1610 GUIDING PRINCIPLES AND COMPONENTS OF ALTCS CASE MANAGEMENT

REVISION DATES: 10/01/17, 01/01/16, 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

EPD YH18RFP-DRAFT

Description

Case management is the process through which appropriate and cost effective medical, medically related social and behavioral health supports and 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~~ AMPM C~~c~~hapter 1600 and provided by a qualified case manager.

The case management 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 and least restrictive setting. In serving ALTCS members, t~~T~~he case manager must ~~foster a person-centered approach and maximize member/family self-determination while~~ promot~~ing~~e the values of dignity, independence, individuality, privacy, ~~and~~ choice and self-determination, and adhere to guiding principles outlined below. ~~Case management begins with a respect for the member's preferences, interests, needs, culture, language and belief system.~~

ALTCS Guiding Principles

- Member-Centered Case Management
  The member is the primary focus of the ALTCS Program. The member and family/representative, as appropriate, are active participants in the planning for and the evaluation of the provision of long term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goals(s) for achieving or maintaining his/her highest level of self-sufficiency. Education and up-to-date information about the ALTCS program, choices of options and mix of services must be readily available to members.

- *Member-Directed Options*
  To the maximum extent possible, members are to be afforded the opportunity to exercise responsibilities in managing their personal health and development by making

decisions about how best to have needs met including who will provide the service and when and how the services will be provided.

- *Person-Centered Planning*
  The Person-Centered Planning process maximizes member-direction and supports the member to make informed decisions, so that he/she can lead/participate in the Person-Centered Planning process to the fullest extent possible. The Person-Centered Plan safeguards against unjustified restrictions of member rights, and ensures that members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible. The Plan ensures responsiveness to the member's needs and choices regarding service delivery and personal goals and preferences. The member and family/representative shall have immediate access to the member's Person-Centered Plan.

- *Consistency of Services*
  Development of network accessibility and availability serve to ensure delivery, quality and continuity of services in accordance with the Person-Centered Plan as agreed to by the member and the Contractor.

- *Accessibility of Network*
  Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for aging members and members with disabilities, cultural preferences, and individual health care needs. Services are available to same degree as services for individuals not eligible for AHCCCS.

- *Most Integrated Setting*
  Members are to live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are to be afforded the choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.

- *Collaboration with Stakeholders*
  Ongoing collaboration with members/families, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

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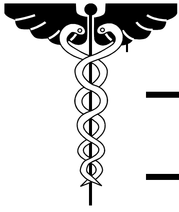
Amount, Duration and Scope

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.

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