UCare CT/CT + Med and MSC+/MSHO

Care Coordination and Long-Term Services and Supports

Title: Moving Home Minnesota Job Aid

Purpose: To aid care coordinators (CC) in understanding the Moving Home Minnesota program, roles and expectations.

Summary: Moving Home Minnesota (MHM) is a federal demonstration project with the goal of creating opportunities for members to move from institutions to their own homes in the community. MHM promotes the development and implementation of transition plans that reflect the preferences of those receiving services and the opportunity to receive services in the most integrated setting.

UCare covers MHM for MSC+ and MSHO members. UCare CT and CT + MED members, MHM is paid for by Fee for Service Medical Assistance.

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Lead Agency Responsibility

Lead agencies (counties, Tribes, or health plans) assign a transition coordinator to each person receiving MHM services. For members age 65 and over who are enrolled in either UCare MSHO or Minnesota Senior Care Plus (MSC+), UCare serves as the lead agency and is responsible for making a referral for transition service coordination.

Reference: DHS Provider Manual: Lead Agency Responsibilities | MHM Program Manual

Who acts as the lead agency?	
Members	Acting Lead Agency
Connect/Connect + Medicare (CT/CT+MED) members	County of Financial Responsibility (CFR) or Tribal Nation
Fee-for-Service (FFS) MA (not enrolled in managed care)	CFR or Tribal Nation
UCare MSC+/MSHO (age 65 &over) eligible for EW	Managed Care Organization (UCare)

Member Eligibility

To be eligible for MHM, a member must currently reside in one or more qualified institutions for 60 or more consecutive days. Accessing MHM services requires members to be eligible for the Elderly Waiver (EW) or a disability waiver program (CADI/CAC/DD/BI). To enroll in MHM and receive transition planning, coordination and services, the member must meet **all** of the following criteria:

- Currently residing in a qualified institution
- Continuously resided in one or more qualified institutions for 60 or more consecutive days
    - Example: A member may start their institutional stay in a hospital and then move to another qualified institution without a stay in the community. The member's stay is continuous and fulfills the 60-day institutional stay requirement.
- Enrolled in Medical Assistance (MA) before discharge from the qualified institution, with MA paying for at least one day of the institutional stay
- Maintain enrollment in MA during the time they are eligible to receive MHM services
- Desire to transition to a qualified community residence

Qualified Institution

A qualified institution can be any of the following:

- Hospital, including a community behavioral health hospital (CBHH)
- Nursing facility, including TCU
- Intermediate care facility for persons with developmental disabilities (ICF/DD)
- Psychiatric residential treatment facility (PRTF)
- Institute for Mental Disease (IMD) for people older than age 64 who reside in an IMD, to the extent the services are covered by federally funded MA as described in the Eligibility Policy Manual – Program for people living in IMDs (section 2.5.4)

Qualified Community Residences

Members receiving MHM services must transition to a qualified community residence. This includes the following:

- A home owned or leased by the member or the member's family
- An apartment with an individual lease and living areas over which the member or the member's family has control
- An assisted-living residence that provides an apartment with separate living, sleeping, bathing, and cooking areas; lockable entrance and exit doors
- A home in a residential setting in which no more than four unrelated individuals live

Moving Home Minnesota Process Flow

Member resides in Qualified Institution
- CC completes MnCHOICES Assessment
- Member must meet NFLOC/ EW eligible
- Referral to DHS for MHM

DHS Review
- DHS determines MMH eiligibility
- DHS Communicates eligiblity results or actions needed with CC

MHM Begins
- CC completes a referral to Transition Services (TS) Coordinator
- TS Coordinator begins Pre-transition services/planning

Member transitions Qualified Community Setting
- CC open member to EW and authorizes EW covered services
- TS bills for non-EW MHM services and supports

Members must have completed a MnCHOICES assessment that meets the nursing facility level of Care (NFLOC)/EW eligibility. DHS determines member eligibility and will communicate the next steps to UCare's Clinical Liaison Team and/or directly to the member's assigned care coordinator.

UCare MSC+/MSHO Care Coordinator's Responsibility

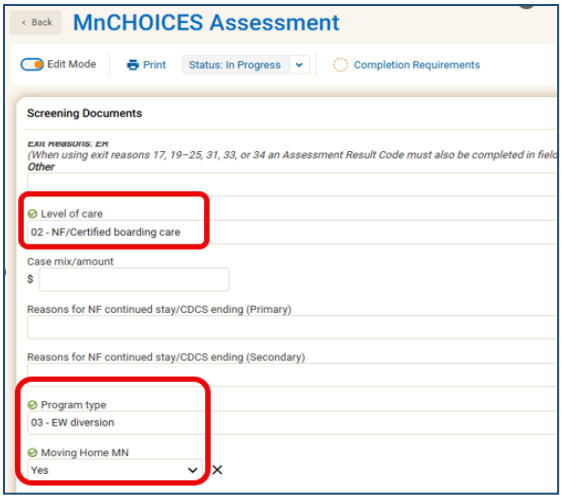
1. Complete the MnCHOICES Assessment and enter MMIS upon discharge from a qualified institution.
2. Complete the Moving Home Minnesota Referral to inform DHS and obtain approval.
3. Locate and assign, and collaborate with an MHM transition services provider.
4. Upon discharge to a qualified community residence, identify and authorize EW services using UCare's Waiver Service Approval Form.
5. Respond to DHS email notifications with needed information.
6. Notify DHS of any changes affecting MHM participation or when the person disenrolls from MHM.
7. Ensure EW authorized services follow Denial, Termination or Reduction (DTR) requirements. See Reinstitutionation During MHM Participation.

NOTE: CT/CT + MED members wanting to enroll in MHM would refer to the CFR who acts as the lead agency. The CFS completes the MnCHOICES assessment and all other MHM-related activities. CT/CT + MED care coordinators continue to assist with transition of care activities and collaborate with the community disability waiver case manager (or other case manager) and the assigned transition services provider as needed.

MnCHOICES Assessment

To receive MHM services, a MnCHOICES assessment must be or have been completed within the previous 365 days, resulting in meeting the nursing facility level of care (NFLOC)/Waiver eligibility.

- Best Practice: Ensure the selected Transition Service provider is noted in the Support Plan under People and Community Organizations That Support Me
- MnCHOICES assessment must be in one of the completed statuses (MMIS ready, pending MMIS)
  - When the member is discharged to the community, update the status to "approved by MMIS"
- MHM Indicator must be marked "Yes" as a part of the MHM eligibility process
- Complete MMIS entry upon member discharge from the institution using one of the following:
  - Activity type: 02 (face-to-face assessment), 04 (Relocation/transition assessment), or 06 (Reassessment)
  - Must have an activity date within the last 365 days | Nursing Facility Level of Care: 02



MHM Referral

Care coordinator (most common), member, family member, nursing facility staff or any other invested person with the member's permission can make a referral to the Department of Human Services (DHS) to begin the enrollment process to receive MHM transition services at any point during the institutional stay by completing the online MHM Intake Form (DHS-5032). The intake form can also be faxed to 651-431-7745 or mailed to:

- Moving Home Minnesota
  P.O. Box 64250
  St. Paul, MN 55164-0250

The MHM service begin date, which is the date the member consents to begin receiving MHM transition coordination services identified on the intake form, cannot be a date during which the member is currently receiving any other form of Targeted Case Management (TCM).

What happens next?

UCare Clinical Liaison will contact the assigned CC if the CC is not included in the DHS communication to inform of the MHM determination and/or additional next steps. Upon confirmation, if a transition coordinator is not already working with a member approved to receive MHM services, the care coordinator will need to assign one.

Locating a Transition Service Coordinator Provider

To identify transition services (TS) coordinator provider options, refer to the DHS Transition Services Provider contact list. UCare does not contract directly with transition service providers. TS providers must be registered with the Minnesota Department of Human Services to be eligible as a participating provider and be enrolled with UCare's claims payment system. TS Providers can view information on UCare's website at Non-Contracted Providers (ucare.org). Refer to the Care Coordination Manual for additional information on Elderly Waiver Service Providers.

Care coordinators and transition service coordinator providers work closely to avoid claim denials due to eligibility, exceeded service limits, or duplication of services.

MHM Covered and Non-Covered Services

MHM services coverage is time limited. Members are eligible for MHM services during the following time spans and circumstances:

- 180 days of eligibility for transition coordination and planning services while in a qualified institution
  - The 180 day limit starts with the service date of the first paid claim
- MHM enrolled individuals may begin utilizing select transition services at any point during their stay in a qualified institution
  - Refer to the MHM Program Manual: Services page for additional information on services allowable prior to the 60-day institutional stay requirement
- MHM start dates cannot be backdated. Retroactive enrollments will not be approved by DHS.
- DHS may grant extensions to the 180 day transition planning and transition coordination eligibility span on a case-by-case basis.
  - The CC (most common) or transition coordinator may request an extension using the Moving Home Minnesota Communication Form (DHS-6759H)

Authorizing EW and MHM services

Members enrolled in MHM must use EW eligible services and supports authorized by the care coordinator using the UCare Waiver Service Authorization Form with the codes specific for EW services (not MHM codes), which is shown in the chart below. All other non-EW MHM services do not require authorization. For example, if a member is eligible

for Transitional Services, the member must access EW Transitional Services vs MHM Transitional Services. A member using Comprehensive Community Support Services does not require CC authorization, as this is not an EW service.

Reference: DHS Long-term Services and Supports Rates

MHM Service	Coordinated by (TS/CC)	EW Budget & WSAF Authorization
Community education and integration	TS	No
Comprehensive community support services	TS	No
Costs for finding housing and employment	TS	No
Demonstration case management (NA once on EW)	NA	No
Environmental modifications (EW EAA)	TS/CC	**Yes**
Environmental modifications deposit (pre-transition only)	TS/CC	No
Home care training (AKA post-discharge case consultation & collaboration)	TS	No
Membership fees	TS	No
Overnight assistance (NA once on EW)	NA	No
Pantry stocking (cost of setting up household)	TS	No
PERS	CC	**Yes**
Pre-discharge case consultation and collaboration	TS	No
Pre-transition clean-up	TS	No
Pre-transition non-medical transportation	TS	No
Records and fees	TS	No
Respite	CC	**Yes**
Specialized supplies and equipment (may not use MHM (T2029 U6) in addition to EW)	CC	**Yes**
Tools, clothing and equipment (NA for people of age 65)	NA	No
Transition coordination (CC locates and refers to, TS facilitates once assigned)	CC	No
Transition integration fund (some services may be covered by EW)	TS/CC	No/**Yes**
Transition planning	TS	No
Transitional services (basic household items, etc.)	TS/CC	**Yes**

Reference: DHS MHM Services | HCBS waiver program services | MHM program interactions

Non-Covered Services

Receiving MHM services does not make the member ineligible to receive any state plan services, as long as the services are not duplicative of any other state plan or waiver services.

A member cannot receive MHM transition planning and transition coordination services at the same time as they are receiving any of the following services:

- Relocation Service Coordination (RSC) – Targeted Case Management (TCM)
- Housing Stabilization Services (HSS) Transition Services

Reference: MHM Manual: Noncovered Services

Transition Service Coordinator Responsibilities

Transition service coordination are activities that help a person in a qualified institution access medical, social, educational, financial, housing, and other services and supports needed so they can move to the community. The transition coordinator will begin meeting with the member in the institution and does all of the following:

- Facilitates signing of MHM enrollment and Moving Home Minnesota Informed Consent Form (DHS-6759I) to review the member's rights and responsibilities
- Develops an individualized person-centered Moving Home Minnesota Transition Planning Tool (DHS-6759J) to assist in identifying what's important to and for the member as part of the planning for the member's transition to a qualified residence in the community.
- Leads the transition planning process
- Works with the UCare care coordinator to arrange details of waiver services if appropriate
- Works with the housing specialist to locate housing:
    - The transition coordinator completes the Moving Home Minnesota Housing Transitions Worksheet (DHS-6759G) to assist the member in choosing a qualified residence.
    - When a residence in the community has been selected, the transition coordinator must submit the online Moving Home Minnesota Communication Form (DHS-6759H) and select the option "Assurance of Qualified Community Residence" to notify DHS once an estimated date for move is identified. DHS will verify that housing meets qualifications and is affordable for the member.
- Sets up transportation to look for housing and/or employment for the member
- Coordinates details in order to set up a home for the member
- Coordinates meeting, medical follow-up appointment, delivery of medical equipment, etc.
- Coordinates the day of discharge. The transition coordinator is present on the day of the move. Ensures medications and required services are in place.

Changes to and Ending Enrollment with MHM

If a member receiving MHM services has a change in provider or case manager, or chooses not to utilize MHM services at any point in time after they have been approved and enrolled in MHM, the CC (most common), transition coordinator, or case manager must notify MHM Eligibility and Enrollment of the change using the Moving Home Minnesota Communication Form (DHS-6759H).

Reinstitutionalization During MHM Participation

A member receiving MHM community-based services may need to return to an institution for short or long-term care, such as a hospital or nursing facility rehabilitation. In these situations, the UCare care coordinator, transition coordinator, or case manager must notify MHM Eligibility and Enrollment of the change using the Moving Home Minnesota Communication Form (DHS-6759H). Select the option "Moving Home Minnesota participant has been re-institutionalized".

Ongoing MHM participation will be affected depending on the length of stay:

1. 30 days or less: MHM participation and eligibility spans will not be interrupted, but MHM services will not be reimbursed during this period.
2. More than 30 days: MHM participation will be suspended; however, members may:
    a. Use any time left on the 365-day eligibility span after the member returns to the qualified community-based residence; or
    b. Reapply for MHM services if the member has continuously resided in a qualified institution for 60 or more days.
    c. CC to follow the temporary MMIS EW exit process if the member returns to an institution for more than 30 days. DTR EW services on day 31.
    d. If institutionalized 121 days, complete DTR to exit EW process.