services. Case managers should advise members who refuse LTC services of the possibility of disenrollment
- MCRs sent must indicate the effective date(s) of ACO (at least the begin date of this status) and the reason for change (Refusing Home and Community Based Services [HCBS] or Services Not Available).
- The “D” placement code dates on CA161/Placement Maintenance must match the dates indicate on the MCR.
- AHCCCS capitates Elderly and/or Physically Disabled [E/PD] Contractors at a lower rate for all days that any member is in a “D” placement. AHCCCS will recoup funds for all members in “D” placement for whom the E/PD Contractor has received full LTC capitation.

EXHIBIT 1620-4
ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

CASE EXAMPLES:

1. Member enrolls on 4/03/10. Case manager conducts on-site visit and HCBS begin on 4/17/10. “H” placement begins on the date LTC services begin following initial contact.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Z	1	11	4/03/10	4/16/10
H	1	13	4/17/10	

2. Member enrolled on 1/15/10 with HCBS in place. Member stops receiving HCBS on 5/25/10. Member begins to receive HCBS again on 6/19/10. This member’s placement will remain “H” since the member received LTC services at home in both May and June.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
H	1	13	1/15/10	

3. Member enrolled on 1/15/10 with HCBS in place. Member stops receiving HCBS on 5/25/10. As of 6/30/10, the member is still not receiving any LTC services. Case manager should change placement code to “D” beginning 6/01/10 and send MCR indicating change from full LTC to ACO effective 6/01/10 with no end date.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
H	1	13	1/15/10	5/31/10
D	1	12	6/01/10	

4. Member enrolled on 1/15/10 with HCBS in place. Member stops receiving HCBS on 5/25/10. As of 6/30/10, the member is still not receiving any LTC services. Case manager should change placement code to “D” beginning 6/01/10 and send MCR indicating ACO effective 6/01/10 with no end date.

Member then begins to receive HCBS on 7/20/10. Case manager should change placement code to “H” beginning 7/01/10 and send another MCR indicating change from ACO back to full LTC effective 7/01/10.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
H	1	13	1/15/10	5/31/10
D	1	12	6/01/10	6/30/10
H	1	13	7/01/10	

EXHIBIT 1620-4
ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

5. New member enrolls on 7/13/10 with no services in place. Case manager completes on-site assessment on 7/20/10 and member declines any LTC service. Member should be in a “Z” placement beginning 7/13/10. After 30 days, the member’s placement code should be changed to “D” if no LTC services have begun. If the member has still not received LTC services by the end of the calendar month, case manager should send MCR indicating change from full LTC to ACO effective 8/13/10 (the 31st day after enrollment) with no end date.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Z	1	11	7/13/10	8/12/10
D	1	12	8/13/10	

6. New member enrolls on 7/13/10 with no services in place. Case manager completes on-site assessment on 7/20/10 and member begins to receive HCBS on 8/26/10. This member’s placement can be changed to “H” beginning on the 1st of August since LTC HCBS services were provided within the month of August.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Z	1	11	7/13/10	7/31/10
H	1	13	8/01/10	

7. New member enrolls on 7/13/10 with no services in place. Case manager completes on-site assessment on 7/20/10 and member declines any LTC service. Member should be in a “Z” placement beginning 7/13/10. After 30 days, the member’s placement code should be changed to “D” if no LTC services begun. If the member has still not received LTC services by the end of the calendar month case manager should send MCR indicating change from full LTC to ACO effective 8/13/10 (the 31st day after enrollment) with no end date.

Member then begins to receive HCBS on 9/13/10. Case manager should change placement code to “H” beginning 9/01/10 and send MCR indicating change from ACO back to full LTC effective 9/01/10.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Z	1	11	7/13/10	8/12/10
D	1	12	8/13/10	8/31/10
H	1	13	9/01/10	

EXHIBIT 1620-4
ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

8. Member enrolled 5/13/10 residing in an ALF that is not contracted with the Program Contractor. As long as the ALF is licensed by ADHS and registered with AHCCCS, the member will be enrolled as full LTC benefits even though it is not contracted. If the facility is not contracted with another PC in the area, or there is no other PC in the area, and the member refuses to move, an MCR should be sent indicating a change from LTC to ACO (refusing LTC services) effective 5/13/10.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
D	*1	12	5/13/10	

*Residence code(s) for Assisted Living Facilities (B, 5, 9, etc.) can not be combined with “D” placement so must use (1) as above.

9. Member enrolled 5/13/10 residing in an ALF that is not contracted with the Program Contractor. As long as the ALF is licensed by ADHS and registered with AHCCCS, the member will be enrolled as full LTC benefits even though it is not contracted. If the facility is not contracted with another PC in the area, or there is no other PC in the area, and the member refuses to move, an MCR should be sent indicating a change from LTC to ACO (refusing LTC services) effective 5/13/10.

Member moves to a nursing facility on 6/17/10. MCR should be sent requesting a change from ACO to full LTC status effective 6/17/10. Unlike when HCBS are provided in the calendar month the “Q” placement does not begin at the first of that month but rather on the actual date of admission. This is because member share of cost is assessed based on date of admission and/or discharge.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
D	1*	12	5/13/10	6/16/10
Q	2	01	6/17/10	

*Residence code(s) for Assisted Living Facilities (B, 5, 9, etc.) can not be combined with “D” placement so must use (1) as above.

10. Member enrolls on 3/19/10 in a nursing facility placed and leaves AMA on 8/11/10. Case manager is unable to locate the member until 9/09/10 and member agrees to HCBS that begin on 9/18/10. As long as the member receives HCB services in the calendar month, the “H” placement may begin on the 1st of that month. An MCR is needed to change the member’s status to ACO and then back to full LTC effective 9/01/10 to match the placement.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Q	2	01	3/19/10	8/10/10
D	1	12	8/11/10	8/31/10
H	1	13	9/01/10	

EXHIBIT 1620-4
ACUTE CARE ONLY “D” PLACEMENT GUIDELINES

11. Member who has been residing in a nursing facility placement leaves the facility before HCB services are in place on 2/13/10. Case manager becomes aware of discharge and visits member to set up home services on 2/16/10. HCB services begin on 2/18/10. Since member will receive LTC services during the entire calendar month the “H” placement may begin on 2/14/10 immediately after “Q” placement ends even though home services did not begin right away.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
Q	2	01	03/19/08	2/13/10
H	1	13	2/14/10	

12. Member enrolls on 4/12/10 with ACO status due to an uncompensated transfer status will end 10/31/10. Regardless of member’s residence type, placement must be “D” during this time period. Member begins receiving HCBS services on 11/03/10. As long as the member receives HCB services in the calendar month the “H” placement may begin on the 1st of that month. No MCR is necessary because the change from ACO status to full LTC status has already been processed by the eligibility office with the end of the transfer period.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
D	1	12	4/12/10	10/31/10
H	1	13	11/01/10	

13. Member enrolls on 4/12/10 with ACO status due to an uncompensated transfer, status will end 10/31/10. Regardless of member’s residence type, placement must be “D” during this time period. Member is admitted to a NF on 11/05/10. Unlike when HCBS are provided in the calendar month, the “Q” placement does not begin at the first of the month but rather on the actual date of admission. This is because member Share of Cost is assessed based on date of admission and/or discharge.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
D	1	12	4/12/10	11/04/10
Q	2	03	11/05/10	

14. Member enrolls on 4/12/10 with ACO status due to an uncompensated transfer, status will end 10/31/10. Regardless of member’s residence type, placement must be “D” during this time period. Member begins to receive HCB services on 12/09/10. Since AHCCCS would not be aware of the continuation of Acute Care status after the end of the transfer period on 10/31/10, an MCR needs to be sent requesting a change from full LTC status to ACO status through 11/30/10.

CA 161 SCREEN:

PLACEMENT CODE	RESIDENCE CODE	PLACEMENT REASON	PLACEMENT BEGIN DATE	PLACEMENT END DATE
D	1	12	4/12/10	11/30/10
H	1	13	12/01/10	

EXHIBIT 1620-5

RESERVED

EXHIBIT 1620-6

HIGH COST BEHAVIORAL HEALTH REINSURANCE FORM

EXHIBIT 1620-6
DIVISION OF HEALTH CARE MANAGEMENT
HIGH COST BH REINSURANCE REQUEST FORM
PAGE 1 OF 3

REQUEST/NOTIFICATION TYPE

MEMBER NAME: _____ AHCCCS #: _____

RENEWAL AUTHORIZATION

PLACEMENT CHANGE

EFFECTIVE DATE: _____

REASON: _____

TERMINATION

EFFECTIVE DATE: _____

REASON: _____

CONTRACTOR CHANGE

NEW CONTRACTOR: _____

EFFECTIVE DATE: _____

OTHER

SIGNATURE: _____ Date: _____

PROGRAM CONTRACTOR NAME: _____

EXHIBIT 1620-6
DIVISION OF HEALTH CARE MANAGEMENT
HIGH COST BH REINSURANCE REQUEST FORM
PAGE 2 OF 3

MEMBER DEMOGRAPHIC INFORMATION

MEMBER NAME:	AHCCCS #:
FACILITY NAME AND TYPE:	DOB:
PLACEMENT DATE:	DAILY RATE:

DIAGNOSES

Include Psychiatric and Medical, as relevant:

CURRENT BEHAVIORAL ISSUES

Describe member's current behaviors and the frequency and intensity of those behaviors;

FACILITY PROGRAMMING DESCRIPTION

Explain programs and activities at the facility specific to this member that assist this member in managing inappropriate behaviors:

BEHAVIORAL TREATMENT PLAN

Explain/describe behavioral and chemical interventions in place to actively manage member's current behavioral issues:

EXHIBIT 1620-6
DIVISION OF HEALTH CARE MANAGEMENT
HIGH COST BH REINSURANCE REQUEST FORM
PAGE 3 OF 3

MEMBER NAME: _____

AHCCCS #: _____

PLACEMENT HISTORY

Explain why this member cannot live in a non-behavioral living arrangement and include specific information (including dates) regarding reason (s) previous placement(s) were unsuccessful

RE-EVALUATION OF PLACEMENT

Results of periodic re-evaluation of the member's ability to function with a lower level of intervention than provided under current treatment plan (not just attempts at placement change). Explain any discharge plans:

DOCUMENTATION TO INCLUDE

- Behavioral Treatment Plan
- Psychotropic Medication Record
- Psychiatric or psychological evaluation reports
- Nursing notes with behavioral issues highlighted
- Facility staff notes with behavioral issues highlighted
- Any other information in the member's records that support the need for a high-cost behavioral treatment program and specialized placement

SIGNATURE: _____ DATE: _____

PROGRAM CONTRACTOR NAME: _____

EXHIBIT 1620-7

**FEE-FOR-SERVICE (FFS) OUT-OF-STATE NURSING FACILITY
PLACEMENT REQUEST FORM**

EXHIBIT 1620-7
FEE-FOR-SERVICE (FFS) OUT-OF-STATE NURSING FACILITY
PLACEMENT REQUEST FORM

SECTION A: TO BE COMPLETED BY THE CASE MANAGER

Member Name: _____ Tribal Contractor: _____

AHCCCS ID #: _____ Date of Birth: _____

Current Residence/Placement: _____

Diagnosis/Condition: _____

Distance from NF to nearest family: _____

Level of involvement by family: _____

Names & outcomes for AZ NFs contacted about availability: _____

Indicate requested nursing facility: _____

San Juan Manor
806 W. Maple
Farmington, NM 87401

Four Corners Care Ctr
818 North 400 West
Blanding, UT 84511

St. George Care Ctr.
1032 East 100 South
St. George, UT 84770

Bloomfield Nursing
803 Hacienda Lane
Bloomfield, NM 87413

Red Rocks Care Ctr.
3720 Church Rock Rd.
Gallup, NM 87301

PCP Name: _____ AHCCCS Provider ID: _____

Case Manager: _____ Date: _____

SECTION B. TO BE COMPLETED BY AHCCCS

Comments: _____

Approved _____ Signature _____ Date _____
(Name and Title)

Denied _____ Signature _____ Date _____
(AHCCCS Medical Director or designee)

Revision Date: 01/01/2011
Review Date: 05/01/2012
Initial Effective Date 04/01/2004

EXHIBIT 1620-8

PROGRAM CONTRACTOR CHANGE REQUEST FORM

**EXHIBIT 1620-8
PROGRAM CONTRACTOR CHANGE REQUEST**

Member/Recipient's Name:		AHCCCS ID #:		
I. CURRENT PROGRAM CONTRACTOR INFORMATION				
Person Requesting Change:		Phone #:		
Contractor Name:				
Fiscal County Name:		Fiscal County #:	Provider ID #:	
Transfer: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		Date:		
Reason: <input type="checkbox"/> Member/Recipient Leaving Service Area <input type="checkbox"/> Member/Recipient Resides Out of Service Area <input type="checkbox"/> Within Service Area for Medical Continuity of Care <input type="checkbox"/> Family Request <input type="checkbox"/> Other – Specify:		Comments/Current Medical Condition: (Attach Medical Release, Current Plan of Care and Other Necessary Information)		
Authorized Signature:		Title:	Date:	
II. RECEIVING PROGRAM CONTRACTOR INFORMATION				
Contractor Name:				
Fiscal County Name		Fiscal County Number:	Provider ID #:	
Transfer: <input type="checkbox"/> Approved <input type="checkbox"/> Denied		Effective Enrollment Date:		
Authorized Signature		Title	Date	
If approved, complete member/recipient information below and send this form to the AHCCCS Administration. If request denied, return form to originator.				
III. MEMBER/RECIPIENT INFORMATION				
Is this a change in Program Contractors within Maricopa County? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Is the change due to a move to a new county of fiscal responsibility? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Has the member/recipient physically moved to a new county of fiscal responsibility? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, provide the new address below.				
Effective Date of the Move:				
Residential Address:		Facility Name (if applicable)		
Phone #:	Street	City	State	Zip
Mailing Address (if different):	Street	City	State	Zip
Type of Placement: <input type="checkbox"/> Home & Community Based – Specify: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other – Specify:				
IV. AHCCCS PROGRAM CONTRACTOR CHANGE REQUEST COORDINATOR USE ONLY				
<input type="checkbox"/> Local Office Contacted: NAME:		Date:	Initials:	
<input type="checkbox"/> Local Office Changes Made:		Date:	Initials:	
<input type="checkbox"/> MFIS Referral Completed		Date:	Initials:	
<input type="checkbox"/> Enrollment Effective Date Adjusted in PMMIS		Date:	Initials:	
Comments:				

EXHIBIT 1620-9

**ARIZONA LONG TERM CARE SYSTEM (ALTCS)
ENROLLMENT TRANSITION INFORMATION (ETI)
FORM**

EXHIBIT 1620-9
ARIZONA LONG TERM CARE SYSTEM (ALTCS)
ENROLLMENT TRANSITION INFORMATION (ETI) FORM

Sending PC: _____ Receiving PC: _____
Transition Date: _____ Rate Code: _____
Member Name: _____ DOB: _____
AHCCCS ID: _____ M or F (*circle one*)
Primary Language Spoken: _____
Contact Person / Relationship: _____
indicate if Guardian, POA, etc
Contact Person Phone #: _____

PRIMARY HEALTH INSURANCE

Medicare #: _____ Part A B D (*circle all that apply*)
Medicare Advantage -PDP: _____ SNP? YES NO
PDP: _____ Other: _____

MEMBER LOCATION

Current Address: _____
Phone Number: _____
Facility Name (*if applicable*): _____
Type of Facility: Skilled Nursing Facility Assisted Living Facility Behavioral Health
Admission Date: _____ Specialty Unit: _____
Level of Care: _____ ALF Room and Board Amount: _____

MEDICAL INFORMATION

Diagnoses: _____
PCP Name: _____ PCP Phone #: _____
Specialists (*Including out of area*)
Name: _____ Type: _____ Phone #: _____
Name: _____ Type: _____ Phone #: _____
Scheduled appointments/procedures: _____
Special Medications/Treatments: _____
CRS Services: _____
Pending Physicians orders not yet completed: _____

EXHIBIT 1620-9
ARIZONA LONG TERM CARE SYSTEM (ALTCS)
ENROLLMENT TRANSITION INFORMATION (ETI) FORM

ALTCS ETI FORM, Page 2

Member Name: _____

DIALYSIS

Site Name and Address: _____

Days: M T W Th F Sat Sun Time: _____ Phone Number: _____

Transportation Provided by: _____

Assistance and/or Type of Transportation Required: _____

DME/SUPPLIES (see attached information for additional details on DME/Supplies as needed)

DME: _____ Rented? Owned? Provider: _____

DME: _____ Rented? Owned? Provider: _____

DME: _____ Rented? Owned? Provider: _____

DME: _____ Rented? Owned? Provider: _____

Supplies Needed: _____ Provider: _____

Supplies Needed: _____ Provider: _____

Supplies Needed: _____ Provider: _____

Pending Issues requiring follow-up: _____

PENDING GRIEVANCE?	Yes	No	Expected Resolution Date: _____
---------------------------	-----	----	--

What is nature of grievance? _____

HOSPITALIZED MEMBERS (complete if member is hospitalized on date form is completed)

Hospital: _____ Phone: _____

Admission Date: _____ Admitting Diagnosis: _____

Inpatient Treatments: _____

Expected Discharge Date: _____ D/C To: _____

OTHER COMMENTS: _____

MEMBER NAME: _____

HCBS SERVICES (Check all that apply or attach Service Authorizations for details)

- Adult Day Health** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Attendant Care** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Home Delivered Meals** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Homemaker** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Personal Care** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Respite** **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Other** _____ **Provider:** _____ **Phone#:** _____ **Frequency:** _____
- Emergency Alert** **Provider** _____ **Phone#:** _____

<input type="checkbox"/> HOME HEALTH NURSING	Provider:		Frequency:	
	Phone#:			
	Payer Source:			
<input type="checkbox"/> HOME HEALTH AIDE	Provider:		Frequency:	
	Phone#:			
	Payer Source			
<input type="checkbox"/> HOSPICE	Provider:		Frequency:	
	Phone#:			
	Payer Source:			

EXHIBIT 1620-9
ARIZONA LONG TERM CARE SYSTEM (ALTCS)
ENROLLMENT TRANSITION INFORMATION (ETI) FORM

ALTCS ETI FORM, Page 4

MEMBER NAME: _____

BEHAVIORAL HEALTH

BH Diagnosis: _____

BH Medications: _____

BH SERVICES/PROVIDERS:

SERVICE	PROVIDER	PHONE #	FREQUENCY

Last Date of Judicial Review: _____ **Outcome:** _____

COT _____ **Name on Court Order:** _____ **Expiration Date:** _____

REQUIRED ATTACHMENTS AND OTHER TRANSITIONING INFORMATION:

- | | |
|--|--|
| <input type="checkbox"/> Last CM Assessment
<input type="checkbox"/> Last Quarterly Behavioral Health Consult, if applicable
<input type="checkbox"/> List of Medications
<input type="checkbox"/> Contingency Plan, if member receiving critical services
<input type="checkbox"/> <u>Out-Pt Adult</u> Physical Therapy Service. The number of visits received for current contract year _____
<input type="checkbox"/> Respite Hours Utilized
<input type="checkbox"/> Inpatient Days Utilized | <input type="checkbox"/> CM Summary
<input type="checkbox"/> Advanced Directives (Living wills, Powers of Attorney, etc), if applicable
<input type="checkbox"/> EPSDT Forms, if applicable
<input type="checkbox"/> Guardian/Conservatorship or Power of Attorney, if applicable
<input type="checkbox"/> Lifetime use of Community Transition Service (CTS) Benefit Community Transition Service Date: _____ |
|--|--|

CASE MANAGER NAME: _____ **PHONE:** _____

DATE: _____

Revision Date: 10/01/2011, 02/01/2011, 10/01/2010, 07/01/2008, 10/01/2007, 12/01/2006
 Reviewed Date: 05/01/2012

EXHIBIT 1620-10

**SAMPLE
IMPORTANT MEMBER RIGHTS NOTICE FORM**

**[Must use Times New Roman and 14 point font, and be on AHCCCS letterhead]
AHCCCS Contractors may obtain an electronic copy of this form by contacting
AHCCCS Division of Health Care Management.**

IMPORTANT MEMBER RIGHTS NOTICE

As a result of the lawsuit *Ball v. Betlach* (also known as *Ball v. Biedess*), the AHCCCS Administration is sending you this notice about your rights to receive “critical” long term care services at home when you are enrolled in the Arizona Long Term Care System (ALTCS) Program.

You have the right to receive all the services in your care plan to help you with bathing, toileting, dressing, feeding, transferring to or from your bed and wheelchair and other similar daily activities. These services are called “critical services.” Your program contractor or tribal contractor must make sure that you receive these critical services without delays. If there is a delay and you do not receive these services on time, your program contractor or tribal contractor must provide them within two hours of the time they are notified of the gap. (A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual’s care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.) Your other long term care services cannot be reduced to make up for the critical services that you did not receive on time.

If you do not receive your critical services on time, call your provider to report the issue. In addition, you may also call your program or tribal contractor or AHCCCS, at the telephone numbers listed below, to report the problem. Your case manager will also provide you with phone numbers to call if there are delays in getting your critical services. Your program contractor or tribal contractor will also give you a form that you can fill out and mail back if there is a gap in critical services. You will get an answer by phone or in writing. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again.

AHCCCS will collect reports on gaps in critical services from each program contractor on a monthly basis. AHCCCS will also collect information to help determine how to set rates to pay workers who provide critical services. The program contractors will also give information to AHCCCS every 6 months about home care workers' current wages and benefits. This information will be made public once a year beginning August 15, 2005.

AHCCCS has hired experts to look at the amount of critical services available for AHCCCS members and the general population. This information will be available on October 15, 2005.

We will send you another Notice if a Court makes changes to this information. If you have any questions about this Notice, please call your program contractor or tribal contractor, your case manager or AHCCCS. Telephone numbers are listed below.

Arizona Health Care Cost Containment System (AHCCCS)
1 (800) 218-7509

***[CONTRACTOR INSERTS THEIR SPECIFIC CONTACT INFORMATION
HERE]***

Exhibit 1620-10 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

Revision Date: May 7, 2010, December 1, 2009

EXHIBIT 1620-11

**SAMPLE
CRITICAL SERVICE GAP REPORT FORM**

LOGO AND ADDRESS OF CONTRACTOR HERE

[Must use Times New Roman and 14 point font]

CRITICAL SERVICE GAP REPORT FORM

All ALTCS members have the right to receive all critical services in their care plan to help with bathing, dressing, toileting, feeding, transferring to or from your bed or wheelchair and other similar daily activities. If you do not receive your critical services as specified in your care plan, you should report this as quickly as possible. You should immediately call the AHCCCS, provider agency or contractor at the phone numbers listed on the Contingency Plan Form your case manager filled out with you. You may also call your case manager. You have the right to receive these critical services from a back-up substitute caregiver within two hours of you reporting the gap.

In addition, you can mail this form to us at the address listed above telling us the services you have not received. As your program contractor, we will respond to you either by telephone or by the mail. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again. Please fill in the following:

Your Name: _____

AHCCCS ID Number (if available) _____

Date of Birth: _____

Date(s) you did not receive your services: _____

Critical Service(s) not received: _____

Comments: _____

Exhibit 1620-11 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

Revision Date: May 01, 2012, May 7, 2010, August 16, 2005

EXHIBIT 1620-12

**SPOUSE ATTENDANT CARE
ACKNOWLEDGEMENT OF UNDERSTANDING FORM**

EXHIBIT 1620-12
SPOUSE ATTENDANT CARE
ACKNOWLEDGEMENT OF UNDERSTANDING

MEMBER NAME: _____ AHCCCS ID#: _____

We, the people who have signed on the next page, choose to have Arizona Long Term Care System (ALTCS) pay _____ (the spouse) for _____'s (the member's) care. We know and agree that:

- The ALTCS Case Manager will decide the number of hours that will be paid for _____'s (the member's) care;
- All services will be medically necessary and cost effective; and
- We cannot have more than 40 hours of Attendant Care (or similar services) in a seven day period.

We know and agree that if _____ (the spouse) is paid for giving care:

- There will be an increase in the earned income of _____ (the spouse);
- The extra income could cause us to lose benefits from other publicly funded programs; and
- This change in benefits could affect us and/or others in our household.

Publicly funded programs may include but are not limited to the following:

BENEFIT TYPE	AGENCY RESPONSIBLE	PHONE NUMBER
AHCCCS, ALTCS and/or KidsCare eligibility	AHCCCS	
Supplemental Security Income (SSI)	Social Security Administration	
Medicare Part D Low Income Subsidy	Social Security Administration	
Food Stamps	Arizona Department of Economic Security	
Temporary Assistance to Needy Families (TANF)	Arizona Department of Economic Security	
General Assistance	Arizona Department of Economic Security	
Housing and Urban Development (HUD) Housing	Local Housing Authority	
Social Security Disability	Social Security Administration	
Qualified Medicare Beneficiary (QMB)	AHCCCS	
Specified Low-Income Medicare Beneficiary (SLMB)	AHCCCS	
Qualified Individual – 1 (QI-1)	AHCCCS	
Other:		
Other:		

EXHIBIT 1620-12
SPOUSE ATTENDANT CARE

ACKNOWLEDGEMENT OF UNDERSTANDING

We know it is up to us to get in touch with any agencies from whom anyone in our household receives benefits. We will:

- Talk about how a change in the income for _____ (the spouse) may affect those benefits;
- Talk about this before making a decision to pay _____ (the spouse) for care; and
- Tell any agency from whom we currently receive benefits of the change in income if/when we decide to pay _____ (the spouse) for care.

We understand that some or all of our publicly funded benefits could be stopped or reduced. This depends on the amount of income _____ (the spouse) receives as an ALTCS paid caregiver. We will ask _____'s (the member's) ALTCS case manager for assistance if we need it.

We also know:

- We can change our minds about paying _____ (the spouse) for care at any time;
- We can decide that _____ (the member) should receive other ALTCS services; and
- These services must be medically necessary and cost effective.

Signature of Member:		Date:
Signature of Spouse:		Date:
Signature of Case Manager:		Date:

ANNUAL REVIEW OF CHOICE FOR SPOUSE ATTENDANT CARE

My spouse has been my paid ALTCS caregiver. I wish to continue with that plan. I know that there are other agencies and caregivers who could provide my care. I know that by choosing my spouse, I only get **up to 40** hours of Attendant Care (or similar services) per week.

Signature of Member:		Date:	
Signature of Member:		Date:	
Signature of Member:		Date:	
Signature of Member:		Date:	
Signature of Member:		Date:	

cc: Member
Case file

Exhibit 1620-12 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

Effective Date: 10/01/2007

EXHIBIT 1620-13

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ALTCS MEMBER SERVICE PLAN**

Exhibit 1620-13
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ALTCS Member Service Plan

Member's Name:	AHCCCS ID#:	Date:	Next Review Date: check one <input type="checkbox"/> Not to exceed 90 days (HCBS) <input type="checkbox"/> Not to exceed 180 days (Nursing Facility or DD Group Home) <input type="checkbox"/> Annual (Acute Care Only)
-----------------------	--------------------	--------------	--

I choose the following service model: (Check "N/A" for members not receiving Attendant Care, Personal Care, Homemaker, or Habilitation)

TRADITIONAL
 AGENCY WITH CHOICE
 SELF-DIRECTED ATTENDANT CARE
 N/A

 INDEPENDENT PROVIDER (DD or FFS members)

Where do I want to live?

I am living where I want to live (**check one**) Yes No

If no, where do you want to live? (**check one**) Own Home Alternative Residential Setting Institutional Setting
 I want to live in the same type of setting, but in a different place Other: _____

What are the reasons why you can't live where you want? (**Case Manager: Please address barriers in goal setting**)

In accordance with their contract with the ALTCS Contractor and receipt of the service authorization, providers are notified and agree to their roles and responsibilities in implementing this service plan.

Service & Provider	Service Frequency in place prior to this assessment	Service Frequency currently assessed	Service Change	Start/End Date	Member/ Representative
			<input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Increase <input type="checkbox"/> Reduce <input type="checkbox"/> Terminate <input type="checkbox"/> Suspend		<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
			<input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Increase <input type="checkbox"/> Reduce <input type="checkbox"/> Terminate <input type="checkbox"/> Suspend		<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
			<input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Increase <input type="checkbox"/> Reduce <input type="checkbox"/> Terminate <input type="checkbox"/> Suspend		<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
			<input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Increase <input type="checkbox"/> Reduce <input type="checkbox"/> Terminate <input type="checkbox"/> Suspend		<input type="checkbox"/> Agree <input type="checkbox"/> Disagree
			<input type="checkbox"/> None <input type="checkbox"/> New <input type="checkbox"/> Increase <input type="checkbox"/> Reduce <input type="checkbox"/> Terminate <input type="checkbox"/> Suspend		<input type="checkbox"/> Agree <input type="checkbox"/> Disagree

Comments:

Service Plan Acknowledgement: My service plan has been reviewed with me by my case manager. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that any reductions, terminations or suspensions (stopping for a set time frame) of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that above. I know that my case manager will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended or terminated. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

Member's Name:	AHCCCS ID#:
-----------------------	--------------------

My case manager has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

Case manager: Please list all non-ALTCS funded services and providers and/or informal supports. Information provided on informal supports must align with HCBS Needs Assessment Tool. Attach a separate page if more lines are needed.

Non-ALTCS Funded Service	Responsible Party/Payer Source	Approximate Service Frequency (example: daily, weekly, monthly)

I know that I can ask for another service planning meeting to go over my needs and any changes to this plan that are needed. I can contact my case manager _____ at (____) ____-____. I also know that I can contact my case manager at any time to discuss any questions, issues, and/or concerns that I may have regarding my services. My case manager will contact me within 3 working days. Once I have talked with my case manager, s/he will give me a decision about that request within 14 days. If the case manager is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Member/Legal Representative Signature Date

Individual Representative Signature (Agency with Choice only) Date

In the absence of home and community-based services and supports, I believe this member would require an institutional level of care or the member continues to require an institutional level of care. If my assessment did not indicate this level of need, I will refer the member for a Medical Eligibility re-assessment.

Case Manager Signature Date

Other Attendees: (Attendees please note that by signing below, you are saying you participated in today's service planning meeting and not attesting to whether or not you are in agreement/disagreement with this service plan)

Name Signature Name of Agency/Relationship Date

Name Signature Name of Agency/Relationship Date

Name Signature Name of Agency/Relationship Date

Case Managers: Please document when the service plan was sent to the Member, Individual Representative and/or the Legal Representative.

Name	Date

EXHIBIT 1620-14

**AHCCCS/ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER
CONTINGENCY/BACK-UP PLAN**

EXHIBIT 1620-14
AHCCCS/ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER CONTINGENCY/BACK-UP PLAN

MEMBER NAME: _____ AHCCCS ID#: _____ DATE OF PLAN: _____

IN-HOME SERVICES PROVIDED BY ALTCS	FREQUENCY	PROVIDER
1)		
2)		
3)		

MEMBER SERVICE PREFERENCE LEVEL – based on member’s choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members must be informed that they have the right to a back-up caregiver within 2 hours if they choose. Circle member’s choice:

1	Needs services within 2 hours.
2	Needs services today.
3	Needs services within 48 hours.
4	Can wait until next scheduled visit by provider.

Member has been advised that s/he may change the Member Service Preference Level and also his/her back-up plan, as indicated below, at any time, including at the time of a gap*

Case Manager Initial and Date

If my ALTCS caregiver does not show up to provide services as scheduled, my back-up plan is as follows (check all that apply):

BACK-UP PLAN	NAME	PHONE NUMBER
<input type="checkbox"/> I will contact AHCCCS.	AHCCCS	1-800-218-7509
<input type="checkbox"/> I will contact my provider agency.		
<input type="checkbox"/> I will contact my case manager.		
<input type="checkbox"/> I prefer to have family or friends provide my care instead of another ALTCS provider/caregiver.	1)	
	2)	
	3)	
	4)	
<input type="checkbox"/> I can wait until the next scheduled visit from my provider agency to receive authorized care.		
<input type="checkbox"/> Other:		

* A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual’s care plan and the hours of the scheduled type of critical service that are actually delivered to the individual. The following situations are not considered gaps:

- The member is not available to receive the service when the caregiver arrives at the member’s home as scheduled.
- The member refuses the caregiver when s/he arrives, unless the caregiver is not able to do the assigned duties.
- The member refuses services.
- The member’s home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

AHCCCS/ALTCS MEMBER CONTINGENCY/BACK-UP PLAN – CONT'D

MEMBER NAME: _____

AHCCCS ID#: _____

I understand that I have the right to receive all the services in my care plan to help me with bathing, toileting, dressing, feeding, transferring to or from my bed and wheelchair, and other similar daily activities as needed. These services (Attendant Care, Personal Care, Homemaker and Respite) are called “critical services.” I understand that my health plan must make sure that I receive these critical services without delays. I understand that if I do not receive my critical services on time I can call AHCCCS to report the problem so they can assist in replacing my caregiver as soon as possible. I may also call my provider agency or case manager for help. If there is a delay and I do not receive these services on time, my health plan must provide a back-up caregiver within 2 hours of the time they are notified of the gap, unless I specify otherwise at the time of the gap. I understand I also have the right to file a written complaint about the failure to provide such services as scheduled.

I understand that in order to receive services I must be available and willing to accept the scheduled services. If I choose not to accept the services I understand I must tell my case manager this. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

Please have member/representative sign here at time of initial plan development:

Member/Representative Signature: _____ Date: _____

Relationship to Member: _____

QUARTERLY VISIT

This plan was reviewed with me by the case manager during my quarterly service review. My signature below indicates I still agree with this plan and no changes are needed. I understand that I may change my Member Service Preference Level at any time, including at the time a gap may occur. My case manager and I will fill out a new Contingency Plan form if I have changes to my plan, but at least once a year.

Please have member/representative sign here to indicate continued agreement with plan at the time of each 90 day service assessment. If the member/representative wishes to make changes to the information in this plan, a new plan must be written. A new plan is required at least once a year.

Date of Review: _____ Member/Representative Signature: _____

Date of Review: _____ Member/Representative Signature: _____

Date of Review: _____ Member/Representative Signature: _____

cc: Member/Representative
Case File

Exhibit 1620-14 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

**AHCCCS/ALTCS CONTINGENCY PLAN
INSTRUCTIONS**

- All ALTCS Contractors must use this standardized form. It may be altered in the ways listed below without AHCCCS approval. All other changes to the form must be prior approved by AHCCCS.
 1. Contractor letterhead may be added.
 2. Terms such as “case manager” and “health plan” may be changed to terms more commonly used by the Contractor.
 3. Contractor-specific member ID numbers may be added.
- This form must be completed by the case manager for all Home and Community Based Service (HCBS) members who receive one or more of the following ALTCS services:
 1. Attendant Care
 2. Personal Care
 3. Homemaker
 4. In-home Respite
- The member must be advised of his/her right to have a back-up on-call caregiver provided in the event an unforeseeable gap occurs.
- The member must be advised of his/her right to change a previously designated Member Service Preference Level at any time, including at the time a gap occurs. The case manager must initial and date the statement on the first page indicating this was done at the time the plan was developed.
- The member should designate the back-up plan for how the **member chooses** to have his/her needs met in the event the regular caregiver is not available as scheduled. More than one option can be chosen.
- The member/representative should not indicate “I can wait until the next scheduled visit from my provider agency to receive authorized care” in the back-up plan unless the designated Member Service Preference Level is 4 (can wait until next scheduled visit by provider).
- If the member indicates s/he wants family or friends to provide unpaid back-up care for some or all of the time that the ALTCS provider was scheduled to be there, the names of those individuals should be listed. **The selection of this informal support system as the back-up plan must be the member’s choice and not assumed simply because those individuals live in the home and/or appear to be available.**
- The phone number for the AHCCCS toll-free phone line must be listed. The name and phone number(s) of the member’s provider agency must be listed, including the after-hours number. The case manager’s name and phone number(s) should also be included. The Contractor’s after-hours phone number should be included on this form or made available to members when they call the case manager’s phone number.
- The member or representative must sign the completed form indicating it has been reviewed with him/her and that s/he is in agreement with it. A copy of the signed plan must be given to the member/representative. **This form must be signed upon initial completion as well as at each 90-day service review if there are no changes to the plan.** If there are changes to any part of the plan, a new plan must be written, signed and a copy left with the member/representative. **A new plan must be written at least once a year.**

EXHIBIT 1620-15

**ASSISTED LIVING FACILITY (ALF)
RESIDENCY AGREEMENT**

EXHIBIT 1620-15
ASSISTED LIVING FACILITY (ALF)
RESIDENCY AGREEMENT

1. _____, an approved Assisted Living Facility (hereinafter "ALF"), and
(Name of ALF)
- _____, an Arizona Long Term Care System / ALTCS Member (hereinafter "Resident"),
(Resident's Name)
- agree to the placement of Resident, by _____ (hereinafter "PC"), represented herein
(Program Contractor)
- by _____ (hereinafter "Case Manager") in ALF effective _____ .
(Case Manager) (Date of Placement)

The PC will pay ALF based on the Contracted Rate for the Authorized Care Level minus Resident's Room and Board cost as described below.

For ALTCS Fee For Service (FFS) only: AHCCCS will pay ALF \$ _____ per day minus
(Daily Rate)
Resident's Room and Board cost as described below.

2. ALF and Resident further agree to the following terms and conditions of this placement. Resident shall pay the ALF for Room and Board. Resident agrees to pay ALF the pro-rated Room and Board amount of \$ _____ per day from _____ to _____.
(Admit Date) (End of 1st partial month)

Thereafter Resident agrees to pay the amount of \$ _____ per month. The Room and Board amount that the Case Manager enters in the PC's service authorization system, if different from the amount on this form, supercedes the amount in this Residency Agreement. The Resident must pay the monthly Room and Board to ALF on or before the 10th of each month effective _____.
(1st Full month)

If Resident's Room and Board payment is not made by the 10th of the month, ALF will send Resident a notice of delinquency of payment. If the payment is not made within two weeks of the date of such notice, Case Manager must be informed by ALF so that Resident and/or other responsible party will receive a 14-day notice, from the facility, to make other living arrangements.

The Room and Board amount is subject to change as the Resident's income amount changes and will be Initial adjusted in accordance with program guidelines. Anytime the Resident, other responsible party or ALF becomes aware of a change in the amount of the Resident's income, immediate notification to the PC Case Manager and AHCCCS Eligibility Worker is required.

EXHIBIT 1620-15
ASSISTED LIVING FACILITY (ALF)
RESIDENCY AGREEMENT

3. ALF agrees to comply with the Arizona Administrative Code Title 9, Chapter 10, Article 7, Assisted Living Facility as appropriate.
4. ALF shall be paid by PC and Resident for the Date of Placement but not the date of discharge. For partial months and care level changes, payment from PC and Resident as appropriate shall be pro-rated to reflect changes on a daily basis.
5. During Resident's temporary absence (of greater than 24 hours), ALF is not entitled to any payment from PC. ALF shall notify the Case Manager of any absences within one working day. Resident remains obligated to pay ALF the Resident's Room and Board amount during any and all temporary absences.
6. No gifts will be accepted by the ALF from the Resident except nominal gifts during the holidays or for birthdays.
7. This placement may be terminated upon PC being provided with a written request from either ALF or the Resident. PC shall have 30 days from the date of the request to make other placement arrangements for the Resident. Except when R9-10-709 (E) applies.
8. Within 30 days after the date of termination of residency, the ALF shall refund any Room and Board prepaid by Resident for the date of discharge and any and all days thereafter.
9. ALF has not and will not pay any referral fees for placement at said ALF (42 USC § 1320a-7b and 42 CFR Part 1001).
10. Neither ALF nor any other party on behalf of the ALF can charge for the development of resident care plans.
11. Residents residing in Assisted Living Facilities may have to share a room. If the Resident chooses a private room, there may be a charge, unless the facility does not have semi-private rooms as an option.
12. Resident/representative is not to be charged for transportation of Resident to medical appointments. If applicable, ALF may arrange transportation with the PC.
13. All medically necessary durable medical equipment is provided by the PC. Resident/representative is not to be charged a rental fee for any medical necessary equipment. The ALF shall contact the PC to obtain this equipment.

EXHIBIT 1620-15
ASSISTED LIVING FACILITY (ALF)
RESIDENCY AGREEMENT

14. No ALF licensee, staff or their family members may act as a representative, agent, surrogate, health care power of attorney, power of attorney, guardian, or conservator of a Resident who is not a relative. [R9-10-703(A)(6)].
15. ALF may, with the Resident's or Resident's representative's written permission, administer personal funds that do not exceed \$500.00 per month. If ALF administers such funds, ALF must keep receipts for expenditures and give a written accounting to the Resident or _____, Resident's representative, every three months.
16. ALF may enter into an agreement with Resident/representative to provide non-covered services, however, the Case Manager must review the agreement to ascertain that the service is not covered by ALTCS.
17. Effective May 1, 2012, ALF shall refund to Resident any deposits (including security deposits) paid prior to ALTCS enrollment (inclusive of Prior Period Coverage), within 30 days of ALTCS enrollment, unless such deposits (or a portion thereof) are necessary to remedy default in the payment of rent or repair damages to the premises exclusive of ordinary wear and tear.

ALF AND RESIDENT AGREE TO ABIDE BY THE TERMS AND CONDITIONS AS OUTLINED IN THIS RESIDENCY AGREEMENT:

Member or Representative _____ **Date** ____/____/____

ALF Sponsor/Manager _____ **Date** ____/____/____

Case Manager _____ **Date** ____/____/____

EXHIBIT 1620-16

**ASSISTED LIVING FACILITY (ALF)
FINANCIAL CHANGE AGREEMENT**

EXHIBIT 1620-16
ASSISTED LIVING FACILITY (ALF)
MEMBER FINANCIAL CHANGE AGREEMENT

FACILITY NAME: _____ **PC NAME:** _____

MEMBER NAME: _____ **AHCCCS ID:** _____

THE FOLLOWING BILLING/MEMBER LOC CHANGE(S) HAVE OCCURRED

	Rate:	Effective:
I. Facility Reimbursement: LOC _____	\$ _____	_____
II. Level of Care (LOC) Changed to: _____	\$ _____	_____
III. Member Room & Board Responsibility	\$ _____	_____

I HAVE READ AND AGREE WITH THE ABOVE CHANGES.

FACILITY REPRESENTATIVE:

Printed _____ Title: _____

Signature _____ Date: _____

MEMBER / REPRESENTATIVE: (ONLY REQUIRED FOR CHANGES IN ROOM & BOARD)

Printed _____ Relationship: _____

Signature _____ Date: _____

CASE MANAGER:

Printed _____

Signature _____ Date: _____

**A SIGNED COPY MUST BE PROVIDED TO THE PROGRAM CONTRACTOR'S CASE MANAGER
FOR THE MEMBER'S FILE.**

Exhibit 1620-16 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.

EXHIBIT 1620-17

**HOME AND COMMUNITY BASED SERVICE (HCBS)
MEMBER NEEDS ASSESSMENT**

Exhibit 1620-17 HCBS MEMBER NEEDS ASSESSMENT

This tool is to be used as a guide and is not intended to replace professional experience. If there are questions or comments about a specific task, please review with your supervisor.

This tool is to be used anytime a member is requesting Attendant Care, Personal Care, or Homemaker Services.

Living Situation: Lives Alone Lives with Family Lives with Non-family

Supervision Need: Wandering Risk Confused/Disoriented at risk to themselves Unable to call for help, even with lifeline NA

Name/ Relationship of Informal Supports that will be assisting with care:

Tasks completed by Informal Supports must be marked "IFS" on the spreadsheet below in the appropriate space to clearly identify when IFS is being provided. Ensuring members needs are met.

If lives with others, indicate Days/Hours others are not available to assist member:

TASK	DESCRIPTION	APPROX TIME	TASKS PE DAY R	MON	TUE	WE D	THU	FRI	SAT	SUN	TOTAL	COMMENTS (WHO IS PROVIDING CARE/ WHY> <TIME NEEDED)
HOUSEKEEPING AND CLEANING	Independent: No assistance needed.	0 min/day										
	Lives with others: Cleaning member's area only.	1-60 min/week										
	Without Support: Member lives alone. Consider the size of the home.	1-120 min/week										
LAUNDRY Folding and Putting Away Laundry is included.	Independent: No assistance needed.	0 min/week										
	Washer & dryer are on site, inside the member's home, garage, or yard.	1-30 min/week										
	Washer is on site but clothes are line dried.	1-60 min/week										
	Laundry is done in Apartment Laundry Facility	1-90 min/week										
	Laundry facility is off site , such as community Laundromat facility.	1-120 min/week										
Incontinence Episodes – Soiled Clothes and Linens	1-10 min/week											
SHOPPING Including medication pick-up	Independent: No assistance needed.	0 min/day										
	Pick-up with Family Shopping	1-5 min/week										
	Lives alone.	1-90 min/week										
MEAL PREP & CLEAN UP In general, should not exceed 75 minutes per day Includes blenderizing or pureeing but not cutting up food	Independent: No assistance needed.	0 min/day										
	Breakfast: If member eats same meal with others:	1-15 min/day 1-5 min/day										
	Lunch: If member eats same meal with others:	1-20 min/day 1-5 min/day										
	If HDM is in place, please note this on this line for the appropriate day.											
	Dinner: If member eats same meal with others:	1-40 min/day 1-5 min/day										
	Alternative Meal Schedule or snacks: Ex: Diabetic with multiple small meals/snack per day requiring prep.	1-10 min/meal										

Member Name: _____

AHCCCS ID: _____

Page 1 Total:

TASK	DESCRIPTION	APPROX TIME	TASKS PER DAY	MON	TUE	WED	THU	FRI	SAT	SUN	TOTAL	COMMENTS (WHO IS PROVIDING CARE)
EATING & FEEDING Enter number of meals eaten per day requiring assistance, then enter the time per meal	Independent: No assistance needed	0 min/day										
	Minimum: Meal set up, cutting food, or cueing /reminders.	1-10 min/meal										
	Moderate: As above plus hands-on assist, cueing, or supervision for 50-75% of meal.	1-15 min/meal										
	Maximum: Hands-on assist with 75%+ of meal, bringing food to mouth or totally feeding member. Constant supervision and cueing.	1-30 min/meal										
BATHING As needed per week. In general not to exceed 45 transfers including in bath time.	Independent: No assistance needed	0 min/day										
	Sponge bath:	1-5min/day										
	Minimum: Some supervision, cueing, or set-up. Assist with getting in & out of tub. Help with back or lower body.	1-15 min/day										
	Moderate: Step-by-step cueing or supervision. Hands-on assist with 50-75% of the bathing process.	1-30 min/day										
	Moderate: Step-by-step cueing or supervision. Hands-on assist with 50-75% of the bath process.	1-30 min/day										
Maximum: 75%+ with bathing process. One or more assist. Hoyer needed / bed-baths.	1-45 min/day											
DRESSING AND GROOMING AM	Independent: No assistance needed	0 min/day										
	Minimum: Some supervision, reminding, selecting clothes.	1-10 min/day										
	Moderate: Supervision or hands-on with 50-75% of dressing activity. Regular asst. with buttons, shoes & socks, fixing hair or brushing teeth.	1-15 min/day										
	Maximum: Hands-on with 75%+ of dressing and grooming tasks. Complete assist with dressing includes transfer if needed.	1-20 min/day										
DRESSING AND GROOMING PM	Independent: No assistance needed	0 min/day										
	Minimum: Some supervision, reminding, selecting clothes.	1-10 min/day										
	Moderate: Supervision or hands-on with 50-75% of dressing activity. Regular asst. with buttons, shoes & socks, or brushing teeth.	1-15 min/day										
	Maximum: Hands-on with 75% of dressing and grooming tasks. Complete assist with dressing includes transfer if needed.	1-20 min/day										

Member Name: _____

AHCCCS
ID: _____

Page 2 Total:

TASK	DESCRIPTION	APPROX TIME	TASKS PER DAY	MON	TUE	WED	THU	FRI	SAT	SUN	TOTAL	COMMENTS (WHO IS PROVIDING CARE)
TOILETING	Independent: No assistance needed	0 min/event										
	Minimum: Stand-by assist, supervision, reminders	1-5 min/event										
	Moderate: 50-70% assist with clothing, diapers, post-toilet hygiene or equipment	1-10 min/event										
	Maximum: Total assist with clothing, briefs, entire toileting process. Includes episodes of incontinence.	1-15 min/event										
	Catheter: Pouring out bag and cleaning bag or other supplies.	1-15 min/day										
	Ostomy: Pouring out and cleaning bag	1-15 min/day										
MOBILITY	Independent: No assistance needed with/without assistive devices	0 min/day										
	Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices or restraints	1-10 min/day										
	Moderate: Needs hands-on assist. One-person assist with/without assistive devices	1-15 min/day										
	Maximum: One or more person assist, totally dependent.	1-30 min/day										
TRANSFERRING Includes bathing and Toileting Transfers	Independent: No assistance needed with/without assistive devices	0 min/day										
	Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices or restraints.	1-10 min/day										
	Moderate: Needs hands-on assist. One-person assist with/without assistive devices.	1-15 min/day										
	Maximum: One or more person assist, totally dependent.	1-30 min/day										
	Bed Bound: Frequent turning & repositioning in the bed. Outside caregiver 20-40 min/day. Live-in caregiver 60-90 min/day.	20-40 min/day 60-90 min/day										
	Hoyer: If hooyer time assessed no transfer time in other areas.	1-20 min/event										

Member Name _____ AHCCCS ID: _____ **Page 3 Total:** _____

Total minutes w/o Supervision:	_____
Total Hours:	_____

GENERAL SUPERVISION	DESCRIPTION	APPROX TIME	TASKS PER DAY	MON	TUE	WED	THU	FRI	SAT	SUN	TOTAL	COMMENTS
	Supervision is based on need, and can be provided based on member need identified on Page 1.	X Time/Day										

Total minutes with Supervision:	_____
Total Hours:	_____

**ATTENDANT CARE-PERSONAL CARE- HOMEMAKER
WORKSHEET SUMMARY**

TOTAL PAID HOURS INDENTIFIED

Page 1 Total Minutes:	0
Page 2 Total Minutes:	0
Page 3 Total Minutes:	0
Supervision (if Applicable)	0
Total Minutes	0
Total Hours	0.00

I have contacted the IFS/s named above (top of page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

_____	_____	_____	_____
<i>Case Manager Signature</i>	<i>Original Date</i>	<i>Supervisor Signature >20 hrs</i>	<i>Original Date</i>

I have contacted the IFS/s named above (top of page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

_____	_____	_____	_____
<i>Case Manager Signature</i>	<i>1st Review Date</i>	<i>Supervisor Signature ≥20 hrs</i>	<i>1st Review Date</i>

I have contacted the IFS/s named above (top of page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

_____	_____	_____	_____
<i>Case Manager Signature</i>	<i>2nd Review Date</i>	<i>Supervisor Signature ≥20 hrs</i>	<i>2nd Review Date</i>

I have contacted the IFS/s named above (top of page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

_____	_____	_____	_____
<i>Case Manager Signature</i>	<i>3rd Review Date</i>	<i>Supervisor Signature ≥20 hrs</i>	<i>3rd Review Date</i>

HCBS NEEDS TOOL (HNT) INSTRUCTIONS

HCBS NEEDS TOOL GUIDELINES:

Attendant Care, Personal Care, and Homemaker services are intended to augment and support the existing informal care and community services being provided to allow the member to remain in a home setting.

The HCBS Needs Tool (HNT) is intended to evaluate the member's functional care needs and which of those needs will be met by informal support system and which parts will be provided by the formal paid caregiver.

Prior to authorizing Attendant Care, Personal Care or Homemaker services, the case manager must complete the program contractor's assessment tool, the HNT, the Uniform Assessment Tool (UAT) and the service plan.

The HNT must be completed with direct involvement of the member and/or representative. Discussion must take place about what care is needed, the average amount of time it takes to complete that care for the member and the availability of informal supports and community services to meet those needs. Discussion should include stressors the informal caregivers may be experiencing in providing care and the supports that can be provided through community resources as well as Arizona Long Term Care System (ALTCS) services.

Times shown on the HNT are only guidelines that reflect approximate the time frame that it takes to complete tasks based on **general and reasonable expectations** in homecare provision. Time for each category must be based on the evaluation of the member's individual needs and informal supports available.

Time above the suggested amount in any category may be assessed but the case manager must provide an explanation for the amount of time needed to complete that task for the member.

There must be adequate case file documentation to support the assessment and hours authorized. There must be consistency between the program contractor's assessment tool, the HNT, the UAT and the service plan.

After the member's needs are assessed, the Cost Effectiveness Study (CES) must be calculated to determine what can be provided within the ALTCS cost effectiveness standards. Services whose costs are at or below 100% of the cost of institutionalization or those that are expected to be at this level within 6 months may be authorized.

COMPLETING THE HCBS NEEDS TOOL
TOP OF FORM – PAGE 1

LIVING SITUATION:

Select appropriate choice based on the member's situation.

SUPERVISION NEED:

Select one or more of the choices or NA if none of the other choices apply.

- Wandering Risk - Member has already been found to leave their home unsafely and/or is unable to find their way back.
- Confused/Disoriented - Member is confused and/or disoriented to the point they are unable to perform functional activities on the HNT and in fact are at risk if they do, such as leaving the stove on when cooking, leaving the shower running after a bath, not being able to judge the temperature of the water for bathing, attempting to walk without necessary assistive devices, etc.
- Unable to call for help, even with lifeline - Member's medical condition is such that even with a lifeline system they would be unable to call for help, such as a member in a coma or on a vent or a member with Dementia who does not understand how the system works.

If member lives alone and one of the applicable choices is selected, a discussion about an alternative living situation should take place. Consider completing a Care Management Risk Agreement.

NAME/RELATIONSHIP OF INFORMAL SUPPORTS:

List the individuals who are available to provide informal support.

On the worksheet enter "IFS" on the specific tasks and days for which the informal support is present to provide the care.

Listing the IFS information is mandatory as it is always necessary to clearly document what care is already being provided to the member in order to demonstrate what needs remain unmet.

In addition to informal supports, if the member is receiving care from another source, such as Medicare home health or hospice, be sure to include this.

DAYS/HOURS FAMILY NOT AVAILABLE:

Make note of the time others in the household are away from the home on a regular basis for other obligations.

COMPLETING THE HCBS NEEDS TOOL TASKS

HOUSEKEEPING/CLEANING

Housekeeping includes cleaning tasks necessary to attain and maintain sanitary living conditions for the member.

ASSESSMENT CONSIDERATIONS

- Housekeeping does not include excessive tasks such as mowing the lawn, carpet cleaning, moving furniture, etc.
- For members living alone, housekeeping may apply to the entire residence. The size of the home may be considered if the member and/or provider are able to show that more than 2 hours per week is necessary to maintain sanitary living conditions.
- For members sharing a residence, housekeeping applies only to the areas used by the member. This area includes the member's bedroom and one bathroom.
- Case managers should staff the case with a supervisor if the member's paid caregiver is not maintaining the member's living area appropriately.

TIME GUIDE: Do not write in the gray areas.

- Independent: Member needs no assistance in maintaining sanitary living conditions
Time Guide: 0 min/week.
- Member lives with others. Cleaning for member areas only, including the member's bedroom and bathroom.
Time Guide: 1 to 60 min/week.
- Without Support. Member lives alone. Consider the size of the home.
Time Guide: 1 to 120 min/week.

LAUNDRY

Laundry tasks include preparing clothes to be washed, putting the clothes in the washer, putting the clothes in the dryer or on the line, and folding/putting away the clothes, with the goal of maintaining the member's clothing in a clean manner and neat appearance. These tasks apply only to member's clothing and linens.

ASSESSMENT CONSIDERATIONS

- Routine changing of bed linens is considered part of bedroom housekeeping.
- Caregiver should be completing other activities in the home while the washer/dryer are in process.
- If laundry must be done at Apartment laundry complex and community laundry complex more time can be given since the caregiver must sit and watch the clothes and cannot perform other activities during that time.
- If a member soils their clothing or bedding due to incontinence, the laundry may need to be washed more frequently (even daily) which means a single smaller load each time versus multiple larger loads once a week.

TIME GUIDE: Do not write in the gray areas.

- Independent: No assistance needed
Time Guide: 0 min
- Washer/dryer on site:
Time Guide: 1-30 min/week.
- Washer is on site but clothes are line dried:
Time Guide: 1-90 min/week.
- Laundry is done in apartment complex laundry room:
- Laundry facility is off site such as community laundry facility:
Time Guide: 1-120 min/week.
- Incontinence Episodes: Soiled clothes and Linens
Time Guide: 1-10 min/day

SHOPPING

Shopping includes grocery shopping, obtaining medications or medical supplies, and household items for the member. Travel time and time to put away groceries is included.

ASSESSMENT CONSIDERATIONS

- If the member is living with informal supports, the informal supports should obtain items for the member at the same time that they are obtaining items for themselves or others in that household.
- If a family member or other live-in is a paid caregiver, this caregiver is expected to provide this service efficiently and pick up items for the member at the same time they are shopping for themselves/household and not make unnecessary extra trips. Some time may be allotted for these caregivers in picking up items for the member while shopping for their own household as well.
- Efforts should be made to coordinate that medications may be picked up at the same store/location where they will get their groceries and other household items.
- If a caregiver must take the bus or walk to the store more time may allotted to address the individual situation.
- Multiple trips to the grocery store per week or trips to a preferred store further away are personal preferences and are not a necessity.
- Shopping for recreation is not considered a medical necessity.

TIME GUIDE: Do not write in the gray areas.

- Lives with Informal Supports / Independent: 0 min/week.
- Lives with paid caregivers: 1-5 min/week
- Lives alone and needs outside assistance: 1-90 min/week.

MEAL PREPARATION & MEAL CLEAN-UP

Meal preparation includes meal planning, preparing the foods to be cooked or served, and actually cooking or putting foods together. This task is inclusive of tasks associated with the time spent putting the meal together before it is brought to the table or is served to member. This

includes blenderizing or pureeing foods. Cutting foods into appropriate size pieces for the member to eat is part of Eating/Feeding, not Meal Preparation.

Clean-up includes storing the foods utilized/left over and the cleaning of the dishes involved in the preparation and presentation of the food.

Alternative Meal Schedule is for members with diabetes or others that eat multiple small meals throughout the day to maintain proper levels in their bodies for medical reasons. This can include getting the member an apple or some cheese and crackers or other small meals to help regulate the body. Adjust time to the appropriate levels based on the situation, for example, cleaning or cutting up an apple may only take 2 minutes, cutting and putting together cheese and crackers might only take 5 minutes, etc.

ASSESSMENT CONSIDERATIONS

- Ask the member how many times a day s/he eats and needs assistance in the preparation and cleanup involved with the meals. Some may only eat lunch and dinner and can manage morning coffee on their own.
- Ask the member what they normally eat for breakfast/lunch/dinner. This could give an idea of the complexity of meals being prepared.
- Does the member have any special diet / special food preparation requirements. Are they eating the same meals as others that live in the home?
- Will the member eat more often if this support is put in place? This could help the member if there are nutritional or weight loss concerns.
- If the caregiver will not be at the residence all day, meals can be prepared in advance and left in a convenient place for the member, such as a lunch or dinner plate can be left in the fridge and quickly micro-waved, or cold foods can also be left in the fridge or a cooler close to the member for their convenience. If the caregiver prepares meals for the day early in the day, time can be assigned for those meals. The feasibility of this ahead of time preparation depends on whether the member is able to access the prepared meal and serve him/herself.

TIME GUIDE: Do not write in the gray areas.

- Independent: 0 min/day.
- Breakfast: 1-15 min
- Breakfast with others: 1-5 min/day
- Lunch: 1-20 min.
- Lunch with others: 1-5 min/day
- Dinner: 1-30 min.
- Dinner with others: 1-5 min/day
- Alternative Meal Schedule: 1-10 min per meal.

EATING/FEEDING

Eating/Feeding is the process of getting oral nourishment from a receptacle (dish, plate, cup, glass, bottle, etc.) into the body after it is cooked or prepared for eating. This does not include tube feeding as that is considered a skilled task not performed by a Direct Care Worker.

ASSESSMENT CONSIDERATIONS

- How many meals does the member eat per day?
- Time for the preparation of meals is calculated in the Meal Preparation category but cutting foods into appropriate size pieces for the member to eat is considered part of Eating/Feeding.

TIME GUIDE: Do not write in the gray areas.

- **Independent.** Needs no assistance in eating or feeding one's self.
Time Guide: 0 min/meal.
- **Minimum.** May need assistance to have meal set-up, including cutting food, opening carton, and/or cueing.
Time Guide: 1-10 min/meal.
- **Moderate.** As above, plus, may need hands-on physical assistance, supervision, or cueing with 50% to 75% of the meal task, but the member is still able to participate physically.
Time Guide: 1-15 min/meal.
- **Maximum.** Needs hands-on physical assistance with approximately 75% or more of the meal task. Total set-up, constant supervision, and/or continual cueing, bringing food to mouth, or must be fed.
Time Guide: 1-30 min/meal.

BATHING

Bathing is the process of washing, rinsing, and toweling the body or body parts and transferring in/out of the tub or shower. This includes the ability to get the bath water and/or equipment ready for bathing in either the shower or tub or at the sink or bedside. Use of assistive devices such as tub/shower chair, pedal/knee controlled faucets, or long-handled brushes do not disqualify the client from being independent.

If the client has a problem getting to and from the bathroom to bathe, this should be reflected in the mobility section and not affect the score for bathing.

Transfer time into the shower/tub is included in the bath time.

Daily bathing of the elderly is not recommended due to damage that occurs to the skin from the water and the soap. Bathing more than once per day is a personal preference and not a necessity.

ASSESSMENT CONSIDERATIONS

- How many times per week does the member bathe (member specific, as needed)?
- A person may not need a full bath (bathtub, shower or bed bath) every day. If a person does not want to be bathed daily they generally need to at least have their face, underarms and private areas washed on a daily basis.

- Sponge baths can be completed by the member or the caregiver if the member is not able to use the sponge or wash cloth to clean himself/herself.
- A bed bath is for members who are bed bound and cannot get out of the bed to be bathed in a shower or tub.
- Clean up after incontinence episodes would generally be considered under the TOILETING section as it does not usually require a full bath. If however, the clean up does require a bath, the frequency and time for this must be included in BATHING.

TIME GUIDE: Do not write in the gray areas.

- Independent. The member is able to bathe without any supervision or assistance.
Time Guide: 0 min/day.
- Sponge bath. The member does not bathe on these days but still wants to freshen up with water and a sponge or washcloth.
Time Guide: 1-5 min/day.
- Minimum. The member needs minimal supervision and set-up. Needs some cueing or assistance getting in/out of the tub/shower. May need some assistance with washing back and/or lower extremities.
Time Guide: 1-15 min/day.
- Moderate. The member needs step-by-step cueing or supervision with the entire bathing process or hands-on assistance with 50% to 75% of the bathing process.
Time Guide: 1-30 min/day.
- Maximum. The member is dependent on others for assistance with 75% or more of the bathing process. May require two or more person assist to get in and out of the shower/tub or requires the use of a mechanical lift or member is only able to receive bed baths.
Time Guide: 1-45 min/day.

DRESSING/GROOMING AM & PM

Dressing includes the laying out, taking off, putting on, and fastening of clothing and footwear. Grooming includes oral hygiene, nail care, shaving and fixing hair.

ASSESSMENT CONSIDERATIONS

- Can the member choose their own clothes, put them on, and put on socks and shoes?
- If someone lays out the clothes, can the member put them on?
- Does the member successfully use assistive devices in dressing, such as reachers, sock pullers, shoehorns?
- While it may be faster for a caregiver to put on a member's clothes, if the member is still physically able to do this activity then the member should be considered independent.
- Dressing and grooming in the morning is likely to take more time than evening activity.
- Not all people get changed multiple times a day. Some people get changed once in the morning into fresh clothes and may wear and sleep in the same clothing. Examples include: a house coat, shorts and tee-shirts, or sweat pants, etc.
- For a member with Diabetes, nail care of the feet should only be completed by the member or a medical professional.

TIME GUIDE: Do not write in the gray areas.

Complete time for the AM section and, if appropriate, give additional time in the PM section. The time in the AM section is not expected to match the time in the PM section.

- Independent. The member does not need assistance with any part of dressing, undressing, or grooming.
Time Guide: 0 min/task.
- Minimum. The member needs some supervision or reminding. Includes selecting and laying out clothes.
Time Guide: 1-10 min/task.
- Moderate. The member needs hands-on assistance by another person, or supervision with 50% to 75% of dressing/grooming activities. Regular assistance with buttons, zippers, and buckles, socks, and shoes. Regular assistance with fixing hair and/or oral hygiene.
Time Guide: 1-15 min/task.
- Maximum. The member needs hands-on assistance with 75% or more of the dressing/grooming activities. Complete assist with dressing including transfer assist if needed.
Time Guide: 1-20 min/task.

TOILETING

Toileting tasks include reminders, toileting schedule, the taking off and putting on of clothing and/or diapers, post-toilet hygiene, use of equipment such as a urinal, and cleaning of a catheter or ostomy bag.

ASSESSMENT CONSIDERATIONS

- It is not healthy/safe to use suppositories or laxatives to have more than one bowel movement per day. If this is occurring, notify the member's PCP.
- If the member is incontinent but is able to manage his/her own incontinence supplies and change themselves, then the member is still independent.
- The time to pour out the urine from a catheter bag should generally not require more than 15 minutes/day.
- The time to take care of a member's ostomy bag (even when twice a day) should generally not require more than 15 minutes/day.

TIME GUIDE: Do not write in the gray areas.

- Independent. The member does not need assistance in any part of toileting or is able to manage own incontinence with use of briefs or pads that the member is able to change on their own.
Time Guide: 0 min/task.
- Minimum. The member needs standby assist or supervision with toileting.
Time Guide: 1-5 min/task.
- Moderate. The member needs moderate assistance with clothing, diapers, post-toilet hygiene, and/or equipment for either continent or incontinent members.
Time Guide: 1-10 min/task.

- Maximum. Total assist with clothing, diapers, post-toilet hygiene and/or equipment for either continent or incontinent members.
Time Guide: 1-15 min/task.
- Catheter: The member has catheter and needs assistance to pour out the urine and clean the bag.
Time Guide: 1-15 min/day.
- Ostomy: The member has an ostomy and needs assistance to pour out the feces and clean or change the bag.
Time Guide: 1-15 min/day.

MOBILITY

Mobility is the extent of the member's purposeful movement within their residence. The use of assistive devices such as a wheelchair, walker, or quad cane does not disqualify the member from being independent, nor does it guarantee an increase in the need for assistance by another person.

Transfer time is not counted in the mobility section but in the transfer section below.

ASSESSMENT CONSIDERATIONS

- Can the member purposely move about his/her residence independently with or without the use of assistive devices? A member that can propel themselves in a wheel chair should be considered independent.
- Is the member unsafe without the assistance of another person in ambulating?
- Does the member have weakness, unstable gait or unstable balance?

TIME GUIDE: Do not write in the gray areas.

The number of times a member is assisted with mobility per day is Not counted; rather an approximate amount of time spent per day in mobility assistance must be assessed.

- Independent. The member is independent in mobility with or without assistive devices.
Time Guide: 0 min/day.
- Minimum. The member needs some supervision, standby, or reminders for safety. This may include adjusting of assistive devices or restraints
Time Guide: 1-10 min/day.
- Moderate. The member needs hands-on assistance for safety. One person assist, with or without assistive devices.
Time Guide: 1-15 min/day.
- Maximum. May need one or more persons or may be totally dependent on others for mobility.
Time Guide: 1-30 min/day.

TRANSFERRING

Transferring is the member's ability to move horizontally and/or vertically between the bed, chair, wheelchair, commode, etc.

ASSESSMENT CONSIDERATIONS

- Is the member able to use any mechanical devices such as a walker, cane, or handrails of wheelchair to assist with transfers?
- Is the member unsafe without the assistance of another person in transferring?
- Can the member physically participate in the transfer by pivoting, holding on, or bracing themselves to assist the caregiver?
- If a mechanical lift is needed, then all transfer time must be noted in the lift section and not in the other min-max assistance sections.

TIME GUIDE: Do not write in the gray areas.

- The number of times a member is transferred per day is NOT counted (except when transferred by Lift); rather an approximate amount of time spent per day is transfer assistance must be assessed. Independent. The member is independent in transfer with or without assistive devices.
Time Guide: 0 min/day.
- Minimum. The member needs some supervision, standby, or reminders for safety. This may include adjusting of assistive devices or restraints
Time Guide: 1-10 min/day.
- Moderate. The member needs hands-on assistance for safety. One person assist, with or without assistive devices. The member may be able to bear weight and pivot.
Time Guide: 1-15 min/day.
- Maximum. May need one or more persons or may be totally dependent on others for transfers.
Time Guide: 1-30 min/day.
- Mechanical Lift: Member requires the use of a mechanical lift. If member transferred by Lift, time for transfer will be counted in this area only and not in any of the min-max areas above.
Time Guide: 1-20 min/event
- BED -BOUND: Requires frequent turning and repositioning in bed.
Time Guide: 20-90 min/day

GENERAL SUPERVISION

Supervision time must be considered for members who, in the first section of this tool, were assessed, because of their disability or medical condition, to be at risk of being unsafe if they were left alone.

ASSESSMENT CONSIDERATIONS

- For those needing supervision time, the time assessed should cover the time between the specific tasks the caregiver is performing and the time the family/IFS is available/willing to supervise the member.

For example: The member needs around the clock care due to dementia, and has a history of unsafe behaviors, but the family is unavailable to provide this care 7 AM to 6 PM (11 hours) Monday through Friday, totaling 55 hours per week of care. If the functional assistance adds up to 20 hours, then the supervision need would be the remaining 35 hours.

- Informal Supports (IFS) must be clearly noted on the tool if they are available and willing to cover supervision time so it is clear that the member is receiving care and not being left unattended.
- For those receiving supervision time, the caregiver may need to assist with the self-administration of medications (as applicable), monitoring of the member's medical condition, monitoring the member's level of functioning, oversight of decision making and activities of daily living, and documentation of the same during this supervision time.

Reminder: Only licensed medical professionals are allowed to be paid to administer or use discretion/judgment in the dispensing of medications to another person. Family members working as caregivers who choose to administer medications or set up med-boxes are allowed to do so but they *cannot be paid* to do so.

- For those receiving supervision time, the caregiver may need to attend medical appointments with the member, if the member's family or IFS is not able to attend. Additional time will not be added as the member's supervision time has already been calculated to include the time between the functional needs and the time the family or IFS is available to supervise the member.

TIME GUIDE

Varies upon the needs of the individual member to fill in the period of time between functional assistance being provided and when family/IFS is able to supervise the member.



1630 ADMINISTRATIVE STANDARDS

REVISION DATES: 03/01/13, 05/01/12, 01/01/11, 02/01/09, 10/01/2007

INITIAL
EFFECTIVE DATE: 10/01/2004

Administrative responsibilities related to case management of enrolled members include the following:

A. CASE MANAGER QUALIFICATIONS

Individuals hired as case managers must be either:

A degreed social worker

A licensed registered nurse, OR

A person with a minimum of two Years' experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities.

B. CASE MANAGEMENT PROCEDURES/TECHNICAL

Contractors are responsible for maintaining case management procedures that are reflective of AHCCCS policy, as defined in this Chapter.

Contractors may develop their own standardized forms and tools for recording information regarding members' needs and services. However, all Contractors must utilize the standardized forms found in this Chapter, including, but not limited to the Uniform Assessment Tool (Exhibit 1620-3), the Member Service Plan (Exhibit 1620-13), the Contingency Plan (found in Exhibit 1620-14) and the HCBS Needs Tool (Exhibit 1620-17).

Contractors will establish a mechanism to ensure that CATS data is entered accurately and within established timeframes (ten business days of the date the action took place).

C. TRAINING

Case managers must be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used must be maintained.



1. Contractors must ensure that there is a structure in place to provide uniform training to all case managers. This plan should include formal training classes as well as mentoring-type opportunities for newly hired case managers.
2. Newly hired case managers must be provided orientation and training in a minimum of the following areas:
 - a. The role of the case manager in utilizing a member-centered approach to Arizona Long Term Care System (ALTCS) case management, including maximizing the role of the member and their family in decision-making and service planning
 - b. The principle of most integrated, least restrictive settings for member placement
 - c. Member rights and responsibilities
 - d. Case management responsibilities as outlined in this Chapter, including, but not limited to service planning, contingency plans, reporting service gaps and Notices of Action.
 - e. Case management procedures specific to the Contractor
 - f. An overview of the AHCCCS/ALTCS program
 - g. The continuum of ALTCS services, including available service delivery options, placement settings and service restrictions/limitations
 - h. The Contractor provider network by location, service type and capacity. Included in this should be information about community resources for non-ALTCS covered services.
 - i. Information on local resources for housing, education and employment services/program that could help members gain greater self-sufficiency in the areas.
 - j. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect and/or exploitation
 - k. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the ALTCS population service by the Contractor



- l. General social service information, such as family dynamics, care contracting, dealing with difficult people, risk management.
 - m. Behavioral health information, including identification of member's behavioral health needs, covered behavioral health services and how to access those services within the Contractor's network and the requirements for initial and quarterly behavioral health consultations
 - n. Pre-Admission Screening and Resident Review (PASRR) process
 - o. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for members under the age of 21, and
 - p. ALTCS management information system Client Assessment Tracking System (CATS) that maintains member-specific data such as Cost Effectiveness Studies, Placement/Residence codes, behavioral health codes, review dates and, for Tribal Contractors, service authorizations. The level of orientation to CATS will be dependent on the level of direct usage by the Contractor case managers.
3. In addition to review of areas covered in orientation, all case managers must also be provided with regular ongoing training on topics relevant to the population(s) served. The following are examples of topics that could be covered:
- a. Policy updates and new procedures
 - b. Refresher training for areas found deficient through the contractor's internal monitoring process
 - c. Interviewing skills
 - d. Assessment/observation skills
 - e. Cultural competency
 - f. Member rights
 - g. Medical/behavioral health issues, and/or
 - h. Medications – side effects, contraindications and poly-pharmacy issues.
4. Training may also be provided by external sources, for example:



- a. Consumer advocacy groups
 - b. Providers (for example, medical or behavioral health), and
 - c. Accredited training agencies.
5. The Program Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources within the Contractor's service area. This individual must be available to assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options.

D. CASELOAD MANAGEMENT

Adequate numbers of qualified and trained case managers must be provided to meet the needs of enrolled members.

Contractors must have written protocols to ensure newly enrolled ALTCS members are assigned to a case manager immediately upon enrollment.

ELDERLY AND/OR PHYSICALLY DISABLED (E/PD) MEMBERS

Each case manager's caseload must not exceed a weighted value of 96. The following formula represents the maximum number of members allowable per E/PD case manager:

1. For institutionalized members, a weighted value of **0.8** is assigned. Case managers may have up to 120 institutionalized members ($120 \times 0.8 = 96$).
2. For Home and Community Based Services (HCBS) (own home) members, a weighted value of **2.0** is assigned. Case managers may have up to 48 HCBS members ($48 \times 2.0 = 96$).
3. For assisted living facility (ALF) members, a weighted value of **1.6** is assigned. Case managers may have up to 60 ALF members ($60 \times 1.6 = 96$).
4. For Acute Care Only (ACO) members, a weighted value of **1.0** is assigned. Case managers may have up to 96 ACO members ($96 \times 1.0 = 96$).
5. If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

$$(\# \text{ of HCBS members} \times 2.0)$$



$$\begin{aligned} &+ \\ &(\# \text{ of ALF members} \times 1.6) \\ &+ \\ &(\# \text{ of ACO members} \times 1.0) \\ &+ \\ &\underline{(\# \text{ of Nursing Facility (NF) members} \times 0.8)} \\ &96 \text{ or less} \end{aligned}$$

6. **Intellectually Disabled members** – case manager caseloads must not exceed a per District average ratio of 1:40 members, regardless of setting.

Caseload Exceptions – Program Contractors must receive authorization from AHCCCS/Division of Health Care Management prior to implementing caseloads whose values exceed those outlined above. Lower caseload sizes may be established at the discretion of the Contractor and do not require authorization.

The Contractor's annual Case Management Plan must describe how caseloads will be determined and monitored.

E. ACCESSIBILITY

Members and/or member representatives must be provided adequate information in order to be able to contact the case manager or Contractor office for assistance, including what to do in cases of emergencies and/or after hours.

A system of back-up case managers must be in place and members who contact an office when their primary case manager is unavailable must be given the opportunity to be referred to a back-up for assistance.

There must be a mechanism to ensure members, representatives and providers are called back in a timely manner when messages are left for case managers.

F. TIME MANAGEMENT

Contractors must ensure that case managers are not assigned duties unrelated to member-specific case management for more than 15% of their time if they carry a full caseload.

G. CONFLICT OF INTEREST

Contractors must ensure that case managers are not:

1. Related by blood or marriage to a member, or any paid caregiver of a member, on their caseload



2. Financially responsible for a member on their caseload
3. Empowered to make financial or health-related decisions on behalf of a member on their caseload
4. In a position to financially benefit from the provision of services to a member on their caseload
5. Providers of ALTCS services for any member on their caseload, and
6. Individuals who have an interest in, or are employed by, a provider of ALTCS services for any member on their caseload.

Exceptions to the above may be made under limited circumstances as described under 42 CFR 441.555c with prior approval from AHCCCS Administration.

H. SUPERVISION

A supervisor to case manager ratio must be established that is conducive to a sound support structure for case managers. Supervisors must have adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers.

A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of member assessments and service authorizations, must be established and applied, at a minimum, on a quarterly basis.

Results from this monitoring including the development and implementation of continuous improvement strategies to address identified deficiencies must be documented and made available to AHCCCS upon request.

I. INTER-DEPARTMENTAL COORDINATION

The Contractor should establish and implement mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with Medical Management (MM) and Quality Management (QM). For example, there should be coordination of information between case management, MM and QM regarding poly-pharmacy issues to ensure measures are taken to effectively address this issue.

The Contractor should ensure the Medical Director is available as a resource to case management and that s/he is advised of medical management issues as needed.



J. REPORTING REQUIREMENTS

A Case Management Plan must be submitted annually to AHCCCS on or before November 15th by all Program Contractors. Tribal Contractors are not required to submit a plan. The plan must address how the Program Contractor will implement and monitor the case management and administrative standards outlined in this Chapter, including specialized caseloads.

An evaluation of the Contractor's Case Management Plan from the previous year must also be included in the plan, highlighting lessons learned and strategies for improvement.

EXHIBIT 1630-1

ATTENDANT CARE GUIDELINES

EXHIBIT 1630-1
ATTENDANT CARE GUIDELINES

In developing and/or implementing an Attendant Care assessment tool or process, the following guidelines should be used:

1. The process must assess the member's total need for care.
2. The assessment must be done with direct involvement of the member and/or representative.
3. There must be a discussion about what care is needed, the average amount of time needed to complete that care and the availability of informal caregivers to assist with that care. Consideration must be given to the stressors the informal caregivers are under in providing care and how the provision of ALTCS services to relieve them may increase their ability to continue with that care.
4. The assessment must allow for individual member needs. Pre-determined/maximum time limits or task frequencies (for example, maximum of ten minutes for eating or no more than 1x/week for laundry) cannot be established. Guides may be used as a starting point, but the case manager must have the freedom to vary from those with adequate justification.
5. The assessment must address the member's need for general supervision as well as specific tasks. If the member is not safe to be alone, this must be considered. For example, if the member needs around the clock care due to dementia, and has a history of unsafe behaviors, but the family is unavailable to provide this care 7 AM to 6 PM (11 hours) Monday through Friday, then the attendant care need in this case begins at 55 hours/week.
6. There can be no differentiation or discrimination in the types of frequencies of service authorized simply because the member's caregiver will be a family member or other live-in person.
7. There must be adequate case file documentation to support the assessment and hours authorized.
8. After the member's needs are assessed, the CES must be calculated to determine what can be provided within the ALTCS cost effectiveness standards. Services whose costs are at or below 100% of the cost of institutionalization or those that are expected to be at this level within 6 months may be authorized.

These same guidelines, with the exception of #5, may be used in assessing a member's need for personal care and homemaking services.



1640 TARGETED CASE MANAGEMENT STANDARDS

REVISION DATE: 01/01/01

REVIEW DATE: 03/01/13

INITIAL

EFFECTIVE DATE: 10/01/2004

Targeted Case Management (TCM) is a covered service provided by the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) to members with Developmental Disabilities (DD) who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program. ADES/DDD provides the TCM services to these members; however, the members receive their acute care services through the AHCCCS acute care Contractors. Members must be given a choice of available Contractors and primary care providers registered with AHCCCS and a choice of case managers from ADES/DDD. Members are not required to accept case management services.

Members receiving TCM may reside in any of the ADES/DDD approved settings and may choose the type (on-site visit, telephone, letter) and frequency of case management contact except under the following circumstances:

1. New ADES/DDD members eligible for TCM must be visited every 90 days for the first six months. Thereafter, they may choose the frequency of contact.
2. Members receiving non-medically related services funded by the Arizona Early Intervention Program (AzEIP) must be visited every 90 days.
3. Members residing in any licensed residential setting must be visited every 180 days.
4. Members receiving attendant care provided by the family must receive an initial 30 day visit and a visit every 90 days thereafter, and
5. Members receiving State-funded services must be seen at the time of the annual Individual Service Plan (ISP).

Targeted case manager responsibilities include, but are not limited to, the following components:

1. Informing the member of service options, including medical services available from Contractors based on assessed needs
2. Coordinating and participating in the plan of care ISP meetings, including developing, revising and monitoring of the ISP.



3. Locating, coordinating and arranging social, educational and other resources to meet the member's needs
4. Providing necessary information regarding the member's functioning level and any changes in the member's level of functioning to assist the provider in planning delivering and monitoring services.
5. Providing family members, or other caregivers, the support necessary to obtain optimal benefits from available services/resources
6. Providing assistance to strengthen the role of family as primary caregivers
7. Providing assistance to reunite families with children who are in an alternative setting whenever possible
8. Preventing costly, inappropriate and unwanted out-of-home placement, and
9. Identifying services provided by other agencies to eliminate costly duplication.

ADES/DDD administrative responsibilities include, but are not limited to, the following components:

1. Ensuring staff are qualified and employed in sufficient numbers to meet case management needs and responsibilities
2. Ensuring that staff receive initial and ongoing training regarding case management responsibilities for the TCM program
3. Identifying new members who are eligible for TCM services and assigning case managers
4. Ensuring the member is informed of the assignment of the case manager, when the case manager is changed and how the case manager can be contacted
5. Assisting the member with requesting a new case manager from those available if s/he is dissatisfied with the assigned case manager
6. Informing ongoing DD members receiving TCM of visit options and requesting their decision on the options, and
7. Following ADES/DDD prescribed timeframe guidelines for Inventory for Client and Agency Planning (ICAP) and ISP:
 - a. The ICAP must be done at the initial visit and upon re-determination.



- b. The ISP must be developed within 12 business days of enrollment to ADES/DDD and TCM, and completed annually thereafter.
- c. The ISP must consist of a narrative including, but not limited to:
 - i. Identification of member as enrolled in TCM
 - ii. A description of the type and frequency of contact requested or required
 - iii. Identification of TCM contacts made and/or attempted
 - iv. Demonstration of attempts made to contact member, including certified letter (when applicable)
 - v. A description of member abilities, supports and needs, and
 - vi. Member refusal, when applicable.

The completed ISP must be signed by the member or representative and a copy of it sent to the member or representative within 15 business days following its completion. The ISP may be completed by telephone if the member is not receiving ADES/DDD funded services. When completed by telephone, the ISP must be sent to the member or representative for signature within 15 business days of the telephone conversation.

- 8. Establish and maintain an internal monitoring system of the TCM program, and make results available at the time of annual review, to include a summary/analysis and corrective action plan, when applicable.