



CFP TECHNICAL ASSISTANCE BULLETIN

CFP SERVICES IN INSTITUTIONAL SETTINGS



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Background

Skilled nursing and intermediate care facilities are particularly important for enabling timely hospital discharge through short-term rehabilitation, sub-acute care, and crisis management. However, short-term stays often become long term residence when complicated planning is required for a return home, special housing or housing modification needs to be arranged, or exceptional one-time expenses must be paid.

Recently, federal regulations have prompted revisions to policy regarding the provision of ***Targeted Case Management (TCM)*** services to people with disabilities who are transitioning to the community from institutional settings. Previously, intensive case management or TCM could be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, ***if provided for the purpose of community transition.*** Changes in federal regulations affect the **timeframes during which CFP services may be rendered as well as the enrollment and reimbursement processes** that will be allowable.

Targeted Case Management (TCM), defined in section 1915(g) of the Social Security Act, ***may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.***

Program Standards and Guidance

When feasible, CFP case management teams are expected to provide transitional support for institutional consumers. Transitional services are those activities not within the scope of discharge

planning, however required for transitioning individuals with complex, chronic medical needs. ***Transitional services may begin 60 days within discharge date if stay is greater than 180 days, or 14 days within discharge if stay is less than 180 days.***

PLWA's who are living in an acute care setting, nursing home or residing in a long-term rehabilitation setting, including residential substance abuse setting, may receive transitional services from a Community Follow-up Program when there is a need for assistance with obtaining housing, entitlements, etc. necessary to live in the community provided that:

- Discharge is pending (within **60 days** of discharge date) if stay is greater than **180 days**.
- Discharge is pending (within **14 days** of discharge date) if stay is less than **180 days**.
- Case conferences and a joint service plan (see attached form) is developed with the agency social worker/discharge planner. This must be in the case record.
- A clear need for intensive case management services must be documented.
- Enrollment in CFP ***cannot occur until the date of discharge from the institutional setting.*** Enrollment can be retroactive to capture the transitional services that were provided to the client during the allowable timeframe.
- Claims cannot be submitted for payment until a client is discharged from the institution, is enrolled with the CFP, and is receiving medically necessary services in the community.

(Note: This does not affect those who are incarcerated since they lose their Medicaid eligibility during that time.)