DEPARTMENT OF HUMAN SERVICES

DHS Housing Transition Services

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Agenda

DHS staff will provide overviews of the following transition supports:

- Elderly Waiver Transitional Supports
- Moving Home Minnesota
- Relocation Service Coordination

Elderly Waiver (EW) Transitional Services

EW Transitional Services

What are EW transitional services?

- Items and supports necessary for a person to move from a licensed setting to independent or semi-independent community-based housing.

Eligible licensed settings include:

- Hospitals licensed under Minn. Stat. §144.50 to 144.58
- Adult foster settings licensed under Minn. R. 9555.5105 to 9555.6265
- Certified nursing facilities and intermediate care facilities licensed under Minn. R. 9505.0175, subp. 23.

Transitional items/services

Transitional services cover items such as:

- Basic household items
- Essential furniture, window coverings
- Lease and rental deposits
- One-time pest and allergen treatment of the setting
- Personal items
- Utility set-up fees and deposits
- Reconditioned items if the lead agency determines they are appropriate and safe.

Transitional services/supports:

- Transitional services also cover personal supports to help the person:
- Locate and transition to community-based housing
- Move personal items from the licensed setting to the home
- Arrange for utilities to be connected
- Purchase household items and essential furniture.

Who is eligible?

A person is eligible to receive EW transitional services if they are:

- Enrolled on EW **or** is reasonably expected to enroll within 180 days.
- Moving from an eligible licensed setting to independent or semi-independent community-based housing
- Moving from a setting where the items were provided to a setting where these items are not normally furnished
- Not able to access the items or support from other funding sources

- Transitional services can be delivered through remote support.

Authorization prior to discharge/enrollment and unforeseen circumstances

The lead agency may:

- Authorize transitional services before a person's discharge from a licensed setting if the person is expected to be discharged and enrolled on the waiver
- Only bill the waiver after the person enrolls.
- The items must be purchased or supports provided within 90 days of the date the person enrolls on the waiver.

Unforeseen circumstances

If the person does not enroll on the waiver for an unforeseen reason (i.e., death or a significant change in condition) and meets certain criteria, the county or contracted tribal nation lead agency may request reimbursement for expense(s) it incurred in anticipation of the person enrolling. For more information, see CBSM — Waiver/AC reimbursement for unforeseen circumstances.

Managed care organization (MCO)

If the person receives or was receiving services through an MCO, the lead agency contacts the specific MCO about procedures it needs to follow for reimbursement. An MCO may not request reimbursement from DHS under unforeseen circumstances.

Additional EW supports for move from institution to community

EW nursing facility (NF) conversion budget

A person is eligible to request an EW nursing facility conversion budget when:

They are a resident of a certified NF for 30 or more consecutive days and services are billed as skilled nursing per diem.

A support plan is developed and includes services that exceed the EW case mix budget cap. Request form is submitted in MnCHOICES.

They meet all eligibility criteria for EW.

EW hospital high needs budget exception (available 1/1/2026 or upon federal approval)

A person is eligible to request an EW hospital high needs exception when:

Hospitalization is no longer medically necessary but participant has not been discharged from the hospital. Services must be billed as hospitalization.

A support plan is developed and includes services that exceed the EW case mix budget cap. Request form is submitted in MnCJOICES.

They meet all eligibility criteria for EW.

- EW NF conversion budget request uses specific calculations to determine new maximum amount available for EW services.
- EW hospital high needs exception is individualized budget amount determined by service costs in support plan for the person and documentation to reflect complex medical and/or behavioral/cognitive needs.
- EW conversion and exception address ongoing/long-term needs for person that cannot be met by available EW case mix cap/budget. Person must receive an assessment to continue or modify the exception.

Moving Home Minnesota (MHM)

Money Follows the Person (MFP)

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What is Moving Home Minnesota?

- **Federal Medicaid demonstration project**
  - Federal name: Money Follows the Person (MFP)
  - Originally authorized by Congress through passage of the 2005 Deficit Reduction Act

- **MFP/MHM objectives:**
  - Supports people with transitions from qualified institutions to community living
  - Allows states to develop, implement and evaluate demonstration and supplemental services not otherwise covered by the state's Home and Community Based Services (HCBS) waivers or State Plan.
  - MFP Tribal Initiative – offers tribes and tribal organizations resources to build a sustainable community-based long-term services and supports (LTSS).

Benefits of Moving Home Minnesota

- Utilizes a person-centered planning approach.
- Focuses on community integration.
- Allows for 180 days of MHM Transition Coordination.
  - Extensions are allowed on a case-by-case review basis
- Access to MHM community services in addition to waiver plan services for 365 days while residing in their qualified community residence.
- Minnesota accrues rebalancing funds for all HCBS delivered to the individual, including pre-transition and first year in the community.
  - Used to fund internal projects focused on housing, service quality, equity, self-advocacy, person-centered thinking, and administrative & systems improvement.

MHM Eligibility Requirements

- A person may be eligible for Moving Home Minnesota if they:
  - Are a resident of Minnesota
  - Are enrolled in Medical Assistance
  - Have lived in an institution for 60 or more days
  - Meet institutional level of care

NOTE: All people age 65 or older who receive MHM must enroll in the Elderly Waiver (EW), once they return to the community, to access MHM services, unless they are eligible to enroll in a disability waiver program.

MHM Qualified Institutions

- Nursing Facilities
- Hospitals, including Community Behavioral Health Hospitals (CBHH)
- Intermediate Care Facilities for persons with developmental disabilities (ICF/DD)
- Child and Adolescent Behavioral Health Services facility (CABHS)
- Psychiatric Residential Treatment Facilities (PRTF)

MHM Qualified Institutions - IMD

- Institutions for Mental Disease (IMD)
  - **Note:** For a person age 21 to 64, days spent in an IMD can count toward the required 60 days if the person spent at least one full day in a qualified institution **immediately after** IMD discharge and maintained their state-funded MA coverage while in the IMD.

- Institutions for Mental Disease (IMD) /Substance Use Disorder (SUD)
  - Licensed under Minn. Stat. Ch. 245G as a residential SUD treatment program.
  - Attested to provide a specified ASAM level of care and meet ASAM criteria standards under the 1115 Substance Use Disorder System Reform Demonstration, as required by Minn. Stat. §265B.0759, subd. 2b.

MHM Qualified Residences

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease and living areas over which the individual or individual's family has domain and control;
- A Minnesota Department of Health licensed assisted-living residence with an individual lease, lockable access and egress and living areas in which the person or the person’s family has access or control; or
- A home in a community-based residential setting (i.e., community residential settings [CRS], adult foster care or family foster care) in which no more than four unrelated people live.

MCO Responsibilities

MCOs have the following responsibilities:

- Determine the person's institutional level of care using the MnCHOICES Assessment completed within the past year
  - Assessment must be in a "Completed – Ready for MMIS," "Pending MMIS" or "Approved by MMIS" status in MnCHOICES.
  - Assessments still "In Progress" in MnCHOICES cannot be used to establish level of care.
- Provide MHM Transition Coordination or assign a private MHM Transition Coordination Provider
- Authorize MHM Services
- Authorize and provide MHM Case Management in addition to EW case management

Available MHM Services Pre-Move to the Community

- Costs for finding housing and employment
- Environmental modifications deposit*
- Pantry stocking*
- Pre-discharge case consultation and collaboration
- Pre-transition clean-up*
- Pre-transition non-medical transportation*
- Records and fees*
- Transition coordination
- Transition integration fund*
- Transition planning
- Transitional services (65+ must use EW Transitional Services)

Available MHM Services Post-Move with HCBS Waivers

- Community education and integration costs
- Comprehensive community support services
- Costs for finding employment
- Home care training (family and non-family)
- Membership fees
- Pantry stocking*
- Records and fees*
- Transition integration fund*

Available MHM Services Post-Move **without** HCBS Waivers

- Community education and integration costs
- Comprehensive community support services
- Demonstration Case Management
- Environmental modifications
- Home care training
- Membership fees
- Overnight assistance
- Pantry stocking*
- Personal emergency response system (PERS)
- Records and fees*
- Respite
- Specialized supplies and equipment
- Tools, clothing and equipment
- Transition integration fund*

Provider Requirements

Providers must be enrolled in Minnesota Health Care Programs (MHCP).

- They must have the correct specialty codes, licenses, and service categories listed in their MHCP provider record for each service they want to provide.

Auto-Enrollment of Providers

Auto-enrollment of providers

- Provider Eligibility and Compliance (PEC) has auto enrolled existing Minnesota Health Care Programs (MHCP) providers into the following services:
  - Chore services – PEC will add MHM clean-up services
  - Environmental Accessibility Adaptations – PEC will add MHM Environmental Mods Deposit
  - Transition Coordination (TC) – PEC will add MHM pantry stocking, records and fees, transition integration, and communication education & integration

Note: Providers are being auto-enrolled into the corresponding services above, as the services have the same licenses/credentials. A TC provider would not be auto-enrolled into pre-transition clean-up or environmental modifications deposit.

Transition Coordination Auto-Enrollment

Question: Do transition coordinators have to provide all of the new supplemental services they have been auto-enrolled for?

Response: No, a transition coordinator does not have to provide every supplemental service. These are separate distinct services from transition coordination.

Additional information:

- A provider may update their provider records to remove any services they do not want to provide.
- **People participating in MHM must be informed of ALL services available to them under the MHM program.**
- **People participating in MHM must have informed choice of providers.** If the provider they are using for Transition Coordination does not offer all of the supplemental services, a person is allowed to change providers to a Transition Coordination provider who will.

Provider Enrollment

If new (not previously enrolled) provider want to provide MHM supplemental services, they must update their enrollment record themselves:

- Use the MPSE portal (Minnesota Provider Screening and Enrollment portal) **OR** Home and Community-Based Services Programs Service Request DHS-6638

AND

- Moving Home Minnesota Provider Assurance Statement DHS-3879

MHM Forms and Brochures

- MHM Intake Form DHS-5032
- MHM Communication Form DHS-6759H
- MHM Informed Consent DHS-6759I
- MHM Transition Planning Tool DHS-6759J
- MHM Money Follows the Person Demonstration Participant Handbook DHS-6580B
- MHM Brochure DHS-6580A

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Relocation Service Coordination – Targeted Case Management (RSC-TCM)

What is Relocation Service Coordination?

- Relocation Service Coordination (RSC) is a type of Medical Assistance (MA) reimbursed case management
- Helps people who want to move out of certain institutions and into the community
- Helps to coordinate activities designed to help a person gain access to needed services and supports to remain successful in the community.

RSC Eligibility Criteria

To receive Relocation Service Coordination, a person must:

- Be eligible for and receiving MA
  - MA - Federally Paid Medical Assistance (AX – Adult, DX – Disability, EPD - Employed with Disability)
  - NM - State-Paid Medical Assistance
  - RM - Refugee
- Reside in an eligible institution at the time services are rendered
- CHOOSE to live in the community
- CHOOSE to receive Relocation Service Coordination services
- Be closed to any home and community-based services waivers due to their stay in an eligible institution

RSC Eligible Institutions

- Hospitals
- Nursing Facilities (NF), including certified boarding care facilities
- Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD)
- Regional Treatment Centers (RTC)* providing inpatient services to persons currently receiving Medical Assistance (MA)
- Institute for Mental Disease (IMD)
  - The person must be younger than 22 or older than 64

Limits to Relocation Service Coordination

- 180 consecutive days available
  - No extensions allowed
  - Per eligible institutional admission
  - Must have one full day in the community between discharge and eligible admission, as updated by the person's financial worker.
- Duplicative of other Targeted Case Management Services
  - The use of any one of the following case management types will begin the 180-day eligibility period and will exhaust the benefit after 180 days.
    - Mental Health TCM
    - Vulnerable Adults with Developmental Disabilities TCM

Obtaining RSC with a Managed Care Plan

- If a person is on MN Senior Health Options (MSHO) or MN Senior Care Plus (MSC+) through a Managed Care Organization (MCO), a care coordinator would be assigned to them.
  - The care coordinator should be contacted to discuss RSC to ensure continuity of care, payment and non-duplication of effort.
  - The care coordinator supports the person with resources and services to help the person move out of the facility and return to the community.
- If the person is on SNBC, the county or tribal nation is responsible for determining eligibility and authorization for RSC.

What services are provided by Relocation Service Coordination?

- Planning and coordination services:
  - Develop a budget, review services that could support the person in the community, researching housing options.
  - Develop and update a relocation plan, based on the person's needs and preferences.
- Monitoring the implementation of the relocation plan.
- Routine communication with the individual, their team and service providers.
- Referrals and assisting the person with accessing services.
- Collaboration with the discharge planner and other care team members.

Benefits of Relocation Service Coordination

- Up to 40 hours a week to support plan for community discharge.
- Support the person and chosen caregivers in developing a plan for long term stability.
- Offer a customized plan including housing, expungement, transportation, and community resources.
- Knowledge of geographical areas including housing resources and tools.
- Coordinate collaboration and hand-offs with other TCM services as well as MCO care coordinators.

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MHM and RSC Resources & Engagement Opportunities

MHM & RSC Transition Services Resources

- Moving Home Minnesota Program Manual
- MHM New Supplemental Services Video on YouTube
- Relocation Service Coordination TCM (RSC-TCM) CBSM page
- RSC: Learning the Basics on YouTube
- Comparison Table of MHM & RSC-TCM
- Transition Services Provider Contact List

Engagement Opportunities

Transition Services Community of Practice

- MHM and RSC Transition Coordinators, Counties, and Tribes
- Quarterly hybrid (in-person and virtual)

Office Hours for Lead Agencies (Counties, Tribes, MCOs)

- Quarterly
- Virtual via Teams

Office Hours for Transition Services Providers

- Quarterly
- Virtual via Teams

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EW/MHM/RSC Program Interactions

MHM and EW

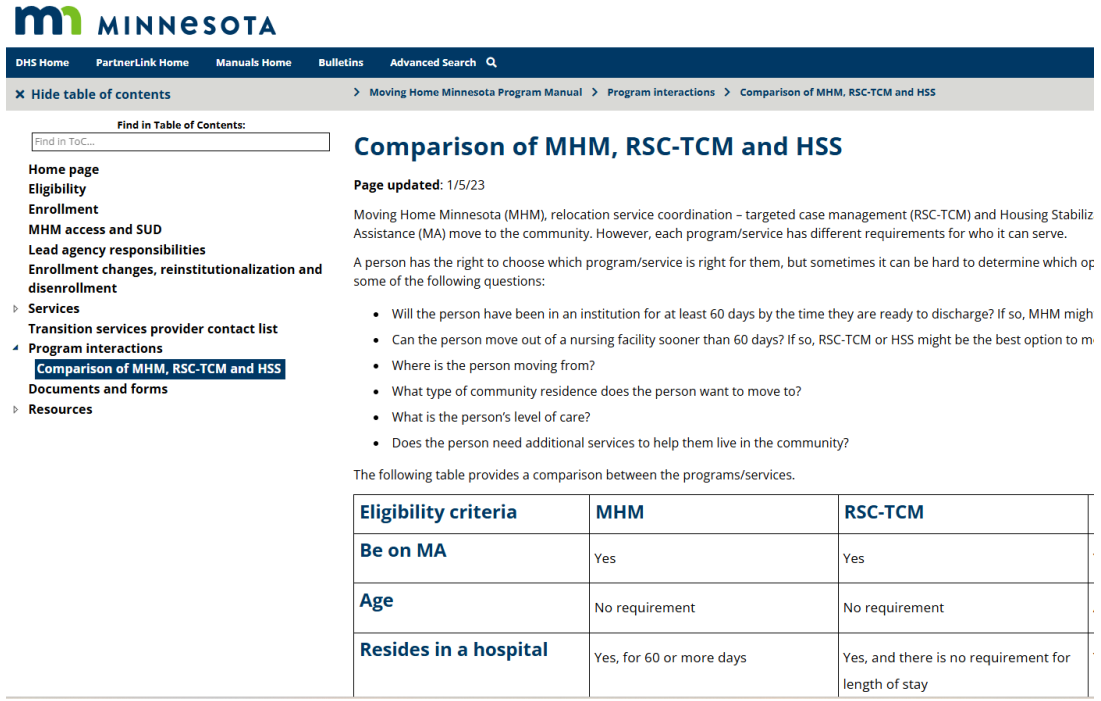
- A person 65 years of age or older must open to EW, in order to be eligible for MHM.
  - Exception: If a person 65 years of age or older can return to their disability waiver, they remain eligible for MHM.
- A person can receive MHM while in an institutional setting, before they are opened to EW.
- A person can receive both MHM and EW services once they have moved to their qualified community residence.
- If a service is available under both EW and MHM (such as Transitional Services), the person must use the EW version of the service.

EW and RSC

- A person can receive RSC while in an institutional setting, before they are opened to EW.
- A person cannot receive RSC once they have moved to the community and are opened to EW.
- RSC only covers the work to transition a person to the community. It does not cover furnishings, supplies, movers, etc. A person must access these additional transitional services through EW, or switch to MHM.

RSC and MHM

- A person cannot receive MHM and RSC at the same time.
- A person is not required to access RSC before they can enroll in MHM.
- A person can start RSC and then transition to MHM at any time. A person does not have to use their entire 180 day period of RSC before moving to MHM.
- Refer to the MHM/RSC comparison table for more information



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Comparison of MHM, RSC-TCM and HSS

Page updated: 1/5/23

Moving Home Minnesota (MHM), relocation service coordination – targeted case management (RSC-TCM) and Housing Stabiliz Assistance (MA) move to the community. However, each program/service has different requirements for who it can serve.

A person has the right to choose which program/service is right for them, but sometimes it can be hard to determine which op some of the following questions:

- Will the person have been in an institution for at least 60 days by the time they are ready to discharge? If so, MHM migh
- Can the person move out of a nursing facility sooner than 60 days? If so, RSC-TCM or HSS might be the best option to m
- Where is the person moving from?
- What type of community residence does the person want to move to?
- What is the person's level of care?
- Does the person need additional services to help them live in the community?

The following table provides a comparison between the programs/services.

Eligibility criteria	MHM	RSC-TCM
Be on MA	Yes	Yes
Age	No requirement	No requirement
Resides in a hospital	Yes, for 60 or more days	Yes, and there is no requirement for length of stay

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Thank You!

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