N.C. Department of Health and Human Services

An Introduction to NC MFP

May, 2016

North Carolina MFP MONEY FOLLOWS THE PERSON

NC

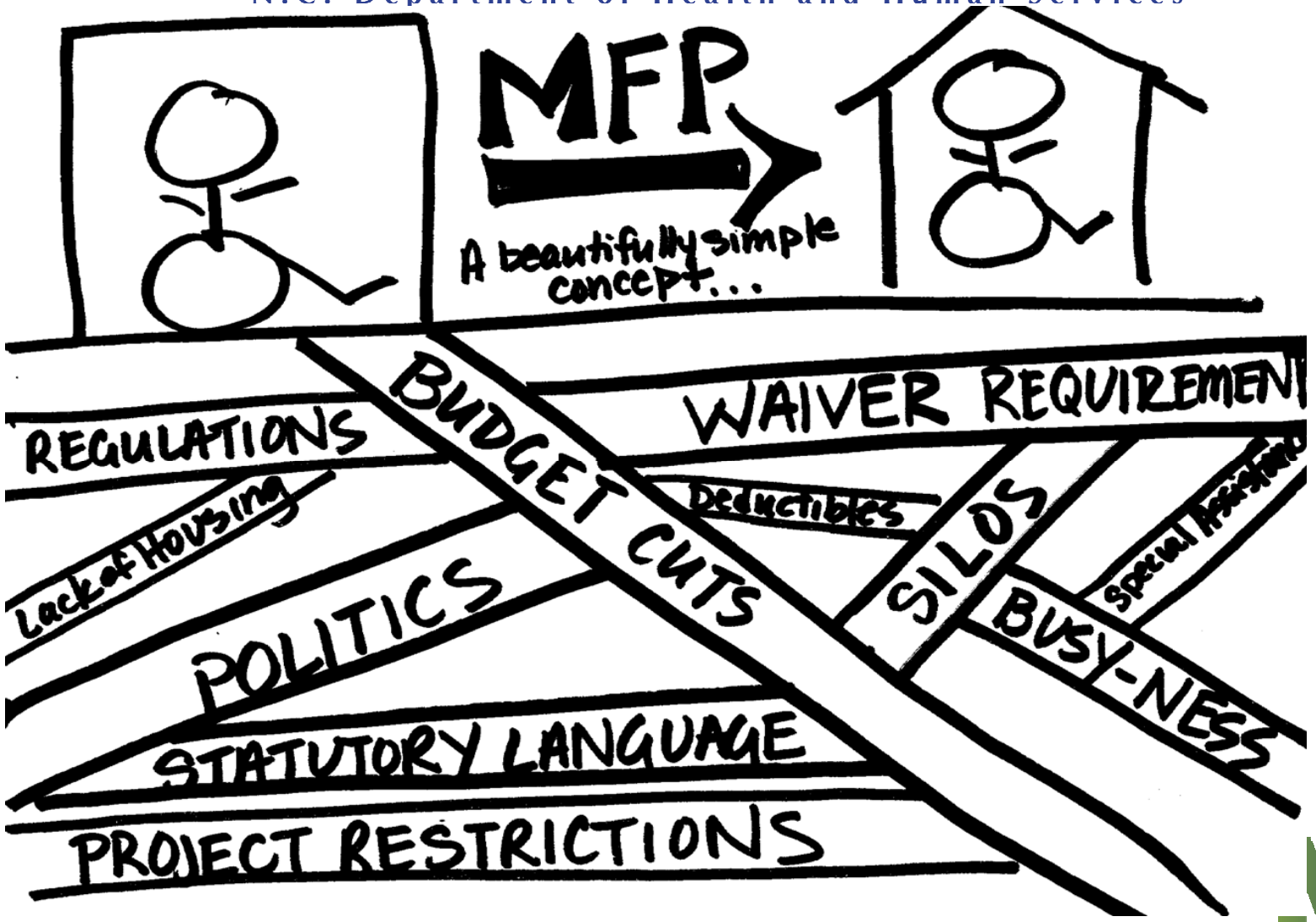
Today's Presentation

- Part I: MFP Refresher/101
  - What MFP is
  - Who it serves in NC
  - How the transition process works
  - How to make an MFP application
- Part II: Where we are going over next few years
- Feel free to pose questions in the chat box!

What is MFP?

A beautifully simple concept….

An opportunity to support people to transition into their homes and communities.


MFP
A beautifully simple concept...
REGULATIONS
BUDGET CUTS
WAIVER REQUIREMENT
Lack of Housing
Deductibles
SILOS
Special Application
POLITICS
BUSY-NESS
STATUTORY LANGUAGE
PROJECT RESTRICTIONS

MFP: 2 Primary Purposes

- Support the transition process
- Systems change:
  - Increase Home and Community Based Services
  - Eliminate Barriers
  - Continued Provision of Services
  - Quality Improvement

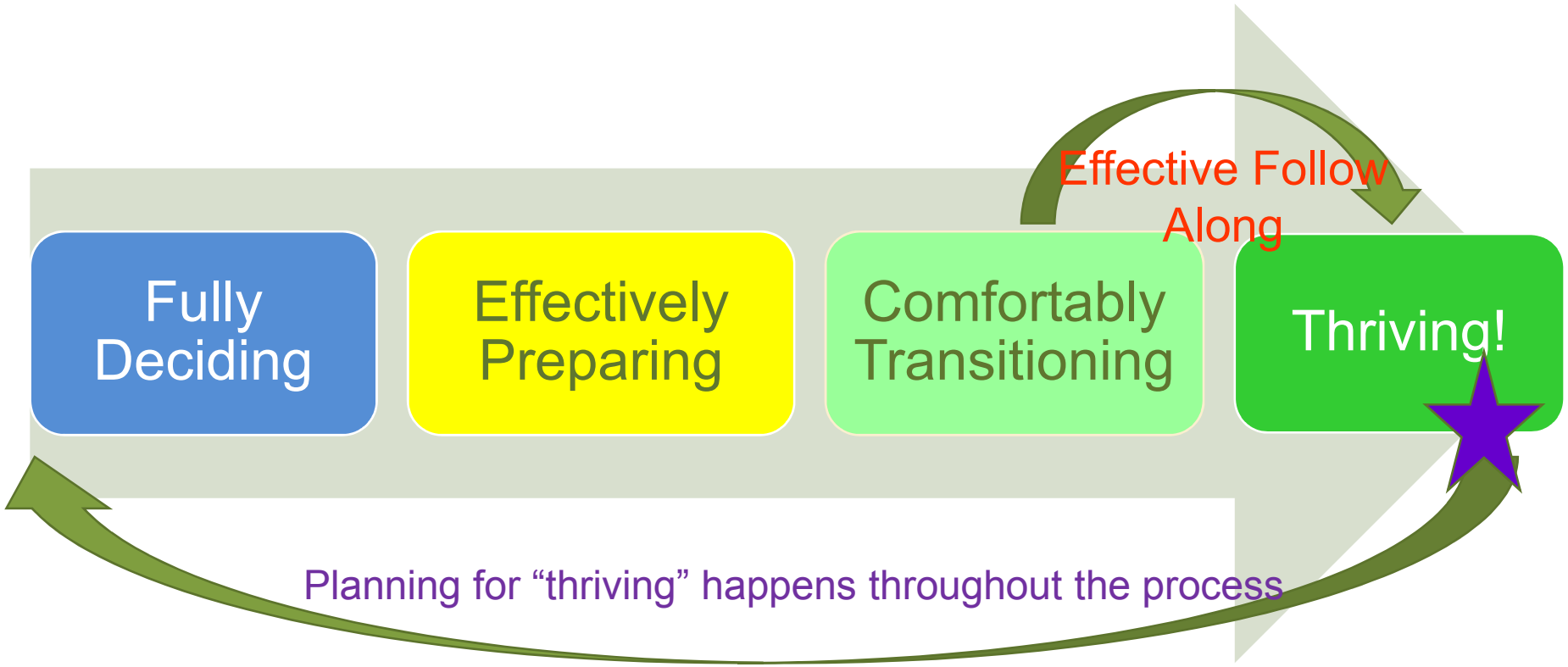
If we only support people to transition,
we're only doing half our job.

A Quick History Lesson

- A Public Initiative and a Community Effort
  - Grass-roots advocacy + Medicaid management
- 2005: Federal MFP legislation (extended in 2010).
- 2006: NC application
- 2009: Transition services begin
- To date, MFP has supported nearly 675 transitions
- 2018: NC MFP ends transition activities, but transitions will continue!

So, when we say "transitions…"

The Aspirational Stages of Transition Planning



"So.....exactly who does MFP serve and what do you do?"

"The MFP Demonstration Project will transition qualified individuals from qualified inpatient facilities to qualified residences in the community."

What does this mean?

NC MFP Focuses On 3 Primary Populations

NC MFP Eligibility on a Page…

Who Can Apply for NC MFP:

- Medicaid eligible residents of:
  - Nursing Facilities
  - ICFs-IDD
  - State Developmental Centers
  - PRTFs if also qualifies for Innovations
  - State Psych hospitals in extremely limited situations.
  - NOT adult care homes
- Resident must have been in facility setting (or combination of) for three months prior to transition.
  - Medicare Part A Rehab considerations
  - Timeframe may include time in acute care settings.
  - Three months must be continuous.

Who Can Transition Under NC MFP

- MFP participants who meet the criteria for:
  - Innovations waiver
  - CAP DA
  - PACE

NC MFP's Benefits to the Individual…

- CAP/Innovations slot or PACE participation
  - Project pays for first year, becomes regular waiver slot afterwards.
  - NO change to waiver services---just more support through MFP for the transition time.
- Start up funding to assist in transitions
  - Broadly construed: furniture, ramps, services (like therapeutic consultation, staff training, etc.)
- Additional case management
- Transition coordination support
- Priority access to housing subsidies

The MFP Transition Process

- Every transition is unique, facing different issues and different circumstances.
- Transitions can take a few weeks to several months.
- Not everyone will need MFP to transition.
- Not everyone transitions.
- Transitions are collaborative between MFP transition coordinators, participants, supports and facilities.
- Person guides process.

Who Coordinates the Transition

For MFP participants who have IDD:

- LME/MCOs coordinate transition planning; Innovations waiver enrollment and MFP Innovation waiver slot allocations.
- Each MCO has transition coordinators specifically trained to support MFP participants.

For MFP participants who are residing in Nursing Facility

- MFP partners with different transition coordinator contractors in each region.
- MFP has long-standing partnership with DVR-IL
- CAP DA case managers or PACE staffers work in partnership with MFP transition coordinators and are responsible for enrollment into specific CAP DA or PACE program.

Occasionally, MFP will receive an application from someone who is in a nursing facility but is also eligible for IDD services. NC MFP will work to ensure all transition partners are brought together.

Coming Soon: Revised Map

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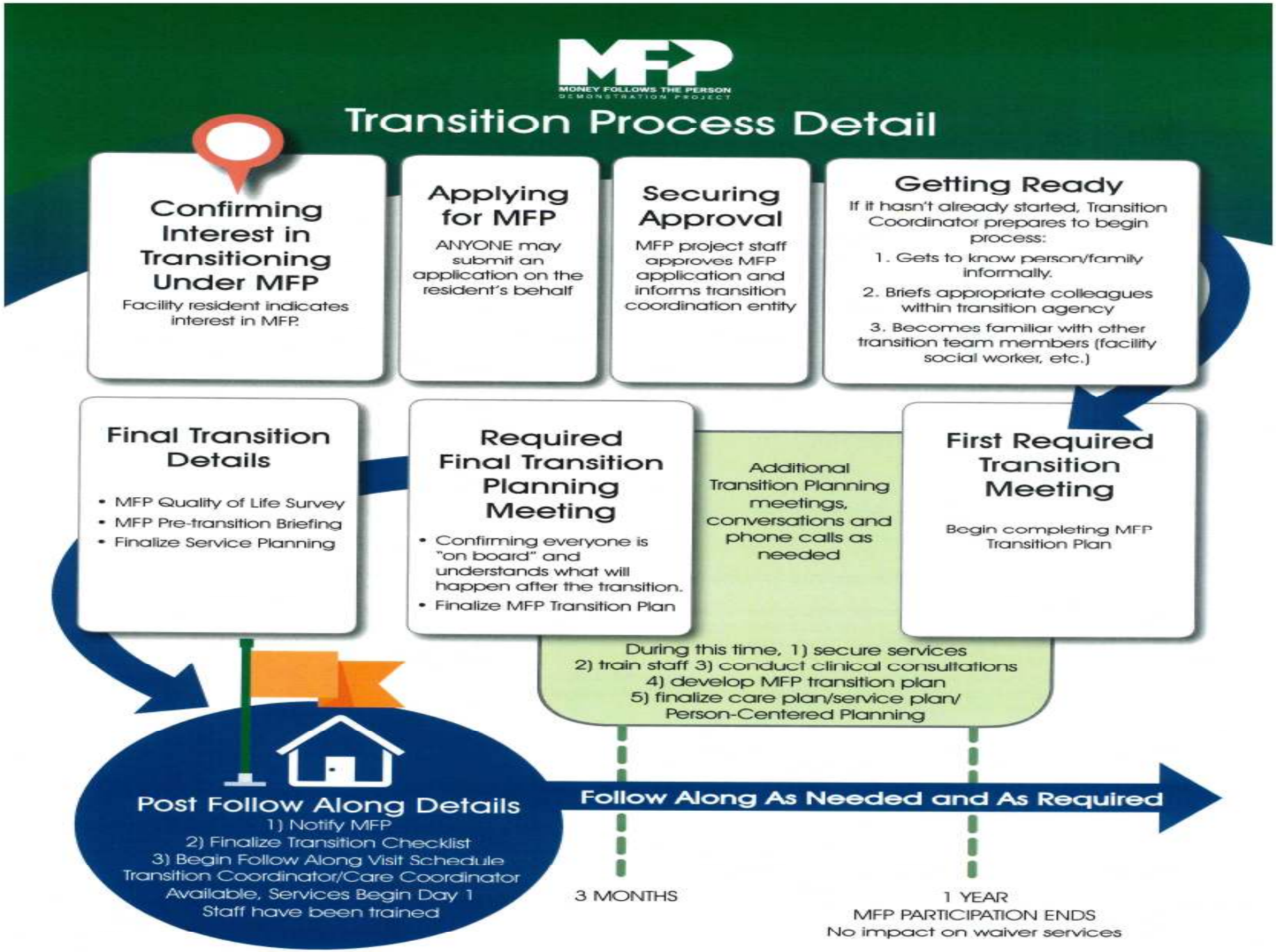
How to Make an MFP Application

NC MFP Application Information

- Application forms available at: http://dma.ncdhhs.gov/providers/programs-services/long-term-care/money-follows-theperson
- Anyone can submit a referral.
- Referral takes about a week to process.
- Approval for MFP does not guarantee approval for waiver or PACE program.

What Will Happen after Application is Submitted?

- Application Reviewed by MFP staff
  - If questions or concerns, will follow up with submitting entity
  - If ok, will approve.
- Linkage email sent to all anticipated partners who have an email address:
  - Transition Coordinator, waiver team, facility, others
  - Challenge: communicating approval to resident.
- Transition coordinator will reach out to resident/family/social worker to introduce self and gather some primary information.
- Transition planning meetings, integrating housing search and solidifying natural support.


MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT
Transition Process Detail
Confirming Interest in Transitioning Under MFP
Facility resident indicates interest in MFP.
Applying for MFP
ANYONE may submit an application on the resident's behalf
Securing Approval
MFP project staff approves MFP application and informs transition coordination entity
Getting Ready
If it hasn't already started, Transition Coordinator prepares to begin process:
1. Gets to know person/family informally.
2. Briefs appropriate colleagues within transition agency
3. Becomes familiar with other transition team members (facility social worker, etc.)
Final Transition Details
• MFP Quality of Life Survey
• MFP Pre-transition Briefing
• Finalize Service Planning
Required Final Transition Planning Meeting
• Confirming everyone is "on board" and understands what will happen after the transition.
• Finalize MFP Transition Plan
Additional Transition Planning meetings, conversations and phone calls as needed
First Required Transition Meeting
Begin completing MFP Transition Plan
During this time, 1) secure services
2) train staff 3) conduct clinical consultations
4) develop MFP transition plan
5) finalize care plan/service plan/
Person-Centered Planning
Post Follow Along Details
1) Notify MFP
2) Finalize Transition Checklist
3) Begin Follow Along Visit Schedule
Transition Coordinator/Care Coordinator
Available, Services Begin Day 1
Staff have been trained
Follow Along As Needed and As Required
3 MONTHS
1 YEAR
MFP PARTICIPATION ENDS
No impact on waiver services

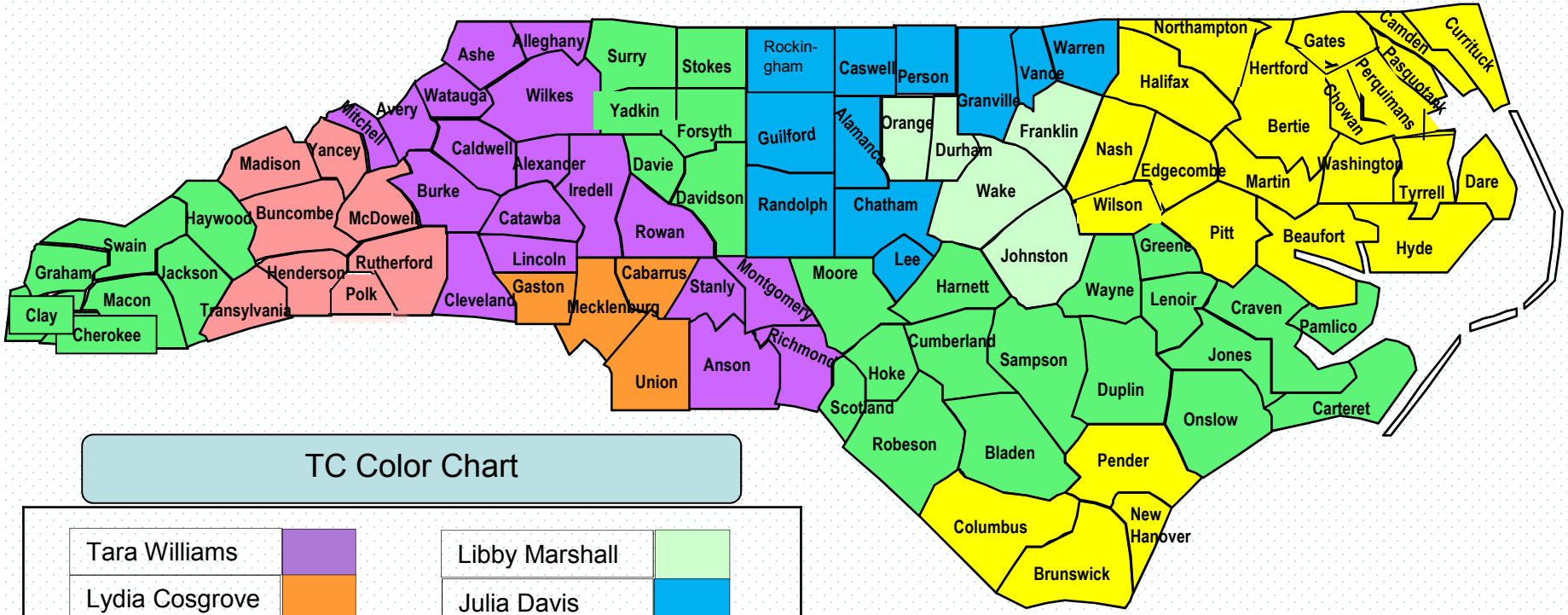
MFP Transition Coordination:

DVR-IL & CILs*

WESTERN REGION
-Tara Williams: DVR-IL
-Lydia Cosgrove: DR&R
-Vacant position: DVR-IL

CENTRAL REGION
-Libby Marshall: Alliance
-Julia Davis: DVR-IL

EASTERN REGION
-Becky Tyndall: DVR-IL



TC Color Chart

Tara Williams		Libby Marshall	
Lydia Cosgrove		Julia Davis	
Vacant Position		Becky Tyndall	

Indicates another TC entity

***AAAs, CAP-DA Lead Agencies and MCOs also provide Transition Coordination; Please see the counties served by each IL office in the state on page 2.**

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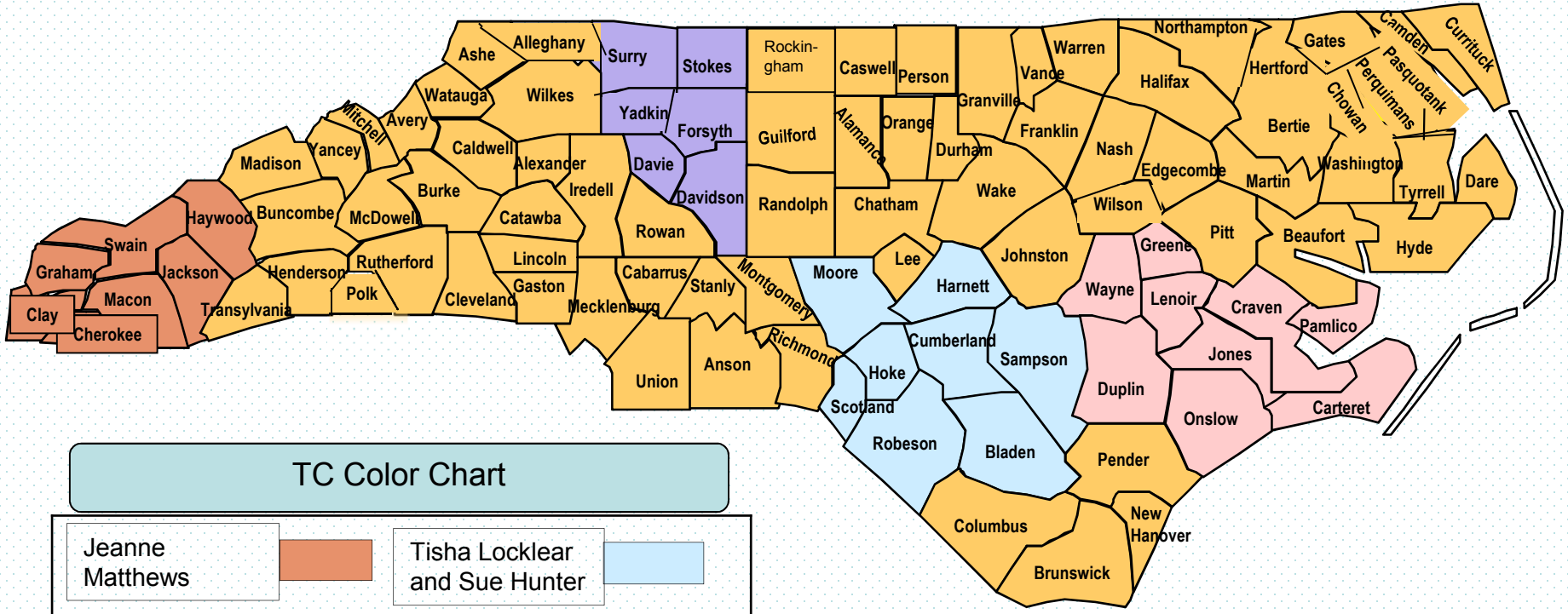
Revised 6/2016

MFP Transition Coordination:
AAA and CAP-DA Lead Agencies*

WESTERN REGION
-Jeanne Matthews: SW AAA

CENTRAL REGION
-Diane Baker and Angie Wall:
Senior Services CAP-DA

EASTERN REGION
-Tisha Locklear and Sue Hunter:
Cape Fear Valley Health
-Andi Reese: ECCOG AAA



TC Color Chart

Jeanne Matthews		Tisha Locklear and Sue Hunter	
Diana Baker and Angie Wall		Andi Reese	
Indicates another TC entity			

***DVR - IL and MCOs also provide Transition Coordination.**

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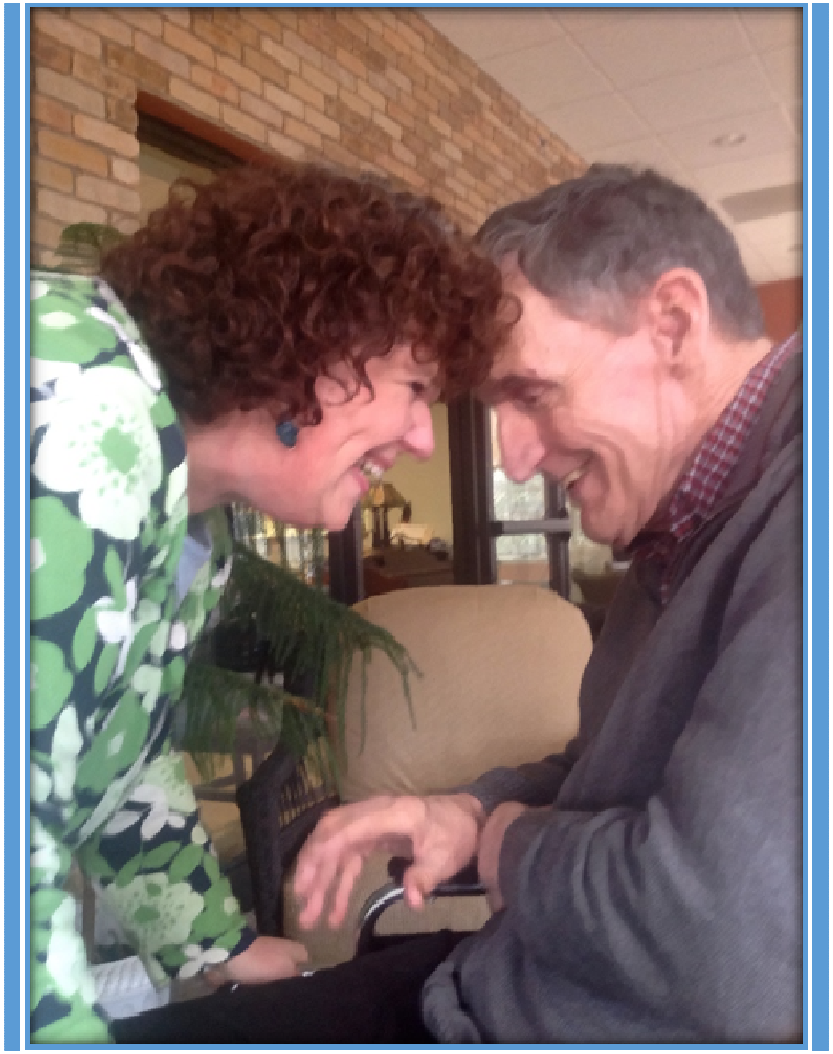
Revised 7/2016

What We Know Works in Transition Planning

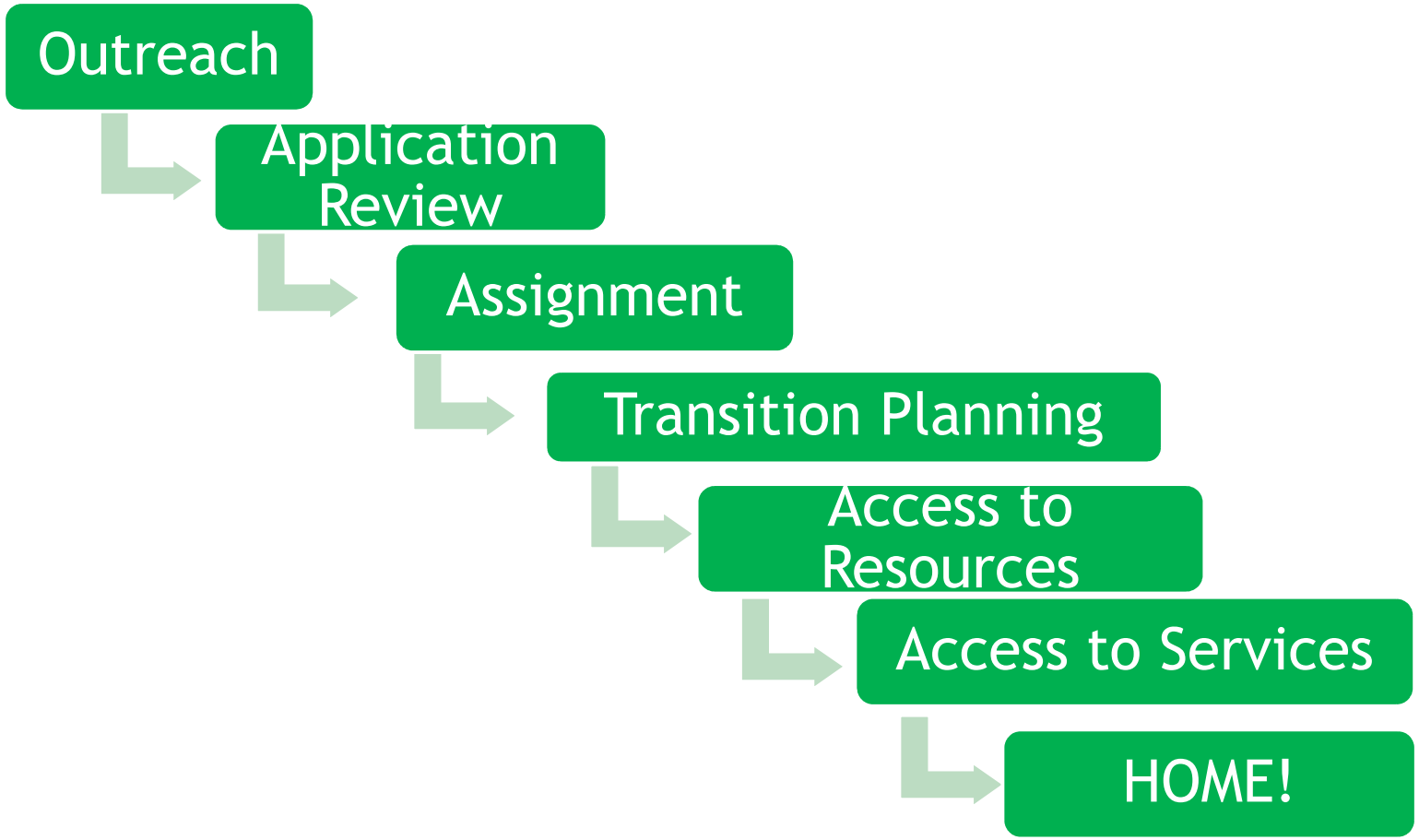
- Participants/their families or guardians are central in the planning
- Services identified, available and staff trained *prior* to transition.
- A clear “good fit” between staff/AFL and person.
- Strong, clear, ample communication between transition team members.
- Making sure key details are clearly identified and addressed prior to transition.
- Ensure behavioral supports
- Effective follow along—troubleshoot early.
- Services/supports must remain coordinated and cohesive after the transition.

So How Will Our Time Be Spent Over the Next Few Years?



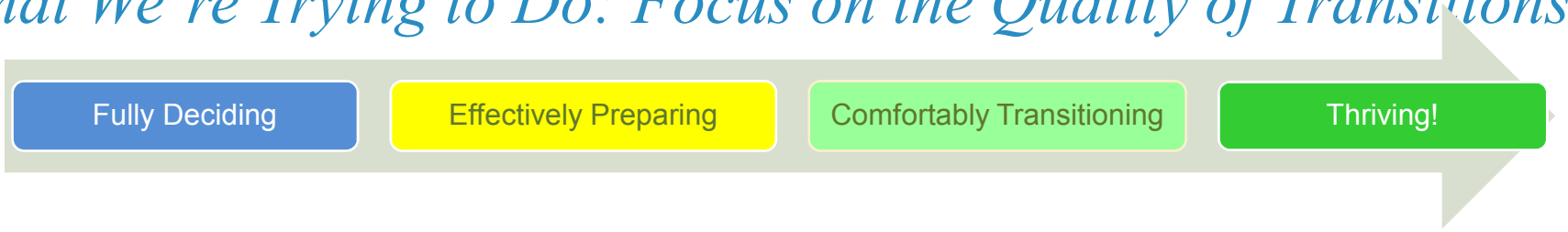
- Improving transition practices
- Helping shape a person-centered LTSS system
- Check out our NC MFP Sustainability Plan

Analyzing the Steps of Our Process



Working to Address the Challenges

What We're Trying to Do: Focus on the Quality of Transitions



- In partnership with DVR-IL, expand transition coordination network.
- CAP DA case management transition coordination pilot
- Develop relationships with other services to streamline access to needed services:
  - TBI
  - Mental Health Partners
  - CCNC
  - Housing
- NC DHHS Community Transitions Institute
- The MFP Lunch & Learn Series
- Guidance Paper development on transition-specific topics such as housing access, working with social security.
- Transition Bridging Project
- Quality of Life and Quality of Transition Support Tracking
- In partnership with DAAS, increase capacities of options counselors

What Stakeholders Told MFP in 2014 Were Our Key Contributions

Clarity to transition function and process

Working around barriers

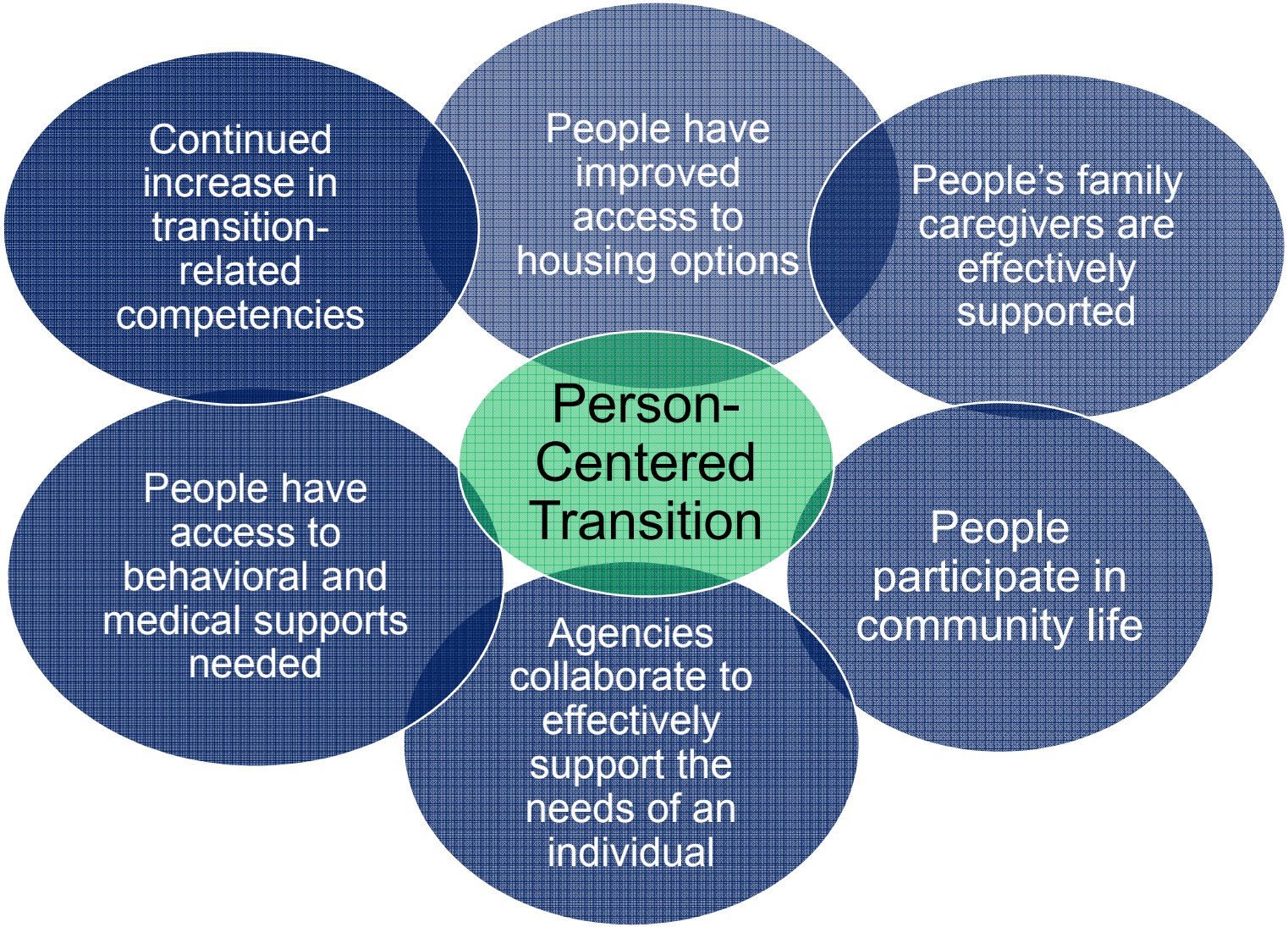
Emphasis on high risk/engagement populations

MFP is a Source of Data

Reducing silos, improving collaboration

Elevating competencies of LCAs, transition coordination function

Helping Develop a More Person-Centered System: Our Framework



Helping Develop a More Person-Centered System: Our Priorities

- Develop opportunities to support and inform person-centered program efforts:
  - Innovations waiver supported living definitions
- Supporting methods for ensuring payment stability of HCBS programs
- Other opportunities for innovation related to:
  - Assistive technology
  - Housing

- The Biggie: Medicaid Reform
  - Informing design of 1115 waiver
  - Supporting upcoming stakeholder engagement efforts

Coming this Summer: LTSS and Medicaid Reform, A Learning Series

All Sessions 12:00-1:00, by webinar

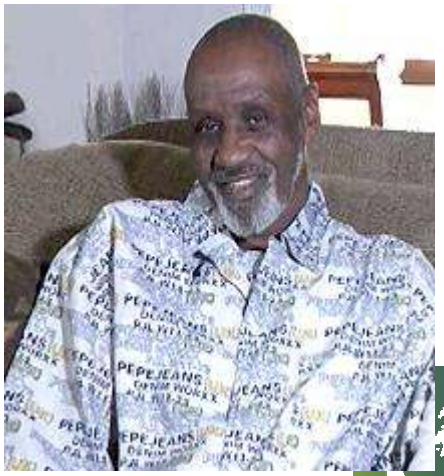
- **Friday, July 8**
  - **Session 1:** Overview intent of Reform, highlighting areas specific to LTSS
- **Friday, July 15**
  - **Session 2:** Managed Care Mechanics 101
- **Friday, July 22**
  - **Session 3:** What NC is Proposing: a Tour of the 1115 Application

We Find that Person-Centered, Community Living Can be Transformative….

"This is a real home…"
-Mandy

"Life is fabulous here."
-Jackie

"People have a great desire to have control over their day-to-day activities, to lead self-determined lives and to be included in their local communities."
-- Henry's DSS Social Worker



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Would you like more information about MFP?

- Join our Roundtable stakeholders' group by emailing: mfpinfo@dhhs.nc.gov
- Next Roundtable Meeting: Friday, August 19 in Asheville
- Visit our Website: http://dma.ncdhhs.gov/providers/programs-services/long-term-care/money-follows-theperson
- Give us a (toll free) call! 1-855-761-9030
- Contact our wonderful local partners!

Questions and Thank You!