Nothing Compares
NORTH CAROLINA

NC MFP: Refresher Overview and Upcoming Opportunities

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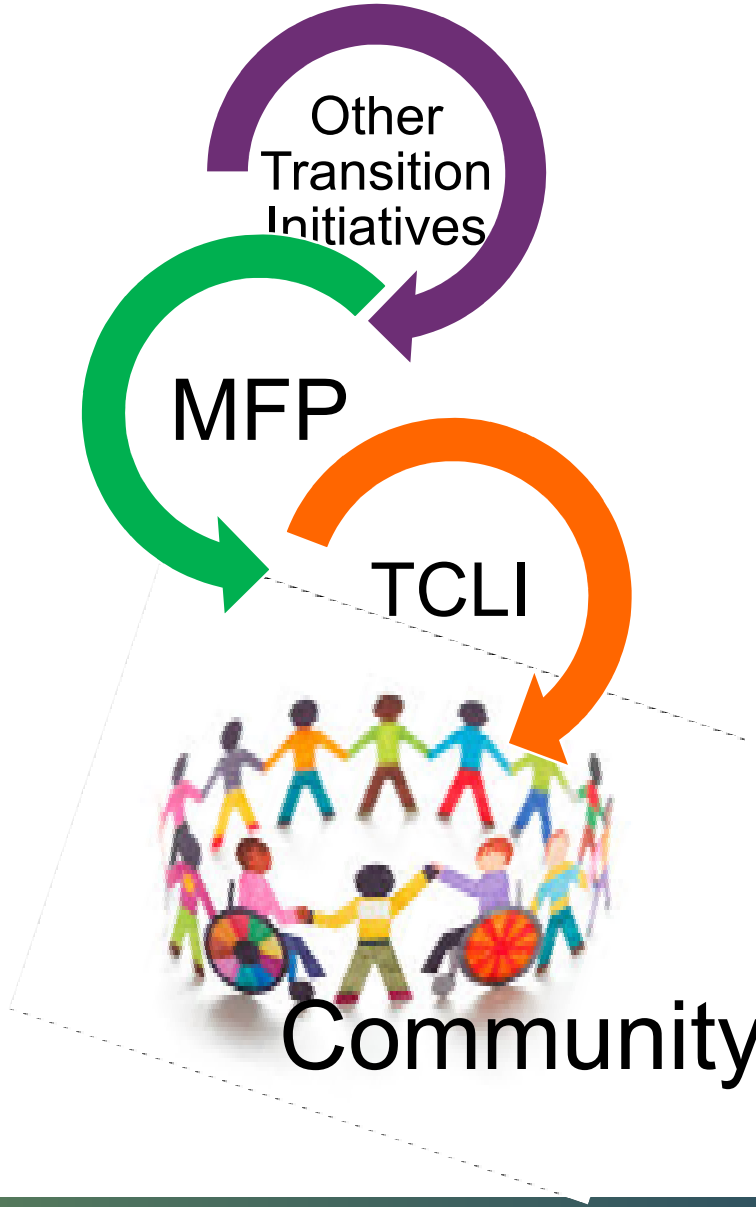
Some Important Transition History: Two Women, A State, and A Landmark Decision

In 1999, the Supreme Court of the US held in Olmstead v. L.C., that under Title II of the ADA, states were required to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. (extracted from ADA.gov)

NC's Transition Efforts



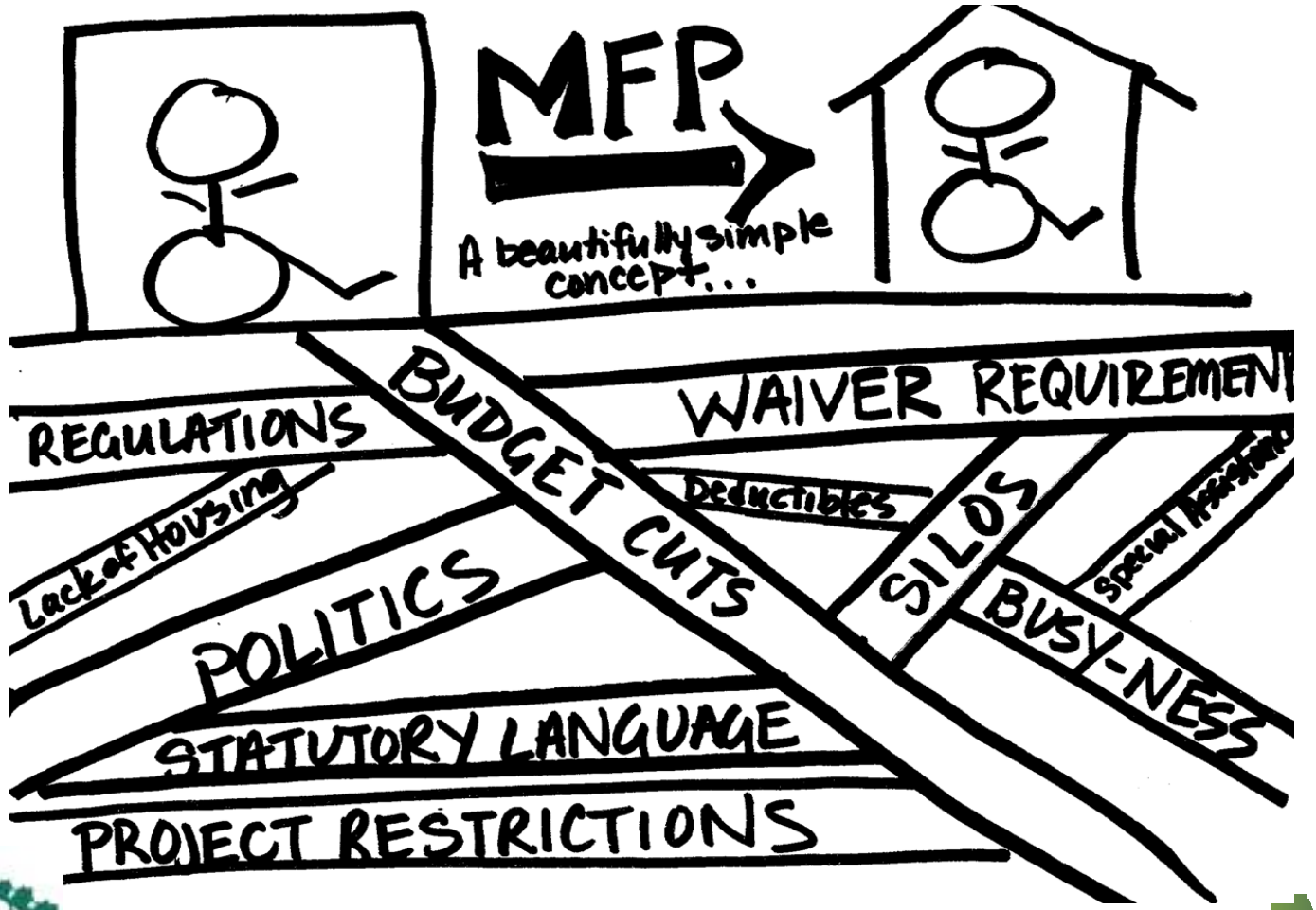
N.C. Department of Health and Human Services

North Carolina's Money Follows the Person Demonstration Project

What is MFP?

A beautifully simple concept….

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



North Carolina MFP
MONEY FOLLOWS THE PERSON

NC

MFP: 2 Primary Purposes

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

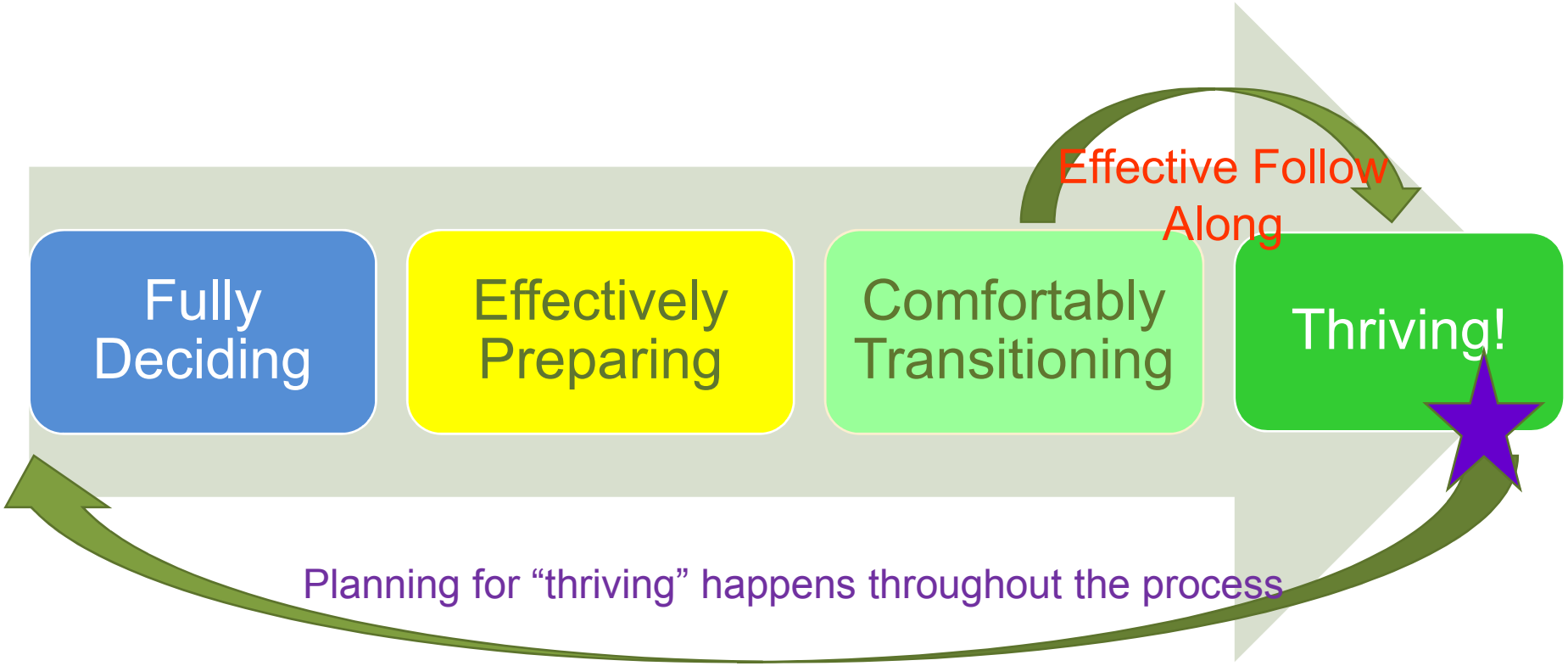
If we only support people to transition,
we're only doing half our job.

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 to have MFP Demonstration Project
- 2009: Transition services begin
- To date, MFP has supported over 800 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

Innovations

CAP DA, PACE

NC MFP Transitions Support

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
    - Can't transition into a group home with more than 4 people.
  - CAP DA
  - PACE

NC MFP's Benefits to the Individual…

- CAP/Innovations priority slot or PACE participation
- 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 (Division of Vocational Rehabilitation, Independent Living)
- 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.

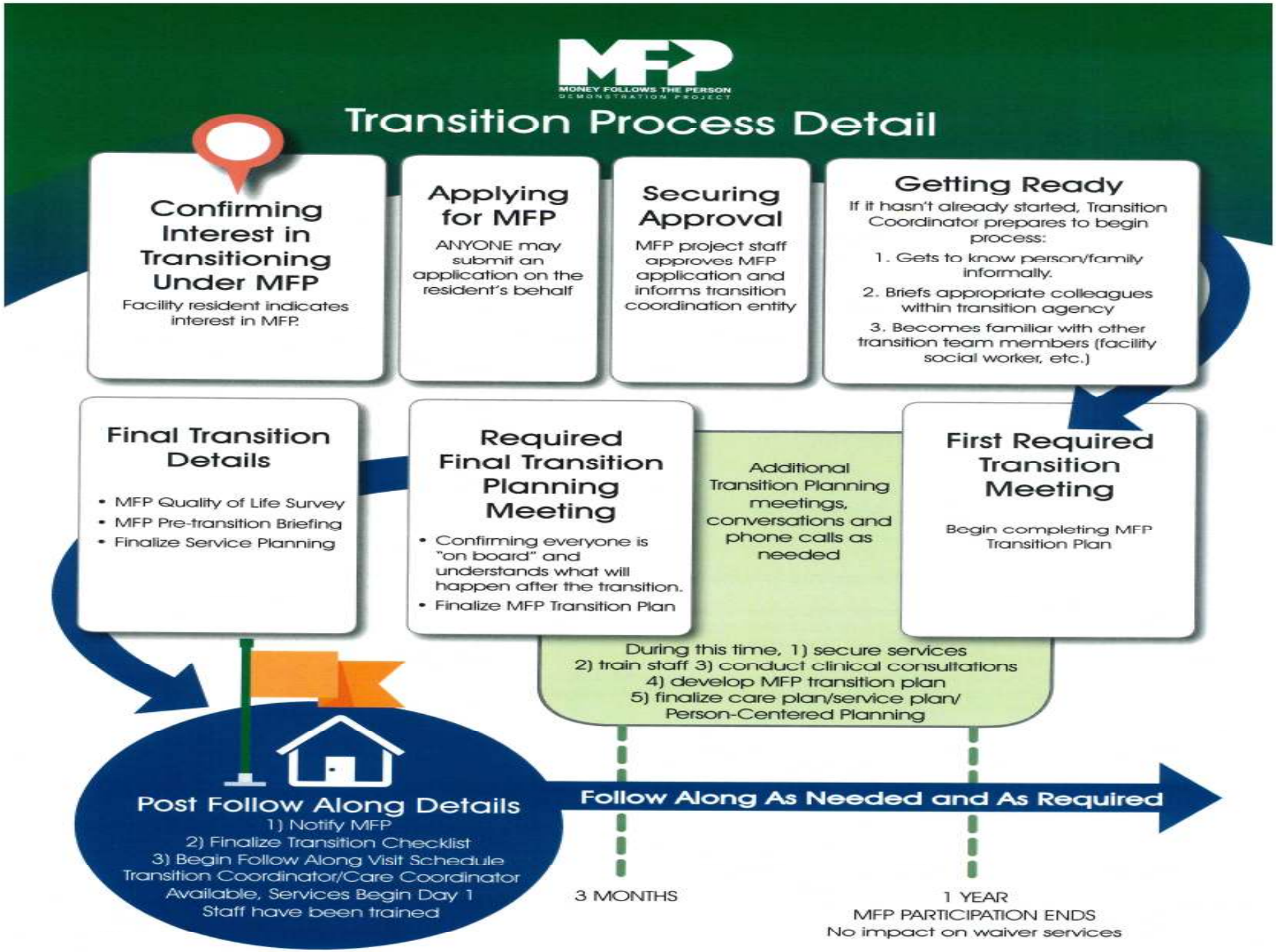
How to Make an MFP Application

NC MFP Application Information

- Application forms available on NC MFP's website
- Applications received and reviewed by MFP staff.
- 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?

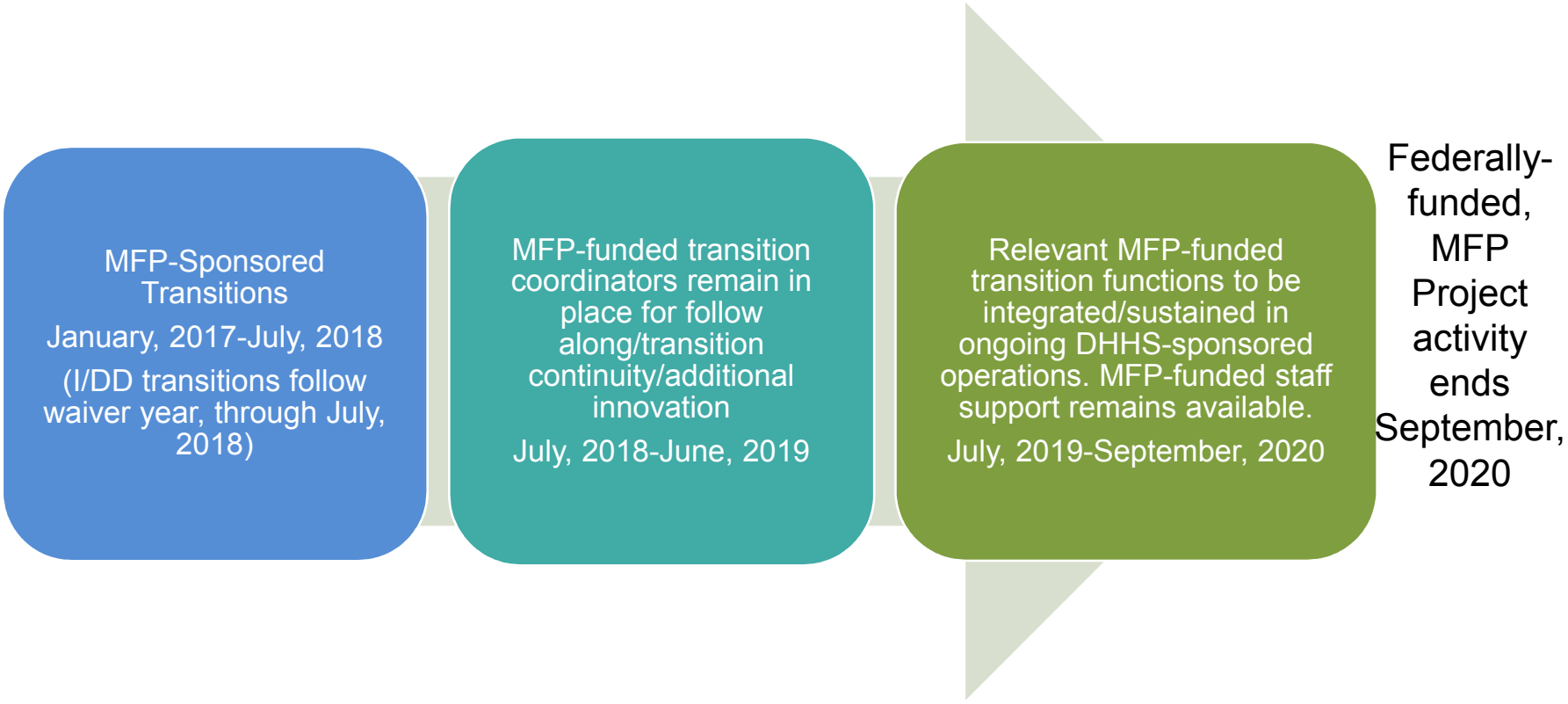
- Application Reviewed by MFP staff
  - If questions or concerns, will follow up with submitting entity
  - If ok, will approve.
- Linkage email sent to all anticipated partners who have an email address:
  - Transition Coordinator, waiver team, facility, others
  - Challenge: communicating approval 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

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.

NC MFP's Transition Activity Timeframe



Importantly, MFP will eventually go away, but quality transition activity should not.

Navigating the change that will come

When nothing is sure,
everything is possible.

Margaret Drabble, writer

NC MFP in an Ever-Changing Landscape: Internal Restructuring

- NC MFP now a part of the Special Initiatives Team within DMA
- Current priorities are:
  - Transition Policy
  - Medicaid Reform/Transformation (primarily related to Duals integration, care coordination/transition, Innovation)
  - Housing
- Trish now AD of Special Initiatives
- MFP Project Director recruitment process underway
  - Hoping to be finalized this month.
- Playing to strengths: MFP Project Director will focus on I/DD population and overall project management. MFP Assistant Director remains lead on Aging and Disability transitions.

NC MFP in an Ever-Changing Landscape: Within the State

- NC MFP will formally continue transitions through June, 2018, with follow along through June, 2019.
- Developing projections to sustain transition coordination function using Rebalancing Funds after formal MFP transitions end to ensure continuity if needed until reformed system is operational.
- The goal is seamless continuity of transition activity.
- Medicaid Transformation remains underway.
  - Focus on shift to managed care
  - Development of a new Medicaid division.
- Timelines are still soft for a variety of reasons but it is possible that managed care plans will start “going live” by 2020.
- Intent is for transition coordination function to be embedded in plan design, but not yet known.
- New President, New Governor, New Secretary

NC MFP in an Ever-Changing Landscape: The Federal Perspective

- Technically, MFP's federal grant allocation ended in 2016. This had always been the plan under ACA. No changes.
- The federal discussions about "Obamacare" and "Repeal and Replace" are relevant to LTSS and Medicaid and, based on information we have to date, will not likely have any immediate impact on MFP's current transitions or operations. Importantly, this landscape changes daily and may impact the long-range direction of MFP's goals, so it's important to pay attention to the discussion.
- Good resources/listserves to follow if interested:
  - NASUAD: http://www.nasuad.org/
  - Kaiser Health News: http://khn.org/
  - Manatt: https://www.manatt.com/Health

Additional Updates: The Beginnings of a Transition Policy Agenda

(Developed in Partnership with TCLI, DHHS Colleagues, Transitions Institute Members, MFP Roundtable and Other Stakeholders)

The Beginnings of NC Medicaid's Transition Policy Agenda

1. Supporting Quality Transitions: Partnering with others to determine how to most effectively sustain quality transition-related functions for long-term care transitions.

2. **Revised: Supporting Quality Transitions: "The 'Day One' Priority: Partnering with others to help ensure eligibility and enrollment processes do not cause lag or gap in services.**

3. Supporting Quality Transitions: *Meet No One Naked!* Ensuring People Who Are Transitioning and their Community Support Staff have Pre-Transition Opportunities to Meet and Learn about Each Other.

Preliminary Medicaid Transition Policy Agenda (continued)

4. **Revised:** Supporting Quality Transitions: Improving long-term care coordination of care at the time of hospital discharge and among various community-based services and programs. This includes long-term supports, housing and clinical supports.

5. Supporting Quality Transitions: Develop and Sustain Professional Development Opportunities for Transition-Related Capacities

6. Supporting Community Capacity: Support Opportunities to Support Family Caregivers

Preliminary Medicaid Transition Policy Agenda (continued)

7. Supporting Community Capacity: Ensure Transitioning Beneficiaries Have Expanded, Person-Centered Housing Options and Tenancy Supports

8. Supporting Community Capacity: Expanding Access to Assistive Technology and other Support Services to Enable People to Remain in and Return to their Homes and Communities

9. Supporting Community Capacity: Addressing Institutional Bias for Medically Needy Beneficiaries.

10. Supporting Quality Systems Design: Inform Long-Term Medicaid Program Design, including how to address current gaps in coordination of care.

11. Supporting Quality Systems Design: Provide Support to DHHS Olmstead Planning

Contributing to the Long-Term Medicaid Direction: Informing the NC's 1115 Waiver Application

NC Section 1115 waiver application includes LTSS-related goals that health plan design should address [Section 2.3.1.4]. [DEAC edits reflected]
Support and build a system that promotes consumer choice.
Build upon current system by ensuring continued access to facility-based services when necessary, and expanding the continuum of services and variety of settings in which to receive them, including expanded access to home and community-based service.
Promote use of enabling technology to further the waiver's LTSS-related goals; promote health and quality outcomes such as hospitalization prevention; and improve communication among supporting providers.
Invest in service strategies that prevent, delay or avert need for Medicaid-funded LTSS through appropriate upstream interventions.
Recognize and bolster key role family caregivers and other natural supports play in supporting beneficiaries with long-term care needs.
Ensure that LTSS beneficiaries have access to, as needed, hands-on streamlined service. Coordination that is responsive to their clinical and social needs, and fosters a holistic/whole person approach to care.
Focus on care transitions and opportunities for early interventions related to transition planning.

A Polling Opportunity

Some of our priorities are a “given” for us or will be best addressed by our HCBS colleagues. We want to focus on those things that MFP is best-positioned to address.

1. Day One and Coordination of Care: Help ensure eligibility and enrollment processes do not cause lag/gap in services. Improving coordination of care among programs and disciplines at time of discharge. [In partnership with TCLI]

2. Meet No One Naked—ensuring access to pre-transition staff training

3. Develop and sustain professional development opportunities for transition-related capacities (like the Lunch and Learns, the Transition Institute, etc.)

4. Supporting Expanded Access to Housing, Tenancy Support Initiatives and Assistive Technology that Support People to Return to and Remain in their own homes.

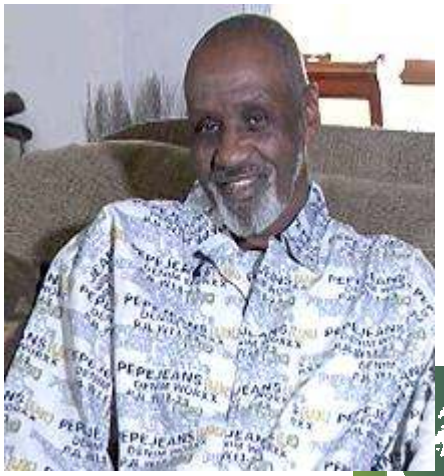
5. Working to address Institutional Bias for Medically Needy Beneficiaries (the Deductible)

And Why This All Matters: 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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NC

Would you like more information about MFP?

- Interested in collaborating on these initiatives? Please send an email to Lakeisha.Laporte@dhhs.nc.gov
- Join our Roundtable stakeholders' group by emailing: mfpinfo@dhhs.nc.gov
- 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!