DIVISION OF MEDICAL ASSISTANCE

Home and Community Based Services

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Money Follows the Person

- MFP is a state demonstration project that assists people who live in inpatient facilities to move into their own communities with supports.

- The Project's intent is to support North Carolinians to have greater choice about where they receive their long-term supports.

- The Project also helps identify and address barriers to receiving quality, community-based, long-term care and supports.

NC Community Transitions Institute: Ensuring Quality Transitions to Community Life

- In collaboration with community partners, DHHS will soon launch a pilot initiative that provides a collective learning opportunity for professionals who assist individuals with long-term care needs to transition from facility settings to their homes and communities.

- The NC Community Transitions Institute creates a learning community among participating transition coordinators, care managers, care coordinators, discharge planners, options counselors and others in order to collectively deepen the skills and approaches necessary to best ensure a quality transition.

Goals for the Institute

- Piloting a learning opportunity that:
  - Includes quality content immediately relevant to the practice of supporting a transitioning individual;
  - Strengthens Institute members' knowledge of and utilization of person-centered practices and motivational interviewing techniques;
  - Determines which training methods/approaches are most effective in conveying practical application of information and fostering collaboration among Institute members.
- Collect clear data on the efficacy of the Institute and clear recommendations for improvements, including both content and approach

Community Alternatives Programs (CAP)

- Currently, there are three Community Alternatives Programs that help people who need long-term care stay in their own homes. CAP provides both medical and non-medical services to prevent or delay care in a facility.

  - ✓ **Disabled Adults (CAP/DA)** provides an array of home and community-based services to adults with disabilities 18 years of age and older who are at risk of institutionalization.
  - ✓ **Children (CAP/C)** also known as the *Katie Beckett waiver* provides home and community-based services to medically fragile children who, because of their medical needs, are at risk for institutionalization in a hospital or nursing home.
  - ✓ **CAP/Choice**, an option under the CAP/DA program, is consumer-directed care for disabled adults who wish to remain at their primary private residence and have increased control over their own services and supports.

Community Alternatives Programs (CAP)

- In 2009, DMA received a legislative mandated to consolidate case management and waiver functions; in 2011, DMA implemented a plan to consolidate the CAP waivers to streamline waiver processes and case management functions.

- The Community Alternatives Program Waiver for Children (CAP/C) will expire June 30, 2015. DMA will need to submit a renewal waiver application for continuity of waiver planning.

  - ✓ The CAP/DA waiver application was submitted and approved by CMS in the fall of 2013
  - ✓ The renewal CAP/C waiver application that will be submitted to CMS will combine the CAP/C and CAP/DA waivers.

CAP Merge

- The newly proposed CAP waiver will serve Medicaid beneficiaries between the ages of 0-155+ who are disabled and are at risk of institutionalization.

- Waiver beneficiaries between the ages of 0-20 must meet the criteria of medical fragility in addition to being disabled in order to participate in the waiver.

- The waiver will serve a limited number of Medicaid beneficiaries based on the Medicaid allotted resources.

  - ✓ 11,214 unduplicated individuals between the ages of 18-155+ are able to receive waiver services in a given year.

  - ✓ 4,000 unduplicated individuals between the ages of 0-20 are able to receive waiver services in a given year.