



1620-E SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

REVISION DATES: 10/01/17, 01/01/16, 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, with the member present, within the following timeframe:
 - a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in non-Medicare uncertified institutional settings)

~~At least every 90 days for a member determined to have a SMI and in an institutional setting (this includes members receiving hospice services and those in unc~~ertified institutional settings)
 - b. At least every 90 days for a member receiving Home and Community Based Services (HCBS)

~~b.a. At least every 90 days for a member determined to have a SMI and in an institutional setting (this includes members receiving hospice services and those in unc~~ertified institutional settings)
 - c. At least every 90 days for a community-based member receiving acute care services only and living in an HCBS setting. Acute care service monitoring for these members may be conducted on-site, via telephone or by certified letter. However, an on-site visit with the member must be completed at least once a year. Acute Care Only members residing in a non-contracted or uncertified institutional setting must have an on-site visit at least every 180 days, and
 - d. At least every 180 days for -DDD members 12 years or older residing in a group home, unless the member is medically involved or Seriously



Mentally Ill/Severely Emotionally Disturbed (SMI/SED). 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.

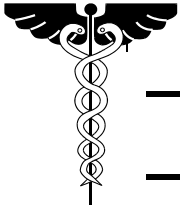
Contractors may develop standards for more frequent monitoring visits of specific types of members/placements at their discretion but may not determine members to need less frequent visits.

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

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

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

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 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. 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.~~ 6.7. 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. For E/PD and DDD, refer to Chapter 1000 for discharge planning requirements.

~~For a member determined to be SMI, and admitted to a behavioral health inpatient facility, the case manager shall participate in Inpatient Treatment and Discharge Plan (ITDP) meetings to assist with coordination of the member's discharge needs. can be arranged. In-home services must be initiated within ten business days following a member's discharge to HCBS. Within 3 days of the member's admission, the case manager must collaborate with the facility treatment team to develop a preliminary ITDP and a full ITDP within 7 days of a member's admission. If a member's anticipated stay is less than 7 days the inpatient facility must develop a preliminary ITDP within 1 day and a full ITDP within 3 days of a member's admission. Refer to A.A.C R9-21-301~~

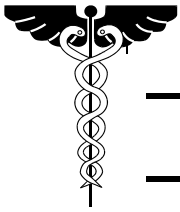
~~At a minimum, the facility treatment team, other representatives of the clinical team, the member/member representative and the case manager shall review the ITDP as frequently as necessary, but at least once with the first 30 days of completing the plan, every 60 days thereafter during the first year, and every 90 days thereafter during any subsequent year that the member remains a resident of the inpatient facility. Refer to A.A.C R9-21-301~~

~~6.7.~~ 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.~~

In accordance with A.A.C. R9-21-307, for ALTCS E/PD and Tribal ALTCS members determined to have a SMI, the case manager must adhere to the following timeframes and associated responsibilities:

- Initiate contact with service providers when new services are identified to meet the member's needs within 5 days of an assessment.



- Request that the identified providers participate in the development of the member's service plan within 10 days of the assessment.
- Convene the interdisciplinary team to review and discuss the implementation of the member's services within 20 days of the assessment.

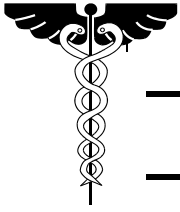
7.8. If the case manager is unable to contact an enrolled member to schedule a visit, a letter must be sent to the member or representative requesting contact by a specific date (ten business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, 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.

8.9. 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.
- c. Determine if a referral is needed for an SMI Determination to a qualified clinician, as defined in A.A.C. R9-21-101(B) for assessment and evaluation.

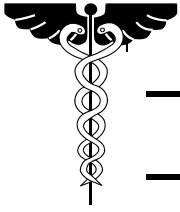
The case manager shall use the HCBS Needs Tool (HNT) found in Exhibit 1620-17 to review the service hours a member needs when Attendant Care, Personal Care, Homemaker, Habilitation and/or Respite services will be authorized for the member. The HNT must also reflect care that is provided and agreed to 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 goals that need to be developed and/or 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.



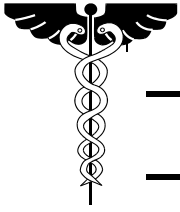
If the member is not capable of making his/her own decisions, but does not have a legal representative or member representative available, the case manager must refer the case to the Public Fiduciary or other available resource. If a guardian/fiduciary is not available, the reason must be documented in the file. For members determined to have an SMI who may qualify for Special Assistance, refer to AMPM Policy 320-R.

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 HChapter 1200 of this Manual for more information on which services require an order from the member's Primary Care Provider (PCP)).



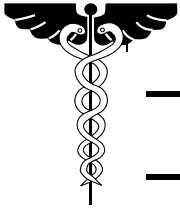
If the case manager and PCP or attending physician disagree regarding the need for a change in level of care, placement or physician's orders for medical services, the case manager may refer the case to the Contractor's Medical Director (or the AHCCCS Medical Director for members enrolled with a Tribal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

Members determined to have a SMI have the option to choose between the appeal process for members determined to have a SMI or the standard appeal process. Refer to A.A.C Title 9, Chapter 21.

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 H, 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.

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