Content Focused Slide Deck

Iowa Medicaid Competency-Based Training (CBT) Session

MONEY FOLLOWS THE PERSON

April 16, 2025

The Partnership for Community Integration

Please consider completing this pre-test while we wait.
Link: https://www.surveymonkey.com/r/MFP-pre

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Objectives

- Participants will learn the fundamental goals and structure of the MFP initiative, including how it helps individuals transition from institutional settings to community-based care.
- Attendees will gain insight into the specific services offered through the MFP program and how it supports individuals' independence, choice, and quality of life.
- Participants will understand the role of various stakeholders, including case managers and service providers, in the success of MFP and the continued development of community-based long-term care options.

Who We Are

- Transition Specialists & Supervisors
- Behavior Support Specialists & Supervisor
- Employment Specialists
- Housing Specialist
- Data and Quality Analyst
- Program Coordinator
- Administrative Services Coordinator
- Project Director

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Philosophy

- *People with disabilities of any age should have choices about how and where to get quality services.*

MFP is Nationwide

- 43 states and territories have MFP programs
  - Iowa is often a resource to other MFP programs
    - Provided contracted on site and virtual Technical Assistance to American Samoa in the creation of their MFP program
    - Provided virtual technical assistance to 3 other states as they started MFP programs in recent years
- Each MFP program is unique – no two operate the same way

Program Goals

- Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
- Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Put procedures in place to provide quality assurance and improvement of HCBS

MFP in Iowa

- Vision: assist people in transitioning to independent settings in the community of their choice, where they will receive the enhanced services and supports they need to pursue their personal goals and to achieve a high quality of life

MFP in Iowa

- Part of the State's larger strategy to rebalance its systems of long-term support
  - The driver for the strategy is the primary value the State of Iowa places on choice
  - Major milestones preceded the creation of MFP, starting with the development of Iowa's 1915(c) waivers

MFP in Iowa

- Iowa's 2005 Real Choice Systems Transformation grant provided support for a legislatively mandated, intensive year long process to develop a plan to reduce populations served by ICF/IDs and to increase populations served by HCBS
  - The Enhancing Community Options Workgroup (ECOW), a 30-member stakeholder group, was established by Iowa Medicaid in collaboration with the Governor's Developmental Disabilities Council and the Iowa Association of Community Providers
  - As their work was underway, CMS issued the first round RFP for MFP

MFP in Iowa

- The Operational Protocol for *The Partnership for Community Integration*, Iowa's MFP program, was developed on the basis of recommendations from the Partners Group and its five Subcommittees
  - Over 70 people formed the Partners Group, consisting of representatives from individuals receiving services and their family members, advocates, ICF/ID administrators and staff, community providers, direct care workers, State agencies, case managers, and counties
  - A Partners Group continues to meet semiannually

MFP in Iowa

- Began operating in 2008

MFP Guiding Principles (slide 1 of 9)

1. MFP participant preferences and choices will be respected. This includes
   - the decision whether or not to transition to community living
   - the composition of the transition planning team
   - preferences regarding the community and residence
   - roommates (if any)
   - service providers
   - employment or other meaningful daytime activities.

MFP Guiding Principles (slide 2 of 9)

2. All Medicaid-eligible individuals who
   - have resided in a Qualifying Facility,
   - for at least 60 consecutive days, and
   - would meet criteria for the ID or BI Waiver

   are eligible for MFP services and are assumed capable of successful transition to community living.

MFP Guiding Principles (slide 3 of 9)

3. Continuity in transition assistance and supports will be provided by a single transition specialist who will in most instances work with the MFP participant from initial contact to the close of the demonstration year.

- The transfer of responsibilities from one transition specialist to another, or from the transition specialist to a targeted case manager at the end of the demonstration year, will be preceded by careful planning and communication regarding the participant's needs and preferences and the status of transition planning, to ensure a smooth transfer.
- MFP participants have a right to choose to receive transition services from a Transition Specialist of their choice.

MFP Guiding Principles (slide 4 of 9)

4. Involvement of the participants' parents, guardians or legal representatives in transition planning, including such key decisions as the choice of residence and service providers, will be encouraged.

MFP Guiding Principles (slide 5 of 9)

5. Planning and service coordination will be carried out by an Interdisciplinary Team (IDT) capable of and responsible for

- understanding all barriers to successful community living faced by a participant
- identifying the full range of service and support needs
- providing the participant with a choice of providers to meet those needs

The transition specialist assumes responsibility for

- working with the participant to identify and recruit members of the IDT
- scheduling planning meetings
- ensuring that the transition plan developed by the IDT provides for an orderly transition, for the health and safety of the participant at all times, and for full participation in community life

MFP Guiding Principles (slide 6 of 9)

6. All MFP participants can elect to participate in the Consumer Choices Option.

MFP Guiding Principles (slide 7 of 9)

7. Full community participation for MFP participants must include meaningful daytime activities. A high priority will be placed on the creation of satisfying employment options for participants in the community of their choice.

MFP Guiding Principles (slide 8 of 9)

8. MFP participants will enjoy the same health safety and rights protections as HCBS Waiver participants.

MFP Guiding Principles (slide 9 of 9)

9. The MFP demonstration is subject HCBS quality assurance requirements.

Key Numbers

- 93% remain in the community at the end of the MFP Demonstration Year

- #3 in the country for IDD transitions
  - Source: https://clpc.ucsf.edu/publications/evidence-impact-money-follows-person-program (July 2019)

- In 2022, Iowa was one of six Best Practice States identified by Mathematica

Lessons Learned

Although everyone's needs can vary and bring unique challenges to community living, Iowa was able to identify six themes needed to support people transitioning to living in the community.

Lesson One

Individuals need intensive transition coordination and ongoing support through the transition process.

Lesson Two

Individuals need Transition Specialists to work with them while they are in a facility to develop a transition plan.

Lesson Three

Individuals need a Transition Specialist to provide on-going monitoring and support during the first year, including at least monthly face-to-face visits.

Lesson Four

Transition Specialists only carry a caseload of people in the transition process.

Lesson Five

Training for direct support professionals prior to the individual's transition and ongoing on-site consultations and behavioral plan development are essential.

Lesson Six

Securing employment opportunities and support to seek those opportunities can be challenging

What Does MFP Offer?

Behavioral Support Services

Supports MFP participants who have complex behavioral health needs to move to and/or maintain living in the community through:

- Functional behavioral assessment
- Behavioral Support Plans (BSPs)
  - Development
  - Training
  - Maintenance and revisions
- Data collection and monitoring

Behavioral Support Services

To meet the needs of people with complex behaviors:

- Collaborative partnerships with other behavior support entities (i.e., PPSS, IDMI, etc.)
- Educational training to build the capacity of providers:
  - Positive Behavior Supports (PBS)
    - 1 day training
    - 2-day train-the-trainer training
  - Safety Care
  - Other training topics as requested that align with the scope of the role

Employment Support Services

- Supports MFP participants who are interested in working to locate employment opportunities in their community of choice through
  - Vocational planning
  - Resume building
  - Data collection and monitoring
  - Employment support training
  - Connections with collaborative partners

Employment Support Services

- Conducts outreach activities to promote employment for MFP participants as well as other Iowans with disabilities
- Provides technical assistance to partner agencies and organizations to build systems capacity for employment opportunities for individuals with disabilities

Housing Support Services

- Supports MFP participants (if additional assistance is needed) with
  - locating housing
  - applying for rent and/or utility assistance
  - coordinating home modification projects
  - providing support to address challenges they may face in maintaining their living arrangements (related to housing-specific challenges)

Housing Support Services

- Conducts outreach activities to provide education regarding the housing needs of MFP participants and works to overcome barriers
- Collaborative partnerships with other housing-related entities

Transition Coordination Services

- Facilitates a person-centered process for individuals transitioning from a Qualifying Facility to a Qualified Residence in the home or community-based setting of their choice with the supports and services that meet their needs and preferences via
  - Transition Planning Assistance
    - intensive service coordination to assist participants with planning their transition
  - Transition Monitoring and Case Management
    - contact with the individual and their family as stipulated in the Operational Protocol
    - assists individuals with in gaining access to medical, social and other appropriate services needed for their transition and/or to remain in the community, provided at the direction of the participant and the IDT.
  - Conducting social marketing and outreach
  - Working with community providers to build capacity for individuals to live and work in their community

Qualified HCBS

Intellectual Disability Waiver

- Adult day care
- Consumer-directed attendant care
- Day habilitation
- Home and vehicle modifications
- Home health aide
- Respite
- Supported community living
- Supported employment
- Transportation
- Consumer choice option

Brain Injury Waiver

- Adult day care
- Career exploration
- Consumer-directed attendant care
- Home and vehicle modification
- Personal emergency response system
- Respite
- Supported community living
- Supported employment
- Transportation
- Consumer choice option (CCO)

Demonstration Services

- Transition Services Coordination
- Facility Staff Participation in Trial Community Visits
- Community provider participation in transition planning and preparation
- Assistive Technology not covered in ID or BI Waiver (e. g., computers, med. dispensing equipment)
- Environmental modifications (e.g., for safety)
- Nurse Delegation
- Initial household setup costs
- DME
- Clothing

Supplemental Services

- In development

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Qualified HCBS

The Medicaid service package(s) that the state will make available to an MFP participant when they move to a community-based residence.

Can be comprised of any Medicaid home and community-based state plan services and HCBS waiver program services

Most Frequently Used Services

*not a comprehensive list of services available

Intellectual Disability Waiver	Brain Injury Waiver
Adult Day Care	Adult Day Care
Consumer-Directed Attendant Care (CDAC)	Career Exploration
Day Habilitation	Consumer-Directed Attendant Care (CDAC)
Home and Vehicle Modifications	Home and Vehicle Modifications
Home Health Aide	Personal Emergency Response System (PERS)
Respite	Respite
Supported Community Living (SCL)	Supported Community Living
Supported Employment	Supported Employment
Transportation	Transportation
Consumer Choices Option (CCO)	Consumer Choices Option (CCO)

Providers

- MFP uses the same provider pool and pays the same established rates in most circumstances

Rates for Services

- Typically, MFP pays the Tier or other assigned rate
- MFP can pay an Enhanced Rate for services when the IDT agrees it is appropriate
  - The MCO Case Manager is part of the IDT and should be discussing this heightened rate with MCO leadership for awareness

Rates for Services

- If a heightened rate is agreed to, this does not obligate the MCO to pay the higher rate, however the MCO's participation in the IDT indicates agreement that the rate is appropriate for the individual's needs and in good faith they intend to evaluate the continuation of the rate past the end of the MFP year
- There are typically not more than 5% of people on MFP with heightened rates

What's Different About MFP?

Enhanced Services Paid During the MFP Transition Year

DEMONSTRATION SERVICES

- Transition Services Coordination
- Facility Staff Participation in Trial Community Visits
- Community provider participation in transition planning and preparation
- Assistive Technology not covered in ID or BI Waiver (e. g. computers, med. dispensing equipment)
- Environmental modifications (e.g., for safety)
- Nurse Delegation
- Initial household set up costs
- DME
- Clothing

Demonstration Services

qualified HCBS that could be provided, but are not currently provided, under the state's Medicaid program

must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan

are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period

Allowable Expenses

- Allowable expenses are those necessary to enable a person to establish a basic household that does not constitute room and board.
- Demonstration Services are furnished only to the extent that:
  - they are reasonable and necessary as determined by the IDT process;
  - they are clearly identified in the individual service plan; and
  - the person is unable to meet such expense or when the services cannot be obtained from other sources

Transition Services Coordination

- Services that assist with the transition of a person from a qualifying facility to a qualified residence in the community

Facility Staff Participation in Trial Community Visits

- Provides reimbursement for costs of day visits or trial overnight stays by participants in the residence to which they plan to move
  - The facility provider will be reimbursed for staff time and travel (mileage only) for community visits and training
  - All visits must be identified as a need in the transition service plan

Community Provider Participation in Transition Planning and Preparation

- Once the community provider is identified and agreed upon, the provider will participate in all transition meetings, short trial visits and/or overnights and any necessary individual-specific trainings
  - The community provider will be reimbursed for staff time and travel (mileage only) for such pre-transition services
  - The provider must agree, as a condition of payment, to provide services for at least 90 days after transition and to provide 30 days notification if discharge of consumer is planned
  - Funds to train other community providers such as employment providers may also be available
  - Must be identified as a need in the transition service plan

Assistive Devices *(not covered in ID or BI Waiver)*

- Practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence
- Must be authorized in the plan

Environmental Modifications and Equipment

- Includes modifications to the home not otherwise covered under Home and Vehicle Modification
- Must be authorized in the plan

Nurse Delegation

- Services provided by a licensed registered nurse to train and oversee the procedures carried out on behalf of the individual either by the individual himself or herself or another direct care provider, and to provide consultation.
- The nurse determines that the activity can be performed in the home or community setting and that the unlicensed direct care provider or the consumer can demonstrate that he or she can perform the task.
- The nurse determines the level of oversight of the care that would ensure the health and safety of each consumer, but at a minimum the licensed nurse shall make on-site supervisory visits every two months with the provider present.
  - More frequent visits can be provided as long as medically necessary.
- The licensed nurse retains accountability for his or her actions in the consultations, training and management of the delegation process but is not accountable for the actions of the caregiver that is trained.
- Must be authorized in the plan.

Initial Household Setup Costs (Establishing Community Household)

- Funds cover the initial expenditures needed to help an individual establish a community residence
- Can be used for expenses directly related to moving
- Must be authorized in the plan

Enhanced Durable Medical Equipment

- Equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose is generally not useful to a person in the absence of an illness and is appropriate to assist the consumer for use in the community.
- An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.
- Must be authorized in the plan

Clothing

- A one-time clothing allowance for individuals to assist with transitioning to a community setting
- Must be authorized in the plan

Supplemental Services

short-term services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program

must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan

are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period

In process

- Iowa is submitting a proposal, and more details will be available at a future date.

How Does Someone Access MFP?

Eligibility Criteria

- Medicaid eligible (with a disability determination)
- Meet criteria to qualify for eligibility and LOC for BI or ID Waiver
- Reside in a Qualifying Facility for at least **60** consecutive days
  - Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID)
  - Nursing Facility (SNF or NF)
  - Psychiatric Medical Institutions for Children (PMIC)
  - Hospital

What is the Process and What is the MCO's role?

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Funding and Oversight Structure

- When a person chooses to use MFP, their Home and Community Based Services (HCBS) are carved out of Managed Care.
- HCBS for MFP participants are funded Fee For Service
  - Carved out of Managed Care
- The QIO with Iowa Medicaid is the entity responsible for Quality Assurance oversight

Who is a “Case Manager”?

- Iowa uses the collective term “case manager” to include Iowa’s many types of case management, including:
  - Managed Care Community-Based Case Managers
  - Targeted Case Managers
  - MFP Transition Specialists
  - Integrated Health Home Care Coordinators
- The entity responsible for funding supports and services is the entity with **case management authority/responsibility**.

Roles and Tasks

MFP Process	MCO/FFS Case Manager Roles and Tasks
Referral 470-5151, Money Follows the Person Referral Information (iowa.gov)	IDT and/or individual determines who will submit referral to MFP If CM is to submit the referral, CM will complete referral form for MFP and submit to MFP Project Director with supporting documents *requirements noted on form*
After MFP Project Director receives a fully completed referral it will be assigned to a Transition Specialist Supervisor	Complete any tasks noted in email from MFP Project Director

Roles and Tasks

MFP Process	MCO/FFS Case Manager Roles and Tasks
Once Level of Care is determined with Iowa Medicaid, TSS will transfer the referral to a Transition Specialist for the transition planning process to begin • The TSS will email known members of the IDT to notify when a Transition Specialist has been assigned	Remain in contact with the MFP Transition Specialist Supervisor and/or Transition Specialist

Roles and Tasks

MFP Process	MCO/FFS Case Manager Roles and Tasks
Transition Planning (at a minimum) typically includes: • Informational Meeting • Transition Planning Meeting(s) • *Throughout the Transition Planning process, the IDT collaborates to develop the Transition and Service Plan. The MFP Transition Specialist is responsible for writing and disseminating the plan* • Facility Discharge Meeting	Actively participates as an IDT member, supporting the Transition Specialist with transition tasks identified during the planning process • Attends meetings (coordinated by MFP TS) • Assist with transition tasks as identified during the planning process • Serve as liaison with the MCO (where applicable) for Medicaid services not covered by MFP • Contribute to the MFP Transition and Service Plan (not responsible for developing own plan)

Roles and Tasks

MFP Process	MCO/FFS Case Manager Roles and Tasks
Move takes place	
MFP Demonstration Year • Transition Specialist acts in a case management capacity for the individual throughout the Demonstration Year • *These tasks include, but aren't limited to, those defined on the next slide* • Post-Transition Visit (within 2 business days of move) • 30 Day IDT Meeting to review Transition and Service Plan • Ongoing monitoring (at least monthly in person)	Serve as Interdisciplinary Team Member during the Demonstration Year • Visit participant to build rapport- coordinating visits as much as possible with Transition Specialist (not required to be done together, but minimizes disruption for participant) • Attends meetings (coordinated by MFP TS) • Serve as liaison with the MCO (where applicable) for Medicaid services not covered by MFP • Contribute to the MFP Transition and Service Plan (not responsible for developing own plan) • Ensure CSR is completed when due and CSR document is submitted to Transition Specialist after completed

Overview of MFP TS Roles & Responsibilities in Case Management Capacity

- During the Demonstration Year, the Transition Specialist acts in a case management capacity for the individual.
  - The Transition Specialist is the entity responsible for ensuring supports and services are in place to best meet the needs of the individual in their new community, authorizing the funding of services, monitoring goal progress, reviewing documentation (including Medication Administration Records), etc.

Overview of MFP TS Roles & Responsibilities in Case Management Capacity

- The following occurs throughout the course of the month in a mix of informal and formal interactions with the individual and members of their IDT:
  - Observation of the individual
  - Assessment of the environment
  - Assessment of the status of identified risks, injuries, needs, or other changes in status
  - Assessment of Transition and Service Plan implementation
  - Assessment of Transition and Service Plan appropriateness
  - Assessment of the implementation of supports/services

Preparing for end of MFP Demonstration Year and After

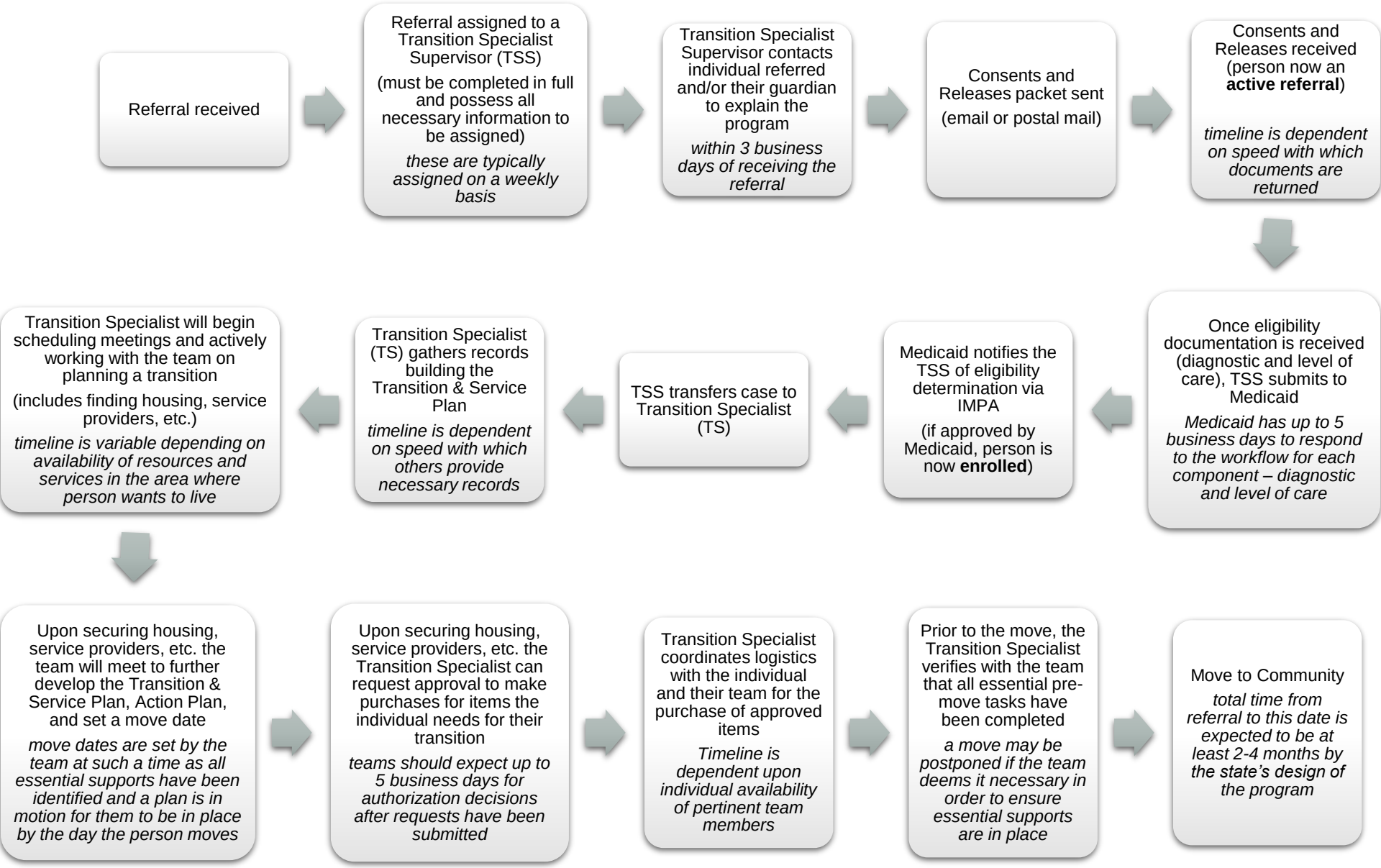
MFP Process	MCO/FFS Case Manager Roles and Tasks
TS will coordinate Transition to Waiver meeting	Attend IDT meeting within 60 days of end of MFP year to plan for transition to waiver This is the point at which the CM begins developing their plan to support the individual after the Demonstration Year ends, including beginning the process for authorization of Waiver services

Preparing for end of MFP Demonstration Year and After

MFP Process	MCO/FFS Case Manager Roles and Tasks
Participants make a smooth transition (no service interruption) to a Medicaid HCBS Waiver after the Demonstration Year is completed. The MFP participant will be changing from a Transition Specialist to a case manager, either with an MCO or the FFS system, for service coordination. This is the point at which the CM assumes responsibility as the case management entity for the individual	CM assumes responsibility as the case management entity for the individual

Preparing for end of MFP Demonstration Year and After

MFP Process	MCO/FFS Case Manager Roles and Tasks
Behavior Support Specialist and Employment Support Specialist remain available to the person as long as MFP continues to exist.	Assist individual and IDT to access Behavior Support Specialist and/or Employment Support Specialist services as needed



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Jack’s Story

Brain Injury pathway to MFP

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Jack

age 37

- Resided in a NF after his condition progressed to a point that was beyond what his aging parents could support themselves
- Referral received by the Project Director and, after an initial eligibility review, was assigned to a Transition Specialist Supervisor (TSS)
- The TSS provided education to Jack and his legal guardian regarding the MFP program
- Jack's guardian completed consents and releases to proceed with the MFP enrollment process
- The TSS facilitated the eligibility review process with Iowa Medicaid Medical Services after receiving all necessary documents

Jack

- Jack was determined eligible for MFP under BI diagnostic criteria and Level of Care
- A Transition Specialist (TS) was assigned to Jack
- The TS connected with Jack's MCO case manager, who made the referral to learn more about him and how to support him best
- The TS met with Jack and his family at the NF to learn about his preferences, support needs, and goals for his return to the community

Preferences	Needs	Goals
Concerts	Routine enemas for bowel elimination	Exercise
Exercising	Accessible housing	Work

- The TS worked with the NF to identify alternatives to routine enemas (a potential barrier) that would meet his health needs

Jack

The IDT met to discuss Jack's wants and needs more comprehensively

- social and leisure goals
- housing preferences and supports
- adaptive equipment and DME needs
- physical health supports
- mental health needs
- risk factors to consider
- finances
- rights restrictions
- employment preferences

Jack

- TS talked with Jack about potential providers who could meet his needs and preferences in the community where he wanted to live
- An agency expressed interest in meeting him and came to visit to get to know him
- Jack met a potential host home provider who had an accessible house – they hit it off!
- The agency's director explored options with the team about ensuring the compensation rate would match Jack's support needs. The IDT worked collaboratively and determined a request for an enhanced rate was appropriate. This was requested by MFP and approved by Iowa Medicaid
- The IDT continued to meet to plan for Jack's transition.
  - The MCO brought the person who would be Jack's future CBCM in to join the planning process, and they attended all planning meetings
  - They worked together to develop and organized and comprehensive plan to ensure all of Jack's essential supports were in place prior to his move from the NF
    - Grab bars were installed where needed
    - A shower chair and specialized bed were purchased
    - Arrangements were made for him to continue participating in a specialty PT clinic that allowed him to exercise in ways he would otherwise not be able to
    - A plan was developed regarding how finances, bills, and shopping would occur
    - The TS made a referral to the MFP Employment Specialist who then joined the IDT and assisted Jack with connecting with resources like the Department of the Blind, Brain Injury Association, Easter Seals, and the Helen Keller Institute to support Jack with his goal to work

Jack

- Jack moved to his new home where everything he needed was there and waiting for him
  - The IDT met six times over the course of six weeks for a total of 9 hours prior to the move
  - The TS facilitated the transition process to keep things moving by way of
    - action plans to identify who was responsible for what tasks and by when
    - follow-ups to ensure completion of tasks identified in action plans
  - There was a lot of behind-the-scenes work that every member of the IDT completed to help get everything ready for Jack's transition
- The TS visited Jack two days after he moved to make sure everything was going well and address any newly identified needs if anything had come up
  - There were some bumps with his medications being filled by the pharmacy timely, but everything else went according to plan
- The TS visited Jack monthly to see how he was doing
- The IDT met monthly, as well, and stayed in close communication between meetings

Highlights of Jack's Demonstration Year

- accommodated engagement in artwork and puzzles
- went to:
  - the movies
  - an art festival
  - music in the park
  - fireworks
  - farmers markets
  - a casino with a friend
  - an art studio
  - an arcade bar
- watched the Hawkeyes at a sports bar and had beer
- watched many movies on his large screen TV
- got new glasses
- received a new customized wheelchair
- weaned off a medication that made him drowsy
- worked with IDT to devise plan to ensure that his sexual needs were met in a socially safe manner
- received new shoes and AFOs
- enjoyed a variety of homecooked meals which had had an active part in planning and shopping for ingredients for

Special Circumstances

Reinstitutionalization

Critical incident reports (CIRs)

Reinstitutionalization

MFP Process	MCO/FFS Case Manager Roles and Tasks
If a participant is admitted to a qualifying facility for >3 days, this counts as a reinstitutionalization for MFP purposes	No required actions for MFP purposes *see policies within CM agency for actions that may be needed internally*
If >3 days but < 30 days, the participant's MFP year will be extended by the length of stay in the qualifying facility	No required actions unless the team determines a non-MFP qualifying setting is where the person wants to move to For non-MFP qualifying settings, CBCM makes referrals and oversees transition process
If > 30 days, the participant will need to be re-referred to MFP once 60 days is reached (individual then qualifies for a new demonstration year)	Re-refer to MFP if individual wants to use the program to return to community from the Qualifying Facility

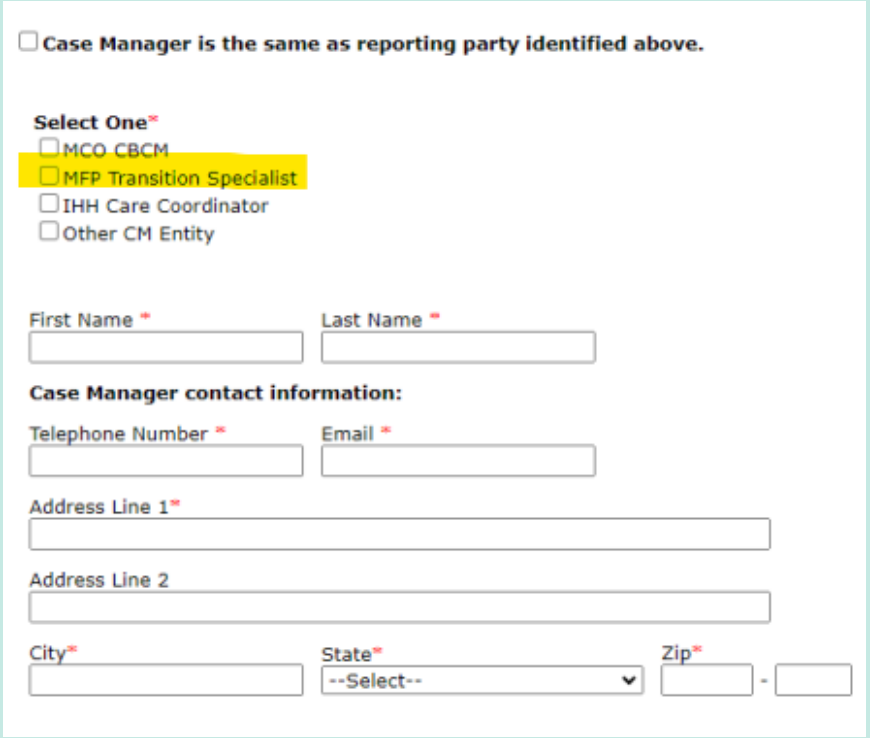
Critical Incident Reports (CIRs)

MFP Process	MCO/FFS Case Manager Roles and Tasks
All CIRs are to be submitted **via IMPA** with MFP selected (not a Waiver) *HCBS QIO and the Transition Specialist will follow up on CIRs for MFP participants*	If a CIR is received by the CM because Waiver, not MFP, was selected on the form • Advise the Transition Specialist so they have awareness • Follow up with the provider to remind them the MFP box must be checked on the CIR form as the individual's HCBS is Fee For Service during the Demonstration Year

Critical Incident Reports

▶Section 3

▶Section 4



Note: these are found on slides 19 and 20 of the Critical Incident & Reporting User Guide

Other MFP-Funded Work

Rebalancing Initiatives

- Iowa COMPASS
- ITABS
- Increased HCBS Spending

Capacity Building Initiative

- Provider Prevention and Support Services (PPSS)

Definitions & Acronyms

Definitions

TERM	DEFINITION
IDT Meeting	• Service planning meeting held at least annually, when goal changes are needed • Identify who it consists of (grab from MCO governing documents)
Team meeting (not IDT meeting)	Team follow up meeting to check in, address acute concerns, etc.
Monthly face-to-face	Informal visit between MFP participant and Transition Specialist
Transition and Service Plan	MFP person centered planning document to support transition planning and service delivery throughout the Demonstration Year

Definitions

TERM	DEFINITION
Demonstration Year	• The 365 days of services and supports, beginning the day the individual discharges from a Qualifying Facility, paid by the Money Follows the Person program
Qualifying Facility	• ICF/IDs, Nursing Facilities, PMICs, and inpatient hospital settings

Definitions

TERM	DEFINITION

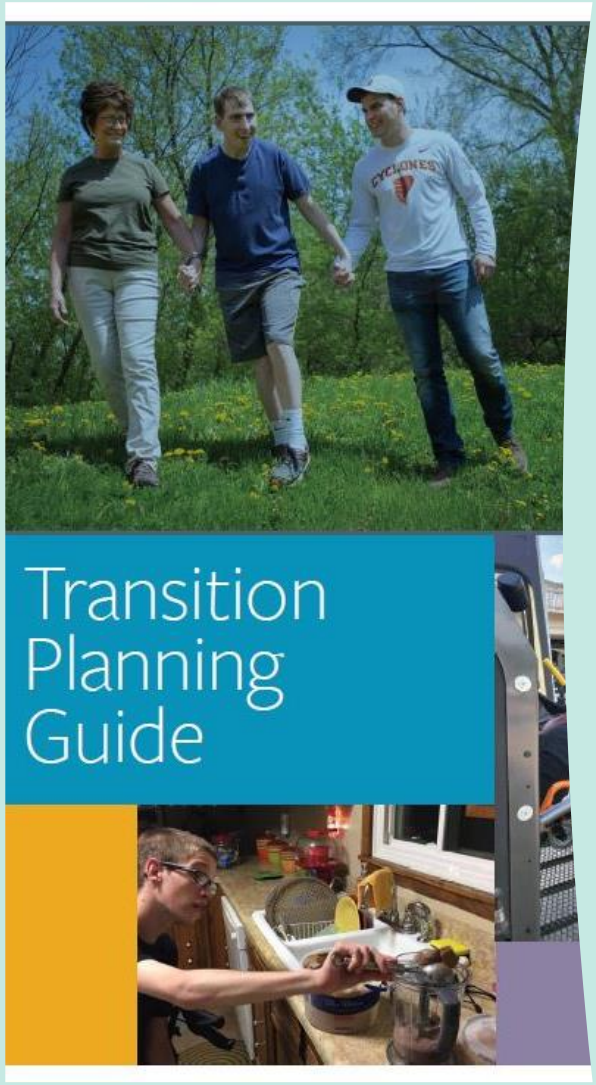
Qualified Residence	• As defined by section 6071(b)(6) of the DRA the term “qualified residence” means, “with respect to an eligible individual”:
	  • a home owned or leased by the individual or the individual's family member;
	  • an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
	  • a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

Acronyms

ACRONYM	DETAILS
IDT	Interdisciplinary Team
MFP	Money Follows the Person
MCO	Managed Care Organization
CM	Case Manager
TSS	Transition Specialist Supervisor
TS	Transition Specialist
PD	Project Director
FFS	Fee For Service
CSR	Continued Stay Review

Acronyms

ACRONYM	DETAILS
ICF/ID	Intermediate Care Facility for People with Intellectual Disabilities
NF	Nursing Facility
PMIC	Psychiatric Medical Institutes for Children
HCBS	Home and Community Based Services



Resources for Transition Planning

- Transition Guidebook
  [Transition Guidebook_Web.C.pdf (iowa.gov)]

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Questions
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Thank You!

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