MERCER
MAKE TOMORROW, TODAY

MFP SUSTAINABILITY ANALYSIS SUMMARY OF RECOMMENDATIONS

SHORT-RANGE RECOMMENDATIONS

IN-REACH/MARKETING/READINESS

1.	Amend Minimum Data Set (MDS) Data Use Agreement (DUA) to access Section Q data.
2.	Based on analysis of MDS data make referrals to Local Contact Agency (LCA) for in-person in-reach activity.
3.	Reinforce existing contractual requirements in LCA contracts that require LCA staff to help with the completion of Money Follow the Person (MFP) application while in-person with nursing facility resident and then submitting directly to the State.
4.	Develop a comprehensive marketing strategy for MFP program or future transition program.
5.	Consider hiring a dedicated marketing/outreach contractor.
6.	Develop or re-deploy MFP marketing materials including, but not limited to, video, posters, etc.
7.	Post MFP posters alongside Long Term Care (LTC) Ombudsman posters within facilities.
8.	Post a recorded webinar regarding MFP and Home and Community Based Services (HCBS) options on MFP website for nursing home social workers.
9.	Work with Traumatic Brain Injury (TBI) partners to develop targeted training for hospitals and nursing facilities regarding services/programs for individuals with a brain injury.
10.	Develop readiness assessment to be used by transition coordinators that includes psychosocial impacts of transition into the assessment.
11.	Include Substance Use Disorder (SUD) screening in readiness assessment.
12.	Develop and implement a family readiness assessment to help educate families about their caregiving role.

TRANSITION COORDINATION

13.	Increase visibility of incident management by expanding access to Emergency Department (ED) use and hospitalizations data.

SHORT-RANGE RECOMMENDATIONS	
14.	Increase the number of transition coordinators. Hiring and contracting processes should be reviewed and modified as necessary.
15.	Confirm local understanding of required timelines related to the Community Alternatives Program for Disabled Adults (CAP/DA) assessment and enrollment process. Ensure the process is responsive to both the time-sensitive nature of transition work (i.e., ensure do not lose housing) and the logistical constraints of nursing facility residents (e.g., lack of transportation, etc.).
16.	Staffing incidents together (MFP and Department of Vocational Rehabilitation-Independent Living (DVR-IL)) could help provide a more consistent and effective approach to incident management.
17.	Adding claims level data to the enhanced care management (e-CAP) system or at least adding functionality to connect ED and hospital utilization to the incident management system.
18.	Consider providing access to e-CAP for all transition coordinators for progress input and access to incident information.
19.	Include incident management training in a Lunch and Learn session and in Community Transitions Institute.
CAP/DA WAIVER AND CASE MANAGEMENT	
20.	Institute curriculum or leverage existing CAP/DA training to include additional training on incident management.
21.	Review local CAP/DA agency specific policies that may act as a barrier to transition.
22.	Staffing incidents together (MFP and CAP/DA) could help provide a more consistent and effective approach to incident management.
23.	Address issues related to local variation in practices among CAP/DA Lead Agencies. Recommended strategies include clarification and training on required practices: increased, in-person technical assistance and examination of oversight models (e.g., regionalization, contract agreements, etc.) that promote consistency among local practice.
24.	Provide on-going training to CAP/DA agencies on the philosophy of MFP and community living.
25.	Prioritize individuals who are participating in MFP for CAP/DA waiver assessments.
26.	Review cost neutrality calculations in CAP/DA waiver and evaluate the feasibility of increasing cost cap in order to serve people with more complex needs.

SHORT-RANGE RECOMMENDATIONS	
27.	Review financial eligibility process for all Long Term Services and Supports (LTSS) programs
28.	Provide MFP training to Department of Social Services (DSS) eligibility workers.
29.	Educate CAP/DA case managers on the ability to be on Medicaid Buy-In for Workers with Disabilities (MBIWD) and CAP/DA waiver.

MID-RANGE RECOMMENDATIONS	
IN-REACH/FRONT DOOR	
30.	Work to establish a community-based entity as the front door for LTSS.
31.	Expand in-reach activities to discharging hospital patients and non-Transitions to Community Living Initiative (TCLI) adult care home (ACH) residents.
32.	Complete preadmission screening prior to a nursing facility to ACH admission to discuss HCBS options and to provide seamless follow-up upon admission as needed.
TRANSITION COORDINATION/TRANSITION POPULATIONS/TRANSITION SUPPORT	
33.	Separate transition coordination from CAP/DA case management functions, with each function having coordinated but delineated roles and individual reimbursements.
34.	Consider contractual and Clinical Policy provisions to incent CAP/DA Lead Agency engagement in transition activity.
35.	Include ACHs as a qualified facility from which an individual can receive transition services.
36.	Emphasize availability of State Plan Personal Care Service (PCS) as an allowable “program” that an individual can transition into.
37.	Add transition coordination as a Prepaid Health Plan (PHP) function under NC’s 1115 waiver.
38.	Integrate Community Transition Services (“startup funds”) into 1115 Waiver.
39.	Strengthen State funded transition coordination function to assist with transitions not covered under MFP 2.0 or under the 1115 waiver.
40.	Require as part of their contracts that PHPs include “Staff and Clinical Capacity Building Service”, which allows transitioning individuals and community-based staff to meet and train with each other prior to the transition, as a value-added service to individuals transitioning from institutional settings including ACHs.

MID-RANGE RECOMMENDATIONS	
41.	Review durable medical equipment (DME) clinical policies; consider expanding coverage for items that help support people in the community.
CAP/DA WAIVER/CASE MANAGEMENT	
42.	Amend waivers in order to expand pre-transition case management in CAP/DA and Community Alternatives Program for Children (CAP/C) to be available 180 days prior to the transition.
43.	Add transition coordination, distinct from case management, as a discrete waiver service to the CAP/DA and CAP/C waivers.
44.	Consider regionalization or other administrative mechanisms for creating more consistent practices among CAP/DA agencies.
45.	Explore the possibility of allowing certain waiver services (such as home modifications) that are currently paid to the provider by the CAP/DA agencies be billed directly to Medicaid.
46.	Develop a legislative strategy to identify appropriations necessary to reduce and eventually eliminate waiting lists for CAP/DA and Innovations waivers.
47.	Address NCTracks defects that impact ability for waiver claims payment. Department of Health and Human Services (DHHS) should work with internal and external stakeholders to inventory all known defects and work with NCTracks vendor on the development and implementation plan for addressing all known defects.
48.	Review services that are currently funded with State-only funds to determine if any could be Medicaid services and thus eligible for federal match. Take any savings in State share to invest in more waiver slots.
FINANCIAL ELIGIBILITY	
49.	Add Medicaid eligibility group available under 42 Code of Federal Register (CFR) §435.217 along with Special Income Level (SIL) methodology to CAP/DA waiver. This will allow individuals with up to 300% of the Federal Benefit Rate and who would otherwise be Medicaid eligible in an institutional setting to receive CAP/DA services.
50.	Examine communication protocol between resident, transition team and DSS staff to better ensure responsive communication and to ensure the resident fully understands any anticipated change in Medicaid eligibility early in the transition process. Suggested strategies include mandatory team call with the beneficiary and his/her DSS worker, improved educational materials about the Medicaid deductible, strengthened budget scenario development during the transition process.

LONG-RANGE RECOMMENDATIONS

LTSS SYSTEMS CHANGES THAT SUPPORT CHOICE AND INDEPENDENCE

51.	Manage all Medicaid State funding for LTSS within one budget line item.
52.	Fully fund Special Assistance /In-Home (SA/IH) program or consider flexibility in funding that allows funding for individuals who transition from an ACH to the community to have their Special Assistance funding be available through SA/IH upon transition.
53.	Consider the development of a program to incent ACHs to transition their business model to a more independent/less congregate model.
54.	Continue efforts to expand the availability of affordable/accessible housing, in order to equalize access for all transitioning beneficiaries.
55.	As part of the State's CON process consider including the availability of HCBS available, as part of the bed need determination process.
56.	In North Carolina's future Medicaid managed LTSS (MLTSS) program, transition coordination should remain a discrete and separate service from case management. Payment for the service is the responsibility of the PHP; however, the activity should be delegated to qualified local entities.
57.	The State should include as part of its MLTSS Quality Strategy quality incentives or withholds (depending on the preference of the State) for measures related to diversion, transition and balance of services provided in an institutional vs HCBS settings.
58.	When developing its capitation payment, the State should consider a blended rate for individuals with an institutional LOC regardless of setting (institutional vs community).