

Moving Home Minnesota (MHM) transition coordination

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Legal authority	Deficit Reduction Act, 2005 (PL 109) §6071 (PDF) , Patient Protection and Affordable Care Act, 2010 §2403 (PDF) , Minn. Stat. §256B.04, subd. 20	
Definitions	<p>Transition coordination: MHM service that provides coordination of activities to support a person who resides in a qualified institution to gain access to medical, social, education, financial, housing and other services and supports that are necessary to move to the community.</p> <p>Transition coordinator: Professional who carries out the transition coordination service and supports a person to move from a qualified institution to the community with MHM.</p> <p>Lead agency: County, tribal nation or managed care organization (MCO).</p>	
Eligibility	A person is eligible to receive MHM transition coordination if they meet the criteria on MHM Manual – Eligibility .	
Covered services	<p>MHM transition coordination includes, but is not limited to the following activities:</p> <ul style="list-style-type: none"> • Support a person in a qualified institution to access medical, social, educational, financial, housing and other services and supports needed to move to the community based on the person's preferences and needs. • Develop and implement MHM Transition Planning Tool (TPT), DHS-6759J. • Coordinate and monitor the implementation of the TPT. • Communicate with the person, legal representative (if applicable), informal supports, service providers and other as necessary to implement the TPT. • Coordinate referrals and assistance to access services and housing. • Travel to conduct a visit with the person and others identified as necessary to develop and implement the goals of the TPT. This may include touring housing options, shopping for household furnishings and supplies and setting up the person's home. • Coordinate transitional services that help the person with their rent deposits, utility deposits and moving expenses. For more information, refer to MHM Manual – Transition planning. • Assist the person with setting up their home (e.g., assemble furniture, set up kitchen, stock pantry). • Update the TPT when necessary. • Complete and maintain documentation in case notes and MHM communication forms that supports and verifies MHM activities. 	
Non-covered services	<p>MHM transition coordination services do not cover:</p> <ul style="list-style-type: none"> • Services for a person who lives in the community or an ineligible institution. • Services for a person currently receiving relocation service coordination – targeted case management (RSC-TCM), as described on CBSM – RSC-TCM. While RSC-TCM serves as the model for transition services to people enrolled in this demonstration, a person cannot receive MHM and RSC-TCM at 	

	<ul style="list-style-type: none"> • the same time. • Services for a person currently receiving Housing Stabilization Services (HSS) housing transition, as described on DHS – HSS. • Services available under the home and community-based services (HCBS) waivers. • Transition assistance when a person moves from one institution to another, unless the person’s TPT indicates a move to another qualified institution is a necessary step toward their eventual move to the community
<p>Services for out-of-state moves</p>	<p>For a person who chooses to move to a different state, transition coordination services may be covered up to the date of the person’s move and if the person both:</p> <ul style="list-style-type: none"> • Meets all MHM eligibility criteria. • Chooses to move to a qualified community residence in the chosen state. <p>If the other state participates in the Money Follows the Person (MFP) program, it is the transition coordinator’s responsibility to notify that state’s MFP staff to determine if the person chooses and may receive MFP community services.</p>
<p>Roles and responsibilities</p>	<p>The transition coordinator begins transition coordination by meeting with the person in the institution.</p> <p>The transition coordinator is responsible to:</p> <ol style="list-style-type: none"> 1. Facilitate the completion and submission of MHM Intake Form, DHS-5032 if not already done. 2. Lead the transition planning process once the lead agency confirms the person is approved for MHM (refer to MHM Manual – Lead agency responsibilities). 3. Complete and keep on record the following forms: <ul style="list-style-type: none"> • MHM Informed Consent, DHS-6759I (PDF) to review the person’s rights and responsibilities. • MHM Transition Planning Tool, DHS-6759J to create a person-centered transition plan with the person. • MHM Transition Planning Tool (Part 2): Risk mitigation and emergency backup planning, DHS-6759K (PDF) if no other risk mitigation tool is in place. • MHM Housing Transitions Worksheet, DHS-6759G if necessary to help the person identify their housing needs and preferences. 4. Maintain routine contact, communicate and/or travel to visit with the person or others identified as necessary to develop and implement the goals of the transition plan. 5. Coordinate and monitor the overall implementation of the TPT. 6. Work with the DHS MHM housing specialist to help the person locate affordable 811 project-based rental assistance (PRA) supportive housing, if appropriate. 7. Work with Disability Hub MN to identify appropriate employment supports if necessary. 8. Set up transportation so the person can search for housing and/or employment. 9. Report assurance of qualified residence to DHS. For more information, refer to the communication with DHS section lower on this

	<p>page.</p> <p>10. Coordinate with the discharge planner at the qualified institution.</p> <p>11. Coordinate details to set up the person's home.</p> <p>12. Coordinate meetings, medical follow-up appointments, delivery of medical equipment, etc.</p> <p>13. Arrange a smooth transition with the community case manager (if different from the transition coordinator), which includes the following activities:</p> <ul style="list-style-type: none"> • Discuss with the person and their case manager any additional programs and resources the person needs to remain in the community after MHM services end. • Coordinate opening and closing of MHM and waiver service agreements, if applicable. <p>14. Coordinate the person's day-of discharge activities.</p> <p>15. Ensure the person's medications and required services are in place.</p> <p>16. Report the person's confirmed move to DHS. For more information, refer to the communication with DHS section lower on this page.</p>
<p>Communication with DHS</p>	<p>Pre-transition communication</p> <p>The transition coordinator must submit MHM Communication Form, DHS-6759H to DHS in the following situations:</p> <ul style="list-style-type: none"> • When the transition coordinator is assigned to a person. Use the "Other" reason for communication to report this information. • Before the person transitions to a qualified residence. Use the "Assurance of Qualified Community Residence" reason for communication to report the transition date and type of qualified residence. DHS will use this information to confirm the person will be eligible for community-based services. • If a person chooses a non-qualified residence in the community. Use the "Participant is to be disenrolled from Moving Home Minnesota" communication reason to inform DHS and disenroll the person from the MHM program. <p>Post-transition communication</p> <p>When the person has transitioned successfully to the community, the transition coordinator must submit MHM Communication Form, DHS-6759H to DHS. Use the "Participant has transitioned to the community" reason for communication and provide the information requested on the form. DHS will use this information to update MMIS with the date the person moves into a qualified residence to allow claims to pay. The person's move-in date is the start date for their 365/366-day period of MHM community-based services eligibility.</p> <p>Additional communications</p> <p>Transition coordinators must submit MHM Communication Form, DHS-6759H to DHS in the following situations:</p> <ul style="list-style-type: none"> • The person has changes in eligibility and enrollment. • The person reenters an institution. • The transition coordinator needs help with denied claims. • The transition coordinator needs to submit supporting documentation. • The transition coordinator has questions that contain private

	<ul style="list-style-type: none"> health information about a specific person.
Extensions	<p>DHS may grant extensions to the 180-day transition planning and transition coordination eligibility span on a case-by-case basis. The transition coordinator may request an extension by submitting MHM Communication Form, DHS-6759H. Use the "Transition Coordinator Extension Request" reason for communication.</p> <p>The transition coordinator must:</p> <ul style="list-style-type: none"> Identify and describe the reason for the extension request. Identify the estimated number of additional days of transition planning and transition coordination services needed to transition the person to a qualified residence.
Limitations	<p>Transition coordination is limited to pre-transition services up to the day the person moves to the community.</p> <p>A provider cannot deliver transition coordination to more than one person at the same time.</p> <p>A person cannot receive MHM transition coordination if they also receive RSC-TCM or HSS housing transition.</p>
Provider standards and qualifications	<p>Transition coordination can be provided by a lead agency or a DHS-approved provider who meets the relocation targeted county case management provider qualifications per Minn. Stat. §256B.0621.</p> <p>License requirements</p> <p>Depending on their age and circumstances, the person may choose one of the following to be the transition coordinator:</p> <ul style="list-style-type: none"> County case manager. Developmental disability case manager. Mental health case manager. MCO care coordinator. RSC-TCM case manager. <p>DHS-approved transition coordination providers must complete HCBS Programs Service Request, DHS-6638 (PDF) and MHM – Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement, DHS-3879 (PDF) either online through the Minnesota Provider Screening and Enrollment (MPSE) portal or fax the forms to MHCP Provider Eligibility and Compliance at 651-431-7493.</p> <p>Background studies</p> <p>Minn. Stat. Ch. 245C requires a licensed program to conduct background studies. Providers who have direct contact with the person must have a completed background study (for a complete list, refer to Minn. Stat. §245D.03). A provider must complete and submit individual background studies using New Electronically Transmitted Study (NETStudy) through DHS licensing.</p>
Authorization, rates and billing	<p>Service authorization</p> <p>MHM transition coordination does not need a service authorization.</p> <p>Rate</p> <p>The lead agency or provider claims the actual 15-minute units provided. The transition coordination rate cannot exceed limit in the Long-Term Services and Supports (LTSS) Service Rate Limits, DHS-394 (PDF).</p> <p>Billing</p> <p>The transition coordination provider must plan and deliver services</p>

	<p>based on the person's needs as documented in the person's TPT. All submitted claims must be based on actual services delivered. The transition coordination provider cannot bill services based on an average of billing units provided to a person.</p>
<p>Additional resources</p>	<p> CBSM – Transition services provider contact list MHM Manual – Eligibility MHM Manual – Services MHM Communication Form, DHS-6759H MHM Transition Planning Tool, DHS-6759J MHM Transition Planning Tool (Part 2): Risk mitigation and emergency backup planning, DHS-6759K (PDF) MHM Housing Transitions Worksheet, DHS-6759G MHM Informed Consent, DHS-6759I (PDF) HCBS Programs Service Request DHS-6638 (PDF) MHM Transition Planning, Transition Coordination and Demonstration Case Management – Provider Assurance Statement, DHS-3879 (PDF) MPSE portal </p>