I. PURPOSE

This Policy applies to ALTCS/EPD, DES/DDD (DDD) Contractors and the Tribal ALTCS Programs as delineated within this Policy. This Policy establishes case management standards for members in the ALTCS Transitional Programs.

II. DEFINITIONS

**ARIZONA LONG TERM CARE SYSTEM (ALTCS) TRANSITIONAL PROGRAM**

A program for currently eligible ALTCS and Tribal ALTCS members who have improved either medically, functionally or both, to the extent that they are no longer at immediate risk of institutionalization at a Nursing Facility (NF) or Intermediate Care Facility (ICF) for persons with Intellectual Disabilities level of care. These members continue to require some long term care services, but at a lower level of care. The ALTCS Transitional Program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary.

**HOME AND COMMUNITY BASED SERVICES (HCBS)**

Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.

**PRE-ADMISSION SCREENING (PAS)**

A process of determining an individual’s risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.

III. POLICY

The ALTCS Transitional Program is available for members (receiving institutional or HCB services) who, at the time of medical reassessment, have improved either medically, functionally or both to the extent that they no longer need institutional care, but who still need significant Long Term Care Services and Supports (LTSS).

In addition to all other ALTCS and Tribal ALTCS case management standards, the following standards apply for members in the ALTCS Transitional Program:

1. The ALTCS and Tribal ALTCS case manager, upon notification of the change of a member to the ALTCS Transitional Program shall discuss the change in level of care
with the member/guardian/designated representative to ensure understanding of the change.

2. The ALTCS and Tribal ALTCS case manager shall ensure that a member in an HCBS setting that meets transitional criteria continues to receive all covered HCBS as necessary.

3. While institutional services are no longer considered medically necessary for transitional eligible members, a short-term stay in a NF or ICF is available.

4. Members in the ALTCS Transitional Program whose medical condition temporarily worsens to the extent that NF services are medically necessary may receive up to 90 consecutive days of care at any one admission.

5. For members already residing in a NF or ICF who becomes eligible for the ALTCS Transitional Program, the case manager shall ensure that the member/guardian/designated representative, understands that discharge from the NF or ICF is necessary within 90 consecutive days after the effective date of eligibility for the ALTCS Transitional Program. The case manager shall work with the member/guardian/designated representative towards HCBS placement as soon as possible, but discharge shall not occur later than 90 consecutive days after the effective date of eligibility for the ALTCS Transitional Program.

6. A PAS reassessment shall be requested, via electronic Member Change Report (MCR), within 45 days of institutional admission, for any members in the ALTCS Transitional Program whose condition has deteriorated and who is expected to need NF or ICF services for greater than 90 consecutive days. Refer to the AHCCCS ALTCS Member Change Report User Guide on the AHCCCS website. A PAS reassessment is not needed if a member in ALTCS or Tribal ALTCS will remain in or return to an HCBS setting within 90 days.

The ALTCS and Tribal ALTCS case manager shall follow up on the MCR with the local ALTCS or Tribal ALTCS office after the PAS reassessment has been requested if there has been no response by the 60th day following admission. Alternate placement options may be explored in the event that the member continues to meet the ALTCS Transitional Program criteria.

Case file documentation shall demonstrate that the ALTCS or Tribal ALTCS case manager has taken appropriate and timely action to either pursue discharge to an HCBS setting or facilitate a PAS reassessment as indicated.