Nursing Home Transition Case Management

Section 1

Service Description and Procedures

What is Transition Case Management?

- Transition case management (TCM) is a new service component added to regular case management for both the Aged and Disabled Adult and Assisted Living for the Elderly Waivers.

- Transition case management is a service provided to Medicaid eligible clients currently residing in a nursing home and wish to transition into a less restrictive environment.

Who Can Receive Transition Case Management?

- Clients that have resided in a nursing home for at least 60 consecutive days.

  Note: Hospital stays are excluded from the 60 day requirement.

- Clients that have been enrolled in the Aged and Disabled Adult or Assisted Living for the Elderly Waiver at the time of discharge.

  Note: Clients receiving hospice care cannot receive TCM.

Transition Case Manager Responsibilities

- Conducting face-to-face visits with the client to develop nursing home transition plan.
- Assisting with navigating the transition process.
- Identifying and securing additional appropriate non-waiver community supports who may include: family, relatives, friends, organizations, and/or a legal representative that may serve as caregivers or provide community support.

Transition Case Manager Responsibilities

- Facilitating waiver enrollment
- Making arrangements for services prior to discharge
- Notifying all parties and agencies involved in transitioning a client

Nursing Home Transition Case Management Procedures

Nursing Home Transition Case Management Procedures for Transition Case Managers

1. Transition case manager will receive referral from ARC. Within 10 business days of receipt Transition case manager updates client's 701B & completes NHT plan (face-to-face visit).

2. Transition case manager notifies CARES of the estimated date of discharge using the NHT Plan & requests LOC.

3. ALL REQUIREMENTS MUST BE MET PER THE WAIVER HANDBOOKS IN ORDER TO BILL:

A. Client resided in NH for 60 consecutive days by the time discharge occurs.

B. No more than 20 hours of transition case management can be billed within 6 months of waiver start date.

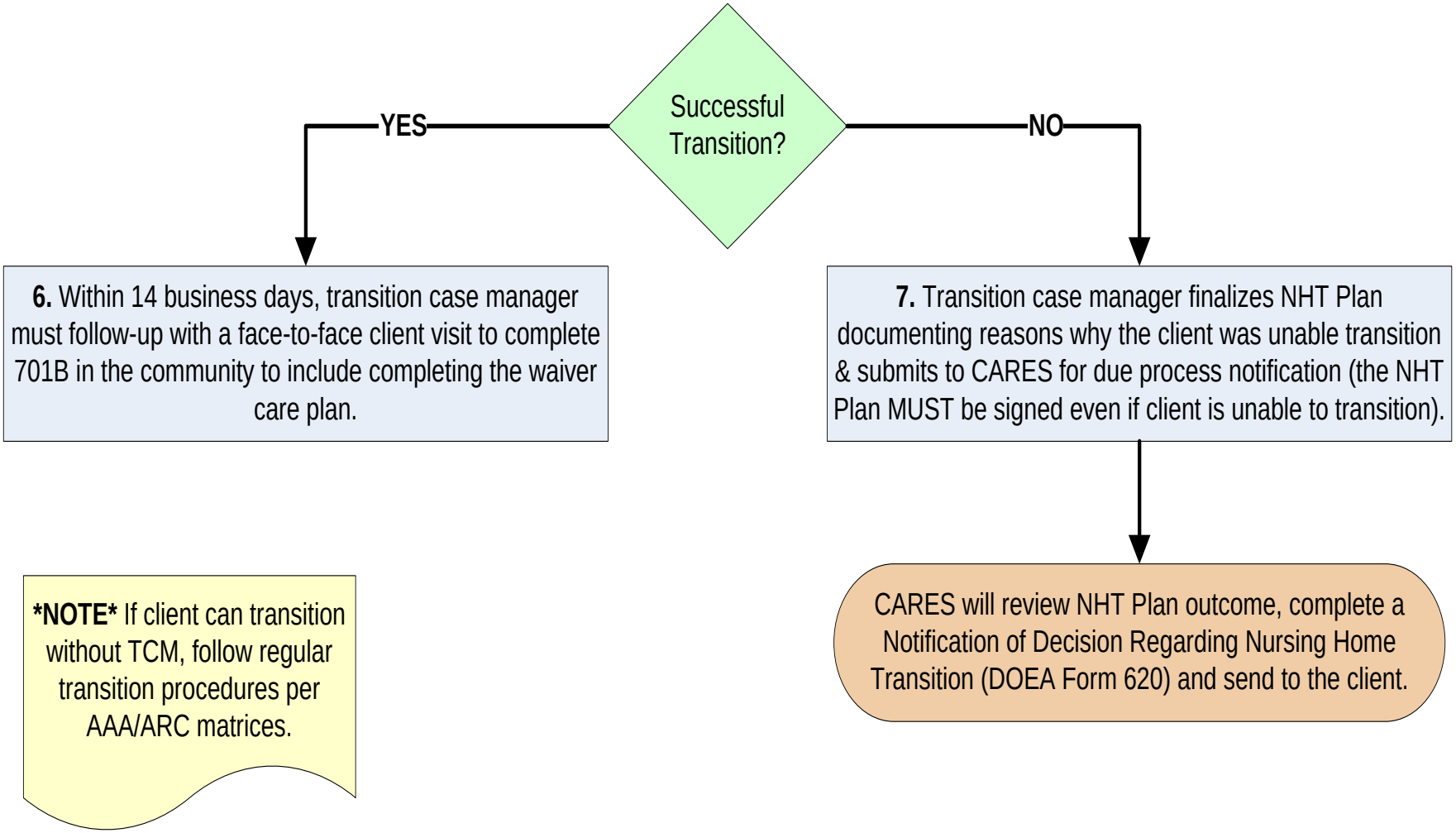
C. Client has a completed and signed nursing home transition (NHT) Plan.

D. Upon nursing home discharge, client is enrolled in the ADA or ALE Waiver.

[**NOTE**: The first opportunity to bill is the waiver start date.]

4. Upon receipt of waiver LOC, transition case manager submits Form 2515 to DCF & requests ex-parte.

5. The Notice of Case Action will be provided by DCF to the client & transition case manager will submit to the AAA/ARC.


Successful Transition?
YES
NO
6. Within 14 business days, transition case manager must follow-up with a face-to-face client visit to complete 701B in the community to include completing the waiver care plan.
7. Transition case manager finalizes NHT Plan documenting reasons why the client was unable transition & submits to CARES for due process notification (the NHT Plan MUST be signed even if client is unable to transition).
NOTE If client can transition without TCM, follow regular transition procedures per AAA/ARC matrices.
CARES will review NHT Plan outcome, complete a Notification of Decision Regarding Nursing Home Transition (DOEA Form 620) and send to the client.

Discharge from the Nursing Home

- After discharge from the nursing home and enrollment in the waiver, transition case management services end and regular waiver services can begin.

Technical Assistance

- All questions regarding this presentation should be directed to your local Medicaid Waiver Specialist for guidance.

Please Review Section 2: Developing a Nursing Home Transition Plan