North Carolina
Medicaid Special Bulletin

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Attention:
CAP/DA Providers

Money Follows the Person
Information about Pre-Transition and Transition Services

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SECTION I

MFP Transitions Involving CAP/DA Case Manager and MFP Transition Coordinator: Who Does What?

Background

Supporting a Money Follows the Person (MFP) participant to transition from institutional care to successfully living in the community with support requires the collaboration of several entities. Additional entities are often involved when individuals decide to move to a different county.

This guidance attempts to outline the roles and responsibilities of three key functions in the transition experience:

1. The MFP Transition Coordinator
2. The Community Alternatives Program for Disabled Adults (CAP/DA) case manager
3. The DSS Medicaid caseworker

This guidance also clarifies roles during "cross-county" transitions.

Medicaid is a statewide public insurance program that entitles eligible beneficiaries to receive healthcare services in any area of North Carolina. Medicaid beneficiaries are allowed to move between NC counties. For additional information about Medicaid, visit: **www.ncdhhs.gov/dma** or **http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2280-04.htm**

Supporting an MFP Participant to Transition: Identifying Roles

The process of identifying "Who does what?" is important throughout the transition process. Below is a basic breakdown of the Transition Coordinator's role, CAP/DA Lead Agencies role, and the DSS Medicaid Caseworker's role. While these lists **do not** fully outline **all** responsibilities related to the position, they outline those functions that have been ambiguous or are particularly critical in determining how well entities work together.

MFP Transition Coordinator/MFP State Staff Roles:

- After approving an applicant for the MFP program, MFP state staff and/or the transition coordinator will contact the identified Medicaid county's caseworker, skilled nursing facility and CAP/DA Lead Agency(s) to inform each entity that a MFP participant has been identified and that the transition process *may* involve each contacted entity.
- The Transition Coordinator makes sure to include all applicable CAP/DA Lead Agencies in all early discussions involving the transition process. Lead Agency involvement is encouraged, but it is not mandatory. In the case of cross-county transitions, the applicable Lead Agencies will determine "who will do what" regarding the CAP/DA assessment and enrollment process.

- Along with the participant, the transition coordinator identifies the participant's Medicaid caseworker and to which county the participant's Medicaid is currently assigned.
- The MFP Transition Coordinator assists participants in requesting changes of residence with their Medicaid caseworker or the Social Security Administration.
- The Transition Coordinator works collaboratively with the Medicaid caseworkers in the assigned county and the county where the person intends to live after transitioning.
- The Transition Coordinator ensures that the Transition Team (MFP participant, participant's family/friends, Transition Coordinator, CAP/DA Lead Agency, Skilled Nursing Facility (SNF) staff, and any other significant persons in the community) is clear about the specific health, functional, mental and emotional needs of the participant while planning the transition to the participant's permanent home environment
- The Transition Coordinator follows the MFP transition protocols and practices outlined in the NC MFP Transition Coordination Handbook.
- The Transition Coordinator is **ALWAYS** the point person during the transition process.

Medicaid County Staff:

- Work collaboratively with the Transition Coordinator to assure that Medicaid eligibility is consistent with CAP/DA Long-Term Care criteria to participate in the CAP/DA-CAP/CO waiver
- Work with the MFP Transition Coordinator to ensure Medicaid contact information is correct and be available to assist with any technical needs identified by the state CAP/DA Leadership Team
- Work collaboratively with the DSS in the current county of residence and the county where the person intends to live after transitioning and/or the Social Security Administration to assure seamless transfer to the county where the person will be living.

Ready for Transition to the CAP/DA Program: Identifying Roles

MFP Transition Coordinator will:

- Notify the CAP/DA Lead Agency(ies) within 60 days prior to the MFP transition date, after housing has been identified
- Work collaboratively with the CAP/DA Lead Agency in the county that the participants have identified as their home communities
- Ensure it is clear who takes the lead on home modifications, DME needs, etc.
- Inform the CAP/DA Lead Agency of the nursing facility social worker's name and contact information to facilitate the receipt of a completed FL-2. The MFP Transition Coordinator will also ensure that discharge needs such as prescriptions for medications or equipment are obtained prior to participants discharge to home.
- Always invite the Lead Agency to the final Transition Planning meeting. This is billable time for the Lead Agency (as long as the FL-2 has been called in for prior approval and approved).
- MFP Transition Coordinator will stay involved with the MFP participant for the months after the transition/deinstitutionalization has occurred. The Transition Coordinator will communicate at least monthly and as needed with the Lead Agency during this time.

CAP/DA Lead Agency(ies) will:

- Schedule and conduct the assessments (**Note:** Because of the time-sensitive nature of housing availability, DMA encourages CAP/DA Lead Agencies to be as responsive as possible when scheduling and conducting the assessments.)
- Work collaboratively with the MFP Transition Coordinator and the Nursing Facility to facilitate the receipt of the FL-2 to: (1) establish NF LOC; and (2) to begin the assessment process of determining CAP/DA eligibility
- Call in the FL-2 to HP Enterprise Services (HPES) to determine prior approval of Level of Care
- Work collaboratively with another CAP/DA Lead Agency to identify a checklist of responsibilities when a cross-county transition requires the involvement of two CAP/DA Lead Agencies
- Work collaboratively with the participant and the MFP Transition Coordinator upon approval of the FL-2 to initiate the CAP/DA Assessment Process. The CAP/DA Lead Agency(s) will negotiate which entity will conduct the home environment and assessment of health, safety, and well being. These decisions are based on the proximity of the participant to the CAP/DA Lead Agency. The development of the Plan of Care should be completed by the Lead Agency of the county in which the participant will reside
- Appropriately assign the MFP participant in a CAP/DA slot based on the Lead Agency's allocation. When necessary, a request for a borrowed against slot can be made to the CAP/DA Consultant
- Continue to work collaboratively with the Transition Coordinator to coordinate any additional identified needs after the transition
- Communicate with the MFP Transition Coordinator at least monthly and as needed for the first three months after the participant is home to ensure a successful transition
- By the end of the three month post-transition period, CAP/DA Lead Agency assumes "point of contact status" for the transitioned individual and the transition team, but may call on MFP Staff and transition coordinator to troubleshoot or help address individual needs at any point during the MFP transition year

Special Allowances for Cross County Transitions

MFP/DMA recognizes that individuals often transition to a neighboring county, which makes the transition process more logistically involved. In an effort to minimize logistical complexity – and to better ensure continuity for the transitioning individual – **MFP/DMA will allow the following:**

1. The CAP/DA Lead Agency covering the county where the participant will live ("receiving county" or "Receiving Lead Agency") may elect to complete the FL-2, the assessment and Plan of Care process in its entirety.

2. If the "receiving Lead Agency" elects to provide **all** CAP/DA functions, the Lead Agency may include travel time when traveling to an adjoining county to conduct an assessment or otherwise participate in the planning process.

Travel Time Limitations:

1. This time is incorporated into the MFP CAP/DA Pre-Transition Case Management Service. This "travel time" allowance is **NO**T allowed under regular CAP/DA case management services. Please see MFP Pre-Transition Case Management Guidance for additional information and billing parameters.

2. MFP CAP/DA Pre-Transition Case Management only covers travel time if the Lead Agency must cross county lines.

For transitions that involve a larger geographic distance, transition coordinators and case managers from applicable counties should work together to identify "who is doing what," following the roles outlined in this guidance.

Need Help? Have Questions?

Always feel free to contact Christy Blevins or your CAP/DA State Leadership Team for guidance or questions:

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Section II

CAP/DA Pre-Transition Case Management Demonstration Service Medicaid Billing for MFP Participants

The Need

It is essential that Money Follows the Person (MFP) participants are assessed for applicable community services **PRIOR** to the transition from institutional care to independent community living. The majority of MFP participants residing in nursing facilities will be assessed for Community Alternatives Program for Disabled Adults (CAP/ DA) services.

The Challenge

Revisions to CAP/DA and CAP-Choice case management (most recently outlined in *October 2011 Medicaid Bulletin*) necessitate that a case manager now use a portion of his/her annual 42-hour allotment to assess and create a care plan for MFP participants prior to the transition date. As a result, case managers have fewer hours during the first year after the transition (often the participant's most vulnerable time) to provide on-going case management services.

The Solution

To address this challenge, MFP is redesigning its Pre-Transition Case Management Demonstration Service. These resources will be drawn from MFP's operating budget (not CAP/DA's), and will only be available for MFP participants who enroll in the CAP/DA waiver.

Effective September 1, 2012, and until further notice, MFP is revising its "Pre-Transition Case Management Demonstration Service" to provide CAP/DA case managers and care advisors with up to 8 hours/32 units – at applicable T1016 and T2041 rates – of pre-transition case management (assessing, planning) to be used **at any point** between the date the original FL-2 is approved and the deinstitutionalization date. This change provides additional flexibility to CAP/DA case managers to participate in the transition planning process **without it impacting their annual 42-hour allotment of case management.**

This demonstration service recognizes that case management time is essential in the pre-transition assessment and planning process and that this is a "one-time" expense related to the act of supporting an individual's out of a facility and back into their community, under CAP/DA or CAP/Choice.

Pre-Transition Case Management is an MFP demonstration service and is **ONLY** available for pre-transition case management services provided to MFP-designated participants. Further, these invoices are not processed by Hewlett-Packard (HP) but by MFP staff.

Pre-Transition Case Management is separate and distinct from both:

1) MFP Transition Coordination Demonstration Services
2) CAP/DA Assessment Only Claims (see below for additional guidance).

Payment for MFP CAP/DA Pre-Transition Case Management Demonstration Service

While MFP Pre-Transition Case Management Demonstration Service will eventually be incorporated into the HP/CSC claims process, the transition to CSC has required initiatives that change the claims architecture to be "frozen" until the conversion to CSC is completed.

In an effort to "work around" this circumstance, MFP/DMA has secured authorization from CMS to provide invoice-driven administrative payments to CAP/DA Lead Agencies. **MFP Pre-Transition Case Management Services will not be billed through the claims process until further notice.**

Lead Agencies conducting MFP Pre-Transition Case Management will continue to follow standard CAP/DA documentation requirements for all activities performed and will maintain documentation of these activities.

For the purposes of invoicing MFP for Pre-Transition Case Management Demonstration Services, CAP/DA Lead Agencies shall submit the "Money Follows the Person, Pre-Transition Case Management Work Around Invoice," available on the MFP website, www.mfp.ncdhhs.gov under *General Information about the MFP Application and Transition Process* link.

CAP/DA Case Managers may not bill for both MFP Pre-Transition Case Management hours (which went into effect September 1, 2012) and case management hours through the Transition Year Stability Resource Funds (TYSR). Beginning November 1, 2012, MFP will no longer approve case management hours through TYSR.

Steps for Payment

1. Pre-transition FL-2 is prior approved through the current CAP/DA process.
2. Applicable CAP/DA Lead Agency conducts needed pre-transition assessment and care planning.
3. MFP participant transitions
4. CAP/DA Lead Agency invoices MFP by completing the MFP CAP/DA Pre-Transition Case Management Demonstration Administrative Payment Request ("Request") and submitting it either by fax 919-715-4159 or by encrypted e-mail to diane.upshaw@dhhs.nc.gov.
5. MFP staff reviews and authorizes.
6. MFP staff authorizes DMA Budget staff to process an electronic transfer payment in the amount authorized to the invoicing Lead Agency
7. DMA will use the account the CAP/DA Lead Agency has on file for receiving such transfers and will indicate the following in the Memo Line: "CAP/DA PreTransCM for

[initials of participant], [last 4 digits of MID on file]" The payment process is anticipated to take 10 days once MFP approves the Request

The "MFP CAP/DA Pre-Transition Case Management Demonstration Administrative Payment Request" template form is available on the MFP website at www.mfp.ncdhhs.gov

Cross-County Transition Considerations

MFP participants often transition out of a qualified facility in one county into a different county. These inter-county transitions require a higher degree of coordination between participating Lead Agencies. Current CAP/DA practice does not allow case managers to bill for travel time, including travel time outside their home county.

Under the MFP Pre-Transition Case Management Services, the CAP/DA Lead Agency "receiving" county (the county that will provide ongoing support to the participant upon transitioning) will be authorized to bill travel time to contiguous counties (not in-home county) or nearby counties, up to 50 miles.

If the transition involves two or more counties that are **NOT** contiguous, CAP/A case managers should coordinate with their colleagues in the counties involved to meet the assessment and pre-transition case management needs of the MFP participant.

See *Section I - MFP Transitions Involving CAP/DA Case Manager and MFP Transition Coordinator: Who Does What?"* for additional guidance.

MFP shall authorize partial payment of Pre-Transition Case Management Demonstration to two or more Lead Agencies **as long as the total number of hours/units invoiced does not exceed the approved 8 hours/32 units**.

Outlining the Differences Between MFP Pre-Transition Case Management And CAP/DA Assessment Only Claims

The MFP Pre-Transition Case Management demonstration service is separate and distinct from CAP/DA Assessment Only Claims and makes **NO CHANGES** to current CAP/DA Assessment Only Claim Policy.

The following table clarifies the appropriate billing for anticipated transition scenarios.

Important Considerations:

- All scenarios are for MFP participants only.
- MFP Pre-Transition Case Management is **NOT** available to transitioning individuals who are **NOT** MFP participants.
- Only activity conducted **AFTER** the FL-2 is activated is reimbursable.
- A case manager may **NOT** bill for **BOTH** MFP Pre-Transition Case Management and Assessment Only Claims

MFP CAP/DA Pre-Transition Case Management or CAP/DA Assessment Only Claim: **Which One to Use?**			
Scenario	**Appropriate billable service**	**When Billed**	**Notes**
Case manager conducts assessment and MFP participant transitions with CAP/DA services.	MFP Pre-Transition Case Management	After the transition has occurred, through invoicing process to MFP.	
If Case Manager calls in FL-2 to conduct assessment and the FL-2 expires – requiring a new one to be called in – but the person still transitions. Pre-transition case management for ALL time used (under any FL-2) up to 8 hours, billed upon transition.	MFP Pre-Transition Case Management	After the transition has occurred, through invoicing process to MFP	Maximum total allowed billing remains 8 hours, even if broken up between multiple FL-2s
If a transition begins and MFP determines that the transition is not viable: Pre-transition case management is used.	Pre-Transition Case Management	CAP/DA Lead Agency may invoice upon MFP providing written notice that the transition process has ended for the identified individual.	
If person dies prior to transition	Assessment Only claim		
If CAP/DA denies person: Assessment only.			

Questions

For billing or procedural questions about using the MFP Pre-Transition Case Management Demonstration Service, please call MFP at 1-855-761-9030.

For questions about how the MFP Pre-Transition Case Management Demonstration Services impacts CAP-specific practices, contact either MFP or your CAP consultant.
For questions about Assessment Only claims, contact your CAP consultant.

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