

1610 - GUIDING PRINCIPLES AND COMPONENTS OF ALTCS CASE MANAGEMENT

EFFECTIVE DATES: 02/14/96, 10/01/17, 06/01/21

APPROVAL DATES: 10/01/04, 02/01/05, 05/01/10, 05/01/12, 01/01/16, 07/20/17, 05/28/20

I. PURPOSE

This Policy applies to ALTCS E/PD, DES/DDD (DDD) Contractors, and Fee-For-Service (FFS), Programs including Tribal ALTCS; excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes an overview of the Guiding Principles and Components of ALTCS Case Management.

II. DEFINITIONS**CASE MANAGERS**

Arizona licensed registered nurses 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, 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 have been determined to have an SMI.

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.

**DESIGNATED
REPRESENTATIVE**

A parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs as specified in A.A.C. R9-21-101(B).

**HEALTH CARE DECISION
MAKER**

An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

**SECTION 1610 – GUIDING PRINCIPLES AND
COMPONENTS OF ALTCS CASE MANAGEMENT****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 Person-Centered Service Plan shall also reflect the member's strengths and preferences that meet the member's social, cultural and linguistic needs, individually identified goals and desired outcomes, and reflect 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 and with the member's/Health Care Decision Maker's consent, the member's family, individual representative, Designated Representative, 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.

III. POLICY

Case Management is the process through which appropriate and cost effective medical and medically related social and behavioral health services and supports are identified, planned, obtained and monitored for individuals eligible for Arizona Long Term Care System (ALTCS) services. Each individual enrolled as an ALTCS member shall receive Case Management services as specified in AMPM Chapter 1600 and provided by a qualified Case Manager.

The Case Management process involves review and assessment of the member's strengths, preferences, service, and support needs with the member/Health Care Decision Maker, Designated Representative, and the Planning Team. The review should result in an individualized, mutually agreed upon, appropriate and cost effective PCSP 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, the Case Manager shall promote the values of dignity, independence, individuality, privacy, choice and self-determination, and adhere to the guiding principles specified in this Policy.

A. ALTCS GUIDING PRINCIPLES**1. Member-Centered Case Management**

The member is the primary focus of the ALTCS Program. The member/Health Care Decision Maker and Designated 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 individually identified goals. Education and up-to-date information about the ALTCS program, choices of options and mix of services shall be readily available to members.

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

3. 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 AHCCCS PCSP 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 individual goals and preferences. The member/Health Care Decision Maker shall have immediate access to the member's PCSP.

4. Consistency of Services

Development of network accessibility and availability serve to ensure delivery, quality, and continuity of services in accordance with the PCSP as agreed to by the member/Health Care Decision Maker and the Contractor.

5. 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 the same degree as services for individuals not eligible for AHCCCS.

6. 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 Home and Community Based Services (HCBS) Setting rather than residing in an institution.

7. Collaboration with Stakeholders

Ongoing collaboration with members/Health Care Decision Makers, Designated Representatives, family members, service providers, community advocates, and AHCCCS Contractors plays an important role for the continuous improvement of the ALTCS Program.

B. ALTCS CASE MANAGEMENT COMPONENTS

1. Person-centered service planning and coordination

To identify services and supports that will effectively meet the member's needs in the most cost effective manner and to develop and maintain the member's PCSP. Development of the PCSP shall be coordinated with the member/Health Care Decision Maker and Designated 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 member/Health Care Decision Maker, and Designated Representative 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 PCSP. 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 shall also consider and integrate non-ALTCS covered community resources/services as appropriate based on the member's needs.

3. Facilitation and 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 services provided are beneficial for the member. The Planning Team shall assist the member in maintaining or progressing toward his/her highest functional level through the coordination of all services.

4. Review and reassessment

To review, evaluate and make modifications as appropriate to the member's PCSP, as required and as necessary including when the member's condition changes and/or at the request of the member/Health Care Decision Maker, and Designated Representative.

5. Monitor and assess

To determine medically necessary and cost effective ALTCS services for the member. This includes evaluating the member's placement, and authorized services, and taking necessary action to ensure that placement, services and supports are appropriate to meet the member's individual goals and needs.