1620-B NEEDS ASSESSMENT/CARE PLANNING STANDARD

REVISION DATES: 10/01/17, 01/01/16, 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 and the member's rights

    b. Support the member to have a meaningful role in planning and directing their own supports and services to the maximum extent possible.

    c. Provide adequate information and teaching to support the member representative to make informed decisions and choices.

    d. Be available to answer questions and address 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 planning process

    f. Educate the member/family on how to report unavailability or other problems with service delivery to the Contractor in order that unmet service 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 supports and 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 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 goals, 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,

~~n.~~o. Educate members/family on End of Life care person centered planning, services and supports including covered services and assist members in accessing those services,

~~o.~~p. 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.~~q. Refer member cases, via Eelectronic Member Change Report (EMCR), 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 the AHCCCS ALTCS Member Change Report Guide 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. Anyone can be involved in the planning the meetings at the member's or member representative's request. The member, family, and/or significant others partner with the case manager in the development of the plan and ~~-~~the case manager ~~-~~is generally the facilitator.

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 face-to-face discussion with the member and/or member representative that includes:

   a. Documentation of a member's life experiences related to:
      i. Developmental history
      ii. Education
      iii. Employment
      iv. Justice system involvement
      v. Previous living situations

   ~~a.~~b. A~~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 (including need for Special Assistance in accordance with AMPM Policy 320-R)
      iv. Social/environmental/cultural factors, and
      v. Existing support system
      ~~v.~~vi. Health and safety risks to the member, as well as risks to others as a result of the member's actions

      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.

The case manager will assist the member to identify meaningful and measureable goals for him/herself, including long-term and short-term goals to assist the member in attaining the most self-fulfilling, age-appropriate goals consistent with the member's preference.

5. ~~.~~ 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. Define member and provider responsibilities for each objective/goal

   ~~b.~~d.

   ~~c.~~e. Specify a plan of action/interventions to be used to meet the goals

   f. Include a timeframe for the attainment of the desired outcome

   ~~d.~~g. Be stated in terms in which the member understands and agrees to implement, and

   ~~e.~~h. 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.

In addition to the grievance and appeals procedures described above, the Contractor shall also make available the grievance and appeals processes described in Arizona Administrative Code Title 9, Chapter 21, Article 4 for persons determined to have a SMI under Arizona law.

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.