NURSING HOME TRANSITION SERVICES

September 13, 2011
BACKGROUND

- A Class Action lawsuit was filed against the Agency for Healthcare Administration (AHCA) and the Department of Elder Affairs (DOEA).
- The lawsuit alleged that people who could live in the community are forced to remain in nursing homes.
- AHCA agreed to use the same funds for nursing home care to provide services in the community for individuals who could move into a community setting.
FUNDING

- A nursing home resident who is appropriate to transition home will be enrolled in the Aged and Disabled Adult (A/DA) Medicaid Waiver.
- AHCA will transfer funds appropriated for a Medicaid nursing home resident to the Aged/Disabled Medicaid Waiver budget to cover the in-home community services for the transitioned individual.
CRITERIA

To be considered a potential NHT candidate, the individual must....

• Be Medicaid eligibility
• Be between 18 through 59 years old
• Meet nursing home LOC
• Have adequate support in the community
• Must have resided in a nursing home for 60 consecutive days within the last year
NURSING HOME TRANSITION PROCESS
INTAKE

Referrals

• Can come from any source, CARES, Long Term Care Ombusman, nursing home staff, general public, even YOU!

All referrals are to be directed to Agency for Persons with Disabilities (APD) statewide toll free line.

1-877-232-4968
• APD will ask minimal information to determine which agency should receive the referral.....

–DOEA for 60+ years of age
–DOH TBSC for any age
–DCF for ages 18 - 59
ONCE ASSIGNED..... CIL OR HSC

• Screening *(with potential eligibility)*
  – A 1022 AS Screening for Consideration for Community-Based Programs
    • This may be in person or by phone
  – If meets the criteria for NHTS
    • Medicaid eligible
    • Meets nursing facility LOC
    • Adequate community support to be safely served with waiver services
    • Resided in the nursing home for 60 days within the last 12 months
  – Then a face to face appointment required
• **Screening (with NO potential of eligibility)**
  
  - *Screening or assessment process results in a denial of service*

  • **Within three working days** counselor/NHT case manager to send signed and dated denial letter with due process information

  • **Notify DCF program office** (and provide a copy of letter)

  **NOTE:**

  CILs will use their letterhead;

  DCF staff will use DCF letterhead.
INITIAL FACE TO FACE

• Face to face interview w/individual to:
  – Complete resident transitional assessment form (3-26-2009)
  – Determine need for assistance/equipment/supplies
  – Learn/consider/develop existing informal supports

• Develop care plan and cost plan
  – Obtain/view/document information regarding source & amount of individuals income and assets
  – Obtain individual’s signature on
    • Release of Information form (1113)
    • DOEA Informed Consent (2040)
  – Provide HIPAA policy and Due Right pamphlet
  – Obtain copy of current 3008
SOURCES OF INFORMATION

- Interview and observation of
  - NHT applicant and referral source
  - Family members, household members, previous caregivers
  - Medical records/medical staff; including psychological exams
  - Ensure to obtain consent from the NHT applicant – release of information (1113)

- Importance of case manager’s narrative
  - Summarizes the individual’s history, disabilities, diagnoses
  - List all income and asset sources and amounts
  - Identifies any informal support
  - Addresses home environment pros and cons
  - Identifies service needs and barriers
DEVELOPING CARE PLAN and COST PLAN

- **Group Effort to develop a care plan**
  - Include individual, family and/or caregivers
  - Care plan MUST list all services & support client currently has and needs
  - Be specific....
    - What service to be provided
    - Number of service units
    - Provider of service
    - Frequency of the provision of service
    - Projected begin and end dates
- **Medicaid only funds medically necessary items**
  - Other funding sources must be ruled out prior to Medicaid Waiver funding being utilized: third party insurance, Medicare, State Plan Medicaid, volunteer and service organizations
  - Transition case management is a service
• COST PLANS
  – Care plan is used to develop the cost plan
  – Care plan and cost plan must be consistent
  – Cost plans identify unit cost, units per week, units per month
  – Cost plans identify monthly cost and annualized cost
• Case managers must discuss with the individual, prior to transition, available providers
  – Individuals must be offered the choice to choose providers off Medicaid provider list
ENROLLMENT

• Once complete submit
  – 3019, narrative, care plan and cost plan for DCF review
  – Once review of above items DCF will provide a cover letter to request a LOC

• A LOC referral to CARES must include
  – Current 3008
  – DOEA informed consent (2040)
  – Resident transitional assessment form (3-26-2009)
  – Completed care plan
  – DCF cover letter (DCF will provide once review of the above items is complete)
• CARES office will review the information and complete a Notification of Level of Care (0603)
  – If CARES assessment does not recommend an appropriate LOC for the community a denial letter and due process rights information MUST be sent immediately to the recipient
  – If CARES assessment is recommended for community living the case manager will pursue financial eligibility
FINANCIAL ELIGIBILITY

• No Need for ACCESS Determination
  – If individual receives SSI or is in receipt of ICP Medicaid they are eligible for ADA Medicaid Waiver
  – ACCESS must change the client’s Medicaid status after receiving the following from the case manager
    • Certification of Enrollment Status Home & Community Base services (2515)
    • A copy of the Level of Care (LOC)
• Need For ACCESS Determination if:
  – Individual has never been SSI or ICP eligible
    • Must be referred to ACCESS for determination of financial eligibility
    • CM to assist with ACCESS application
    • Application to be submitted to ACCESS with LOC
  – If eligibility determined for ADA Medicaid Waiver send 2515 to ACCESS once transition occurs
  – If eligibility not granted recipient not eligible for NHT/ADA Medicaid Waiver services
    • Must send a denial letter and Due Process pamphlet to the NHTS applicant
DISCHARGE PLANNING

• Team Effort
  – Doctor
  – NH social worker
  – NHT case manager
  – Client/family/friends
  – Any person/agency who may have a role in the client’s community living
Don’t forget to include

• Medication
• Prescriptions
• Equipment and supplies
  • The nursing home may have equipment that was purchased for the client that should go to the client’s new residence
    – Delivery of equipment and supplies should be coordinated so that they can be delivered the day of discharge
REMINDERS FOR CASE MANAGERS

• All other sources for equipment and supplies MUST be exhausted prior to using ADA Medicaid Waiver funding.

• Prior Authorization for DME from the State Plan Medicaid may be required.
  - NHT CM will give the provider a completed form requesting authorization of DME indicating the date the individual is expected to transition back to the community.
• In Home Services
  - Prior to discharge CM staffs case with service providers to ensure services are commenced upon transition
    • Service provider needs an authorization specifying the services, the frequency and duration
      – Inform the services are to be billed to ADA Medicaid Waiver funding
    – CM must ensure persons providing informal supports understand specifically what their responsibilities are to be
      – Social Security (all income) will need to be redirected back to the recipient
TRANSITION DAY & ONGOING CASE MANAGEMENT

- Make contact the day of the transition
- Notify the APS Region NHT contact person of completed transition
  - APS Region will notify headquarters
- CM to follow up with client NO more than 10 days after transition
- Follow up with ACCESS to assure Community Medicaid eligibility is activated
- Within 30 days face to face required
CASE FILE

- Each transition client shall have a case file and will include:
  - Case notes documenting all activities, contacts, and service coordination beginning with receipt of the referral
  - All forms associated with the client, i.e. resident transitional assessment form, 3008, LOC, referrals and etc.
TRANSITION CASE MANAGEMENT BILLING

• Six months prior to client’s transition
  – 24 hours allowed for NHT CM Provider
    • Actual date of service for billing will be the date they are discharged from the nursing home

• Client must be enrolled in ADA Medicaid Waiver for billing to be paid

• After transitioned home, billable CM services will be billed using regular CM code
RESOURCES

• Your best resources
  – ADA Waiver Services Coverage & Limitations Handbook
  – Your colleagues
  – Your providers
  – Your contact at DCF
THANK YOU!