COMMUNITY REINTEGRATION

Turquoise Care Joint MCO Training

DEFINITIONS

- **Allocation Packet**: The documents sent by HCA/MAD/LTSSB to a registrant that includes the Letter of Interest (LOI), Primary Freedom of Choice (PFOC), Withdrawal Form, Medicaid Application for Assistance, and a self-addressed stamped envelope.
- **Central Registry**: A database that maintains a list of individuals who are interested in receiving CBs and may be eligible for an allocation.
- **HCA 100**: "Medicaid Application for Assistance" that is used to apply for Community Benefits and is available online or at a local HCA/ISD office.
- **Letter of Interest (LOI)**: The letter that is sent to a registrant informing him or her that an allocation is available and that he or she may apply for Community Benefits.

DEFINITIONS CONT.

- **Notice of Allocation (NOA)**: The letter that is sent to a registrant informing him or her that the PFOC was received at HCA/MAD/LTSSB and informs him or her of the next steps in the allocation process. The date of the NOA is the allocation date.
- **Primary Freedom of Choice (PFOC)**: The form included in the Allocation Packet that allows a registrant to confirm his or her interest in pursuing the opportunity to apply for Community Benefit services.
- **Withdrawal Form**: The form that is contained in the Allocation Packet that allows a registrant to withdraw his or her request to apply for Community Benefit services.

COMMUNITY REINTEGRATION OVERVIEW

Provides individuals the opportunity to move out of a Nursing Facility and back into the community for a registrant who is residing in a Nursing Facility at the time of registration.

- In order to be eligible, the registrant must have resided in a Nursing Facility for 90 consecutive days and meet NFLOC criteria. This may include days during which the registrant was hospitalized and returned to the Nursing Facility.
- The individual must be capable of comprehending the decisions being made or have a primary caregiver or legal guardian that understands the options.
- The individual must not require ABCB services 24 hours per day in his or her home.
- The goal is to assist the individual to become integrated into his/her community and be as independent as possible.

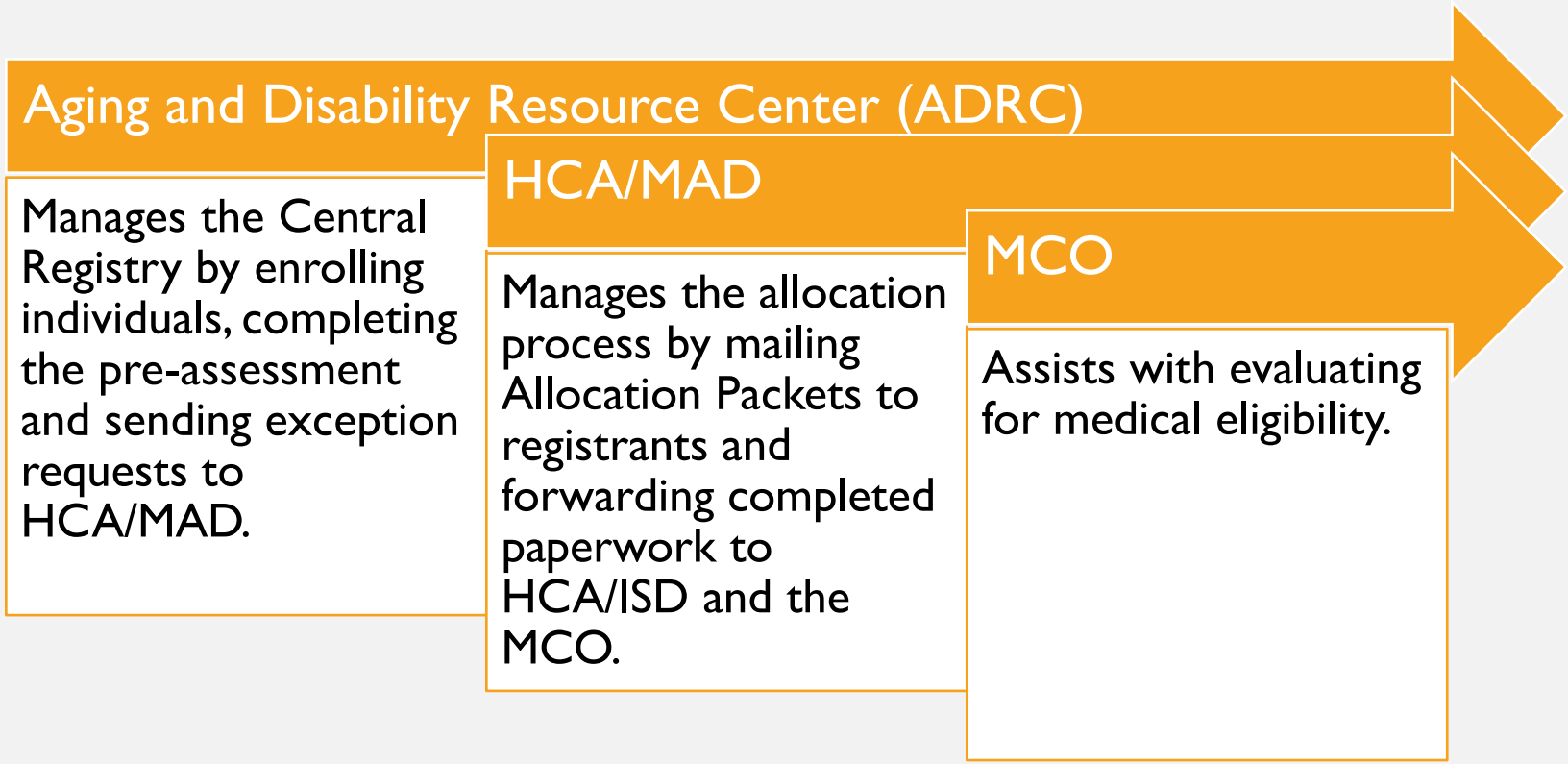
WAIVER NEEDS

Member's with an Institutional Category of Eligibility (COE) will require a Community Waiver allocation. COE's 081/084

To request an allocation, contact the Aging and Disability Resource Center (ADRC) 1-800-432-2080 and placing the Member on the Central Registry. Upon confirming a 90-day stay, a community reintegration allocation packet is mailed out.

The allocation paperwork must be completed within 45 calendar days or the allocation will be closed. An extension may be requested by contacting HCA/MAD.

ALLOCATION PROCESS



AGING AND DISABILITY RESOURCE CENTER

- Maintains accurate registrant information in the Central Registry, including coding of category or registration for each resident

- Changes a registrant's category of registration upon receipt of a notification of a change. For example, when a registrant leaves the nursing facility prior to meeting the 90-day requirement for reintegration

HCA/MAD

- Sends an Allocation Packet to the registrant upon issuing an allocation
- The Registrant is asked to complete a PFOC, HCA 100 form or a Withdrawal form
- The Allocation Packet contains the following:
  - LOI;
  - PFOC;
  - Withdrawal Form;
  - HCA 100 "Medicaid Application for Assistance";
  - CBs Information Brochure; and
  - Self-addressed stamped envelope addressed to HCA/MAD/LTSSB

HCA/MAD CONT.

- Allocation Packets are completed within 45 calendar days
- A one-time extension may be requested by contacting HCA/MAD to provide an additional 30 days for completion
- If no response is received, HCA/MAD sends a closure letter to the Registrant

- PFOC Processing:
  - If incomplete or not signed, the PFOC is returned to the registrant. The registrant has 30 days to complete and re-submit.
  - If the PFOC and HSD 100 are completed and signed, HCA/MAD/LTSSB will process them by sending:
  - • A NOA letter to the registrant
  - • A copy of the NOA, PFOC, and HSD 100 to the HCA/ISD Eligibility system
  - • A copy of the PFOC to the registrant's MCO

- Upon receipt of the PFOC, the MCO assists with determining medical eligibility via a NF LOC review
  - The NF LOC assessment and review is completed and transmitted within 40 calendar days from receipt of the PFOC
  - NF LOC determination is sent to HCA/ISD via the ASPEN interface file within 5 business days of the NF LOC determination
  - If there is an existing NF LOC determination on file, the MCO submits the NF LOC effective dates to HCA/ISD via the ASPEN interface file within 5 business days of receipt of the PFOC
  - Upon receiving the updated COE on the enrollment file, the MCO will assign the appropriate Setting of Care and transmit it to Omnicaid within 5 business days
- Care Coordinator develops a transition of care plan to address reintegration planning and post-discharge follow up



HCA/ISD RESPONSIBILITIES

Complete a review for financial eligibility. In order to be financially eligible, income and assets must be below the Institutional Care Medicaid (ICM)/Waiver maximum allowable amount. In addition, all other financial and non-financial eligibility requirements must be met as determined by HCA/ISD.



COMMUNITY REINTEGRATION AND DISCHARGE PLANNING

- Once a member is eligible for community benefits (via an approved waiver or Full Medicaid COE) the MCO Care Coordinator assists with reintegration planning to include:
  - Completion of a Comprehensive Needs Assessment and Community Benefit Services Questionnaire to determine benefit needs
    - Environmental Modifications and the Community Transition benefit should be requested immediately if a need is identified.
    - Identification and authorization of other needed CB services (PCS, respite, etc)
  - Discharge planning to address needs including: Primary Care Provider, pharmacy, DME, transportation, community resources, MCO involvement with every discharge from start to finish.

MCO POLICY MANUAL UPDATES

RE-REVIEW

- If a Nursing Facility provider is not in agreement with a review decision, the Nursing Facility must request a Re-review of the decision(s) before requesting a Reconsideration.
- The Nursing Facility must request a Re-Review within ten (10) calendar days after the date on the written notification of the MCO decision or action.
- The Nursing Facility must be submitted in writing directly to the MCO and must reflect on the Notification Form.

RE-REVIEW PROCESS

- The MCO must make a decision within six (6) business days from the date of notification and will include the decision. If there is not a change in determination, the MCO will also provide information on the reconsideration process. a
- Please note, that Nursing Facility Providers who do not meet the ten (10) calendar days to request a Re-Review may request a reconsideration within 30 calendar days.

MCO CONTACT INFORMATION

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The UnitedHealthcare Community Plan Turquoise Care UM team is available to help you with utilization management and/or prior notification questions. You can reach the team by calling toll-free at **1-877-236-0826**. The Provider Services number is **1-888-702-2202.**

QUESTIONS?