AHCCCS Medical Policy Manual (AMPM)
Chapter 1600 Revisions

General

- There were many revisions that are not substantive but were added for improved clarification
- Program Contractor was changed to just "Contractor" throughout policy
- Services are now revised to read "Supports and Services" to align with new Managed Care Regulations

Policy 1600-Chapter Overview

- Definition for Managed Risk Agreement added to the this section

Policy 1620-B (1) (p)-Needs Assessment/Care Planning

- Reference to the Member Change Report (MCR) policy, was deleted as this policy was previously removed from the AHCCCS Contractor Operations Manual (ACOM) and was made into its own User Guide (link was provided)

Policy 1620-D Placement/Service Planning Standard

- DOL language added: Effective January 1, 2015, Direct Care Worker (DCW) provider agencies were no longer able to claim the companionship exemption for in-home services. As a result, most provider agencies elected to limit their employee hours to 40 hours per week. Since CMS expects states to institute measures to ensure that a member's service plan is not negatively impacted by a provider's plan to comply with Fair Labor Standards Act (FLSA), the following language was added:

  "A provider's compliance with the U.S. Department of Labor, Fair Labor Standards Act, has no bearing on a member's assessed needs and corresponding authorized services and service hours."
- Language added to clarify what the process is, should a member be unable to acknowledge the written service plan by signing.
- All references to Important Member Rights Notice was removed. More about this under changes to Policy 1620-10
- GAP language added to clarify CMs role in documenting gaps in critical services

Policy 1620-E Service Plan Monitoring and Reassessment Standard

- In-home visits language added throughout policy. ALTCS Contractors/Managed Care Organizations (MCOs) were experiencing issues with some members not allowing Case Managers (CMs) to come into their home to conduct assessments and service planning

Policy 1620-H Behavioral Health Standard

- PASRR language was revised for clarification and to be consistent with Chapter 1200 of the AMPM

Policy 1620-M Contractor Change Standard

- Language around conditions necessary to request a change of Contractor was removed as same criteria (as wells additional information) around change of Contractor is detailed in ACOM Chapter 403
- Language around email chains to be sent to AHCCCS in lieu of the Program Contractor Change Requests (PCCRs) form was removed, as a PCCR must be used when a change in Contractors occurs

Exhibit 1620-4 Acute Care Only (ACO) Guidelines

- Language was changed to clarify that the UAT is not just limited to NF rates. Can also be ICF-MR rates
- Language Added for consistency and guidance to Contractors when CMs are not allowed by members and/or guardians to conduct assessments/service planning in the member's home

Exhibit 1620-7 Fee-For-Service Out-of-State Nursing Facility Placement Request Form

- Additional language to ensure OOS placement necessary and all other options were exhausted
- Updated Provider IDs
- Removal of terminated provider

Exhibit 1620-10 Important Member Rights Notice Form

- Exhibit removed from policy, as no longer required. The Ball v. Bidess case was dismissed in its entirety and Gap Reports to Plaintiffs' counsel were no longer required after November 2014. However, AHCCCS continues to require Contractors to provide a monthly report outlining instances of gaps in services

Exhibit 1620-13

- Duplicative language that was required under the Community First Choice Rules was removed. However, language in policy was strengthened to ensure member's have opportunities to develop goals around placement options if they are not residing in the setting of their choice
- Duplicative language around the providers' acknowledgement of notification and agreement of their roles/responsibilities in implementing the service plan (also required under the Community First Choice Rules) was removed. When providers receive an authorization for services, they agree to their designated roles and responsibilities in implementing the service plan
- Duplicative language around Informal/natural supports was removed. This information is required in the HCBS Member Needs Assessment Tool (HNT)
- Language around acknowledgement of the CM that member would require an institutional level of care, in the absence of HCB services/supports, was removed. Policy already covers this requirement as well steps CMs must take when a member is accessed as o longer requiring an institutional level of care
- Spanish version of this document will be revised following the approval of these changes
- Duplicative language around the requirement for CMs to document that the informal/natural supports provider's voluntary agreement to provide the services (also required under the Community First Choice Rules) was removed. Instead, this requirement is outlined in policy

Exhibit 1630 (D)-Caseload Management

- Caseload weights were revised effective 10-01-14 and outlined in a contract amendment
- Citation to the Community First Choice rule removed, as AHCCCS did not pursue a state plan amendment for Agency with Choice