Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

1	**What is Open Doors? What is the difference between the Money Follows the Person Program and the Open Doors Program?** Money Follows the Person is a federal demonstration project administered by the New York State Department of Health (NYS DOH) to re-balance the state's Long Term Care system from institutional to home and community-based services and supports. The NYS DOH MFP program funds Open Doors through a contract with the New York Association on Independent Living (NYAIL) to operationalize assistance to individuals to facilitate transitions from nursing homes and intermediate care facilities to homes in their communities. NYAIL's Open Door program is the state designated contact for MDS Section Q referrals (Local Contact Agency). The program consists of a network of 24 Transition Centers, located within Independent Living Centers throughout New York State. Working with Nursing Home and Intermediate Care Facility staff, managed care plans, Home and Community-Based Services (HCBS) waivers, Health Homes and community service providers, Transition Specialists assist participants with identifying and accessing needed supports, benefits, and services in the community. Open Doors serves as a bridge between pre-discharge planning and coordination in the facility and the delivery of medical and supportive services in the community. Peers are available to provide support during the transition process and can assist with community integration by sharing their life experiences in transitioning from facilities to the community. Family members of individuals who have previously transitioned are also available to meet with the families of transitioning individuals. Veteran peers are available as well. Dedicated Education and Outreach staff provide outreach and information about Open Doors, community resources and referral processes to nursing homes throughout the state.
2	**What is the eligibility criteria for an Open Doors referral?** Any adult age 18 years or older who is in a nursing home or Intermediate Care Facility (ICF) and wishes to transition to the community can be referred to Open Doors.
3	**How can I make a referral to Open Doors?** Referrals can be made by calling several ways: • Call the main number at: 1-844-545-7108 • Contact the local regional contact. An interactive map with regional contact information can be found at: https://ilny.us/programs/open-doors • E-mail: secq@ilny.org • Fax: 1-518-465-4325

Questions and Answers
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January 10, 2022

4	What areas of the state does Open Doors cover?
	Open Doors is statewide. Offices are located regionally. Use the interactive map to local your local office at: https://ilny.org/programs/open-doors.
5	Does Money Follows the Person provide cash assistance to the participant?
	No, Money Follows the Person (MFP) does not provide direct cash assistance to participants. MFP is a federally funded grant which supports New York State's efforts to maximize community transitions and access to home and community-based services.
6	For a member who is already in an MLTC plan and goes into the nursing home for short-term rehabilitation, would they be able to be referred to your program for additional community support?
	MLTC members who are in nursing homes for short-term rehabilitation can be referred to Open Doors if it is anticipated that they will be in the nursing home for at least 60 days.
7	How does MFP/Open Doors deal with members who lack capacity to make decisions?
	For individuals who have a legal guardian, the guardian can sign the consent to participate form. The Transition Specialist can work with the guardian, the nursing facility and the care manager, waiver service coordinator or care provider to provide assistance with transition planning and peer support.
8	Is there a letter/correspondence that is sent to the plan if a referral is rejected?
	No, there is no formal rejection process. All referrals are considered.
9	Can a person be referred to Open Doors after a person is discharged from a nursing home? A lot of times, MLTCs find that a person is discharged from the nursing home already with little community support.
	The primary mission of Open Doors is to facilitate the community transition, which typically begins with meeting the individual in the nursing home.
10	Are the Transition Specialists visiting people in-person?
	Some Transition Specialists are going in-person to nursing homes, others are working remotely based on the restrictions currently in place in the nursing homes.

Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

11	What is the turn-around time from the time of referral to first contact?
	Usually, the Transition Specialist will have the first contact with a potential participant within 10 working days of referral.
12	Would a person be eligible for Open Doors if they had been in a nursing home for less than 120 days?
	Yes, Open Doors can get involved before someone has been in the nursing home for 120 days. The minimum length of stay for a qualified MFP transition is at least 60 consecutive days in a nursing home or intermediate care facility. Open Doors can begin working with the individual before that time in order to begin transition planning if it is anticipated that the individual will be in the nursing home for at least 60 days prior to discharge.
13	For a MTLC member who is already in a plan and is assigned a Transition Specialist, how often does the specialist collaborate with the plan Care Manager to coordinate needed services in the community?
	The Open Doors Transition Specialist starts by providing nursing home residents who voice an interest in transitioning with information about the services and supports that are available in their local community. They coordinate with the Care Manager and the facility social worker/discharge planner as often as is necessary during the pre-transition period to develop a transition plan, assist with facilitating the transition, and follow the individual post-transition to support the start of services. Please note that Transition Specialists are not case managers. The Transition Specialist's role is to identify and remove barriers to returning to and integrating into the community. The Transition Specialist serves as a bridge between facility and home and community-based services.
14	If a person is on Medicare, would they be eligible for the Open Doors program?
	Open Doors works with individuals that that have been in a nursing home or intermediate care facility for 60 or more days, wish to transition to the community and have Medicaid and Medicare (dual eligible), Medicaid only or are Medicaid eligible. If they are not yet on Medicaid but may be eligible, the Transition Specialist can help them apply for Medicaid. Medicare-ONLY individuals are not the intended target population for MFP/Open Doors, however, if a Medicare-ONLY individual is referred, the Transition Specialist may provide an initial consultation, provide initial information on community resources, and then make sure they are referred appropriately to the resources that can assist them.

Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

15	Can Open Doors participants transition to the community with a PACE plan?
	Yes, Open Doors participants can transition to the community on a PACE plan, provided they meet PACE eligibility requirements and a PACE plan is available in the area where the participant plans to live.
16	What is the Good Neighbor Program and what type of support does it provide?
	The Good Neighbor Program is part of the Open Doors Program. Good Neighbor Volunteers provide informal support/companionship for Open Doors participants whose lack of natural/informal supports presents a barrier to discharge. Volunteers provide a range of non-medical support in the event that the formal support system is not available, for example: • light housekeeping/chores • meal preparation • running errands • transportation • telephone reassurance or visitation/social support • assistance with obtaining direct services participants may not have received. This support is not intended to replace or supplant formal care giving services, such as home health aide or personal care services when an aide does not show up for a shift. The Good Neighbor acts as back-up support in a manner similar to a family member or friend.
17	How long is the Good Neighbor in place for after Nursing Home discharge?
	There are no end date criteria for the Good Neighbor program.
18	Can someone already in the community be referred to the Good Neighbors program?
	Yes, but only if the person is an active Open Doors Participant who transitioned within the past 60 days and informal supports have not been able to provide back-up needed, resulting in either a return to the nursing home/hospital OR lack of
19	How does Maximus become aware of an individual's enrollment in MFP?

Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

20	Does Open Doors provide post-transition reporting to plans that highlight the successes of post-transition with Open Doors as well as areas of improvement, specific to the plan's members?
	There is no formal post-transition reporting between Open Doors and plans. Transition Specialists have contact with participants on at least a monthly basis for up to 365 days post-discharge to monitor adjustment in the community. If issues arise related to a MLTC service, the Transition Specialist would contact the Care Manager. Transition Specialists are not Care/Case Managers and, therefore, play a supportive role, not a primary case management role.
21	Will MLTC members who have been in a nursing home for 90 days or more be part of the batch disenrollment process?
	MLTC members in a nursing home who are active with Open Doors AND have an ACTIVE discharge plan are excluded from the batch disenrollment process. An active discharge plan means a plan that is being currently implemented for the nursing home resident to return to the community within three months. The resident's care plan has current goals to make specific arrangements for discharge and/or staff are taking active steps to accomplish discharge. An active discharge plan includes situations where the resident: • is currently working with the Local Contact Agency (Open Doors); and/or • has a Transition Plan in place, which has been incorporated into the resident's Discharge Plan; and/or • has an expected discharge date of three (3) months or less.
22	Does an MLTC member need to disenroll from Managed Care in order to be referred to Open Doors?
	Managed Care members can participate with Open Doors. MLTC members do not have to disenroll from MLTC in order to be enrolled to Open Doors. Open Doors is not an insurance-based program.

Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

Refer to the following federal guidance for more information:
https://www.hhs.gov/sites/default/files/mds-guidance-2016.pdf

23	Can Open Doors help a participant to change programs if it is found that people are not appropriate for the MLTC program or another waiver program (i.e., needing supervision for safety but not having that as a covered benefit on MLTC programs, but it can be with an NHTD or TBI Waiver)?
	Making referrals to another program, such as the NHTD or TBI waiver, would be the primary responsibility of the care manager. Transition Specialists are not case managers. Transition Specialists can assist with coordination and follow-up on a referral and can assist participants to explore other options for services.
24	How will it be determined if the person is safe to self-administer their medications?
	Transition Specialists and/or other Open Doors staff do not make clinical decisions regarding safety or ability to self-administer medication. Transition Specialists will help the participant to explore training, adaptive equipment, or other supports that can assist with medication administration.
25	Who will provide transportation to get the person to go look at where they may live?
	The nursing home is responsible for arranging transportation for the resident.
26	What is the MLTC Housing Disregard?
	New York State has a special income standard to help pay for housing expenses for MLTC members who are Medicaid eligible and can safely transition back to the community. The special income standard, called the MLTC Housing Disregard, permits an individual to retain income for housing expenses. Information about the MLTC Housing Disregard can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-02.htm
27	Does LDSS know about the MLTC Housing Disregard?
	Local Department of Social Services (LDSS) staff should know about this special income standard. However, newer LDSS staff may need to be reminded. The MLTC Housing Disregard special income standard (MLTC Housing Disregard) is applied by the LDSS/HRA. They may need to be prompted to use the higher income limit when calculating the community budgeting levels. The LDSS/HRA may not be aware that the person is leaving a nursing home. This is the link to the GIS about the housing disregard that can be provided to LDSS/HRA staff: https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/18ma012.pdf

Questions and Answers
Money Follows the Person Program/Open Doors Presentation to MLTC plans
January 10, 2022

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	The link to the Open Doors video can be found at: Open Doors video. The link is also
30	Are there continuing education credits for Nurses, Social Workers or Care/Case Managers for this presentation?
	No. We are not able to offer continuing education credits for this presentation.
31	Will you be sharing the slides with the attendees?
	Yes. The PowerPoint slides will be shared with attendees and posted to the DOH webpage.