Downstate
Long Term Care Forum

March 11, 2015
Howlett Building
Springfield, IL

ABE - Application for Benefits Eligibility

- Apply for medical, SNAP or cash benefits online
- Upload verification documents with app
- Partially complete and save – return later
- Automatically referred to correct state office
- Usually takes 30-45 minutes to apply

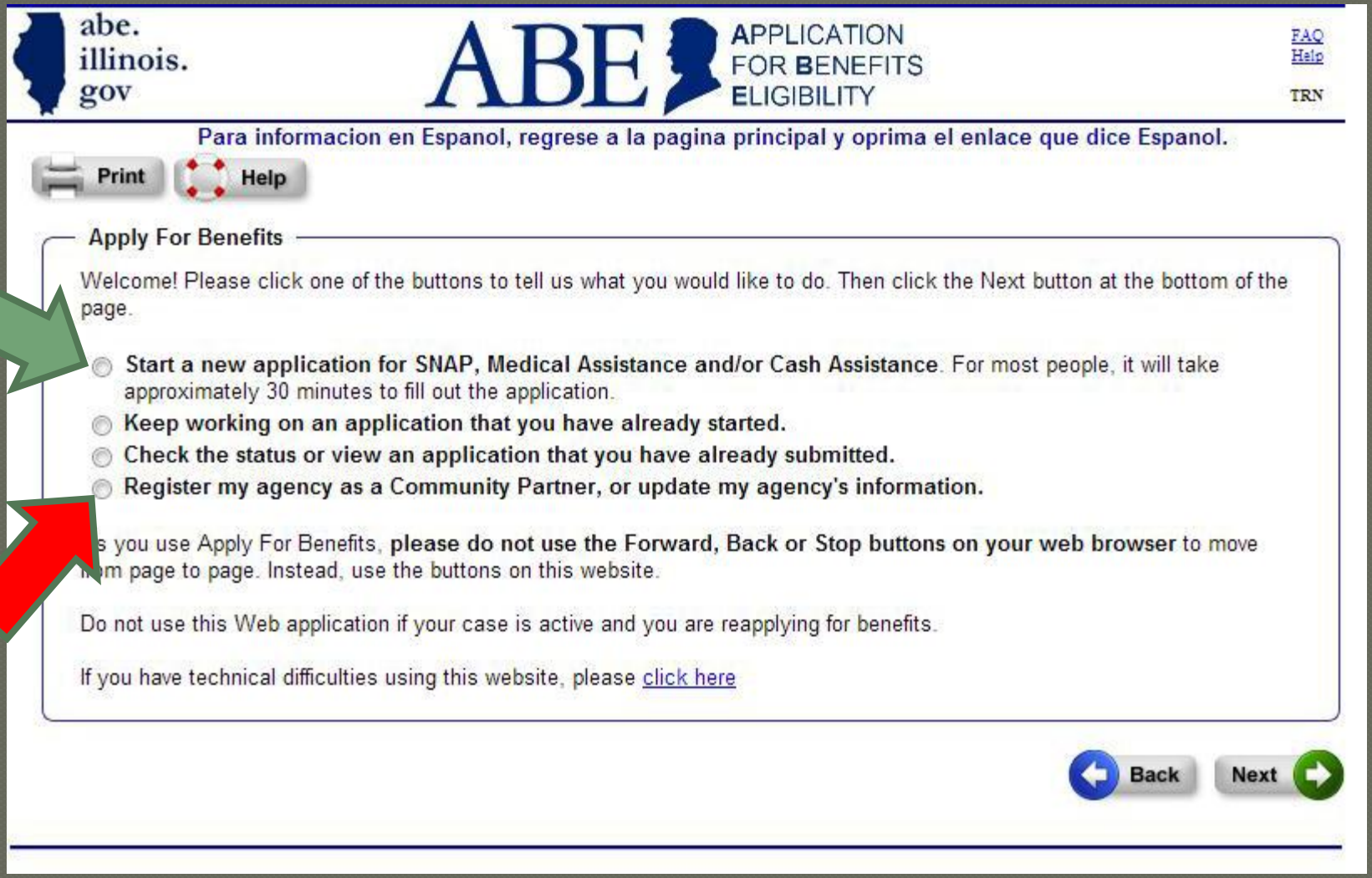
Abe.illinois.gov

Things you want to have on hand

- Income information
- Resource Information
- Immigration information for individuals who are not U.S. citizens
- Completed Form 3654 or any other documents you want to upload

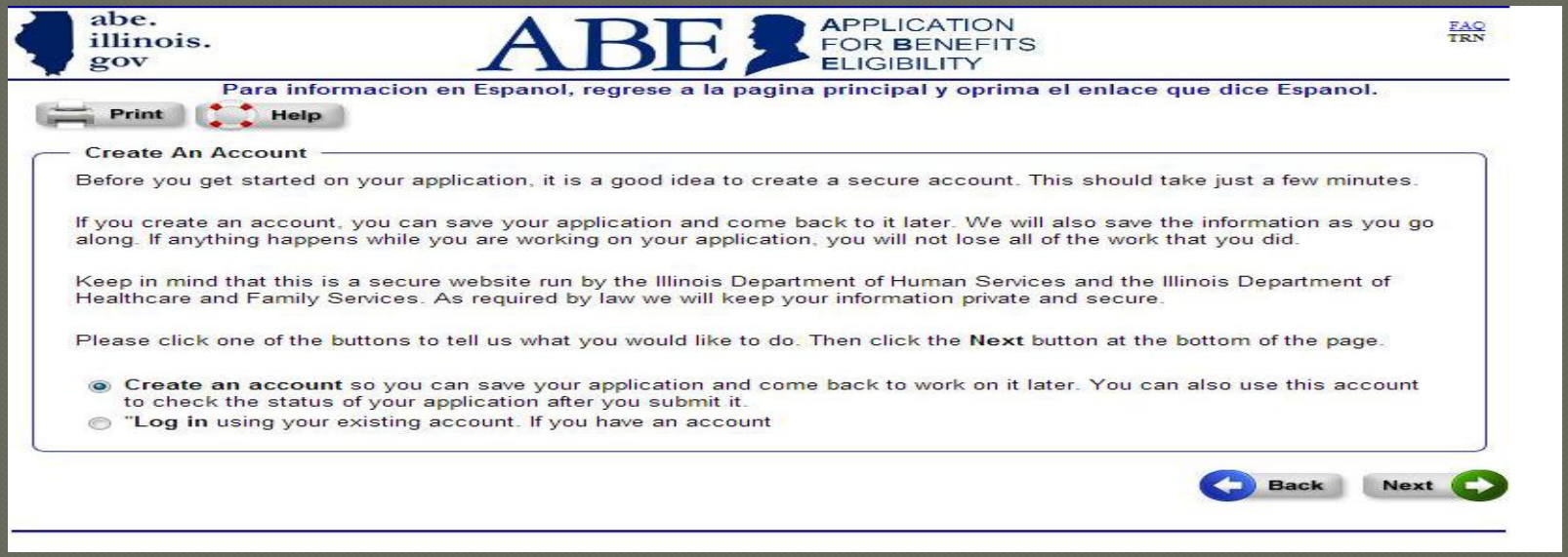
- Information does not have to be uploaded but may reduce state processing time

Starting an Application



Create a Personal Account

Each application needs a separate account



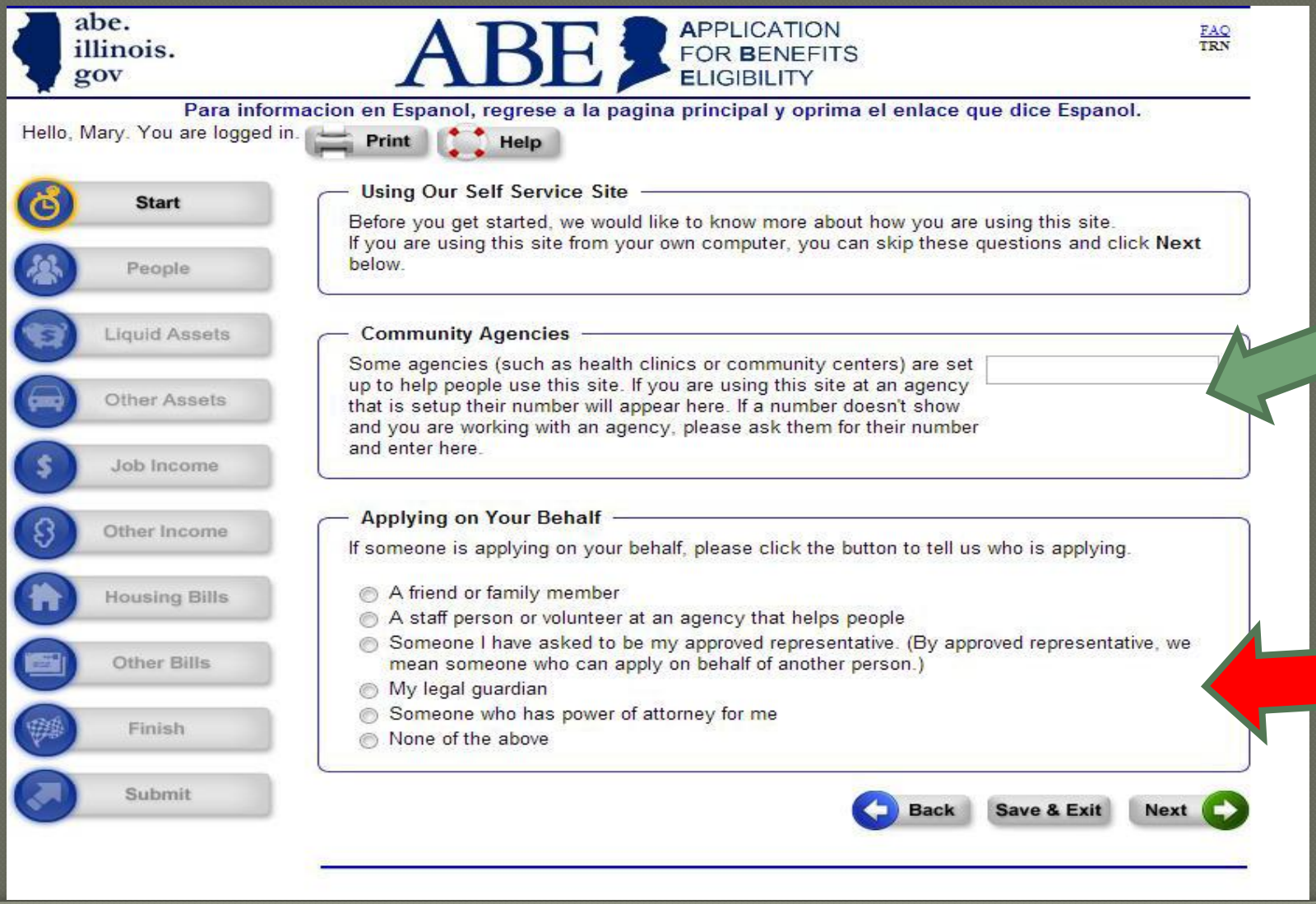
User ID – at least one capital letter, one number, no special characters, 8-16 characters long

ex: John0220 – name, birth date

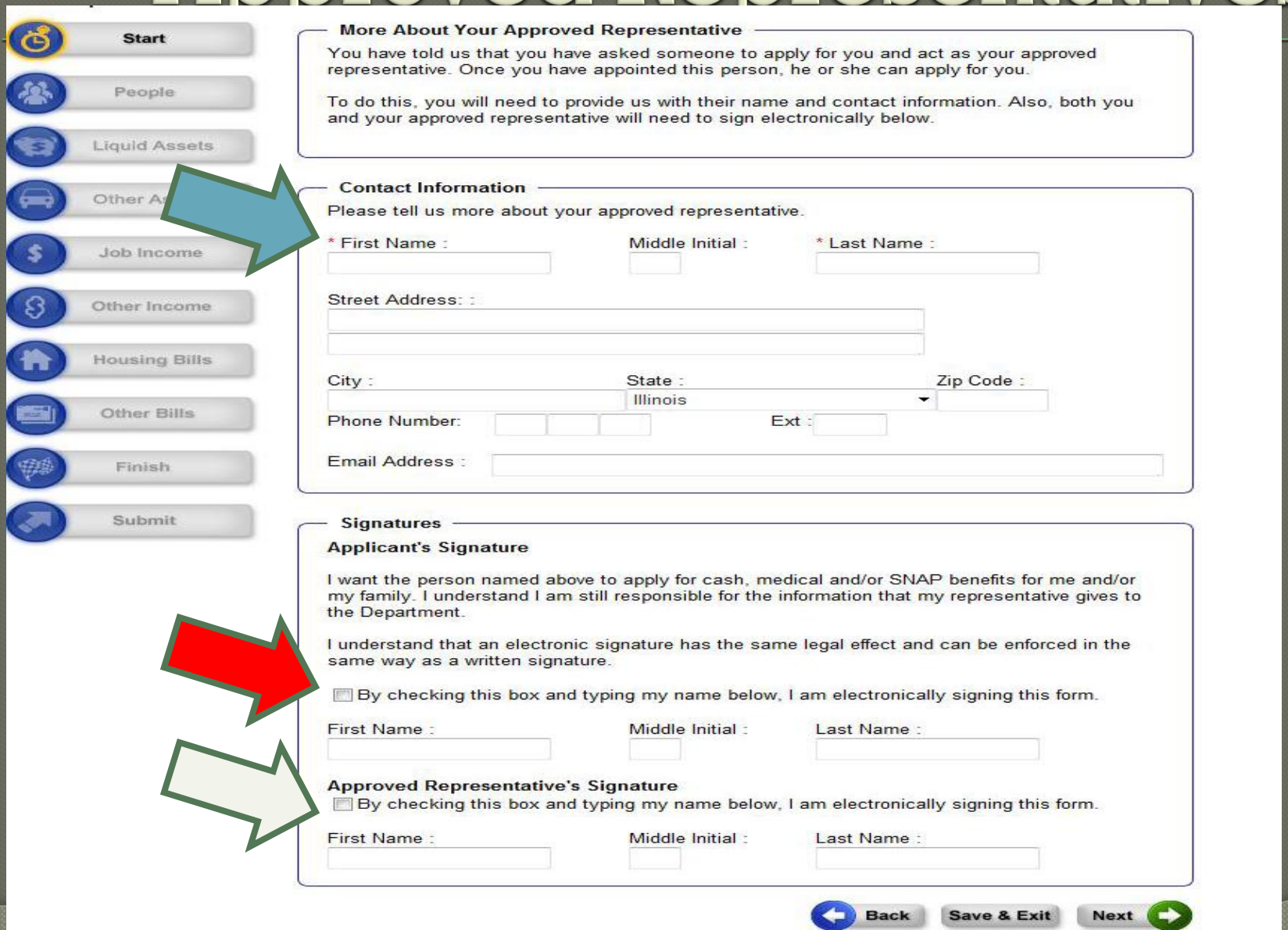
Password– at least one capital letter, one lower case letter, one number, no special characters, 8-16 characters long, cannot reuse name

ex: Js02208420 – initials, birth date and last 4 SSN

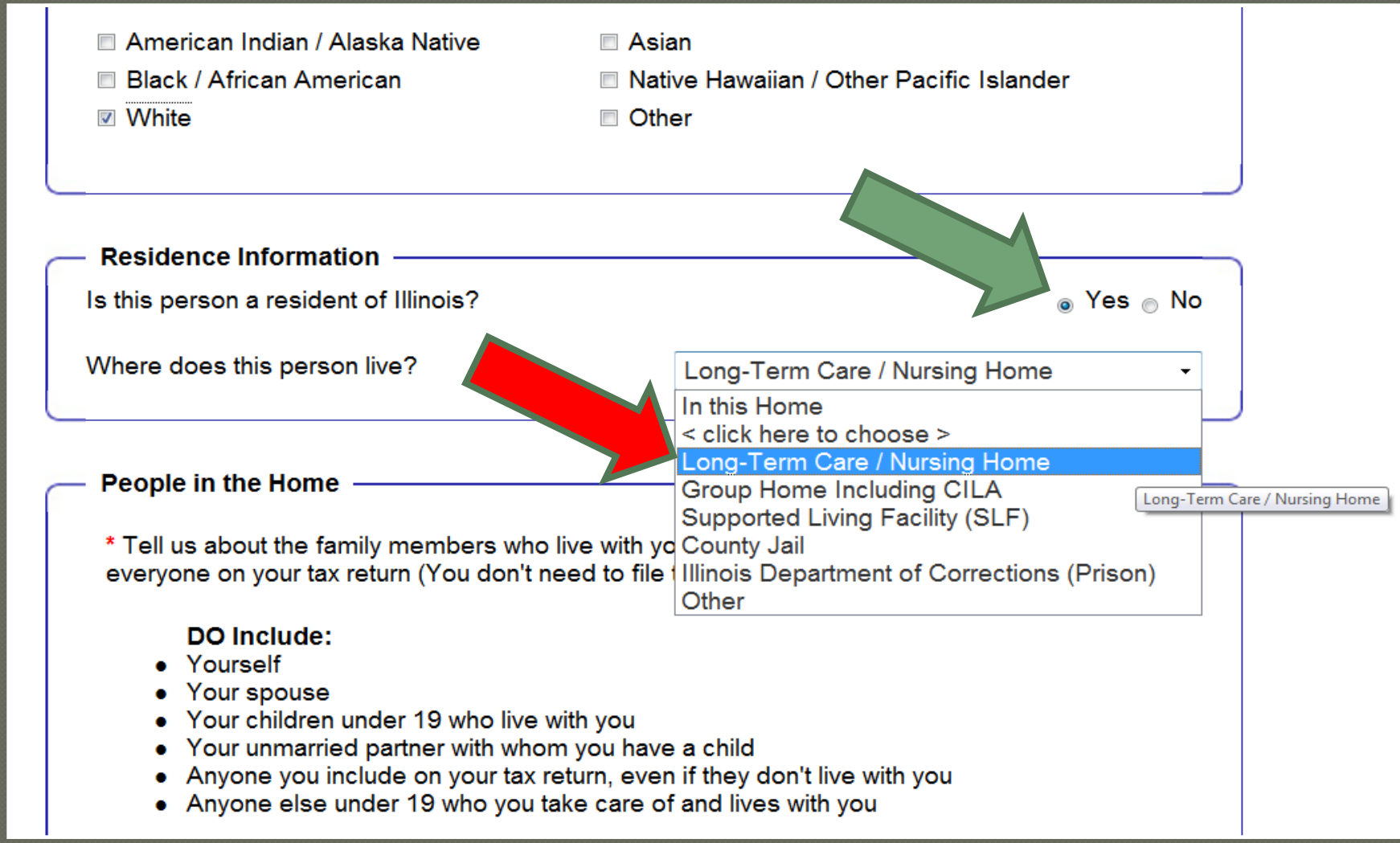
Application Assistance



Approved Representatives



Where does the Person Live?



Offer of Illinois Voter Registration Application

* If you are interested in registering to vote, you may complete the Illinois Voter Registration Application (Illinois Voter Registration Application — SBE R-19)

- Illinois Voter Registration Application (English Version) (pdf)
- Aplicación Para Registro De Votantes De Illinois (Spanish version) (pdf)
- 伊利諾州選民註冊申請 (Chinese version) (pdf)

and return it to your local election office or your Family Community Resource Center.

Office Information

Based on the information you provided in your application, the system will send your application to the following DHS/HFS office:

South Loop FCRC
1112 S WABASH
CHICAGO IL 60605-2351
Phone Number: (123) 456-7890

If you would like to be served at an alternate office, please select your office of choice from the list below:

Service Office:
SOUTH LOOP FCRC

Electronic Attestation

I have agreed to submit this application by electronic means. By signing this application electronically, I declare under penalties of perjury that my answers are correct and complete to the best of any knowledge and belief. I also declare the following:

- I understand the questions and statements on this application.
- I have read and understand my Rights and Responsibilities in the box above.
- I understand the penalties for giving false information.
- I understand that upon verification of my information, this attestation will have the same legal effect and can be enforced in the same way as a written signature.

* ☐ By checking this box and typing my name below, I am electronically attesting to the information in the application.

* First Name : Middle Initial : * Last Name :

Back Submit

Para informacion en Espanol, regrese a la pagina principal y oprima el enlace que dice Espanol.

Hello, Mary. You are logged in. Print Help

100% Complete

Logout

Thank You!

Thank you! Your online application has been sent to the following DHS office for processing:

Mailing Address :

South Loop FCRC
1112 S WABASH
CHICAGO IL
60605-2351
Phone Number:
(123) 456-7890

Keep Track of Your Application

Your tracking number for this application is **T11018040**.

Be sure to write this number down or print this page for your records.

If you are applying because you have a disability, you will get a notice about medical benefits within 60 days of your application date. If you do not have a disability, you will get a notice within 45 days.

"

If you have a question about your application or need to report new information you may contact the office listed at the top of this page. It will be helpful to have your tracking number.

Print Your Application

DO NOT MAIL THIS APPLICATION. Print or save it for your own records only.

To print, click on the Print My Application button below. If you decide to print or save a copy keep in mind this application has your private and personal information on it.

Print My Application

You will need to have a program called Adobe Acrobat Reader to see and print this application. If you do not have this program on your computer, you may install it for free by clicking on the icon below.

Get Adobe Reader

Your Next Steps

Based on the application you submitted, here are some steps that you may take to help us process your application. Click Next to continue.

View and Submit Types of Proof
View and Submit documents to confirm the information you provided in you request.

Return to IES Home

Next

Redeterminations

IMRP Process

- Renewal Notice mailed to client notifying them that rede is coming in about 2 weeks
- 2 weeks later, rede form mailed to customer with 22 working days to return
- Rede can be returned by mail in the enclosed, post-paid envelope or faxed
- Case canceled if not returned and no response from consumer/rep
- Include proof of income or any other changes
- Special central rede unit reviews the rede and updates case.

Rede Tips

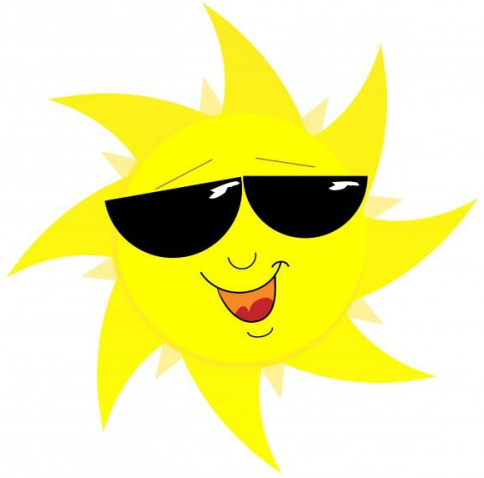
- Keep the address updated.
- Return the rede by the due date
- Call IMRP to request a replacement if the form is lost/not received.
- Fax the rede and proofs, if possible. The rede automatically loads to the person's case.
- Include proof of income/expenses in the latest 30 days or any information that has changed (state will electronically review SSA/SSI).

IMRP Questions

- Contact the IMRP
  - 1-855-HLTHYIL (1-855-458-4945)
  - TTY: 1-855-694-5458
- If a case is canceled for not responding to the rede, send the rede as soon as possible and the case will be reviewed for reinstatement
- Cases can be reopened for 3 months following the cancelation (without having to reapply).

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bureau of Long Term Care Updates



Janene Brickey
BLTC Policy and Rules

HFS Home Page

http://www2.illinois.gov/hfs/Pages/default.aspx

HFS Major Initiatives

Budget and Legislative Medicaid Reforms

Medicaid Redetermination Project

Medicaid Redetermination Project

Accountable Care Entity (ACEs) and Care Coordination Entities (CCEs)

Care Coordination

Child Support Services

1115 Waiver

Family Planning & Birth Control

Affordable Care Act

Public Involvement

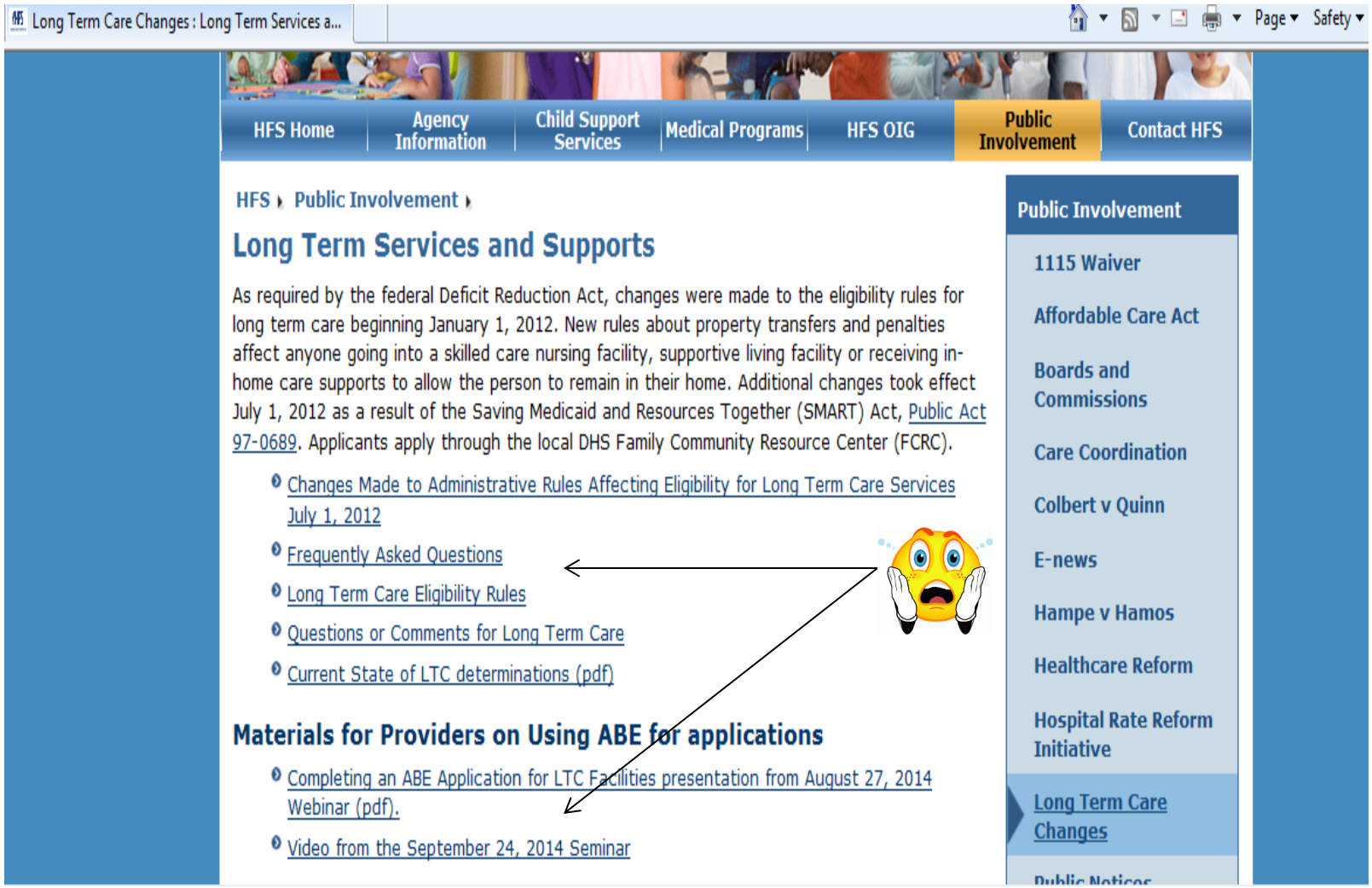
- HFS Advisory Groups
- HFS E-News and Registration
- HFS Public Notices

News and Announcements

- Health Homes Concept Paper (pdf)
- Transplant Policy Recommendations for Comments (pdf)
- Potentially Preventable Readmissions (PPR) FY 2013 Reconciliation – Remaining Amount Owed

Special Projects

- Eligibility Requirements for Long Term Care and Support Services
- Pathways to Community Living: Rebalancing Initiative


Long Term Care Changes : Long Term Services a...
Page
Safety
HFS Home
Agency Information
Child Support Services
Medical Programs
HFS OIG
Public Involvement
Contact HFS
HFS
Public Involvement
Long Term Services and Supports
As required by the federal Deficit Reduction Act, changes were made to the eligibility rules for long term care beginning January 1, 2012. New rules about property transfers and penalties affect anyone going into a skilled care nursing facility, supportive living facility or receiving in-home care supports to allow the person to remain in their home. Additional changes took effect July 1, 2012 as a result of the Saving Medicaid and Resources Together (SMART) Act, Public Act 97-0689. Applicants apply through the local DHS Family Community Resource Center (FCRC).
Changes Made to Administrative Rules Affecting Eligibility for Long Term Care Services July 1, 2012
Frequently Asked Questions
Long Term Care Eligibility Rules
Questions or Comments for Long Term Care
Current State of LTC determinations (pdf)
Materials for Providers on Using ABE for applications
Completing an ABE Application for LTC Facilities presentation from August 27, 2014 Webinar (pdf).
Video from the September 24, 2014 Seminar
Public Involvement
1115 Waiver
Affordable Care Act
Boards and Commissions
Care Coordination
Colbert v Quinn
E-news
Hampe v Hamos
Healthcare Reform
Hospital Rate Reform Initiative
Long Term Care Changes

Long Term Care Changes : Frequently Asked Que...

Page ▾ Safety ▾ Tools ▾

HFS ▸ Public Involvement ▸ Long Term Care Changes ▸

Frequently Asked Questions

The answers below address common questions about the eligibility process for Illinois Medicaid coverage of nursing facility and other long term support services (LTSS).

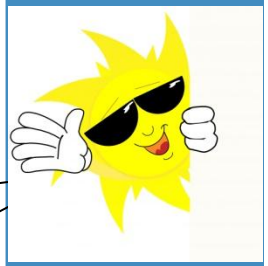
These FAQs are oriented toward the prospective of providers of long term care supports and services. We are working on similar FAQs for clients.

Some of the answers will change in the near future. The Department is working to improve the process of LTSS eligibility determination. For that reason, we encourage users to check back as we will post updates from time to time. Other online resources are described below.

- Information concerning applying for long terms supports and services is posted and will be updated on the HFS Long Term Services and Supports webpage. Presentation material from the HFS webinars on how to use ABE, the online Application for Benefits Eligibility, is posted on that webpage and the direct links are shown below.
  - A Client's View of the Self Service Portal - ABE Webinar. A slide presentation with audio recording.
  - Completing an ABE Application for LTC Facilities (pdf). A slide deck in pdf format.
  - Completing an ABE Application for LTC Facilities. A video of the presentation with captioning.
- The annual re-determination process for Medicaid is explained in FAQs posted on the HFS Illinois Medicaid Redetermination Project (IMRP) Frequently Asked Questions (FAQs) (pdf).
- The procedures for determining resources (assets) and the regulations surrounding resource (Asset) transfers are explained in FAQs posted on the HFS Long Term Care Changes Frequently Asked Questions webpage.

Public Involvement

- 1115 Waiver
- Affordable Care Act
- Boards and Commissions
- Care Coordination
- Colbert v Quinn
- E-news
- Hampe v Hamos
- Healthcare Reform
- Hospital Rate Reform Initiative
- Long Term Care Changes
- Public Notices



Illinois Medicaid Redetermination Project (IMRP)
Frequently Asked Questions (FAQs)
June 2014

We have operators who speak Spanish, and free interpreter services for other languages. All calls to IMRP are free.

Tenemos operadoras que hablan español, y servicio de intérpretes gratis para otros idiomas. Información en español disponible 1-855-458-4945 (TTY: 1-855-694-5458) Todas las llamadas telefónicas an IMRP son gratis.

1. ***What is a redetermination?***

A redetermination is a review of eligibility for Medicaid, All Kids, SNAP or cash assistance. Eligibility for Medicaid and All Kids must be reviewed at least once a year. The state must decide whether a client meets the rules to keep getting benefits. For example, to get Medicaid a person must be an Illinois resident and must have income that is less than the maximum allowed under Illinois law. Sometimes there are other rules that must be reviewed. Clients will be notified if other rules apply to their eligibility.

Frequently Asked Questions About Medicaid Eligibility for Long Term Supports and Services

1. Completing the ABE Application

1.1. If the resident receives Pension or Social Security Administration (SSA) which one would we choose?

A: Check whichever apply. If the person has an employer pension, mark 'Other Income' and for SSA income, check 'RSDI Income'. If the person has both types of income, you would check both

COMPLETING AN ABE APPLICATION FOR LTC FACILITIES

John Spears
IL Dept. of Healthcare &
Family Services
8/27/2014

HFS Home | Agency Information | Child Support Services | Medical Programs | HFS OIG | Public Involvement | Contact HFS

Welcome to the Website for Healthcare and Family Services, the state agency dedicated to improving the lives of Illinois families through healthcare coverage and child support services. Our mission is to empower Illinois residents to lead healthier and more independent lives by providing adequate access to healthcare coverage at a reasonable cost, and by establishing and enforcing child support obligations. We are proud to make a positive difference in the lives of Illinoisans.

HFS Major Initiatives

Budget and Legislative Medicaid Reforms

Medicaid Redetermination Project

Medicaid Redetermination Project

Accountable Care Entity (ACEs) and Care Coordination Entities (CCEs)

Care Coordination

Public Involvement

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- HFS E-News and Registration
- HFS Public Notices

News and Announcements

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HFS ▸ Public Involvement ▸

Care Coordination

Welcome to the Care Coordination Policy Forum. PA96-1501 (pdf) (also known as "Medicaid Reform") requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by a variety of "managed care entities," a general term that will include Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs) and Accountable Care Entities (ACEs).

This site will be the major electronic channel for communication on this policy change. Please continue to consult this site, as we will post information about next steps as available.

Public Involvement

- 1115 Waiver
- Affordable Care Act
- Boards and Commissions
- Care Coordination
- Colbert v Quinn

LIST OF CONTACTS AT MEDICAID HEALTH PLANS

For each of the Health Plans serving the various Medicaid populations, the following are contacts of persons designated to work with providers on network development and contract negotiation.

For MCOs and MCCNs, payments to providers are made by the managed care entity. For CCEs and ACEs, payments to providers are currently paid fee-for service by the Medicaid Program.

Care Coordination Roll-out – *Questions from 06/30/14 Webcast*

Types of organizations referred to in these responses:

Health Plan:

ACE **Accountable Care Entity (ACE)** - provider-based organizations on a three-year path to operating a full-risk capitated plan. Within the first 18 months, medical and other services are paid on a fee-for-service basis.

CCE **Care Coordination Entity** - a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets, in order to provide care coordination services for its Enrollees. Medical and other services are paid on a fee-for-services basis.

CSN CCE **Children with Special Needs Care Coordination Entity** - provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. Enrollees in a CSN CCE will be limited to children that the Department has identified through claims data or other information as having complex medical needs.

MCCN **Managed Care Community Network** - an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services for Medicaid clients. They are paid on a full-risk, capitated basis, and therefore pay all claims for services for the enrollees in their Health Plan.

MCO **Managed Care Organization** - a health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.). They are paid on a full-risk, capitated basis, and therefore pay all claims for services for the enrollees in their Health Plan.

Care Coordination Roll-out – *Questions from 06/30/14 Webcast*

	Category	Question	Response
1	Roll-out, enrollment, mailings	I was unable to print out all the useful information in the webinar. Can you send me a link so I can try to do this again?	All of the information from the webcast can be found on the Department's website in the care coordination section at: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx
2	Roll-out, enrollment, mailings	Is there an official start/effective date for clients based upon when mailings are distributed to Medicaid clients?	The mailing schedule that is posted on the Department's website reflects the first date that mailings will begin in an area for all eligible clients. That is the date that clients can begin to voluntarily enroll. Auto-assignments for clients that do not select a health plan will be effective approximately 60 days after their initial mailing.
		When will recipients of the All Kids program receive letters stating they need to pick a Managed Care program? Is there a specific deadline for those recipients? When will their Manage Care begin?	
3	Roll-out,	Can you share the link to this	See the "Managed Care Expansion Mail Schedule" that

HFS Healthcare and Family Services
HFS Home
Agency Information
Child Support Services
Medical Programs
HFS OIG
Public Involvement
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Public Involvement
HFS Advisory Groups
HFS E-News and Registration
HFS Public Notices

HFS.Illinois.gov | HFS News | Contact Us | Illinois Home
Search
HFS
ILLINOIS DEPARTMENT OF
Healthcare and
Family Services
HFS Home
Agency Information
Child Support Services
Medical Programs
HFS OIG
Public Involvement
Contact HFS
HFS
HFS Medical Programs
The Department of Healthcare and Family Services (HFS), Division of Medical Programs, administers and, in conjunction with the federal government, funds medical services provided to about 20 percent of the State's population. Illinois' Medical Assistance Programs, consisting of Medicaid and numerous other medical programs associated with it, provide comprehensive health care coverage to over 2.6 million Illinoisans and partial benefits to another 290,000+. The programs cover children, parents or relatives caring for children, pregnant women, veterans, seniors, persons who are blind, and persons with disabilities.
Medical Programs
General Information
Medical Customers
Medical Providers

HFS Home | Agency Information | Child Support Services | Medical Programs | HFS OIG | Public Involvement | Contact HFS

HFS ▸

Medical Providers

- Medical Providers
  - General Information
  - Medical Customers

- Contact Us
- Brochures and Forms
- Care Coordination Innovations Project
- Care Coordination Innovations Project Matchmaking
- Care Coordination Innovations Project Matchmaking Search for Partners
- Children's Mental Health
- Claims Processing System Issues
- Community Mental Health Centers
- Contraception from Most Effective to Less Effective
- Cost Reports
- Dental
- E-Mail Notification
- Electronic Data Interchange (EDI)
- Electronic Health Record Medicaid Incentive Payment Program (eMIPP)
- Fee Schedule
- Forms (Medical Programs)

State of Illinois
Department of Healthcare and Family Services
Department of Human Services

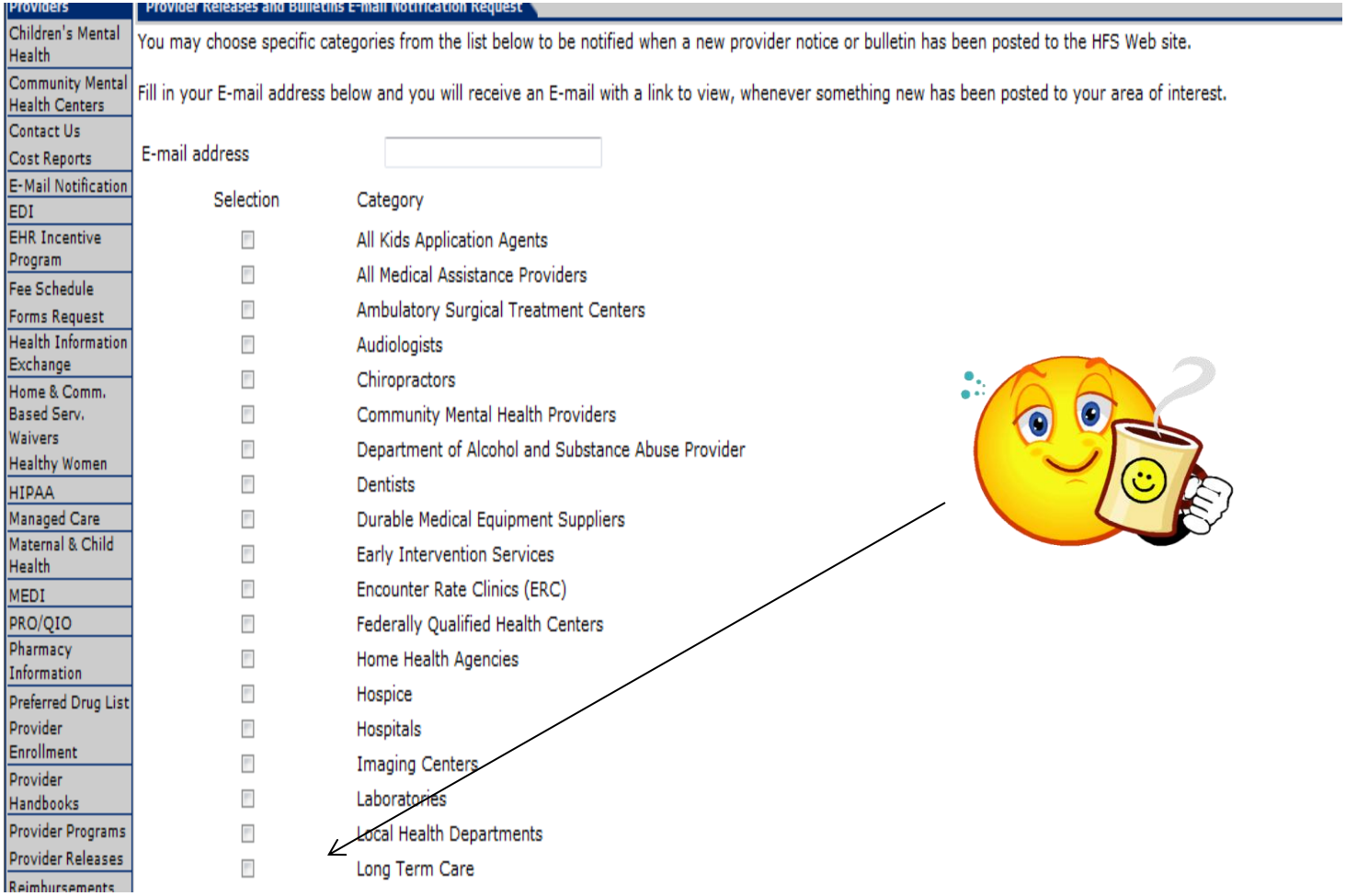
ADDITIONAL FINANCIAL INFORMATION FOR LONG TERM CARE APPLICANTS

Read carefully and follow all instructions:

- **For new applicants applying for Nursing Home Services, Supported Living Program or Department on Aging Home and Community based services, this form must be included with your paper application (see last page of this form for mail/fax information) or upload with your electronic application when you file through abe.illinois.gov.**
- **For current medical clients who are applying for Nursing Home Services or Supported Living Program or requesting Department on**

HFS USE ONLY
DHS CASE No.
OIG USE ONLY OIG CASE No.

HFS 3654 (R-10-14)



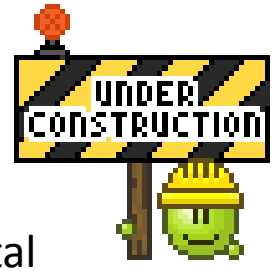
http://www.hfs.illinois.gov/provrel/

Monthly Billing Requirement

Requirement of Public Act 98-0104.

Facilities will transition to HIPAA compliant X12 837 claim or paper UB-04 format for monthly claim submission.

Additional Informational Notices will be released regarding further instruction and training and to explain any operational, structural, and rule changes .



Includes:

* Skilled Nursing Facilities
* Facilities eligible for provisional licensure of Specialized Mental Health Rehabilitation Act of 2013
* Supportive Living Program providers

Does not include at this time:

*Intermediate Care Facilities for Individuals Intellectually Disabled
* State Operated Facilities

Facility Notification of Redeterminations of Eligibility

HFS is developing a temporary process in which providers of nursing facilities and the Supportive Living Program will be able to receive a monthly list of facility residents that are due for a Medicaid Redetermination (REDE).

The list will be sent to the facility by secure encrypted/password protected email. A facility designated representative must be selected to be responsible for receiving the list to ensure HIPAA compliance and the privacy of the residents.

The list will be generated based on the current Department of Human Services information and may not reflect residents whose admission has not yet been processed.

An Informational Notice will be released explaining the process and instruction to facilities wishing to participate in this process.

Bureau of Hearings
Department of Human Services

Nick Lucius

APPEALS
FREQUENTLY ASKED QUESTIONS
FOR LONG TERM CARE PROVIDERS

- **Q: As a nursing home, how can I help residents with the appeal process?**
- **A:** If the resident appoints you as his/her representative for the appeal process, you can file an appeal on behalf of the appellant. If you are the representative, you will receive copies of all letters and can participate in the hearing as the appellant's representative. Please be aware, however, that any action or inaction on your part will be viewed as the action or inaction of the appellant.

- **Q: How do I become a representative for an appellant in the appeal process?**
- **A:** On the appeal form, there is a space for the appellant to indicate that s/he would like a representative. Your name, address and phone number should be clearly delineated in this section. Please note that an actual person must be designated as the representative; a company such as "nursing home A" cannot be listed as a representative. The appeal form is then signed by the appellant and submitted directly to the Bureau of Hearings at the following: DHS.BAHNewAppeal@illinois.gov, Fax: 312-793-3387, Mail: DHS Bureau of Hearings 69 W. Washington, 4th Floor, Chicago, IL 60602.

- **Q: How do I become a representative if the appellant has signed a Power of Attorney?**
- **A:** If the appellant has an existing Power of Attorney for claims and litigation, the appeal form must be signed by the individual with Power of Attorney (POA) if the client does not sign the appeal. On the appeal form, the individual with POA can then designate you as the representative for the appeal. When you submit the appeal form, you must include a copy of the Power of Attorney along with the appeal form to the Bureau of Hearings. If the Power of Attorney is not submitted with the appeal form, the appeal request will be rejected. Also, please keep in mind that not all Power of Attorney forms are the same. For example, if the person has the Power of Attorney for Healthcare decisions only, then that person does not have the right to appeal a decision on behalf of the client and, therefore, does not have the right to assign you as the representative. An easy way to remember this is if the client is not the one signing the appeal form, you need to submit all of the documents that show the "chain" of how each person who did sign the appeal form has the right to sign the document on behalf of the appellant.

- **Q: What happens if I submit the appeal form but didn't submit the Power of Attorney and the appeal was rejected? Can I resubmit a new appeal request**?
- **A:** Yes, you can submit a new appeal request. Keep in mind that a valid appeal request must be received by the Department no more than 60 days after the letter sent by DHS denying the application for benefits. A valid appeal request is one that contains all of the appropriate signatures along with the supporting documentation for those signatures. For example, DHS sends a denial of application to John Doe on June 1, 2015. On behalf of John Doe, a nursing home employee submits an appeal request on June 30, 2015, signed by John Doe's Power of Attorney, designating the nursing home employee as a representative. However, the POA is not attached to the appeal request. After realizing that the proper documents were not submitted, the nursing home employee resubmits the appeal request on September 5, 2015 with a copy of the Power of Attorney. This is now considered a valid appeal as all signatures and documents were properly submitted. But, this appeal will be dismissed for lack of jurisdiction as the appeal request with the supporting documentation was not submitted within 60 days of June 1, 2015.

- **Q: What if the resident has died or is not competent to appoint a representative?**
- **A:** Since the resident cannot sign a POA or authorization form, an individual (such as a guardian, executor, or administrator) must be approved by a court to represent the resident or his/her estate. When filing the appeal, you must submit Letters of Office or a court order appointing that individual, stamped or signed by the Clerk of Court or Circuit Court Judge of the county in which the individual was appointed. That individual must then sign the appeal authorizing the provider representative to file the appeal on behalf of the resident. Like mentioned above, in all cases you must show the "chain" of authorization from the resident or his/her estate to the person who signed the appeal.

Illinois' Money Follows The Person Demonstration "Pathways to Community Living"

Updated – 3/9/2015

Pathways

To Community Living

Presentation Overview

1. Overview and Background
2. Program Requirements
3. Referral Process

Overview and Background

Pathways
To Community Living

The ***Money Follows the Person Demonstration Program*** is one prominent example of a rebalancing initiative. Created by the Deficit Reduction Act of 2005, Money Follows the Person now operates in 43 states and the District of Columbia. Under the Affordable Care Act, MFP was extended through December 31, 2016.

Re-balancing in Illinois

- MFP is part of a larger rebalancing effort across the state of Illinois
  - Balancing Incentive Payment Program
  - Olmstead related lawsuits
    - *Williams v. Quinn* - Individuals with mental illness residing in nursing homes classified as Institute's for Mental Disease (IMDs)
    - *Ligas v. Quinn* - Individuals with intellectual or developmental disabilities
    - *Colbert v. Quinn* - Individual with disabilities and who are elderly residing in non-IMD nursing facilities in Cook County
- State facility closures

What is Money Follows the Person (MFP)?

- MFP is a Federally administered demonstration program, not a grant, that provides resources which enable states to help individuals move from a qualified institution, such as a nursing home, to a community based setting
  - Authorized by the Deficit Reduction Act of 2005 and extended until 2016 by the Affordable Care Act (ACA)
  - Administered by the Federal Centers for Medicare and Medicaid Services (CMS)
  - 43 states and the District of Columbia currently participate in MFP
  - Participating states receive 25% enhanced federal match on Medicaid services received by MFP participants who move to the community

Money Follows the Person Goals

- Goals Include:
  - Increase the use of Home and Community Based Services (HCBS)
  - Eliminate state barriers that prevent the use of Medicaid funds to enable individuals to receive care in the settings of their choice
  - Strengthen the ability of Medicaid programs to assure continued provision of HCBS
  - Ensure procedures are in place to provide quality assurance and continued quality improvement

Illinois' MFP "Pathways to Community Living"

- Illinois' Operational Protocol was approved in 2008, with transitions beginning in 2009
- State legislation - Money Follows the Person Implementation Act (2008) amended the Disability Services Act of 2003
- Illinois' MFP program, "Pathways to Community Living," includes six populations:
  - Individuals over age 60
  - Individuals with developmental disabilities
  - Individuals with physical disabilities
  - Individuals with serious mental illness
  - Individuals with Acquired Brain Injuries (new in 2013)
  - Individuals with HIV/AIDS (new in 2013)

Participating State Departments

- Department of Healthcare and Family Services (DHFS)
- Department on Aging (IDoA)
- Department of Human Services (DHS)
  - Division of Mental Health (DMH)
  - Division of Rehabilitation Services (DRS)
  - Division of Developmental Disabilities (DDD)
- Other partners include:
  - The Illinois Housing Development Authority
  - The University of Illinois at Chicago – College of Nursing

Program Requirements

Pathways To Community Living

How Does it Work?

- Each participating state agency/division contracts with community providers that complete identification, follow up, assessment, and transition coordination
  - IDOA
    - Case Coordination Units (CCU)
  - DHS DRS
    - Centers for Independent Living (CIL)
  - DHS DMH
    - Community Mental Health Centers (CMHC)
  - DHS DDD
    - Bureau of Transition Services/PAS agencies

MFP Eligibility Requirements

- To be eligible for the MFP program, an individual must:
  - Meet a qualified institutional stay of 90 days or more
  - Be a Medicaid recipient for at least one day before transitioning
  - Meet a Nursing home level of care for IDoA, DRS, and DMH participants and an ICF/DD level of care for DDD participants
  - Sign an informed consent
  - Transition to a qualified community based setting

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To Community Living

Qualified Institutions

- Qualified Institutions include:
  - Nursing Homes, not including those classified as Institutes for Mental Disease (IMD)
  - State Operated Developmental Centers
- Days in a hospital or an IMD also count towards the 90 day length of stay requirement, but the individual must be residing in a qualified institution for one day pre-transition

Qualified Community Settings

- Home owned or leased by the individual or a family member of the individual
- Apartment with individual lease, secure access, and living, sleeping, bathing, cooking areas over which the individual or his/her family has control
- Community-based residential settings with no more than four unrelated individuals
- In Illinois, transition to a Supportive Living Facility (SLF) is a qualified community setting
- Other assisted living settings are allowable under certain conditions

MFP Services

- Once transitioned, an MFP participant is eligible to receive the same services that make up the home and community based waiver or mental health state plan service package for which the person is eligible
  - Upon completing the MFP year an individual is transitioned into the service package for which they are eligible
- For more information on waivers in Illinois, please visit http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx

MFP Enhanced Services

- Support with a move into the community including individualized assistance and available financial support
- Development of a transition and care plan with linkage to community services
- Assistance and enhanced follow up from a qualified transition coordinator for 365 days after transition
- Housing services including assistance in finding a home and home modification
- Quality assurance and case consultation and review by the University of Chicago – College of Nursing

Pathways

To Community Living

Referral Process

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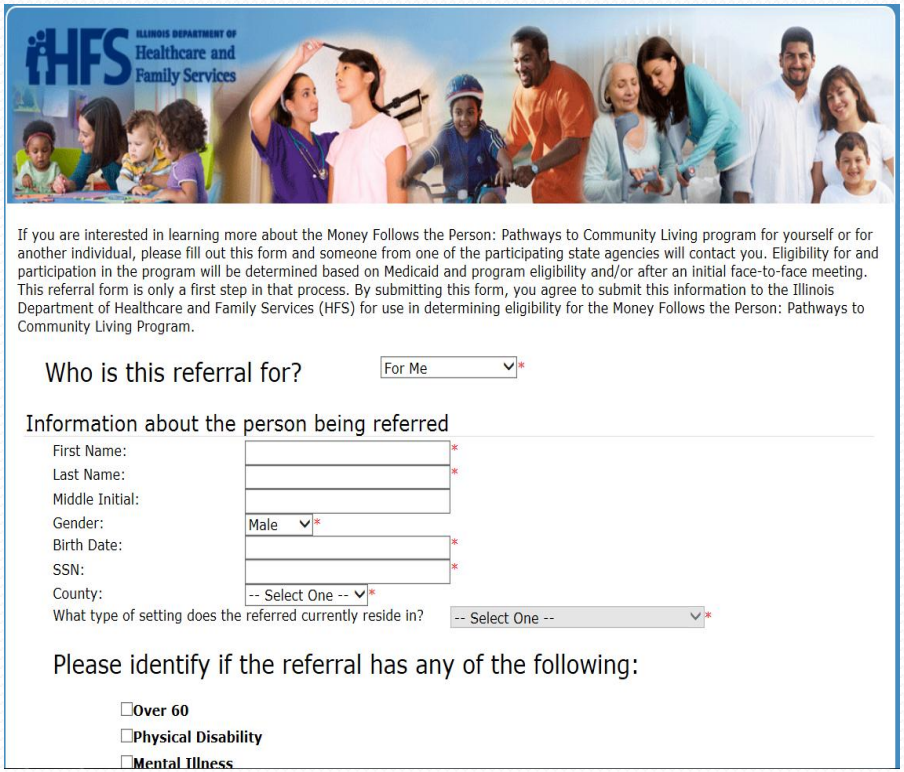
Process

- All referrals must be submitted through the MFP web based referral system
  - A referral confirmation receipt is sent via email
- Upon receiving a referral, cases are automatically routed for follow up by the CRM web application based on county and population
  - Note, data issues may delay referral routing
- Agencies have 10 business days to follow up on referrals or they are considered late
- To inquire on the status of a referral, email HFS.MFP@Illinois.gov

Referral Form

- Illinois utilizes on online web referral program to generate referrals for MFP
  - https://mfp.hfs.illinois.gov/mfpreferral.aspx
  - The web referral form is open to the public and gathers referrals from multiple sources



Pathways To Community Living

Provider Notice

- HFS issued a provider notice to Nursing Facilities on 9/21/2014 designating the MFP web referral form as the process to be used for submission of MDS, Section Q referrals
  - http://www.hfs.illinois.gov/html/091214n2.html
- HFS is tracks MDS Section Q referrals and is required to report this information to the Federal Centers for Medicare and Medicaid Services

Pathways To Community Living

Website: www.mfp.illinois.gov

- Includes online referral and email contact
- Includes links to;
  - All participating agencies and divisions
  - All marketing and outreach material
  - Housing Locator (IHDA)
  - Federal and other resources

Pathways

To Community Living

Thank you!

- Questions?
- Feedback?

OIG/LTC-ADI

- What is an asset
- What is valid documentation
- FMV/Penalties

Please send status of cases or information to our

LTC-ADI designated email:

HFS.OIG.LTC-ADI@illinois.gov

Asset (Resources)

- Annuities
- Bank Accounts, Money Markets, CD's, Mutual fund accounts, and Investment accounts
- Bonds
- Burial Funds
- Contents of Safe Deposit Box
- Inheritance
- IRA accounts/401K accounts
- Life Insurance
- Nursing Home trust funds
- Property
- Stocks or Exchange Traded Funds
- Trust
- Vehicles

Annuities

- Need the value of the asset at the beginning of the review period, or date of inception if opened during the review period.
- Verification of the source of funds used to open annuity if inception occurs during the review period.
- If paying out – date opened, terms of the annuity contract including number of payments, amount of payment, first payment date and/or current cash value. If withdrawals have occurred a history of $1000.00 withdrawals will be requested.
- Surrendered annuities – date of surrender, amount received and direction of proceeds.

Bank Accounts, Money Market, Mutual Funds, Investment accounts, and CD's

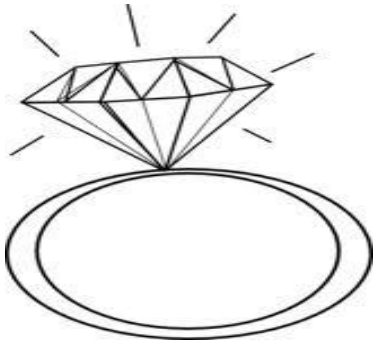
- Monthly (quarterly) statements or transaction reports for the entire review period
- Verification of transactions (withdrawals or deposits)in excess of $1000.00 – cancelled checks, deposit slips and specifically copies of items deposited.
- Verification of recurring deposit and withdrawals during the review.
- Direction of proceeds for closed accounts.

Bonds

- Verification of the face denomination of government and non-government bonds owned, redeemed or purchased during the review period.
- Verification supporting liquidation of bonds including date and amount.
- Direction of proceeds

Contents of Safe Deposit Box

- Verification of ownership of safety deposit boxes
- Needed is a list of contents of what is in the box
- Many times cash/jewelry/bonds are in the box. If needed an appraisal may be requested.



Inheritance

- Written confirmation from the Estate Attorney regarding amount of settlement and number of disbursements.
- Documentation to make sure that no more disbursements are to be made.

IRA Accounts/401K accounts

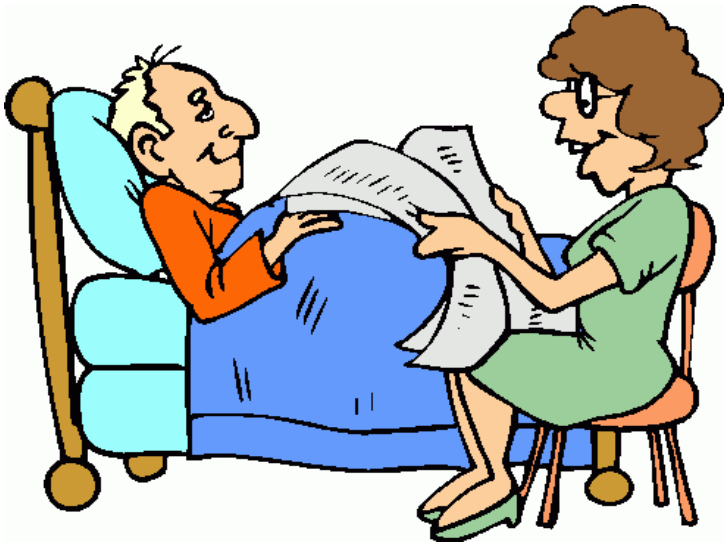
- Monthly (quarterly) statements or transaction reports for the entire review period
- Verification of transactions (withdrawals or deposits)in excess of $1000.00 – cancelled checks, deposit slips and specifically copies of items deposited.
- Verification of recurring deposit and withdrawals during the review.
- Direction of proceeds for closed accounts.

Life Insurance

- Verification of ownership of life insurance policy.
- Policy type, face value and current cash value of active life insurance policies owned by the applicant during the review.
- Loan transactions – date and amount
- Amount received from cashed in life insurance policies and direction of proceeds
- Life insurance provided through an employer as a benefit of retirement.

Nursing Home Trust Account

- Nursing home inquiry will be completed verifying any personal accounts
- Verification of any security deposits with the nursing home.



Property

- Verify FMV of all property owned by the applicant or transferred by the applicant during the review period. FMV can be derived from tax bills other than businesses or farmland. FMV for farmland is completed by LTC-ADI from U of I.
- Verify all property transfers that occur during the review period.

Property (cont.)

- Verify transfer date, value at time of transfer and reason for transfer
- Verify income received from rental and farm property.
- Verify mortgage agreements, reverse mortgage and home equity loans

Reverse Mortgage

- Verify if the funds have been dispersed in one lump sum or over a period of time.
- Verify where the proceeds went if dispersed during the review period.

Stocks and Exchange Traded funds

- Verify stock owned or acquired by the applicant during the review period from financial institution source, private or public entity or a copy of the certificate
- Verify the number of shares at the beginning of review (this could be on a 1099)
- Verify the current number of shares as of application date.

Stocks and Exchange Traded funds

- Verify source of funds used to purchase shares during the review
- Verify date and amount of shares sold during the asset review period.
- Direction of proceeds

Trust

- A copy of the trust is always needed regardless of what is in it.
- Make sure that all amendments are attached
- Verify assets that are used to fund the trust (schedule A if possible should be attached to the trust).

Vehicles

- Verify all vehicles owned by the applicant
- If vehicle is sold, verify when, how much and the direction of proceeds

Fair Market Value

- **Fair Market Value PM 07-02-20-b**
- Transfers for fair market value (FMV) are allowable.
- Fair market value is the value of the resource/income on the open market at the time of the transfer. It is **not** the highest value that the resource/income could be worth under ideal circumstances. Instead, it is the average value of the resource/income when all factors are considered.
- Neither the FMV nor the value received for the resource/income have to be figured exactly. The two values do not have to be equal for it to be an allowable transfer.

Admits

Anne Bradley
Local Office Administrator
Macon LTC Unit
Department of Human Services

Question & Answer Session

Thank you!