Money Follows the Person: Frequently Asked Questions

The Questions in this document were generated by Transition coordinators and other MFP staff in training sessions and small group meetings. Contact your UIC pod leader with additional questions you would like answered in this document.

Categories

General Questions

1A When did the MFP program begin?

MFP Start Date for Division of Rehab Services: 2/6/2009
MFP Start Date for Department on Aging: ~5/1/09 (Phase 1); ~10/1/09 (Phase 2), 7/1/2010 (Phase 3)
MFP Start Date for Department of Mental Health: 2/13/2009
MFP Start Date for Division of Developmental Disabilities: Jan 1, 2012

1B Will there be brochures and other marketing or outreach materials?

Yes. Brochure, fact sheets, and NH staff guidance is available on state MFP website, www.mfp.illinois.gov on the additional information page

1C Will we be getting an MFP badge or other identification that links us with the State?

HFS cannot provide photo ID badges to individuals who are not employees or under contract with the agency. Please use your current nametags and business cards. If there are any problems encountered please contact the state agency or division designated program staff.

1D What is the status of the provider letter/notice?

If any transition coordinator receives push-back from a facility, notify your agency supervisor, MFP Department (DRS, IDOA, DMH, DD) Lead and the MFP Project Director.

1E When do the transition coordinators receive the potential participant referral list? Who will TCs receive the list from and how will this information be disseminated?

Transition Coordinators (TCs) will receive referrals in the MFP WebApp on their "Unassigned" Cases view. The referrals aresubmitted from the online referral form located at: https://mfp.hfs.illinois.gov/mfpreferral.aspx

If you need more names for your outreach, inform your State contact person.

1F Will there be any referral duplications amongst the agencies?

There should not be duplications. However,it's not impossible.

1G When will a letter be sent to pharmacies notifying them about MFP?

Notices went out to Pharmacies and Nursing facilities on March 25,2009 informing them of the Money Follows the Person (MFP) Rebalancing Demonstration. The NFs were reminded of the importance of making sure medications are sent home with Participants and pharmacists were instructed on how to request a lift on the Refill Too Soon edits for MFP Participants. Please note this policy exception is only for MFP Participants.

Transition Coordinators should communicate with the pharmacies about one week prior to the Participant's planned discharge sharing the pharmacy notice, recognizing that the notices do not always get to the right person. The week advanced notice is needed to assure enough time is available to lift edits. This notice is available on the HFS website at http://www.hfs.illinois.gov/assets/032509n1.pdf.

General Questions

1H Will there be another program to serve the needs of MFP participants after the demonstration ends?

The HCBS waivers and mental health state plan services should provide vehicles for continued services.

1I Who do we notify about consumers that are on the referral list who we know are inappropriate? (e.g., already transitioned, age limit, deceased, or otherwise inappropriate based on earlier contact).

This information is critical for HFS to know as soon as possible.
If a Transition Coordinator discovers a referred participant is no longer at the nursing home (discharged or deceased), they should send the case back to HFS for triage in the webapp.

Also, TCs should submit the Case Contact form as usual for referrals that they were unable to contact.

1J Beyond the MFP program, are there any additional resources to which MFP participants have access?

Any person who receives community services should be assessed to identify all risks and needs. Linkage and referrals to other services should be made even if the services are not available under the MFP program. This may include a wide variety of resources, such as mental health, alcohol and substance abuse, medical services through Medicare and Medicaid, Older Americans Act programs through the local Area Agency on Aging, faith-based and community resources.

1K What if someone wants to transition from a nursing home into a different area within the state? How is this handled?

The participant should have the choice of where they want to live. Transition coordinators will need to work together to develop a plan for transition. IDOA, DRS, DD and DMH will all handle this situation slightly different. This process should be coordinated with your division lead, agency supervisor, staff at the new agency where the participant will be transferred and UIC staff.

1L What is the agency's responsibility after a MFP participant's demonstration year is up?

The MFP participants will be followed through the life of the MFP demonstration program. Each state agency or division has its own process for continuing to follow and provide home and community based services. Do NOT dis-enroll participants when they complete their transition year. Their cases will be updated to "365 Complete" by state/UIC admins in the WebApp.

1M Can someone be enrolled in MFP after reintegration is complete?

Yes, participants can be eligible for a second transition. Contact UIC and state leads to confer on these cases prior to enrollment.

General Questions

1N How long will an MFP case be open? For instance, if an MFP referral is placed on a waiting list for housing for 3-4 years.

The case may remain open as long as housing is being actively pursued and the participant continues to choose to move to the community during the demonstration period.

1O What happens to the participant after the end of the 12-month demonstration?

The participant will continue HCBS waiver services or Mental Health services (whichever applicable) and care/case management or coordination will continue through the life of the demonstration as long there is a continued need and Medicaid eligibility. Each state department/division has a process to continue following the participant.

1P Are nursing homes compensated or do they receive any incentive for meeting an independent living quota?

Nursing homes are responsible for participating in discharge planning activities but they are not compensated under the MFP initiative.

1Q Can a person be enrolled in MFP after their reintegration process has already been started?

Yes, as long as they have not already transitioned and meet all other MFP criteria. (see MFP participant eligibility)

1R Where can I find a list of licensed nursing facilities in the state of Illinois?

You may obtain this list at the Illinois
Department of Public Health website http://www.idph.state.il.us/

Once you reach the homepage for IDPH, click on "A to Z topics" on the left and scroll down to "nursing homes" (under section "N") and select "Nursing Homes, A listing of Illinois". Now you will select the county or city you want to search within. A listing of licensed nursing facilities that exist within that city or county should be showing.

1S How much SSI do nursing facility residents receive?

When a person is in a LTC the only SSI they are entitled to is $30. Once in the community they will likely be eligible for more.

MFP Eligibility

3A What are the enrollment criteria for MFP?

MFP requires that participants meet the following criteria:
•Qualified institutional stay of at least 3 continuous months*
•Medicaid eligibility/benefits 1 day before transition
•Nursing Facility Level of Care
•Willing to transition to Qualified community setting
•Illinois resident
*A Qualified individual must reside as an inpatient in an institution for 90 consecutive days (this may now be several institutions where a patient has transferred to/from, but resides in for a total of 90 consecutive days - including Hospital, Psychiatric Hospital, Nursing Home, ICF-MR, or a PRTF.

3B If someone's Medicaid eligibility changes (such as if they were to receive an inheritance) how does that effect MFP eligibility?

MFP requires that the individual meet Medicaid eligibility. If the individual has more income or assets than allowed under Medicaid eligibility, the individual will not be eligible for the MFP program.

3C Is it required for an MFP participant to have a DON score of 29 or higher?

The DON applies only to those in the Aging and DRS programs. MFP requires that the persons meet the eligibility requirements for nursing home admission or HCBS waiver services. Persons that score less than 29 points on the DON do not qualify for nursing home care or home and community based care. While they may have needs, it is not enough to qualify for government-subsidized programs and they are not eligible for federal matching dollars.

Forms and Processes

4A What is the forms submission process?

The online data system is available: http://mfp.medicaid.illinois.gov. Please submit all MFP forms online. If you have questions about the online forms, contact your UIC contact person.

Informed Consent and Quality of Life Surveys should be faxed: Attn: UIC to: 217-586-6059

If you are unable to fax, please copy the forms for your records and send them in the mail to:

UIC College of Nursing
Attn: Cheryl Schraeder
P.O. Box 718
Mahomet, IL 61853

Forms and Processes

4C When does the actual 365 day clock start? Is it the date of enrollment on Form B or is it the date they actually transitioned?

The 365-day clock begins on the day of transition to the community. Transition coordinators should complete Form C - Transition form on the day of transition or within 48 hours after transition. Form C should never be completed prior to transition.

4D Are the guidelines given on the process flow absolute (i.e. does so-and-so have to happen on the first and second visit, etc.)?

Not necessarily. Use your own judgment and follow the participant's lead.

4E What do we do about inaccurate referrals on the HFS referral list?

Inaccurate referrals (deceased, discharged, not Medicaid eligible) should be sent back to HFS for triage in the WebApp.

4F What if a person changes their mind and no longer wants to enroll in MFP after a first contact form is completed?

As long as the person never completed the Informed Consent and therefore never enrolled in MFP, the Transition Coordinator should enter a new case contact with an outcome that describes the person's current situation. If the person did enroll by completing an informed consent, then they should be disenrolled from MFP using Form D.

4H What does "LOC Assessment" mean?

LOC = Level of Care. For Aging and DRS, the DON (Determination of Need) establishes the level of care. If a person has 29 points on the DON, then they are eligible for nursing home level of care. However, they have a choice, nursing home or home and community based care. The LOCUS, completed by a resident reviewer, establishes the level of care for DMH.

4I If we have been working with a consumer for 8 months, do we enroll them in MFP and do a new DON, or change the date of the DON to match the MFP forms?

No, you do not have to do a new DON if the consumer's situation has not changed. You would also never change the date of a DON. You should proceed with MFP enrollment and list the date of most recent assessment and the scores from that assessment on the MFP enrollment forms and complete the MFP Risk Assessment and Mitigation Planning process.

4J Why aren't home-delivered meals listed under IDOA services on Form C, but are listed under DRS?

Home delivered meals have been a service in the DRS waiver for years, but most participants likely have the PA prepare the meals.
The Department on Aging does not have home delivered meals as a waiver service. Most of the Area Agencies on Aging Older Americans Act offer home delivered meal programs. There may also be other locally sponsored meal programs. Similar to DRS, CCP homemakers are likely to prepare meals.
MFP Participants are not restricted to only the services on the list on Form C, but these are the ones eligible for enhanced match during the first year post transition.

Forms and Processes

4K Will there be a print option for the online forms? How will the participant receive a copy of the form when they ask for it?

Online forms can be printed. Use your browsers Print function on the file menu or right click on the screen and select Print. Participants should have a copy of their Informed Consent, Form G- Medication Chart, Form J -Mitigation Plan, Form K- Back Up Plan, and Form L - Personal Resource List. The WebApp has printable reports for these documents.

4L What forms do you need to complete once a consumer re-enrolls in MFP?

If a consumer disenrolls and then re-enrolls all forms must be completed and updated. Notify UIC so the participant's status can be updated in CRM Webapp from Dis-enrolled to Enrolled. A re-enrollment date will be added to Form D.

4M What if we are unable to fill forms out online due to a disability?

Contact your Department head for reasonable accommodation requests.

You may request printed forms be mailed to you. The detailed instructions for ordering forms are posted at http://www.hfs.illinois.gov/handbooks/ go to Chapter 100 and Appendix 10-11.

In order to receive forms from HFS, you must submit an HFS 1517, Provider Forms Request, at least three weeks in advance. The request may be faxed, mailed or ordered online as follows:

Fax Number: 217-557-6800

Mail-in Address:
Illinois Department of Healthcare and Family Services
Medical Desk, HFS Warehouse
2946 Old Rochester Road
Springfield, Illinois 62703-5659

On-Line Order at: http://www.hfs.illinois.gov/forms/

When completing the HFS Form 1517, please use your phone number in place of the provider identification number. It is also very important to include your name, a full address (No PO BOX) and a zip code.

If you are completing paper forms, fax completed forms to UIC at 217-586-6059.

Informed Consent

6A Will additional training be provided for the Informed Consent?

No. This was covered in the original TC trainings. There are instructions and guidelines online: http://nursing-mfp.webhost.uic.edu/process/forms/MFP_InformedConsent_Procedures.pdf. Specific questions should be directed to UIC staff or agency supervisors.

Informed Consent

6B When do we complete the informed consent?

Complete the Informed Consent with the MFP participant after they have decided to enroll in the program and you have determined that your agency can facilitate their transition with the supports available. The date the Informed consent is completed is the enrollment date in MFP.

6C Who is keeping the original informed consent? Would this be the agency?

When the transition coordinator completes the Informed Consent with the participant, they should take two copies and have the participant (or their legal guardian or proxy) sign both copies. One copy is left with the participant and the transition coordinator keeps the other original on file. Page 2 should be faxed to UIC.

6D What information should be recorded on the Informed Consent for reporting abuse, neglect and exploitation?

IDoA, DRS, DMH
Adult Protective Services
1-800-252-8966 (V)
1-800-206-1327 (TTY)

DDD (CILAs):
Office of Inspector General (OEIG)
1-866-814-1113

6E In the Informed Consent, on page 2 under "Information, Surveys, and Confidentiality" it states that there is a risk that the participant might not be able to return to a nursing facility. What does this mean?

This means that in the event they need to go back to a nursing facility they might not be able to go back to the same facility they were in before they moved (e.g., if there are no beds available there).

Risk Assessment and Mitigation Planning

9A If an MFP participant has frequent, uncontrolled ER visits, where does MFP draw the line to re-institutionalize the participant?

Part of the quality assurance activities will include analysis of emergency room visits and non-avoidable hospitalizations. Risk mitigation plans should be reviewed to assure that proper supports are available including assurances that medical appointments are confirmed, persons are following medical treatment plan, awareness and use of the 24 hour nurse, referrals as needed. Every effort should be conducted to assure that the person understands their plan of care, risks and compliance expectations. The choice of returning to the institution would be that of the participant, except in extreme cases.

Risk Assessment and Mitigation Planning

9B How often do you reassess an MFP participant whose case is pending?

Reassessment isn't necessary if they are in the nursing facility, unless they have changes in their situation that warrant a change in the mitigation plan. In this case all assessment forms should be updated. Also, follow your departmental guidelines for completing reassessments.

Billing Questions

10A How is the time I spend on MFP billed to Medicaid? What is Medicaid billable?

Time is not billed to Medicaid directly, but will be billed based on activities defined by the operating agency for assessments and case management activities.

10B How many hours are transition coordinators allowed to clock for their time on a case? How much money do transition coordinators receive per assessment?

Case management activities, billing and fees are determined by the operating agencies. Direct this question to your agency lead for your agency specific response.

Housing

11A What is qualified housing under MFP?

Home owned or leased by the individual or a family member of the individual
Apartment with individual lease, secure access, and living, sleeping, bathing and cooking areas over which the individual or his/her family has control
Community-based residential setting with no more than four unrelated individuals
Supportive living facility in Illinois

11B Are we able to transition people from ICF/MR Housing?

The Department of Human Services, Division of Developmental Disabilities will be taking the lead on ICF/DD transitions. They are active in MFP effective January 2012.

11C Can we transition persons out of a SLF for Money Follows the Person?

The primary transition for MFP must be out of a Nursing Facility into a community-based setting, so no. However, if during the transition year an MFP participant were to wish to move from a SLF to an even more independent setting, then the transition coordinator should assist with the relocation arrangements as much as possible, including adjustments to all aspects of the mitigation plan. The new residence must still meet the approved housing requirements for MFP for the duration of the demonstration year, else the participant would need to be disenrolled.

Quality of Life Survey

12A Who completes the Quality of Life (QOL) survey?

The transition coordinator must complete the Quality of Life survey within one month to one week prior to transition. UIC will complete Quality of Life surveys at one and two years post transition, except in DDD where the TC completes the follow up surveys.

Quality of Life Survey

12B What happens when a potential participant refuses to complete the QOL?

Individuals do not have to complete the QoL, but if they do not there is an alternate document that must be completed. If a MFP participant refuses to answer the Quality of Life survey, it remains critical that the transition coordinator be aware of how the participant is doing. The completion of the Quality of Life survey is only one effective mean to obtain that information. Contact Mary McGuire at Mary.McGuire@illinois.gov with questions.

Critical Incident Reporting

13A What is the critical incident reporting process?

Critical Incident Reports (Form M) are completed in the online system. When a TC learns of a critical incident, they should complete the form as soon as possible. There is also a section on the incident report for the TC supervisor (agency supervisor) to complete their Internal Review of the critical incident. Next, a critical incident conference should be scheduled with your UIC staff contact. UIC will complete an external review of the incident after the review conference.

13B Currently, an MFP TC is aware of a consumer who is displaying alarming behaviors that are extremely detrimental to their health and wellbeing. Although she has notified the behavioral health center, the Div. of Rehab Services and other local healthcare providers, no one will intervene to help this person with their extreme depressive behaviors. In a situation like this, what else can she do to get help?

We plan to have an interagency committee review extraordinary cases. Please contact your agency lead and U of I staff contact to request a special review of this case.

Educational Materials

14A Will the participant education tools be accessible, i.e., available in Braille, large-print and audio format?

Specific requests for reasonable accommodations should be sent to your State contact and will then be directed to UIC staff for follow-up.

DRS Specific

15A How is MFP different from CRP?

MFP is a federal demonstration program that allows the state to test ideas and implement strategies to improve Home and Community Based services. In addition, the State receives an enhanced match for certain services. CRP is a state funded program. Plus, through MFP, consumers get intensive case management follow-up from their MFP transition coordinator. Those that participate will provide an opportunity for the state to earn additional federal dollars that can be used to improve community living opportunities and resources for others.

MFP

- Consumer needs to be on Medicaid at least 24 hours before transition
- Over 29 on DON
- In Nursing Facility at least 90 days
- Ages 18-59
- CILs retain case management for up to 1 year post discharge from the nursing home

CRP

- Consumer needs to be on Medicaid or submit an application to be on Medicaid
- Scored at least 29 on the DON to receive home care, but can receive up-front funds to transition if less than 29 points
- In Nursing Facility less than 90 days
- Ages 18-59, unless TBI or HIV/AIDS
- CILs retain case management for up to 1 year post discharge from the nursing home. For Under 29 cases, CILs retain case management for up to 3 months post discharge from the nursing home

15B What can we do to make the client want to enroll in MFP over CRP?

Through MFP, consumers get intensive case management follow-up for one year from their MFP transition coordinator. Those that participate will provide an opportunity for the state to earn additional federal dollars that can be used to improve community living opportunities and resources for others.

15C How will CRP and MFP paperwork tie together?

MFP paperwork is required for the demonstration. We want to make every effort to avoid duplicate efforts, but hope you understand that the federal requirements of the MFP program will mandate certain documentation.

15D For those in the nursing facility that are under CRP and have been in for 90 days do you switch them over to MFP?

You can do that after explaining the benefits of the demonstration and as long as they have not yet transitioned to the community.

15E If a person is in CRP and then hits the 90-day mark and we complete the MFP forms, do we still fill out Form A, since the case has been open for such a long time, if so, what date is used?

The date of First Contact on Form A is the date the participant was first contacted for MFP which must be after the "MFP roll-out date" for your Division/Department.

DRS Specific

15F Will MFP case management be transferred from the CIL to the local DRS office after a certain amount of time?

No. The CIL will maintain the case indefinitely. Our HSP state staff have not been trained on MFP therefore those cases will remain with the CIL.

15G Is there a possibility of a partnership between DMH and DRS to provide more comprehensive waiver services for persons with physical disabilities and mental illness?

Yes. The MFP program will give us an opportunity to work collaboratively.

15H What is the IDoA age limit ?

The Department on Aging serves clients age 60 and older.

15I What are the requirements for DRS consumers to be transitioned into a SLF?

Adults between the ages of 22 and 64 can be residents of SLFs that are specifically designated for adults with physical disabilities. For example, there is a SLF in Springfield specifically for the blind. Unfortunately, there are very few of these designated SLFs in the state. Also, if the physically disabled adult has a co-occurring MI diagnosis they would not be eligible for these SLFs, because SLFs in general do not accept any individuals with MI. Physically disabled adults cannot be served in SLFs designated for seniors, which is most of the SLFs in the state.

Disenrollment

17A What is the length of time before an MFP participant is disenrolled from the program?

Enrollment in MFP is 365 days. MFP participants that experience out-of-community experiences, such as hospitalizations and/or transitions back to a nursing home for 30 or more days, should be disenrolled from MFP using Form D. They would remain eligible for re-enrollment into MFP for the balance of the original demonstration year. In other words, if someone were transitioned on April 1, 2009, their demonstration year would begin on that day and end on March 31, 2010. If they were reinstitutionalized on June 1, 2009 for 30+ days they would be disenrolled from MFP but would remain eligible for reenrollment until March 31, 2010. The original 365-day clock for MFP does not restart. The TC could contact him occasionally during his or her facility stay to monitor the likelihood of a successful re-transition. If a discharge occurs before the end of the 365 days, the TC would reevaluate his risks and assist with the transition process again. Since they are enrolled in the HCBS waiver their services would continue after the 365 days but TC case management would discontinue and the participant would transfer to another existing case management program. Do not "disenroll" MFP participants from the online system at the end of the demonstration year.

When the MFP participant experiences a hospitalization and/or nursing home stay of less than 30 days, they are not disenrolled in MFP and the 365 day clock continues.

17B If an individual is disenrolled then re-enrolls and is re-transitioned to the community, does this person receive their initial funding again?

The person would be reassessed and a plan would be developed to meet their needs.

DMH Specific

18A Why isn't mental health being covered all over the state of Illinois?

Like Aging, Mental Health is phasing-in MFP enrollment. By the last year of the MFP demonstration, it is anticipated that all programs will have state-wide coverage.

18B Who covers mental health participants?

MFP Mental Health Transition Coordinators and Community Mental Health Centers

Miscellaneous

19A Who would a Transition Coordinator contact when requesting reasonable accommodations?

Communicate requests for accommodations to your Division/Department contact who will review the request and provide a recommendation:

See the Current MFP Lead contact list at: http://mfp.nursing.uic.edu/mfpweb/contact.pdf

19B Is there going to be training for legality issues regarding PoA, guardianship, etc.?

There is an educational module that discusses legal issues in healthcare. Contact UIC for a copy or access it here: http://nursing-mfp.webhost.uic.edu/education/legal/MFP.LegalIssues.Modulel.pdf

19C How do we get a birth certificate for a person who doesn't have a picture ID?

Birth certificates can be accessed for a fee at the County Court house in the county/state where the person was born.

19D Will the state need any documents showing that the consumer has completed programs such as AA, Narcotic Anonymous, etc.?

No.

Miscellaneous

19E What are advance directives?

What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on.

A living will tells how you feel about care intended to sustain life. You can accept or refuse medical care. There are many issues to address, including

* The use of dialysis and breathing machines
* If you want to be resuscitated if breathing or heartbeat stops
* Tube feeding
* Organ or tissue donation

A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions if you are unable to do so. (Source: http://www.nlm.nih.gov/medlineplus/advancedirectives.html)

Medicare and Medicaid

20A What is a SLF?

The State of Illinois developed the Supportive Living Facility (SLF) Program as an alternative to nursing home care for low-income older persons and persons with disabilities under Medicaid. By combining apartment-style housing with personal care and other services, residents can live independently and take part in decision-making. Personal choice, dignity, privacy and individuality are emphasized in this community based setting.
To test the concept of supportive living for Medicaid clients, the Department of Healthcare and Family Services obtained a HCBS "waiver" to allow payment for services that are not routinely covered by Medicaid. These include personal care, homemaking, laundry, medication supervision, social activities; recreation and 24-hour staff to meet residents' scheduled and unscheduled needs. The resident is responsible for paying the cost of room and board at the facility.
There are four SLFs (Supportive Living Facilities) for persons with physical disabilities: two are specifically for persons with visual impairments. We recently requested providers to apply to open SLFs for persons with disabilities. So, there could be a chance that this service would be an option for DRS participants. There are many SLFs for IDoA participants.

20B What are the other payer designees aside from HFS?

Doral Dental and First Transit

20C For dual-eligible participants, who is billed first?

Medicaid and Medicare cover different services including.
If the participant is over 65 years old and eligible for Medicare, Medicare is billed first and Medicaid is the secondary payer.

Medicare and Medicaid

20D When a person has Medicare as primary and Medicaid as secondary and Medicare does NOT pay for a service but Medicaid does--how do you get it covered?

The person must request the service from Medicare and send the denial letter to Medicaid with the Medicaid required prior approval and then it will be authorized.

20E What is the number to the HFS Nurse hotline?

Medicaid recipients can call the Nurse Helpline if they have a medical problem and can't reach their doctor. The hours are 6:00 p.m. to 7:00 a.m. Monday through Friday and 24 hours a day on the weekends. A nurse will answer your medical questions. The nurse can also help you decide if you need to go to the Emergency Room or call 9-1-1 (if available in your area).
Toll-Free: 1-877-912-1999
TTY: 1-866-565-8577

20F Are MFP participants eligible for home health care?

Medicare only pays for Home Health Care if the person is homebound. Medicaid pays for Home Health Care with a physician's order and "prior approval".

20G What is the definition of "home-bound"?

The person does not leave the home for ANY reason-including doctor visits.

20H What is a "home assessment" for home health services?

A "Home Assessment" Visit is a service provided by a Home Health Agency enrolled with HFS. The "Home Assessment" visit does NOT require prior approval. The "Home Assessment" is conducted by a registered nurse from the Home Health Agency who assesses the participants' condition and determines the level of care needed based on information received from the attending physician and information from the home assessment.

20I How can we get a home assessment completed for MFP participants?

The MFP Transition Coordinator (TC) first requests the Nursing Home M.D. (or community primary care physician) to write an order for an initial "Home Assessment RN Visit" to be conducted upon transition.
T.C. contacts a Home Health Care Agency that is enrolled with HFS to conduct the initial "Home Assessment Visit" which does NOT require prior approval. The Mitigation Plan/Plan of Care should state that "services are needed to facilitate transition from nursing home to community and prevent the necessity of in-patient long-term care".

Medicare and Medicaid

20J What are skilled nursing services and are MFP participants eligible to receive them?

Skilled Nursing Services are services ordered by the physician and are provided in the participant's home by licensed nursing personnel. Services include initiation and implementation of restorative/palliative nursing procedures, coordination of plan of care and patient/family education. After a "Home Assessment" is completed, the Home Health Agency will complete the Medicaid "Prior Approval" form and create a plan of care for all applicable services for that participant. The Home Health Agency will contact the physician for orders for these services. Services shall be provided for participant under direct order of the Primary Health Care Practitioner (MD, NP, PA) and in accordance with the Plan of Care (CMS/HCFA 485) and reviewed by the Practitioner at least every sixty (60) days. The Home Health Agency will revise the Plan of Care as needed.

20K What are Home Health Aide services and are MFP participants eligible to receive them?

Home Health Aide services include the performance of simple procedures or services as an extension of therapeutic services; ambulation and exercise; personal care; household services essential to healthcare at home; and assistance with medications that are ordinarily self-administered. Home Health Aide Services can be provided by RN, LPN or CNA. Need for Home Health Aide services must be established in the initial "Home Assessment Visit", written in the Plan of Care, ordered by the physician and receive prior approval. The Home Health Agency conducting the "Home Assessment Visit" will write the Plan of Care, obtain the physician's order and obtain prior approval for the needed services.

Medicare and Medicaid

20L What is a Home Assessment for therapy services and how can we get them completed for MFP participants?

A "Home Assessment" Visit is a service provided by a Home Health Agency enrolled with HFS. The "Home Assessment" is conducted by a therapist (physical therapist, occupational therapist and/or speech therapist) from a Home Health Agency who assesses the participants' condition and determines the level of care needed based on information received from the attending physician and information from the home assessment. PROCESS: The MFP Transition Coordinator (TC) first requests the Nursing Home M.D. (or community primary care physician) to write an order for an initial "Home Assessment PT Visit" (or OT Visit or Speech Therapy Visit) to be conducted upon transition. The T.C. contacts a Home Health Care Agency that is enrolled with HFS to conduct the initial "Home Assessment Therapy Visit" which does NOT require prior approval. The Mitigation Plan/Plan of Care should state that "services are needed to rehabilitate patient to independent self-care" and "facilitate transition from nursing home to community and prevent the necessity of in-patient long-term care".

After the "Home Assessment" is done, the Home Health Agency will complete the Medicaid "Prior Approval" form and create a plan of care for all applicable therapy services for that participant. The Home Health Agency will contact the physician for orders for these services.

Physical Therapy Services are ordered by the physician and provided to the participant by a qualified physical therapist or assistant under the supervision of the physical therapist. These services include but are not limited to, range of motion exercises, positioning, transfer activities, gait training, use of assistive devices for physical mobility and dexterity. These services must be provided by a Home Health Agency (with PT services) that is enrolled with HFS.

Occupational Therapy Services are ordered by the physician and given by a qualified occupational therapist or occupational therapist assistant under the supervision of an occupational therapist for the purpose of developing and improving the physical skills required to engage in activities of daily living.

Speech Therapy Services are ordered by the physician for individuals with speech disorders, or swallowing disorders, and provided to the participant by a qualified speech pathologist and/or speech assistant under the supervision of a speech pathologist for individuals with speech disorders which include diagnostic, screening, preventive or corrective services.

Medicare and Medicaid

20M A nursing facility has said that PT/OT evaluation and treatment is not covered by Medicaid, is that true?

The facility is refusing to provide the services because the nursing home is "paying" for it in a sense. If the nursing home has a PT/OT department within their facility they must provide the service. Medicaid does not reimburse because the service is available by salaried nursing home staff. However, the nursing home MUST provide the service with a doctor's order. Process: Request the participant's MD write an order for "PT/OT evaluation and treatment". Ask for this order to facilitate transition from nursing home to community and prevent necessity of in-patient long-term care. If the nursing home does NOT have a PT/OT department within their facility then HFS will pay. The nursing home needs to contact an outside PT/OT agency for the services and the agency will bill Medicaid. (Need MD order)

20N How do we obtain durable medical equipment (DME) for MFP participants?

DME must be ordered (written script) by physician.

Provided by an HFS enrolled Medical Equipment Supplier.

May or may not need prior approval, depending on type of equipment requested. The HFS enrolled Medical Equipment Supplier can apply for Prior approval.

20O Is there a special process for expedited approval, versus prior approval, for durable medical equipment?

This is further detailed in the Chapter 200 DME Handbook. See below for an excerpt.

Expedited Approvals: Expedited telephone approval may be obtained for items or supplies that must be delivered immediately (within 24 hours of request). Examples would include items, which are needed for hospital or nursing home discharge. Expedited approval may be requested by calling the phone number listed on the previous page.

When medical supplies or rental of equipment are approved on an expedited basis, coverage will be for a maximum of one month. If the item or supplies are needed for longer than one month, continuing approval must be requested via phone, fax or mail, or electronically, as described above, and must be fully documented as described in Topic M-211.2.

20P What does "hand priced" mean in reference to DME?

Hand priced refers to a claim submitted to HFS that requires an explanation, such as an operative report, of the service performed. The claim and accompanying medical documentation is manually reviewed in order to determine what HFS will pay for the service.

20Q Is it known when Doral providers begin taking new patients?

No. Since this can change on a frequent basis, it is hard for HFS, or its contracted program administrators, to track whether or not a dental or medical provider is accepting new patients.

Medicare and Medicaid

20R Is it possible to request prior approval for ongoing transportation services only once, rather than each time?

First Transit may grant standing prior approval for certain services, but keep in mind some may not be applicable. Standing prior approvals for non-emergency transportation are available for physical therapy, speech therapy, occupational therapy, chemotherapy, radiation therapy, behavioral health and renal dialysis. In addition, upon request by First Transit, HFS may authorize a standing prior approval override for a maximum of six (6) months for other treatments, such as, wound therapy and chronic obstructive pulmonary disease.

20S How frequently is the HFS Preferred Drug List updated?

At a minimum, the Preferred Drug List (PDL) is updated quarterly. Additional updates may be issued between quarterly updates as needed. To receive electronic notification when the PDL is updated go to: http://www.hfs.illinois.gov/pdl/pdlform.html

20T What type of psychological evaluations are covered for MFP participants?

If nursing home psychiatrist accepts Medicaid he/she should be able to bill. Neuropsych evaluations are covered by Medicaid in some situations.

20U Are in-home mental health services available?

These are not reimbursed by Medicaid. These services may be available through the Department of Human Services, Division of Mental Health.

20V If a resident is on "spend-down" status, does this qualify as Medicaid eligible under MFP?

In order for Medicaid to begin paying for assistance, an individual can only have $2,000 or less in assets, known as the $2,000 asset disregard. A person may be enrolled in MFP while still meeting a spend-down requirement and transition coordinators are encouraged to work with individuals with this scenario. However, before an MFP enrollee can transition out of a nursing facility under MFP, they must have spent down to the $2,000 minimum threshold and be formally receiving Medicaid benefits for a minimum of 30 days prior to discharge.

20W I received a claims file from UIC/HFS regarding a participant I am working with. What do I do with this and who can I share it with?

The claims contain a 2-year history of Medicaid billing information and includes hospitalizations and ER visits, institutional admissions and discharges, diagnoses, medications, nursing facility services and providers. The claims file can be used to generate questions to ask the participant and any caregivers, family members and/or medical staff who are currently providing care to the participant and can assist with developing a comprehensive mitigation plan.. Since it contains protected health information (PHI) it should not be shared with anyone. If you have questions about any of the information in the claims file, contact your UIC staff contact.

Managed Care Program Coordination

22.1. Any new changes in outreach and in the referral process for Colbert transition engagement specialists?

No, there is no change to the current process for Colbert Transition Engagement Specialists.

22.1. The Colbert goal for 2015 should be revised. We still have our mandated Colbert goal to transition a total of 1,100 Class Members this year. With 600 already transitioned we still need to transition 500, most of which will be eligible for MFP.

The PowerPoint is listing only the MFP projected transitions, not the overall Consent Decree projections/requirements.

22.1. How will you coordinate the MCO's into Colbert with Illinicare and Aetna, as they are responsible by contract to transition individuals in Cook County as well?

The Illinois Department on Aging is responsible for Colbert oversight and administration. Additional guidance will be provided as it becomes available.

22.1. Why is Colbert not included as part of care coordination on slide 9?

Colbert has its own separate model. The MFP and Managed Care program coordinated process only involves MFP participants outside of Cook County.

22.2. Within the DD system....who is the MFP provider who will receive the incentive payment? E.g., CILA Provider? Individual Service Coordination Agency?

To be determined. However, DD waiver services are currently carved out of Managed Care.

22.2. Will there be an updated flow chart for non-MCO participants who have a DD diagnosis?

DD flowcharts are developed separately.

22.3. Who are the MFP providers that will be awarded the incentive money?

The MFP agency with the lead transition coordinator. This includes IDOA Case Coordination Units (CCUs), DHS-DRS Centers for Independent Living (CILs) and DHS-DMH Community Mental Health Centers (CMHCs).

22.3. Will incentive payments only apply to new MFP enrollees who enroll on or after Feb 1st?

Yes, only cases that are enrolled in an MCO and enroll in MFP on or after Feb 1, 2015 are eligible for the incentive payments.

22.3. Do the incentive payments apply to cases retroactively, e.g., MFP customer transitioned in December and is still in community at the 3 month level and the 12 month level?

No, Only cases that are enrolled in an MCO and enroll in MFP on or after Feb 1, 2015 are eligible for the incentive payments.

22.3. If a participant is enrolled prior to February 1st 2015 but does not transition until after Feb 1, 2015, will they be eligible for the incentive payment?

Only cases that are enrolled in an MCO and enroll in MFP on or after Feb 1, 2015 are eligible for the incentive payments.

Managed Care Program Coordination

22.3. What happens if a person enrolls in MCO after MFP enrollment? Are they eligible for the incentive payment if the participant enrolled in MFP after Feb 1, 2015, is still awaiting transition and enrolls in the MCO prior to transition?

If an individual is enrolled with an MCO at the time of the transition to the community, the MFP provider will be eligible to receive incentive payments.

22.3. Does the incentive payment go only to the agency or is there some provision specifically for the TC?

The incentive payment is made to the MFP provider agency. Utilization of the incentive payment is the decision of the MFP provider agency once it has been received.

22.3. How will incentive payments from MCOs get to the CCUs? Will IDOA invoice the MCOs and then generate a payment to the CCU? I need to have a way to track this and record revenue/income to my VP of finance.

This policy and process will be developed in the contracts. MFP providers and MCOs will need to coordinate with one another and enter into contractual agreement to enable the transfer of incentive payments from the MCO to the MFP provider.

22.3. With the $1,000 the MCO's are paying at 3 months and 12 months, if the participant transitions to another county, which county would receive the funding?

The MFP provider agency that is the lead assigned to the case at the time of the 3 month or 12 month mark is the agency that is eligible to receive an incentive payment. In other words, the MFP provider serving the county where the MFP enrollee is residing at the 3 and 12 month marks.

22.4. If an individual referred for MFP then refuses MFP participation does that preclude them from transitioning to community? Or can MCO proceed with transition to community?

MFP is and always has been optional so the participant would still be free to transition with the MCO alone. Individuals can refuse MFP at any time. However, an MFP referral is still required for all potential candidates to enable an MFP provider to provide the individual with information on the benefits of the MFP program.

22.4. After months 3-12 (monthly visit), how often are MFP visits conducted?

The MFP program lasts for 365 days. After that, it depends on agency and division policy. MFP policy is that individuals should be transitioned directly into the appropriate Home and Community Based Waiver or Mental Health State Plan services package after completing the MFP year.

Managed Care Program Coordination

22.4. How will we know if the participant is enrolled with an MCO?

The MCO enrollment is on the participant's case page in the webapp with the Referral Summary. It states which MCO, if any, the participant is enrolled with. Every referral is updated with current MCO enrollment information at the time the referral is received. HFS is also
developing a behind-the-scenes process to make frequent updates to reflect MCO enrollment changes post-referral.

22.4. Of the 603 transfers for 2013, you mentioned earlier, what is the mortality rate?

603 transitions was for 2014 and UIC is currently working on a cumulative mortality report. The rate is low though. In 2013 for MFP only (not Colbert) it was 6%

22.4. If a person is living in a county with One of these other entities such as Accountable Care Entities, do we follow this same flow chart in serving an MFP client?

HFS is planning to continue to develop policy on this

22.4. We don't have managed care in our area except for Stark county, but what would be the ramifications if we had an MFP participant who is enrolled in an MCO transition into our area from another area that does have MCO and we are responsible for the follow-up?

If an MFP individual transitions into an MFP provider's county the new MFP provider is expected to coordinate and collaborate with the MCO as outlined in the process flowchart. The new MFP provider is eligible to receive the incentive payments if the person remains in the community at 3 and 12 months post transition.

22.4. Will a copy of this Power Point be made available?

The materials from this meeting are posted at this URL: http://nursing-mfp.webhost.uic.edu/mco.shtml

22.4. How do we know if a referral has been made by an MCO?

In the WebApp, the MCO enrollment is on the case with the referral summary on the case screen. The source of the referral, or referral type, is also listed.

22.4. Please provide examples of Long Term Care Services and Supports that MCO's will arrange

MCOs are responsible for the approval of all community based Long Term Care Services and Supports (Waiver and Mental Health State Plan services) for their enrollees with the exception of Developmentally Disabled waiver services. At this time DD Waiver services are carved out of Managed Care.
The MFP provider and MCO are expected to work closely together throughout the MFP process, especially during the pre-transition planning process. The MFP provider is responsible for working directly with the potential MFP candidate and UIC-CON to develop a care/service plan, with input from the MCO. The MCO is required to be involved in MFP staffings throughout the process

Managed Care Program Coordination

22.4. Can you review the specific MCO's you have met with to work out these details?

HFS has met with all MCOs that serve MFP eligible populations.

22.4. Do we notify case manager for individual or individuals on sheet that you gave us for MFP contacts with MCO's?

Use the contact persons on the MCO contact list posted at this URL: http://nursing-mfp.webhost.uic.edu/mco.shtm

22.4. Are we expecting that MCO clients will still have all the current MFP $ that we are able to spend and will the MCO's also have some funding to supplement if need be???

There will not be decreases in the services and supports available to MFP participants. But the MCO could be an additional
resource for funding. If additional resources are required. This should be identified during the collaborative planning pre-transition

22.4. What if they are enrolled with an MCO but it isn't updated on the WebApp?

If you know they are enrolled in an MCO but it isn't updated in the MFP WebApp, email HFS.MFP@illinois.gov with the participant's case number and the information you have so that the information can be verified and updated.

22.4. With the number of changes with MFP happening (MCOs and Bridge) are there going to be any adjustments in the number of staff at agencies for these programs?

Not at this time.

22.4. Were the follow up visit requirements changed? We have been doing twice month visits during months 2 and 3.

The requirement for frequency of follow-up contacts differs across divisions, but there have been no changes to the division specific follow up requirements

22.4. Will MCO's be arranging DME, Waiver services, etc and MFP TC buying furniture, clothing, household items, etc?

MFP providers should collaborate with the MCO to develop a transition and service plan. This includes identification of necessary Waiver or Mental Health State Plan services and one time transition services (e.g. furniture, household items, etc.). The process should take place during the MFP pre-transition planning process and pre-transition staffing with UIC-CON. The MCO must approve all Waiver or State Plan Services with the exception of DD Waiver services which are carved out of Managed Care at this time.

22.4. Will the MCO staff complete the service plans? Who completes the service plans in this new model?

The MFP provider is responsible for taking the lead in development of all required MFP form sand documentation, including identification of services required by the individual to safely transition and live in the community. This plan should be finalized through collaboration with the MCO and be included in the MCOs comprehensive care plan.

Managed Care Program Coordination

22.4. What documents will MCOs be able to attach to cases? Awards letters, DON scores, PAS screenings, I.D.s,?

MCO users can attach documents to participant cases in pdf, jpg, gif, doc, txt, xls, ppt. MCO users are expected to attach any relevant documentation which can assist with the MFP pre and post transition planning process.

22.4. Will the MCO's be doing the DONs or will TCs continue to do the DONs the same as currently done?

TCs will continue to do the DON

22.4. How are MCOs notified when we have a member that is enrolled in MFP?

Check the MFP WebApp frequently to stay current on active cases. New referrals will be shown as cases in the "Unassigned Cases" view in the WebApp. In the near future email notifications will be sent to MFP providers whenever there are unassigned cases. Once a case is assigned to a lead MFP TC, it is removed from this view.

CRM

23A Why can't I see anything on the MFP Resources dashboard?

It turns out the reason we are not seeing these iframes/webpages – security is preventing it. In IE you can change this, it's a security setting. Select Tools>Internet options>Custom level>Miscellaneous: Launching programs and files in an IFRAME. (Change to prompt, then it will prompt you to allow you to show iframes). This dashboard displays the URL for the ILHFS MFP Online Referral form and the TC Website hosted by UIC.

23B I am unable to save anything - what's wrong?

Try clearing your browser's cache/history. How to clear IE cache --
http://kb.wisc.edu/page.php?id=15141
For other browsers, use a web search to find out how to clear the cache.