1620-E - SERVICE PLAN MONITORING AND REASSESSMENT STANDARD

EFFECTIVE DATES: 02/14/96, 10/01/17, 06/01/21, 10/01/22, 07/26/24, XX/XX/XX[1]

APPROVAL DATES: 10/01/04, 02/01/05, 09/01/05, 10/01/07, 02/01/09, 01/01/11, 05/01/12, 03/01/13, 01/01/16, 07/20/17, 06/04/20, 04/07/22, 05/16/24, XX/XX/XX[2]

I. PURPOSE

This Policy applies to ALTCS E/PD, ~~ALTCS~~ DES ~~/~~DDD (DDD) Contractors; and Fee-For-Service (FFS) Program Tribal ALTCS; excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). Where this Policy references ALTCS or Contractor requirements the provisions apply to ALTCS E/PD, ~~ALTCS~~ DES DDD, and Tribal ALTCS unless otherwise specified. This Policy establishes requirements for ALTCS service plan monitoring and reassessment Person Centered Service Plan (PCSP)[3] visits.

II. DEFINITIONS

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

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

CASE MANAGER Arizona licensed R~~r~~egistered N~~n~~urses (RNs) in good standing, social workers, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience as specified in the case management experience definition; or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or individuals with a Serious Emotional Disturbance (SED) identification or Serious Mental Illness (SMI) designation.

~~**CASE MANAGEMENT** A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes~~.

[1] Date Policy is effective
[2] Date Policy is approved
[3] Adding for clarity that the visits are in relation to the Person Centered Service Plan (PCSP).

~~CASE MANAGEMENT EXPERIENCE~~	~~Human service-related experience requiring care coordination across service delivery systems and work involving assessing, evaluating, and monitoring services for individuals with special health care needs related but not limited to conditions such as physical and/or intellectual disabilities, aging, physical and/or behavioral health disorders, and Substance Use Disorder (SUD).~~
~~DESIGNATED REPRESENTATIVE (DR)~~	~~An individual parent, guardian, relative, advocate, supporter, friend, or other individual, designated orally or in writing by a member or guardian who, upon the request of the member assists in protecting the member's rights and voicing the member's service needs.~~
~~HEALTH CARE DECISION MAKER (HCDM)~~	~~An individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in ARS Title 14, Chapter 5, Article 2 or 3; or ARS 8-514.05, 36-3221, 36-3231 or 36-3281.~~
~~HOME AND COMMUNITY BASED SERVICES (HCBS)~~	~~As defined in ARS 36-2931 and 36-2939.~~
~~PERSON-CENTERED SERVICE PLAN (PCSP)~~	~~A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified and prioritized goals, desired outcomes, and reflects risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.~~

~~**PLANNING TEAM**~~	~~A defined group of individuals that shall include the member/Health Care Decision Maker (HCDM) and with the member's/HCDM's consent, their family, individual representative, Designated Representative (DR), and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.~~
~~**SERIOUS MENTAL ILLNESS (SMI)**~~	~~A designation as defined in ARS 36-550 and determined in an individual 18 years of age or older.~~
~~**SERIOUS MENTAL ILLNESS DETERMINATION**~~	~~A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for Serious Mental Illness (SMI) services.~~
~~**SPECIAL ASSISTANCE**~~	~~The support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.~~

~~Additional definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.~~[4]

III. POLICY

ALTCS [5] Case Managers are responsible for ongoing assessment and monitoring of the needs, services, and placement of each member assigned to their caseload 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.

1. A Person-Centered Service Plan (PCSP) shall be fully documented/revised ~~completed~~ on an annual basis[4] with the member present.~~,~~ Additionally, the PCSP will be reviewed regularly with members[4] to ensure services are still meeting member needs[6,] within the following timeframes:

[4] Revised to align with Contract and Policy standard formatting
[4] Revised to align with national best practices and recent guidance to MCOs
[5] Adding to clarify that it is the ALTCS Case Manager responsible revised throughout policy.
[6] Allowing for annual Person-Centered Service Plans (with some exceptions) and subsequent review/updates throughout the year. More details are provided in a subsequent section.

a. At least every 180 days for a member in an institutional setting (this includes members receiving hospice services and those in non-Medicare certified 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 receiving ~~a~~Acute ~~c~~Care Only services ~~only~~ and living in their "own home" or an Alternative HCBS setting. Acute care service monitoring for members may be conducted on-site, via telephone or by certified letter. However, an on-site PCSP meeting ~~visit~~ with the member shall be completed at least once a year,
d. At least every 180 days for Acute Care Only members residing in a non-contracted or uncertified institutional setting an on-site PCSP meeting is required, and
e. At least every 180 days for ALTCS DDD members 12 years or older residing in a group home, unless the member is medically involved or determined to have a Serious Mental Illness (SMI) designation or a ~~/~~Severely Emotionally Disturbed ~~(SMI/~~SED) identification[7]. For members with medically involved needs or determined SMI or identified ~~/~~SED, a PCSP shall be conducted at least every 90 days.

Refer to AMPM Chapter 1600 and AMPM Exhibit 1620-1 for required Case Management timeframes.

The Contractor may develop standards for more frequent monitoring PCSP visits of certain members and/or specific types of placements at their discretion. However, at a minimum, the Contractor shall adhere to the Case Management PCSP standards as specified in this Policy.

ALTCS Case Managers are expected to attend Nursing Facility (NF) care planning meetings on a periodic basis to discuss the member's needs and services jointly with the member, Health Care Decision Maker (HCDM) and Designated Representative (DR) (as appropriate). At a minimum, ALTCS Case Managers shall consult with facility staff during 180-day PCSP meetings to assess changes in member level of care.

2. The PCSP meetings shall be conducted where the member receives services, including the member's home ~~and other service settings~~ as described below. ~~At a minimum,~~ ALTCS Case Managers shall conduct PCSP meetings with the member in the member's home ~~at least twice~~ annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs. For members who are not utilizing the parents as paid caregiver, spouse as paid caregiver, self-directed attendant care or DDD independent provider network service model options, it is permissible for up to two PCSP visits per year to be conducted virtually or in-person at a location where the member receives services as outlined below. Virtual meetings must include both audio/visual capabilities. If the member does not have access to the internet/devices, or lives in a location with nonexistent infrastructure for internet access, and/or if a member must incur additional costs for internet access, in-person visits are required.

Type of Meeting	Location
Annual PCSP	Member's Home
90 Day Review	Virtual or service location (in-person)
90 Day Review	Member's Home
90 Day Review	Virtual or service location (in-person)

[7] Revised to state Identification for SED vs determination for SMI, changes made throughout Policy.

~~If a member receives services in a setting outside of the home, at a minimum, a PCSP meeting shall be conducted at one of the member's service setting locations. At the election of the member/HCDM remaining PCSP meetings may be conducted at an alternate location that is not a service setting. The location of each PCSP meeting, whether at a service setting location or an alternate site, shall be determined by the member or HCDM and not for the convenience of the Case Manager or providers. The choice of location by the member/HCDM shall be documented in the member's case file.~~

In-person PCSP meeting are required if the member is utilizing the parents as paid caregiver, spouse as paid caregiver, self-directed attendant care or DDD independent provider network service model options; these visits shall occur in the member's home.

In-person PCSP meetings are required if the member experiences a change in condition (decline or improvement) or other life changes or transitions (e.g., death of a family caregiver, loss of home, major hospitalizations, quality of care concerns).

The choice of a virtual PCSP meeting or an in-person PCSP meeting at an alternate site (when permitted) is only permitted at the election of the member or HCDM and is not for the convenience of the ALTCS Case Manager or providers. Members may elect to have all of the 90-day PCSP meetings in their home. These choices shall be documented in the member's case file.[8]

If an ALTCS Case Manager is unable to conduct a PCSP meeting as specified above due to the refusal by the member/HCDM to comply with these provisions, services cannot be evaluated for medical necessity and therefore will not be authorized. The Contractor shall issue a ~~A~~ Notice of Adverse Benefit Determination (NOA) ~~shall then be issued~~ to the member setting forth the reasons for the denial/discontinuation of services[9].

~~2.~~3. The member/HCDM/DR shall be able to contact the member's ALTCS Case Manager between regularly scheduled PCSP meetings to ask questions, discuss changes/needs, and/or to request a meeting with the ALTCS Case Manager. The ALTCS Case Manager shall respond to the questions and/or requests made by the member/HCDM/DR~~,~~ within 48 hours (not including weekends and holidays).

~~3.~~4. Case Managers shall take appropriate action when they identify or are notified of an urgent or ~~a~~ potential emergency situation. ALTCS Case Managers shall report any urgent or potential emergent situations to their supervisor/manager to determine the level of intervention and appropriate action, including referral to quality management.

The ALTCS Case Manager may be required to perform more[10] ~~More~~ frequent case monitoring ~~may be required~~ following the occurrence of an urgent or emergent need or change of condition, which will require revisions to the existing PCSP.

[8] Allowing for some visits to be held virtually or in-person at a location as directed by the member, with some exceptions.
[9] Sentence reworded for flow.
[10] Sentence reworded for flow.

~~An~~ The ALTCS Case Manager is required to conduct an emergency visit ~~is required~~ [11] when the situation is urgent and cannot be handled over the telephone or when the ALTCS Case Manager has reason to believe that the member's health and/or safety is at risk.

~~4.~~5. Adequate services shall be arranged by the ALTCS Case Manager prior to ~~the~~ a member's discharge to the member's own home or to an Alternative HCBS setting. Additional discharge planning requirements for ALTCS E/PD, ALTCS DDD, and Tribal ALTCS ~~as~~ are specified in AMPM Chapter 1000.

For a member determined SMI and admitted to a B~~b~~ehavioral H~~h~~ealth I~~i~~npatient F~~f~~acility (BHIF), the ALTCS Case Manager shall participate in Inpatient Treatment and Discharge Plan (ITDP) meetings to assist with coordination of the member's discharge needs. Within three days of the member's admission, the ALTCS Case Manager shall collaborate with the facility treatment team to develop a preliminary ITDP and a full ITDP within seven days of a member's admission. If a member's anticipated stay is less than seven days, the inpatient facility shall develop a preliminary ITDP within one day and a full ITDP within three days of a member's admission. Refer to AAC R9-21-312.

The facility treatment team, other representatives of the Planning Team, the member/HCDM and DR (if applicable) and the ALTCS Case Manager shall review the ITDP as frequently as necessary, but no less than once within 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 in the inpatient facility. Refer to AAC R9-21-312.

~~5.~~6. ALTCS Case Managers shall conduct an on-site PCSP meeting within 10 business days following a member's discharge from an inpatient setting or a change of placement type [~~(~~e.g., from HCBS to an institutional setting, own home to A~~a~~ssisted L~~l~~iving F~~f~~acility (ALF) or institutional setting to HCBS]~~)~~ or from the date the ALTCS Case Manager is made aware of such a change. The PCSP meeting shall be conducted to ensure that appropriate services are in place and that the member/HCDM agrees with the PCSP as authorized. For members discharged from an inpatient hospital stay and returning back to the NF from which they were admitted, a post discharge PCSP meeting is not required. However, if a member is discharged from the hospital to a new NF, a post discharge PCSP meeting is required within 10 business days.

For members enrolled with the Contractor during an inpatient stay in a hospital, ALTCS Case Managers shall conduct an on-site PCSP meeting[12] ~~review~~ within 10 business days post-discharge. This ~~review~~ PCSP meeting shall be conducted to ensure the provision of services identified through discharge planning, to assess for any unmet needs, and to ensure that the member agrees with the PCSP as authorized.

~~6.~~7. Once it has been determined that new behavioral health service(s) are medically necessary and cost effective, the Contractor shall ensure the service(s) are initiated within 14 calendar days.

[11] Reworded for clarity
[12] Clarified expectations

~~7.~~8. If the ALTCS Case Manager is unable to contact a member to schedule a visit, a certified letter shall be sent to the member/HCDM requesting contact by a specific date (10 business days from the date of the letter is the suggested timeframe). If no response is received by the designated date, the ALTCS Case Manager shall send an Electronic Member Change Report (eMCR), indicating loss of contact, to the local ALTCS Eligibility office for possible disenrollment from the ALTCS program. The eMCR shall be sent after 30 days of no contact with a member.

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

~~8.~~9. The ALTCS Case Manager shall meet with the member/HCDM, according to the established standards, in order to:

a. Discuss the type, amount, and providers of authorized services,
b. Educate the member/HCDM and DR (as applicable), on how to report unavailability or other problems with service delivery to the Contractor ~~or Tribal ALTCS Program~~ to ensure unmet service needs can be addressed as quickly as possible. If any issues are reported to, or discovered by, the Contractor ~~or Tribal ALTCS Program,~~ the ALTCS Case Manager shall take, and document actions taken to resolve these issues as quickly as possible. The Contractor's administration or AHCCCS~~/~~ Division of Fee-For-Service Management (DFSM)~~/~~ Tribal ALTCS Unit shall also be advised of member grievances and provider issues for purposes of tracking/trending,
c. Assess the member's current functional, medical, behavioral, and social strengths and needs, including any changes to the member's informal support system, in accordance with the Needs Assessment/Care Planning Standard as specified in AMPM Policy 1620-B. If the member is assessed to no longer need an institutional level of care, the ALTCS Case Manager shall refer the case for a medical eligibility Pre-Admission Screening (PAS) reassessment via the eMCR process,
d. Convene the interdisciplinary team for member's determined to have an SMI or identified to have an~~/~~ SED to review and discuss the following:
    i. The outcome of the assessment, the need for further evaluations (as necessary) and any interim services provided (e.g., crisis services), and
    ii. The existing Inpatient Treatment and Discharge Plan (ITDP), according to AAC~~.~~ R9-21-312 (if applicable).
e. ~~The Case Manager shall use the HCBS Needs Tool (HNT) and refer to the HNT Guidelines found in AMPM Chapter 1600 and Exhibit 1620-17 to A~~assess and~~/~~ review the service hours a member needs when attendant care, personal care, homemaker, and/or habilitation, ~~and/or respite services~~[13] ~~-~~are, or will be, authorized for the member utilizing the HCBS Needs Tool (HNT) AMPM Exhibit 1620-7[14]. The HNT shall also reflect care that is provided and agreed to by the members' informal support system. This tool shall be reviewed at each PCSP meeting and shall include a discussion with the member and/or HCDM regarding the voluntary provision of informal support. ALTCS Case Managers shall regularly assess the informal support systems to ensure that the individuals providing the support continue to be willing and able to provide uncompensated care,

[13] Technical correction. The HNT is not used for respite services
[14] Section reworded for flow.

f. ~~A Uniform Assessment Tool (UAT), used to d~~Determine the necessary and appropriate level of care for members, shall be completed/reviewed at least annually, or more often as indicated by a change in member condition utilizing AMPM Exhibit 1620-3[15]. Depending on contractual requirements, it may also be updated as requested for NF or intermediate care facility for individuals with Intellectual Disability (ICF/ID) authorizations,
   i. At a minimum, ALTCS Case Managers shall review the UAT every 180 days for NF or ICF/ID members, comparing it with facility documentation. For NF, this would include documentation from the Minimum Data Set (MDS) to determine changes in Level of Care,
   ii. Changes in Level of Care shall be communicated to the NF or ICF/ID, and
   iii. The Contractor and Tribal ALTCS Programs are required to administer a UAT tool specific to the applicable program: ALTCS E/PD, Tribal ALTCS, or ALTCS DDD. A copy of the UAT for E/PD members may be found in AMPM Exhibit 1620-3.

g. Assess the need for an SMI~~/SED~~ Determination or SED identification and as appropriate, make a referral to a qualified clinician, as specified in AAC R9-21-101(B) for assessment and evaluation and as specified in AMPM Policy 320-P and AMPM Policy 550[16]~~,~~

h. Assess the continued appropriateness of the member's current placement and services, including whether the member is residing in the setting of their 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 and identify risks that may compromise the member's general health condition and quality of life,

i. Assess the cost effectiveness of services provided and/or requested (AMPM Policy 1620-C)[17],

j. Discuss with the member/HCDM the member's progress toward established goals, prioritize/reprioritize goals as specified in AMPM Policy 1620-B,

k. Identify any barriers to the achievement of the member's goals,

l. Develop new goals as needed,

m. Review service delivery options available to the member, including member directed options, at each PCSP meeting for members living in or preparing to transition to their "own home" from an institutional setting or Alternative HCBS setting. The ALTCS Member Service Options Decision Tree (AMPM Exhibit 1620-18) is an optional tool that is available for use by the ALTCS Case Managers when reviewing member directed options in order to support members in making an informed decision on the alternatives,

n. Review and document, at least annually, the member's continued choice of the member's spouse as the paid caregiver. Documentation shall include the member's signature on the "Spouse Attendant Care Acknowledgement of Understanding Form" (AMPM Exhibit 1620-12),

~~n.~~o. Review, at least annually, caregiver options for minors including the parents as paid caregiver service model option in accordance with AMPM Policy 1240-A and 1240-E utilizing and documenting decisions utilizing the AMPM Exhibit 1620-21 - Minor Caregiver Options Discussion Guide and Decision Roadmap. This discussion shall also occur if a member experiences a change in condition that necessitates either a reduction or increase in assessed and authorized services and hours. [18]and

[15] Added Exhibit reference for clarification.
[16] Adding reference to new AMPM Policy 550, Serious Emotional Disturbance Identification.
[17] Added Policy reference for clarification
[18] Incorporating standard pertaining to the new parents as paid caregiver service model option

~~o.~~p. Review, at least annually, the Contractor's (or the Administration's for members enrolled with a Tribal ALTCS Program) member handbook to ensure member/HCDM are familiar with the contents, especially as related to covered services and their rights/responsibilities.

~~9.~~10. The HCDM/DR shall 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 their own decisions but does not have a HCDM, the ALTCS Case Manager shall refer the case to the Public Fiduciary or other available resource, such as a Guardian ad Litem (GAL), Private Fiduciary, Tribal Government, or family members. If an HCDM is not available, the reason shall be documented in the member's case file. A notification for Special Assistance shall be completed for members determined to have an SMI who meet the criteria for Special Assistance, in accordance with AMPM Policy 320-R.

~~10.~~11. Members who reside in a residential setting shall be regularly assessed using the PCSP 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 members residing in a NF to discharge to their "own home" (refer to AMPM Policy 1240-C for definitions and limitations related to CTS).

~~11.~~12. The ALTCS Case Manager shall complete a PCSP (AMPM Exhibit 1620-10) at a minimum on an annual basis or at the time of the initial visit, or at the request of the member/HCDM, when there are any changes in the member's condition (decline or improvement) or other life changes or transitions the member may be experiencing (e.g., death of a family caregiver, loss of home, major hospitalizations, quality of care concerns) ~~services, and at the time of each PCSP meeting (every 90 or 180 days).~~ The member/HCDM shall indicate whether they agree or disagree with each service authorization. The member/HCDM shall be given a copy of the signed PCSP and all forms documenting review or updates to the PCSP during the 90/180 review visits.[19]

~~12.~~13. The ALTCS Case Manager shall educate the member/HCDM on how to work with the provider agency around contingency planning including when to contact the provider agency or the contractor when the member experiences a short, late, or missed visit at each PCSP meeting for all members receiving services in their own home. The development of the Member Contingency/Back-Up Plan (found in AMPM Policy 540, Attachment D) is the responsibility of the provider agency and the member/HCDM.

~~13.~~14. If problems or issues are identified by the member/HCDM, DR or ALTCS Case Manager, the ALTCS Case Manager shall contact the appropriate HCBS provider to address the concerns. The Case Manager shall also contact, at least annually, the member's HCBS providers if they are not present at the time of the PCSP meetings to discuss and document the ongoing assessment of the member's needs and status. This shall include providers of services such as personal or attendant care, home delivered meals, homemaker, therapy, etc.

If the member is receiving skilled nursing care from a home health agency, the ALTCS Case Manager shall contact the service provider quarterly as specified in AMPM Policy 1620-K.

[19] Allowing for annual Person-Centered Service Plans (with some exceptions) and subsequent review/updates throughout the year

For members receiving behavioral health services, the ALTCS Case Manager may need to contact the service provider to complete the behavioral health consultation as specified in AMPM Policy 1620-G.

~~14.~~15. The ALTCS Case Manager is responsible for coordinating physician's orders for those medical services requiring a physician's order as specified in AMPM Policy 1620-20.

If the ALTCS Case Manager and PCP or attending physician disagree regarding the need for a change in a member's level of care, placement or physician's orders for medical services, the Case Manager shall refer the case to the Contractor's Medical Director (or the AHCCCS Medical Director for members enrolled with a Tribal ALTCS Program) for review. The respective 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.

~~15.~~16. If the ALTCS Case Manager determines through the PCSP process a change in the member's condition may necessitate a change of placement or services, the ALTCS Case Manager shall discuss any potential changes with the member/HCDM prior to the initiation of any changes. This is especially critical if the change~~s~~ will result in a reduction or termination of services.

~~16.~~17. The member/HCDM shall be issued an NOA in the event of a denial, reduction, termination, or suspension of services, when the member/HCDM has indicated, on the PCSP, that they disagree with the type, amount, or frequency of services to be authorized. Refer to 42 CFR 438.404 and ACOM Policy 414 for more detailed information and specific timeframes.

All grievances and requests for hearings and appeals of members enrolled with a Tribal ALTCS Program are to be directed to AHCCCS~~/~~ Office of the General Counsel (OGC). A managed care member's request for hearing and/or appeal is initiated through the member's ALTCS Contractor.

Members determined to have an SMI have the option to choose between the appeal process for members determined to have an SMI or the standard appeal process. Refer to ACOM Policies 444 and 446 .

~~17.~~18. The ALTCS Case Manager shall 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, 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 shall recertify hospice eligibility at the beginning of each election period, and
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 hospice 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 services may be provided in conjunction with hospice services. If the hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services shall be provided by the Contractor. The Contractor and Tribal ALTCS may report such cases to Arizona Department of Health Services (ADHS) as the hospice-licensing agency in Arizona. Refer to AMPM Policy 310-J, for additional information regarding hospice services.

~~18.~~19. All NFs that participate in AHCCCS are dually certified as Medicare and Medicaid facilities. Therefore, beds in these NFs may not be designated as Medicare-only. An ALTCS member may not be asked to leave a Medicaid-participating NF after their Medicare benefit days have exhausted.

~~19.~~20. In most cases, the member/HCDM shall receive a written 30-day advance notice before discharge from a NF as outlined in 42 CFR 483.15. Exceptions to this 30-day timeframe are provided under specific circumstances including but not limited to when the health and/or safety of the member or other residents is/are at risk.

The ALTCS Contractors shall set their own rules regarding advance notice of discharge for members who reside in assisted living facilities in the Contractor's contracts with those facilities.

~~20.~~21. ALTCS Case Managers are responsible for using the eMCR process to notify AHCCCS of a variety of changes in the member's status. Refer to the ALTCS MCR User Guide on the AHCCCS website, for instructions in completing the eMCR. Refer to AMPM Exhibit 1620-2 for a hard copy of the eMCR form and more information on the circumstances for using this form. The hard copy form shall only be used as a last resort when electronic submission is not available (~~for example~~e.g., when a member is no longer enrolled with the Contractor).

~~21.~~22. The ALTCS Case Manager is responsible for updating information in the Client Assessment Tracking System (CATS) within 14 business days of the PCSP meeting. Refer to the AHCCCS Tutorial for Pre-paid Medical Management Information Systems (PMMIS) Interface for ALTCS Case Management.

~~22.~~23. The ALTCS Case Manager shall educate the member/HCDM about fraud, waste, and abuse, and provide information to the member/HCDM including how to report abuse, neglect, exploitation, and other critical incidents. Refer to AMPM Policy 1620-O for additional ALTCS Case Management requirements regarding reporting abuse, neglect, and/or exploitation of a member.