

1000.00 Preadmission Screening (PAS)

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1001.00 General Information About the PAS

The ALTCS Eligibility Administration (AEA) within the AHCCCS Division of Member Services is responsible for determining financial and medical eligibility for ALTCS. Medical eligibility is determined by the Preadmission Screening (PAS) process. There are two PAS instruction manuals (Appendices 10A and 10B) attached to this chapter and five PAS tools used in the process of determining medical eligibility. The PAS instructions and tool used to assess ALTCS customers who are elderly and/or physically disabled (EPD) are referred to as Appendix 10A in the AHCCCS Eligibility Policy Manual. Customers who are developmentally disabled (DD) over age 6 and residing in nursing facilities are also assessed using the EPD PAS tool. The population assessed with the DD instruction and tools, referred to as Appendix 10B, includes persons with Developmental Disabilities (DD) of all ages and children with physical disabilities under six years of age (who are not clients of DES/DDD) who apply or are currently customers of ALTCS. Refer to Appendix B1 of Appendix 10B (the DD PAS instructions) for the PAS tool Matrix by DD status and age.

1002.00 Goal of PAS

The goal of PAS is to ensure the proper eligibility determination of ALTCS customers. Only customers who are determined to be at risk of institutionalization and require care equal to that provided in a Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF-MR), are medically eligible for ALTCS services.

1003.00 PAS Performed by Registered Nurse or Social Worker

The PAS instrument is completed by a PAS Assessor who is a registered nurse or a social worker as follows:

- A. For both EPD and DD customers, the PAS instrument is completed by a registered nurse or social worker, who has attended a minimum of 24 hours of classroom training for each type of PAS (EPD and DD);
 - B. For customers who are hospitalized, the PAS instrument is completed by a registered nurse or under some circumstances a social worker;
 - C. For ventilator dependent customers, the PAS instrument is completed by a registered nurse. (For more information see MS 1012.)
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1004.00 PAS Assessors Responsibilities for Completing the PAS Process

In all cases (other than a posthumous PAS) the customer must be observed and preferably the interview occurs in the customer's usual living arrangement.

The PAS Assessor must:

- A. Conduct a face-to-face interview with the customer;
- B. Obtain information from the caregivers and/or authorized representative;
- C. Obtain verification of major medical conditions on all cases and pertinent medical documentation on cases requiring physician review;
- D. Provide information to the customer and/or the customer's representative regarding the ALTCS program;
- E. Provide information about possible alternative services to customers who may not be ALTCS eligible;
- F. Determine whether a case requires physician review; prepare and send case for review;
- G. Prepare for and conduct Pre-hearing Discussions and testify at appeal hearings.

1005.00 Other PAS Assessors Responsibilities

The PAS Assessor has a variety of other duties in addition to completing the PAS.

The PAS Assessor must:

- A. Determine the First Continuous Period of Institutionalization on Community Spouse cases;
- B. Complete Customer Issue Referrals, as necessary;
- C. Communicate with case managers, physicians and other health care providers;
- D. Maintain schedules of appointments and productivity logs;
- E. Perform financial eligibility functions.

1006.00 PAS Timeframes/Timeliness

Complete the initial PAS at least six days before the end of the application period. The application period is 45 days for an ALTCS application.

In some situations, such as a referral made by an AHCCCS Health Plan on a customer who is hospitalized, the case must be treated as a priority and the PAS must be completed as soon as possible.

1007.00 Using an Eligible PAS Within 60 Days

Sometimes an eligible PAS is completed on a customer who is denied by the Program Services Evaluator (PSE). The eligible PAS may be used for up to 60 days. This is only done when it appears the customer's condition is unlikely to improve to a point where PAS eligibility could be in question. The PAS Assessor must verify by telephone that the customer's condition is essentially the same as on the PAS date and document in an addendum to the PAS summary.

An ineligible PAS is never used on a new application. An **eligible** Private Request PAS may be used within 60 days, using the same criteria as stated above. The Private Request PAS is updated in ACE with an addendum documented in the PAS summary.

1008.00 Developmentally Disabled (DD) Status

- A. Customers may be determined to be eligible for services by the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). DES/DDD eligible customers include those who have been diagnosed with mental retardation (cognitive disability), cerebral palsy, seizure disorder or autism, and have significant impairment in their functional abilities. For children less than six years of age, a diagnosis of developmental delay or the risk for developmental disability may serve as the qualifying diagnosis for DES/DDD. By Arizona Revised Statute, DES/DDD is required to be the provider of services to persons with a developmental disability.

The PAS process is intended to determine whether or not a customer's current functional abilities and medical stability, resulting from a developmental disability, indicates a need for services at the NF or ICF-MR level of care. Frequently, customers with developmental disabilities are eligible to receive services from DES/DDD but are not at risk of institutionalization at the ICF-MR level of care and therefore not eligible for ALTCS. ALTCS assigns a DD status to each case depending on eligibility for DES/DDD services. This status is indicated on the PAS Intake Notice.

- B. The DD status classifications are as follows:

Potential DD. The customer appears to have mental retardation (cognitive disability), cerebral palsy, seizure disorder or autism, but has not been determined to be Developmentally Disabled by DES/DDD. Refer the customer to DES/DDD for evaluation and use both DD and EPD assessment tools. If DES/DDD has not determined the DD status within 30 days, complete the EPD PAS but do not change the DD status. The PAS Assessor may complete a DD PAS in addition to the EPD PAS pending a DES/DDD eligibility status determination on customers age six and over. A potential DD is assessed with the EPD tool, but the DD tool is required if the customer is approved by DES/DDD for services. A customer who is still pending DES/DDD eligibility will be enrolled with DES/DDD if an eligible PAS is completed. It is imperative the PAS Assessor discuss this type of case with a supervisor prior to completing the eligible PAS. Communication must also occur with DES/DDD regarding the status of the eligibility determination. In some cases it may benefit

the customer to allow DES/DDD more than 30 days to make the determination. These cases can be referred to Medical QC to assist in communication with DES/DDD.

DD. DES/DDD has identified the customer as Developmentally Disabled. Use the age appropriate DD assessment tool.

DD in NF. DES/DDD has identified the customer as Developmentally Disabled and residing in a nursing facility. Use the EPD assessment tool unless the customer is less than six years old.

Not DD. The customer is not diagnosed as Developmentally Disabled or has a DD diagnosis but has been determined ineligible for DES/DDD services. Use the EPD assessment tool unless the customer is less than six years old.

- C. For further information on which PAS tool is used, refer to the PAS Tool Matrix by DD Status and Age, Appendix A2 of the EPD PAS manual or Appendix B1 of the DD PAS manual.

1008.01 Children with Developmental Delay

Children age six and over who are customers of DES/DDD must have one of the four DD qualifying diagnoses (mental retardation [cognitive disability], autism, cerebral palsy, or seizure disorder) to be considered DD for their ALTCS application or reassessment. If they have developmental delay only and are over the age of five the PAS Assessor must:

- A. Look at all available records to determine if the child has been given a diagnosis not previously found. The DES/DDD case file should contain any evaluations the child has had, but diagnoses might be found elsewhere as well, such as medical records and school records.
- B. Contact the support coordinator if a diagnosis is not found in any of the case records reviewed. The support coordinator has a responsibility to make sure the customer is evaluated before the customer turns 6, and that the results are in the record.
- C. The PAS Assessor must call or e-mail the AHCCCS Central Office ALTCS Eligibility Administration (AEA) to report any cases where no diagnosis is found. These cases are referred to DES/DDD Central Office. The PAS Assessor must document the efforts made to obtain the diagnosis. If the support coordinator gives a valid reason for delay in obtaining the diagnosis that indicates a long delay, such as a delay in the child starting school and thus receiving a school psychological evaluation, the PAS reassessment may be completed without the diagnosis and the reasons explained. On the next reassessment, attempts must be made again to obtain the DD qualifying diagnosis. ALTCS Eligibility Administration will communicate with DES/DDD Administration when the DD diagnosis cannot be obtained.

1008.02 Changing DD Status

- A. The DD status dates entered in ACE must coincide with the PAS date to insure that the PAS is properly processed and that enrollment is correct. In general, EPD customers are enrolled

with a program contractor. DD customers are enrolled with DES/DDD. Customers who are pending DES/DDD determinations (Potential DDs) and determined PAS eligible are also enrolled with DES/DDD.

- B. Changes in DD status may occur on a new application while the case is still pending, particularly if the customer is a potential DD. When DES/DDD notifies the ALTCS office of the change in status enter the new status in ACE. If the PAS has already been entered but not completed, the new DD status may be applied retroactively back to the PAS date to ensure accurate processing and enrollment of the case.
- C. For changes in DD status on ongoing DD cases, the change is received from DES/DDD on an Electronic Member Change Report (MCR). The Electronic MCR should include, as an attachment, a copy of the notice that has been sent to the customer or family from DES/DDD. Alternately, the notice could be sent to Medical QC via mail or FAX. The PAS Assessor must allow for the customer's 35 day appeal period based on that notice and communicate with the support coordinator to determine status of a potential appeal.

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Once it is determined there is no appeal of the DES/DDD discontinuance or the discontinuance has been upheld, the EPD PAS must be completed on paper. The DD status **must not** be changed to EPD until the outcome of the PAS and physician review, if indicated, is known. The DD status change and the EPD PAS must be completed on the same day as the change in DD status affects enrollment. A change in DD status prior to completion of the EPD PAS would result in enrollment with an EPD program contractor even though the PAS eligibility has not been determined. The same is true for the rare case that changes from EPD to DD.

- D. It is also important to note that even though a customer may have been eligible with DDD for years, the first assessment as Not DD is treated like an initial in regards to enrollment and transitional program eligibility is not available. The same would be true going from EPD to DD. The PAS in ACE is entered as a reassessment.

1009.00 Preadmission Screening for the Elderly and Physically Disabled (EPD)

- A. The PAS instrument for the elderly and physically disabled includes four major categories: intake information, functional assessment, emotional and cognitive functioning and medical assessment.
1. The intake information category collects demographic information, the source of information and personal contacts information (entered on the Personal Contacts tab of the PAS summary window) and additional information which includes the customer's height and weight, acute care status, and ventilator status.
 2. The functional assessment category collects information about the customer's:
 - a. Activities of daily living;
 - b. Communication and sensory abilities; and
 - c. Continence.
 3. The emotional and cognitive functioning category collects information on the customer's:
 - a. Orientation; and
 - b. Behavior.
 4. The medical assessment category collects information on the customer's:
 - a. Medical conditions and their impact on the customer's ability to independently perform activities of daily living and whether such conditions require medical or nursing treatments;
 - b. Medications, treatments, allergies and diet;

- c. Specific services and treatments that the customer receives or needs and the frequency of those services and treatments; and

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- d. PAS summary.

- B. The responses selected by the PAS Assessor in ACE calculate three scores: a functional score, a medical score and a total score, and compare to the established thresholds (Appendix 10A, the EPD PAS manual).

1010.00 Preadmission Screening for the Developmentally Disabled (DD)

There are four age-specific PAS tools for customers with developmental disabilities and all children less than six years old. The tools are: 0-2; 3-5; 6-11; and 12+.

- A. The PAS instrument for customers with developmental disabilities includes three major categories: intake information, functional assessment and medical assessment.
 - 1. The intake information category (entered on the PAS summary window) collects demographic information, source of information, personal contacts, and additional information that includes height and weight, measurements at birth, acute care status, and ventilator status.
 - 2. The functional assessment category collects information on the customer's:
 - a. Developmental growth for children less than six years of age;
 - b. Motor and independent living skills;
 - c. Communication and cognitive functioning; and
 - d. Behaviors.
 - 3. The medical assessment category collects information on the customer's:
 - a. Medical conditions;
 - b. Specific services and treatments that the customer receives or needs and the frequency of those services and treatments;
 - c. Medications and treatments;
 - d. Medical stability in terms of hospitalizations, caregiver training and special diet;
 - e. Sensory functions; and
 - f. PAS summary.

- B. The responses selected by the PAS Assessor in ACE, calculate three scores, a functional score, a medical score, and a total score and compare to the established threshold. (See Appendix 10B, the DD PAS manual.)

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- C. The PAS Assessor must pay close attention to the age of the customer less than 12 years of age. If the customer is approaching a birthday or an age milestone as indicated on the 0–2 PAS, the PAS may need to be delayed until after the birthday or other age milestone in order to ensure an accurate eligibility determination. For example, if the customer is 5 months old, 8 months old, 11 months old, 17 months old or is approaching their 3rd, 6th or 12th birthday, the PAS should be conducted after the next age milestone is reached, if at all possible. The PAS Assessor must verify age and discuss these cases with a supervisor or with Medial QC. In most cases the PAS should not be completed until after the birthday or other age milestone.

1011.00 Completion of PAS for Hospitalized Customers

- A. In order to be PAS eligible, customers must require care equal to that provided in a NF or ICF-MR. Customers who are hospitalized may not meet this requirement if, at the time of the PAS, they require a higher (acute) level of care. Process customers who apply for ALTCS and who are in hospitals or intensive rehabilitation facilities as follows:
1. When the referral is received, check to see if the customer is ready for discharge within seven days. If the customer is ready for discharge, complete the PAS within two working days. It is important to make immediate contact with the hospital nursing or social service personnel involved in the discharge planning of the hospitalized customer and fully document the details including dates and names.
 2. If there is no discharge date but one is anticipated before or soon after the PAS due date, hold the referral until there is a discharge date and complete the PAS as soon as the discharge date is known.
 3. If there is no anticipated discharge date within 14 calendar days after the PAS due date, the PAS is completed as Acute Care, ALTCS ineligible. This should be thoroughly documented in the summary and the box indicating “currently hospitalized/rehab” on the DD or EPD information tab in ACE should be checked. When the next box “Imminent discharge from acute care facility” is not checked, the PAS will be determined “acute”. In rare cases no further PAS information will be completed. The PAS Assessor must discuss these cases with a supervisor before proceeding, then document the reason there is no discharge date for this customer with the dates and names of the hospital staff providing this information in the summary section.
- B. The Program Services Evaluator (PSE) cannot complete an application as eligible while the customer is hospitalized or in intensive rehabilitation. The PAS Assessor and PSE must work together closely on these cases to insure appropriate eligibility determinations.
- C. If a customer is hospitalized after the PAS has been completed, but before the case has been dispositioned by the PSE and discharge is not imminent, change the PAS in ACE to reflect the customer’s acute status and document the date and reason for the change in the summary.

1012.00 Completion of PAS for Ventilator Dependent Customers

- A. A customer who is ventilator dependent is medically dependent upon a mechanical ventilator for life support at least six hours per day and has been dependent on ventilator support for at least 30 consecutive days.
 - B. A registered nurse conducts the PAS. In addition to completing the PAS, the registered nurse must research respiratory therapy records to verify that the customer meets the ventilator dependent criteria and if so, complete the Ventilator Dependent Eligibility Determination Worksheet in ACE. Send notification via e-mail to the PAS QC unit in the Division of Member Services, ALTCS Eligibility Administration (AEA).
 - C. Ventilator Dependent status impacts enrollment as customers with scores below thresholds may be eligible if the ventilator dependent criteria is met. This does not apply for babies under the age of 6 months and for children who are not DD eligible under the age of 12. These cases will be submitted for physician review per policy.
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1013.00 Posthumous PAS

Sometimes an initial PAS must be completed after the customer has died to determine if the customer would have been eligible prior to death. A deceased customer must have resided in a NF or an ICF-MR for at least one day during the application month for a PAS to be completed.

1014.00 Private Request PAS

To determine whether customers who are not applying for ALTCS are at risk of institutionalization and require care equal to that provided in a NF or ICF-MR complete a private request PAS. These customers are assessed upon request and completed without a charge to the customer. The Private Request PAS is processed through Eligibility Review (see MS 1017), if indicated. A face-to-face assessment must be conducted to be considered a Private Request PAS and to be entered into ACE.

1015.00 PAS Reassessments

PAS reassessments must be completed on some ALTCS customers to determine continued medical eligibility. The criteria for continued qualification for ALTCS services is the same as for the initial preadmission screening (PAS). Customers meeting the following criteria require an annual reassessment:

- A. Customers who are **elderly or physically disabled** under the age of 65 who were made eligible by Physician Review on their last assessment.
- B. Customers who are **elderly or physically disabled** under age 65 with scores under 70 points and no dementia diagnosis.
- C. Customers who are **elderly or physically disabled** with a **MAJOR DIAGNOSIS** of any of the psychiatric diagnoses and no dementia diagnosis.
- D. Customers who are **elderly or physically disabled** under age 65 with one or more hospitalizations in the past 6 months and no dementia or paralysis diagnosis.
- E. Customers who are **developmentally disabled** under the age of 6 who were made eligible by Physician Review on their last assessment.

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- F. Customers who are **developmentally disabled** age 6 and over who do not have a DD qualifying diagnosis (cerebral palsy, autism, mental retardation, or seizure disorder).
- G. Program Contractor requests a reassessment through the electronic member change report on the web system.
- E. A reassessment may be completed at any time for the following reasons:
 - 1. A review of the PAS by Administration reveals a question regarding the eligibility determination.
 - 2. A review by Administration or an ALTCS physician consultant determines the customer may not have a continuing need for long-term care services.
 - 3. A review of the PAS requested by a Program Contractor, case manager, nursing facility or other party reveals a question regarding continuing eligibility.

1016.00 Eligibility Review

- A. Eligibility review is an integral part of the PAS assessment process. It is designed to address those customers whose final score is not thought by the PAS Assessor to be an accurate reflection of the customer's need for a NF or ICF-MR level of care.
- B. Eligibility reviews may occur for customers who score either below or in some cases above the entry level scoring threshold. A physician consultant performs these reviews on all initial PAS referred and on all reassessments that may no longer be eligible. The physician consultant determines the need for NF or ICF-MR level of care and this decision overrides the PAS score.
- C. The PAS Administrative Review Committee (PARC) may perform eligibility reviews on reassessments only and also only on a PAS that appears to continue to be eligible. If PARC reviews the PAS and determines the customer may no longer be eligible the case will be referred to a physician consultant for eligibility review.

D. Review may be requested for but not limited to these cases:

1. The customer does not meet the threshold score but the PAS Assessor thinks the customer may be at risk of institutionalization;
2. The customer has a serious mental illness and the PAS Assessor determines that despite the customer's score meeting or exceeding the minimum threshold score, a review is necessary to determine if the customer has a non-psychiatric medical condition or a developmental disability that by itself or in combination with other medical conditions, necessitates the level of care provided in a nursing facility or ICF-MR;
3. The customer requests a hearing;

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4. An initial ALTCS customer with a score at or above threshold, who is already a customer of an AHCCCS health plan and appears to need less than 90 days of convalescent (NF or ICF-MR level) care;
 - a. Physician consultants review the PAS of customers who may be eligible by score or appear to be at risk of institutionalization and are enrolled with an AHCCCS health plan and who have a condition which may indicate a need for less than 90 days of long term care services. For an AHCCCS enrolled customer to be made ALTCS eligible, the physician must determine that in all likelihood the customer's need for long-term care services, or convalescent period, will be more than 90 days. If the PAS Assessor thinks that the customer may require less than 90 days of LTC services, the PAS Assessor should check with the customer's health plan to verify that nursing facility services are still available to the customer (customer has not used all 90 days within the contract year) prior to sending the case for physician review.
 - b. This does not apply to customers who are not members of an AHCCCS health plan or AHCCCS customers receiving services through the Indian Health Services (IHS). Non-AHCCCS customers are made eligible for ALTCS based on their current need for long-term care services. If it appears that such a customer may not have a continued need for long-term care services, the physician or PAS Assessor (in conjunction with his/her supervisor) may schedule a six-month reassessment.
5. The customer is less than six months of age;

Complete only the medical assessment and the PAS summary sections of the PAS on an infant less than six months of age. A description of the emerging developmental patterns must be documented in the summary describing muscle tone, visual perception and social interaction. Send the assessment, along with medical records, for physician review on all PAS cases completed on infants less than six months of age.

For an infant less than six months old to be eligible, the child must have recognizable developmental delays. The child shall also not be in need of only acute services (e.g., frequent hospitalizations, surgeries or other acute type treatments). An infant who is not stabilized from acute illness or prematurity and related conditions is not generally considered a candidate for long term care.

6. The customer is EPD less than twelve years of age. Send all PAS on EPD children less than twelve years of age for physician review. These cases are uncommon, diverse and frequently quite medically involved, so a physician review is necessary to determine eligibility.
- E. The physician consultant reviews the PAS and available medical records to determine whether the customer, regardless of the PAS score, has a non-psychiatric medical condition or has a developmental disability that, by itself or in combination with other medical conditions, necessitates the level of care which is provided in a nursing facility or ICF-MR. If the physician is unable to make the determination from the available medical records and the completed PAS, the physician may contact the primary care physician or other professionals regarding the customer's conditions and needs.

- F. All cases referred by PAS Assessors to the physician consultant for review must be returned and read after the physician review by the appropriate PAS Assessor and supervisor. If the PAS Assessor is not in agreement with the eligibility determination by the physician consultant, the PAS Assessor and supervisor or branch/regional manager should discuss the issues involved. If determined appropriate, the case may be referred to the ALTCS Eligibility Manager for re-review. Submit additional information or clarification with any case when a re-review is requested.
 - G. A PAS may be sent to the ALTCS Eligibility Manager for review if requested by the PAS assessor, supervisor, branch/regional manager or physician.
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1017.00 Customer Issue Referrals

When a PAS Assessor sees a situation with a customer that calls for immediate intervention, call the paramedics for a life-threatening situation or notify Adult Protective Services (APS) or Child Protective Services (CPS) of serious physical or medical neglect. (CPS must make a home visit within 24 hours after receiving a report and APS must make a home visit within 48 hours of the report, excluding weekends).

In addition, if there is abuse, neglect or issues of substandard care, report the issue to the Division of Health Care Management/Clinical Quality Management (DCHM/CQM) so the circumstances can be investigated.

Use the ALTCS Customer Issue Referral (CIR) form to inform the DHCM/CQM when a Program Services Evaluator or PAS Assessor suspects:

- A. A problem with quality of care being provided to the customer;
- B. The customer is being abused or neglected;
- C. Provider fraud;
- D. The customer has unmet medical or dental needs;

Or when the PAS Assessor discovers:

- E. A customer who is residing in an unlicensed or uncertified room and board home is receiving direct, personal or supervisory care services on other than a temporary basis pending ALTCS approval; or
- F. There appears to be a problem with the case manager regarding the customer.

See the Customer Issue Referral (DE-638) form instructions in the Medicaid Forms Manual for additional information.

1017.01 Severity Status Levels

The severity status levels on the Customer Issue Referral are as follows:

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Severity Level #1: Potential quality of care issue with minimal adverse effects (issue may impact the customer if not resolved);

Severity Level #2: Potential quality of care issue with moderate adverse effects (issue will impact the customer if not resolved); and

Severity Level #3: Potential quality of care issue that immediately impacts the customer and is life-threatening or dangerous.

Examples of these issues are described on the Customer Issue Referral form.

1017.02 Discussion with Supervisor Prior to Referral

Whenever it appears that a referral to CPS or APS may be appropriate, discuss the issue with the supervisor. In some cases, depending on the severity of the issue, the discussion may occur after the referral has been made. In less urgent situations, the supervisor may contact DHCM/CQM staff for guidance regarding contacting CPS or APS. In all cases, the Customer Issue Referral must be completed and the problem and all actions taken to resolve the problem must be fully documented. The Referral should be reviewed by the supervisor prior to being forwarded to DHCM/CQM.

1018.00 Preadmission Screening and Resident Review (PASRR)

Federal nursing home reform legislation enacted through the 1987 Omnibus Reconciliation Act (OBRA) established the Preadmission Screening and Resident Review (PASRR) program. The PASRR regulations require all customers entering a Title XIX (Medicaid) certified nursing facility after January 1, 1989, to be screened to identify mental retardation and/or serious mental illness (MR/MI) to avoid inappropriate placement.

The PASRR is a two-level screening process. Hospital discharge planners and nursing facility staff complete the PASRR prior to admission to a NF. The Level I screening determines whether the customer has any diagnosis or other presenting evidence that suggests the potential presence of MR/MI. If there is an indication of MR/MI, then the case must be referred for a Level II determination.

The Level II screening determines whether the customer is indeed MR/MI and whether the person can be appropriately treated in a NF setting. If a Level II determination is indicated in Section E. of the PASRR Screening Document, the PAS Assessor must obtain the signature of the customer or their representative in Section F. on the form prior to the referral for Level II evaluation. An admission to a NF cannot occur until the Level II is completed and indicates the NF admission is appropriate.

Referrals for Level II evaluation are sent to the PASRR Coordinator at Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS) for potential mental

illness and to Arizona Department of Economic Security (ADES), Division of Developmental Disabilities (DDD) for potential mental retardation.

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Nursing facilities must ensure that the Level I screening and, if appropriate, Level II determinations have been completed and are kept in the customer's current medical chart. The PAS Assessor must report any nursing facilities that are not in compliance with this regulation to the PASRR Coordinator in DHCM.

Sometimes a Level I screening needs to be redone by the NF. If a customer entered a NF because of convalescent or respite care and is later found to require more than 30 days of NF care, a new Level I must be completed. If a Level II is indicated, the referral must be made as soon as possible. Also, when the most recent Level I screening does not indicate a need for Level II referral but the customer's mental health condition changes or new medical records information becomes available that might indicate a need for a Level II referral, a new Level I screening needs to be completed. The PAS Assessor needs to be aware of these situations when reviewing the PASRR at the time of the initial PAS or the reassessment.

A new Level I screening is not required for readmissions or interfacility transfers. The transferring or readmitting facility is responsible for ensuring that copies of the most recent Level I screening and Level II, if appropriate accompany the transferring or readmitted resident.

The PAS Assessor plays an important role in ensuring that ALTCS customers and recipients are appropriately screened.

1019.00 First Continuous Period of Institutionalization/Community Spouse Resource Allowance

The spousal impoverishment amendments to the Social Security (Medicaid) Act allow one spouse to retain sufficient property and income to live on when the other spouse requires institutional care. In some cases, the Program Services Evaluator may need to do an assessment of the resources owned by both spouses during a past period of time.

As part of their process, PAS assessors may need to determine the "first continuous period of institutionalization" (FCPI) for customers with a community spouse. The FCPI date is the date an individual started receiving services for 30 consecutive days that prevented the individual from becoming institutionalized. This determination of the FCPI provides the Program Services Evaluator with the necessary date to determine the countable resource amount. (See Appendix A7 of Appendix 10A, the EPD PAS manual). For consistency, due to the infrequency of these cases, the manager and/or PAS QC should be consulted prior to making the determination.

1020.00 The ALTCS Transitional Program

ALTCS Transitional is a program for currently eligible ALTCS customers who have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) level of care. These customers continue to require some long-term care services, but at a lower level of care. The ALTCS Transitional program allows those customers who meet the lower level of care, as determined by the preadmission screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. NF/ICF-MR services are excluded, since reassessment has determined that NF services are not medically necessary.

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The ALTCS Transitional program is not available to an ALTCS customer who fails the initial PAS and is not at risk of institutionalization.

ALTCS Transitional provides all covered acute care, behavioral health services and long term care services except those at an institutional level in a NF or ICF-MR. If the customer is a resident in a NF or ICF-MR when determined eligible for ALTCS Transitional, institutional services may continue to be provided for up to 90 days while the customer is discharged from an institutional placement to an HCBS placement by the Program Contractor.

1020.01 PAS Medical Eligibility for ALTCS Transitional

A. Developmentally Disabled (DD) population (all ages)

ALTCS Transitional eligibility would require a score of 30 or more or a diagnosis of moderate, severe or profound mental retardation.

B. Elderly and Physically Disabled (EPD) population

Age 0-11

These children will be allowed into ALTCS Transitional only by physician review, since there is no scoring methodology for EPD children less than twelve years of age.

Age 12 and older

ALTCS Transitional eligibility would require a total score of 40.

C. Scoring

When a reassessment is completed in ACE, the system will:

1. Perform the scoring routine for ALTCS eligibility and compare to the pre-established thresholds.
2. If the reassessment scores ineligible for ALTCS, the system will perform the scoring routine for the ALTCS Transitional program and compare it to the ALTCS Transitional eligibility criteria.

D. The PAS Assessor must include the case manager in the PAS interview and/or discuss the eligibility with the case manager when customers are becoming eligible for Transitional from ALTCS. This is especially important on customers who reside in a NF or ICF-MR.

E. Physician Review

The PAS Assessor requests a physician review:

1. On all customers living in a NF or ICF-MR;
2. If the customer does not meet either eligibility criteria (ALTCS or ALTCS Transitional);
3. If the DD status of a customer has changed since the last assessment or reassessment; or

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4. If the customer is an EPD child under twelve years of age.

The physician may determine customers to be eligible for ALTCS or ALTCS Transitional, or ineligible for either program.

1020.02 Transition of Customers Into ALTCS Transitional Program

A. HCBS Customers

Upon being notified of the change in the customer's status, the case manager will discuss the issue with the customer and/or customer's legal or authorized representative to insure the customer's understanding of the change. Since the HCBS covered services are the same for both programs, these customers should experience no change upon moving from ALTCS to ALTCS Transitional.

B. NF/ICF-MR Customers

Upon being notified of the change in the customer's status, the case manager must discuss the change in level of care and the need to move the customer with the customer's PCP, the member and/or customer's representative. The Program Contractor must arrange for HCBS placement as soon as possible and within 90 days.

Failure to move the customer within the allowable time frame will be a Program Contractor (PC) compliance issue for review under regular PC monitoring procedures as part of the Case Management Services Review (CMSR).

If the customer appeals, the PC should not be considered non-compliant if the customer is kept in the NF pending appeal. Transitional cases pending appeal will not be reopened and placed back at an ALTCS level of care.

1020.03 ALTCS Transitional Covered Services

ALTCS Transitional eligible customers shall be eligible to receive the following services:

- A. Up to 90 days in a NF or ICF-MR,
 - B. Acute medical services,
 - C. Behavioral health services,
 - D. Home and Community Based Services (HCBS) in a home and community based setting, and
 - E. Supported employment services for the DD population.
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1020.04 ALTCS Transitional Notification/Effective Date

A. Customer Notification

A notice to the customer is generated from ACE for members becoming Transitional who are in a NF or ICF-MR, with a copy sent to the Program Contractor. The notice, in accordance with the requirements of 42 CFR 431.210-431.213, will:

1. Include an explanation of the change in status to the ALTCS Transitional program;
2. Advise the customer that all medically necessary services will continue to be provided;
3. Notify customers that their case manager will be contacting them to discuss and plan for the move from the NF or ICF-MR to a home and community based setting;
4. Advise customers of appeal rights.

Notices will be printed and mailed from the Central Office. A copy is available electronically.

B. Notification to Program Contractor

1. In addition to receiving a copy of the notice sent to the customer, the ALTCS transitional status will be reflected on the PC's monthly customer roster.
2. A copy of the PAS, which is available electronically, will identify the ALTCS Transitional customer.
3. A copy of the monthly report ALTCS TRANSITIONAL PROGRAM MEMBERS BY PROGRAM CONTRACTOR, will be sent to the Program Contractor. This report will also be used by the Administration to track ALTCS Transitional customers and timely placement as appropriate.

C. Effective Date of Customer's Eligibility for the ALTCS Transitional Program

ALTCS Transitional effective date will be the first of the month following the PAS decision date, in accordance with the customer roster cut-off date.

1020.05 ALTCS Transitional Customers Requiring Short Term NF Placement

A short term nursing facility stay will be available to ALTCS Transitional HCBS customers whose condition worsens to the extent that NF services are temporarily medically necessary. The PC can place the ALTCS customer in a NF, and remain in compliance, provided the stay does not exceed 90 continuous days at any one admission.

The PC should request AHCCCSA to complete a PAS reassessment if the ALTCS Transitional customer may need NF care longer than 90 days. The reassessment will be completed within ten working days. If the customer is determined to be at risk of institutionalization based on the PAS

reassessment, the customer's status will be changed to the ALTCS program effective with the first day of the following month.

1020.06 Reassessment of the ALTCS Transitional Customer

Reassessment of members in the ALTCS Transitional program occurs according to the same criteria as ALTCS customers (MS [1016](#)).

1021 Quality Control

The Central Office Quality Control Unit is comprised of nurses and social workers who monitor and evaluate the EPD and DD PAS process. The goal of the unit is to attain accuracy and consistency of PAS implementation statewide.

- A. Quality Control Analysts will conduct a review of a percentage of PASs completed statewide. This includes a review of the ACE data entry for each PAS Assessor and/or their supervisors based on review findings.
- B. Quality Control Analysts may accompany the PAS Assessor while completing on-site PAS interviews to provide technical assistance.
- C. Statistics will be collected and used to identify problems requiring additional training, changes to the PAS tools, PAS manuals or orientation process.

Regional and local office staff have a responsibility for monitoring and improving the quality of PAS conducted in their respective offices. Supervisors must review the PAS completed by their employees, accompany them on PAS interviews, and provide technical assistance, coaching and training opportunities on an ongoing bases.