

DEPARTMENT

**DEPARTMENT OF HUMAN SERVICES AND THE LONG TERM CARE OMBUDSMAN OFFICE**

**FEDERAL INITIATIVE:** MONEY FOLLOWS THE PERSON (MFP) DEMONSTRATION PROJECT

**NEW JERSEY'S MFP PROGRAM:** “I CHOOSE HOME NEW JERSEY”

**EFFECTIVE DATE:** July 1, 2014

**UPDATED:** March 29, 2023

1. **TITLE:** MFP Nursing Facility Transition Process for Individuals receiving Managed Long Term Services and Supports (MLTSS).
2. **PURPOSE:** To establish guidelines for transitioning an MFP eligible individual from an institution to a community setting.
3. **SCOPE:** All MFP eligible nursing facility residents transitioning to community living receiving MLTSS.
4. **POLICIES:**

• An MFP eligible individual must:

* Reside in an inpatient facility for a period of not less than 60 consecutive days (Medicare rehab days do count toward the 60 day stay count);
* Receive Medicaid benefits for inpatient services furnished by the inpatient facility at least one day prior to discharge;
* Meet clinical and financial eligibility for MLTSS;
* Eligible for MLTSS on day of discharge from the inpatient nursing facility;
* Transition to an MFP qualified Community Setting as defined by CMS:
	+ A home owned or leased by the individual or the individual’s family member; the lease/deed must be held by the individual or the individual’s family member;
	+ An apartment with an individual lease, with lockable access and egress and which includes living, sleeping, bathing and cooking areas over which the individual or the individual’s family has domain and control;
	+ A residence in a community-based residential setting in which no more than 4 unrelated individuals reside.
* Sign an informed consent agreeing to participate in MFP.

1. **PROCEDURE:**
2. Upon identification of an individual for potential transition to the MFP program, the MCO Care Manager shall complete and document, in the Member’s electronic Care Management record, the required transition counseling. Upon completion of transition counseling, the MCO Care Manager shall submit the MFP Eligibility referral form (MFP 77) to the appropriate regional OCCO MFP Liaison (see Article 9.7.2).

B. The MCO Care Manager shall be notified of the individual’s approval into the MFP Program by the OCCO MFP Liaison.

C. The MCO Care Manager shall lead and coordinate all required Inter-Disciplinary Team (IDT) meetings and other communications necessary to ensure a seamless transition of the individual back into the community. The MFP Nurse Liaisons are the subject matter experts and must participate in the IDT meetings for all MFP transitions (see Article 9.7.2 (A).

D. The MCO Care Manager shall identify, approve and enter appropriate service authorizations into the MCO’s utilization management system for all agreed upon Transition Services including PCA services prior to the Member’s discharge from the NF.

E. Prior to the effective date of transition, the MCO Care Manager shall conduct a full assessment of the individual’s needs, utilizing the NJ Choice assessment system and the state mandated PCA tool and shall work with the individual to create and execute an agreed upon person-centered plan of care in the community prior to discharge from the institution. If Community Transition Services (see B.9.0) are identified, they should be set up in the home no later than the day of discharge (see Article 9.7.2 (D) 4.)

F. MFP Transition Outreach Standards. Upon discharge from the institution, the MCO’s Care Management staff shall adhere to the following visit standards:

1. The MCO shall outreach telephonically to the individual within five (5) business days of discharge.

2. The MCO shall complete the face-to-face visit at the individual’s residence within ten (10) business days of discharge.

3. The MCO shall complete the plan of care with individual’s signature prior to discharge and shall revise the plan as necessary.

4. The MCO shall, at a minimum, complete monthly telephonic outreach and quarterly face-to-face visits with the individual for the first three hundred sixty-five (365) calendar days of enrollment in the MFP program. 5. After the three hundred and sixty-fifth (365th) calendar day of enrollment in the MFP program, the MCO may implement outreach and visit standards in accordance with section 9.6.5 of the MCO contract with the state.

6. Compliance with the MFP Operational Protocol for Care Management and coordination/outreach and visit standards after the MFP participant returns to the community up to the three hundred sixty-fifth (365th) day of participation in the MFP demonstration program;

G. The MCO shall electronically track all MFP qualified days, through their Care Management system, for each MFP demonstration participant and notify the MFP Project Director and the MFP Associate Project Director, via the MFP 76 form, of any triggers that would stop the MFP clock or disqualify the Member from participation in the MFP demonstration program within forty-eight (48) hours of a trigger event (see Article 9.7.3 (G).

H. Compliance with all monitoring and reporting of MFP performance measures in a manner prescribed by the State (see Article 9.7.4).